2023 Annual Conference of England LMC Representatives

SHEFFIELD LMC EXECUTIVE ATTENDANCE: Alastair Bradley, Krishna Kasaraneni, Gareth McCrea, Danielle McSeveney

THURSDAY 23 NOVEMBER 2023

MORNING SESSION

The morning started with the customary introductions and procedural aspects, followed by a report from Dr Katie Bramall-Stainer, Chair of General Practitioners Committee (GPC) England. Dr Bramall-Stainer presented information about the current state of General Practice. She highlighted the phenomenal value that General Practice offers for the proportional funding that is received, and the impact of dwindling workforce and increasing demand, in parallel with austerity and the long-lasting effect of it on General Practice. The focus of her presentation, backed up with data from a wide range of sources, was about safe working. From a contractual perspective, her presentation suggested that the direction of travel towards 'Modern General Practice' will continue for another year. There is a survey that is coming our way (finance survey for Practice Managers) that will form part of the evidence that the GPC will submit to the Department of Health and Social Care (DHSC).

MOTION 4: COVID VACCINATION PROGRAMME
AGENDA COMMITTEE TO BE PROPOSED BY WORCESTERSHIRE (Dr Gillian Farmer): That conference is dismayed by the inconsistent and chaotic approach of NHS England towards delivery of Covid vaccines, particularly the significant reduction in the IOS payment and the changes to vaccination programme timelines, and asks that GPC England:
(i) negotiates with NHSE to ensure that IOS payments for Covid for future years are increased to at least 2022-2023 levels
(ii) negotiates annual inflationary rises for all vaccination IOS payments
(iii) negotiates that general practice is offered terms no less favourable than pharmacies
(iv) demands that, in the future, general practice is given at least six weeks' notice in advance of any changes in the timeline of the Covid vaccination programme, or additional funding should this lead time not be met
(v) rejects any future vaccinations programmes that have an IOS payment less than previously agreed and will strongly advise the profession to decline signing up.

The debating part of the conference started with the motion on the Covid vaccination programme and the decreased funding for the programme in 2023-24. Not surprisingly, there were no speakers against the motion for all the obvious reasons, and the motion was passed.

MOTION 5: ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
LEEDS (Dr Lucy Clement): That conference, in recognition of the increased awareness and identification of ADHD, expected prevalence rates, significant secondary complications and impact on an individual, the NHS, the wider system, and society as a whole; we demand:
(i) the prompt establishment of an NHS England Any Qualified Provider (AQP) list of neurodevelopmental services, including private providers available through NHS Right-to-Choose.
(ii) an England-wide self-referral mechanism to a single-point-of-access offering screening and triage to deem "clinical appropriateness" and care-navigation to inform and enable patient choice.
(iii) that urgent measures are taken by NHS England to remedy the fact that NHS ADHD Services across all ages in have been chronically underfunded for years
(iv) a direct enhanced service to cover the implementation of an ADHD annual health check, that would also properly fund the workload for ADHD medication shared-care agreements

(v) accredited career pathways in ADHD for interested GPs and other primary-care HCPs, with nationally funded mechanisms to enable the training and subsequent skills to be utilised.
Dr Lucy Clement proposed the motion and spoke passionately about her own journey of ADHD and the lack of NHS investment ringfenced for ADHD. She highlighted the difficulties that are associated with the complex array of service provision and the expectations on GPs to pick up the pieces. Others spoke about similar journeys and supported the motion. There were speeches against parts (i) and (ii) due to concerns about AQPs rather than the sentiment of these parts. All but part (i) were passed.

MOTION 6: SHARED CARE OF MEDICATION
AGENDA COMMITTEE TO BE PROPOSED BY KINGSTON AND RICHMOND (Dr Richard Van Mellaerts): That conference demands that GPC England negotiates an agreed national voluntary shared care drug scheme that:
(i) ensures universal availability for patients
(ii) is equitable and fully funded for participating practices
(iii) is added to only with the agreement of elected representatives of general practice.
(iv) also applies to private specialist providers.

The motion focused on the complex nature of the GP contract now with so many 'add-ons'. Interestingly, the debate focused significantly on the push of Inclisiran, which is a live issue in Sheffield and South Yorkshire Integrated Care Board (ICB), where a Shared Care Protocol (SCP) does not exist. There was resistance about part (iv) as it may imply NHS subsidising private care. There was also a much wider point about the need for shared care arrangements when the real issue that was being ignored was Secondary Care's inability to prescribe electronically. That could negate the huge amount of resource and time that is spent on shared care. The motion was carried.

