

# GPDF

General Practitioners  
Defence Fund



# LMC conference 2015

## *'Representing all GPs'*

## Agenda

21 and 22 May  
Institute of Education, London

# Conference of Representatives of Local Medical Committees

## Agenda

To be held on

**Thursday 21 May 2015** at 9.30am

**Friday 22 May 2015** at 9.00am

At the Logan Hall, University of London, Institute of Education  
20 Bedford Way, London WC1H 0AL

**Chairman** Mike Ingram (Hertfordshire)

**Deputy Chairman** Guy Watkins (Cambridgeshire)

### **Conference Agenda Committee**

Mike Ingram (Chairman of Conference)

Guy Watkins (Deputy Chairman of Conference)

Chaand Nagpaul (Chairman of GPC)

Stuart Blake (Edinburgh)

Peter Horvath-Howard (Dyfed Powys)

Hal Maxwell (Ayrshire)

Helena McKeown (Wiltshire)

Rachel McMahan (Cleveland)

Stephen Meech (Kent)

Emmanuel Owoso (Swansea)

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## NOTES

Under standing order 18, in this agenda are printed all notices of motions for the annual conference received up to noon on 23 March 2015. Although 23 March 2015 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 21, the agenda committee has grouped motions or amendments which cover substantially the same ground, and has selected and marked in bold 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 Friday 15 May 2015**.

	Motions	Time
Opening business	1 - 2	9.30
Standing orders	3 - 4	
Report of the Agenda Committee	5	
Annual report	6	10.00
<b>Session 1 – Demand, Supply and Patient Safety</b>		
Government	7	10.20
Workload	8	10.30
Primary care workforce	9 – 12	10.40
Patient safety	13	11.20
GP education and training	14 – 16	11.30
Access	17 – 18	12.00
CCGs	19	12.20
Premises	20	12.30
General Practitioners Defence Fund (GPDF)	21	12.40
Charities		12.50
Dain Fund	22	
Claire Wand Fund	23	
Cameron Fund	24	
LUNCH		13.00
<b>Session 2 – New Models of Care</b>		
New models of care including presentations from Scotland, Wales and Northern Ireland	25 – 35	14.00
GP partnerships	36 – 37	15.40
Private fees / NHS work	38 – 39	16.00
Soapbox	40	16.20
Contract negotiations	41 – 43	16.40
NHS 111	44	17.10
Other motions 1	45	17.20
Chosen motions and contingency		17.25
Close		17.30

	Motions	Time
<b>Session 3 - Regulation</b>		
Regulation, monitoring and performance management	46 – 53	9.00
Medical indemnity	54	10.10
Clinical and prescribing	55 – 57	10.20
Dispensing	58	10.40
Enhanced services	59	10.50
Breakout groups	60 – 102	11.00
LUNCH		12.30
<b>Session 4 – Funding</b>		
Funding for general practice	103 – 107	13.30
Information management and technology	108 – 109	14.20
Primary and secondary care interface	110 – 111	14.40
Co-commissioning	112	15.00
Ask the Executive Team		15.10
Breakout group motions		15.30
Medical certificates and reports	113	16.00
Occupational health	114	16.10
Pay negotiations	115	16.20
Pensions	116	16.30
Public health	117 – 118	16.40
Other motions 2		16.50
Contingency		16.55
Close		17.00

## ELECTIONS

The following elections will be held on Thursday 21 May and Friday 22 May 2015.

### **Chairman of conference**

Chairman of conference for the session 2015-2016 (see standing order 72 - nominations to be handed in no later than **12 noon Thursday 21 May**).

### **Deputy chairman of conference**

Deputy chairman of conference for the session 2015-2016 (see standing order 73 - nominations to be handed in no later than **9.30am Friday 22 May**).

### **Seven members of the GPC**

Seven members of the GPC for the session 2015-2016 (see standing order 74 - nominations to be handed in no later than **1.00pm on Thursday 21 May**).

### **Seven members of the conference agenda committee**

Seven members of the conference agenda committee for the session 2015-2016 (see standing order 75 - nominations to be handed in no later than **1.00pm on Thursday 21 May**).

### **One trustee of the Claire Wand Fund**

One trustee of the Claire Wand Fund for 2015-2017 (see standing order 77 - nominations to be handed in no later than **1.00pm on Thursday 21 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 2013-2014) of the 2014 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 74 shall be replaced by a new standing order:**
- 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.**
- 74.2 Only representatives shall be entitled to vote.**
- 74.3 Nominations, election statements and photographs must be received by the GPC office seven working days before the start of the conference.**
- 74.4 Nominees may submit an election statement of no more than 50 words, excluding numbers and dates in numerical format, in a manner and format which will be specified by the Agenda Committee (that format being specified one calendar month before the start of conference). Recognised abbreviations count as one word.**
- 74.5 Nominees may also submit a photograph in a format specified by the Agenda Committee (that format being specified one calendar month before the start of conference).**
- 74.6 All nominees shall have the opportunity to take part in any hustings arranged by the agenda committee.**
- 74.7 All lists of candidates, in whatever format, shall be in random order.**
- 74.8 Elections, if any, will take place on the first day of conference and be completed by the start of the afternoon session.**
- 74.9 The GPC shall be empowered to fill casual vacancies occurring among the elected members.**

## REPORT OF THE AGENDA COMMITTEE

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

## ANNUAL REPORT

10.00

- 6 THE CHAIRMAN: Report by the Chairman of GPC, Dr Chaand Nagpaul.



- 7 **AGENDA COMMITTEE to be proposed by HERTFORDSHIRE:** That conference believes that politicians irresponsibly fuel unrealistic public expectation of the NHS for their own political ends, and:
- (i) urges the government to stop using patients and the NHS as a commodity to win votes
  - (ii) demands an end to political interference in NHS structures
  - (iii) calls on the GPC to demand that the government relinquishes political control of the NHS to allow GPs to focus on issues that make people better
  - (iv) calls on the new health secretary to celebrate publicly at every opportunity the amazing work being done every day by GPs up and down the UK
  - (v) supports the BMA's 'No More Games' campaign.
- 7a HERTFORDSHIRE: That conference laments that the profession which used to work for the health of the people has become a commodity working for the health of the government and
- (i) calls on the GPC to demand that the government relinquishes political control of the NHS to allow GPs to focus on issues that make people better, and
  - (ii) supports the BMA's No More Games campaign.
- 7b CITY AND EAST LONDON: That conference believes that politicians irresponsibly fuel unrealistic public expectation of the NHS for their own political ends and that this diverts resources from where they are most needed.
- 7c ROCHDALE AND BURY: That conference urges the Government to stop using patients and the NHS as a commodity to win votes.
- 7d DEVON: That conference condemns politicians' addiction to NHS reorganisation and:
- (i) demands an end to political interference in NHS structures
  - (ii) calls for a 10 year period of organisational stability in the NHS.
- 7e DEVON: That conference calls on the new health secretary to celebrate publicly at every opportunity the amazing work being done every day by GPs up and down the UK.
- 7f LANCASHIRE PENNINE: That conference believes that the government rhetoric around unbridled access to NHS care against a background of limited resources and manpower stokes unrealistic public expectations.
- 7g HERTFORDSHIRE: That conference calls on GPC to make it very clear to government that raising public expectations about what general practice can offer has led to an increase in stress for practice managers and administrative staff and is overwhelming clinical services.
- 7h SHEFFIELD: That conference supports a policy of non-politicisation of the NHS and demands that political parties stop using it as a weapon of manifesto.
- 7i MID MERSEY: That conference deplores the NHS being used as a political football and believes that general practice is not valued or respected by politicians who pay lip service to it.
- 7j NORTH STAFFORDSHIRE: That conference deplores the tokenistic short term investments in general practice by the government, exemplified by the latest round of headline electioneering gestures.
- 7k DEVON: That conference is fed up of the use of general practice as a political football and calls on the government to work with GPC to stabilise the profession.
- 7l AVON: That conference deplores the way that the NHS has been used by successive governments as a political football, leading to impossible demands on the service as public expectations are raised, and wholly unrealistic claims by politicians are made. It calls on this new government to:
- (i) invest properly in the NHS, particularly in primary care
  - (ii) engage with GPC to secure funding, so to provide the UK with an NHS that is fit for purpose
  - (iii) state publicly its wholehearted support for a comprehensive health service free at the point of delivery
  - (iv) recognise the pivotal role of primary care within the NHS, specifically general practitioners.
- 7m CUMBRIA: That conference believes that all political parties should hold a cease-fire, disarm and de-weaponise the NHS.
- 7n SHROPSHIRE: That conference believes the government should acknowledge the NHS as the most-effective healthcare system in the developed world and the pivotal role played by UK general practice which is fundamental to its success and deplores the constant political interference that has been so damaging in recent years.
- 7o LEWISHAM: That conference calls on the politicians of all parties to stop asking voters what they want from the NHS and work with and support GPs to deliver excellence in what patients need.
- 7p ROCHDALE AND BURY: That conference urges the government to stop increasing patient expectations beyond the deliverables.

7q CORNWALL AND ISLES OF SCILLY: That conference that the demand-led rather than needs-led NHS is killing general practice and calls on the government to be honest with the public about what the NHS can deliver.

## WORKLOAD

10.30

8 **GLASGOW: That conference believes that the increase in GP workload and increase in GP work intensity is unsustainable and is a disincentive to join the profession leading to an exodus of doctors away from the profession and calls for urgent action to limit GP workload to manageable levels.**

8a SOMERSET: That conference wishes to warn the public that the failure of government and the Department of Health to address the workload in general practice means that:

- (i) there is a growing risk to patient safety due to unavoidable errors
- (ii) the ability of primary care to offer a timely and responsive service is heavily compromised
- (iii) recruitment of doctors to GP training and a career in general practice is woefully inadequate
- (iv) established GPs are reducing their working hours or retiring early
- (v) there is a real risk that practices will collapse leaving parts of the country with no GP service.

8b ENFIELD: That conference warns of the unsustainable workload in general practice which will lead to:

- (i) the consequent danger of collapse of services
- (ii) with the imminent risk to the safety of patients, and
- (iii) be a threat to the health and welfare of GPs.

Conference demands that this is urgently recognised and resolved by the UK government.

8c CITY AND EAST LONDON: That conference believes that GPs can't work any harder and that general practice is at breaking point. Conference demands that the GPC identifies GP activities which do not impact on patient care and mounts a serious campaign to implement a collective boycott.

8d AYRSHIRE AND ARRAN: That conference believes that current GP workload is unsustainable.

8e SCOTTISH CONFERENCE OF LMCs: That conference feels that there needs to be a frank consultation with the public and politicians to make them aware of the pressures affecting primary care.

8f GLASGOW: That conference is concerned about the increasing workload in GP out-of-hours services.

8g LEWISHAM: That conference encourages Health Education England, CCGs and the RCGP to develop and provide an educational programme for general practice that informs GPs how to spell, enunciate and appropriately use the word 'no'.

8h DEVON: That conference recognises that current levels of workload are not safely sustainable and calls upon the GPC to work with the RCGP to produce guidance on what constitutes a safe workload.

8i LANCASHIRE COASTAL: That conference believes that the current pressures on GP practices make it imperative that a clear definition of safe working levels is agreed to protect GPs in their ability to provide services to their patients of an adequate quality.

8j AVON: That conference calls upon the GPC to refuse any transfer of healthcare provision from secondary to primary care unless NHSE and CCGs guarantee and ensure that proper financial resources follow the patient.

8k NORTH YORKSHIRE: That conference believes that general practice is past the point of workload saturation; it is essential that resources follow the flow of work.

8l ISLINGTON: That conference warns the UK government of the increasing workload moving into general practice, which is unsustainable, and demands it reverses urgently the reduction in resources and manpower before the service collapses.

8m AVON: That conference deplores the conduct of NHSE because it has:

- (i) incrementally increased the workload of primary care without providing additional funding
- (ii) persistently failed to actively support practices who experience difficulty with staffing and funding
- (iii) persistently attempted to introduce APMS contracts when partnerships change
- (iv) little or no local knowledge now that its geographical footprint has changed and is therefore wholly insensitive to local needs
- (v) has been made aware of the parlous state of general practice time and time again but has compounded the problem rather than assisted.

8n SCOTTISH CONFERENCE OF LMCs: That conference is concerned about the use of clinical guidelines and referral pathways by health boards to shift work from secondary care to general practice without any funding or acknowledgement of the impact on GP workload.

