2023 Annual Conference of UK LMC Representatives

Sheffield LMC

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

THURSDAY 18 MAY 2023

The Keynote speech was given by Chris Morris, Writer and Comedian. As the son of 2 GPs he recognised the benefit of maintaining continuity of care and investing in General Practice as the bedrock of universal care, free at the point of delivery. He was scathing about the current Government's handling of the NHS. However, he recognised that, currently, Labour does not have a cohesive or sustainable policy on the NHS either. He noted that the only sensible strategy had been delivered by Jeremy Hunt as Chair of the Health Select Committee, but he had then failed to fund it as Chancellor. He hoped that we could convince Wes Streeting, Shadow Secretary of State for Health and Social Care that this was actually the sensible, sustainable option.

MOTION 4: SURVIVAL OF GENERAL PRACTICE

CAMBRIDGESHIRE: That conference requests that the BMA supports GPC UK by undertaking a series of FOI requests to:

(i) determine the number of practices which have been dispersed; merged; novated; or reprocured via APMS across the UK
(ii) determine the total cost of NHS-funded management consultancies across the UK since the contracts were devolved to single nations
(iii) extrapolate how many patients are now 'without' a GP assuming recommended ratio of 1 whole-time equivalence to registered list size
(iv) then publicise the real crisis around a depletion of patient choice, and fractured continuity of care by the destruction of general practice.

During the debate it was noted that practices were closing or merging at increasing rates, many being tendered as Alternative Provider Medical Services (APMS) contracts, which are short-term and expensive. Funding of General Practice had been lagging behind inflation for many years and the NHS was spending £300m pa on management consultancies. Most practice closures affected the most deprived areas. Overwhelmingly passed.

MOTION 5: GMC

GATESHEAD AND SOUTH TYNESIDE: That conference thanks the GMC for confirming they will not act against junior doctors taking industrial action and demands that the same pledge be extended to GPs, should they also invoke their legal right to take industrial / coordinated action.

This was a fairly simple discussion noting that during the 2016 Junior Doctors strike the GMC had threatened those taking Industrial Action (IA) with removal from the register. This time the GMC had recognised their legitimate right to strike, but they needed to ensure patient safety in line with Good Medical Practice. The same recognition should be given to GPs if Industrial Action is called for.

MOTION 6: COST OF LIVING CRISIS

NORTHERN IRELAND CONFERENCE OF LMCS: That conference notes with dismay the destabilizing effect of rapidly increasing expenses and energy costs which are being absorbed by GP practices and instructs GPC UK to negotiate an urgent package of support measures for all practices.

There has been a 3-4 times increase in energy costs. Practice consumables have increased significantly, as have staff pay rise recommendations outstripped the 2.1% uplift to GP funding. This was taken as a reference as it is not for the General Practitioners Committee (GPC) UK to negotiate, but each of the devolved nations individually.

MOTION 7: COLLAPSE OF THE NHS

AGENDA COMMITTEE TO BE PROPOSED BY FORTH VALLEY: That conference acknowledges patients are increasingly seeking healthcare privately, including travelling abroad for surgery. We call on the GPCs to work with appropriate authorities and stakeholders to:

(i) ensure patients are not required to seek approval from their NHS GP prior to accessing private healthcare
(ii) obligate private providers to inform patients of the total cost of recommended investigations, treatments and follow-up, highlighting these may not be provided by their NHS GP
(iii) obligate private providers to act upon investigations undertaken, and not simply pass results or further management suggestions onto NHS GPs to action
(iv) ensure that those who cannot access required follow up are not left without adequate specialist care
(v) ensure any involvement in a patient's care by an NHS GP as requested by a private healthcare or insurance provider is remunerated appropriately.

The NHS in Northern Ireland is in a more perilous state than elsewhere. Neurology waiting times are 7 years and Rheumatology is 9 years. There was debate about whether GPs should be involved in private referrals, with some arguing that they should help their patients make wise decisions about seeking private care, as patients sometimes embarked on poor pathways that the private sector are less likely to abort. All parts were passed.

UK CHAIRS: SESSIONAL GP REPORT

There was then a talk from the Co-Chairs of the Sessional GP Committee and 2 proposed motions. The Sessional GP Committee was established in 1997 and now represents a majority of the GP workforce. It is supported by the Deed of Grant between the General Practitioners Defence Fund (GPDF) and the British Medical Association (BMA). The Co-Chairs recognised that General Practice was best represented by working together with partner-led negotiations, but did want to strengthen the salaried contract due to the large gender pay gap with Sessional GPs, and promoting safe working. There was also to be a first Sessional GP Conference in September.

MOTION 8: GP WORKING SCHEDULES

CONFERENCE OF ENGLAND LMCs: That conference:

(i) believes referring to GPs as "full time", "part time", or "full time equivalent" in terms of numbers of "sessions" worked fails to capture the real hours worked by many GPs
(ii) demands that any new BMA model contract or new GMS contracts define GP working schedules in terms of hours rather than sessions
(iii) demands that any workforce data collection (eg for NHS workforce planning) be done on the basis of hours worked, not contracted sessions.

