General practice: stability in changing times

22-23 May 2012

Conference of Representatives of LMCs

AGENDA

BT Convention Centre, Kings Dock, Liverpool

GPDF
General Practitioners Defence Fund

BMA

Conference of Representatives of Local Medical Committees

Agenda

To be held on

Tuesday 22 May 2012 at 9.30am
Wednesday 23 May 2012 at 9.00am
at The BT Convention Centre, King's Dock,
Liverpool Waterfront, Liverpool L3 4FP

Chairman Mary Church (Lanarkshire)

Deputy Chairman Mike Ingram (Hertfordshire)

Conference Agenda Committee
Mary Church (Chairman of Conference)
Mike Ingram (Deputy Chairman of Conference)
Laurence Buckman (Chairman of GPC)

Stuart Blake (Edinburgh)
David Grant (Gwent)
Hal Maxwell (Ayrshire)
Helena McKeown (Wiltshire)
Stephen Meech (Kent)
Peter Swinyard (Swindon)
Guy Watkins (Cambridgeshire)

GPDF
General Practitioners Defence Fund

BMA

NOTES

Under standing order 18, in this agenda are printed all notices of motions for the annual conference received up to noon on 26 March 2012. Although 26 March 2012 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the secretary prior to the conference, or handed in, in writing, at as early a stage of the conference as possible.

The agenda committee has acted in accordance with standing order 20 to prepare the agenda in two parts. The first part, 'Part I' being those motions which the agenda committee believes should be debated within the time available. The second part, 'Part II' being those motions covered by standing orders 25 and 26 and those motions submitted for which the agenda committee believes there will be insufficient time for debate or are incompetent by virtue of structure or wording. If any local medical committee submitting a motion included in Part II of the agenda objects in writing before the first day of the conference, the transfer of the motion to Part I of the agenda shall be decided by the conference during the debate on the report of the agenda committee.

Under standing order 22, the agenda committee has grouped motions or amendments which cover substantially the same ground, and has selected and marked with an asterisk * one motion or amendment in each group on which it is proposed that discussion should take place.

Attached is a ballot form for chosen motions. The ballot closes at **noon on Wednesday 16 May 2012**.

SCHEDULE OF BUSINESS TUESDAY 22 MAY 2012

	Motions	Time
Opening business	1 – 6	9.30
Annual report	7	9.50
The future of general practice and the NHS	8 – 9	10.10
Major debate: Appraisal and revalidation	10 – 48	10.30
The NHS in economic crisis	49 – 50	11.20
NHS reforms / Health and Social Care Act	51 – 55	11.40
Government	56 – 57	12.20
Practice boundaries	58	12.40
Patient registration	59	12.50
Lunch		13.00
Primary and secondary care interface	60 – 63	14.00
Commissioning of care	64 – 73	14.30
GPC Scotland	74 – 75	15.50
GPC Wales	76 – 78	16.00
GPC Northern Ireland	79	16.10
General Practitioners Defence Fund	80	16.15
Primary care workforce	81 – 82	16.20
Care pathways	83	16.40
Private fees / NHS work	84	16.50
Prison doctors	85	17.00
Chosen motions		17.10
Contingency		17.20
Close		17.30

	Motions	Time
Ask the Negotiators		09.00
Care Quality Commission (CQC)	86	09.20
GP education and training	87 – 90	09.30
LMC conference	91 – 95	09.50
Soapbox		10.10
Pensions	96 – 97	10.30
Contingency		11.00
Access	98	11.10
General Practitioners Committee	99 – 100	11.20
Contract negotiations	101 – 102	11.30
Medical certificates and reports	103 – 107	11.40
Funding for general practice	108 – 110	12.00
Charities		12.20
Dain Fund Claire Wand Fund Cameron Fund	111 112 113	
Lunch		12.30
Motions arising from major debate on revalidation		13.30
Premises	114 - 115	14.00
Sessional GPs	116 – 118	14.10
Dispensing	119	14.30
Information management and technology	120 – 123	14.40
Public health	124 – 125	15.10
Quality and Outcomes Framework (QOF) and quality indicators	126	15.20
Community services	127	15.30
Essential, additional and enhanced services	128 – 131	15.40
Clinical and prescribing	132 – 135	16.10
Other motions	136 – 139	16.40
Contingency		16.50
and finally ...	140	16.55
Close		17.00

ELECTIONS

The following elections will be held on Tuesday 22 May and Wednesday 23 May 2012.

Chairman of conference
Chairman of conference for the session 2012-2013 (see standing order 72 - nominations to be handed in no later than **12 noon Tuesday 22 May**).

Deputy chairman of conference
Deputy chairman of conference for the session 2012-2013 (see standing order 73 - nominations to be handed in no later than **9.30am Wednesday 23 May**).

Seven members of the GPC
Seven members of the GPC for the session 2012-2013 (see standing order 74 - nominations to be handed in no later than **1.00pm on Tuesday 22 May**).

Seven members of the conference agenda committee
Seven members of the conference agenda committee for the session 2012-2013 (see standing order 75 - nominations to be handed in no later than **1.00pm Tuesday 22 May**).

Three trustees of the Claire Wand Fund
Three trustees of the Claire Wand Fund for 2012-2013 (see standing order 77 - nominations to be handed in no later than **1.00pm on Tuesday 22 May**).

RETURN OF REPRESENTATIVES 9.30

1 THE CHAIRMAN: That the return of representatives of local medical committees (AC3) be received.

MINUTES

2 **Receive**: Minutes (AC19 2010-2011) of the 2011 Annual Conference of Local Medical Committees as approved by the Chairman of conference in accordance with the provision of standing order 87.

STANDING ORDERS

3 THE CHAIRMAN (on behalf of the agenda committee): That the standing orders (appended), be adopted as the standing orders of the meeting.

4 AGENDA COMMITTEE: That standing order 9 be amended to read:
Local medical committees may nominate personnel from their organisations to attend conference as observers, subject to chairman of conference's discretion. In addition the chairman of conference may invite any person who has a relevant interest in conference business to attend as an observer.

5 KENT: That conference requests that standing orders are amended to invite any member of conference who is a sole voter against an otherwise unanimous vote, to come forward to explain their reasoning.

REPORT OF THE AGENDA COMMITTEE

6 THE CHAIRMAN (on behalf of the agenda committee): That the report of the agenda committee be approved.

ANNUAL REPORT 9.50

7 THE CHAIRMAN: Report by the Chairman of GPC, Dr Laurence Buckman.

THE FUTURE OF GENERAL PRACTICE AND THE NHS 10.10

* 8 BRADFORD AND AIREDALE: That conference believes that patient advocacy and holistic care are under attack; the profession calls on the GPC to defend the vital role of the generalist as the bedrock of the NHS in its negotiations with the government.

8a WORCESTERSHIRE: That conference believes it is 'Time for general practice' again!

* 9 SOMERSET: That conference notes the Commonwealth Fund review in November 2011 rates the NHS as one of the best healthcare systems in the world and believes that this is substantially attributable to the high and improving quality of evidence based care provided by general practices across the country.

9a LANCASHIRE COASTAL: That conference is aware that up to last year:
(i) the NHS had the shortest waiting times in its history
(ii) the highest patient satisfaction in its history
(iii) better health outcomes than the USA
(iv) longer life expectancy than the USA
(v) the independent Commonwealth Fund reported the NHS as the most efficient healthcare system as compared to the six other leading world health economies
and therefore conference believes that the biggest top down reorganisation in NHS history must continue to be challenged by the profession.

9b NORTHERN IRELAND CONFERENCE OF LMCs: That conference congratulates the GPs and their staff in continuing to provide an exemplary level of care to their patients as evidenced by the Commonwealth Report, despite the present economic and contractual restraints.

MAJOR DEBATE: APPRAISAL AND REVALIDATION 10.30

Keynote speech by Mr Niall Dickson, Chief Executive and Registrar of the General Medical Council, who will address conference on the subject of appraisal and revalidation. This will be followed by 20 minutes of debate from the floor with contributions of not more than one minute from representatives. Mr Niall Dickson will respond and sum up.

The motions already submitted to conference and published below **plus** new motions submitted to the Agenda Committee by 14:00 on Tuesday 22 May will be considered by the agenda committee.

The Agenda Committee will consider all motions, new and old, and create a section for formal debate, which will be published on the morning of Wednesday 23 May.

The formal debate on the new section amalgamating all motions will take place on the afternoon of Wednesday 23 May.

10 DERBY AND DERBYSHIRE: That conference notes the current attempts by some deaneries, SHAs, PCTs and other NHS authorities within the British Isles to introduce enhanced appraisal for general practitioners by the backdoor and it:
- (i) insists that such attempts have no legal basis
- (ii) insists that such attempts have no contractual basis
- (iii) demands that the GMC publicly clarifies the matter
- (iv) encourages appraisees to report all such attempts to their LMC, LNC, BMA division or regional council for action
- (v) instructs BMA and its branch of practice committees to negotiate accordingly.

11 HULL AND EAST YORKSHIRE: That conference notes that there have been no changes to the regulations regarding appraisal and therefore believes that:
- (i) in the absence of support from the LMC, attempts to impose additional requirements into the appraisal process are premature
- (ii) any additional requirements cannot be made retrospective to legislation
- (iii) attempts to introduce the concept of passing or failing an appraisal are to be condemned.

12 AVON: That conference deplores any attempt by PCOs or appraisers to make the use of the RCGP toolkit mandatory for GP appraisal and calls on the GPC to:
- (i) order a halt to this process, which could ultimately result in the College determining the right of GPs to practise their vocation and
- (ii) ensure that there is appropriate competition and therefore freedom for GPs to choose how they construct and store their appraisal documentation.

13 MID MERSEY: That conference deplores the attempts in some PCO areas to roll out extended appraisal in advance of revalidation.

14 CENTRAL LANCASHIRE: That conference believes that appraisal should be clinically led and not administratively burdened such that GPs are required to undertake excessive extra work to the detriment of their clinical commitments.

15 WALTHAM FOREST: That conference believes that the GMC has been silent for far too long on the practical application of appraisal and revalidation, thus allowing local enthusiasts in PCO clusters to develop complex and confusing agendas, and insists that the GMC take hold of the situation.

16 DEVON: That conference notes that there is no national agreement on revalidation. Despite this there are increasing reports on the circulation of 'mandatory' requirements for appraisal in anticipation of the implementation of revalidation. We ask our negotiators to continue their current actions in rejecting any recommendations that are not in the regulations and to reject any further requirements that do not have a supporting evidence base.

17 THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee:
That conference calls for the maintenance of local deanery networks of tutors so that they can continue to provide vital support in:
(i) the quality assurance of appraisal systems, and
(ii) appropriate and timely support for motivated and hard working practitioners who may from time to time require additional support to remain on track for revalidation.

18 EALING, HAMMERSMITH AND HOUNSLOW: That conference recognises the challenges sessional GPs face in relation to compiling evidence for their appraisals.

19 THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee:
That conference believes that it is important that responsible officers, appraisal leads, and appraisers, have knowledge and understanding in accordance with GMC guidance regarding the types of acceptable supporting information that sessional GPs can submit for appraisal.

20 LEICESTERSHIRE AND RUTLAND DIVISION: That conference insists that responsible officers (ROs), appraisal leads and appraisers understand types of acceptable supporting information specified in GMC guidance that sessional GPs may submit for appraisal.

21 LEICESTERSHIRE & RUTLAND DIVISION: That conference demands that the GPC ensures that the local deanery networks of tutors be retained to provide vital support:
(i) for quality assurance of appraisal systems
(ii) to enable motivated and hard working GPs to achieve revalidation.

22 SEFTON: That conference calls upon the GPC to discuss with the GMC the proposal to enshrine in the schedule of 'Good Medical Practice' an explicit principle that clinicians must not support preferential treatment on any grounds other than clinical need.

23 CORNWALL AND ISLES OF SCILLY: That conference demands that issues of clinical performance assessed at local levels are dealt with by a team with appropriate clinical leadership and training.

24 LIVERPOOL: That conference believes that local knowledge and factors affecting performance of GPs must be acknowledged by performance advisory groups.

25 NORTH YORKSHIRE: That conference believes that all NHS GP appraisers should have contracts of employment with the new organisation responsible for appraisal and not nationally negotiated terms and conditions.

26 AVON: That conference condemns the GMC's failure to recognise GPs as expert patients and requests that the GPC work with the GMC to try to ensure that self-prescription for minor illness is not treated as unprofessional behaviour.

27 HULL AND EAST YORKSHIRE: That conference believes that just as doctors must be able to communicate with their patients to provide safe clinical care, it should be mandatory for doctors involved in management to ensure communication with colleagues is in clear English.

28 HARINGEY: That conference deplores the GMC's policy of using money obtained from the annual retention fee to fund private health insurance schemes for its staff.

29 SCOTTISH CONFERENCE OF LMCs: That conference supports the concept of revalidation but believes that revalidation should not be introduced until:
(i) arrangements have been fully worked out for GPs working out of hours, locum GPs and other sessional GPs
(ii) arrangements and funding are agreed for GPs returning to general practice after a career break or after working in a closely related area
(iii) full arrangements are in place for remediation
(iv) remediation has been properly resourced by the NHS
(v) remediation is able to be provided without financial penalty to the individual GP's practice.

30 HULL AND EAST YORKSHIRE: That conference, with regard to revalidation, insists that:
(i) it must not go ahead without adequate arrangements for remediation which are no more burdensome for GPs than for other doctors
(ii) it must not go ahead without proper arrangements for all types of GPs, including sessional and prison GPs
(iii) doctors must be called for on a random basis
(iv) arrangements for responsible officers are independent of their own organisation
(v) requirements for periods of less than five years need to be reduced pro rata.

31 DERBY AND DERBYSHIRE: That conference expresses grave concern that the chief executive of the GMC has stated that the introduction of revalidation is not dependent on having an effective remediation system in place. It is essential that there is a clear process for remediation in place before the start of the revalidation of doctors.

32 DERBY AND DERBYSHIRE: That conference instructs the BMA and branch of practice committees not to agree the start of revalidation UNTIL remediation is available to all doctors on an equal basis.

33 GRAMPIAN: That conference supports revalidation, but demands that remediation is properly resourced by NHS funds and that there is never a cost to colleagues of affected practitioners.

34 MID MERSEY: That conference believes that the revalidation process should not proceed until it is fully funded.

35 NORTHAMPTONSHIRE: That conference insists that revalidation should not result in any increase in GMC fees for GPs.

36 SURREY: That conference believes the process of professional revalidation must be appropriately funded. (Supported by KINGSTON AND RICHMOND)

37 MID MERSEY: That conference believes that revalidation should not draw an unfair distinction between principals and non principals.

38 MID MERSEY: That conference believes revalidation is complex and should be tailored to the individual.

39 BORDERS: That conference believes that revalidation should not be introduced until:
(i) arrangements for sessional doctors, those working out-of-hours and locum GPs are fully worked out
(ii) arrangements and funding for remediation are fully in place
(iii) arrangements for funding of doctors who wish to return to general practice after a career break are agreed.

40 NEWCASTLE AND NORTH TYNESIDE: That conference demands that PCOs do not pre-empt the introduction of revalidation by implementing more stringent frameworks before it has begun.

41 NORTH AND NORTH EAST LINCOLNSHIRE: That conference insists that a fully funded remediation scheme is an integral and indispensable part of revalidation, and must be provided before revalidation becomes mandatory.

42 SOUTHWARK: That with respect to revalidation, conference:
(i) notes with concern that recent pilot models of revalidation project that a high proportion of GPs will fail revalidation
(ii) that such a high number of GPs failing could destabilise practices and healthcare provision to patients
(iii) is gravely concerned by the likely lack of GP remedial training provision occasioned by the abolition of the GP deaneries
(iv) insists that the GPC withholds support for the implementation of revalidation until adequate funding and robust arrangements are guaranteed for remedial training of GPs who fail to pass.

43 NORTH YORKSHIRE: That conference believes that revalidation is not a good use of funding. Its development should be suspended in favour of supporting local governance in conjunction with current GMC performance procedures when needed and calls on the GPC to negotiate this change of policy.

44 LEEDS: That conference believes that if a patient and a colleague survey is to be required for revalidation, that approved surveys that can be both used and analysed at no cost to practices or peripatetic GPs, should be made available.

45 LEEDS: That conference believes that a minimum of one clinical session per week would be a realistic expectation to satisfy the safety requirements for revalidation of experienced portfolio GPs.

46 WIRRAL: That conference directs GPC to seek substantive resource from the Department of Health to support GPs who are struggling to satisfy the demands of appraisal and revalidation.

47 THE GPC: The GPC seeks the views of conference on the following motion from the sessional GP subcommittee: That conference insists that medical performers lists should be:
(i) able to identify sessional GPs so that they can receive important national and local information that is relevant to their working practices
(ii) made fit for purpose so that those bodies that represent or work with sessional GPs can contact their constituents.

48 SOUTH STAFFORDSHIRE: That conference urges the GPC to:
(i) ensure that the appraisal process is formative and suitably, educationally rigorous
(ii) but user friendly and not over-complex, and
(iii) done using the toolkit of appraisee's choice, not one imposed upon them.

49 CORNWALL AND ISLES OF SCILLY: That conference believes that the present model of free at the point of delivery in general practice is unsustainable.

* 50 AGENDA COMMITTEE: That conference:
(i) welcomes the NHS panel's decision to define the rules for rationing
(ii) calls on the government to be honest with the public about NHS resources being limited
(iii) asserts that the primary moral, ethical and professional duty of a general practitioner is to the patient whose care they are managing
(iv) deplores the fact that the government wastes billions without a political mandate on the unnecessary reorganisation of NHS structures and bureaucracy
(v) deplores the government's waste of public funding on unfounded initiatives and policies that do not deliver a defined outcome that benefits patient care.

50a BRADFORD AND AIREDALE: That conference believes that 'free at the point of access' is a misleading statement and:
(i) a proper debate on rationing take place with the public
(ii) fees be introduced for non-commissioned NHS services.

50b MID MERSEY: That conference welcomes the NHS panel's decision to define the rules for rationing.

50c AVON: That conference calls on the government to be honest with the public about NHS resources being limited and inform them that rationing within healthcare is inevitable.

50d CORNWALL AND ISLES OF SCILLY: That conference requires the GPC to persuade the State to 'come clean' and allow the public insight in to the current parlous state of the NHS.

50e ROCHDALE AND BURY: That conference urges government to be open with the public on the impact of healthcare reform on their future healthcare service.

50f ENFIELD: That conference asserts:
(i) the primary moral, ethical and professional duty of a general practitioner is to the patient whose care they are managing
(ii) that GPs in their clinical role should have an awareness of NHS budgetary issues but such considerations come second to adequate, comprehensive and compassionate care for patients
(iii) that whilst GPs are acting in a managerial role, such as membership of a clinical commissioning group board, they are not absolved of the obligations to patients described in parts (i) and (ii).

50g BARNET: That conference deplores the government's waste of public funding on unfounded initiatives and policies that do not deliver a defined outcome that benefits patient care.

50h WALTHAM FOREST: That conference deplores the fact that the government's direction of travel will further bureaucratise the NHS, wasting resources in a time of severe financial restriction, and urges the government to seek a different route.

50i BEDFORDSHIRE: That conference deplores the way CCGs have been asked to try to save money by rationing patient care while the government wastes billions without a political mandate on the unnecessary reorganisation of NHS structures and bureaucracy.

50j MID MERSEY: That conference believes that the NHS faces a previously unrivalled economic reality and calls on the government to communicate this in public debate.

50k SOUTHWARK: That conference in re-affirming its position in passing motion 10 at the 2011 conference, encourages clinicians to enter into an open debate with members of the public, government and commissioners, about the reality of cuts in NHS services, and expose the myth of rationing labelled as 'cost-effectiveness'.

50l AVON: That conference deplores the effect of the Nicholson challenge which bleeds primary care and feeds secondary care.

50m DEVON: That conference urges the Department of Health to be open and honest about the progress of the NHS in delivering the 'Nicholson Challenge' and asks them to publicly acknowledge that the only way of achieving a 20% reduction in cost is to reduce expectation and demand.

50n NORTH YORKSHIRE: That conference demands that NHS funding addresses health needs in times of economic crisis without political interference.

50o ROCHDALE AND BURY: That conference still aspires to support World Class NHS primary care in a worldwide financial crisis.

50p ROCHDALE AND BURY: That conference recognises the current financial climate of this country but urges the government not to undo over 60 years of healthcare developments.

50q SALFORD AND TRAFFORD: That conference deplores the creation of additional layers of bureaucracy in the Health and Social Care Act.

50r NEWCASTLE AND NORTH TYNESIDE: That conference believes that:
(i) the Health and Social Care Act will allow fewer services for fewer people
(ii) the Health and Social Care Act will allow clinical commissioning groups (CCGs) to provide fewer services for fewer people
(iii) CCGs must inform the GP practices and publicise to local patients when a service is removed or decommissioned from that area's NHS provision and where that service was previously free.

50s ROCHDALE AND BURY: That conference believes that decommissioning clinical services is pushing ill patients to turn to the private sector.

* 51 KENT: That conference reprimands the BMA leadership for taking so long to wake up to the malignant effects of the Health and Social Care Act.

51a CORNWALL AND ISLES OF SCILLY: That conference believes that the phrase 'critical engagement' when used by our representative bodies are merely synonymous with 'procrastination'.

* 52 AGENDA COMMITTEE: That conference:

(i) believes the reforms proposed within the Health and Social Care Act will further widen population health inequalities
(ii) recognises that the Health and Social Care Act in the current form will compromise the health of the nation
(iii) reasserts that the core strength of general practice lies in the relationship between individual doctors and their patients
(iv) believes that core general practice is seriously threatened by the scale of the current NHS reforms
(v) calls on every English GP practice to consider withdrawing from involvement in CCGs and other NHS management roles in order to focus on core practice work.

52a NEWCASTLE AND NORTH TYNESIDE: That conference in respect of the Health and Social Care Act believes:

(i) it poses the greatest threat to the NHS since its inception
(ii) the Act will compromise the health of the nation (England) and endanger patients due to the scale and pace of change
(iii) that it will lead to an increase in inequalities in health throughout England
(iv) that its complexity will lead to an increase in bureaucracy.

52b ROCHDALE AND BURY: That conference recognises that the Health Act in the current form will compromise the health of the nation.

52c MID MERSEY: That conference believes that quality of care should not be sacrificed on the altar of reforms.

52d SOMERSET: That conference reasserts that the core strength of general practice lies in the relationship between individual doctors and their patients, and that any organisational changes that weaken this relationship must be resisted.

52e CROYDON: That conference believes the reforms proposed within the NHS Health and Social Care Act will further widen population health inequalities. (Supported by KINGSTON AND RICHMOND)

52f WORCESTERSHIRE: That conference believes that urgent discussion is needed with the government to safeguard core general practice which is seriously threatened by the scale of the current NHS reforms.

52g SHROPSHIRE: That conference believes the proper resourcing of new work and responsibilities in primary care, established by the 2003 GP contract, is threatened by the Health and Social Care Act.

52h SHROPSHIRE: That conference believes the Health and Social Care Act will damage the NHS, increase in-hours workload and undermine the basis of the doctor-patient relationship and that every English GP practice should consider withdrawing from involvement in CCGs and other NHS management roles in order to focus on core practice work.

52i ROCHDALE AND BURY: That conference urges government to reconsider the pace of healthcare reform to protect the health of the nation.

52j SHROPSHIRE: That conference believes the principle motivation behind the Health and Social Care Act is to drive down costs in the NHS despite the detrimental effects this will have on patients and their care.

52k SHROPSHIRE: That conference believes there is no evidence that the NHS is less efficient, more costly or less effective than its European counterparts and that the rationale for the upheaval caused by the Health and Social Care Act remains unclear.

52l KENT: That conference calls on GP members of CCGs to suspend commissioning work in order to support the majority of the profession who believe that the Health and Social Care Act will damage patient care and undermine the founding principles of the NHS.

52m NEWCASTLE AND NORTH TYNESIDE: That conference in respect of the Health and Social Care Act believes that:

(i) it is a fundamental threat to the overriding duty of doctors to make the care of their patient their first concern
(ii) GPs will be forced to ration care and deny the sick some aspects of the treatment they may need
(iii) that it risks losing the trust that the public and patients have in GPs.

52n KENT: That conference demands that the Health and Social Care Act continue to be resisted and recognises that:
(i) GPs will need adequate time and training to successfully commission and this will need appropriate funding
(ii) the implementation of the Act will mean multiple expensive governance structures on top of CCGs, increasing not reducing cost
(iii) implementation of the Act will widen the health inequalities gap and promote postcode lotteries
(iv) the introduction of multiple commercial providers will imperil quality.