8o MID MERSEY: That conference is appalled that shared care policies between secondary and primary care are being used as a vehicle to shift extra work into primary care rather than as a partnership to provide improved care.

- 9 **AGENDA COMMITTEE as proposed by HULL AND EAST YORKSHIRE:** That conference believes that general practice is experiencing the biggest workforce crisis since its inception and calls upon the newly elected government to take action to ensure that:
- (i) GP funding, recruitment and retention are addressed as its first priority for the NHS
  - (ii) GPs who are leaving the profession early are supported to stay in practice
  - (iii) all those wishing to return to the profession are fully supported and encouraged to do so
  - (iv) the contribution of all GPs to the delivery of NHS services is valued regardless of their contractual status.
  - (v) general practice is supported as an integrated progressive career from medical school right through to retirement.
- 9a HULL AND EAST YORKSHIRE: That conference believes that general practice is heading for the biggest workforce crisis since its inception and it may be too late to save it.
- 9b CLEVELAND: That conference believes that there is no end in sight for the current workforce crisis in general practice and calls upon the newly elected government to take action to address funding, recruitment and retention as its first priority for the NHS as a matter of urgency.
- 9c HERTFORDSHIRE: That conference welcomes all recent commitments to revitalising general practice and providing new GPs and calls on the GPC to ensure that
- (i) GPs who are leaving the profession early due to pension changes and burnout are supported to stay in practice
  - (ii) all those wishing to return to the profession are fully supported and encouraged to do so
  - (iii) the image of general practice within medical schools is actively promoted as a positive career choice
  - (iv) resources are made available to improve GP premises to help make general practice an attractive career for young doctors more used to working in shiny hospitals.
- 9d GLASGOW: That conference values the contribution of all GPs to the delivery of NHS services regardless of their contractual status.
- 9e HEREFORDSHIRE: That conference ask NHS England to support general practice as an integrated progressive career from medical school right through to retirement.
- 9f GWENT: That conference believes that the current recruitment crisis for doctors and nurses in primary care is real and will only worsen if additional extra resource is not found to support general practice.
- 9g DEVON: That conference recognises that the current UK GP workforce is on the verge of a collapse and calls on the British media to fulfil its social responsibility to hold politicians to account and highlight to the public the current high risk that they will soon lose the NHS, as they know it, forever.
- 9h AYRSHIRE AND ARRAN: That conference is concerned about the current workforce crisis and demands that GPC along with SGPC and the four UK governments agree a long term strategy to address this.
- 9i MID MERSEY: That conference believes that general practice morale is at an all-time low, threatening a meltdown in the provision of primary care and demands that the GPC takes urgent action to reverse the trend.
- 9j ROCHDALE AND BURY: That conference urges the government to explore ways in which to retain the experienced senior workforce to avoid a workforce crisis.
- 9k GLASGOW: That conference acknowledges the severity of the workforce crisis facing general practice and calls on GPC to address the current issues affecting GP recruitment and retention.
- 9l BRADFORD AND AIREDALE: That conference calls on NHSE to explain their proposals to avert disaster given the current and rising demands on general practice when the number of GPs leaving the profession is greater than the number joining.
- 9m DUMFRIES AND GALLOWAY: That conference that the home nation governments take immediate action to address the severe recruitment crisis which is now threatening the existence of general practice in the United Kingdom.
- 9n AYRSHIRE AND ARRAN: That conference believes that morale in general practice is at rock bottom and that this is exacerbating recruitment difficulties.
- 9o AYRSHIRE AND ARRAN: That conference recognise the worsening GP workforce crisis and demands that the four UK governments act on this as a matter of priority.
- 9p COUNTY DURHAM AND DARLINGTON: That conference is dismayed about poor workforce planning and calls for urgent action to recruit and retain GPs, especially in deprived areas, due to a real and continuing workforce crisis.
- 9q CENTRAL LANCASHIRE: That conference believes that the primary care workforce is in crisis and that urgent action is needed to try to retain the large number of GPs planning to retire in the next few years, otherwise the NHS will be further plunged into crisis, making primary care unsustainable.
- 9r DEVON: That conference urges the Department of Health to increase substantially funding of Health Education England to tackle the workforce crisis and promote new training places for the primary care team.

- 9s WILTSHIRE: That conference demands GPs are exempted from jury service as part of an urgent measure to tackle the current GP crisis.
- 9t WALTHAM FOREST: That conference has dire concerns regarding the current recruitment and retention crisis in general practice and insists that the GPC, alongside LMCs, RCGP and HEE develop a significant and sustainable policy to improve both recruitment and retention in primary care.
- 9u LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the current crisis and pressures on general practice is being exacerbated by a lack of primary care trained nurses and health care assistants, and urges the GPC to work with the relevant organisations to ensure that primary care placements are part of the nurse training programme.
- 9v ISLINGTON: That conference believes the viability of general practice is threatened by fast-declining resources, increased patient expectation and unsustainable workload and that is reflected by the number of GPs leaving practice early and puts the physical and mental well-being of GPs at risk.
- 9w GLASGOW: That conference believes that the future of general practice is at risk due to the triple whammy of a GP workforce crisis, unmanageable GP workload and rock bottom GP morale and calls on GPC to urgently seek solutions to safeguard the profession.
- 9x BRO TAF: That conference calls on the Westminster government to prioritise national GP recruitment by restoring its positive image through adequate resourcing.
- 9y CORNWALL AND ISLES OF SCILLY: That conference calls upon GPC to look at innovative ways of working to facilitate retention and recruitment.
- 9z NORFOLK AND WAVENEY: That conference calls on GPC to negotiate the reinstatement of the seniority allowance to retain experienced GPs. This is needed to counteract the pension changes and incentivise GPs to stay in the profession when nearing retirement and thereby pass on their experience.
- 9aa CLEVELAND: That conference deplores the ending of seniority payments – the loss of which is a further encouragement for GPs to consider early retirement - and calls on the government to introduce an alternative system of payments that recognises experience and long term commitment to the NHS and thereby encourages retention of the workforce.
- 9bb SUFFOLK: That conference believes that the following changes will go some way to help the GP recruitment and retention crisis:
- (i) NHS England becomes responsible for paying employer insurance contributions for GPs (and staff)
  - (ii) NHS England introduces a scheme to pay off the student loans of trainee GPs and young GPs in order to encourage them to enter British general practice rather than to leave the UK
  - (iii) that the decision to withdraw seniority pay be revisited and reversed, recognising the valuable additional contribution of long-serving GPs.
- 9cc WIGAN: That conference notes the recent proposal that more pharmacists should work in GP surgeries. A far better development would be to make it possible for more GPs to be working in GP surgeries. It calls on the government and NHSE to deliver:
- (i) an increase in the share of general practice in NHS funding to achieve 12 percent of total NHS funding
  - (ii) a serious financial incentive for doctors in training to take up and complete VTS training
  - (iii) a cure for the financial disincentives which are driving GPs into early retirement.
- 9dd DEVON: That conference welcomes the recent small amount of additional funding to address the GP workforce crisis and the problems of recruitment and retention of GPs but calls upon the Department of Health to increase substantially the funding and support of innovative solutions to help general practice.
- 9ee AVON: That conference deplores the government's lack of action on the workforce crisis in general practice and:
- (i) calls upon the GPC to negotiate again with the Department of Health, RCGP and NHSE to remedy the situation
  - (ii) call on this new government and NHSE to reaffirm publicly general practice as the cornerstone of the NHS
  - (iii) believes that unless all parties work together in a meaningful way primary care provision as we know it will cease to exist in the next few years.
- 9ff LEEDS: That conference is alarmed at the crisis in recruitment and retention of GPs and calls on governments and health bodies to:
- (i) make a long-term commitment to significant and sustainable investment in general practice
  - (ii) take urgent action to reduce the bureaucratic burden and micro management of general practice
  - (iii) take urgent action to address the workload burden currently experienced by GPs
  - (iv) talk up and promote the essential role GPs play in making the NHS successful
  - (v) proactively challenge the negative stereotypes about general practice in medical schools, hospital training or in the media.
- 9gg BEDFORDSHIRE: That conference believes that the loss of GPs is an equally important problem as the poor recruitment in to the profession and instructs the GPC to:
- (i) urgently investigate and attack the causes
  - (ii) develop practical solutions to stem the haemorrhage, and
  - (iii) ensure the rapid implementation of these practical solutions.

- 9hh SOMERSET: That conference recognises that the GP workforce crisis is now so far advanced that new solutions are required and that:
- (i) financial inducements should be offered to doctors entering GP training
  - (ii) it should be made easy for trainees in other specialties to transfer to GP training
  - (iii) practices should be helped to recruit and retain other clinicians such as physiotherapists and registered mental nurses to help with the primary care workload
  - (iv) no attempt should be made to expand GP practice opening hours until existing provision can be stabilised
  - (v) the procedure for closing a practice list should be simple and non-penalising.
- 9ii SALFORD AND TRAFFORD: That conference expresses grave concern for the future provision of general practice in the light of the paucity of new entrants to the profession, and potential early retirement due to the current stress levels of those in post. GPC is asked to work with all necessary authorities to address not only recruitment but also retention issues.
- 9jj NORFOLK AND WAVENEY: That conference asks GPC to negotiate reduce BMJ advertisement charges for GP vacancies in this time of national workforce crisis or the setting up of a single national database where practices can advertise freely their vacancies and contact details.
- 9kk WIRRAL: That conference believes that senior / experienced GPs should do everything they can to protect general practice and keep it a worthwhile and a rewarding career that young junior doctors will want to enter.
- 9ll SCOTTISH CONFERENCE OF LMCs: That conference can again see hope in the future, and feels that general practice has the potential of becoming once again one of the most rewarding and fulfilling branches of medicine, and therefore calls on junior colleagues to come and join us in increasing numbers.
- 9mm SCOTTISH CONFERENCE OF LMCs: That conference recognises that GPs starting out in their careers can face isolation both professionally and emotionally and calls on SGPC to explore ways that GPs can be supported or mentored in the early years of their careers.
- 9nn AYRSHIRE AND ARRAN: That conference believes that the four UK governments should urgently fund a campaign to recruit more doctors to a career in general practice.
- 9oo BRADFORD AND AIREDALE: That conference recognises the need to raise the profile of general practice as a rewarding and fulfilling career pathway, especially in light of the central and expanding role of a general practitioner in the changing healthcare landscape, and adequately train the future workforce as such, thereby addressing misconceptions of general practice being merely a default career setting or community SHO role and attempting to offset a decline in recruitment and retention.
- 9pp DEVON: That conference would like to congratulate the RCGP on their recent campaign to promote general practice as an attractive career for medical students but it asks the GPC to take this message further by considering:
- (i) employing a PR company to research and mount a targeted promotional campaign
  - (ii) ensure any future campaign is stronger, longer and makes a bigger impact on the profession than the RCGP promotion.
- 9qq DEVON: That conference recognises the breadth of skills and interests that GPs throughout the United Kingdom possess and strongly advocates that retention of the plurality in general practice is achieved by protecting:
- (i) the variation in size of individual practices ie very big as well as very small
  - (ii) opportunities for GPs to follow a portfolio career including political, managerial and clinical specialisation.
- 9rr LIVERPOOL: That conference believes that general practice is seen as an increasingly less attractive career option for doctors and calls upon GPC to examine the issues which are turning young doctors away from general practice.
- 9ss CITY AND EAST LONDON: That conference demands that urgent steps are taken by the Department of Health to increase recruitment of GPs and provide remuneration that encourages newly trained doctors to enter into general practice.
- 9tt GRAMPIAN: That conference calls for a mechanism to be found to make it easier for GPs to take time out and experience other practices, both to reduce professional isolation, and to help refresh them from the wearing down combination of practice administration and increasingly heavy and complex workloads.
- 9uu CORNWALL AND ISLES OF SCILLY: That conference believes that general practice is at present unattractive to young doctors and urges GPC to partner with RCGP in exploring ways of increasing recruitment.
- 9vv ROCHDALE AND BURY: That conference urges the government to recognise the value of the senior primary care medical workforce.
- 9ww WAKEFIELD: That conference feels that the extension of general practice hours; with extended hours and seven day opening, makes general practice unattractive to newly qualified doctors as a career option.
- 10 **HAMPSHIRE AND ISLE OF WIGHT: That conference supports the creation of an intermediate grade qualification for GPs, similar to staff grade in hospitals, to allow a career path for GP registrars whose practice is safe but does not reach the standard required for the MRCGP qualification, to avoid the loss of this potentially useful workforce to the profession.**