This motion was essentially about considering the hours GPs work rather than keyholing them into sessions. There was debate for and against; those against noting it still did not reflect the workload as some may see 4 patients in an hour and some may see 6. There was a danger of data being used against us as 1 Full Time Equivalent (FTE) is considered 37 hours, so this could artificially inflate the "number" of FTEs towards the government's magical 6000 extra GPs. Part i) was passed overwhelmingly, the other parts just passed.

MOTION 9: UK SALARIED MODEL CONTRACT

AGENDA COMMITTEE TO BE PROPOSED BY GP TRAINEES COMMITTEE: That conference believes that the model contract for salaried GPs must be strengthened, with improved advised rates of pay, and calls on GPC UK and the Sessional GP Committee to:

(i) rapidly arrange mechanisms to renegotiate the model contract, with ongoing review reinstated
(ii) ensure that salary rates are increased to reflect pay restoration, with a view to protecting the profession in a time of crisis
(iii) amend the model salaried GP contract to be consistent, by including the BMA safe working limits of 25 patient contacts per day.

Part i) was asking for a mechanism for regular review of the contract. This was uncontroversial. Part ii) was particularly contentious as, without any statement around uplifting salaries through an uplift in core funding, this would negatively impact partner salaries. This could have a further negative impact on GP recruitment. Parts ii) and iii) were lost. A supplementary iv) was debated around whether a salaried contract should be "contractual for all bodies engaging salaried GPs." Despite reassurances from the proposers, this was thought to have a negative impact on GP partnerships. Part iv) was lost.

MOTION 10: THE ROLE OF THE EXPERT GENERALIST

AGENDA COMMITTEE TO BE PROPOSED BY GRAMPIAN: That conference recognises that GPs have a key role in primary care with providing continuity, dealing with complex physical and psychosocial presentations whilst leading the MDT team and:

(i) agrees that GPs are expert medical generalists whose training allows them to deal with complexities in patient presentations that no other members of the primary care team can
(ii) recognises the importance of RCGP exam and CCT to ensure GPs have been trained to a high standard to enable them to deal with the complexities involved in being a GP in 2023
(iii) demands the GMC immediately merge the specialist register with the GP register and recognise the profession as specialists in primary care
(iv) calls on UK government to appreciate this key role GPs play by rebranding GPs as consultants in family medicine
(v) calls on governments to include leadership of MDT as a contractual requirement with appropriate funding and time for this role.

This motion, encapsulating the importance of the role of the expert generalist, was carried in parts i) to iv), despite some dissenting voices around the term 'consultant in family medicine' from attendees. Part v was more controversial, given the increasing demand on GPs to supervise Additional Roles Reimbursement Scheme (ARRS) staff and Allied Health Professionals (AHPs). There was agreement that supervision needed to be funded in the GP Contract, but attendees were concerned about the implications of supervision becoming a contractual requirement and thus this Part v) was lost.

PRIMARY CARE DOCTORS - MAJOR ISSUE DEBATE

Conference heard from Dr Ujjwala Mohite, an Associate Specialist in Histopathology and Chair of the BMA's Associate Specialist Committee, and Dr Sarah Matthews, GP and Policy Lead for Education, Training and Workforce GPC England, introducing the concept of Primary Care doctors in General Practice. These would be doctors of any denomination who had not completed CCT in General Practice. The purpose of the debate was to ascertain whether there is interest amongst the profession to explore the advent of a Speciality and Associate Specialist (SAS) GP role to tackle workforce issues in General Practice. The intended benefits would be to tackle the recruitment and workforce crisis in General Practice, but attendees discussed a number of drawbacks to the proposal, including:

- Additional burden of supervision on existing GPs
- Concerns about devaluing SAS doctors
- Estates issues - lack of space for additional doctors in GP surgeries
- Indemnity issues - would non-CCT GPs be covered by Clinical Negligence Scheme for General Practice (CNSGP)?
- Workforce issues elsewhere in the system - "robbing Peter to pay Paul"
- Impact on General Practitioner Vocational Training Scheme (GPVTS) - if Primary Care Doctors are facilitated, would the system lose the incentive to support GPVTS trainees that require an extension to training? Would these trainees be exited into an SAS role?

Interestingly, the view from the BMA SAS UK is that SAS doctors would not be in favour of the introduction of Primary Care Doctors in General Practice, as it would create a two-tier service, leaving SASs potentially open to exploitation. They would support adjustments to the GPVTS scheme to reduce duration of training to 2 years with no hospital rotations to compensate for their pre-existing hospital experience.

MOTION 12: PRIMARY CARE DOCTORS – MAJOR ISSUE DEBATE

NORFOLK AND WAVENEY: That conference asks GPC to reject the GMC's proposed changes to the Performers' List to enable non-CCT holders to work within general practice as primary care doctors.

Conference voted in favour of GPC rejecting the GMC's proposed changes to the Performers List to enable non-CCT holders to work within General Practice as Primary Care doctors.