* 53 KENT: That conference deplores the government's attempts to cover up the true consequences of the Health and Social Care Act by refusing to publish the 'risk analysis'.

53a ROCHDALE AND BURY: That conference believes that the government refusal to release the Health and Social Care Act risk assessment places unnecessary risk on emerging CCGs.

53b BRADFORD AND AIREDALE: That conference believes that the Secretary of State is not disclosing the risks associated with the Act and GPC should press for these risks to be disclosed.

54 CLEVELAND: That conference, which represents all GPs in the UK, is mindful of recent events over the Health and Social Care Act, and reasserts the position of the conference and the GPC as the only representative bodies for NHS general practitioners in the UK.

55 SHROPSHIRE: That conference commends the health secretaries of Wales, Scotland and Northern Ireland for the way they have focussed on NHS service improvements rather than needless and expensive reorganisation.

GOVERNMENT 12.20

* 56 AGENDA COMMITTEE: That conference deplores the political arrogance towards the medical profession illustrated by, and calls for the resignation of:
(i) the Prime Minister
(ii) the Secretary of State for Health.

56a SEFTON: That conference calls for the resignation of the Prime Minister for showing a contemptible disregard for the institution of the NHS by abetting the Secretary of State for Health in his mission to fundamentally recast health services as a profit making venture.

56b SHEFFIELD: That conference deplores the political arrogance towards the medical profession illustrated by the Prime Minister and his Secretary of State for Health.

56c SEFTON: That conference calls for the resignation of the Secretary of State for Health.

* 57 AGENDA COMMITTEE: That conference believes that the government's changes to the NHS in England are:
(i) merely a smoke screen for the true intent of parcelling up the NHS in to bite size chunks in preparation for privatisation
(ii) designed to make scapegoats of GPs for the rapidly deteriorating state of the health of the NHS.

57a CORNWALL AND ISLES OF SCILLY: That conference believes that the proposed changes to the NHS are merely a smoke screen for the true intent of parcelling up the NHS in to bite size chunks in preparation for privatisation.

57b REDBRIDGE: That conference calls on the government to admit publically that its NHS reforms are a move towards privatisation.

57c AVON: That conference formally requests Earl Howe to explain his comments that there are big opportunities for private sector providers to make money by taking patients away from the NHS.

57d KENT: That conference believes that the NHS reforms are designed to make scapegoats of GPs for the rapidly deteriorating state of the health of the NHS.

57e WIRRAL: That conference recognises the role of political dishonesty in the current process of reconfiguration of health services.

57f MERTON, SUTTON AND WANDSWORTH: That conference concerned that:
(i) CCGs are being set up to fail
(ii) the small budgets and changes to commissioning risk GPs being blamed for something they are not responsible for.

57g BEDFORDSHIRE: That conference believes that the 'choice' agenda has led patients to develop unrealistic beliefs about the services that the overstretched NHS can realistically provide for them and calls on GPC to ensure government is honest in pointing this out to the public.

57h BEDFORDSHIRE: That conference notes the inherent conflict between the government's insistence that patients should be given free 'choice' whilst putting GPs under undue pressure to direct patients to cost-effective pathways and calls on the GPC to demand that one or other of these mutually exclusive requirements should be dropped.

PRACTICE BOUNDARIES 12.40

* 58 CITY AND EAST LONDON: That conference demands that the GP practice of your choice pilot be abolished as it has been proposed without any clear criteria for assessment and threatens the provision of equitable health care, benefitting the fit and mobile to the detriment of the sick.

58a WELSH CONFERENCE OF LMCs: That conference insists that pilots taking place in England about dual registration are monitored closely to ensure appropriate communication and funding streams.

58b WEST SUSSEX: That conference believes current GP choice pilots represent a waste of scarce NHS resources.

58c WALTHAM FOREST: That conference believes that the pilots addressing the abolition of practice boundaries have not been well devised and insists there must be better structuring to ensure that the results are valid.

58d CITY AND EAST LONDON: That conference insists that the GP practice of your choice pilots do not disadvantage resident patients in deprived inner city communities by losing out in terms of access to services.

PATIENT REGISTRATION 12.50

* 59 SOMERSET: That conference believes that the FP69 procedure for removing patients from practice lists is discriminatory towards vulnerable groups of patients and that asks the GPC to press that:

(i) practices should be notified of FP69 correspondence before it is sent out
(ii) letters to patients should be sent in envelopes that clearly state action is needed by the recipient to keep their NHS GP, and
(iii) correspondence should be provided in a range of languages.

59a HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the current national drive to list cleansing of general practice will result in some of the nation's most vulnerable patients being left without registration with a general practice.

59b BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that the nationally mandated list cleaning exercise has:

(i) often been implemented poorly
(ii) often resulted in patients being wrongly de-registered
(iii) has a disproportionate impact on practices with higher numbers of Black and Minority Ethnic (BME) and student patients.

LUNCH 13.00

PRIMARY AND SECONDARY CARE INTERFACE 14.00

* 60 LEEDS: That conference believes that:
(i) the current amount of work being moved from secondary to primary care without appropriate movement of resources to support the work is unacceptable and unsustainable
(ii) local agreements must be made to define, control and resource shifted hospital work in to the community before it takes place
(iii) commissioning bodies must recognise the significant workload pressures in general practice and that expecting practices to do more work without resources puts patients at risk.

60a BEXLEY: That conference insists that government recognises that failure to ensure that adequate resourcing follows the patient will lead to the breakdown of an overburdened primary care system.

60b SOMERSET: That conference reaffirms the principle of 'no new work without new money' enshrined in the 2004 GMS contract, and insists that:
(i) no additional work should be transferred to general practice without a commensurate transfer of resources
(ii) all new services commissioned from primary care must be adequately resourced and
(iii) general practices must retain the right to decline additional work that is inadequately resourced.

60c NORTHUMBERLAND: That conference supports development of a clear financial mechanism or framework to facilitate safe and correctly resourced shift of activity into primary care.

60d REDBRIDGE: That conference deplores the lack of investment made in general practice particularly at a time when there is such emphasis on moving care out of hospitals and into the community.

60e MID MERSEY: That conference believes that any transfer of work from secondary care to primary care must be properly resourced.

60f GRAMPIAN: That conference welcomes care nearer to patients, but insists that work transfer from secondary care is fully resourced.

60g CHESHIRE: That conference recognises the increasing workload shift from secondary to primary care and deplores the fact that:
(i) insufficient financial resources are given to practices to undertake this extra work
(ii) in many cases premises are not fit for purpose to support this workload shift, and
(iii) the primary care workforce is demoralised by the incessant workload dumped on it.

60h WIRRAL: That conference recognises that additional funding to practices is required in order to facilitate the transfer of routine care from secondary to primary care and to mitigate the risks associated with early hospital discharge.

60i DONCASTER: That conference deplores the increase in workload moving from secondary to primary care without any associated increase in resources, and demands that the GPC/BMA negotiates with this in mind and that the Department of Health structures new DESs or local equivalents to recognise this.

60j AVON: That conference deplores the relentless creep of costs from secondary to primary care as part of a money saving exercise for the NHS. It calls upon the Department of Health to:
(i) acknowledge and accept that any shift of services from secondary to primary care, no matter how small, has financial implications for general practice
(ii) recognise that GPs will need financial support to bring about the provision of these services
(iii) guarantee that financial support is forthcoming which can be recovered from secondary care.

60k WAKEFIELD: That conference believes that the unplanned and unresourced transfer of work from secondary to primary care is:
(i) inappropriate and distracts GPs from fulfilling their basic core responsibilities to patients
(ii) poses a risk to patient care.

60l BEXLEY: That conference insists that government publicly acknowledges the exponential rise in GP workload occasioned by the transfer of secondary care services to GPs and their surgeries and the tremendous personal efforts which have been made by GPs to meet this challenge.

60m BEXLEY: That conference insists that government publicly acknowledges the heavy and increasing administrative burden which this transfer of care places upon GP practices and GPs themselves.

60n MANCHESTER: That conference reconfirms and reiterates the policy that any transfer of work from secondary or community to primary care must be accompanied by appropriate and adequate funding and resources, either by a service level agreement or a local enhanced service, or equivalent.

60o BEXLEY: That conference insists that government recognises that adequate and proportionate resources have not accompanied this transfer of services.

60p NOTTINGHAMSHIRE: That conference believes that efforts to reduce costs by transferring work from secondary to primary care will fail unless practices have easy access to infrastructure funds to support the development of premises and additional staff needed to sustain such initiatives on a recurrent basis, and urges the GPC to negotiate new funding for such developments which is outside the current contractual framework and not dependant on commissioning success.

60q NORTHAMPTONSHIRE: That conference demands that 15 minutes becomes the standard length for a GP consultation, in order to fulfil both contractual requirements and clinical expectations. This should be adequately funded otherwise general practice will not be able to continue to absorb increasing clinical risk.

60r BRADFORD AND AIREDALE: That conference believes the current 10 minutes length of GP consultation is insufficient for modern primary care and that general practice should be adequately resourced in terms of both manpower and income so that general practice can continue to be the cornerstone of the NHS.

60s CORNWALL AND ISLES OF SCILLY: That conference believes that general practice is working at full capacity and that further transfer of secondary care workload to primary care must be accompanied by new revenue streams.

60t BARNET: That conference is concerned about the transfer of responsibilities from secondary to primary care, particularly mental health services, without adequate resources being put in place to support the transfer of work.

60u MORGANNWG: That conference is supportive of the actions that can be taken to promote early recovery after surgery (ERAS) but believes that this could have significant unresourced workload implications for general practice

60v LINCOLNSHIRE: That conference instructs GPC to ensure that the 'galloping' movement of unfunded secondary to primary care work, as a result of pressure from CCGs is recognised and funded appropriately.

* 61 SHROPSHIRE: That conference believes that attempts to drive down costs in secondary care, by unresourced transfer of work to primary care, puts at risk the physical and mental health of already overstretched primary care teams.

61a EALING, HAMMERSMITH AND HOUNSLOW: That conference is concerned by the increased pressure, workload and responsibility being imposed on practices as a result of the transfer of services from hospitals into the community.

61b MERTON, SUTTON AND WANDSWORTH: That conference is concerned by the increased pressure and workload being imposed on practices due to the rushed transfer of services from hospitals into the community.

* 62 HULL AND EAST YORKSHIRE: That conference believes the frequency with which patients are discharged from hospital prior to the results of investigations being known is increasing and:

(i) this represents a significant threat to patient care and safety
(ii) reaffirms the accepted principle that the clinician ordering a test is responsible for receiving the result and ensuring proper action is undertaken
(iii) calls on all secondary sector providers to urgently review their procedures for dealing with such results and ensuring that all staff are kept aware of their responsibilities.

62a DERBY AND DERBYSHIRE: That conference notes with alarm the rapid and accelerating shift of workload from secondary to primary care and reminds all concerned that:

(i) GPs are not peripatetic community house officers
(ii) any doctor who deems that a patient requires further investigation or treatment must formally make arrangements for such treatment or investigation, follow up the request themselves, follow up the results themselves and not rely upon remarks buried in a 'flimsy discharge' in the expectation that the GP will pick up such work
(iii) unless a formal arrangement is made to shift resources with the workload, the PCO is effectively paying twice for the work, particularly in terms of opportunity costs in primary care.

62b MORGANNWG: That conference recognises the array of standards that have been put in place to ensure that high quality information is sent to primary care in a timely fashion when a patient is discharged from hospital but asks GPC to seek:

(i) confirmation that this is essential if GPs are to support early discharges
(ii) an understanding as to why some organisations find this so challenging
(iii) an understanding as to what will help those organizations that are unable to deliver the standards required.

63 EALING, HAMMERSMITH AND HOUNSLOW: That conference condemns the practice of secondary care hospitals discharging patients from outpatient care after a single 'DNA' attendance or when a patient asks to postpone a follow up appointment. The practice of asking the general practitioner to send a new referral in these circumstances is a waste of time for patients and general practitioners and carries significant increased workload and medico legal risk.

64 CUMBRIA: That conference applauds the achievements obtained by GPs in reconfiguring local services and reducing secondary care activity when given true delegated commissioning authority from a PCO.

* 65 NEWCASTLE AND NORTH TYNESIDE: That conference welcomes and supports the increased role for GPs in NHS England in service design but is concerned that:
(i) GPs' initial impressions of clinical commissioning have been changed by the reality the Health and Social Care Act imposes on GPs
(ii) new layers of bureaucracy will limit freedom for clinical commissioners
(iii) the potential future larger role for private companies will control commissioning in many areas
(iv) elements of the Health and Social Care Act have the potential to damage the doctor patient relationship.

65a BOLTON: That conference seeks to uphold the autonomy and strength of CCGs against the overweening influence of unelected PCO clusters.

65b SALFORD AND TRAFFORD: That conference deplores the manacles of interference and the lack of freedom for CCGs which will severely restrict their ability to innovate.

65c LANCASHIRE COASTAL: This conference believes that CCGs should be allowed to get on with the business of commissioning without unnecessary top down managerial interference.

65d NORTHUMBERLAND: That conference fully supports the GP role in clinical commissioning, and calls for the Department of Health to ensure bureaucracy does not smother genuine clinical input; and:
(i) calls for maximum transparency in financial decisions
(ii) makes the true cost and value of treatments explicit.

65e SOUTHWARK: That conference believes that imposition of PCO cluster commissioning models on shadow CCGs will perpetuate current inefficiencies and stifle innovation in the delivery of patient care.

65f REDBRIDGE: That conference demands that clinical commissioning groups are given true autonomy as originally planned.

* 66 CAMBRIDGESHIRE: That conference believes that GPs involved in commissioning have an increased potential for conflicts of interest and so calls on the GPC to:
(i) inform the profession of the likely consequences of not managing conflicts of interest well
(ii) explain that having a conflict of interest must not be perceived as bringing into question your integrity
(iii) highlight the risks of the same GP working on both the development of a new pathway and also providing the service
(iv) consider whether the creation of an external reference group could support GP commissioners.

66a ROCHDALE AND BURY: That conference seeks clarification on the issue of conflict of interest for local GPs who sit on their CCG.

66b DEVON: That conference respects the GPC's stance on senior members and officers of LMCs being encouraged not to be governing body members of clinical commissioning groups. We ask that this conflict of interest is more forcefully recognised and that LMCs are actively encouraged to remove such members who decline to accept this recommendation.

66c HERTFORDSHIRE: That conference recognises that the Health and Social Care Act now, more than ever before, puts GPs in an impossible position with regards to their GMC good medical practice obligations to address the needs of the patient in front of them while simultaneously making good use of available resources and addressing public health needs of their wider population.

66d ROCHDALE AND BURY: That conference request specific clarification from the GMC on their expectations of clinicians adopting management roles in CCGs.

66e BRADFORD AND AIREDALE: That conference notes the greatly increased risk of conflict of interest arising from the changes brought about by the Health and Social Care Act and resolves that all bodies involving GPs in the new NHS should have robust procedures for declaring and recording personal and prejudicial interests, including procedures for excluding those with prejudicial interests from decision making.

* 67 HAMPSHIRE AND ISLE OF WIGHT: That conference insists that all CCGs must consult with LMCs on any decision that affects the providers of general practice and that this should be written into legislation.

67a DERBY AND DERBYSHIRE: That conference asserts that LMCs are the only bodies that truly represent the views of GPs as providers of primary care at local level and that CCGs, as commissioning bodies, cannot undertake this role.

67b NEWCASTLE AND NORTH TYNESIDE: That conference celebrates the centenary year of local medical committees and believes:
(i) LMCs will represent the profession for the next 100 years
(ii) the future must start with an engagement and working relationship entered into by CCGs which recognises LMCs as the statutory committee which represents the interests of all NHS GPs in their localities.

67c NORTH AND NORTH EAST LINCOLNSHIRE: That conference expresses concern that some CCGs are excluding LMCs from their activities and once again calls upon the GPC to negotiate with the Department of Health that there be a requirement for continued and comprehensive involvement of LMCs within the new NHS.

67d MANCHESTER: That conference urges the list of functions of LMCs is carried forward and updated to include the requirement for CCGs and the NHS commissioning board to consult local representative committees on aspects of primary care.

67e GREENWICH: That conference notes with alarm the growing tendency of CCGs and Commissioning Support Organisations (CSOs) to develop detailed and advanced plans for future healthcare commissioning, without involving LMCs in meaningful consultation.

67f MANCHESTER: That conference deplores the side-lining of LMCs by PCO clusters, as LMCs, not CCGs are the representatives of GPs.

67g GREENWICH: That conference calls upon the GPC to issue a clear statement to CCG/CSOs reminding them of their duty to meaningfully consult the LMC on matters pertaining to the regulation, resourcing and delivery of general practice.

67h BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that some practices and the non primary care NHS often misunderstand the distinction between LMC and GP commissioners, and recommends that LMCs actively promote their value as an advocate of GP providers.

67i ROCHDALE AND BURY: That conference urges emerging CCGs to work with local LMCs to ensure they are well informed regarding contractual and statutory responsibilities.

67j BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference regrets the increasing tendency of commissioners to make local decisions about rationing GP prescribing without knowledge of the regulations or liaison with LMC.

* 68 AGENDA COMMITTEE That conference believes that CCGs must each be constituted in such a way so that their governing body:
(i) has GP members who are elected by a democratic process endorsed by the LMC
(ii) has GP members who are elected by a process of one GP one vote
(iii) has GP members who are elected by a process open to all local GPs whatever their contractual status
(iv) may be recalled should a majority of member practices support such action.

68a DERBY AND DERBYSHIRE: That conference deplores the actions of those clinical commissioning groups that have adopted voting mechanisms for their board members that are other than one GP : one vote, and believes that many salaried and locum GPs, in particular, have been disadvantaged and denied a say in the organisation of healthcare in their area.

68b NORTH ESSEX: That conference insists that practices have the power to recall their CCG governing body should a majority of practices support such action.

68c NORTH ESSEX: That conference insists that LMC agreement to the selection process for GP members of the governing body of a CCG is required prior to their authorisation by the NHS.

68d LEWISHAM: That conference believes that all GPs, irrespective of contractual status, must have an equal opportunity for involvement in their CCG. Elections for board members should be conducted on the basis of one GP, one vote, and all GPs should be eligible to stand for positions on the board

68e EALING, HAMMERSMITH AND HOUNSLOW: That conference insists that when electing a CCG board in 2012-13, the election process should be fair, democratic and non discriminatory - it should be one vote per GP performer, not dependent upon the practice list size and it should include all GP performers.

68f BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that shadow GP commissioning organisations:
(i) divert clinicians from delivering clinical care
(ii) have a tendency to mimic their predecessor PCOs
(iii) tend not to involve sessional GPs
(iv) vary in their adherence to democratic principles
(v) have not grown sufficiently quickly as PCOs have shrunk.

* 69 LEEDS: That conference believes the proposed quality reward payment to CCGs:
(i) could undermine the doctor patient/relationship
(ii) could widen health inequalities
(iii) should be opposed.

69a LANCASHIRE COASTAL: That conference believes that the quality premium in the Health and Social Care Act will threaten the bond of trust in the doctor/patient relationship.

69b GATESHEAD AND SOUTH TYNESIDE: That conference believes that the introduction of a quality reward to recognise the CCG and their constituent practices for delivering effect commissioning is unfair and unjust, and will lead to the actions and behaviour of others outside their control determining a proportion of practice income.

69c CAMBRIDGESHIRE: That conference believes that there should be no circumstances whereby the GPC accepts any form of a commissioning outcomes framework or quality premium that fails to uphold the principles enshrined in good medical practice.

69d EDGWARE AND HENDON DIVISION: That conference rejects the government's proposal for a Quality Reward for CCGs on the basis that:
(i) it is not a reward but a withholding of resources to CCGs which needs to be earned back on achieving central performance indictors
(ii) will result in reduction of care and services to patients due to up-front withholding of resources
(iii) will impair the ability of CCGs to commission effectively due to inadequate management resources
(iv) will exacerbate inequalities in care geographically
(v) will result in CCGs being distracted in fulfilling a Quality Reward agenda due to the financial penalty of non achievement, rather than meeting the local needs of patients.

70 LEEDS: That conference believes the commissioning outcome framework:
(i) could, if reduced in size, form the basis of a method of assessing the achievements of CCGs
(ii) should be limited to areas directly related to the CCG
(iii) could, as with other targets, lead to adverse unintended consequences
(iv) should be used for patient and peer information and not for the allocation of the 'quality reward'.

* 71 AGENDA COMMITTEE: That conference believes that commissioning support services should:
(i) be NHS led
(ii) not be sold to the private sector
(iii) be managed directly by CCGs working in cooperation with other CCGs
(iv) be retained in house by CCGs where possible
(v) always be chosen by CCGs and not influenced from above.

71a LANCASHIRE COASTAL: That conference believes that commissioning support services should be NHS led and not sold off to the commercial sector.

71b DEVON: That conference calls on the clinical leaders of clinical commissioning groups (CCGs) to consider their commissioning support service arrangements extremely carefully, and would urge them to retain these functions in house. This may be done independently or in partnership with neighbouring CCGs where economies of scale require, and the conference encourages collaborative working with LMCs, which are in a position to facilitate such discussions.

71c LEEDS: That conference believes that CCGs should:
(i) employ their own commissioning support or share it with other CCGs
(ii) not become dependent on commissioning support services external to the NHS.

71d LANCASHIRE COASTAL: That conference opposes the compulsory privatisation of all commissioning support services by 2016 and believes that CCGs should retain the right to obtain commissioning support from the most appropriate provider.

71e LEWISHAM: That conference believes CCGs should not need to be dependent on commissioning support from outside the NHS, and should be able to employ an infrastructure of commissioning managers and staff. Commissioning support organisations will be best able to provide cohesive and patient-focused support if they remain within NHS bodies. Even if specialised support is required, eg commissioning for rare conditions, it should still come from an NHS organisation.

71f SOMERSET: That conference believes that commissioning support organisations will be central to the safe and effective delivery of care and are too important to be allowed to leave the NHS.

71g CAMBRIDGESHIRE: That conference demands that the GPC work to ensure that the right balance of power is maintained between CCGs and any CSU they choose to contract with.

71h WALTHAM FOREST: That conference demands that clinical commissioning group support is not tied to provision by private consultancies which will give rise to high administrative costs and as a result reduce resources for local care and provision.

71i ROCHDALE AND BURY: That conference believes that any 'back office' commissioning of services should be at the choice of CCGs and not influenced from above.

71j EDGWARE AND HENDON DIVISION: That conference vigorously opposes the government's proposals to force all NHS commissioning support services to become "free standing enterprises" by 2016, and believes that this will de facto lead to privatisation of commissioning in the NHS.

71k SOUTHWARK: That conference deplores the:
(i) insinuation made by some PCO clusters that authorisation will be withheld from non compliant CCGs
(ii) assumption by PCO clusters that the only viable form of support for CCGs are CSOs staffed by existing PCO staff.

72 EDGWARE AND HENDON DIVISION: That conference believes that in the light of the government's support for 'integration' in the NHS, and the right of clinical commissioning groups (CCGs) to choose to use competition only if it benefits patients:
(i) CCGs should support local NHS services as preferred provider
(ii) CCGs should only consider alternative providers after establishing that local NHS services are unwilling or unable to improve services to requisite standards
(iii) the decision to tender for alternative provides must consider an impact analysis on local NHS services, and prohibit cherry picking
(iv) CCGs should choose to replace Payment by Results with funding arrangements that support integration.

73 LIVERPOOL: That conference believes that clinical commissioning groups should be encouraged to have LMC observers in attendance at CCG governing body meetings.

GPC SCOTLAND 15.50

74 **Receive**: Oral report by the Chairman of Scottish GPC (Dr Dean Marshall).

* 75 SCOTTISH CONFERENCE OF LMCs: That conference congratulates the SGPC secretariat and the BMA Scotland public affairs department for their further work on the document 'The Way Ahead' and asks the SGPC to seek an early meeting with the Cabinet Minister for Health and Wellbeing so this can be taken forward as a template for the future development of general practice in Scotland.

75a AYRSHIRE AND ARRAN: That conference congratulates the SGPC secretariat for their further work on the document 'The Way Ahead' and asks SGPC to seek an early meeting with the Scottish Health Minister so this can be taken forward as a template for the future development of general practice in Scotland.

GPC WALES 16.00

76 **Receive**: Oral report by the Chairman of GPC Wales (Dr David Bailey).

* 77 WELSH CONFERENCE OF LMCs: That conference insists that there are clear cross boundary plans for patients affected by Welsh/English border issues as well as cross local health board boundary issues.

77a WELSH CONFERENCE OF LMCs: That conference recognises the unique difficulties experienced by border GP practices when it comes to referring patients to increasingly disparate health services across the UK and urges the GPC to address this issue urgently.