- 11 **THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee: That conference congratulates NHS England in its intention to reduce the barriers to accessing the induction and refresher scheme, and asks GPC to insist that:**
- (i) **these are not confined to under doctored areas**
  - (ii) **GPs are funded to undergo the scheme at no less than the pay scale of a trainee GP**
  - (iii) **practices who supervise these GPs receive funding commensurate with the GP trainers' grant.**
- 11a DEVON: That conference requests immediate changes to remove the obstructions that prevent GPs who have had a career break from re-entering the profession and specifically requests
- (i) new funding is released to deaneries to pay for the training and the salaries of returners
  - (ii) establishment of a list of countries where work and CPD criteria are recognised as equivalent to employment as a NHS GP so that there are no re-entry requirements on return to the UK
  - (iii) those who are currently taking a career break are given a financial incentive to return by the government.
- 11b DEVON: That conference calls on the government to put their efforts into encouraging lapsed UK trained GPs back into practice rather than looking abroad for much needed NHS manpower as is currently happening in the nursing profession.
- 12 **AGENDA COMMITTEE to be proposed by NORFOLK AND WAVENEY: That conference welcomes UK trained GPs who wish to return to practice in the NHS after a period working abroad and:**
- (i) **seeks assurances that all efforts are made to reduce the barriers to their re-integration into the NHS**
  - (ii) **asks that returning GPs need not all be subjected to full induction and refresher training**
  - (iii) **demands that certain overseas qualifications be recognised by the NHS**
  - (iv) **demands that outreach appraisal programmes be available for these GPs while working abroad**
  - (v) **demands that a financial resettlement programme be created to incentivise GPs to return from working abroad.**
- 12a NORFOLK AND WAVENEY: That conference welcomes GP returnees from overseas and seeks assurances that all efforts are made to reduce the barriers to their re-integration into the NHS which currently is proving to be a major deterrent
- 12b NORFOLK AND WAVENEY: That conference asks NHSE to recognise certain overseas qualifications rather than subjecting returning doctors to undergo full induction and refresher training.
- 12c WILTSHIRE: That conference deplores the loss of talent, often our newly qualified GPs working abroad and demands:
- (i) the British taxpayer is made aware of this waste of money and talent
  - (ii) an outreach appraisal programme for GPs working abroad in first world primary care to complete annual appraisal and be guided in how to try and maintain specialist GMC registration and achieve revalidation
  - (iii) a national financial re-settlement programme created to incentivise GPs to return in hard to recruit areas and also to retain older GPs and those who want a career break to return.
- 12d DORSET: That conference believes that the government should pay air fares and expenses or a golden handshake for GPs returning from working abroad, as an incentive to them to return to general practice in the UK.
- 12e DERBYSHIRE: That conference, whilst recognising the necessity to maintain and assure the standards of general practice within the United Kingdom, highlights the unnecessarily burdensome obstructions placed in the way of UK trained general practitioners who wish to return to practice in the NHS after a period overseas broadening their horizons and professional skills for the benefit of the national health service. The GPC is instructed to catalogue and highlight these burdens and take all necessary steps to demolish the obstructions.
- 12f EAST MIDLANDS REGIONAL COUNCIL: That conference, whilst recognising the necessity to maintain and assure the standards of general practice within the United Kingdom, highlights the unnecessarily burdensome obstructions placed in the way of UK trained general practitioners who wish to return to practice in the NHS after a period overseas broadening their horizons and professional skills for the benefit of the national health service. The GPC is instructed to catalogue and highlight these burdens and take all necessary steps to demolish the obstructions.
- 12g DEVON: That conference demands that each deanery be given adequate additional ring-fenced funding for the purpose of financing GP returner courses.

- 13 **AGENDA COMMITTEE to be proposed by DEVON: That, in the interests of the safety of patients and the health of GPs, conference demands that practices should:**
- (i) be resourced to limit the maximum list size to no more than 1500 patients per whole time equivalent GP
  - (ii) receive increased funding to be able to offer standard consultation times of 15 minutes
  - (iii) be able to declare major incidents and capacity shutdowns in a similar manner to A&E, supported by equal access to emergency resources at times of system stress
  - (iv) have the right to close their list when they alone decide it is unsafe to take on more patients
  - (v) be enabled to ensure GPs do not work beyond the legislated hours of the European Working Time Directive.
- 13a DEVON: That conference believes that no GP should be working more than ten hours a day as this is potentially detrimental to the health of our patients and the health of the GP and asks that:
- (i) average list size per whole time equivalent should be reduced to 1500 patients per whole time equivalent
  - (ii) consultation times should increase to 15 minutes as 10 minutes is wholly inadequate for the complex needs of our patients
  - (iii) the above should be supported by an increase in general practice funding that is adequate to achieve these aims.
- 13b SOUTH STAFFORDSHIRE: That conference believes the current workload levels are affecting the health and wellbeing of doctors adversely, endangering patient safety and propagating attrition in the GP workforce, potentially making general practice unsustainable. Conference therefore calls upon the GPC to:
- (i) restore work-life balance to the profession by implementing the UK Working Time Regulations (WTR) for 'ALL' general practitioners
  - (ii) introduce a workload monitoring system that records time spent working outside contracted hours
  - (iii) develop a banded payment mechanism that recognises and compensates GP for the intensity and duration of work carried out during unsociable hours
  - (iv) negotiate a new deal contract that protects patients from overtired doctors, by reducing the maximum hours worked per week to 48.
- 13c BUCKINGHAMSHIRE: That conference calls upon NHSE and the devolved nations to:
- (i) recognise that overtired and overstretched GPs potentially risk patient safety
  - (ii) identify the maximum number of patients for whom a GP can safely provide complete holistic care
  - (iii) ensure GPs have a sustainable and safe workload
  - (iv) ensure GPs do not work beyond the legislated hours of the European Working Time Directive
  - (v) limit the number of patients, pro rata to whole time equivalent GPs, that a GP practice can look after.
- 13d OXFORDSHIRE: That conference believes that full-time and many part time GPs work more than the current European Working Time Directive hours to the detriment of patients and themselves and just as happens in the airline, haulage or public transport industries, calls upon NHSE to enforce a maximum number of patients a GP can have on their list to prevent tired doctors making decisions that have profound effects on people's lives.
- 13e LANCASHIRE COASTAL: That conference believes that the ten minute GP appointment, fundamental building block of the NHS, is no longer fit for purpose.
- 13f BIRMINGHAM DIVISION: That conference believes the current standard GP consultation time of ten minutes is out of date, takes no account of changes in medical practice, is not fit for purpose and should be increased.
- 13g SURREY: That conference demands general practitioners have time to care and that a longer consultation time is needed to deliver safe and quality general practice.
- 13h HIGHLAND: That conference recognises that to have an effective impact on complex health problems, GPs do need to spend adequate amounts of time with patients and this is a message that must inform negotiations around changes to the GMS contract.
- 13i AYRSHIRE AND ARRAN: That conference believes that GPC and SGPC should negotiate for a move to 15 minute appointments as part of the annual contract negotiation cycle.
- 13j AYRSHIRE AND ARRAN: That conference believes that GPC and SGPC should negotiate for practices to be given the extra resources to allow the 15 minute consultation to become the norm without it extending the already long days that general practitioners work as part of the on-going contract negotiations.
- 13k DEVON: That conference recognises general practice consultations have become much more complex over the last decade and calls on government to increase funding so that practices may safely and professionally move from the current standard 10 minute consultation to the necessary 15 minutes
- 13l BRADFORD AND AIREDALE: That in the interests of patient safety conference calls for general practice to be able to declare major incidents and capacity shutdowns in a similar manner to A&E and other secondary care sectors and has equal access to emergency resources at times of system stress.
- 13m SALFORD AND TRAFFORD: That conference believes that current workload means many practices are being asked to work beyond a safe level for their patients and the health of their staff. GPC is asked to investigate the potential for a practice applied Red Amber Green (RAG) rating – to allow practices to self-declare Red when they feel that the quality of their service is compromised.

- 13n NORTHAMPTONSHIRE: That conference demands that practices are given the right to close their list when they alone decide it is unsafe to take on more patients.
- 13o CLEVELAND: That conference condemns NHS England's failure to recognise the regulations with regard to a practice's right to appropriately manage their registered list, in terms of new applicants and removal of patients, without the need for full list closure or NHS England approval.
- 13p CLEVELAND: That conference insists that a practice has the right under the regulations, to manage its registered list so as to manage capacity, ensure continuity and maintain safe and effective care for registered patients. This includes the right to temporarily decline new registrations where the practice deems it would be reasonable to do so in a non-discriminatory manner.
- 13q BRADFORD AND AIREDALE: In the interests of patient safety and sustainability of services and in an effort to avoid the impending disaster of high numbers of GPs leaving the profession, we call on conference to negotiate sufficient funding to limit the maximum list size to 1200 patients per whole time equivalent GP.
- 13r CITY AND EAST LONDON: That conference is adamant that unrealistic workload expectations amount to an abuse of the workforce and are resulting in large numbers of GPs taking early retirement and young doctors deciding against a career in general practice. Conference demands that expectations of general practice are made more realistic and that funding is significantly increased so that we can sustain a workforce into the future with manageable levels of workload and improved recruitment and retention.
- 13s CAMDEN: That conference calls upon the UK government to:
- (i) recognise that there is a limit to the safe workload capacity of each practice; and that practices cannot increase working hours and services without an adverse effect on patients and staff
  - (ii) support the expansion of the workforce in general practice.

## GP EDUCATION AND TRAINING

11.30

- 14 **AGENDA COMMITTEE to be proposed by the GP Trainees Subcommittee: That conference is concerned by the decline in GP training applications and calls on GPC and the RCGP to increase efforts to recruit GP trainees by:**
- (i) ensuring GP training posts are not used for service provision
  - (ii) ensuring GP trainees are provided with adequate support for increasing workload pressures
  - (iii) increasing funding for trainers to enhance the quality of GP training
  - (iv) vigorously opposing plans to cut the pay of GP trainees
  - (v) implementing strategies to improve student perceptions of general practice.
- 14a THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: That conference is concerned that GP training applications are declining and calls upon the GPC and RCGP to make the career more attractive by:
- (i) ensuring GP training posts are not used for service provision
  - (ii) enhancing the quality of training by increasing funding for trainers
  - (iii) ensuring trainees are provided with adequate support to help with the increasing workload pressures.
- 14b CAMBRIDGESHIRE: That conference deplores the government's plans to cut the pay of GP trainees at a time when the numbers of applicants for GP trainee places is already in decline and demands that the GPC vigorously opposes this proposal.
- 14c NEWCASTLE MEDICAL SCHOOL: That conference on:
- (i) the GPC to implement strategies to improve student perceptions of general practice.
  - (ii) relevant stakeholders to work with the GPC in producing clear plans to recruit sufficient GPs, without infringing on career choice autonomy.
- 14d HULL AND EAST YORKSHIRE: That conference calls for increased efforts to ensure adequate numbers of GP registrars are recruited especially for training schemes that have been under subscribed in recent years.
- 14e LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is extremely concerned about the reduction in applications to GP training. It urges the GPC to:
- (i) survey why junior doctors are not choosing general practice as a career choice and publicise the results
  - (ii) work with all relevant stakeholders to develop a plan of action to reverse this damaging trend.
- 15 **AGENDA COMMITTEE to be proposed by the GP Trainees Subcommittee: That conference calls on GPC to work with the RCGP to ensure the GP training curriculum encompasses:**
- (i) commissioning, management and clinical leadership skills
  - (ii) finance, business management and business skills
  - (iii) IT
  - (iv) health and justice
  - (v) resilience.
- 15a THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: That conference is concerned that the current GP training curriculum does not equip trainees with the managerial skills of a general practitioner and calls on the RCGP to include in the curriculum:
- (i) leadership training
  - (ii) education regarding the role of CCGs and LMCs.