MOTION 7: GP TO PATIENT NUMBERS
GLOUCESTERSHIRE (Dr Ben Lees): That conference asks GPC England to seek to establish the absolute minimum number of GPs (by WTE) that are required to meet the basic needs of a standard population size, and collate these statistics, in order to:
(i) provide a dataset that complements and gives context to the new OPEL type GP alert systems being established
(ii) assist the GPC England executive to hold NHS England and the Secretary of State to account when they fail to meet their obligation to ensure the provision of primary care services
(iii) clearly demonstrate the superior quality and value created by traditional general practice compared with corporate and private sector alternatives reliant on 'GP lite' models
(iv) protect practices from inappropriate adverse CQC criticism about perceived lack of 'access' caused by inadequate resourcing to meet demand.

The motion had speakers for and against. Whilst the premise of the motion seemed straightforward, there were concerns expressed that a national target could be manipulated by the government, or used against General Practice as a sanction for not having enough GPs. The motion was passed in full.

MOTION 8: WORKLOAD CAPPING
AGENDA COMMITTEE TO BE PROPOSED BY DEVON (Dr Rachel Ali): That conference asserts that NHS England's use of the term "arbitrary" when referring to the workload limit is disgraceful and reasserts that the demand pressure on general practice has long since exceeded the threshold of safety, and:
(i) argues that simple quantification of appointments is disingenuous and needs more nuanced classification to reflect clinical complexity and value of time spent
(ii) supports the BMA Safe Working Guidance and calls for safe working limits to be considered a "red line" in contract negotiations, and for wider system overflow support to be mandated where OPEL reporting systems are indicating high levels of demand on practices
(iii) demands that NHS England make suitable provision for all practices across England to divert urgent workload when their daily safe working limits have been reached
(iv) supports a new above-practice triaging service to manage excessive demand on general practice, which must not include the option to refer back to general practice
(v) encourages the establishment of waiting lists for routine GP appointments in order to reveal, and to go some way toward quantifying, this demand and hidden workload.

This was an interesting and balanced debate about the need to limit workload versus the potential solutions outlined - why do we need to consider classification of appointments to NHS England? Who will run the ‘above practice’ triage system and so on.

Possibly the most interesting debate up till this point, with Devon LMC both proposing and opposing the motion. The motion was passed in full with part (iv) taken as a reference.

THEMED DEBATE: THE FUTURE OF WORKING AT SCALE

The purpose of this themed debate is to ‘remove the mental shackles of the Primary Care Network (PCN) Directed Enhanced Services (DES), and for LMCs to discuss what their constituents may want from a future model for working at scale.

Existing GPC England policy on PCNs is as follows:

- Move all PCN funding into the core contract.
- A ballot of the profession before any extension of the PCN DES.
- Additional Roles Reimbursement Scheme (ARRS) roles to be extended to GPs, practice nurses and support staff.
- Unspent ARRS funds to be retained by PCNs to be spent on other services.
- Annual uplifts to core PCN funding payment.
- Reject PCN responsibility for out of hours provision.
- Investment & Impact Fund (IIF) to be moved to practice level.

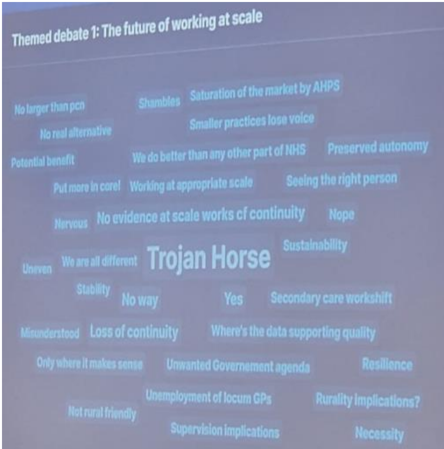
Following the discussions about the future of the PCN DES at the England Conference of LMCs in 2022, there was a mixed response to whether representatives thought their constituents would be prepared to continue the PCN DES in its current form beyond its scheduled end date in April 2024.

At the conclusion of the debate, voting members of conference were asked to vote on a scale of one to six on the following statements:

- My constituents have an appetite for working at scale in the future (vote pre and post-debate).
- My constituents wish to share clinical staff with other practices.
- My constituents wish to share non-clinical staff with other practices.
- My constituents wish to share back-office functions with other practices.
- My constituents wish to share estates with other practices.
- My constituents wish to provide private services through working at scale.
- My constituents wish to tender for NHS services through working at scale.

There was an open debate with numbered voting rather than a binary vote. The outcome of this is included in Conference News.

The following is the word cloud that represents the thinking around working at scale of the delegates at the conference.