78 WELSH CONFERENCE OF LMCs: That conference reminds the government that for some patients the most appropriate place of treatment will be in England.

GPC NORTHERN IRELAND 16.10

79 **Receive**: Oral report by the Chairman of the Northern Ireland GPC (Dr Tom Black).

GENERAL PRACTITIONERS DEFENCE FUND (GPDF) 16.15

80 **Receive**: Report by the Treasurer of the General Practitioners Defence Fund (Dr John Canning).

PRIMARY CARE WORKFORCE 16.20

* 81 AGENDA COMMITTEE: That conference notes with dismay and concern that recruitment in general practice is declining, and calls on the GPC to:
(i) actively promote general practice as a rewarding and exciting career option
(ii) ensure that the Department of Health counts whole time equivalent GPs and not a simple headcount
(iii) acknowledge imminent workforce problems due to retirement and the brain drain of experienced doctors to overseas posts
(iv) protect the financial position of existing GPs to encourage recruitment and retention
(v) ensure that the current excellent standards for entry into the profession are not lowered in order to address this.

81a HERTFORDSHIRE: That conference notes with dismay and concern that recruitment in general practice is declining, and calls on the GPC to:
(i) actively promote general practice as a rewarding and exciting career option
(ii) do whatever they can to ensure that the current excellent standards for entry into the profession are not lowered in order to address this.

81b NORFOLK AND WAVENEY: That conference asks GPC to challenge the methodology used by the Department of Health in its evidence to the DDRB which uses 'headcount' rather than 'whole time equivalent' thereby portraying an inaccurate picture of the current GP workforce and failing to highlight the growing 'recruitment and retention' time bomb.

81c NORTH STAFFORDSHIRE: That conference recognises that there is a GP recruitment crisis in some parts of the UK and that the GPC investigates this and negotiates for equitable and sustainable GP recruitment and retention.

81d ROCHDALE AND BURY: That conference urges the government to acknowledge imminent workforce problems when the ethnic minority clinicians across the country retire.

81e HEREFORDSHIRE: That conference agrees that if the current financial and political attacks on the profession continue it will rapidly contribute to a massive shortage of general practitioners due to early retirement and emigration.

81f MORGANNWG: That conference is gravely concerned that the ever increasing workload compounded by worsening terms and conditions for UK GPs, particularly when compared with nations such as Australia and Canada, may have a negative long term impact on recruitment and retention of skilled GPs in the NHS and it urges the government to acknowledge and address the potential 'brain drain' that is looming.

81g NORFOLK AND WAVENEY: That conference asks GPC, as a matter of urgency, to look into the adverse affect changes in the profession's demographics, more attractive posts overseas, alterations to the pension scheme, uncertainty over the future of general practice and, indeed, of the NHS, are having upon partner recruitment and the ability to provide primary care, in and out-of-hours.

81h MORGANNWG: That conference urges GPC to work with the government to find ways to increase GP numbers without financially penalising existing GPs in order to rebalance the workforce and better address the burgeoning workload in primary care.

81i SOUTHWARK: That conference believes there is a growing number of fully trained GPs facing lower remuneration, growing competition for posts, job insecurity and lack of career progress towards professional maturity and autonomy.

81j JUNIOR MEMBERS FORUM: That conference:
(i) notes with concern the rising workload of GPs together with increasing rates of stress and emotional exhaustion amongst the profession
(ii) believes the current trend of increasing workload is unsustainable
(iii) believes that general practice should not be treated as the sump for all medical and social care.

* 82 GWENT: That conference requests GPC to work with the relevant authorities to develop a framework of requirements for those wishing to return to practice, after an absence, that is:
(i) proportionate and uniform
(ii) applicable across all health authorities in the UK
(iii) sympathetic to their developmental needs
(iv) not onerous, expensive nor discouraging.

82a THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee:
That conference believes that those who wish to return to general practice after a career break are a valuable resource that should not be squandered, and calls for adequate assistance both in terms of funding and support mechanisms to be made available to these doctors.

82b KENT: That conference views with great concern the difficulty that trained general practitioners experience in getting back to work after a career break and instructs the GPC to negotiate a working, properly funded returner scheme.

82c WELSH CONFERENCE OF LMCs: That conference, with reference to doctors who wish to return to general practice after periods away on maternity leave, working abroad or suspension under GMC or Performance List Regulations:
(i) is concerned about the lack of clear and separate funding streams for ensuring adequate numbers of places in advanced training practices (ATPs) for the retraining of such doctors
(ii) believes that adequate funding should be made available for retraining as this is likely to be a small proportion of what it would cost to retrain another doctor as an alternative to a potential returner
(iii) believes that the NHS cannot afford to 'throw away' GPs who are capable of very useful professional lives and who are committed to working in the NHS.

82d MID-SURREY KINGSTON AND ESHER DIVISION: That conference regrets the lack of funding by PCOs and deaneries for the necessary retraining of GPs wishing to return to practice after a career break resulting in a waste of resources.

82e THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee:
That conference calls for GPs who are not working in the UK for a period of two years or more, and who are therefore no longer on a performers list, be allowed back onto a performers list if they can demonstrate that whilst abroad, they have kept up to date with required knowledge and clinical skills to work in UK practice.

CARE PATHWAYS 16.40

* 83 SHROPSHIRE: That conference believes the increasing imposition of decision algorithms, protocols and tick box referrals undermines the established role of the British GP as their patients' advocate and threatens the intelligent and compassionate delivery of care tailored to individual needs.

83a LIVERPOOL: That conference believes that whilst the concept of having care pathways appears to make sense, in reality their use rarely takes into account the manner in which GPs work as patient frequently have multiple pathology and views on which treatment they find acceptable.

83b BARNET: That conference demands that any referral management schemes should be focused on patient care and not overly bureaucratic.

83c HILLINGDON: That conference demands that any referral management schemes should be focused on patient care and not overly bureaucratic.

83d EALING, HAMMERSMITH AND HOUNSLOW: That conference believes that bureaucratic requirements should not hinder a GP's ability to process urgent referrals.

83e SOUTHWARK: That conference believes that a GP's duty to refer patients appropriately is being undermined by over-enthusiastic and poorly evidenced models of referral management which compromise patient safety and wellbeing.

83f SOUTHWARK: That conference insists that prior to commissioning referral management systems are:
(i) the subject of meaningful consultation with LMCs
(ii) are fully financially modelled
(iii) acknowledge patient choice, and the role of the GP as patient advocate in referral choice
(iv) subject to full independent evaluation.

83g BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that referral hubs:
(i) were usually set up to contain commissioner costs
(ii) tend to delay referrals to the specialist chosen by a GP
(iii) should never be made mandatory by commissioners.

83h HARINGEY: That conference deplores the failure on the part of some NHS cluster/PCOs which have implemented policies to reduce and/or monitor referrals to secondary care to recognise that it is:
(i) a GP's right to refer a patient for an opinion
(ii) the responsibility of the clinician who recommends any procedure to be undertaken to provide evidence in relation to individual treatment requests and not the GP.

83i ROCHDALE AND BURY: That conference believes that introduction of clinical gateways has restricted patient choice.

		PRIVATE FEES / NHS WORK	**16.50**
*	84	MORGANNWG: That conference urges GPC to negotiate a change to the GMS contract that would allow patients to receive treatment not funded by the NHS from their own GPs on a private basis.	
	84a	NORTHAMPTONSHIRE: That conference insists that a GP practice be able to provide private services to registered patients, if the NHS does not fund or provide the low priority treatments locally.	
	84b	NORTH YORKSHIRE: That conference demands that GPs should be allowed to offer and charge their registered patients for private services not commissioned by the NHS.	
	84c	LEICESTERSHIRE AND RUTLAND: That conference believes that the GPC needs to add to the GPs contract the right for GPs to charge non eligible patients for administration of the flu vaccine.	
	84d	HAMPSHIRE AND ISLE OF WIGHT: That conference calls on the negotiators to seek that patients have the right to purchase health care from any appropriate provider, including their provider of general medical services, especially relevant now with the ever increasing list of services no longer available on the NHS.	
	84e	SOUTH CENTRAL REGIONAL COUNCIL: That conference believes that patients should have the right to purchase health care from any appropriate provider, especially relevant now with the ever increasing list of services no longer available on the NHS, including their provider of General Medical Services, and that any future negotiation of the GP contract should include this provision.	
		PRISON DOCTORS	**17.00**
	85	MORGANNWG: That conference recognises the importance of continuity of care for offenders on release from detention and calls on the home office and departments of health to ensure that all prisons have computerised clinical record and information systems to: (i) facilitate rapid transfer of information to GPs to ensure that the management of offenders is not compromised (ii) assist in reducing reoffending (iii) support rehabilitation.	
		CHOSEN MOTIONS	**17.10**
		CONTINGENCY TIME	**17.20**
		CLOSE	**17.30**

ASK THE NEGOTIATORS 09.00

CARE QUALITY COMMISSION (CQC) 09.20

* 86 AGENDA COMMITTEE: That conference with regard to the Care Quality Commission (CQC):
(i) demands that registration should not incur any expense on practices
(ii) demands standards applied by the commission for GP practices should be appropriate to a primary rather than secondary care setting
(iii) expects the commission to always use transparent and explicit evidence based criteria when establishing which practices will receive a visit and assessing practices against the standards
(iv) believes registration is still a bridge too far.

86a NORTH YORKSHIRE: That conference insists that registration with CQC should not attract a fee for the provision of NHS General Medical Services and for any qualified provider (AQP) status by general practitioners

86b WOLVERHAMPTION: That conference supports the proposal that GPs should not have to pay to be registered with the CQC. (Supported by WALSALL)

86c BARNET: That conference demands that registration with the CQC should not incur any expense on practices and that the GPC should consider what action might be taken should any proposal for non reimbursed costs be put forward.

86d GLOUCESTERSHIRE: That conference demands that CQC standards for GP practices should be appropriate to a primary rather than a secondary care setting.

86e AVON: That conference instructs the GPC to obtain clear assurances from CQC that they fully understand the difference between the practice of medicine in primary and in secondary care and that they will not impose criteria or standards on GP surgeries that are irrelevant, inappropriate or unworkable.

86f CENTRAL LANCASHIRE: That conference expects the Care Quality Commission to always use transparent and explicit evidence based criteria when establishing which practices will receive a visit after initial registration and assessing practices against the standards. CQC decisions should never be made on an unsupported belief or presumed criteria.

86g MID MERSEY: That conference believes that CQC registration is still a bridge too far.

86h ROCHDALE AND BURY: That conference urges GPC to ensure that forthcoming CQC practice registrations are clear, concise and cost-effective.

86i ROCHDALE AND BURY: That conference believes that CQC registration should be reimbursed by current and future commissioning bodies.

86j WAKEFIELD: That conference can only support infection control measures in general practice if they:
(i) are proportionate
(ii) have an evidence basis in the primary care context
(iii) are appropriately resourced.

GP EDUCATION AND TRAINING 09.30

* 87 AGENDA COMMITTEE: That conference:
(i) supports the principle of lengthening of GP training
(ii) insists that any extension of GP training is fully funded as an educational and developmental scheme
(iii) demands that GP consortia act on the need for training of doctors when commissioning services away from secondary into primary care
(iv) believes that it is not the length of training that makes good GPs but its content and that the programme must be revised and strengthened
(v) believes the out-of-hours experience for GP trainees should be increased to ensure competency.

87a CLEVELAND: That conference supports the extension of GP training, but only when it is fully funded as an educational and developmental scheme.

87b MORGANNWG: That conference supports the principle of lengthening the training for GP trainees, given the evolution of their role in the NHS and particularly when GP training is benchmarked against training for consultants.

87c HOLLAND DIVISION: That conference is concerned that extending GP training without funding provision for doing so, or by removing the trainer grant for the final year, will discourage GPs from undertaking the role of trainer, and calls for extended training to be adequately funded by deaneries.

87d THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: That conference believes that it is not the length of training that makes good GPs, but it is what takes place in the training programme that counts. We therefore call for COGPED and RCGP to ensure that the following are put in place before any extension to training is introduced:
(i) the educational content of all training posts to be made explicit to all trainees in advance of courses commencing (via 'Form B') by August 2014 with at least half of all posts complying by August 2013
(ii) no GP trainee should be asked to spend more than six months (full-time equivalent) in a single broad hospital specialty
(iii) no GP trainee should be asked to spend less than four (full-time equivalent) months in a single hospital specialty
(iv) if it is felt that the trainee is able gain the competencies in less than four months (full-time equivalent), then it should be offered as a part of integrated GP post.

87e LIVERPOOL: That conference believes that there must be no increase in the length of GP training until such time as it can be adequately funded.

87f PLYMOUTH DIVISION: That conference calls for any proposal to lengthen GP training to ensure that GP practices are incentivised to provide good quality placements in sufficient quantities.

87g AVON: That conference demands that GP consortia acknowledge and act on the need for training of hospital doctors/specialists and GP VTSs when commissioning services away from secondary care into primary care or private providers so that future service providers are adequately qualified and equipped to provide training.

87h CROYDON: That conference believes clinical commissioning groups should ensure hospital providers are required to maintain junior doctor training functions. (Supported by KINGSTON AND RICHMOND)

87i SOMERSET: That conference asserts that the current specialist training programme for general practice should be revised and strengthened to prepare doctors for the realities of working as independent practitioners.

87j SHROPSHIRE: That conference believes the current out-of-hours experience required for GP registrars is not adequate to encourage interest or ensure competency and should be increased.

88 NORTHERN IRELAND CONFERENCE OF LMCs: That conference rejects the current proposed ST4 year as lacking in educational merit.

* 89 GLASGOW: That conference believes that the current remuneration for GP training practices for providing GP training is:
(i) undervaluing our role in the maintenance and promotion of excellence in practice for the long term future of our profession
(ii) demoralising to the extent whereby practices that potentially could become trainers are discouraged from taking up this role
(iii) causing practices that have already taken on this key position in the profession to consider withdrawing their expertise and service.

89a SCOTTISH CONFERENCE OF LMCs: That conference believes that the current remuneration for GP training practices for providing GP training is:
(i) undervaluing the GP trainer role in the maintenance and promotion of excellence in practices for the long term future of the profession
(ii) demoralising to the extent whereby practices that potentially could become training practices are discouraged from taking up this role
(iii) causing practices that have already taken on this key position in the profession to consider withdrawing their expertise and service.

89b CAMBRIDGESHIRE: That conference applauds training practices for continuing to have registrars in their practice despite the additional pressures this creates for the practice and calls on the GPC to negotiate a training grant that truly reflects the costs incurred.

89c CLEVELAND: That conference insists that the funding for undergraduate education in general practice is:
(i) maintained at least at current real term levels
(ii) ring-fenced for use in general practice
(iii) increased to reflect increased teaching in general practice.

89d ISLINGTON: That conference deplores the loss of GP educational funding in many areas and insists that GP educational funding must be protected in any new arrangements.

* 90 NOTTINGHAMSHIRE: That conference believes the new arrangements for education and training introduced in the government's reforms threaten to overlook the needs of the general practice workforce and calls on the GPC to persuade the Department of Health to ensure that:
(i) adequate funds are ring-fenced for practice staff education and training
(ii) healthcare workforce planning incorporates recognised career pathways for practice nurses
(iii) the new local education and training boards (LETBs) are constitutionally required to consult with LMCs as representatives of general practice.

90a NOTTINGHAMSHIRE: That conference believes that, as representatives of GP provider businesses, LMCs are best placed to represent practices in negotiations and consultations with local education and training boards (LETBs) about GP and practice staff education, training and workforce issues.

90b WALTHAM FOREST: That conference believes that the development and appointment of personnel to local education and training boards (LETBs) is haphazard and demands that this be replaced by a national and standardised process.

LMC CONFERENCE 09.50

91 CORNWALL AND ISLES OF SCILLY: That conference calls for increased representation of grass roots GPs on the LMC conference agenda committee so that the agenda chosen reflects the concerns of real grass roots GPs.

* 92 AGENDA COMMITTEE: That conference believes that composite motions:
(i) often remove the intention of the original proposer
(ii) often dilute the strength of expression
(iii) often reduce democracy
(iv) should not be the normal way of expressing motions.

92a DERBY AND DERBYSHIRE: That conference believes that composite motions often:
(i) remove the intention of the original proposer
(ii) dilute the strength of expression
(iii) reduce democracy and
(iv) should not be the normal way of expressing motions.

* 93 LIVERPOOL: That conference believes that conference was exceptionally wise in choosing Liverpool for its conference venue, and hopes that Liverpool will become a regular fixture.

93a MID MERSEY: That Mid Mersey LMC would like to congratulate the conference on its historic decision to come to Liverpool and would like to propose a vote of thanks to the organising committee for a fantastic conference.

94 CROYDON: That conference believes the LMC conference should be relocated to London. (Supported by KINGSTON AND RICHMOND)

95 CORNWALL AND ISLES OF SCILLY: That conference looks forward to enjoying next year's conference on the Isles of Scilly.

SOAPBOX 10.10

PENSIONS 10.30

* 96 AGENDA COMMITTEE: That conference calls on the government to reconsider its proposed reforms to the NHS superannuation schemes, and return to negotiations, given that:
(i) the reforms are unnecessary as the schemes are financially healthy following the review in 2008
(ii) NHS workers are being asked to make disproportionate superannuation contributions compared with other public sector workers
(iii) the schemes may be destabilised due to workers choosing to retire early or choosing to cease making contributions to the schemes
(iv) a cohort of workers may be compelled to continue with demanding, high intensity work despite no longer being mentally or physically fit enough to do so
(v) there is a danger of workers of all ages leaving the NHS and destabilising healthcare in the UK.

96a DEVON: That conference calls on the government to reconsider its changes to the NHS pension scheme and return to the negotiating table in view of the inherent dangers of destabilising healthcare in the UK due to clinicians of all ages leaving the NHS through lack of trust in the future of the pension scheme.

96b HAMPSHIRE AND ISLE OF WIGHT: That conference is appalled at the betrayal of trust displayed by the government in making further changes to the financially healthy NHS pension scheme following the negotiated agreement made in 2008 and imposing them on all NHS employees. We believe that:
(i) this is likely to result in doctors exercising their personal choice to stop paying into the scheme and/or to take their pensions early with the risk of destabilising the whole scheme
(ii) this is an additional tax on NHS workers
(iii) this is a further attempt to undermine the financial position of UK general practice
(iv) this is an additional step towards privatisation of the NHS in England and GP service in particular
(v) the government should return to negotiations on public sector pensions and agree a way forward that is fair across the whole of the public sector.

96c SCOTTISH CONFERENCE OF LMCs: That conference demands that governments explain to the public why:
(i) they are discriminating against NHS workers in the current pension reforms
(ii) NHS workers are being asked to pay more in pension contributions per pound earned than any other public sector worker.

96d NORTHERN IRELAND CONFERENCE OF LMCs: That conference deplores the further increase in superannuation contributions coming so soon after the renegotiation of the HPSS pension scheme and considers this to be a barely disguised tax on the prudent.

96e WIRRAL: That conference deplores the government's meddling with doctors' pensions so soon after the 2008 review.

96f SALFORD AND TRAFFORD: That conference wishes to express distrust in a government that is unable to stand by previous agreement on pensions.

96g CROYDON: That conference believes the government's reforms of the NHS medical practitioners' pension scheme are unjust. (Supported by KINGSTON AND RICHMOND)

96h WELSH CONFERENCE OF LMCs: That conference deplores the misplaced priorities of a government that places expenditure on supporting banks and investment bankers' inflated bonuses above that on the pensions of its hardworking public servants.

96i NOTTINGHAMSHIRE: That conference recognises the unquestioned merits which the NHS superannuation scheme offers and deplores the recent changes, which it considers to be:
(i) unfair and demoralising to the profession
(ii) unnecessary, according to actuarial opinions available to the BMA
(iii) disproportionate in its effects particularly as regards GPs and younger doctors.

96j SOLIHULL: That conference deplores the unjust superannuation payment discrepancies between doctors and MPs. We call on conference to resist in the strongest possible terms this extra tax on NHS workers, thinly veiled as increased pension contributions. Clearly we are not 'all in it together'.

96k AYRSHIRE AND ARRAN: That conference demands that if NHS staff are forced to accept the proposed changes to pension contributions, there should be a level playing field with MPs, MSPs and civil servants paying the same rate of contributions as health service workers.

96l ROCHDALE AND BURY: That conference believes that public sector pensions should at the worst be no different to that of MPs.

96m KENT: That conference recognises that existing NHS pension arrangements already provide the tax payer with very good value for money and that interference with the scheme will:
(i) make the NHS less efficient
(ii) result in general disillusionment in health service workers too young to retire
(iii) precipitate the loss of vital expertise by the early departure of those who can retire.

96n ROCHDALE AND BURY: That conference recognises that the current pensions proposal from government is pushing more clinicians into retirement.

96o HERTFORDSHIRE: That conference believes that the attack on GP pensions will demotivate and decimate the workforce and destabilise the pensions scheme, and calls on GPC to continue to support the BMA's fight against this daylight robbery. (Supported by BEDFORDSHIRE)

96p DUMFRIES AND GALLOWAY: That conference fully supports the BMA in the ongoing negotiations over pensions and impresses on the governments the demoralisation among doctors in response to the present proposals which could lead to major workforce issues through earlier retirement and younger doctors seeking employment abroad.

96q ROCHDALE AND BURY: That conference urges Lord Hutton to consider the impact of increasing pension age and contribution on new doctors who will have student fees to payback.

96r SURREY: That conference deplores the government's imposition of changes to the NHS medical pension scheme, and believes:
(i) this represents a tax on doctors
(ii) extending doctors' retirement age could affect patient safety
(iii) the changes may lead to the premature retirement of many experienced general practitioners. (Supported by KINGSTON AND RICHMOND)

96s BORDERS: That conference believes that making GPs work till 68 for their pension may:
(i) lead to a lack of patient choice of the age of their GP, with an increasingly ageing work force
(ii) lead to a cohort of GPs who may be working when they feel physically or mentally unfit to do so due to the ever increasing demands of general practice
(iii) lead to lack of career progression for younger GPs
(iv) lead to a cohort of GPs who may feel burnt out by the pressures of keeping up to date
(v) cause increased burnout due to the increased non patient time needed to prove you are up to date for revalidation.

96t SCOTTISH CONFERENCE OF LMCs: That conference believes that making GPs work till 68 for their pension may:
(i) lead to a lack of patient choice of the age of their GP, with an increasingly ageing work force
(ii) lead to a cohort of GPs who may be working when they feel physically or mentally unfit to do so due to the ever increasing demands and complexity of general practice
(iii) lead to lack of career progression for younger GPs
(iv) lead to a cohort of GPs who may feel burnt out by the pressures of keeping up to date
(v) cause increased burnout due to the increased non-patient time needed to prove they are up to date for revalidation.

96u SOMERSET: That conference believes that patient safety will be severely compromised if doctors are expected to continue to work full time in modern high intensity practice beyond the age of 60, and that altering this should be a priority objective in pension discussions with the government.

96v WIRRAL: That conference has grave concerns that doctors will be forced to continue working to an age where they might consider themselves to be a danger to patient safety.

96w DONCASTER: That conference believes that the great UK tradition of 'cradle to grave' care through trusted vocational family medicine be preserved by protecting GPs' pensions.

96x CAMBRIDGESHIRE: That conference believes that raising the retirement age of GPs to near where the Red Book forced GPs to retire could compel GPs to self fund an earlier retirement for the good of their patients.

96y KENT: That conference believes that GPs should not be forced to work until their name appears on the end of life register.

***** 97 AGENDA COMMITTEE: That conference deplores the threat to GP pensions and:
(i) supports taking industrial action
(ii) supports industrial action but only that which has the minimum negative impact on patient care
(iii) recommends that disengagement of GPs from clinical commissioning be included in any industrial action.

97a WALTHAM FOREST: That conference notes with regret that the threat to GP pensions is so grave that we must be prepared to:
(i) take industrial action which whilst not harming patients will cause inconvenience
(ii) brace ourselves for the inevitable media backlash that will follow.

97b CLEVELAND: That conference recommends to the BMA that engagement with clinical commissioning is included in any industrial action over changes to the NHS pension scheme.

97c SHEFFIELD: That conference supports disengagement from commissioning by GPs until a better pension offer is negotiated. This action would not adversely affect patient care but would highlight the fact that GPs are being asked to take on more work, for less pay and a worse pension.

97d LEWISHAM: That conference deplores the proposed changes to GP pensions that are being threatened by the government and calls upon the GPC to continue to vigorously resist these changes ideally without resorting to any form of industrial action but if this proves ineffective, to contemplate only such actions which has minimum negative impact on patient services and the good name of the profession.