- 15b NORFOLK AND WAVENEY: That conference believes that the current training model for general practice does little to prepare future GPs to become commissioners and undertake other health management roles and asks GPC to negotiate the resources to include commissioning, management and clinical leadership skills in GP training.
- 15c DERBYSHIRE: That conference notes the significant management and business skills components contained within the training required for the grant of a CCT in many specialties. Conference is dismayed at the absence of such training in many current GP vocational training schemes. The GPC is instructed to catalogue and highlight this deficiency, create a training syllabus in finance, business management and business skills and insist that the RCGP incorporates the subjects into the GP CCT exit exam (aka MRCGP).
- 15d GLASGOW: That conference recognises that the business side of general practice is complex and daunting for newly qualified GPs and calls for training in this area to be improved.
- 15e GLASGOW: That conference believes it is time for the RCGP curriculum to reflect the huge role of IT in general practice.
- 15f NOTTINGHAMSHIRE: That conference believes that now that prison healthcare is properly seen as a branch of primary healthcare led and delivered by GPs, training in health and justice should be a recognised part of the future general practice curriculum.
- 15g COUNTY DURHAM AND DARLINGTON: That conference calls upon the GPC to work with the RCGP to ensure 'resilience' training is an integral part of the GP training curriculum.
- 15h COUNTY DURHAM AND DARLINGTON: That conference is concerned that the current GP training programme is heavily populated by box ticking exercises and calls on the RCGP to address this immediately by focusing more on the practical and management skills of general practice.
- 15i HERTFORDSHIRE: That conference welcomes the recent RCGP video promoting general practice and urges the GPDF to work with the BMA and RCGP in producing resources and material that will explicitly seek to recruit candidates with business acumen, entrepreneurial skills, resilience and fortitude in at least equal measure to empathy, effective communication and patient centredness.
- 15j NORFOLK AND WAVENEY: That conference calls for an overhaul in GP training as it does not:
- (i) provide enough practical experience
  - (ii) provide sufficient experience in specialties appropriate for general practice above the foundation level
  - (iii) take into account registrars moving from other hospital specialties to have their previous experience taken into consideration
  - (iv) provide enough training on the GP contract and partnership model.
- 15k EAST MIDLANDS REGIONAL COUNCIL: That conference notes the significant management and business skills components contained within the training required for the grant of a CCT/CESR in many specialties. Conference is dismayed at the absence of such training in many current GP vocational training schemes. The GPC is instructed to catalogue and highlight this deficiency, to work with the RCGP to create a training syllabus in finance, business management and business skills, and to support the RCGP in incorporating the subjects into the GP CCT exit exam (MRCGP).
- 16 **LIVERPOOL: That conference believes that the requirement for new GP trainers to acquire a Postgraduate Certification in Education (PGCE) is seen as an impediment to becoming a GP trainer on account of the time required and inadequate funding.**
- 16a NORTH YORKSHIRE: That conference believes that any measures to tackle the GP recruitment crisis will be in vain unless the looming GP trainer crisis is also addressed. The current requirement in some regions for potential GP trainers to achieve a Postgraduate Certificate in Education is a significant barrier towards recruitment. This onerous demand needs removing and requirements need standardising in order that GPs are not unnecessarily deterred from taking this route.
- 16b NORTH YORKSHIRE: That conference believes there is an urgent need for younger GPs to become trainers to address the looming GP workforce crisis and that the current requirement for an educational qualification is an unnecessary deterrent to those wishing to apply to become trainers.

- 17 **AGENDA COMMITTEE to be proposed by HERTFORDSHIRE: That conference believes the out of area registration scheme has been a disaster and;**
- (i) believes the scheme fragments patient care
  - (ii) condemns NHS England's failure to provide a comprehensive home visiting service for patients registered as out of area patients
  - (iii) calls on GPC to negotiate the end of this scheme.
- 17a HERTFORDSHIRE: That conference believes that the out of area registration scheme strikes at the heart of general practice by fragmenting patient care, fracturing continuity and diminishing the accountability GPs have for individual patients, and calls on GPC to negotiate the end of this scheme.
- 17b NORFOLK AND WAVENEY: That conference believes the 'out of area registration' scheme has been a disaster in rural areas and NHSE has failed in its responsibility to ensure a complete service has been commissioned across the country. The scheme should be withdrawn and local enhanced services considered according to local need.
- 17c LEEDS: That conference condemns NHS England's failure to provide a comprehensive home visiting service for patients registered as out of area patients.
- 18 **AGENDA COMMITTEE to be proposed by GRAMPIAN: That conference asks GPC to ensure that, for the benefit of patient safety, out-of-hours (OOH) providers have:**
- (i) appropriate staffing skill mix
  - (ii) effective triage algorithms
  - (iii) consideration of the impact on daytime services
  - (iv) sufficient funding
  - (v) an obligation to provide indemnity cover for employees
- 18a GRAMPIAN: That conference, while accepting that increasing workload in the out-of-hours period means that teams have to use appropriate skill mix, is concerned to ensure that these services do not become GP light and do not lead to increased pressures on daytime services.
- 18b NORFOLK AND WAVENEY: That conference asks GPC to ensure a national set of minimum standards is in place for OOH providers to comply with as it believes many OOH providers are working in ways that are unsustainable and ineffective, leading to risks of patient safety as the service is often:
- (i) not being appropriately staffed
  - (ii) uses ineffective triage algorithms that often do not direct patients to the most appropriate place of care and raise expectation
  - (iii) risks urgent cases not receiving priority action as bases become full of less clinically appropriate callers
  - (iv) working too remotely from other care providers
  - (v) insufficiently funded.
- 18c SURREY: That conference believes the only person who should provide medical advice to patients during the OOHs period is a registered clinician.
- 18d HIGHLAND: That conference calls for the whole system of out-of-hours primary health care provision to be scrutinised, and then given the level of funding it deserves.
- 18e NORTHERN IRELAND CONFERENCE OF LMCs: That conference believes that to properly staff OOH, the employing body needs to provide indemnity cover as it does for other employees.
- 18f MORGANNWG: That conference with reference to out-of-hours services:
- (i) congratulates GP-led out-of-hours services for their work in providing care to patients
  - (ii) recognises that even those that are not GP-run or GP-led rely on GPs to provide the majority of care
  - (iii) demands that sufficient resources are allocated to ensure proper remuneration is available to encourage local GPs to work for the local service.
- 18g EAST MIDLANDS REGIONAL COUNCIL: That conference with regards to out-of-hours provision:
- (i) notes that GPs are subsidising the clinical indemnity costs of out-of-hours provision through their indemnity premia
  - (ii) notes that Indemnity cost is a major reason for reluctance among some GPs to take on this work
  - (iii) requires the government to cover 100% of the clinical indemnity component of out-of-hours care.

- 19 **THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee: That conference believes that as a significant part of the GP workforce, sessional GPs should be considered a potential asset by commissioning bodies, and**
- (i) is concerned at the current lack of consistent representation of this group of GPs on commissioning boards
  - (ii) believes these GPs should be encouraged and supported to access leadership roles within these bodies
  - (iii) asks GPC to demand that NHS England instructs these organisations to ensure they have proportionate representation from sessional GPs on their boards
  - (iv) asks GPC to demand that NHS England instructs these bodies to ensure they allow these GPs access to leadership roles within their organisation.
- 19a SUFFOLK: That conference recognises that sessional GPs (locums and salaried) represent an integral part of CCGs nationwide and calls on GPC to provide leadership to facilitate their inclusion in CCGs' constitutions where they are not currently so included.

- 20 **AGENDA COMMITTEE to be proposed by NOTTINGHAMSHIRE: That conference demands urgent attention to investment needed to improve primary care premises for the sake of patient safety, and calls for long term increased funding to be:**
- (i) focused on areas where it is most needed
  - (ii) continued to develop general practice to meet future needs
  - (iii) offered with appropriate notice
  - (iv) offered with inclusive criteria
  - (v) used to ameliorate 'last man standing' liabilities.
- 20a NOTTINGHAMSHIRE: That conference:
- (i) deplores the inadequate manner in which information about accessing the first tranche of the new premises funds was disseminated to practices
  - (ii) is dismayed at the impossibly short timescale in which bids for new premises funds had to be submitted
  - (iii) condemns the restrictive criteria for payment of new premises funds
  - (iv) insists the GPC ensure concerns about accessing the new premises funds are addressed before the next tranche of funds are made available.
- 20b KENT: That conference demands that use of the Primary Care Infrastructure Fund is focused on:
- (i) the further development of practice premises to deliver safe and effective patient care
  - (ii) geographical areas where general practice is under the most strain
  - (iii) geographical areas of high deprivation.
- 20c AYRSHIRE AND ARRAN: That conference recognises that problems with premises are impacting on recruitment and on service delivery and calls on GPC and SGPC to negotiate new dedicated funding for premises development.
- 20d MID MERSEY: That conference asks the Department of Health to pay urgent attention to investment needs to improve primary care infrastructure for the sake of patient safety.
- 20e EAST SUSSEX: That conference demands that NHS England:
- (i) guarantees there are no longer delays in their obligations as described in the Premises Cost Directions
  - (ii) stops abating previously agreed reimbursements to practices where surgery space is utilised by other NHS providers
  - (iii) ensures transparency in the process for prioritising the Infrastructure Fund for and after 2016/17.
- 20f GLASGOW: That conference calls on GPC to work with devolved governments to develop a coherent GP premises strategy.
- 20g CARDIFF AND VALE OF GLAMORGAN DIVISION: That conference urges the government to prioritise the development of primary care premises and recognise the need for additional space to manage the increased shift of work from hospital services.
- 20h CAMBRIDGESHIRE: That conference believes that the prolonged lack of investment in GP premises is a barrier to the evolution of general practice as envisaged in the Five Year Forward View, and demands that the GPC seeks government assistance to remove these barriers.
- 20i GATESHEAD AND SOUTH TYNESIDE: That conference believes that the lack of investment in premises to date was short-sighted and that the present investment announced is wholly inadequate for the tasks of primary care ahead.
- 20j CAMDEN: That conference insists that GPs should be supported financially to improve their practice premises and should not be penalised by withholding of rental payments where improvements in practice premises lead to an increase in rent.
- 20k SOUTH ESSEX: That conference demands that the GP infrastructure fund is fully devolved to NHS England sub regions who must be required to prioritise bids in a fair and transparent way in consultation with the local LMC(s).
- 20l BEDFORDSHIRE: That conference believes that the NHS should shoulder the responsibility of picking up leases where a GP becomes the 'last man standing'.

20m	AYRSHIRE AND ARRAN: That conference recognises the significant impact of negative equity in premises and 'last man standing' on recruitment and retention of the workforce and calls on GPC and SGPC to negotiate protection for GPs faced with this situation.
20n	KENT: That conference instructs the GPC to negotiate with NHS England full rent reimbursement for the provision of out of hospital care from primary care premises, as described in the NHS Five Year Forward View.
20o	HERTFORDSHIRE: That conference believes that ten years of lack of premises investment has led to a reduction in privacy for patients and increased stress for staff.
20p	GWENT: That conference: <ul style="list-style-type: none"> <li>(i) reaffirms that good care is best delivered from adequate surgery premises</li> <li>(ii) deplores the fact that repeated calls for investment in premises appear to have fallen on deaf ears</li> <li>(iii) is disappointed that, where premises are funded, this is more often through third party finance than through the doctors who have an interest in the well-being of their practices and the populations they serve</li> <li>(iv) reiterates the call for adequate capital funding for surgery developments to be instituted in a planned manner, on a recurring basis that is sustainable in the long term.</li> </ul>
20q	ISLINGTON: That conference demands that resources are urgently put into general practice premises to make them fit for the purpose of delivering high quality patient services.
20r	SHROPSHIRE: That conference believes the majority of GP premises are less than adequate, that this reflects the lack of spending by successive governments and that any agreement to cooperate with the proposed transfer of more work from hospitals into the community must be contingent on the prior provision of a primary care infrastructure that is fit for purpose.

## **GENERAL PRACTITIONERS DEFENCE FUND (GPDF)**

**12.40**

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

## **CHARITIES**

**12.50**

### **Dain Fund**

22 **Receive:** Report by the Chairman of the Dain Fund (Dr Mike Downes).

### **Claire Wand Fund**

23 **Receive:** Report by the Chairman of the Claire Wand Fund (Dr Russell Walshaw).

### **Cameron Fund**

24 **Receive:** Report by the Chairman of the Cameron Fund (Dr Stephen Linton).