DR KRISHNA KASARANENI
Executive Officer

AFTERNOON SESSION

MOTION 9: GP CONTRACTS

AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS (Dr Jackie Appleby): That conference notes the recent announcements regarding private providers of NHS general practices withdrawing from their contracts and:

(i) calls for an end to APMS as a contractual option for general practice
(ii) demands that, any new or re-tendered GP core contract is offered as a GMS contract when the successful applicant is able to hold such a contract
(iii) demands that no funding over and above standard GMS should be provided to commercial organisations wishing to run NHS general practice contracts in England.

This motion focused on concerns regarding Alternative Provider Medical Services (APMS) contracts, with particular focus on acquisition by private companies (such as Operose in London and GP at Hand in recent years), and the risk this poses to General Practice as a whole and patient care. These companies have more recently claimed the model is not profitable, subsequently handing back the contract, leaving patients without a GP and local practices picking up the pieces. An argument was made in favour of these contracts and their use when taking on struggling practices or in unusual circumstances, such as contracts for Primary Care services in Prisons. The motion was passed in all parts with a >90% majority.

MOTION 10: REINFORCED AUTOCLAVED AERATED CONCRETE (RAAC)

BUCKINGHAMSHIRE: That conference is appalled to learn of the emerging scandal surrounding the use of reinforced autoclaved aerated concrete (RAAC) in many buildings necessary for public life, and calls on GPC England to demand:

(i) urgent government funded surveys of all primary care estates, to identify any facilities constructed from RAAC
(ii) prompt provision of state funded support for any practice found to have RAAC in order to make it safe either through repair or rebuild
(iii) a public enquiry to investigate why the known dangers of RAAC have been ignored by government for so long.

This was an uncontentious motion calling for urgent government surveys of all Primary Care estates to identify those constructed from RAAC, for safe prompt provision of support for those practices affected, and a public enquiry to investigate why the known dangers of RAAC had been ignored by the government for so long. It was passed in all parts.

MOTION 11: SALARIED GP JOB PLAN

11 CAMBRIDGESHIRE (Dr Caroline Rodgers): That conference is dismayed that despite salaried GPs being offered model contracts, practices are not held accountable for the job plans they create leading to unmanageable workloads, increased risk of burnout and lack of retention and calls on the GPC England to publish gold standard job plans including a certification symbol for adopting practices to:

(i) ensure that true workload of salaried GPs is realistic, fair and follows previously published BMA safe working guidance
(ii) create parity in salaried roles across different practices thus reducing inequalities in areas
(iii) support workload conversations between salaried GPs and partners in a manner which maintains good relationships.

This was a somewhat contentious motion that resulted in a respectful yet lively debate, with members of conference calling for the stem to be voted on. In favour of the motion we heard that salaried GPs are currently working 25% more than contracted hours, and that this could empower our salaried GPs in discussions regarding job plans, which are already an integral part of the British Medical Association (BMA) model contract. It was felt it could support practices which are compliant with this. It was felt, however, that this was a partial solution to a much bigger issue, and may perpetuate inequities. Those struggling to maintain this due to a variety of circumstances out with their control would, indeed, find it even harder to recruit. It was felt this may push further work on to partners and, as such, making partnership less desirable, driving the recruitment crisis further. Ultimately, this motion fell at the stem and, as such, the parts were not voted on. The singular principle of a certification process may have negatively impacted the outcome of this motion.

MOTION 12: GP PERFORMERS LIST SUSPENSIONS

LEWISHAM (Dr Richard Stacey): That conference is appalled that GP performers lists suspensions payments are both punitive and inequitable and as a matter of urgency, calls on government to amend these regulations to:

(i) establish the principle that suspended GPs are entitled to 100% of normal earnings not 90% as per the current regulations

(ii) increase the weekly ceiling on locum payments, so that these are annually set at a realistic level that will fully reimburse the locum payments for the suspended GP

(iii) entitle all GPs to receive suspension payment, including partners who have been expelled from their partnership due to the suspension.

Another uncontentious motion. It was put forward that suspension is not a neutral act as claimed with the regulations currently in place regarding pay-outs during suspension, as above, particularly affecting partnerships. There were no speakers against.

MOTION 13: ADDITIONAL ROLES REIMBURSEMENT SCHEME (ARRS) SUPERVISION

AGENDA COMMITTEE TO BE PROPOSED BY NEWCASTLE AND NORTH TYNESIDE (Dr Lizzy Toberty): That conference believes that Additional Roles Reimbursement Scheme (ARRS) staff have not been nationally supported to develop adequate competence within primary care and:

(i) all ARRS staff should be supervised similarly to GP registrars for three years from commencing their role

(ii) GPC England needs to insist that, as per GMC guidance, levels of supervision should be guided by the needs of the individual rather than a blanket approach

(iii) all ARRS roles and associated supervisors need to have funded and protected time for supervision and learning

(iv) no further push for advanced access whilst the inefficiencies of this model are restructured.