As Motion 12 passed, Motions 13 and 14 were not debated and automatically fell.

MOTION 15: FUTURE OF GP TRAINING

GP TRAINEES COMMITTEE: That conference notes the value of GP trainees maximising their experience of general practice during their training. We call on the BMA to lobby the relevant bodies to ensure that the entirety of general practice speciality training is spent in a primary care setting.

The Trainees committee proposed changes to the VTS scheme to ensure the entirety of training time is in Primary Care with no hospital rotations. Whilst this would increase the experience of General Practice in newly qualified GPs, there was some concern that the benefits of exposure to Secondary Care specialities (such as Obstetrics & Gynaecology, Paediatrics, A&E, Dermatology) that are of significant value to GP trainees would be lost in these circumstances. The motion was lost.

MOTION 16: GP RECRUITMENT AND RETENTION

AGENDA COMMITTEE TO BE PROPOSED BY WIGAN: That conference believes that more strident efforts should be taken to induce medical students and newly qualified doctors to choose general practice as their medical career path, and calls upon governments to provide financial incentives:

(i) that provide an MOD-style sponsorship for GP VTS
(ii) that include a medical student debt cancellation scheme
(iii) with eligibility based on a prescribed number of years' service as a salaried or principal GP.

Wigan LMC proposed a motion to promote the enticement of medical students into a career in General Practice to address the workforce crisis through financial incentives including sponsorship, and student loan reimbursement dependent upon a prescribed number of years of service. It was carried in all parts

MOTION 17: GP RECRUITMENT AND RETENTION

WAKEFIELD: That conference is aware that in some areas 86% of GP trainees are NHS naïve at the point of entry to training. These require much more assistance than those with NHS knowledge. A fully funded NHS induction course is needed for this group of trainees as is extra reimbursement, to recognise the extra workload for their trainers

This motion requested the formal introduction of an International Medical Graduates (IMGs) induction programme for new trainees to the NHS. It was unsurprisingly *passed unanimously*, Conference noting the significant contribution of IMGs to the NHS and General Practice in particular. It is worth noting that Health Education Yorkshire & Humber (now NHS England) already have an IMG-specific induction programme for trainees that has been running for a few years, although it seems Wakefield LMC is unaware of its existence.

MOTION 18: MRCGP

AGENDA COMMITTEE TO BE PROPOSED BY NORTH WALES: That conference, in respect of the MRCGP examination:

(i) asks GPC UK and its component committees to lobby and work with RCGP and other stakeholders to ensure no GP trainee is forced to extend their training due to lack of availability of examination sittings
(ii) calls on all GPCs to work with the RCGP towards a system that will offer GP trainees who score under 480 on selection four- or five-year training at the outset rather than waiting for them to "fail" their examinations
(iii) believes that single sitting, "big bang" RCGP exams such as AKT are no longer an appropriate assessment and calls for them to be replaced by an educationally evidence- based assessment
(iv) notes the significant financial impact MRCGP examination and mandatory RCGP membership fees have on GP trainees and calls upon GPC UK and its component committees to lobby governments and education bodies to fund the first attempt at MRCGP examinations.

This was a somewhat controversial motion requesting alterations to the MRCGP examination. Practically GPC UK has little jurisdiction over RCGP. Part i) was carried overwhelmingly and Part iv) was also carried. Regarding Part ii) the current evidence suggests that trainees scoring under 480 on their Multi-Speciality Recruitment Assessment (MSRA) entry examination are statistically more likely to require extensions to training due to difficulties obtaining the required competencies within 3 years of FTE training time. The proposal from North Wales LMC was to automatically offer a longer training programme of 4-5 years for trainees failing to achieve 480 on the MSRA. Despite benefits including workplace planning, longer visa awards for IMGs needing extensions and cost effectiveness (it is cheaper to offer a longer training contract in advance than fund extensions at short notice), some attendees expressed concerns about pressurising trainees to accept longer training contracts at the outset, and the implied two-tier system. Ultimately Part ii) was narrowly lost. Part iii) was comprehensively lost as many present expressed concerns about the loss of an objective assessment, meaning that GP trainers would feel more pressure attached to their subjective observational assessments to determine a trainee's competence for licencing.

MOTION 19: GP TRAINEES CONFERENCE

GP TRAINEES COMMITTEE: That conference notes the significant value GP trainees derive from attending LMC conferences across the UK. We call on:

(i) GP trainees committee to organise an annual UK GP trainees conference
(ii) GPDF to fund an annual UK GP trainees conference

It was uplifting to feel the enthusiasm that many younger career GPs had for medical politics and for shaping the future of General Practice. Part i) was carried, and GPC UK will work up plans to host a specific GPC UK Conference. Given the recent well-documented concerns about the funding decisions taken by GPDF, there was apprehension about obligating GPDF to fund a new conference while it is sorting out its own financial affairs. Therefore, it was perhaps not surprising that Part ii) of the motion was lost.

DR ALASTAIR BRADLEY
Chair

DR GARETH MCCREA
Executive Officer