CONTINGENCY **11.00**

* 98 SOUTHWARK: That conference maintains serious concerns about the design and precipitous introduction of the 111 model and believes that:
(i) government is ignoring the lessons from evaluations of 111 pilot schemes
(ii) preliminary triage of calls by non-clinicians working from algorithms will result in inappropriate triage decisions and increased attendances at GP surgeries, walk-in centres and accident and emergency departments
(iii) patient safety will be compromised
(iv) costs to both secondary and primary healthcare will increase
(v) imposition of 111 will endanger the continuance of existing GP OOH services of proven high quality.

98a KENT: That conference demands that the procurement of the NHS 111 service be postponed until the following conditions are satisfied:
(i) that the results of the pilot sites are publically available, fully evaluated and any necessary amendments or mitigating actions are both outlined and implemented across the NHS
(ii) that the authorisation and establishment of CCGs becomes complete, recognising that neither clustered PCOs nor nascent CCGs have the capacity adequately to scrutinise the implementation of 111 until this stage of transformation is complete.

98b MID MERSEY: That conference believes that the 111 service is not fit for purpose.

98c GLOUCESTERSHIRE: That conference calls for Department of Health to make considerable savings by scrapping NHS 111 and NHS Direct.

98d CITY AND EAST LONDON: That conference is concerned that CCG involvement in the commissioning of 111 has been tokenistic at best and calls for proper local clinical leadership.

98e DERBY AND DERBYSHIRE: That conference believes that 111 must not be rolled out any further until the full pilot studies are complete and meaningful consideration of the findings has taken place.

98f CITY AND EAST LONDON: That conference insists the roll out of 111 pilots be stopped pending publication of all audit and evaluation data.

98g ROCHDALE AND BURY: That conference feels that the 111 service has been rushed through and may not be in the public's best interest.

98h DERBY AND DERBYSHIRE: That conference has grave doubts as to the validity of the findings of the reports concerning the piloting of the 111 system.

98i CAMDEN: That conference deplores the Department of Health's insistence to implement NHS 111 procurement processes in some areas before the University of Sheffield's final evaluation report of the NHS 111 pilots was published.

98j SHROPSHIRE: That conference deplores the hasty roll out of NHS 111 before data from the pilots has been properly evaluated, particularly in those areas where a high quality out-of-hours service could be replaced by one that is more costly and less effective.

98k CUMBRIA: That conference believes that 111 can only be truly effective when there is local triage as an integral part of the local doctors out-of-hours service.

98l DERBY AND DERBYSHIRE: That conference believes that 111 must not:
(i) operationally or financially destabilise in hours general practice
(ii) operationally or financially destabilise existing out-of-hours general practice providers
(iii) operationally or financially compromise the ability of incoming CCGs to make appropriate operational, financial, or clinical care pathway commissioning decisions
(iv) become a means to deny patients access to appropriate healthcare professionals.

98m CITY AND EAST LONDON: That conference insists that establishment of the new 111 system must not destabilise funding from existing out-of-hours services.

98n SURREY: That conference believes implementation of the 111 pilot scheme may damage existing out-of-hours providers. (Supported by KINGSTON AND RICHMOND)

98o NORTH STAFFORDSHIRE: That conference recognises that the development of 111 and pathways should neither jeopardise out of hours care nor cause dumping of clinical workload back into in hours primary care.

98p BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that NHS 111 has the potential to:
(i) destabilise current out-of-hours (OOHs) provision
(ii) increase local health service costs
(iii) over escalate management of patients
(iv) increase the workload of practices
and calls on the GPC to negotiate a slow down in its implementation until the lessons of pilots are better understood.

98q WEST MIDLANDS REGIONAL COUNCIL: That conference insists that the government must delay the roll out of the NHS 111 until the data from the pilot sites has been properly evaluated to inform a reasoned decision about its safety and cost-effectiveness.

98r EDGWARE & HENDON DIVISION: That conference believes that the government's NHS 111 proposals in England should formally be placed on hold, with no further procurements, due to serious concerns regarding the quality and safety of patient care, duplication and increased costs to the NHS, and increasing fragmentation in provision of urgent care.

98s EAST MIDLANDS REGIONAL COUNCIL: That conference believes that 111 must not be rolled out any further until:
(i) there has been independent peer review of the final pilot study
(ii) evidence has been published on the impact assessment on general practice and out-of-hours providers
(iii) clinical commissioning groups are satisfied that it will not compromise their ability to make appropriate operational, financial, or clinical care pathway commissioning decisions.

98t EAST MIDLANDS REGIONAL COUNCIL: That conference believes that 111 must not:
(i) operationally or financially de-stabilise in-hours general practice
(ii) operationally or financially de-stabilise existing out-of-hours general practice providers
(iii) operationally or financially compromise the ability of incoming CCGs
(iv) become a means to deny patients access to appropriate healthcare professionals.

GENERAL PRACTITIONERS COMMITTEE 11.20

* 99 CORNWALL AND ISLES OF SCILLY: That conference believes that it seriously underestimated the strength of opposition to pension reform within the profession last year and that subsequent reaction has proved that the LMC delegates and the GPC need to improve their representation of grassroots general practice in future.

99a CORNWALL AND ISLES OF SCILLY: That conference insists that the GPC apologises to grass roots GPs for its failure to represent their views on industrial action and pensions last year.

* 100 AGENDA COMMITTEE: That conference requests that the GPC:
(i) provide clarity in all four countries on the relationship between the LMCs and the GPC, GPDF and the BMA
(ii) consider how greater support could be given to LMCs from the GPC and the BMA
(iii) establish its own website to improve communication with LMCs, practices and individual GPs.

100a TAYSIDE: That conference requests the GPC to:
(i) provide clarity in all four countries on the relationship between the LMCs and the GPC (including its sub committees), the GPDF and the BMA
(ii) consider how greater support could be given to LMCs from:
(a) the GPC
(b) the BMA.

100b SOMERSET: That conference demands that the GPC establish its own website to improve communication with LMCs, practices, and individual GPs.

CONTRACT NEGOTIATIONS 11.30

* 101 NOTTINGHAMSHIRE: That conference:
(i) believes the multitude of different GP contractual arrangements is not conducive to a united profession and impedes eradication of health inequalities
(ii) recognises the growing anger among GPs at funding disparities which has led to a proliferation of the 'fairer funding' initiatives around the country aimed at reducing such disparities
(iii) is dismayed by reports suggesting that the GPC believes MPIG may be with us for another 20 years
(iv) believes the GPC should redouble its efforts to negotiate a new national contract with fair, but realistic, transitional funding relief arrangements.

101a DERBY AND DERBYSHIRE: That conference believes that the present contract model:
(i) has given rise to a huge increase in salaried doctors in general practices
(ii) is bad for the future of the profession, for patients and for the NHS
(iii) needs to be renegotiated in a way that positively supports partner-based general practice.

101b GLASGOW: That conference still supports the tartanisation of a UK GP contract rather than a wholly Scottish GP contract.

101c SCOTTISH CONFERENCE OF LMCs: That conference still supports the tartanisation of a UK GP contract rather than a wholly Scottish GP contract.

101d SHEFFIELD: That conference calls for negotiation about a true activity based GMS contract to defend the profession from increasing unresourced work and to illustrate the immense value for money of GP services.

101e MORGANNWG: That conference:
(i) believes that the present GMS contract will not deliver the resources needed to increase the number of whole time equivalent GPs without a reduction in the 'take home pay' of all GPs
(ii) urges GPC to renegotiate a contract that encourages practices to take on more GPs both in partnership and in salaried positions.

102 BIRMINGHAM: That conference instructs the GPC to negotiate changes to the Regulations which make it explicit that primary medical services contractors have no obligation to provide any treatment to hospital in-patients.

* 103 HAMPSHIRE AND ISLE OF WIGHT: That conference, in respect of work capability assessments (WCA) as performed by ATOS Healthcare, believes that the:
(i) inadequate computer based assessments that are used have little regard to the nature or complexity of the needs of long term sick and disabled persons
(ii) WCA should end with immediate effect and be replaced with a rigorous and safe system that does not cause avoidable harm to some of the weakest and most vulnerable in society.

103a SCOTTISH CONFERENCE OF LMCs: That conference, in respect of work capability assessments (WCA) as performed by ATOS Healthcare, believes that:
(i) the inadequate computer based assessments that are used have little regard to the nature or complexity of the needs of long term sick and disabled persons
(ii) the WCA should end with immediate effect and be replaced with a rigorous and safe system that does not cause avoidable harm to some of the weakest and most vulnerable in society.

* 104 AGENDA COMMITTEE: That conference believes that the Med 3 certificate is poorly understood and:
(i) that certification should be limited to a factual description of the illness or injury
(ii) urges the Department for Work and Pensions to publicise proper understanding of the Med 3 rules
RM (iii) believes it is of paramount importance that GPs retain responsibility for providing sick notes and supporting incapacity claims
(iv) there should be no requirement upon doctors to issue Med 3s after the Department for Work and Pensions has adjudicated that a person is fit for work and the individual is appealing this adjudication.

104a BRADFORD AND AIREDALE: That conference believes that sickness certification should be limited to a factual description of the illness or injury as most GPs are not qualified as occupational health physicians.

104b WELSH CONFERENCE OF LMCs: That conference confirms that NHS general practice is neither an occupational health service nor a policing service of those believing themselves unfit for work.

104c WELSH CONFERENCE OF LMCs: That conference believes that the intention of the new Med 3 'sick note' has not been sufficiently taken on board by employers and this causes unnecessary workload for GPs.

104d SCOTTISH CONFERENCE OF LMCs: That conference is disappointed by the behaviours of some employers in demanding fitness to return to work certificates for their employees despite completion of a 'fit note'.

104e MID MERSEY: That conference calls upon the Department of Health and the Department for Work and Pensions to clarify the guidance on issuing statements of Fitness to Work to avoid the continuing waste of GP appointments merely for the purpose of issuing Fit Notes.

104f WELSH CONFERENCE OF LMCs: That conference urges government and Department for Work and Pensions to promote proper understanding of the Med 3 amongst all employers.

104g GWENT: That conference believes the re-launch of sickness certification advice with the recent Med 3 certificates has been a failure and is ill-understood by employers, employees and the Department of Work and Pensions staff themselves.

104h BRADFORD AND AIREDALE: That conference believes that at a time when the doctor-patient relationship is being increasingly eroded it is of paramount importance that GPs retain responsibility for providing sick notes and supporting incapacity claims.

104i GWENT: That conference believes there should be no requirement upon doctors to issue Med 3s after the Department for Work and Pensions has adjudicated that a person is fit for work and the individual is appealing this adjudication.

104j LANCASHIRE PENNINE: That conference believes that the recent changes to eligibility to incapacity benefits have caused stress to patients and undue burden on practices. Loose wording of letters to members of the public and ill informed advice from government offices to 'get a report from your GP' regarding well notes and appeals is counterproductive and potentially damaging to the doctor/patient relationship.

* 105 NORFOLK AND WAVENEY: That conference believes GPC should renegotiate the national agreement reached on the involvement of GPs in the issuing or renewal of Firearms Certificates, particularly in the light of the widespread view held within the profession that is currently not fit for purpose as it lacks

(i) a satisfactory audit trail on the patient record
(ii) a mechanism for practices to be reimbursed for this additional work
(iii) clear guidance from the GPC.

105a BEDFORDSHIRE: That conference recognises how vulnerable GPs feel in responding to requests for information about a patient's request for a firearms certificate and calls on the GPC to:

(iv) clarify to GPs exactly where their responsibility lies regarding firearms certification, and
(v) make sure GPs' responsibilities regarding firearms certification is clearly understood by the government, the police and the GMC.

105b BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that with regard to police letters to GPs about patient suitability to hold firearms:

(i) the Association of Chief Police Officers (ACPO) and police have acted prematurely in implementing an incomplete agreement with the GPC
(ii) there is wide-spread confusion amongst GPs about patient consent, payment and legal liability, all of which require urgent attention
(iii) the workload is felt particularly by rural GPs and is such that a fee is warranted.

105c DEVON: That conference congratulates the GPC on their intermediate agreement with the Association of Chief Police Officers regarding firearm and shotgun certification. However we call upon our negotiators to seek a longer term solution that reflects public and professional concern whilst maintaining trust with legal holders of firearms.

105d WEST SUSSEX: That conference believes the current advice for GP practices receiving firearms licensing information from the police is confusing and serves no useful purpose.

105e NORTHAMPTONSHIRE: That conference deplores the new police process for enquiring about concerns regarding the issue of gun certificates.

* 106 DEVON: That conference is aware of an emerging practice where insurance companies are undertaking subject access requests (SAR) under the Data Protection Act instead of requesting a clinically written report. We ask our negotiators to aim for the following outcomes to:

(i) increase the fee in the primary legislation of £50 for paper and £10 for computer records to reflect the inflationary pressures in the 13 years since its passage
(ii) try to get further agreement from the Association of British Insurers (ABI) on the best practice associated with requests of patient data
(iii) consider a campaign to inform the general public of the potential risks of their confidential data being used for this purpose and that the consequences could include loss of cover or weighted insurance premiums.

106a CAMBRIDGESHIRE: That conference deplores the fact that the maximum charges to provide copies of patients health records have not changed in over 14 years and demands that the GPC urgently seek to review these charges with the Department of Health.

106b SCOTTISH CONFERENCE OF LMCs: That conference believes that the current payment arrangements with insurance companies, for copying records, are out of date, do not reflect the workload involved and requests that the SGPC / GPC address this in national discussions.

106c BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that since the fee for accessing medical records was set in 2000, the costs of photocopying and postage have risen dramatically, and calls upon the GPC to initiate renegotiation of the fee so that practices at the very least break even.

106d CLEVELAND: That conference condemns the misuse of the Data Protection Act by insurance companies and demands that the Information Commissioner takes appropriate action.

106e KENT: That conference deplores the way some assurance companies are using the Data Protection Act to obtain copies of patients' records and:

(i) notes that this is against the agreement reached between the Association of British Insurers (ABI) and the BMA
(ii) doubts if the patient's consent in this situation is truly informed, and
(iii) instructs the GPC to raise the matter with the ABI.

106f MID MERSEY: That conference believes the growing industry of the claims culture following minor accidents (whips/slips and trips) is to be deplored.

* 107 WELSH CONFERENCE OF LMCs: That conference urges the government to assist GPs in improving access to General Medical Services by reminding public bodies (including the NHS) and private companies that general practice has no obligation to issue any form of medical certification in respect of:

(i) sickness absence for periods of sickness of less than seven days, irrespective of whether the period of sickness absence is just before or just after a bank holiday
(ii) fitness to engage in fitness regimes, pantomimes and other courses or events
(iii) silly requests from local authorities such as evidence of a patient's condition before rubbish will be collected from the rear of a patient's property.

107a WELSH CONFERENCE OF LMCs: That conference requests the government to remind all public and private sector employers of the requirements for self-certification for employees.

107b MORGANNWG: That conference requests the government to remind all public and private sector employers of the requirements for self-certification for employees.

107c DYFED POWYS: That conference requests that the government reminds all public and private sector employers that for the first seven days of any period of sickness an employee is required to self certificate and that any additional requirement introduced by employers is a private occupational health service that they must pay for.

107d WELSH CONFERENCE OF LMCs: That conference reminds all employers that for the first seven days of any period of sickness an employee is required to self-certificate and that any additional requirement introduced by employers is a private occupational health service that they must pay for.

107e DERBY AND DERBYSHIRE: That conference, in connection with new government proposals to grant workers taken ill whilst on leave compensatory extra time off work:

(i) insists that such proposals shall not generate extra sickness certification burdens for doctors
(ii) reminds both employers and employees that doctors can only certify those matters of which they have prima facie confirmatory MEDICAL evidence
(iii) instructs the BMA, PFC and GPC to negotiate accordingly.

107f GWENT: That conference requests GPC to remind government that doctors cannot give an opinion on a person's capability for work when that person has - allegedly - become sick whilst away on holiday.

107g MORGANNWG: That conference urges GPC to remind public bodies (including the NHS) and private companies that their requests for non-statutory medical certificates take up GP time that should be available for them to provide General Medical Services to patients who are sick or believe themselves to be sick.

FUNDING FOR GENERAL PRACTICE 12.00

* 108 LEEDS: That conference calls on the DDRB to recognise the increasing workload in general practice and greater complexity of consultations being carried out by GPs throughout the UK.

108a WIRRAL: That conference deplores the GP pay freezes/ cuts in the context of the rise in staff costs and practice expenses, increasing cost of professional fees and indemnities, and the rising cost of living.

108b ROCHDALE AND BURY: That conference believes that lack of primary care investment is strangling the innovation in primary care.

108c HERTFORDSHIRE: That conference calls on GPC to negotiate a mechanism for remuneration that recognises the resource intensive and complex needs of terminally ill patients who are registered for less than three months.

* 109 AGENDA COMMITTEE: That conference calls on GPC to ensure that:
(i) there is equality of funding for the provision of primary care medical services regardless of the type of contract under which it is delivered
(ii) PMS reviews do not result in an overall reduction in the funding available for general practice
(iii) service delivery is not jeopardised by any aggressive approach to remove funds from PMS practices
(iv) any funding removed from PMS practices is re-invested in general practice.

109a HERTFORDSHIRE: That conference calls on the GPC to ensure that
(i) PMS reviews do not result in a reduction of funding for general practice overall.
(ii) any funding removed from PMS practices is reinvested in general practice.

109b ROCHDALE AND BURY: That conference believes that the aggressive approach adopted by commissioners towards PMS contracts to release funds is jeopardising service delivery.

109c COVENTRY: That conference believes that there should be equality of funding for the provision of primary care medical services regardless of the type of contract it is delivered under.

* 110 DERBY AND DERBYSHIRE: That conference:
(i) believes that a more appropriate model than the 'Carr-Hill' formula to distribute resources to general practice is required
(ii) directs GPC to seek to negotiate a new distribution formula as soon as possible.

110a AVON: That conference request GPC to properly account for socio-economic deprivation and the lack of English as a first language in the population when developing any new contractual funding formula.

110b AVON: That conference recognises that one size does not fit all and that there is a need to recognise the make-up of individual practice populations when looking at future formulae and ensure that there are mechanisms in place in any future funding calculations.

CHARITIES 12.20

Dain Fund

111 **Receive**: Report by the Chairman of the Dain Fund (Dr Aamir Syed).

Claire Wand Fund

112 **Receive**: Report by the Chairman of the Claire Wand Fund (Dr Jane Wand).

Cameron Fund

113 **Receive**: Report by the Chairman of the Cameron Fund (Dr Roger Chapman).

LUNCH 12.30

MOTIONS ARISING FROM MAJOR DEBATE ON REVALIDATION 13.30

The motions for debate will be published on Wednesday morning. They will be made up of the motions numbers 10 - 48 in the greyed out section of the agenda, plus any new motions received following the presentation by Mr Niall Dickson.

PREMISES 14.00

* 114 EAST SUSSEX: That conference is dismayed at the woeful neglect of investment in GP premises and demands that the authorities in all four nations prioritise such developments:
(i) to allow transfer of services to primary care
(ii) to reach CQC and other legislative standards
(iii) to accommodate comprehensive primary care teams
(iv) making premises directions obligatory, particularly including obligations to guarantee leases with third party developers. (Supported by KINGSTON AND RICHMOND)

114a AYRSHIRE AND ARRAN: That conference again deplores the lack of any meaningful premises strategy for general practice and asks the national GPC to seek early meetings with the various UK governments to demand urgent action in resolving this difficult problem.

114b SALFORD AND TRAFFORD: That conference believes strongly that general practice will not be able to assist in the transfer of work out of secondary care, with all the benefits to both patients and the public purse this could bring, without appropriate government investment in the provision of adequate premises. GPC is therefore asked to work with the Department of Health in the development of a more appropriate premises strategy.

114c EAST SUSSEX: That conference believes there is currently no coherent primary care premises strategy and that this:
(i) is an astonishing gap for a 21st century NHS
(ii) lack of investment prevents the transfer of work from secondary to primary care.

114d CUMBRIA: That conference deplores the lack of any clear thinking by the Department of Health on a strategy for GP premises to enable care closer to home to be delivered.

114e MERTON, SUTTON AND WANDSWORTH: That conference has concerns over the lack of investment in premises, particularly in relation to the plans to transfer care into the community.

114f NORTHERN IRELAND CONFERENCE OF LMCs: That conference demands that there is a substantial investment in GP premises prior to shifting new work into primary care.

114g HULL AND EAST YORKSHIRE: That conference believes the delivery of high quality care for patients as well as efficiencies for the health economy both depend on good practice premises. Support for premises development has been inadequate under current arrangements and conference demands that measures are enacted to ensure the provision of adequate premises in the future.

114h GLASGOW: That conference is disappointed that once again the loss of ring-fenced primary care premises funding sees practices and community services unable to expand to meet growing demand from patients and allied professionals.

114i GLASGOW: That conference regrets the loss of ring-fenced primary care premises funding and at a time when government sees investment in infrastructure as a way to stimulate the economy, calls on the government to provide ring-fenced funding for primary care premises as part of this initiative.

114j GRAMPIAN: That conference calls on the government departments to reintroduce ring fenced funding for primary care premises development and modernisation.

114k DORSET: That conference calls on GPC to negotiate substantial, protected funding for investing in general practice premises.

114l BEDFORDSHIRE: That conference believes that the crisis in general practice in relation to premises is now critical and calls on the GPC to ensure that there is:
(i) no discretion for PCOs to refuse reimbursement if a practice extends its square footage within Red Book stipulation of appropriate size for the numbers of patients it has and
(ii) a recognition of the necessity for appropriate premises in a 21st century NHS.

114m COVENTRY: That conference deplores the lack of premises money made available by PCOs and insists that contracts are changed to:
(i) require premises funding to be easily available
(ii) include a significant uplift to the global sum to take this into account.

114n ENFIELD: That conference demands that any PCO/Cluster vision strategies put in place to review the way in which primary care is delivered in any given area must be:
(i) based on contractual and statutory requirements
(ii) accompanied by adequate funding to enable practices to make improvements to their premises.

* 115 NORFOLK AND WAVENEY: That conference calls upon the GPC to negotiate fair and reasonable terms with the newly established property company which will take control of NHS estates following the disestablishment of PCOs, particularly focusing on
(i) assurance that practices currently occupying NHS owned premises may continue to do so if they so wish
(ii) equitable terms for the continuation of existing lease arrangements
(iii) an option to purchase the freehold.

115a SEFTON: That conference calls upon the GMC to protect practices currently operating from PCO-owned premises, when these are transferred to non-PCO lessors.

115b NOTTINGHAMSHIRE: That conference is concerned that the transfer of the PCO owned primary care estate to the new NHS 'prop co' should be subject to external and parliamentary scrutiny to ensure:
(i) the tax payer is not being short-changed
(ii) the private sector is not enabled to profit from the exercise
(iii) that existing arrangements for reimbursement of GPs' rent and rates are not undermined
(iv) that GP tenants are not disadvantaged by the property transfer arrangements.

SESSIONAL GPs 14.10

* 116 GLASGOW: That conference calls upon the government to extend the protection of death in service benefit to sessional GPs by revising the entitlement criteria of pensionable employment so that sessional GPs are protected throughout whilst being hosted on a performers list, rather than intermittently whilst undertaking individual locum sessions.

116a SCOTTISH CONFERENCE OF LMCs: That conference calls upon the government to extend the protection of death in service benefit to sessional GPs by revising the entitlement criteria of pensionable employment so that sessional GPs are protected throughout whilst being hosted on a performers list and doing NHS work rather than intermittently whilst undertaking individual locum sessions.

* 117 SOUTHWARK: That conference deplores the current trend for GP contractors employing large numbers of salaried doctors who have limited opportunity for career development.

117a MID-SURREY KINGSTON AND ESHER DIVISION: That conference deeply regrets the lack of career development opportunities for non-principal GPs.

* 118 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: With regard to the model contract for salaried GPs, this conference believes that:
(i) it is financially onerous for practices
(ii) many partners feel its terms are too favourable to employed GPs
(iii) it is often ignored by employing practices without consequences.

118a BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that practices that are contractually obliged to follow the model contract for salaried GPs must be protected against the tendency of PCOs to pay very little maternity and sickness reimbursement.

DISPENSING 14.30

* 119 SUFFOLK: That conference is greatly concerned that the acquisition cost of an increasing number of dispensed medications exceeds the reimbursement received by GP practices and:
(i) believes it is not acceptable to expect doctors and their practices to subsidise patient care in this way
(ii) demands an urgent review of the pricing and reimbursement of medicines supplied in general practice.

119a KENT: That conference is greatly concerned that acquisition costs of an increasing number of dispensed medications exceeds the reimbursement received and:
(i) believes it is unacceptable to expect doctors and their practices to subsidise patient care
(ii) demands an urgent review of the pricing and reimbursement of medicines in general practice.