## **LUNCH**

**13.00**

- 25 **AGENDA COMMITTEE as proposed by MANCHESTER: That conference notes the move to devolve NHS and social care to local authorities in Greater Manchester and:**
- (i) welcomes integration of health and social care when it is in the best interests of patients
  - (ii) deplores the failure to consult with local LMCs, the statutory representative bodies for GPs
  - (iii) supports the involvement of Greater Manchester LMCs in the decision making committees within the new devolved governance framework in Greater Manchester
  - (iv) seeks assurance that existing NHS providers and contracts will have the same protections as under existing NHS commissioning arrangements
  - (v) instructs GPC to ensure that existing funding streams for primary care medical services contracts are properly protected in Greater Manchester.
- 25a MANCHESTER: That conference supports the request for involvement of Greater Manchester LMCs in the decision making committees within the new devolution governance framework in Greater Manchester.
- 25b WILTSHIRE: That conference deplores the unseemly rush into devolution in Manchester and:
- (i) directs GPC to remind Manchester’s Mayor that the LMC is the only statutory representative body for GPs
  - (ii) directs GPC to fight furiously to ring fence resources for practices to the benefit of patients
  - (iii) welcomes integration of health and social care when it is in the patients’ best interests
  - (iv) reminds over-enthusiastic CCG leads that they do not necessarily represent their member practices
  - (v) directs GPC to ensure that GMS / PMS contracts are preserved in Manchester.
- 25c LIVERPOOL That conference notes with interest the move to devolve NHS and social care to local authorities for Greater Manchester, however assurance must be sought that health and social care budgets will be ring fenced and existing NHS providers and contracts will have the same protections as under existing NHS commissioning arrangements and that this will not be a route to challenge by private providers for the right to tender to the lowest cost bidder for all commissioned contracts.
- 25d NORTH ESSEX: That conference instructs GPC to ensure that existing core funding streams for primary care medical services contracts are properly protected as part of any joint devolved budget arrangements as proposed in Greater Manchester.
- 25e MANCHESTER: That conference agrees that health funding and GP contracts should be protected in the devolution process in Greater Manchester.
- 25f MANCHESTER: That conference believes that when devolution changes level 2 co-commissioning to level 3 in Greater Manchester, consultation should be sought from GPs before formalising this decision.
- 25g ROCHDALE AND BURY: That conference recognises that the Devo Manchester Proposal is a potential opportunity but must engage with primary care for it to be effective.
- 25h WIGAN: That conference condemns the failure of NHSE, HM Chancellor of the Exchequer, NHSE GM area team, and GM CCGs to consult with local LMCs, GPs and patient representative groups on the so called 'Devo Manc' commitment to devolving £5 Billion of NHS funding to the control of the Greater Manchester local authority and a yet unelected Mayor.
- 25i COVENTRY: That conference is dismayed that the devolution of the total NHS budget for Greater Manchester to the local councils has been presented as a fait accompli, without due consultation with the public and all other stakeholders. Conference demands debate within the broader BMA and a clear position statement from the BMA. The BMA must not be reticent in voicing its view. Failure to do so would make it complicit.
- 26 **AGENDA COMMITTEE to be proposed by LEEDS: That conference notes the NHS ‘Five Year Forward View’ and:**
- (i) believes that it does not address how the crisis in general practice is going to be resolved
  - (ii) believes it necessary for local GPs to be fully engaged in discussions about new models of care in their localities
  - (iii) insists that any new models of care should not involve pooling of the GMS/PMS global sum
  - (iv) calls on the new government to work with doctors and not impose potentially damaging solutions
  - (v) calls on the new government to declare that the underlying funding gap will be bridged.
- 26a LEEDS: That conference believes that the development of the models of care outlined in the Five Year Forward View could lead to an even bigger NHS re-organisation than that which followed the NHS Health and Social Care Act and calls on the new government to work with doctors and not impose potentially damaging solutions.
- 26b WILTSHIRE: That conference believes that the Five Year Forward plan is a smoke screen document which does nothing to show how the crisis in general practice is going to be resolved.

- 26c NOTTINGHAMSHIRE: That, as regards the NHS Five Year Forward View, conference:
- (i) recognises the opportunities for general practice arising from the shift in the balance of power between commissioners and providers
  - (ii) is concerned at the threat to the national GP contract implicit in a move towards pooling of primary and secondary care capitated budgets
  - (iii) believes it necessary for LMCs, supported by GPC, to ensure local GPs are aware of both the opportunities and threats the Five Year Forward View poses and are fully engaged in discussions about participation in new models of care in their localities.
- 26d DEVON: That conference insists that any new models of care arising from the five year forward view should not include pooling of the GMS / PMS global sum.
- 26e DEVON: That conference supports the Five Year Forward View but calls upon politicians to declare that the underlying funding gap of £8 billion by 2020 will be bridged.
- 26f NORTH YORKSHIRE: That conference believes that the NHS 'Five Year Forward View' does not address the GP workforce crisis as a result general practice as the public expects it to be will become unsustainable unless the GP workforce crisis is addressed as a matter of urgency.
- 26g HERTFORDSHIRE: That conference believes that the Five Year Forward View is full of fine and excellent ideas but gives little comfort to the average GP.
- 26h ROCHDALE AND BURY: That conference warns the government on repeated new models of care, which are having an adverse impact on the medical workforce.
- 26i CAMBRIDGESHIRE: That conference understands the Five Year Forward View document demonstrates that change is inevitable and demands that the GPC lobby for resources to enable practices to make change happen.

## SCOTLAND

- 27 **Receive:** Presentation by the Chairman of Scottish GPC (Dr Alan McDevitt) on development of new models of care in Scotland
- 28 **LEEDS: That conference believes that any new models of care should:**
- (i) build on the foundation of a national core GP contract**
  - (ii) develop health and social care teams around practices in communities**
  - (iii) support organisations working together rather than focus on re-organisation in order to create a single employing organisation for all staff**
  - (iv) focus on the provision of services within an area and not on competition to provide services outside their locality.**
- 29 **AGENDA COMMITTEE to be proposed by BRADFORD AND AIREDALE: That conference:**
- (i) recognises that list based general practice has been shown to be the most effective way of delivering primary healthcare to patients**
  - (ii) insists that the partnership model of general practice remains viable for those that wish to work within it**
  - (iii) warns that any movement towards the formation of larger general practice organisations should not be allowed to destroy the continuity of care that exists in general practice**
  - (iv) urges GPC to resist changes which risk forcing GPs into larger general practice organisations.**
- 29a BRADFORD AND AIREDALE: That conference believes that any movement towards 'working at scale' in general practice should not be allowed to destroy continuity of care that exists within general practice, the cradle to grave approach or the local provision for each population that the current model provides and that is so appreciated by patients.
- 29b BRADFORD AND AIREDALE: That conference believes that the push to provide general practice in ever larger organisations is driven by the interests of providing secondary care in a primary care setting and is not in the interests of good family medicine and urges the GPC to make this point in all future negotiations and to resist changes which risk forcing GPs into ever larger organisations.
- 29c NOTTINGHAMSHIRE: That conference, recognising that list based general practice has been shown by international comparisons to be the most effective way of delivering primary healthcare to patients, urges the GPC to ensure that any legislation designed to implement the new models of care described in the Five Year Forward View maintains the principles of list based general practice and the requirements of the GP performers' list.
- 29d KENT: That conference insists that the partnership model remains viable for those who wish to work within it and that it is not lost in the drive towards the formation of larger organisations.
- 29e NORFOLK AND WAVENEY: That conference believes there is often a reason why local practices are not already in partnership with each other and that the notion within 'Forward View a Five Year Plan' that practices should all suddenly work in partnership with each other after years of competition, will be very challenging.

- 29f ROCHDALE AND BURY: That conference warns the government of proposed vertical integration in the Five Year Forward View document as a method of losing patient continuity.
- 29g NORTHERN IRELAND CONFERENCE OF LMCs: That conference supports and endorses practices and their independent provider status as the core building block of networks and federations.
- 29h SEFTON: That conference notes the new models of care provision espoused in the Five Year Forward View and the experimental vanguard sites. It calls upon the GPC:
- (i) to safeguard independent GP practice from the 'salaried service' implications of 'vertically integrated' providers
  - (ii) work with the medical defence bodies and NHSE to eliminate ambiguities in indemnity cover for GPs working in these novel arrangements.
- 29i SALFORD AND TRAFFORD: That conference believes that integrated care systems with hospital trusts as lead providers pose the greatest individual threat to general practice as patients and GPs currently know it.
- 29j SALFORD AND TRAFFORD: That conference believes that integrated care systems with hospital trusts as lead providers will be the wrong solution to the very real problems being faced in the provision of general practice.
- 30 **AGENDA COMMITTEE to be proposed by LINCOLNSHIRE: That conference:**
- (i) asks that GPC produce guidance on alternatives to the partnership model for the delivery of general practice
  - (ii) agrees that federated working by general practices will provide stability and sustainable general practice for the future
  - (iii) calls on GPC to actively and practically support the formation of GP federations and provider organisations
  - (iv) calls for financial and technical support for GP federations from government.
- 30a LINCOLNSHIRE: That conference agrees that federated working by general practices will provide stability and sustainable general practice for the future, and that government should provide financial and technical support to allow these federations to take shape.
- 30b LIVERPOOL: That conference believes that GPC needs to actively and practically support the formation of GP federations and provider organisations issuing timely advice and sharing information so that all fledgling organisations can benefit from the experience of others.
- 30c NORTH ESSEX: That conference asks that GPC produce guidance on alternative and sustainable provider models for general practice in order to halt the steady decline which has accompanied a simplistic belief that only practice partnerships can maintain the values of UK general practice.
- 30d WALTHAM FOREST: That conference believes that in light of the recruitment and retention problem, the current model of GP is unsustainable and that the GPC needs to support the development of new models of general practice in which the GP is the co-ordinator of care supporting allied health professionals in delivering direct patient care.
- 30e SALFORD AND TRAFFORD: That conference believes that as long as integrated care systems are well balanced and appropriately funded they could bring benefit to both general practice and patient care. Integrated care systems that achieve this are to be encouraged.

## WALES

- 31 **Receive:** Presentation by the Chair of GPC Wales (Dr Charlotte Jones) on development of new models of care in Wales.
- 32 **LIVERPOOL: That conference believes that the model of the self-employed independent practitioner has been so eroded by the current contract and regulatory regime, that the GPC should be exploring the establishment of a fully costed and salaried GP service.**
- 32a MID MERSEY: That conference believes that the days of independent contractor status are numbered and the profession should seriously consider a salaried option.
- 32b CITY AND EAST LONDON: That conference believes that the current form of independent contractor status is not fit for purpose and perpetuates historic inequity. Conference instructs GPC to pursue a new GP contract where all GPs are equitably reimbursed for the work that they do.
- 32c CORNWALL AND ISLES OF SCILLY: That conference believes that the partnership model of general practice is stifling recruitment and calls upon GPC to explore a national salaried model.
- 32d DERBYSHIRE: That conference recognises that a contract where practices who deliver more (employ more staff and deliver more appointments) can result in less profits, and practices that deliver less can result in greater profits (for profit share partners or shareholders) is not a contract that is fit for purpose and should:
- (i) be renegotiated, even if there are going to be winners and losers
  - (ii) contain an option for a fully salaried service
  - (iii) contain a mechanism for GPs who move away from the independent contractor status to be fully recompensed for the investments they have made in the past (including in premises).

- 32e CORNWALL AND ISLES OF SCILLY: That conference believes that the partnership / corner shop model of primary care is dead and that federating two village shops does not make a viable business and calls on the GPC to urgently negotiate a completely different model for the delivery of primary care.

## NORTHERN IRELAND

- 33 **Receive:** Presentation by the Chairman of the Northern Ireland GPC (Dr Tom Black) on development of new models of care in Northern Ireland.

- 34 **NORTHERN IRELAND CONFERENCE OF LMCs: That conference instructs GPC to continue to actively promote the partnership model and to support and encourage the career development of our sessional colleagues.**

- 34a NORTH YORKSHIRE: That conference believes the independent contractor model of general practice should remain available to all and continues to be a driver for responsive, high quality and holistic primary care.

- 34b BRO TAF: That conference is concerned that the message the UK government is probably hearing from the GPC is that independent contractor status is doomed. Conference requests GPC to ensure that it is made absolutely clear that it is primary care which is doomed, unless properly resourced.

