Draft motions to LMC conference from Derbyshire Local Medical Committee.

Model contracts

1.

That conference insists that the concept of a standard model contract for employment of salaried doctors by practices is professionally beneficial, however the current standard model contract imposed upon GMS practices:

i. is not fit for purpose in the second decade of the 21st century.

ii. is inequitable in that it generates unrealistic and unaffordable burdens and privileges upon the parties concerning annual leave entitlements and study leave entitlements,

and instructs the GPC to negotiate a sensible and equitable solution with all speed and in no case later than LMC conference 2016.

Workforce

2.

That conference declares that the activities of many deaneries, in their new incarnation as part of Health Education England, are fundamentally undemocratic, taking powers they do not possess in law, making up ex-cathedra rules concerning medical practice and generally obstructing doctors' right to peaceful enjoyment of their professional qualification. The GPC is instructed to investigate the methods of deaneries, suggest mechanisms to improve their accountability to the profession and to report back by LMC conference 2016.

3.

That conference, with regard to medical education and regulation, reminds the government, educators, and regulatory bodies that the NHS is not the medical profession and the medical profession is not the NHS.

4.

That conference, whilst recognising the necessity to maintain and assure the standards of general practice within the United Kingdom, highlights the unnecessarily burdensome obstructions placed in the way of UK trained general practitioners who wish to return to practice in the National Health Service after a period overseas broadening their horizons and professional skills for the benefit of the national health service. The GPC is instructed to catalogue and highlight these burdens and take all necessary steps to demolish the obstructions.

General practice training

5.

That conference notes the significant management and business skills components contained within the training required for the grant of a CCT in many specialties. Conference is dismayed at the absence of such training in many current GP vocational training schemes. The General Practitioner Committee is instructed to catalogue and highlight this deficiency, create a training syllabus in finance, business management and business skills and insist that the RCGP incorporates the subjects into the GP CCT exit exam (a.k.a. MRCGP).

Practice stability

6.

That conference:

i. highlights to the general public the new and increasing phenomenon of practice implosion and sudden closure, often caused by a combination of a resignation and failure to recruit to replace a doctor.

ii. notes that the impacts of sudden practice failures fall upon neighbouring practices, threatening GP services to an entire locality.

iii. instructs the GPC to explore and negotiate mechanisms with government to stabilise general practice in a locality where sudden practice closures are likely or have occurred.

7.

That conference insists that where a practice list size increases rapidly, for example the acquisition of a large block of patients from a failed neighbouring practice; capitation related payments should be payable from the first day of registration and not from the first day of the next quarter. GPC is instructed to negotiate accordingly.

8.

That conference highlights the inflexible thinking of NHS England when distributing resources towards policy objectives and insists that local discretion is permissible by Area Teams and their successors following consultation with the relevant Local Medical Committee. GPC is instructed to negotiate accordingly.

(Explanatory note: the recent IT monies for mobile working were recently allocated for the purchase of laptops with 3G capability. There are still significant areas of the country where 3G reception capability is several years away and yet the practices refused permission to use the money in a constructive manner on other IT projects in the meantime.

9.

That conference demands that in the light of the policy emphasis in NHS England's ***Five-Year Forward View*** concerning integration between health and social care, integration of primary and secondary care working and co-production of prevention and care for citizens, the government abandons forthwith the concept of the commissioner/provider split in the health and social care arena.

10.
That conference demands that the government revisits as a matter of extreme urgency the changes to pension rules which are resulting in large numbers of GPs retiring earlier than they had originally planned and their skills being lost to the National Health Service.

11.
That conference notes the catastrophic retention crisis in the primary care workforce and demands that NHS England immediately restores a fully funded, comprehensive and accessible occupational health service for GPs and their staff as one way of addressing this crisis.

12.
That conference:

i. believes that level 3 co-commissioning (delegated commissioning authority) by CCGs is inevitable.

ii. is gravely concerned that CCG's will not have sufficient resources to undertake commissioning of primary, secondary and community care.

iii. is concerned that there will always be a perception of conflicts of interest if a co-commissioning CCG attempts to transfer resources along with workload from secondary to primary care.

iv. reminds CCGs that they are membership bodies comprised of their constituent practices and that constituent practices tell the CCG what to do and not vice versa.

Public expectation

13.
That conference informs the public, the press and politicians that there is no magic observation or single test or scan which allows a doctor (or anyone else) to distinguish instantaneously and accurately between a person who is or is not suffering from cancer, dementia or the early prodromal stages of heart attacks, strokes, meningitis and many other conditions.

14.
That conference is of the opinion that Public Health England as currently constituted places the registered medical practitioners it employs in an impossible situation with regard to their medical registration and their obligations as doctors.

15.
That conference insists that in the light of the new drug driving laws the responsibility to ensure that a driver is not impaired by the influence of drugs rests absolutely and at all times with the driver himself/herself and not any attending medical practitioner.

16.
That conference requests the BMA board of science to investigate the increasing problem of the elderly driver with particular reference to those in the early stages of dementia and to offer guidance to those in front-line specialties such as general practice.