INFORMATION MANAGEMENT AND TECHNOLOGY 14.40

* 120 AGENDA COMMITTEE: That conference expresses concern at the imminent demise of the GP Systems of Choice (GPSoC) agreement and the apparent lack of a credible replacement and calls on GPC to:
(i) acknowledge that the current timetable and the imminent demise of the PCOs risks leaving many practices without an adequately modernised IT system
(ii) establish with the Department of Health a clear strategy for central investment in general practice IT
(iii) obtain an assurance that investment in general practice IT will continue to be externally provided and will not revert to the responsibility of the practices
(iv) ensure there is freedom for practices to choose or change a clinical system
(v) establish a credible network support organisation for IT in the NHS that will ensure compatible development across NHS organisations.

120a SUFFOLK: That conference expresses concern at the imminent demise of the GPSoC agreement and the apparent lack of a credible replacement. Conference calls upon the GPC to:
(i) acknowledge that the current timetable and the imminent demise of the PCOs risks leaving many practices without an adequately modernised IT system
(ii) establish with the Department of Health a clear future strategy for central investment in practice IT
(iii) obtain an assurance that investment in practice IT will continue to be externally provided and will not revert to the responsibility of the practices
(iv) establish a credible network support organisation for IT in the NHS which will ensure compatible development across NHS organisations.

120b BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that the responsibility for practices' IT lies with commissioners and calls on the GPC to negotiate an update of agreed specification for what is covered by this responsibility.

120c GLOUCESTERSHIRE: That conference requests confirmation of the provision of GP clinical systems beyond the expiry of GPSoC in 2013, as the current uncertainty is unhelpful to both practices and suppliers.

120d WALTHAM FOREST: That conference notes the GP system of choice policy and demands that local PCOs/sectors must not be allowed to challenge local GPs' prerogatives in assuring the freedom to choose and/or change their clinical systems if it is not delivering to their expectation.

* 121 AGENDA COMMITTEE: That conference, with regard to systems allowing access to a patient's GP held electronic medical record demands that GPC:
(i) ensure the role of the GP as being the responsible data controller is recognised
(ii) establish rules as to the level of access available to third party individuals and the appropriate training required to enable this
(iii) ensure that data added by a third party is auditable and can be corrected with no liability on the GP for such inaccuracies and
(iv) ensure patient participation is by opt in and their consent for viewing their record is enshrined.

121a HULL AND EAST YORKSHIRE: That conference believes that if the NHS has decided that a shared clinical record is needed for patient care:
(i) the role of GP as being responsible data controller should be formally recognised and appropriately funded
(ii) no one in a clinical role should be able to add to that record unless they do so within standards set by the patient's data controller
(iii) the data controller must be able to over-ride inaccurate data entries by others.

121b SUFFOLK: That conference, in the light of the development of systems allowing secondary care and other provider organisations to view a specific patient's entire electronic medical record held by the GP, calls upon the GPC to:

(i) negotiate to establish the ground rules concerning adequate patient consent and potential liability arising from use of the facility
(ii) negotiate to establish ground rules relating to the required grade of person who may view this record and the training in interpretation of GP systems' information that will be required
(iii) attempt to ensure that any facility which becomes available enabling third-party alteration of GP-held records is required to have a clear audit trail and that the altered entry is clearly differentiable from native entries
(iv) seek to limit the liability of the GP where decisions are taken on the basis of records which have not been updated and thus do not represent exact contemporaneous fact
(v) includes in any negotiation the requirement that the Department of Health ensures that the public is fully informed of this initiative before it is brought into operation.

121c HARINGEY: That conference demands that any computerised data sharing puts the patient at the centre and so requires patient permission to opt in than an automatic opt in.

121d BEDFORDSHIRE: That conference believes that the Summary Care Record project is not fit for purpose in its current form and calls on the GPC to:

(i) work with the government to find alternative IT solutions for supporting patient care using existing systems
(ii) resist any attempts to allow access to a patient's personal health information by anyone who does not have any legitimate interest in the patient's care.

121e CUMBRIA: That conference believes that in these days of increasing potential to share information:

(i) the driving principle should be benefit to patients
(ii) rigorous controls need to be in place to protect patient confidentiality
(iii) robust governance and monitoring systems need to be in place in every organisation to ensure access to patient data is on a 'need to know' basis in connection with treatment
(iv) the creeping increase in administrative access to patient data for 'management' purposes should be challenged, and
(v) the sensitivity of certain categories of information, such as sexual health issues requires special consideration.

121f SCOTTISH CONFERENCE OF LMCs: That conference:

(i) believes that the general practice electronic record should remain the primary clinical record
(ii) believes that any developments to integrate records, such as the electronic maternity record, should automatically upload on to the GP system
(iii) insists that health service initiatives to allow patient data sharing are safe and secure.

122 DERBY AND DERBYSHIRE: That conference is concerned about practices liability for emails sent to them containing urgent information about individual patients and requests GPC to formulate guidance on the matter.

123 CROYDON: That conference believes the Information Governance Statement of Compliance (IGSoC) process should be simplified as recurrent annual changes in the process increase GP practice workload. (Supported by KINGSTON AND RICHMOND)

124 NOTTINGHAMSHIRE: That conference believes the transfer of public health to local authorities is one of the greatest flaws in the government's reforms and fears that it will:
(i) reduce CCGs' access to necessary public health advice
(ii) reduce funding available to support necessary public health initiatives
(iii) further diminish public health as a medical specialty
(iv) potentially undo many of the valuable public health initiatives through which the health of the nation has been improved over the past decade.

* 125 AGENDA COMMITTEE: That conference, with reference to the annual seasonal flu immunisation campaign:
(i) urges the government to have a clear and timely policy each year to enable GPs to order their seasonal flu vaccine early enough to ensure adequate supplies for their patients
(ii) deplores late changes in policy that could affect GPs' practice based campaigns and may result in GPs being left with large amounts of unused seasonal flu vaccine
(iii) believes immunisation of the housebound is a district nursing task
(iv) expresses its grave concern at some midwives' reluctance to immunise pregnant women
(v) calls for a halt to some PCOs' insistence that GPs and their staff to have to attend training before they can vaccinate against influenza.

125a WELSH CONFERENCE OF LMCs: That conference, with reference to the annual seasonal flu immunisation campaign, urges the government to:
(i) have a clear and timely policy each year to enable GPs to order their seasonal flu vaccine early enough to ensure adequate supplies for their patients
(ii) avoid late changes in policy that could affect GPs' practice-based campaigns and may result in GPs being left with large amounts of un-used seasonal flu vaccine.

125b BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that immunisation of the housebound is a district nursing task.

125c DERBY AND DERBYSHIRE: That conference expresses its grave concern that midwives' reluctance to immunise pregnant women against influenza virus is not conducive to integrated care of this patient group and may put them at risk.

125d HAMPSHIRE AND ISLE OF WIGHT: That conference calls for a stop to PCOs' insistence that GPs and their staff to have to attend training before they can vaccinate against influenza.

QUALITY AND OUTCOMES FRAMEWORK (QOF) AND QUALITY INDICATORS 15.20

* 126 AGENDA COMMITTEE: That conference believes that QOF has achieved a rise in standards across UK practices but:
(i) believes its complexity, especially QP indicators, is interfering with GPs' capacity to deliver traditional primary care tailored to individual needs
(ii) believes that the present quality and productivity indicators are not evidence based and undermine the scheme
(iii) supports the development of indicators more focused on the needs of the young and the socially disadvantaged
(iv) rejects the Department of Health's idea of an increasingly QOF based system for calculating practice income
(v) demands no changes are made for the next two years in order to accommodate the changes to commissioning.

126a WIRRAL: That conference believes that QOF has achieved a rise in standards across UK practices but has now become increasingly complex so that achieving QOF targets, especially QP indicators, is interfering with GPs' capacity to deliver traditional primary care consistent with the requirements of its population and tailored to individual needs.

126b AVON: That conference encourages GPC to support the development of quality indicators and contract changes that focus on the health of young people, and which are less elderly care biased.

126c MID MERSEY: That conference rejects the Department of Health's idea of an increasingly QOF based system for calculating practice income.

126d MERTON, SUTTON AND WANDSWORTH: That conference proposes that no changes are made to QOF for the next two years in order to accommodate the changes to commissioning.

126e GRAMPIAN: That conference is clear that annual changes to areas such as QOF and quality and productivity are too rapid to allow bedding in. Only major new clinical evidence, and not political games playing, should influence this part of our contract.

126f AVON: That conference asks GPC to press the Department of Health to redress the aggressive impact of QIPP against the soft target of primary care where savings are small while failing to tackle secondary care where savings are huge.

126g SCOTTISH CONFERENCE OF LMCs: That conference:
(i) believes that one of the great strengths of the QOF has been its evidence base
(ii) believes that the present quality and productivity indicators are not evidence based and undermine the QOF
(iii) asks that in negotiations regarding QOF, targets should be evidence based and not what is politically expedient
(iv) demands that changes to the contract, such as quality and productivity, should be allowed to settle in for long enough to be assessed before being changed yet again
(v) demands that the SGPC and GPC insist that there will be no further changes to the QOF unless accompanied by a realistic increase of resources.

126h AVON: That conference recognises the difficulties that socially disadvantaged groups can experience when attempting to access health care. It calls upon the Department of Health to make rectifying this a key quality indicator for all organisations who work within or who contract with the NHS.

COMMUNITY SERVICES 15.30

* 127 AGENDA COMMITTEE: That conference believes that in relation to nursing and care homes there needs to be better definition of:
(i) the range of tasks that should be undertaken by staff
(ii) the role of district nurses
(iii) the complexity of patients placed therein
(iv) expectations of what can be met through GMS resources
(v) specialist medical services or interventions requirements that cannot or should not be met by general practice.

127a BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that in relation to care homes there needs to be better definition of:
(i) the range of tasks that should be undertaken by staff
(ii) the role of district nurses.

127b WELSH CONFERENCE OF LMCs: That conference is concerned that GPs are coming under real pressure by many nursing homes who expect them to provide care beyond GMS and calls upon GPC to issue guidance as to what can be regarded as:
(i) reasonable expectations that can be met under GMS
(ii) specialist medical services or interventions requirements that cannot or should not be met by general practice.

127c MORGANNWG: That conference demands that care homes must arrange adequate medical/psychiatric services for clients rather than assuming that their needs, including prescribing and managing complex drug regimes outside the GP's experience, will be met under GMS.

127d NORTH STAFFORDSHIRE: That conference recognises that there is a gap in the medical cover legislation for nursing homes whereby there is no mechanism or check on the complexity of patients placed in nursing homes during their planning or development and that the GPC investigates this considerable clinical governance risk.

127e HERTFORDSHIRE: That conference calls on the GPC to ensure that there:
(i) is a thorough review of the resources available to primary care to provide services for vulnerable patients in nursing homes, and
(ii) are adequate resources to provide excellent and appropriate care for these patients.

127f HERTFORDSHIRE: That conference calls on GPC to ensure that the Department of Health resources the extra workload for GPs in providing appropriate care for patients in nursing and residential homes.

* 128 BIRMINGHAM: That conference insists that when undertaking service redesign clinical commissioning groups must ensure that resulting non essential GMS work is funded via an appropriate mechanism.

128a NORTH YORKSHIRE: That conference demands that negotiators seek to retain, strengthen and develop the local enhanced services mechanism which has proved to be an effective vehicle for supporting secondary to primary care shift of work.

128b WELSH CONFERENCE OF LMCs: That conference reminds PCOs that when they change the accreditation requirements for enhanced services they will need to renegotiate the remuneration for the service to reflect the additional requirements.

128c KINGSTON AND RICHMOND: That conference believes local enhanced services should be commissioned locally and used to support the transfer of patient services from secondary to primary care.

128d BRENT: That conference:
(i) opposes the imposition of additional work outside that defined in DESs, NESs and negotiated LESs
(ii) insists that LESs are agreed with LMCs.

128e BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that leg ulcer work:
(i) has often landed unfunded on practices
(ii) is activity outside the core GMS contract
(iii) needs to be recognised by commissioners as worthy of separate funding or locality provision.

128f NORFOLK AND WAVENEY: That conference asks the GPC to ensure that the extended hours enhanced service remains financially viable and is not adversely impacting upon GPs ability to deliver high quality care both in and out-of-hours.

* 129 WILTSHIRE: That conference urges negotiation of:
(i) resource to provide enhanced medical care to patients in nursing homes
(ii) resource to provide care beyond GMS to patients who are unable to travel out of residential home
(iii) transport for patients to attend GP surgeries who are unable to venture out of residential homes when well, for routine and preventative care
(iv) resource for care beyond GMS for housebound patients.

129a WILTSHIRE: That conference reminds GPs that they have no obligation to visit a patient in residential care if the patient is fit to be brought to the surgery and that their GMS obligations allow GPs to decide on the appropriate place for the consultation to be held.

129b HAMPSHIRE AND ISLE OF WIGHT: That conference is concerned by the recent trend of blame at general practice for the failures of residential care and asks for additional resource allocation to provide the enhanced general practice that is so often necessary for patients in residential care.

129c NOTTINGHAMSHIRE: That conference takes note of the increasing proportion of frail elderly patients and those with dementia and calls upon the GPC to negotiate to with the Department of Health to:
(i) recognise the increasing burden placed upon primary care looking after such patients in the community
(ii) ensure sufficient funds are available to provide care to such patients without detriment to other patients under GPs' care
(iii) negotiate a new DES for patients in residential and nursing home care to reflect the increased practice workload involved and to enhance the level of care provided.

130 NORTH YORKSHIRE: That conference supports the motion that funding be made available for patients to be transported to GPs rather than GPs being expected to visit at home.

* 131 NORTHUMBERLAND: That conference believes that the time has come now to define core general practice services; and that without this:
(i) there will be no basis to resist constant unresourced shift of work into primary care
(ii) uncertainty of who is delivering a service creates risk where accountability is unclear
(iii) primary care is rendered vulnerable to removal of services to any qualified provider.

131a COVENTRY: That conference deplores the undermining of the spirit of the 2004 contract by the constant erosion of the principle of 'no new work without new money'.

* 132 AGENDA COMMITTEE: That conference, with regard to pharmacy services:
(i) deplores the frequent lack of availability of and substitutions to commonly prescribed medicines
(ii) believes government needs to clamp down on the extortionate costs charged for specials
(iii) has concerns about the conflict between the health care and retail functions of community pharmacies and demands that unproven treatments and screening tests are clearly labelled as such
(iv) calls for an urgent review of regulations that prevent the re-use of medication or dressings returned by patients
(v) believes GPs are not best placed to issue prescriptions for dressings which instead should be done locally by the nurses or community pharmacists.

132a TAYSIDE: That conference deplores the frequent lack of availability of and substitutions to commonly prescribed medicines, which is inconvenient for both patients and their GPs, and urges the BMA to work with all four national governments to discover ways of avoiding this.

132b LEEDS: That conference is concerned about the lack of availability of many commonly prescribe medicines because of so called 'manufacturing problems' and calls upon the government to urgently address the issue.

132c ROCHDALE AND BURY: That conference requests a review of why more and more drugs are becoming unavailable and what can be done to restrict export.

132d CORNWALL AND ISLES OF SCILLY: That conference asks the GPC to ensure the Department of Health get a grip on the recurrent problem of common generic drug unavailability. If there is any evidence that this produces a switch to more expensive or profitable alternatives then retribution and recompense must be swift.

132e WALTHAM FOREST: That conference notes the increased number of drugs that are unavailable in the UK as companies can get a better price for the medication elsewhere and as a result are not importing them in sufficient quantities. This causes patients and primary health care teams huge difficulties, has the potential to result in patient harm, and must be redressed instantly.

132f ROCHDALE AND BURY: That conference believes the government needs to clamp down on the extortionate costs charged by pharmacists for specials.

132g HULL AND EAST YORKSHIRE: That conference has concerns about the conflict between the health care and retail functions of community pharmacies and demands:
(i) that unproven treatments are clearly labelled as such
(ii) that screening tests that fail to meet World Health Organisation standards are clearly labelled as such
(iii) the immediate removal of non-therapeutic high fat and high calorie foods and drinks.

132h GLOUCESTERSHIRE: That conference calls for an urgent review of those wasteful regulations that prevent the re-use of medication or dressings returned by patients, even when unopened, sealed and in-date.

132i GLASGOW: That conference believes that GPs are not best placed to issue prescriptions for dressings and that these prescriptions should be done locally by the nurses or community pharmacists.

* 133 AGENDA COMMITTEE: That conference believes that recent difficulties with PIP implants and metal on metal hip replacements:
(i) resulted in authorities placing unnecessary work on practices
(ii) highlighted the need for better testing and regulation of implantable devices
(iii) necessitate a scheme to provide GPs with detailed information about the medical devices that are used in their patients
(iv) require the GPC to impress on the Department of Health the need for clarity of when secondary care is responsible for managing its own problems.

133a BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that recent difficulties with PIP implants and metal on metal hip replacements have:
(i) resulted in authorities placing unnecessary work on practices
(ii) highlighted the need for better testing and regulation of implantable devices
and asks the GPC to impress on the Department of Health the need for clarity of when secondary care is responsible for managing its own problems.

133b KENT: That conference is concerned that GPs are not provided with detailed information about the medical devices that are used in their patients and calls upon the GPC to negotiate an acceptable scheme with the Department of Health.

* 134 WILTSHIRE: That conference believes that there should be a unified form in each nation which could be the same across the UK for:
(i) the expression of the wishes of a patient or where appropriate, their representatives views regarding resuscitation
(ii) the expression of advanced wishes regarding care at the end of life that replaces the terms 'do not resuscitate' (DNR) and 'do not attempt resuscitation' (DNAR) with 'allow natural death'.

134a MID MERSEY: That conference deplores the lack of a uniform 'do not resuscitate' policy across all levels of care

135 KENT: That conference instructs the GPC to clarify where, post April 2013, responsibility for drafting and approving Patient Group Directions (PGDs) will lie.

OTHER MOTIONS 16.40

* 136 KENT: That conference:
(i) recognises there is a small but increasing number of GPs who have been refused indemnity by the traditional providers
(ii) instructs the GPC to negotiate with the government an indemnity scheme that covers all who work in the NHS in primary and secondary care on an equal basis.

136a HARINGEY: That conference demands that with the political agenda in relation to National Spine and the ever increasing need for data sharing agreements to be developed between primary and secondary care that crown indemnity should apply to GPs.

137 GREENWICH: That conference deplores the lack of support from PCO clusters to practices during the Olympic Games and National Queen's Jubilee celebrations and:
(i) condemns cluster intransigence in failing to acknowledge the level of pressure many London practices will face in terms of increased workload and patient access difficulties
(ii) condemns clusters' unrealistic expectations that throughout, practices can and will be able to provide all aspects of their contract as normal, without any disruption to services
(iii) condemns the lack of guidance, help and additional resources from cluster to support normal service delivery during this time
(iv) requests the GPC to urgently engage with the Department of Health, to secure more supportive leadership and adequate resourcing to practices during the forthcoming uniquely challenging months.

138 NORFOLK AND WAVENEY: That conference calls upon the GPC to seek a national arrangement with the Association of Chief Police Officers to establish a common policy across all police forces to ensure that GP practices are included in the 'other agencies' with whom the police are required to share information concerning sex offenders.

139 WIRRAL: That conference believes that a 24 hour supermarket style access to health care fuels excessive patient demand, is not a cost effective way to deliver a quality health service and conference should support a review of the funding of all day health centres, walk-in centres, and out-of-hours services and a rebalance of funding towards in-hours primary care.

CONTINGENCY 16.50

AND FINALLY… 16.55

140 SHEFFIELD: That conference highlights that when a car's performance is improving it is best not to take the engine out.

CLOSE 17.00

Conference of Representatives of Local Medical Committees

Agenda: Part II
(Motions not prioritised for debate)

Agenda: Part II
(Motions not prioritised for debate)

A and AR Motions

LMCs every year send very many topical and relevant motions to conference which for reasons of space cannot be included. While every LMC can submit its unreached motions to the GPC for consideration, few do so. This year the Agenda Committee in consultation with the GPC Chairman proposes acceptance of a large number of 'A' and 'AR' motions to enable them to be transferred to the GPC. A and AR motions and the procedure for dealing with them are defined by standing orders 25 and 26:

25. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chairman of the GPC as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.

26. 'AR' motions: Motions which the chairman of the GPC is prepared to accept without debate as a reference to the GPC shall be prefixed with the letters 'AR'.

GOVERNMENT

A 141 CORNWALL AND ISLES OF SCILLY: That conference requires the Department of Health regard quality of life as the determinant of success of health policy rather than the arbitrary avoidance of death before the age of 75.

A 142 AVON: That conference requests GPC to create a development programme to assist GPs in standing for parliament in order to get some common sense, energy and pragmatism into Westminster.

A 143 SHEFFIELD: That conference demands a public enquiry with the servants of our democracy, the Members of Parliament, to depoliticise the NHS forever and ensure that health reforms are evidence-led changes, independently scrutinised and recommended, and have the support of the medical profession.

PRACTICE BOUNDARIES

A 144 MID MERSEY: That conference believes that abolishing practice boundaries will be detrimental to the quality of primary care.

A 145 DONCASTER: That conference believes that GPs too should have 'choice' - the choice to control our workload by determining our own practice boundaries.

A 146 SALFORD AND TRAFFORD: That conference believes that the planned removal of practice boundaries will have detrimental consequences on locally based services such as child health, district nursing and health visiting.

A 147 CITY AND EAST LONDON: That conference believes that the defence of local boundaries must be maintained in order for GPs to continue to provide the best care for their patients.

PATIENT REGISTRATION

A 148 DONCASTER: That conference believes that GPs too should have 'choice' - the choice to control our own workload through managing list size without penalty.

AR 149 SOUTH ESSEX: That conference insists that the GPC should not agree to any change to patient choice arrangements which would specifically prohibit a practice from declaring itself 'Open but Full'.

A 150 MID MERSEY: That conference supports practices' freedom to close lists.

COMMISSIONING OF CARE

AR 151 AVON: That conference believes that interventions not normally funded (INNF) is inequitable and reaffirms the right and responsibility of GPs to be gatekeepers of the patient's needs when they require treatment.

A 152 BUCKINGHAMSHIRE DIVISION: That conference believes that it is vital for general practitioners to be able to freely and without interference refer patients directly to a named consultant for a specialist opinion in order to achieve a high standard of medical care and to maintain the trust of patients.

A 153 NORTHERN IRELAND COUNCIL: That conference demands that the NHS and its patients are better served when consultants and general practitioners work in partnership and therefore demands that all commissioning bodies in the NHS have direct input from both consultants and general practitioners.

A 154 CONSULTANTS CONFERENCE: That conference recognises that the NHS and its patients are better served when consultants and general practitioners work in partnership and therefore demands that all commissioning bodies in the NHS have direct input from both consultants and general practitioners, including during the setting of quality indicators.

AR 155 CAMBRIDGESHIRE: That conference demands that the GPC issue guidance to CCGs calling on them to respect their duty to general practice and ensure that new workload is always adequately resourced.

AR 156 LEWISHAM: That conference believes that, apart from being one of a number of sources of information available to the NHS commissioning board, CCGs should have no role in the performance management of the GP contract.

A 157 NORTH YORKSHIRE: That conference demands that all remuneration paid to GPs for their NHS GP commissioning duties should attract superannuation.

AR 158 ROCHDALE AND BURY: That conference recognises that emerging CCGs will require management and financial support to undertake their future statutory responsibilities.

PRIMARY CARE WORKFORCE

A 159 ROCHDALE AND BURY: That conference urges local PCOs to provide access to dedicated community occupational health services to primary care staff to ensure a strong workforce.

CARE PATHWAYS

A 160 NORTHAMPTONSHIRE: That conference insists on the preservation of the right of a GP to refer to a chosen consultant, rather than having to refer to the generic hospital department.

GP EDUCATION AND TRAINING

A 161 LEICESTERSHIRE AND RUTLAND: That conference believes that the GP trainee e-portfolio detracts from, rather than adds to, the GP training.

A 162 NORTHUMBERLAND: That conference continues to resist the pressure on the profession to undertake additional training for activities routinely provided in general practice and that this:
(i) devalues the status of medical training
(ii) reduces clinical time disproportionately to importance of the activity
(iii) biases perceived significance e.g. safeguarding children is universally mandatory whereas safeguarding adults is rarely considered.

A 163 MORGANNWG: That conference in respect of accreditation of GPs to provide enhanced services:
(i) recognises that a GP is trained to deliver services to patients using a wide range of skills
(ii) recognises that the delivery of the services require time and resources over and above GMS rather than an additional skills and expertise such as required by a GPWSI.
(iii) demands that GPC challenges the continual introduction of new 'hoops' that GPs are expected or required to jump through to prove that they are competent to undertake certain tasks and services.