- 34c CLEVELAND: That conference defends the right of GPs to hold independent contractor status as we must ensure that there continues to be a choice for future GPs of partnership status rather than the eventual imposition of a completely salaried service.

- 35 **WILTSHIRE: That conference reasserts our commitment to the holistic care of our patients and believes the strength of UK general practice is our long-term knowledge of our patients and asks that continuity of care is incentivised over access.**

- 35a WEST SUSSEX: That conference recognises the values of UK general practice based on:

- (i) a list based register of patients and
- (ii) continuity of care.

- 35b CLEVELAND: That conference insists that the emphasis must be on continuity of care rather than populist demands for round the clock access when configuring general practice services.

- 35c WAKEFIELD: That conference asks that if the government wishes patients to be given more accountability and continuity with named GPs; that they don't at the same time make continuity of care impossible by ever increasing surgery hours with a finite workforce; or shared care across localities where you are not seeing your own GP.

- 35d GWENT: That conference:

- (i) believes that the independent contractor model remains the best way of providing efficient, effective and flexible primary care
- (ii) recognises that in order to succeed the model requires adequate financial resources, information and infrastructure
- (iii) deplores attempts to micro manage general practice through external agencies instead of giving us the resource and information to manage ourselves
- (iv) calls on politicians in all four devolved governments to adequately invest in primary care services now and in the longer term.

- 35e NORFOLK AND WAVENEY: That conference supports the traditional model of list based general practice where the local knowledge of families and communities by their general practitioner results in the most cost-effective and patient orientated model of health care.

- 35f SOMERSET: That conference affirms that continuity of care embodied in the registered patient list remains the key to the provision of safe and cost effective primary care services, and this principle should be central to all NHS planning.



## GP PARTNERSHIPS

15.40

- 36 **GLOUCESTERSHIRE:** That conference believes that allowing GP partners access to the goodwill in their practices would be the most effective way to enable general medical practice to evolve to meet the challenges of the future.
- 37 **WILTSHIRE:** That conference asks the GPC to act urgently to mitigate the financial risk to the 'last man standing' in practices such as a change in partnership model to limited liability partnerships.
- 37a NORTH ESSEX: That conference instructs the GPC to negotiate changes to primary care contracts that will allow practices to become limited companies by means of a simple process that will not put at risk their existing NHS contract. This would allow:
- (i) practices to become commercially competitive with AQPs
  - (ii) 20% reduction in tax burden
  - (iii) reduced risk (limits of liability)
  - (iv) easier to raise investment and funding
  - (v) corporation tax relief on pension contributions.
- 37b GLOUCESTERSHIRE: That conference believes that Limited Liability Partnerships could reduce the stress involved in running a practice and would encourage GPs to become partners.
- 37c WILTSHIRE: That conference believes that the liability of being a partner in these times is putting both experienced GPs off from staying in practice and new from becoming partners in practice.
- 37d DERBYSHIRE: That conference:
- (i) highlights to the general public the new and increasing phenomenon of practice implosion and sudden closure, often caused by a combination of a resignation and failure to recruit to replace a doctor
  - (ii) notes that the impacts of sudden practice failures fall upon neighbouring practices, threatening GP services to an entire locality
  - (iii) instructs the GPC to explore and negotiate mechanisms with government to stabilise general practice in a locality where sudden practice closures are likely or have occurred.
- 37e EAST MIDLANDS REGIONAL COUNCIL: That conference:
- (i) highlights to the general public the new and increasing phenomenon of practice implosion and sudden closure, often caused by a combination of a resignation and failure to recruit to replace a doctor
  - (ii) notes that the impacts of sudden practice failures fall upon neighbouring practices, threatening GP services to an entire locality
  - (iii) instructs the GPC to explore and negotiate mechanisms with government to stabilise general practice in a locality where sudden practice closures are likely or have occurred.

## PRIVATE FEES / NHS WORK

16.00

- 38 **BUCKINGHAMSHIRE:** That conference, recognising the increasing mismatch between workload and available GP and practice workforce, calls on the governments and NHSE to work with the GPC to urgently define
- (i) what is and is not included in GP essential services
  - (ii) what work can be postponed or abandoned if a practice is unable to recruit sufficient staff to deliver all services safely
  - (iii) what patients and public can and cannot expect from GP service in crisis.
- 38a NEWCASTLE AND NORTH TYNESIDE: That conference is of the view that, with the new proposed models of care which could have implications for income and conditions of service, it is time to re-visit the issue of defining core services and believes:
- (i) the definition of core services would protect the role of the generalist
  - (ii) it would protect general practice which could become vulnerable if, in some future models, resources were to be drawn towards acute care.
- 38b BERKSHIRE: With the current recruitment problem in general practice set to get worse, and rising patient demand, there is an increasing mismatch between the workload of general practice and the workforce available to deliver it. Until the workforce can be increased there is a need to determine what the priorities for GP should be and which work should be abandoned or postponed if there is insufficient staff. Conference calls on the government and NHSE to work with the profession to define this core work as a matter of urgency, to create a framework to allow practices with limited staff to concentrate on this core work and to educate the public as to what they can and cannot expect of a NHS in crisis.
- 38c HULL AND EAST YORKSHIRE: That conference requests GPC to confirm the following statements, and to support practices who run into contractual dispute as a result of following them that:
- (i) essential services covers assessment and treatment of illnesses in keeping with what GPs would have been expected to learn during their early medical education and ongoing through their career
  - (ii) practice nurses are employed by GPs to help them deliver the GMS contract
  - (iii) provision of routine nursing services, whether in housebound patients or those attending surgery, is not part essential services.
- 38d HAMPSHIRE AND ISLE OF WIGHT: That conference insists that, given the insistence of some commissioners to define non-core services as core for GPs (ie unpaid additional work), the GPC produces a clear definition of the work paid for through the global sum.
- 38e WILTSHIRE: That conference believes that it is time to define non-core GP services and treatments that are not available on the NHS.

- 38f HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the arguments against defining GP core services have long been overridden by the crisis in general practice.
- 38g LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes GMS core contract should be well defined. It should be explicit in what is within the core contract and what is not:
- (i) GPC should consider a new work sensitive systems needs payment. This could be called 'core contract plus'
  - (ii) to make sure that any 'left shift' is followed with appropriate funding for resources in primary care. Primary care is not just a 'cheap option' and definitely not a political dumping ground
  - (iii) to negotiate appropriate fees structure for private work like insurance reports / PMAR etc. and to empower GPs to say "NO" to any work stream that is disproportionate to the time and resources it needs.
- 39 **GLOUCESTERSHIRE: That conference believes patient care would be improved were practices to be allowed to offer 'top up' private services to their NHS patients and requests that the GPC include this in their contract negotiations.**
- 39a BRADFORD AND AIREDALE: That conference, in view of the enhanced threat to practice funding, conference supports the principle that GPs should be able to provide private work / services to their own registered patients without having to de-register the patient from their practice list.
- 39b NORFOLK AND WAVENEY: That conference calls GPC to push for a review on the rules about what practices can charge patients for as:
- (i) the current regulations are out of touch with market forces
  - (ii) it would be likely to reduce the requests for non-contractual work
  - (iii) it would better educate patients and organisations about what is available and affordable on the NHS
  - (iv) GPs could expand the services they are able to offer based on demand.

## SOAPBOX

16.20

- 40 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.

- 41 **MID MERSEY: That conference believes it is time to have one GP contract across the UK.**
- 41a NORTH YORKSHIRE: That conference believes that although the current GMS contract is actively under threat nationally, it remains the proven and effective mechanism for providing high standard primary care and should be defended for the sake of patients and practices alike.
- 42 **AGENDA COMMITTEE to be proposed by DERBYSHIRE: That conference, with respect to the standard model contract for salaried GPs:**
- (i) insists that the concept is professionally beneficial
  - (ii) demands that terms no less favourable are offered by all employers of GPs
  - (iii) believes that it is now not fit for purpose
  - (iv) believes that it generates unrealistic and unaffordable burdens concerning annual leave entitlements and study leave entitlements
  - (v) instructs the GPC to negotiate changes.
- 42a DERBYSHIRE: That conference insists that the concept of a standard model contract for employment of salaried doctors by practices is professionally beneficial, however the current standard model contract imposed upon GMS practices is:
- (i) not fit for purpose in the second decade of the 21st century
  - (ii) inequitable in that it generates unrealistic and unaffordable burdens and privileges upon the parties concerning annual leave entitlements and study leave entitlements, and instructs the GPC to negotiate a sensible and equitable solution with all speed and in no case later than LMC conference 2016.
- 42b EAST MIDLANDS REGIONAL COUNCIL: That conference insists that the concept of a standard model contract for employment of salaried doctors by practices is professionally beneficial, however the current standard model contract imposed upon GMS practices:
- (i) is not fit for purpose
  - (ii) is inequitable in that it generates unrealistic and unaffordable burdens and privileges upon the parties concerning annual leave entitlements and study leave entitlements
- and instructs the GPC to negotiate a sensible and equitable solution with all speed and in no case later than LMC conference 2016.
- 42c NORTHAMPTONSHIRE: That conference demands that all salaried GPs be given terms no less favourable than the BMA model contract, regardless of whether they work for a PMS, APMS or GMS practice.
- 42d WEST SUSSEX: That conference believes that all primary medical service contract holders should be required to offer the BMA model contract.
- 42e BIRMINGHAM DIVISION: That the salaried GP model contract should be made more affordable for GP practices.
- 43 **RM DORSET: That conference believes that the BMA model contract for sessional doctors is bad for all GPs and bad for general practice and demands that GPC have its obligatory use removed from the general practice contract. (Will fall if Motion 42 part (ii) is passed).**

- 44 **SOMERSET: That conference believes that NHS 111 in its present form should be scrapped, and it should be:**
- (i) re-commissioned as a local service
  - (ii) fully integrated with unscheduled care providers
  - (iii) based on early skilled clinical triage and not a risk averse algorithm used by call handlers
  - (iv) subject to regular review of its effectiveness and impact on all other providers.
- 44a AVON: That conference has no confidence in NHS 111 as it is:
- (i) wholly ineffective and grotesquely expensive
  - (ii) massively increases demand on already stretched services
  - (iii) is a significant driver for the pressures experienced across the health service over the winter of 2014/15
  - (iv) a political white elephant and should be abolished.
- 44b DERBYSHIRE: That conference declares that, in its professional judgement, NHS 111 as currently constructed is:
- (i) an expensive gimmick
  - (ii) wasteful of GP in hours resource
  - (iii) wasteful of out-of-hours resource
  - (iv) wasteful of ambulance resource
  - (v) wasteful of emergency department resource.
- 44c KENT: That conference believes investment in primary care that improves access to GPs would be more effective than money wasted on NHS 111.
- 44d BEDFORDSHIRE: That conference believes that NHS 111:
- (i) does not add value for the patient
  - (ii) is yet another political white elephant, and
  - (iii) is not fit for purpose.
- 44e NORFOLK AND WAVENEY: That conference believes that the NHS 111 service raises patient expectation beyond what is feasible, affordable or suitable.
- 44f SURREY: That conference believes the NHS 111 service is delivering an inappropriately risk averse service and that this is leading to:
- (i) increased ambulance call outs
  - (ii) increased patient attendance at accident and emergency departments.
- 44g CORNWALL AND ISLES OF SCILLY: That conference believes NHS 111 is:
- (i) often dangerous
  - (ii) a waste of money
  - (iii) should be abolished.
- 44h SOUTHWARKE: That conference insist that the NHS 111 service must be clinician led as it is increasing GP work load unnecessarily and advising inappropriate A&E attendances.
- 44i GATESHEAD AND SOUTH TYNESIDE: That conference believes that the present NHS 111 has not met expectations and that any future government should support the reintroduction of clinically led triage for people who believe that they are ill.
- 44j DEVON: That conference believes IT clinical algorithms cannot manage risk to the same high standards associated with a real live general practitioner and as a consequence of this:
- (i) the NHS 111 system is failing
  - (ii) A&E attendances are rising
  - (iii) the NHS would be safer if the GPC was solely in charge of any future management changes to be imposed on healthcare
  - (iv) if (iii) not possible then a computer would undoubtedly have more success at running the NHS rather than the risk prone highly unpredictable politicians.
- 44k BERKSHIRE: That conference deplores the way in which the substantial and dedicated contribution of the out-of-hours services to the health of the nation is consistently ignored and misunderstood by senior politicians and NHS staff who remain extraordinarily tolerant and uncritical when reviewing the catastrophic damage caused to the emergency and urgent care services by the profligate and ineffective NHS 111 service.
- 44l BROMLEY: That conference is concerned about the quality of the reports from NHS 111 and calls upon the GPC to negotiate with NHS England to ensure that NHS 111 reports are fit for purpose and clearly state the purpose of the patient call to NHS 111.
- 44m DARTFORD GRAVESEND AND MEDWAY DIVISION: That conference proposes that 111 services be dismantled and increase the GP numbers and out of hours provided by clinically accountable people.