Parts i (50%) and ii (66%) passed as references - concerns raised that by stating they should be supervised similarly to GP registrars we would be further contributing to blurring the role, along with concerns that the mention of the General Medical Council (GMC) would contradict recent General Practitioners Committee (GPC) England policy against the GMC being the regulatory body for non-doctor roles. It was put forward that this was a public safety issue, and ARRS staff should not be seeing undifferentiated patients. However, it does not differentiate between the different ARRS roles, such as social prescribers, care coordinators and Physician Associates. The question was posed as to whether we should be supporting these roles at all - are we complicit in the replacement of GPs, and where would the time and money for supervision come from? The burden of supervision of these roles was recognised. The vote was one of the closest of conference.

THEMED DEBATE: INTERFACE SOLUTIONS

Conference moved on to a further themed debate as below. The large number of motions received on the topic of the Interface between Primary and Secondary Care reflects the ongoing challenges which have not yet been resolved. The purpose of this themed debate is to provide GPC England with a clear steer for what is required to address some of these issues, as well as sharing what is working well within individual LMC areas.

Existing GPC England policy on the Interface is as follows:

- Trust staff to request their own prescriptions, investigations and referrals.
- Trusts to have email/telephone contacts for reporting “workload dumps” and for patients experiencing delays in Secondary Care.
- Resource for Advice and Guidance pathways.
- GPs cannot be mandated to use Advice and Guidance by commissioners or providers.
- GPs should be free to refer to a Secondary Care colleague without pre-referral interference.
- Financial penalties for Trusts when hospital contracts are breached around the interface issue, and funding moved into General Practice.

Another lively debate, including a call to define core General Practice and clearly communicate this to General Practice, empowering practices to say no to unfunded, non contractual work. Reference to the risk of holding patients within Primary Care whilst awaiting Secondary Care input, alongside the drive for advice and guidance to reduce referrals.

Conference was asked to vote on the below statements. The outcome of this is included in Conference News.

AGENDA COMMITTEE to be proposed by the CHAIR: That conference instructs GPC England to:
(i) produce an up-to-date suite of guidance and tools for practices on the interface between private providers and general practice
(ii) clearly define what work is and is not core GMS, and produce a suite of resources to empower practices to reject this work if they so choose
(iii) carry out research to quantify the cost impact of unfunded secondary care work undertaken by general practice
(iv) produce and promote legally and contractually enforceable levers for practices to use to financially penalise other providers for unfunded work inappropriately shifted into general practice
(v) work with the BMA's Consultants Committee, Junior Doctors Committee, and Specialist, Associate Specialist and Specialty Doctors Committee, to negotiate with NHS England the rapid implementation of electronic prescribing for secondary care, including the ability connect with community pharmacy.

MOTION 14: ENHANCED SERVICES
AGENDA COMMITTEE TO BE PROPOSED BY AVON (Dr Lee Satheld): That conference demands that general practice funding is consolidated into the GMS payment and calls for:
(i) the cessation of all locally enhanced services in England
(ii) the removal of QOF from GP workload
(iii) additional funding in the core contract for services such as phlebotomy, spirometry and ECGs.

An interesting motion directly calling for a number of services not currently felt to be within core to be brought into core with additional funding. These would constitute a potentially huge amount of work, which many felt there is currently no capacity for or the training/up-to-date skills to do in General Practice, posing a significant risk. This is not to say these could not be done, but that to take away the choice to decline and putting it all into core would be problematic at best, overwhelming for practices already struggling at worst. It would remove local flexibility and take power to negotiate away from LMCs. Overall it was felt to be a step in the wrong direction by conference, with a clear majority against. The motion was lost in all parts.

MOTION 15: GP RETENTION
Proposed by Deborah White, Cleveland: This was a motion speaking to reduce restrictions around the retainer scheme in terms of the 5 year time limit and to increase investment.
(i) removal of the five-year maximum eligibility limit to the NHS England GP Retention Scheme
(ii) levelling up of ICB investment in the NHS England GP Retention Scheme across the country
(iii) increased government investment in the NHS England GP Retention Scheme
(iv) consideration of ways to retain and support GPs further down the line in their careers, so that GPs enjoy their work for longer and avoid burnout and early retirement
(v) all GP retention or fellowship programmes to be open to all GPs on an equitable basis.

It was well received and past in all parts.

MOTION 16: DIGITAL/IT
Proposed by Merryl Watkins, Derbyshire. That conference believes that if it takes 20 minutes to switch on your computer in the morning then Steve Barclay should not be investing in robotic penguins.

Another uncontentious motion carried.

DR DANIELLE MCSEVENEY
Vice Chair