A 164 GREENWICH: That conference notes with concern the continued demands by PCO clusters for GPs and their staff to attend a variety of unnecessary, so called mandatory training events where the standard for training has been set by the PCOs, despite clear guidance to the contrary from the Department of Health. That conference calls on the GPC to ensure that cluster CEOs and their directors are made aware of central guidance on this matter and cease this practice.

PENSIONS

A 165 CAMBRIDGESHIRE: That conference calls on the GPC to address the inequality faced by locum GPs who are prevented from making pension contributions for non clinical NHS work unlike that of all other GPs.

A 166 DERBY AND DERBYSHIRE: That conference emphasises that opposition to the Health Act by doctors is not related to opposition to proposals for pension reform.

GENERAL PRACTITIONERS COMMITTEE

A 167 BEDFORDSHIRE: That conference calls on the GPC to robustly challenge policy initiatives which could reduce public faith or confidence in their GP.

CONTRACT NEGOTIATIONS

A 168 THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee: That conference believes that commitment and service to the NHS of sessional GPs should be recognised by making them eligible for seniority payments.

A 169 GLASGOW: That conference calls upon the government to recognise and reward experience and length of service in sessional GPs as well as GP contractors by extending the system of seniority payments to sessional GPs.

A 170 WELSH CONFERENCE OF LMCs: That conference believes that despite differences across the NHS following devolution, the core UK GMS contract should be maintained.

A 171 GRAMPIAN: That conference reconfirms its support for a UK-wide GMS contract.

A 172 AYRSHIRE AND ARRAN: That conference views with concern the increasing regionalisation of the GP contract and calls on the GPC to defend vigorously the principle of a core United Kingdom GP contract.

A 173 DYFED POWYS: That conference reminds the GPC that when voting on the new GMS contract in 2003/4 they promised GPs that the MPIG would continue in perpetuity or until no longer required; and therefore urges GPC not to negotiate away the guarantee until appropriate financial arrangements are put in place to ensure that no practice is financially prejudiced by its removal.

AR 174 MORGANNWG: That conference demands Home Office and the departments of health ensure that:
(i) contracts awarded for the provision of health care within prisons are equivalent to GMS
(ii) only GPs on the local performers list should be engaged to lead and provide GMS.

AR 175 AVON: That conference reaffirms GPC's right to negotiate our contracts - PMS or GMS on behalf of all GPs.

A 176 ROCHDALE AND BURY: That conference feels that 24 hour responsibility of care should not be reintroduced into any future primary care contract negotiations.

A 177 LEICESTERSHIRE AND RUTLAND: That conference believes that there is a need to identify the core contractual duties of a GP and end the 'John Wayne' contract.

MEDICAL CERTIFICATES AND REPORTS

A 178 GATESHEAD AND SOUTH TYNESIDE That conference believes that complex multi-disciplinary forms should not be introduced without agreement by local GP representatives, and that they should include a simple GP friendly portion that can be completed within the time constraints that general practitioners have to work under.

A 179 CLEVELAND That conference believes that GPs should not be asked to provide reports to patients claiming DLA or AA and demands that Q19 and the associated notes on form DLA1 are redrafted to make it clear that reports should not be sought from a GP prior to making a claim.

A 180 NORTHERN IRELAND CONFERENCE OF LMCS That conference believes that the provision of fit notes for the purpose of employers has little to do with treating those who are ill or believe themselves to be ill and should not be part of general practice.

FUNDING FOR GENERAL PRACTICE

AR 181 CROYDON: That conference is concerned that delays in contract payments to GP practices:
(i) risk destabilising GP practices
(ii) reflect a growing chaos within NHS primary care administrative processes.
(Supported by KINGSTON AND RICHMOND)

AR 182 DUMFRIES AND GALLOWAY: That conference supports the principle that any negotiations on remuneration for GPs working in community and cottage hospitals reflects the increasing complexity of medical care that will be delivered and the consequent time commitment.

A 183 SCOTTISH CONFERENCE OF LMCs: That conference feels that health service payments to general practitioners for maternity, paternity and adoption leave should no longer be discretionary at NHS board level, but should be available at the maximum agreed amount on appropriate application.

A 184 BRO TAF: That conference requests GPC UK to review the guidance for PCOs in giving financial cover to practices for sickness leave. The current position disadvantages part time contractor GPs.

A 185 LEEDS: That conference:
(i) believes that the current variation in maternity payments made by PCOs is unacceptable
(ii) believes that any change to PCO administered funds should not result in maternity payments being fully paid from practice resources
(iii) calls on GPC to negotiate with the NHS Commissioning Board a standard maternity payment.

A 186 NORTHAMPTONSHIRE: That conference insists that discretionary PCO/cluster payments such as maternity locum payments be awarded despite financial pressures.

A 187 EAST SUSSEX: That conference believes the provision of SFE Section 9 parental leave payments should be mandatory rather than discretionary.

GP PARTNERSHIPS

A 188 CROYDON: That conference urges GPC negotiators to seek to negotiate contractual incentives to appoint partners to practices. (Supported by KINGSTON AND RICHMOND)

A 189 SOUTHWARK: That conference acknowledges the differing career needs of young GPs who have completed vocational training but notes with concern the growing number of salaried and sessional GPs unable to find a partnership.

SESSIONAL GPs

A 190 WELSH CONFERENCE OF LMCs: That conference calls for sharing of the contact details held on the non-contract holders medical performers list with various statutory and professional bodies to ensure that all sessional GPs receive information relevant to their work in general practice.

A 191 WELSH CONFERENCE OF LMCs: That conference deplores the continuing situation whereby many sessional GPs are denied access to important administrative, clinical and managerial databases on NHS intranet sites except when actually working in a general practice.

DISPENSING

A 192 NORTHUMBERLAND: That conference supports
(i) the development rather than demise of GP dispensing
(ii) relaxation or abolition of the archaic rules that prevent patients accessing this valuable service.

A 193 NORFOLK AND WAVENEY: That conference instructs the GPC that, in the light of the increasing importance placed upon patient choice for all aspects of health care, it is now time to negotiate the removal of 1.6km limit that currently prevents a patient from receiving medicines from a dispensing practice if that patient lives within 1.6km of any pharmacy, thereby denying the patient their right to choose.

INFORMATION MANAGEMENT AND TECHNOLOGY

A 194 MORGANNWG: That conference urges GPC to ensure that, in line with good information governance procedures, all locum GPs are able to have their unique identity on GP computer systems when logging on to the system, prescribing for a patient and when making electronic referrals to hospitals.

A 195 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that adequate internet bandwidth and email storage capacity are essential for a modern GP, and calls on the GPC to negotiate an increase in these rationed items with Connecting for Health.

AR 196 HERTFORDSHIRE: That conference believes that the current system for cascading vital Department of Health safety alerts to GPs is unwieldy, unsafe and puts patients at risk and calls on GPC to work with the Department of Health to ensure that the mechanism is dramatically improved as a matter of urgency.

A 197 LEICESTERSHIRE AND RUTLAND: That conference believes that the N3 Network is unfit for purpose and needs significant improvement.

AR 198 MORGANNWG: That conference, in these times of austerity, calls for a review of progress on the reduction of general practice paperwork to identify any areas which are yet to be resolved, require urgent attention to improve efficiency and will enable general practitioners to improve access to their services.

QUALITY AND OUTCOMES FRAMEWORK (QOF) AND QUALITY INDICATORS

A 199 SANDWELL: That conference asks that in completing the annual negotiations about changes to the QOF, GPC and the Department of Health should ensure that any changes to the indicators are fully defined and published by 1 April in any given year, or their introduction should be postponed until the following year.

AR 200 HERTFORDSHIRE: That conference calls on GPC to deliver the motion agreed at conference in 2009 which stated that coding changes should be available at the beginning of the QOF year and not half way through.

A 201 WEST SUSSEX: That conference supports a national QOF with a clear evidence base for all indicators used.

A 202 SHROPSHIRE: That conference believes there should be a proven evidence base for all QOF requirements and that the benefit of some current targets, such as lipid levels in very elderly patients, is not clear and should be challenged.

A 203 LIVERPOOL: That conference believes that QOF was introduced to improve quality of care to patients and was never intended to be used as a performance management tool in practices that did not achieve maximum points.

COMMUNITY SERVICES

A 204 DERBY AND DERBYSHIRE: That conference expresses its grave concern that the increasing trend for health visitors to concentrate their efforts solely on the very hardest to reach families:
(i) jeopardises the integrated care by primary health care team of large numbers of families with only slightly less pressing needs
(ii) puts at risk the maintenance and improvement of childhood immunisation uptake across the board.

A 205 LIVERPOOL: That conference believes that in respect of the health visiting service, case management by health visitors has seen a reduction in continuity of care, resulting, in some instances, in haphazard surveillance unless a child is actually on a safeguarding register.

A 206 DUMFRIES AND GALLOWAY: That conference supports the principle that health visitors remain practice attached particularly to aid their work in child protection.

A 207 LIVERPOOL: That conference believes that the health visitor service is now in crisis and that the severing of links with general practice has been greatly detrimental to the provision of care to under five year olds.

A 208 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference regrets that district nurse organisations have tended to impose artificial restrictions on what care they will provide, and no longer provide care to all housebound patients.

A 209 BORDERS: That conference believes that arranging community nursing staff on a geographical basis rather than being practice based can:
(i) lead to poorer communications which is detrimental to patient care
(ii) affect patients' choice of GP when they move house.

A 210 MORGANNWG: That conference calls upon social service departments across the UK to review the design, structure and contents of their child protection reports to GPs to ensure that vital information is not 'hidden' within the body of the report, thus creating a risk that it may be missed and so not acted upon.

A 211 TAYSIDE: That conference recognises the growing importance of high quality multi-disciplinary communication in relation to child and vulnerable adult protection and calls for this to be resourced adequately to allow for GP attendance at case conferences and equivalent meetings and calls for this to be negotiated at a national level.

A 212 SCOTTISH CONFERENCE OF LMCs: That conference recognises the growing importance of high quality multi-disciplinary communication in relation to child and vulnerable adult protection and calls for this to be resourced adequately to allow for GP attendance at case conferences and equivalent meetings and calls on the SGPC / GPC to negotiate this at a national level.

ESSENTIAL, ADDITIONAL AND ENHANCED SERVICES

A 213 HARROW: That conference demands the recognition of additional need and resource for urban practices compensating for the administrative costs associated with meeting the language needs of patients' where English is their second language.

CLINICAL AND PRESCRIBING

A 214 BRADFORD AND AIREDALE: That conference believes that the current medical exemption certification is not fit for purpose and be:
(i) expanded to include other chronic disease areas
(ii) disease specific
(iii) less bureaucratic.

A 215 MID MERSEY: That conference believes that there is no justification for patients receiving thyroid replacement therapy to continue to receive other prescriptions free of charge.

A 216 MID MERSEY: That conference believes that food supplements and special foods should not be available on FP10.

A 217 LIVERPOOL: That conference believes that for convenience to both the patient and their GP, contraceptive implants should be reimbursable, to GP practices, as a personally administered drug.

A 218 DEVON: That conference notes the ongoing requirement for GPs to prescribe gluten free food stuffs for patients with coeliac disease. The prescription of simple food stuffs is an unnecessary use of an experienced clinician's time and we ask our negotiators to negotiate an alternative system that removes this burden, but does not disadvantage patients.

AR 219 KENT: That conference recognises that the Regulations concerning personally administered items and the application of VAT thereon are confusing, arcane and inconsistent and:
(i) supports the concept that reimbursement should at least cover the cost of these items
(ii) acknowledges that addressing these issues would benefit practices, reduce bureaucracy and encourage more treatment in primary care
(iii) calls on the GPC to make the correction of these anomalies a high negotiating priority.

AR 220 CROYDON: That conference supports the continuation of prescribing incentive schemes which invest in cost effective GP prescribing. (Supported by KINGSTON AND RICHMOND)

AR 221 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that the nationally mandated NHS health checks:
(i) have not been assessed for value for money
(ii) are often financially unattractive to practices
(iii) should be commissioned only after local determination of their relative benefit and cost.

A 222 TAYSIDE: That conference believes that the increased enforcement of regulation surrounding the use of controlled drugs has neither improved patient safety nor quality of patient care and in some cases has been detrimental to quality care. Consequently this conference implores the government, at the earliest opportunity, to review, simplify and clarify the legislative framework surrounding the use of controlled drugs

A 223 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that the interval between GP prescriptions should be dictated by clinical need and not distorted by pharmacists seeking to recoup the costs of monitored dosage systems.

OTHER MOTIONS

A 224 BRADFORD AND AIREDALE: That conference instructs GPC to ensure GPs are not compromised and put at professional risk by being expected to practise outwith their competency given that GPs are not usually dentists, pharmacists, optometrists or occupational health physicians.

A 225 GLASGOW: That conference remains disappointed that the government and health boards continue to insist that GPs and their staff are regarded as immigration officers who can readily and easily understand the complexities of the UK visa system and, as such, are left to determine who is and isn't entitled to free NHS care.

A 226 SALFORD AND TRAFFORD: That conference demands that LMCs continue to be recognised in statute.

Agenda: Part II
(Motions not prioritised for debate)

THE FUTURE OF GENERAL PRACTICE AND THE NHS

227 MERTON, SUTTON AND WANDSWORTH: That conference wishes that:
(i) the honour and integrity of primary care in general and general practice in particular is recognised and defended
(ii) calls for an end to the onslaught of negative press and commentary which significantly undermine the relationship with our patients which depends on trust and belief in our professionalism.

228 ROCHDALE AND BURY: That conference supports the reduction of inappropriate referrals and prescribing but supports the reinvestment of any savings in the development of local health services.

229 DUMFRIES AND GALLOWAY: That conference supports GPC and the devolved committees, in regular negotiations with the Health Departments, to gain firm commitments that GPC and the devolved committees are involved early in any health initiatives that have workload implications before general practice and primary care.

230 ROCHDALE AND BURY: That conference recognises that future health and wellbeing boards will be separate from the NHS but needs to retain strong partnership working with the NHS.

231 WEST PENNINE: That conference begs Government to strip out the excess layers of structural bureaucracy within the NHS; enabling and freeing local clinical leadership to identify need and drive change, without well-meaning but misguided interference from regional tiers of administration.

232 WEST PENNINE: That conference champions our looking after our nation's health properly by trading up public accountability to professional responsibility which gives the better deal to patients.

NHS IN ECONOMIC CRISIS

233 WIRRAL: That conference believes that continued focus on national targets is likely to stifle innovation within practices unless additional capacity is created.

234 LIVERPOOL: That conference believes that whilst the concept of integrated care which targets care according to stratification of patients, sounds beneficial for those needing it, unless there are adequate resources to fund good quality social care, the efforts of health care will be wasted.

235 ROCHDALE AND BURY: That conference request that GPC/BMA provides GP practices with support on attaining current and future financial viability in a national recession.

NHS REFORMS / HEALTH AND SOCIAL CARE ACT

236 BRADFORD AND AIREDALE: That conference believes the Health and Social Care Act will lead to a market driven NHS, fragmentation of services and leave the most vulnerable in society without adequate healthcare. The profession calls upon the GPC to ballot GPs on industrial action over the imposition of this dangerous Act.

237 SEFTON: That conference calls upon the GPC to remain clearly and vocally opposed to the Health and Social Care Act and its implementation. The public neither voted for, nor wants, the NHS to be run on a marketised competitive model and it looks to the profession to maintain the fight against this.

238 REDBRIDGE: That conference questions the independence of Monitor, as it is an NHS funded body, and further questions the need to waste further resources monitoring Monitor.

239 SOMERSET: That conference asserts that the current proposals in the Health and Social Care Act risk the loss of the whole organisational memory of the NHS and that it is essential that local staff, experience and skills are retained wherever possible in order to preserve this.

THE MARKET/PRIVATISATION

240 WOLVERHAMPTION: That conference supports the proposal that primary or secondary medical services should not be provided by private organisations outside the NHS. (Supported by WALSALL)

241 WIRRAL: That conference accepts that integration and competition can co-exist within a health delivery system.

242 SALFORD AND TRAFFORD: That conference believes that increasing competition in a market that cannot expand can be short-sighted and potentially more expensive in the long run.

243 ROCHDALE AND BURY: That conference recognises that increasing competition and privatisation has been to the detriment of other sectors and will not improve the health of the nation.

244 CAMBRIDGESHIRE: That conference believes that private companies and doctors running practices are essentially different because private companies have to put the interests of their shareholders first whereas doctors have to put the interests of their patients first.

245 LANCASHIRE COASTAL: That conference believes that there is a world of difference between a self-employed GP and a large multinational private healthcare provider. The claim by politicians that GPs are 'private companies' is mendacious and used merely to justify their unwanted and unnecessary Health Act.

246 AVON: That conference recognises the increasing influence of European legislation and legal rulings on the NHS and urges GPC to support the development of entrepreneurial UK healthcare companies and NHS organisations to compete in the emerging European market.

GOVERNMENT

247 SHEFFIELD: That conference reminds the Secretary of State for Health that the 'N' in NHS stands for National.

248 SEFTON: That conference calls upon all clinicians to be wary of taking on advisory roles to politicians, whether local or national, lest they become unwitting pawns in the kind of political skulduggery which has resulted in the NHS and Social Care Act

249 CORNWALL AND ISLES OF SCILLY: That conference requests the BMA to price up the cost of an ex-minister to wield influence on our behalf.

250 ROCHDALE AND BURY: That conference urges the Prime Minister to engage with health issues affecting this nation with the same passion as he does with international affairs.

PRACTICE BOUNDARIES

251 CITY AND EAST LONDON: That conference opposes the GP practice of your choice pilot and fears that if patients are able to register far from home:
(i) continuity of care, a valuable hallmark of British general practice, will be adversely affected
(ii) community based services will become fragmented
(iii) responsibility for urgent care will be ambiguous
(iv) local health economies will become destabilised
(v) rural and suburban general practices stand to lose large numbers of patients
(vi) urban commuter areas could suffer from an influx of demand undermining their ability to care for their existing patients.

252 SOUTHWARK: That conference believes that current government policy on the abolition of practice boundaries:
(i) potentially destabilises current local models of healthcare delivery
(ii) ignores the proven benefits of continuity of care
(iii) lacks comprehensive financial modelling.

253 BARKING AND HAVERING: That conference discuss the safety and appropriateness of extending practice boundaries.

254 WILTSHIRE: That conference mandates the GPC to discuss the merits of choice of GP verses the economic and better care of a single practice providing care to residents who are unable to normally leave the home for routine and preventative primary care.

255 SOUTH WEST REGIONAL COUNCIL: That conference demands the BMA investigates and propagates opinion and debate on the ethical merits of choice of GP verses the economic and better care of a single practice providing care to residents who are unable to normally leave the home for routine and preventative primary care.

PATIENT REGISTRATION

256 GLOUCESTERSHIRE: That conference wishes the Department of Health to recognise that when a patient moves to another practice the patient record should be transferred electronically; to print it out is wasteful and should not be required by the contract.

257 DEVON: That conference observes multiple factors affecting the potential stability of the GP workforce: pensions changes; an increasingly part time workforce; loss of experienced clinicians to commissioning and revalidation are all causative factors in reducing the availability of GPs to undertake their prime duty, that of seeing patients. In a climate of increasing expectation and demand we call for there to be a duty for the government to provide a coherent workforce planning system to be run nationally.

258 ROCHDALE AND BURY: That conference urges the government to recognise the health of the nation is the cornerstone to a strong future workforce.

259 ROCHDALE AND BURY: That conference believes that culling of the public sector workforce will weaken and compromise the health of this nation.

260 BARNET: That conference demands that practices should not be destabilised during the transitional period due to changes in NHS staffing structures.

PRIMARY AND SECONDARY CARE INTERFACE

261 WELSH CONFERENCE OF LMCs: That conference is concerned that the implementation by PCOs of the policies to deliver more care in the community is fragmenting the primary health care team.

262 AVON: That conference deplores the lack of accountability shown by secondary care in the charges they make for the services they provide and calls on the Department of Health to ensure that:
(i) any creative coding or accounting by secondary care providers is exposed and dealt with as fraud
(ii) access to reliable data is made available on a national scale, on which CCGs are able to base future commissioning decisions.

263 MORGANNWG: That conference believes the timing of appointments offered by GP surgeries should be broadly in line with appointments offered by hospital outpatient clinics so if PCOs expect GPs to provide appointments up to 6:30pm on weekdays then hospitals should be forced to provide an equivalent service.

264 WELSH CONFERENCE OF LMCs: That conference strongly refutes suggestions that GPs are responsible for large numbers of inappropriate hospital admissions as these suggestions are totally unacceptable and untrue.

265 NORTH YORKSHIRE: That conference believes that cooperation between primary and secondary care in planning patient care will never be possible whilst secondary care is paid via payment by results and primary care paid via a block contract.

266 DERBY AND DERBYSHIRE: That conference believes that the double cost of patients transferred to a community hospital from a foundation trust, incurring a second payment, has the potential to cause the closure of many community hospitals. To stop this happening, there must be a way of splitting the tariff between the organisations providing care in a single episode of illness.

267 ROCHDALE AND BURY: That conference recognises the need to redevelop the old relationship between primary and secondary care clinicians in the best interest of patients.

268 LIVERPOOL: That conference believes that the Health and Social Care Act continues to erode collaboration between primary and secondary care and that competition between services is not in the patient's interest.

269 SCOTTISH CONFERENCE OF LMCs: That conference believes that in addition to any new work receiving funding, when patients' chronic disease management is moved from secondary care to primary care, the government needs to remind employers that employees should still be given reasonable time off to attend a clinic in normal hours and not expect that they are seen outwith normal office hours.

270 BEDFORDSHIRE: That conference deplores the fact that GPC has been unable to do anything to stem the flow of secondary care work into general practice without adequate resourcing.

COMMISSIONING OF CARE

271 NORTH YORKSHIRE: That conference believes that NICE should continue to make treatment recommendations to commissioners in England and funding is made available to meet these new demands.

272 SOMERSET: That conference believes that the NHS should lead the way in ensuring that public services are provided in an environmentally sustainable way, and that:
(i) there should be national incentives to encourage sustainability and energy efficiency in general practice, and
(ii) the environmental impact of commissioning alternatives should be an important factor in decision making.

273 KENT: That conference demands that the government and CCGs be open and transparent and acknowledge that the only way to balance the budget is to close hospitals.

274 LINCOLNSHIRE: That conference believes that burdensome procurement processes will have an unintended consequence of exaggerated fragmentation of services in primary care.

275 NORTHUMBERLAND: That conference believes that diversity and adaptability is key to delivery of good health care that meets the needs of a community; and that restriction to a 'one size fits all' mentality risks compromising services particularly to rural and deprived communities.

276 DERBY AND DERBYSHIRE: That conference believes that the difference in budget setting mechanisms between primary care prescribing and commissioning of secondary care via payment by results (PbR) is inexplicable, and that PbR should more reflect age rather than deprivation, bringing it in line with prescribing formulae.

277 AVON: That conference requests GPC to seek a written explanation from the Department of Health as to how on the one hand it expects GP commissioning groups to remain within their budgets, whilst on the other, it fails to guarantee resources for expensive drugs which it requires GPs to provide under NICE recommendations.

278 DONCASTER: That conference believes that, in keeping with the original promise of clinical commissioning, that clinicians should remain in the majority on NHS commissioning boards.

279 SOMERSET: That conference asserts that, in relation to the development or reconfiguration of clinical services, clinical commissioning groups must:
(i) provide constituent practices with management and financial support in order to allow them to develop commissioning proposals
(ii) consult with constituent practices regularly on the prioritisation and commissioning of such proposals, and
(iii) formally notify practices of the rationale employed when making decisions as to which proposals are accepted and which are rejected.

280 WIRRAL: That conference fears that general practitioner involvement in the operational delivery of the Health Act puts real clinical engagement at risk.

281 MERTON, SUTTON AND WANDSWORTH: That conference is concerned by the:
(i) challenges that commissioners face with short timescales and few resources
(ii) risks involved in rushing the reorganising of services at a time when the management structures are not mature or defined.

282 ROCHDALE AND BURY: That conference urges PCOs not to commit future CCGs to any new contracts that go beyond 2013 without extensive local primary care consultation.

283 WEST PENNINE: That conference believes, the NHS risk registers warned of the serious financial dangers to individual CCGs in England. We insist, before CCGs apply for authorisation, they be fully appraised of financial implications for the population they serve from the Department of Health.

284 AVON: That conference declares to the Department of Health and the NHS Commissioning Board that LMCs will not tolerate any bullying, undue pressure or harassment meted out on any GP by any authority, and in particular, on those who have been generous enough to devote their time and energy to serve on CCGs.