## OTHER MOTIONS 1

17.20

- 45 **CLEVELAND:** That conference contends that much of the remaining Quality Outcomes Framework (QOF):
- (i) does not recognise the increasing stratification of management of long term conditions dependent on the patient's general health status and co-morbidities
  - (ii) does not reflect current concepts of patient choice
  - (iii) is unfit for purpose
  - (iv) should be scrapped with the money transferred into the global sum.
- 45a **CORNWALL AND ISLES OF SCILLY:** That conference believes that QOF has outlived its usefulness and demands the GPC negotiate for the attached payment be transferred to the global sum.
- 45b **GWENT:** That conference believes that the QOF has served its purpose of demonstrating to specialist colleagues, managers and politicians how effective general practice can be and should now be retired, with the money being returned to the global sum from which it was originally taken.
- 45c **LIVERPOOL:** That conference believes that GPC should negotiate a further transfer of QOF funding into core funding as target driven health care is now part of the problem rather than the solution to improving the health care of patients.

## CHOSEN MOTIONS AND CONTINGENCY

17.25

## CLOSE

17.30

## FRIDAY MORNING – SESSION 3 – REGULATION

### REGULATION, MONITORING AND PERFORMANCE MANAGEMENT

9.00

- 46 **AGENDA COMMITTEE to be proposed by the SCOTTISH CONFERENCE OF LMCs: That conference:**
- (i) believes that the GMC is creating a climate where doctors practice in fear for their registration
  - (ii) demands that GPs being investigated for alleged misdemeanours should be presumed innocent until proven otherwise
  - (iii) demands that the GMC implement the recommendations of the independent report by Sarndrah Horsfall, 'Doctors who commit suicide while under GMC fitness to practise investigation'.
- 46a SCOTTISH CONFERENCE OF LMCs: That conference:
- (i) believes that doctors in Scotland should be entitled to attend Fitness to Practice proceedings at a venue within Scotland
  - (ii) believes that the GMC is creating a climate where doctors practice in fear for their registration
  - (iii) demands that the GMC implement the recommendations of the independent report by Sarndrah Horsfall, 'Doctors who commit suicide while under GMC fitness to practise investigation'.
- 46b COVENTRY: That conference demands that GPs being investigated for alleged misdemeanours should be presumed innocent until proven otherwise.
- 46c DYFED POWYS: That conference is concerned that healthcare in the UK is in danger of being driven more by the fear of blame rather than best care and decision making for the patient.
- 46d WIRRAL: That conference believes that doctors accused of poor performance / misconduct are at times investigated in an aggressive/ disproportionate way for the alleged issue being looked at and NHS England could do well to take guidance from English law over the last few hundred years – 'innocent until proven guilty!'
- 46e HERTFORDSHIRE: That conference welcomes the GMC report into doctors who commit suicide while under fitness to practise investigation but believes that the offer of emotional resilience training does not go far enough and calls:
- (i) for a UK wide emergency pastoral support service for GPs under mental and physical strain, and
  - (ii) on GPDF to fund an emergency pastoral support service for GPs.
- 46f MID MERSEY: That conference is appalled that the GMC's policy of keeping all complaints on record of doctors without their knowledge is contrary to the laws of natural justice and demand that such practice is stopped.
- 47 **AGENDA COMMITTEE to be proposed by COUNTY DURHAM AND DARLINGTON: That conference with respect to the current complaints system for general practice:**
- (i) believes it has been undermined by the fragmentation of the NHS resulting from the Health and Social Care Act
  - (ii) believes it is letting GPs, practices and patients down
  - (iii) believes that it would benefit from a step for mediation in the process
  - (iv) calls on the GPC to conduct a review of decisions and findings of the Health Service Ombudsman in relation to GPs
  - (v) asks the GPC to work with NHS England to revise it.
- 47a COUNTY DURHAM AND DARLINGTON: That conference believes that the current NHS complaints process as it relates to primary care is not fit for purpose.
- 47b LEEDS: That conference believes that the current complaints system for general practice:
- (i) has been undermined by the fragmentation of the NHS resulting from the Health and Social Care Act
  - (ii) is letting GPs, practices and patients down
  - (iii) needs urgent review and improvement at levels above the practice.
- 47c COUNTY DURHAM AND DARLINGTON: That conference believes that a step for mediation in the complaints process would be helpful for patients and their families and asks the GPC to work with NHS England to revise the current complaints process.
- 47d COUNTY DURHAM AND DARLINGTON: That conference calls on the GPC to conduct a review of decisions and findings of the Health Service Ombudsman in relation to GPs.
- 48 **CAMBRIDGESHIRE: That conference believes that professional regulation of doctors needs to be separate from the regulation of other professions and providers, and protected from political interference, and therefore calls for the GMC to remain independent.**

- 49 **NORTHERN IRELAND CONFERENCE OF LMCs: That conference believes that there should be one central body that oversees performer's lists to avoid multiple, time consuming bureaucratic applications by GPs to so many different bodies for the same thing.**
- 49a THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee:  
That conference calls on the government to end the farcical performer's list regulations that prevent GPs from freely working across the borders between the devolved nations and England. This will in part help to alleviate the difficulties in recruiting GPs in some areas by promoting a flexible, mobile workforce.
- 50 **AGENDA COMMITTEE to be proposed by BERKSHIRE: That conference:**
- (i) **believes that appraisal has become a workload burden for GPs**
  - (ii) **believes that appraisal is no longer a formative experience for most GPs**
  - (iii) **believes that appraisal is being made far more arduous and bureaucratic than is required by GMC**
  - (iv) **believes that appraisal poses particular difficulty for sessional GPs to obtain evidence for their various roles**
  - (v) **calls on GPC to ensure that appraisal returns to a much more valuable process for GPs.**
- 50a BERKSHIRE: That conference believes that appraisal:
- (i) has become a workload burden for GPs
  - (ii) can distract from the main GP job of caring for patients
  - (iii) is increasingly controlled by those who have left or never been in general practice
  - (iv) needs to change so that it addresses genuine developmental needs and not be dominated by feeding responsible officers with evidence for revalidation.
- 50b BUCKINGHAMSHIRE: That conference is losing confidence in the appraisal process:
- (i) as it is no longer a formative experience for most GPs
  - (ii) as it believes the time involved for appraiser and appraisee represents a huge cost in lost appointments for patients
  - (iii) as the demands placed on GPs in completing a satisfactory appraisal are subject to the whims of individual ROs
  - (iv) and instructs GPC to negotiate national standards and interpretations of 'guidance' for appraisals.
- 50c HERTFORDSHIRE: That conference believes that GP appraisal is being made far more arduous and bureaucratic than is required by GMC and calls on GPC to ensure that responsible officers are closely monitored to ensure consistency in how appraisal requirements are interpreted and implemented.
- 50d BEDFORDSHIRE: That conference:
- (i) notes the increasing workload for appraisal each year
  - (ii) notes the decrease in the numbers of GPs willing to be appraisers
  - (iii) believes that appraisal is now a punitive stick with which to beat GPs
  - (iv) and calls on GPC to ensure it returns to a much more valuable process for GPs.
- 50e KENT: That conference recognises that sessional GPs have particular difficulty in obtaining appraisal evidence for their various roles and demands an increase in the number of GP appraisers who work as sessional GPs in order to improve support for this expanding part of the workforce.
- 50f NORFOLK AND WAVENEY: That conference calls for the appraisal and revalidation process to be reviewed for part time GPs so the time and onerous nature of the process is altered to reflect pro rata hours worked. Currently it is discriminatory that part time GPs have to undergo the same amount of study for appraisal as their full time colleagues.
- 50g MID MERSEY: That conference believes that appraisals are not fit for purpose and that these are only accelerating GPs to take early retirement.
- 50h LIVERPOOL: That conference believes that the burden created by the increasing demands required for appraisal and revalidation is causing senior GPs to choose to retire early, disheartened by burn out from a bureaucratic work load and that GPC must look at means of modifying and simplifying the process of appraisal and revalidation.
- 50i NORFOLK AND WAVENEY: That conference calls for the revalidation requirements and processes to be reviewed as currently being not fit for purpose and a major cause for experienced GPs deciding to retire early.
- 50j BERKSHIRE: That conference believes that the time involved for both appraisee and appraiser represents a huge opportunity cost in terms of lost patient appointments and would not pass a cost benefit assessment it asks the GPC to investigate a better way of assuring good clinical practice.
- 50k BUCKINGHAMSHIRE: That conference believes that responsible officers and appraisal teams are arbitrarily deciding on rules about what's necessary and what's mandatory in the conduct of a GP's appraisal.
- 50l OXFORDSHIRE: That conference believes that appraisal is a complete waste of time and serves only to tick boxes for those responsible for revalidation; therefore we call for it to be scrapped.

- 50m NORTH YORKSHIRE: That conference believes that appraisal should remain with NHS England rather than CCGs or the recently merged area teams on the basis that:
- (i) appraisal is mandatory and also an opportunity to annually reflect on those areas going well, and those identified as needing review in individual practice. As appraisal develops it is acquiring a tick box approach to represent appropriate review required in each area for individual responsible officers
  - (ii) as a mandatory exercise it seems appropriate that appraisal, revalidation and returner/ remedial training should have a national structure rather than be tailored to the thinking of regional responsible officers.
- 51 **COVENTRY: That conference deplores the bureaucratic and incompetent nightmare of the CQC, and demands that it is decommissioned forthwith and that the funding is reinvested in frontline services.**
- 51a NORFOLK AND WAVENEY: That conference demands the withdrawal of CQC's intelligent monitoring report as it is unintelligent, lacks appropriate monitoring data, is misleading to the public and is potentially libellous.
- 51b WALTHAM FOREST: That conference is concerned about the approach of CQC general practice inspection reports, these reports:
- (i) are not fit for purpose
  - (ii) contain destructive criticism of practices only
  - (iii) do not make any constructive points on how care could be improve within the financial constraints of the practice, and
  - (iv) are not amalgamated to provide reports to the government on what investment is needed in general practice to improve standards.
- 51c CORNWALL AND ISLES OF SCILLY: That conference believes that the title CQC is an oxymoron.
- 51d BEDFORDSHIRE: That conference instructs GPC to explore the scope for non-cooperation with CQC by practices if the CQC continues to publish ratings.
- 51e GLOUCESTERSHIRE: That conference has no confidence in CQC and:
- (i) believes they have demonstrated time and again their inability to act effectively within their remit in a fair and proportionate manner
  - (ii) consistently demonstrate an intimidating and uncaring attitude towards practices
  - (iii) so requires GPC to seek the withdrawal of CQC inspections from general practice.
- 51f HERTFORDSHIRE: That conference believes that the CQC:
- (i) diverts valuable GP time and resources away from patient care to unevidenced bureaucracy
  - (ii) puts an unacceptable financial burden on general practice
  - (iii) undermines general practice through unsubstantiated accusations and fallacious ratings
  - (iv) is unfit for purpose
  - (v) does not have the confidence of the profession.
- 51g LEEDS: That conference believes the CQC's intelligent monitoring system is not fit for purpose and calls for its immediate withdrawal.
- 51h BIRMINGHAM: That conference believes that CQC must take into account differences in practice funding and other relevant contextual issues when judging and rating the quality of general practices.
- 51i HERTFORDSHIRE: That conference believes that the CQC's inspections of general practice have become excessively intrusive in requiring far greater detail and recording of audit, complaints and significant events than is required for appraisal and revalidation, and calls on GPC to work with CQC to ensure the standards are relevant and appropriate.
- 51j CORNWALL AND ISLES OF SCILLY: That conference has no confidence in CQC or its inspection system and calls on GPC to lobby for its abolition as it has lost the confidence of the profession and is unfit for purpose.
- 51k CORNWALL AND ISLES OF SCILLY: That conference believes that CQC is not fit for purpose as it does not measure holistic high quality general practice and calls for it to be completely overhauled to ensure it has the confidence of the profession and the public.
- 51l LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes the CQC is a monster which needs to be tamed. The conference is of the view that CQC is not fit for purpose and is nothing more than a bureaucratic, box ticking and extremely burdensome process for practices that is distracting.
- 51m LIVERPOOL: That conference believes that CQC's intelligent monitoring is neither intelligent, nor monitoring and is concerned by the indiscriminate use of data obtained from practices, out of context.
- 51n LIVERPOOL: That conference believes that GPC should work with CQC to ensure that its processes are free from political pressure to continually raise standards to avoid 'satisfactory' becoming the new 'inadequate'.
- 51o CAMBRIDGESHIRE: That conference, believes that CQC's intelligent monitoring was always an oxymoron, but still distrusts CQC's use of data and assessment of risk.