17.
That conference commends the GPC on its publication *Quality first: managing workload to deliver safe patient care* and requires GPC to continue its general efforts in this direction but more specifically:

i. to take up with the other branches of practice committees the issue of workload dumping onto general practice.

ii. to co-ordinate and promulgate intelligence from LMCs about successful schemes and strategies introduced locally to prevent workload dumping.

iii. to construct a standard education resource about workload dumping and acceptable professional behaviours for delivery to GP audiences, Hospital Doctor audiences, GP trainees and NHS managers.

iv. to construct a document which will allow practices to calculate their charges for undertaking dumped workload including guidance on enforcing payment by trusts which continue to dump workload on general practice.

v. consider the preparation of test cases on workload dumping for judicial review.

18.
That conference demands that a **functioning** system of global practice expenses assessment and reimbursement is re-introduced without delay.

19.
That conference believes that with regards to Out of Hours provision:

i. General Practitioners are subsidising the **clinical indemnity** costs of out of hours provision through their indemnity premia.

ii. The government must cover 100% of the **clinical** indemnity component of out of hours care.

20.
That conference declares that, in its professional judgement, 111 as currently constructed:

i. is an expensive gimmick.

ii. is wasteful of GP in hours resource.

iii. is wasteful of out of hours resource.

iv. is wasteful of ambulance resource.

v. is wasteful of Emergency Department resource.

21.
That conference notes the dissonance in tone and attitude of the mass media concerning the competence and confidence in general practitioners when compared with the more scientific data from formal reputable surveys and therefore:

i. can only conclude that there is a government inspired malevolent media campaign against GPs.

ii. encourages responsible journalists to be more critical in evaluating data from all sources before building a story.

22.
That conference recognises that cardiovascular risk assessment, the identification, management and treatment of those at risk is an important task for any service that wishes to be seen as a "Health Service", but:

i. it doesn't just happen, and needs to be paid for, and

ii. it should be undertaken at a national level, in a "National Health Service"

iii. and directs negotiators to so negotiate, even if it means an increase in the size of QoF.

23.
That conference deplores the fact that ambulance services frequently alter the service that they are prepared to offer, and require GPs to make unreasonable choices in the timeframes within which patients should be transported, e.g. 999 or 4 hours, and

i. insists that they should ask GPs what they believe is required of them to transport patients to hospital in a timely manner and should attempt to comply with this advice.

ii. insists that they should be audited on their success in delivering a service to patients based on this advice and receive appropriate feedback.

iii. accepts that GPs should be audited on their use of ambulance services and receive appropriate feedback on the use of the service in comparison to their peers.

24.
That conference believes the 4 hour A+E waiting time target distorts clinical priorities placing them after management priorities, wastes resource and puts patients at risk of unnecessary admission, and that they should be replaced with something more appropriate, such as an average wait time target.

25.
That conference recognises the 2 ww (two week cancer referral maximum wait to first outpatient appointment), although sometimes helpful, often means that patients who have been diagnosed as having cancer, or who are very likely to have cancer actually have to wait longer that they would have done in the past because priority is given to the management priority of seeing patients approaching the 2ww target, rather than clinical priority and:

i. requests the BMA to raise this again with NHS management.

ii. suggests that an average wait time to first outpatient appointment target may be more appropriate.

26.
That conference believes that the local variability of access for GPs to investigations such as CT, MRI, isotope scan etc., is whole unacceptable, wasting money and resources, putting patients' lives at risk and wasting the talents of experienced clinicians.

27.
That conference recognises that a contract where practices who deliver more (employ more staff and deliver more appointments) can result in less profits, and practices that deliver less can result in greater profits (for profit share partners or shareholders) is not a contract that is fit for purpose and:

i. should be renegotiated, even if there are going to be winners and losers.

ii. should contain an option for a fully salaried service.

iii. should contain a mechanism for GPs who move away from the independent contractor status to be fully recompensed for the investments they have made in the past (including in premises).

28.
That conference believes that the blocking of inter-consultant referrals does not result in a more efficient health service and calls for it to end.

29.
That conference believes that letters about patients from hospitals to GPs should be required to meet national standards in how they convey information, especially medication that has been stopped and started, and in timeliness.

30.
That conference notes with approval that teenage pregnancy rates in the UK have fallen to the lowest rates in over 45 years, although still the highest in Western Europe. Conference recognises that the marked fall that started in 2009 is likely to have been largely because of the emphasis on Long Acting Reversible Contraceptives (LARCs) and calls on GPC to:

i. negotiate the inclusion of CON002 for giving advice on LARCs back into QoF.

ii. negotiate that the fitting and removal of LARCs should move back into the national NHS contract as a Directed Enhanced Service.

31.
That conference, in respect of Performers List Decision Panels where a decision to remove a practitioner from the list is being considered and where the matter is contested by the practitioner:

i. has no confidence in NHS England's ability to handle such cases.

ii. believes that such cases should be dealt with by either the Tribunals Service or the Medical Practitioners Tribunal Service and requests the GPC to open negotiations to this end with the Department of Health and the Department of Justice.