285 LIVERPOOL: That conference believes that LMCs have an important role reflecting on local knowledge and external factors affecting GP and practice performance, and that his must be acknowledged by cluster wide or national commissioning board based performance advisory groups.

286 NEWCASTLE AND NORTH TYNESIDE: That conference:
(i) believes that CCGs should be publically accountable for taxpayers money that they are spending to commission services
(ii) believes that all organisations that use the NHS logo, commission services for NHS patients, or provide services for NHS patients should have an open book policy and allow independent scrutiny of their policies, contract obligations and performance against such obligations
(iii) calls on clinical commissioning groups to enshrine in their constitutions that they will not commission services from organisations that do not agree to such an open book policy or have a history of poor compliance with freedom of information requests.

287 EALING, HAMMERSMITH AND HOUNSLOW: That conference demands that CCG peer review plans should not become part of GP performance reviews.

288 NORTH AND NORTH EAST LINCOLNSHIRE: That conference insists that performance issues are not managed at CCG level but are retained within the current geographical cluster areas in order to obviate local conflicts of interest.

289 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that practices have been being pressurised into signing inter-practice agreements prematurely and demands that time must be allowed for the publication of regulations and guidance, for proper scrutiny, and for the proper functioning of the democratic process.

290 DORSET: That conference calls on GPC to seek absolute clarity on when CCGs have to go out to tender for a commission decision.

291 SALFORD AND TRAFFORD: That conference wishes to warn all GPs who are thinking about amending partnership agreements when they take on work with CCGs, or consider taking on capital costs to provide care out of hospitals, that they need to exercise caution.

292 ROCHDALE AND BURY: That conference urges PCOs to support local emerging CCGs in relation to HR and development resource.

293 ROCHDALE AND BURY: That conference recognises the need for support and training if CCGs are to adopt a statutory role of 'policing' primary care.

294 ROCHDALE AND BURY: That conference requests that GPs adopting management roles in forthcoming CCGs are provided clarity on their legal cover within CCGs and registration with the GMC in the event of complaint or legal action.

295 ROCHDALE AND BURY: That conference urges PCOs to work with primary care in this transition period to ensure we retain the remaining NHS managers within local consortia.

296 ROCHDALE AND BURY: That conference believes that PCOs should support CCGs in gaining authorisation and not make it dependant on various restrictions.

297 EAST SUSSEX: That conference believes clinical commissioning group boundaries should:
(i) reflect practice patient referral patterns
(ii) not be corralled by local government boundaries.

298 BRENT: That conference strongly opposes, through the abolition of PCOs, commissioning colleagues being driven to performance manage practices.

299 MID MERSEY: That conference believes that local CCGs' financial balance should not be put at risk by the presence of ambitious and unaffordable PFI projects.

300 WEST PENNINE: That conference believes the Health Act means there will be no community services still within the NHS. They'll have gone to the private sector. All but the enthusiast GPs will have given-up trying to commission; leaving it to the commissioning support services run by the private sector. 'Business has no business in our NHS' the BMA/GPC demands that commissioning support remains within the NHS.

PRIMARY CARE WORKFORCE

301 WELSH CONFERENCE OF LMCs: That conference applauds the role of the practice nurse in chronic disease management and calls for additional support to further develop this potential.

302 SCOTTISH CONFERENCE OF LMCs: That conference advocates the attachment and complete integration of named community staff into individual general practices to form truly practice-based primary care teams.

303 SCOTTISH CONFERENCE OF LMCs: That conference supports the principle of community nursing staff being employed directly by GP practices as a way of ensuring the future of community nurses as core members of the primary care team.

304 THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee: That conference believes that in order for general practice to make use of its own valuable workforce resources and to develop in the future, succession planning should be an integral part of practice and commissioning group development.

305 NORFOLK AND WAVENEY: That conference ask the GPC to work, as a matter of urgency, with those responsible for medical education to bring about a higher degree of accuracy in the numbers of places in medical schools to properly reflect the needs across all medical specialities in the future, especially taking into account the likely variations that will affect an average career timetable of a 21st century GP.

306 DUMFRIES AND GALLOWAY: That conference supports the principle of community nursing staff being directly employed by GP practices where the practice feels that this is the best way of ensuring the future of community nurses as core members of the primary care team.

CARE PATHWAYS

307 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that Choose and Book (C&B):
(i) produces overheads for practices that are not funded under basic GP contracts
(ii) predominantly benefits commissioners, who should therefore fund its use by practices.

PRIVATE FEES/NHS WORK

308 GWENT: That conference believes since collaborative fees are paid by a health authority on behalf of one or more public authorities these fees should be able to be negotiated collectively on behalf of doctors.

309 GWENT: That conference requests GPC to look again at the anti-competitive laws in relation to negotiating collaborative fees.

PRISON DOCTORS

310 HARROGATE DIVISION: That conference:
(i) deplores the fact that some prisons do not have physical access to a GP out-of-hours
(ii) supports the widening of the remit of the prison GP rep on GPC to cover all secure environment GPs
(iii) calls for a numerical increase in secure environment GP representation within the BMA.

311 MORGANNWG: That conference recognises the benefits of the improved treatment of offenders with substance misuse problems within many English prisons and calls on the Home Office to ensure similar services are available in all prisons in England and Wales.

GP EDUCATION AND TRAINING

312 HULL AND EAST YORKSHIRE: That conference rejects the proposals by the Committee of General Practice Education Directors to increase the period of GP training to four years, and insists that if training is to be extended it should:
(i) be driven by proven educational need
(ii) not be used as a mechanism for staffing unpopular posts within secondary care
(iii) not be a mechanism for encouraging doctors into less popular geographical areas
(iv) be accompanied by a full trainers grant to facilitate high quality education
(v) not produce an underclass of GPs who have completed the examination process yet are considered unqualified
(vi) have the support of the GPC.

313 AYRSHIRE AND ARRAN: That conference believes that all doctors in hospital speciality training should have an attachment working in general practice to help them understand the complexities, services available and constraints of primary care which will help inform their future work in secondary care.

314 SCOTTISH CONFERENCE OF LMCs: That conference believes that all doctors in hospital speciality training should have an attachment working in general practice to help them understand the complexities, services available and constraints of primary care which will help inform their future work in secondary care.

315 MID MERSEY: That conference calls for every clinical specialist training scheme to include a period of not less than four months training in general practice.

316 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: That conference demands that every GP trainee be given:
(i) a personal study budget per year with a clearly specified sum, that can not be used for mandatory training
(ii) a specified number of personal study days which the trainees can use to better their training experience,
(a) that should not be part of mandatory training
(b) that should not be denied unreasonably
(iii) private study days to prepare for the mandatory examinations of the training program.

317 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: That conference recognises the importance that individual study budgets have to GP trainees and demands
(i) that top-slicing never occurs without educational justification
(ii) that there are appropriate mechanisms in place to keep a register of individual applications
(iii) that applications are audited by budget holders in a transparent manner.

318 CENTRAL LANCASHIRE: That conference believes there needs to be greater clarity about the levels of competence and subsequent training needed by GPs to safeguard children and vulnerable adults.

319 MERTON, SUTTON AND WANDSWORTH: That conference believes there should be more focus on education and training for GPs in this increasingly complex environment.

320 ROCHDALE AND BURY: That conference believes that introduction of student fees has compromised the health of our future nation.

321 ROCHDALE AND BURY: That conference feels that introduction of tuition fees is likely to deter many from applying to medical school and jeopardise the future work force.

322 CROYDON: That conference believes the requirements to be appointed a GP trainer should be standardised across deaneries. (Supported by KINGSTON AND RICHMOND)

323 LAMBETH: That conference with respect to the GP deaneries:
(i) applauds the current high quality of GP training, continuous GP education and strategic workforce planning provided by the GP deaneries
(ii) deplores the proposal to abolish GP deaneries with the resultant loss of their expertise
(iii) recognises the pivotal role the GP deaneries have in maintaining a high quality GP workforce
(iv) states its belief that an equivalent quality of GP education will not be obtainable from alternative providers commissioned by local education and training boards
(v) insists that the GP deaneries are retained.

324 CITY AND EAST LONDON: That conference believes the deaneries should continue to have an integral role in the education and training of general practice.

325 EALING, HAMMERSMITH AND HOUNSLOW: That conference is concerned that the disbanding of the deanery will result in a reduction:
(i) of funding for education and training of the GPs
(ii) in independent governance and quality assurance of training programmes.

326 SCOTTISH CONFERENCE OF LMCs: That conference believes that business and management training must become a routine part of the medical undergraduate curriculum as these skills are required by all doctors whatever and wherever their chosen career path. (part 2)

327 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:
That conference believes that the placements within individual GP training programmes should complement the previous experience of applicants and therefore wishes that any process whereby placements are allocated should be facilitated with the consideration of information about previous training that has been completed.

328 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:
That conference recognises the increasing potential for stress and burnout in general practice and:
(i) believes that attempts should be made to identify how widespread stress and burnout is amongst GP trainees
(ii) asks that further guidance and support is given to trainers to help recognise and provide appropriate support to trainees if there are concerns
(iii) any further changes to the curriculum and assessment process should be made with due consideration to trainee health and welfare.

329 WELSH COUNCIL: That conference calls for an immediate reduction in the number of medical student places such that the number of medical students graduating is better aligned with the requirement for training posts and subsequently career grade posts.

330 CONFERENCE OF MEDICAL ACADEMICS: That conference notes the continued lack of clarity regarding the organisations in the reformed NHS that will hold the honorary clinical contracts for senior academic GPs and for some public health academics. Conference, therefore, calls on the Department of Health to work with the BMA and the Society for Academic Primary Care to resolve this as a matter of urgency.

331 JUNIOR DOCTORS CONFERENCE: That this conference notes that:
(i) increasing numbers of GP trainees are coming from a background of previous training in another speciality (paediatrics, accident and emergency, core medical training)
(ii) GP training consists of a number of hospital rotations, which may include specialities a trainee already has considerable experience in and calls for
(iii) greater flexibility in allowing trainees to choose their rotations, such that training needs are appropriately addressed.

LMC CONFERENCE

332 LEEDS: That conference:
(i) wishes to thank those who have provided document bags and files of a variety of styles, colours and usefulness over the last few years
(ii) believes the cost and environmental impact of providing document bags and files on an annual basis means we would prefer not to have them provided
(iii) suggests that GPs with a special interest in Radley or Mulberry bags are invited to explore the possibility of conference members being given a 'bag for life'.

PENSIONS

333 DUMFRIES AND GALLOWAY: That conference fully supports the BMA in standing firm with RCN and UNISON in the present negotiations on the pensions of all people working in the NHS.

334 TAYSIDE: That conference, in light of the current and likely future attack on NHS pensions, feels that it is time we explore the possibility of creating an alternative 'GP co-operative' pension scheme and asks the BMA pension committee to fully explore this proposal, reporting back to the relevant branch of practice committees and LMCs.

335 AVON: That conference believes that if the government's pension reforms are implemented, it will drive large numbers of younger doctors overseas, or out of medicine, and drive older experienced doctors into early retirement. Conference calls on the GPC to:
(i) continue and strengthen its robust stance against such disastrous actions and
(ii) investigate with the BMA the possibility of establishing a bespoke pension scheme for doctors to serve as a credible alternative to the current NHS superannuation scheme.

336 WAKEFIELD: That conference supports the development of a life expectancy tool for GPs so that we can assess whether our life expectancy beyond 67 is sufficient to make pension contributions worthwhile.

337 BEDFORDSHIRE: That conference:
(i) believes that the blatant raid on the GP NHS pension pot, combined with impending revalidation and the NHS changes, is encouraging GPs to retire early thereby depriving the NHS and patients of their invaluable experience and expertise, and
(ii) supports the GPC in all its endeavours to stem the rising tide of early GP retirements.

338 BEDFORDSHIRE: That conference believes that the blatant raid on the GP NHS pension pot, combined with impending revalidation and the NHS changes, are factors adversely affecting GP morale and calls on the GPC to leave the Secretary of State in no doubt whatsoever that this could have a detrimental effect on patient care.

339 ROCHDALE AND BURY: That conference recognises that potentially increasing pension contributions alongside NI contributions, VAT and fuel cost is likely to compromise viability of GP practices.

340 CORNWALL AND ISLES OF SCILLY: That conference believes that hospital clinicians should have the same pension arrangements as GPs.

341 MANCHESTER: That conference expresses its concern at the potential loss of management expertise from practices resultant from the increase in retirements due to the pensions issue, and urges all practices to encourage the engagement of all doctors in practice management issues as part of succession planning.

342 THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee:
This conference calls for GPC to ensure that the NHS Information Centre makes an adjustment to the published headline figure for average GP remuneration to take account of any future rise in pension contributions, especially if these do not result in any material benefit for GPs.

343 ROCHDALE AND BURY: That conference government to consider that increased pension contributions is likely to deter new clinicians from joining the NHS scheme.

ACCESS

344 MORGANNWG: That conference recognises that access to GPs is perceived by much of the public to be limited and that practices need to continue to work with their registered populations to provide fair and equitable access for all patients taking in to consideration the health needs of the majority of the practice population rather than the wants of the 'worried well'.

345 MORGANNWG: That conference:
(i) recognises the value and importance of good out-of-hours services (OOHS) for patient care and utilisation of NHS resources
(ii) recognises that the involvement of local GPs underpins the provision of high quality OOHS care
(iii) urges all PCOs to ensure that the terms and conditions for doctors contracted to provide OOHS care are such as to encourage local GPs to become involved in leading and providing OOHS.

346 NOTTINGHAMSHIRE: That conference believes the government's reforms have ensured that the postcode lottery is alive and well and that, by ensuring that responsibility for deciding whether to fund new drugs not yet recommended by NICE rests with CCGs, the Secretary of State has 'passed the buck' for rationing care to GPs.

GENERAL PRACTITIONERS COMMITTEE

347 WILTSHIRE: That conference deplores the attempt to curtail the Chair of GPC's gastronomic adventures and insists that these continue and are fully detailed in the weekly negotiators news bulletins.

CONTRACT NEGOTIATIONS

348 CORNWALL AND ISLES OF SCILLY: That conference requests the GPC to ensure that health policy developed for the inner cities is not foisted on rural areas without consideration of the differences in circumstance and demography.

349 BRENT: That conference believes single-handed practices need a viable succession and growth plan in order that they need not resign their contracts and close their doors to the public.

350 ROCHDALE AND BURY: That conference recognises the sterling job being done by the GPC negotiators in the face of difficult government opposition.

351 ROCHDALE AND BURY: That conference urges GPC to ensure that healthcare negotiations remain evidence based and not directed purely by financial targets.

352 ROCHDALE AND BURY: That conference would like any future NHS primary care negotiations to include an appeals process for primary care contract allocations.

353 ROCHDALE AND BURY: That conference request that GPC negotiators re introduce financial reimbursement for non clinical waste in any future contract negotiations.

354 ROCHDALE AND BURY: That conference urges government to review APMS contracts to ensure they are an effective use of local NHS resource.

355 AVON: That conference asserts that if the Government had listened to GPs, the fiasco of APMS contracts would have been avoided.

MEDICAL CERTIFICATES AND REPORTS

356 CORNWALL AND ISLES OF SCILLY: That conference requests the GPC insists that the government backs up its claim that it wants to stop the 'compensation culture', by properly resourcing practices for the work involved in providing records and by changing the laws on 'no win no fee'.

357 DEVON: That conference notes the early signs of implementation of the 2009 Coroner's Act with some alarm. In these times of national austerity, the provision of dedicated medical examiners, funded by bereaved families appears to be a further tax on dying and we call on our negotiators to attempt to call a halt to these developments and work with the government on the overhaul of the death certification system.

358 BEDFORDSHIRE: That conference calls on the GPC to:
(i) overtly deplore the practice of solicitors advertising to support complaints against GPs and
(ii) work with the government to outlaw 'no win, no fee' deals by solicitors in complaints against GPs.

359 CITY AND EAST LONDON: That conference is very concerned at the high level of successful appeals following on from Disability Living Allowance (DLA) assessments and calls for an urgent audit and review of the quality of the initial assessments.

FUNDING FOR GENERAL PRACTICE

360 NORTHAMPTONSHIRE: That conference insists that due to the pay freeze for practices, that all GP professional subscription rates should also be frozen including GMC and RCGP.

361 KENSINGTON, CHELSEA AND WESTMINSTER: That conference believes that financial and managerial plans should be implemented to stop the increasing financial insecurity that GPs working in deprived areas continue to suffer from more than GPs working in wealthy areas.

362 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that the shrinkage of MPIG requires a hardening of practice attitude to unfunded work such as leg ulcer dressing, suture removal, ABP monitoring, phlebotomy for others.

363 BIRMINGHAM: That conference instructs the GPC to negotiate an increase in the global sum to compensate for the decrease in general practice funding resulting from 'list cleansing' initiatives.

364 REDBRIDGE: That conference demands the reinstatement of basic practice allowance.

365 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference welcomes the emergence of new NHS funding flows to GP practices in recognition of increasing extra-contractual demands made on them by nursing and care homes.

366 NORTH YORKSHIRE: That conference supports investment in greater ongoing support and supervision for GPs in the execution of increasingly complex, varied and arduous duties.

367 DORSET: That conference calls on GPC to negotiate funding for practices when the increasing health and safety legislation results in cost requirements to practices to meet them.

368 EALING, HAMMERSMITH AND HOUNSLOW: That conference believes that transparency should be a key principle of the procurement process for primary care services.

369 LINCOLNSHIRE: That conference agrees that a practice's ability to respond to current procurement processes, particularly in smaller units, will be detrimental to their ability to survive and provide.

370 LIVERPOOL: That conference believes that LMC representatives should be invited to observe any PCO or NHS CB tendering and interview process for PCTMS or APMS practices.

371 BEXLEY: That conference insists that government adequately resources these increased clinical and administrative pressures.

372 HAMPSHIRE AND ISLE OF WIGHT: That conference calls for renegotiation of the national allocation formula to reflect a more fair share allocation of resources based on age and gender, which are strong markers of health resource use, rather than the current model which is mainly weighted on social deprivation.

GP PARTNERSHIPS

373 SUNDERLAND DIVISION: That conference strongly supports every doctor in GP practice being offered partnership after one year of a salary post as it gives stability to both to the practice and to the incoming doctor; and it provides confidence and better working atmosphere to all.

REGULATION, MONITORING AND PERFORMANCE MANAGEMENT

374 AVON: That conference insists that, in a world where a well-known healthcare provider has been convicted and fined for removing the kidneys of minors and selling them, the Department of Health applies an appropriate 'fit and proper persons test' to safeguard the NHS against any contracting with criminal organisations.

PREMISES

375 MORGANNWG: That conference in respect of the revaluation of GP premises is concerned that:
(i) some valuations have been lower in this cycle than in previous cycles
(ii) some valuations may have taken place before the end of the three year cycle
(iii) lower valuations may have adverse effects on recruitment to partnerships in the future.

376 MID MERSEY: That conference believes that the time has come to end all Darzi centres and redistribute the resources locally.

SESSIONAL GPs

377 KENT: That conference recognises that many sessional GPs lack essential exposure to and involvement in GP administration and instructs the GPC to negotiate adequately funded practice attachments, workshops and monitoring schemes focused on practice management issues for sessional GPs.

378 MERTON, SUTTON AND WANDSWORTH: That conference deplores the lack of inclusiveness for sessional GPs particularly since there is a trend for a reduction in partnerships and an increase salaried and locum GPs.

379 THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee:
That conference accepts in full the recommendations of the Royal Medical Benevolent Fund's 'Support for Sessional GPs'; that is to support and revitalise the development of sessional GP groups in the regions, and urges the GPC to take action to ensure that:
(i) clinical commissioning groups and LMCs work in partnership to support sessional GP groups; and
(ii) the RCGP should work to fulfil its promise to the RMBF of tackling the professional isolation suffered by sessional GPs.

380 LEICESTERSHIRE AND RUTLAND DIVISION: That conference accepts in full the recommendations of the Royal Medical Benevolent Fund's (RMBF's) 'Support for sessional GPs' which support and revitalise sessional GP groups in the regions and urges the GPC to ensure that:
(i) clinical commissioning groups (CCGs) and LMCs work in partnership to support sessional GP groups
(ii) the RCGP fulfils its promise to the RMBF to remove the professional isolation suffered by many sessional GPs.

381 THE GPC: That the GPC seeks the views of conference on the following motion from the sessional GP subcommittee:
That conference calls for the:
(i) end of closet discrimination of female GPs which causes them to choose low paid salaried posts in return for some maternity leave benefits
(ii) employment of salaried GPs using terms and conditions that are no less favourable than the salaried model contract; and
(iii) fair payment of all salaried GPs.

382 LEEDS: That conference believes that salaried GPs should:
(i) have nationally recognised incremental pay rates depending on experience, as is the norm with other employed staff
(ii) be offered standardised national contract terms (as set out in BMA model salaried GP contract) which should be compulsory for all employers.

INFORMATION MANAGEMENT AND TECHNOLOGY

383 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that local care records:
(i) might benefit patient care
(ii) often share more than has been agreed within the national summary care record
(iii) require greater thought about the extent of sharing
(iv) produce difficult issues of patient consent
(v) require national oversight.

384 MERTON, SUTTON AND WANDSWORTH: That conference hails the GP2GP projects' success in enabling the transfer of entire life long GP held records to become a business normal process.

385 NORTH STAFFORDSHIRE: That conference recognises the need to move to one form of IT based global health economy communication between secondary and primary care and that this is designed for the benefit of the recipient.

386 CAMBRIDGESHIRE: That conference believes that a fully integrated and secure NHS IT system is as essential as a fully functioning neurological system.

387 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that Read coding:
(i) should be kept up to date with clinical practice and terminology
(ii) is showing increasing gaps that need to be filled.

388 NORTHUMBERLAND: That conference believes that truly integrated healthcare requires substantial data sharing and that current rhetoric leads patients to believe otherwise; it is essential that GPs take the lead to inform patients and create a workable process to achieve an IT infrastructure for local health economies.

389 NORTH STAFFORDSHIRE: That conference recognises the need for a uniform transferable summary of patient records that minimises the burden on practice administration and maximises clinical communication and safety.

390 KENT: That conference believes if the NHS is to have a green agenda that:
(i) all paper based forms should be abolished
(ii) PCOs and other health bodies should be fined £50 per transgression for the use of paper based forms.

391 MID MERSEY: That conference believes that the roll out of clinical dashboards is a cheap publicity stunt which has little to do with providing good quality primary care.

392 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that well designed and maintained local websites can help GPs make sensible use of local resources and regrets the lack of investment in such sites by commissioners.

393 MERTON, SUTTON AND WANDSWORTH: That conference believes there is a need for a national data quality agenda.

394 CORNWALL AND ISLES OF SCILLY: That conference asks the GPC to thoroughly investigate that Telehealth will deliver a benefit to some patients but the positive and placebo effects should be further investigated before the national roll out of patient home telemonitoring.

395 GLASGOW: That conference deplores that GP practices are now expected to download and print the explosion of forms, service leaflets, contact numbers and other information at the GPs' own expense before patients can access other services within health and social care.

396 BEDFORDSHIRE: That conference believes that the Summary Care Record project:
(i) has been an astounding waste of taxpayers' money
(ii) is not fit for purpose, and
(iii) should be abandoned.

PUBLIC HEALTH

397 SCOTTISH CONFERENCE OF LMCs: That conference believes that the obesity epidemic facing the UK needs to be tackled primarily by society as a whole and calls on all UK governments to:
(i) ensure that food labelling clearly indicates the potential health impact of all foodstuffs
(ii) make nutritional education a compulsory component of the national school curriculum.

398 NORTH YORKSHIRE: That conference calls upon government to levy VAT on the purchase of unhealthy food.

399 MID MERSEY: That conference call for sales of food containing partially hydrogenated fats to be banned in the UK.

400 GLASGOW: That conference welcomes for the Scottish Government's reintroduction of the Minimum Price Alcohol Bill to the Scottish parliament and urges other UK nations to adopt similar legislation.

401 WALTHAM FOREST: That conference regrets that the government policy on alcohol has been too long delayed and insists that the government must now urgently address issues such as pricing and availability.

402 AYRSHIRE AND ARRAN: That conference welcomes the moves of the Westminster government to follow the Scottish lead in introducing minimum pricing of alcohol.

403 MID MERSEY: That conference believes following the smoking success story, we should ask our Honourable Members of Parliament to set an example to everyone and make the Houses of Parliament an alcohol free zone.

404 SEFTON: That conference calls upon public bodies not to launch public health campaigns without prior consultation with the profession so that the potentially disruptive impact generated by the 'worried well' upon the essential work of general practice can be avoided.

405 NORTHAMPTONSHIRE: That conference insists that if there are public health screening imperatives in a geographical area, that any primary care involvement is adequately remunerated.

406 NORTH YORKSHIRE: That conference believes a B list celebrity should be inoculated with a virulent strain of flu in September each year in order to achieve, for the greater good, a high uptake of influenza vaccination for that season's campaign.

QUALITY AND OUTCOMES FRAMEWORK (QOF) AND QUALITY INDICATORS

407 LEWISHAM: That conference believes that GPs have responded responsibly to the challenges presented by QIPP and are working hard to ensure efficient spending in the NHS. However we demand a period of stability with respect to QOF, prescribing and referral management targets to allow bedding in, and ensure we deliver safe, patient centred and appropriate care.

COMMUNITY SERVICES

408 SCOTTISH CONFERENCE OF LMCs: That conference welcomes care at home / in the community, but wonders whether the reduction of social care budgets is particularly helpful in achieving this laudable aim.

409 GLOUCESTERSHIRE: That conference believes a new contract for managing community hospitals should be nationally negotiated.

CLINICAL AND PRESCRIBING

410 MID MERSEY: That conference believes patients in Scotland, Northern Ireland and Wales should pay for prescriptions.

411 GLASGOW: That conference recognises the benefits of gluten-free products on NHS prescription. However, it believes that doctors are not best placed to decide on the nature or quantities of these products. We believe that ordering and provision of NHS gluten-free products should be the responsibility of the community pharmacy service.

412 SCOTTISH CONFERENCE OF LMCs: That conference notes that consultations for minor ailments, with patients expecting a written prescription, have risen since the introduction of free prescriptions.

413 AYRSHIRE AND ARRAN: That conference notes that consultations for minor ailments, with patients expecting a written prescription, have risen since the introduction of free prescriptions in the Celtic nations.

414 LIVERPOOL: That conference believes that as GPs are now expected to diagnose and manage hypertension on the basis of 24 hour BP monitoring and home BP monitoring, blood pressure monitors should be available on an FP10.

415 HULL AND EAST YORKSHIRE: That conference, with regard to the British National Formulary:
(i) believes it is an invaluable tool for health professionals and congratulates the Joint Formulary Committee on its relevance, ease of use, accuracy, and impartiality
(ii) calls for its rapid integration into clinical IT systems
(iii) believes that it must remain a comprehensive formulary and continue to list those drugs which are less suitable for prescribing but which are nevertheless prescribable.

416 BRADFORD AND AIREDALE: That conference demands the introduction of an NHS drug formulary which clearly states:
(i) 28 days supply only
(ii) additional fees for non formulary items
(iii) whether primary care can prescribe.

417 NOTTINGHAMSHIRE: That conference believes that immunisation is second only to clean water supply in ensuring a healthy population and calls on the Department of Health to recognise the:
(i) value of the primary care immunisation team
(ii) need to support local work via national publicity campaigns
(iii) right of patients to opt out of immunisation without financial detriment to practices.

418 BERKSHIRE, BUCKINGHAMSHIRE AND OXFORDSHIRE: That conference believes that in regard to commissioning of vaccinations in the new GP contracts, the roll over of the Red Book has long passed its sell by date and calls upon the GPC to try harder to renegotiate this element with the Department of Health.

419 SCOTTISH CONFERENCE OF LMCs: That conference expects that all clinical members of the primary health care team should participate in the universal vaccination programme.

420 SCOTTISH CONFERENCE OF LMCs: That conference is disappointed at the lack of progress to a single prescribing number for GPs.

421 ROCHDALE AND BURY: That conference get clarification on why vitamin D is so expensive when it's available in cornflakes.

422 NORTHAMPTONSHIRE: That conference congratulates the Department of Health for their decision to change to the quadrivalent HPV vaccination from September 2012.

OTHER MOTIONS

423 SEFTON: That conference calls upon GP leaders of CCGs to minimise the data collection work etc which is asked of individual practices and to ensure there is adequate reimbursement for all work which has no direct bearing on the day to day running of general practice.

424 HERTFORDSHIRE: That conference believes that GPs should be renamed general practitioner consultants to make it clear to patients and the public that they are at least as well qualified as hospital consultants.

425 CITY AND EAST LONDON: That conference resolves that the gate keeper role of the general practitioner who will know many generations of the same family, who has a wealth of local knowledge, and extensive local networks cannot be overvalued.

426 COVENTRY: That conference should note that over 100 years the basic issues exercising LMCs haven't changed.

427 MERTON, SUTTON AND WANDSWORTH: That conference believes there is not a level playing field in primary care and condemns the trend for APMS practices to 'cherry-pick' their patients.

428 WIRRAL: That conference congratulates Her Majesty the Queen on her Diamond Jubilee and wishes her many more years as our Sovereign.

PUBLIC RELATIONS

429 SALFORD AND TRAFFORD: That conference is deeply concerned by the tone of some of the media coverage which can lead to a worsening public health. Conference asks GPC to develop further the good work of its press and PR department.

430 SEFTON: That conference calls upon the GPC not to be inhibited by fears of short term adverse public opinion when acting in the interests of the profession. The continued long term trust of the public, in their doctors, is repeatedly shown by IPSOS MORI and other pollsters. It must continue a campaign of active opposition to the NHS reforms.

431 CORNWALL AND ISLES OF SCILLY: That conference is appalled at the grudge mentality of the media towards our profession. The public have not been reminded that doctors accept considerable costs (particularly with university fee increases) and years of a difficult working environment before achieving specialist status.

432 NORFOLK AND WAVENEY: That conference requests GPC, when communicating with interest groups, patient associations and the media concerning the need for additional investment, for example in general practice training, to ensure the emphasis is placed on the outcomes of any investment, ie to allow GPs to work better and provide improved care for their patients.

CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

STANDING ORDERS

CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

STANDING ORDERS

Conferences

Annual conference

1. The General Practitioners Committee (GPC) shall convene annually a conference of representatives of local medical committees, ordinarily held in June or July as the GPC determines.

Special conference

2. A special conference of representatives of local medical committees may be convened at any time by the GPC, and shall be convened if requested by one sixth, or if that is not a whole number the next higher whole number, of the total number of LMCs entitled to appoint a representative to conference. No business shall be dealt with at the special conference other than that for which it has been specifically convened.

Membership

3. The members of conference shall be:
   - 3.1 the chairman and deputy chairman of the conference
   - 3.2 365 representatives of local medical committees
   - 3.3 the members of the GPC
   - 3.4 9 members appointed by the Scottish GPC
   - 3.5 3 members appointed by the Welsh GPC
   - 3.6 2 members appointed by the GPC (Northern Ireland)
   - 3.7 up to 5 persons entitled to attend GPC subcommittee meetings, but not otherwise members of conference; these shall be appointed by the GPC
   - 3.8 the seven elected members of the conference agenda committee (agenda committee)
   - 3.9 the regionally elected representatives of the GP trainees subcommittee, together with its immediate past chairman
   - 3.10 the elected members of the sessional GPs subcommittee of the GPC.

Representatives

4. All local medical committees are entitled to appoint a representative to the conference.

5. The agenda committee shall each year allocate any remaining seats for representatives amongst LMCs. Allocation of additional seats shall be done in such a manner that ensures fair representation of LMCs according to the number of GPs they represent. Each year the agenda committee shall publish a list showing the number of representatives each LMC is entitled to appoint and the method of allocating the additional seats.

6. Local medical committees may appoint a deputy for each representative, who may attend, and act at the conference if the representative is absent.

7. Representatives shall be registered medical practitioners appointed at the absolute discretion of the appropriate local medical committee.

8. The representatives appointed to act at the annual conference shall continue to hold office from 15 January for 12 months, unless the GPC is notified by the relevant local medical committee of any change.

Observers

9. Secretaries of local medical committees, who are not members of the conference, may, with the permission of the chairman, attend as observers.

Interpretations

10. A local medical committee is a committee recognised by a PCO or PCOs as representative of medical practitioners under the NHS Act 2006 as amended or by equivalent provisions in Scotland, Wales, and Northern Ireland.

11. 'Members of the conference' means those persons described in standing order 3.

12. 'Representative' or 'representatives' means those persons appointed under standing orders 4 to 8, and shall include the deputy of any person who is absent..

13. 'The conference', unless otherwise specified, means either an annual or a special conference.

14. 'As a reference' means that any motion so accepted does not constitute conference policy, but is referred to the GPC to consider how best to procure its sentiments.

Motions to amend standing orders

15. No motion to amend these standing orders shall be considered at any subsequent conference unless due notice is given by the GPC, the agenda committee, a local medical committee, a constituency of the BMA's representative body, or one of the other BMA craft conferences.
    - 15.1 Except in the case of motions from the GPC, such notice must be received by the Secretary of the GPC not less than 60 days before the date of the conference.
    - 15.2 The GPC shall inform all local medical committees of all such motions of which notice is received not less than 42 days before the conference.

Suspension of standing orders

16. Any decision to suspend one or more of the standing orders shall require a two-thirds majority of those representatives present and voting at the conference.

Agenda

17. The agenda shall include:
    - 17.1 motions, amendments and riders submitted by the GPC, and any local medical committee. These shall fall within the remit of the GPC, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and/or the National Health Service (Scotland) Act 1978 and/or the Health and Personal Social Services (Northern Ireland) Order 1972 and any Acts or Orders amending or consolidating the same and as from time to time extended to all or any part of the United Kingdom
    - 17.2 motions, amendments and riders connected with NHS general practice from constituencies of the British Medical Association's representative body, or one of the other craft conferences convened by a standing committee of the BMA, referred by the BMA's joint agenda committee
    - 17.3 motions passed at national LMC conferences and submitted by their chairmen
    - 17.4 motions relating to the Cameron fund, Claire Wand fund and the Dain fund
    - 17.5 motions submitted by the agenda committee in respect of organisational issues only.

18. Any motion which has not been received by the GPC within the time limit set by the BMA's joint agenda committee shall not be included in the agenda. This time limit does not apply to motions transferred to the conference by the BMA's joint agenda committee. The right of any local medical committee, or member of the conference, to propose an amendment or rider to any motion in the agenda, is not affected by this standing order.

19. When a special conference has been convened, the GPC shall determine the time limit for submitting motions.

The agenda shall be prepared by the agenda committee as follows:

20. In two parts; the first part 'Part I' being those motions which the agenda committee believe should be debated within the time available; the second part 'Part II' being those motions covered by 25 and 26 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording. If any local medical committee submitting a motion included in Part II of the agenda objects in writing before the first day of conference, the transfer of the motion to Part I of the agenda shall be decided by the conference during the debate on the report of the agenda committee.

21. 'Grouped motions': Motions or amendments which cover substantially the same ground shall be grouped and the motion for debate shall be asterisked. If any local medical committee submitting a motion so grouped objects in writing before the first day of the conference, the removal of the motion from the group shall be decided by the conference.

22. 'Composite motions': If the agenda committee considers that no motion or amendment adequately covers a subject, it shall draft a composite motion or an amendment, which shall be the motion for debate. The agenda committee shall be allowed to alter the wording in the original motion for such composite motions.

23. 'Motions with subsections':
    23.1 motions with subsections shall deal with only one point of principle, the agenda committee being permitted to divide motions covering more than one point of principle
    23.2 subsections shall not be mutually contradictory
    23.3 such motions shall not have more than five subsections except in subject debates.

24. 'Rescinding motions': Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters 'RM'.

25. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chairman of the GPC as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.

26. 'AR' motions: Motions which the chairman of the GPC is prepared to accept without debate as a reference to the GPC shall be prefixed with the letters 'AR'.

27. 'C' motions: Prior to the conference, a ballot of representatives shall be conducted to enable them to choose motions, ('C' motions), amendments or riders for debate. Using only the prescribed form, which must be signed and received by the GPC secretariat by the time notified for the receipt of items for the supplementary agenda, each representative may choose up to three motions, amendments or riders to be given priority in debate. Chosen motions must receive the vote of at least ten representatives. The first three motions, amendments or riders chosen, plus any others receiving the vote of at least twenty representatives, shall be given priority.

28. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 44, 45, 46, 47 and 52 shall not apply and the debate shall be held in accordance with standing order 54.

Other duties of the agenda committee include:

29. Recommending to the conference the order of the agenda; allocating motions to blocks; allocating time to blocks; setting aside reserved periods, as provided for in standing orders 59 and 61, and overseeing the conduct of the conference.

30. Identifying, by enclosing within a 'black box', motions received from those local medical committees which have failed to meet their quotas to the General Practitioners Defence Fund Ltd. Before effecting this, one year's grace must be given to such local medical committees, who must have received warning that, unless the deficit is made up by 1 May after the following year, they would become subject to the 'black box' procedure.

Procedures

31. An amendment shall - leave out words; and insert or add others (provided that a substantial part of the motion remains and the original intention of the motion is not enlarged or substantially altered); insert words; or be in such form as the chairman approves.

32. A rider shall - add words as an extra to a seemingly complete statement, provided that the rider is relevant and appropriate to the motion on which it is moved.

33. No amendment or rider which has not been included in the printed agenda shall be considered unless a written copy of it has been handed to the agenda committee. The names of the proposer and seconder of the amendment or rider, and their constituencies, shall be included on the written notice. Notice must be given before the end of the session preceding that in which the motion is due to be moved, except at the chairman's discretion. For the first session, amendments or riders must be handed in before the session begins.

34. No seconder shall be required for any motion, amendment or rider submitted to the conference by the GPC, a local medical committee, or the joint agenda committee, or for any composite motion or amendment produced by the agenda committee under standing order 22. All other motions, amendments or riders, after being proposed, must be seconded.

35. No amendments or riders will be permitted to motions debated under standing order 28.

Rules of debate

36. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.

37. Every member of the conference shall be seated except the one addressing the conference. When the chairman rises, no one shall continue to stand, nor shall anyone rise, until the chair is resumed.

38. A member of conference shall address the chairman and shall, unless prevented by physical infirmity, stand when speaking.

39. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.

40. Members of the GPC, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.

41. The chairman shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.

42. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.

43. The chairman shall take any necessary steps to prevent tedious repetition.

44. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.

45. Amendments shall be debated and voted upon before returning to the original motion.

46. Riders shall be debated and voted upon after the original motion has been carried.

47. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 44, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.

48. If it is proposed and seconded or proposed by the chairman that the conference adjourns, or that the debate be adjourned, or 'that the question be put now', such motion shall be put to the vote immediately, and without discussion, except as to the time of adjournment. The chairman can decline to put the motion, 'that the question be put now'. If a motion, 'that the question be put now', is carried by a two thirds majority, the chairman of the GPC and the mover of the original motion shall have the right to reply to the debate before the question is put.

49. If there be a call by acclamation to move to next business it shall be the chairman's discretion whether the call is heard. If it is heard then the proposer of the original motion can choose to:
    (i) accept the call to move to next business for the whole motion
    (ii) accept the call to move to next business for one or more subsections of the motion
    (iii) have one minute to oppose the call to move to next business.
    Conference will then vote on the motion to move to next business and a 2/3 majority is required for it to succeed.

50. Proposers of motions shall be given prior notice if the GPC intends to present an expert opinion by a person who is not a member of the conference.

51. All motions expressed in several parts and designated by the numbers (i), (ii), (iii), etc shall automatically be voted on separately. But, in order to expedite business, the chairman may ask conference (by a simple majority) to waive this requirement.

52. Any motion, amendment or rider referred to the conference by the joint agenda committee shall be introduced by a representative or member of the body proposing it. That representative or member may not otherwise be entitled to attend and speak at the conference, neither shall he/she take any further part in the proceedings at the conclusion of the debate upon the said item, nor shall he/she be permitted to vote. In the absence of the authorised mover, any other member of the conference deputed by the authorised mover may act on their behalf, and if there is no deputy the item shall be moved formally by the chairman.

53. If by the time for a motion to be presented to conference no proposer has been notified to the agenda committee, the chairman shall have the discretion to rule, without putting it to the vote, that conference move to the next item of business.

54. In a major issue debate the following procedures shall apply:
    - 54.1 the agenda committee shall indicate in the agenda the topic for a major debate
    - 54.2 the debate shall be conducted in the manner clearly set out in the published agenda
    - 54.3 the debate may be introduced by one or more speakers appointed by the agenda committee who may not necessarily be members of conference
    - 54.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
    - 54.5 subsequent speakers will be selected by the chairman from those who have indicated a wish to speak. Subsequent speeches shall last no longer than one minute.
    - 54.6 the Chairman of GPC or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
    - 54.7 at the conclusion of the debate the introductory speakers may speak for no longer two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
    - 54.8 the timing and method for voting on motions covered by or arising from a major issue debate will be determined by the agenda committee and published in the agenda.

Allocation of conference time

55. The agenda committee shall, as far as possible, divide the agenda into blocks according to the general subject of the motions, and allocate a specific period of time to each block.

56. Motions will not be taken earlier than the times indicated in the schedule of business included in the agenda committee's report.

57. 'Soapbox session':
    - 57.1 A period shall be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
    - 57.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
    - 57.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
    - 57.4 GPC (UK) members shall not be permitted to speak in the soapbox session.

58. Motions which cannot be debated in the time allocated to that block shall, if possible, be debated in any unused time allocated to another block. The chairman shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.

59. Not less than two periods shall be reserved for the discussion of other motions, and any amendments or riders to them, which cannot conveniently be allocated to any block of motions.

60. Motions prefixed with a letter 'A', (defined in standing orders 25 and 26) shall be formally moved by the chairman of conference as a block to be accepted without debate during the debate on the report of the agenda committee in the first session of the conference.

61. One period, not exceeding one hour, to be reserved for representatives of LMCs to ask questions of the GPC negotiating team.

62. The allocation of conference time should include a period of 'contingency time' on each day of the conference and a period for debate of chosen motion.

Motions not published in the agenda

63. Motions not included in the agenda shall not be considered by the conference except those:
    - 63.1 covered by standing orders relating to time limit of speeches, motions for adjournment or "that the question be put now" motions that conference "move to the next business" or the suspension of standing orders
    - 63.2 relating to votes of thanks, messages of congratulations or of condolence
    - 63.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association
    - 63.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned
    - 63.5 prepared by the agenda committee to correct drafting errors or ambiguities.
    - 63.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions
    - 63.7 that may arise from a major issue debate; such motions must be received by the agenda committee by the time laid down in the major issue debate timetable published under standing order 54.

Quorum

64. No business shall be transacted at any conference unless at least one-third of the number of representatives appointed to attend are present.

Time limit of speeches

65. A member of the conference, including the chairman of the GPC, moving a motion, shall be allowed to speak for three minutes; no other speech shall exceed two minutes. However, the chairman may extend these limits.

66. The conference may, at any period, reduce the time to be allowed to speakers, whether in moving resolutions or otherwise, and that such a reduction shall be effective if it is agreed by the chairman.

Voting

67. Except as provided for in standing orders 72 (election of chairman of conference), 73 (election of deputy chairman of conference), 75 (election of seven members of the agenda committee) and 76 (election of ARM representatives), only representatives of local medical committees may vote.

Majorities

68. Except as provided for in standing order 48 and 49 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:
    - 68.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC structure, or
    - 68.2 a decision which could materially affect the GPDF Ltd funds.

69. Voting shall be, at the discretion of the chairman, by a show of voting cards or electronically. If the chairman requires a count this will be by electronic voting.

Recorded votes

70. If a recorded vote is demanded by 20 representatives at the conference, signified by their rising in their places, the names and votes of the representatives present shall be taken and recorded.

71. A demand for a recorded vote shall be made before the chairman calls for a vote on any motion, amendment or rider.

Elections

72. Chairman
    72.1 At each conference, a chairman shall be elected by the members of the conference to hold office from the termination of the BMA's annual representative meeting (ARM) until the end of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
    72.2 Nominations must be handed in on the prescribed form before 12 noon on the first day of the conference with any election to be completed by 4.00pm. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

73. Deputy chairman
    73.1 At each conference, a deputy chairman shall be elected by the members of the conference to hold office from the termination of the ARM until the termination of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
    73.2 Nominations must be handed in on the prescribed form before 9.30am on the second day of the conference with any election to be completed by 12 noon. Nominees may enter on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

74. Seven members of the General Practitioners Committee
    74.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. For six of the seats any registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, whether a member of the conference or not, is eligible for nomination providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. All GPs on the retainer scheme, and medically qualified LMC secretaries, are eligible for nomination regardless of their level of commitment to providing or performing NHS primary medical services. For the seventh seat, only an LMC representative at conference may be nominated, and that LMC representative must never have previously sat on the GPC. This LMC representative must also be a registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. The members elected will serve on the GPC from the conclusion of the following ARM until the conclusion of the ARM one year thereafter. Only representatives shall be entitled to vote.
    74.2 Nominations must be handed in on the prescribed form, by 1.00pm on the first day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word. Elections, if any, will take place on the second day of conference and be completed by 10.00am.
    74.3 The GPC shall be empowered to fill casual vacancies occurring among the elected members.

75. Seven members of the conference agenda committee
    75.1 The agenda committee shall consist of the chairman and deputy chairman of the conference, the chairman of the GPC and seven members of the conference, not more than one of whom may be a sitting member of the GPC. In the event of there being an insufficient number of candidates to fill the seven seats on the agenda committee, the chairman shall be empowered to fill the vacancy, or vacancies, by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected, and shall continue in office until the end of the following annual conference.
    75.2 The chairman of conference, or if necessary the deputy chairman, shall be chairman of the agenda committee.
    75.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by 1.00pm on the first day of the conference. Elections, if any, will take place on the second day of conference and be completed by 10.00am. With the exception of those appointed under standing order 3.7, any member of the conference may be nominated for the agenda committee. All members of the conference are entitled to vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
    75.4 The result of the election to the agenda committee shall be published after the result of the ARM election of GPC members is known.

75.5 The two members of the agenda committee to be appointed to the joint agenda committee in accordance with article 53 of the BMA's Articles of Association shall be the chairman of the conference and the chairman of the GPC.

76. The representatives allocated to represent general practice at the BMA Annual Representative Meeting shall be members of the BMA both at the time of their annual appointment/election and throughout their term of office and shall comprise:
    76.1 the chairman and deputy chairman of conference, if eligible
    76.2 the chairman of the GPC, if eligible
    76.3 sufficient members of conference to fill the allocation of seats, elected on a regional basis in advance of conference by those members of the conference who are members of the BMA
    76.4 should there be vacancies after the regional elections these shall be filled by the GPC from the unsuccessful candidates standing in those elections.

77. Three trustees of the Claire Wand fund

    77.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. Any registered medical practitioner who is, or has been, actively engaged in practice as a general medical practitioner under the National Health Service Acts, whether a member of the conference or not, is eligible for nomination.
    77.2 Nominations must be handed in on the prescribed form before 1.00pm on the first day of the conference. Elections, if any, will take place on the second day of conference and be completed by 10.00am. Only representatives in attendance at the conference may vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers.
    77.3 Trustees will be elected on a triennial basis for a period of three years, to run from the termination of the next ARM.

78. Dinner committee
    78.1 At each conference there shall be appointed a conference dinner committee, formed of the chairman and deputy chairman of the conference and the chairman of the GPC, to take all necessary steps to arrange for a dinner to be held at the time of the following annual conference, to which the members of the GPC, amongst others, shall be invited as guests of the conference.

Returning officer

79. The chief executive/secretary of the BMA, or a deputy nominated by the chief executive/secretary, shall act as returning officer in connection with all elections.

Claire Wand award

80. The chairman, on behalf of the conference, shall, on the recommendation of the GPC, present to such medical practitioners as may have been nominated by the trustees of the Claire Wand fund, the award for outstanding services to general practice. Such presentation shall take place at 4.00pm on the first day of the conference.

Motions not debated

81. Local medical committees shall be informed of those motions which have not been debated, and the proposers of such motions shall be invited to submit to the GPC memoranda of evidence in support of their motions. Memoranda must be received by the GPC by the end of the third calendar month following the conference.

Distribution of papers and announcements

82. In the conference hall, or in the precincts thereof, no papers or literature shall be distributed, or announcements made, or notices displayed, unless approved by the chairman.

Mobile phones

83. Mobile phones may only be used in the precincts of, but not in, the conference hall.

The press

84. Representatives of the press may be admitted to the conference but they shall not report on any matters which the conference regards as private.

No smoking

85. Smoking shall not be permitted within the hall during sessions of the conference.

Chairman's discretion

86. Any question arising in relation to the conduct of the conference, which is not dealt with in these standing orders, shall be determined at the chairman's absolute discretion.

Minutes

87. Minutes shall be taken of the conference proceedings and the chairman shall be empowered to approve and confirm them.

Front cover image created with Wordle.
http://www.wordle.net

General Practitioners Committee
British Medical Association, BMA House, Tavistock Square, London, WC1H 9JP
www.bma.org.uk