- 51p SOMERSET: That conference declares that the profession has no faith in process for the inspection of general practices by the CQC, on the grounds that it has failed to:
- (i) demonstrate that its inspection regime is consistent and balanced
  - (ii) produce accurate and meaningful statistics to identify practices in need of early inspection
  - (iii) demonstrate that it offers value for money for the government or the providers forced to pay for inspections
  - (iv) convince practices that the outcomes of registration and inspection merit the huge effort required to prepare for them
  - (v) recognise the destructive effect of adding yet more bureaucracy to an already over-regulated profession and therefore inspections should be ended forthwith.
- 51q AVON: That conference believes CQC is not fit for purpose and deplores its simplistic, damning rating system for practices and demands that:
- (i) CQC takes into account what is deliverable and attainable when making their reports
  - (ii) when appointing new partners, CQC does not interfere and makes the registration process less obstructive
  - (iii) inspections are standardised and made meaningful and constructive to practices and patients
  - (iv) where problems are identified, funding is made available to practices, with appropriate support to quickly rectify issues within premises
  - (v) the rating system is removed altogether.
- 51r LINCOLN DIVISION: That conference highlights the fiasco of the launch of CQC's Intelligent Monitoring Data on GP Practices, and its subsequent retraction, and believes that while CQC may have identified a small minority of practices where improvement was needed, their lasting achievement will have been significantly to constrain the care of patients in practices during the preparatory and inspection phases of their visits.
- 52 **SUFFOLK: That conference requests that the Secretary of State ensures that GP regulation and inspection:**
- (i) is focused**
  - (ii) is relevant to clinical outcomes**
  - (iii) does not demoralise, denigrate or draw resources away from actually delivering healthcare.**
- 52a NOTTINGHAMSHIRE: That conference believes that over regulation of general practice is killing our profession and calls upon the CQC, NHS England, CCGs and the GMC to recognise this and to ensure that regulation is at all times fair, reasonable and proportionate.
- 52b DORSET: That conference believes that the increasing regulatory burden continues to have an adverse effect on the provision of healthcare.
- 52c HULL AND EAST YORKSHIRE: That conference believes that GPs are often judged by external organisations (such as the GMC or the CQC) in a manner that fails to take into account the conditions under which they work. Conference requests GPC to seek formal acknowledgement from those organisations who may make punitive statements against individual GPs or practices that they will take into account the following factors that:
- (i) GPs work under great pressure, often seeing in excess of 40 patients per day
  - (ii) ten minute consultations are the norm.
- 53 **HERTFORDSHIRE: That conference calls on GPC to insist that the CQC can only see anonymised patient notes and staff records or must obtain explicit consent.**
- 53a DEVON: That conference believes that patient consent should be obtained before any patient identifiable data is viewed by the CQC.

- 54 **NOTTINGHAMSHIRE:** That conference:
- (i) is alarmed at the increasingly prohibitive costs of medical defence cover for GPs
  - (ii) is concerned that medical defence societies are unfairly refusing cover to GPs deemed to be 'a high insurance risk' thereby denying them the means to practice and earn a livelihood
  - (iii) invites the government to acknowledge that the cost of medical defence cover is making it uneconomic for GPs to participate in OOH or other non-GMS work and to investigate ways of subsidising these costs;
  - (iv) requests the GPC to undertake a study of medical defence cover for GPs, to address current concerns and determine the pros and cons of crown indemnity being extended to GPs.
- 54a **COVENTRY:** That conference that the additional cost to GPs for indemnity when working in out-of-hours GP services is a disincentive to recruitment, and demands that NHS England arranges central indemnity for this work.
- 54b **MID MERSEY:** That conference is deeply concerned about the astronomical rise in defence subscriptions for salaried and sessional doctors and calls upon the LMC Conference to address the economical strain which is making part time GP work unsustainable.
- 54c **NORTHAMPTONSHIRE:** That conference demands that all medical indemnity for general practitioners be funded centrally regardless of whether the GP works in hours or out-of-hours.
- 54d **DERBYSHIRE:** That conference believes that with regards to out-of-hours provision:
- (i) general practitioners are subsidising the clinical indemnity costs of out-of-hours provision through their indemnity premia
  - (ii) the government must cover 100% of the clinical indemnity component of out-of-hours care.
- 54e **WILTSHIRE:** That conference believes that like other doctors working in the NHS, GPs should be offered the protection of crown indemnity.
- 54f **DORSET:** That conference believes that, given the robustness of revalidation and appraisal, GPs should be given crown indemnity.
- 54g **CORNWALL AND ISLES OF SCILLY:** That conference calls upon GPC to demand crown indemnity for all GPs as:
- (i) rising medical indemnity insurance costs are unfairly discriminating against working in general practice
  - (ii) are putting GPs off working in OOH
  - (iii) discouraging some GPs increasing the number of sessions they work as the expense is too high.
- 54h **ROCHDALE AND BURY:** That conference urges the government to address the extortionate fees charged by the medical indemnity organisations, which is having an adverse effect on the medical workforce.
- 54i **THE GPC:** That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee:  
That conference calls on the Department of Health to halt the decline in the number of GPs able to do out of hours work by funding the prohibitive, inconsistent and incremental cost of medical indemnity which is acting as a disincentive.

- 55 **SOMERSET: That conference believes that generic prescribing should always result in the lowest acquisition cost for the NHS, and that:**
- (i) **category M classification distorts the market and should be ended**
  - (ii) **an annual ceiling price for generic products should be maintained**
  - (iii) **legislation is urgently needed to end patent protection for specific indications for pharmaceuticals**
  - (iv) **direct intervention to ensure continuity of supply of widely used generic products is required.**
- 55a DEVON: That conference in relation to NHS England Gateway Reference: 03126, 'The Pregabalin Guidance' issued on Friday 6th March 2015:
- (i) deplores the instruction to prescribe by brand name for a particular condition other than for a sound clinical reason
  - (ii) continues to support the guidance in the British National Formulary that 'where non-proprietary ('generic') titles are given, they should be used in prescribing'
  - (iii) believes that it is counter to GMC guidance, 'Planning, using and managing resources' Paragraphs 79-81
  - (iv) instructs the GPC to encourage a legal challenge by NHS England.
- 55b MORGANNWG: That conference demands GPC challenge the recent NHSE letter to GPs regarding the prescribing of Lyrica®/Pregabalin as this is likely to be the thin wedge of a very thick wedge of similar challenges that are not consistent with good practice which expects GPs to prescribe generically where bioavailability is not an issue.
- 55c HERTFORDSHIRE: That conference is dismayed at the actions of some pharmaceutical companies in using European court rulings to block the use of new generic formulation with consequent vast pressure on general practice resource and calls for GPC to highlight these actions to GPs so that they can make a judgement on the ethics of the companies involved
- 56 **MID MERSEY: That conference believes that the expected use of antivirals demanded by Public Health England (PHE) has weak evidence and is not part of the core general medical services.**
- 56a NORTHERN IRELAND CONFERENCE OF LMCs: That conference instructs GPC to inform public health that Tamiflu prophylaxis in nursing homes or any other public health initiative are not part of core GMS.
- 56b OXFORDSHIRE: That conference believes that wherever possible GPs try to practice evidence based medicine and calls on PHE to do the same, beginning with changing its current advice which is contrary to the Cochrane Review on the use of Tamiflu in nursing homes.
- 57 **AGENDA COMMITTEE to be proposed by MID MERSEY: That conference, with respect to prescribing, asks the GPC/BMA to negotiate:**
- (i) **for prescription medications to be available free of charge for all patients**
  - (ii) **a unified single tariff for all drugs in primary and secondary care**
  - (iii) **that all drugs started in secondary care should be prescribed in accordance with the same drug formularies that primary care is expected to follow**
  - (iv) **that primary medical services be directed to stop giving patients prescriptions for items that can easily be purchased over the counter**
  - (v) **the need for GPs to prescribe various non-drug products, appliances and food products be removed.**
- 57a MID MERSEY: That conference asks the GPC/BMA to negotiate:
- (i) a unified single tariff for all drugs in primary and secondary care
  - (ii) for medications to be available free of charge for all patients
  - (iii) that over the counter medications not to be made free other than for the vulnerable, children and the elderly patient.
- 57b NEWCASTLE AND NORTH TYNESIDE: That conference believes that charging patients for NHS prescriptions:
- (i) should be abolished in England in line with the rest of the UK
  - (ii) makes the extension of payments by patients such as co-payments, fees for GP NHS services, or fines for patients more likely.
- 57c NORFOLK AND WAVENEY: That conference believes all drugs started in secondary care should be prescribed in accordance with the same drug formularies that primary care is expected to follow.
- 57d CLEVELAND: That conference believes that all primary medical services should be directed, as a means of reducing the demand for appointments for minor illness, to stop giving patients prescriptions for items that can easily be purchased over the counter.
- 57e MORGANNWG: That conference demands GPC UK seeks to reduce time wasted by GPs acting as grocers, haberdashers and nurse prescribers by removing the need for GPs to prescribe various non-drug products, appliances and food products from the GMS contract
- 57f LINCOLNSHIRE: That conference believes that the prescription and monitoring of gluten free foods for patients with coeliac disease and gluten sensitive enteropathy is a specialist skill, and thus is not part of core general practice. Conference thus urges NHS England and CCGs to commission this service separately from GPs with specialist interest, pharmacies, and/or coeliac specialist nurses.

57g HIGHLAND: That conference recognises that good governance is needed around the provision of dressings where patients are receiving ongoing nursing care, and that the issuing of prescriptions for this might comfortably be left to those nurse prescribers who also have up-to-date training in wound management.

## DISPENSING

10.40

58 SHROPSHIRE: That conference believes by effectively excluding dispensing doctors from the roll out of EPS2, NHS England threatens the sustainability of rural medical provision for 8.8 million patients. We call on the GPC to ensure that dispensing doctors and their patients have the same access to EPS2 as pharmacists.

58a SHROPSHIRE: That conference believes by effectively excluding dispensing doctors from the roll out of EPS2, NHS England threatens the sustainability of rural medical provision for 8.8 million patients.

## ENHANCED SERVICES

10.50

59 AVON: That conference calls on the government to abolish the unplanned admissions enhanced service for 2016/17 as it:

- (i) lacks evidence as a policy
- (ii) has not achieved its intended aims, as A&Es are inundated with patients and hospitals struggle to cope with demand
- (iii) has meant clinicians have had to focus on processes and paperwork rather than on patients
- (iv) puts GPs in medico legal danger
- (v) was always destined to fail.

59a DEVON: That conference believes the non-admission DES was poorly designed and as a result:

- (i) the potential aims and benefits were lost in the details
- (ii) GPs have done a lot of work with little benefit for patients
- (iii) the GPC executive team should aim to limit details and regulations of any future DES to be listed on one side of A4 sheet of paper
- (iv) the government should be subject to a financial penalty if they insist on targets that are ultimately shown to be detrimental to patient care or a waste of NHS resources.

59b NORFOLK AND WAVENEY: That conference asks GPC to push for the 'proactive care plan DES' to cease and funding moved to the global sum as it:

- (i) is a poorly thought out box ticking exercise with no evidence that it reduces admissions
- (ii) uses limited GP availability to complete non-evidence based care plans with information that is already known and acted upon in a way the practice has already deemed clinically appropriate for that patient
- (iii) relies on joint working with support services that are often not appropriately commissioned and/or have equally high workload pressures.

59c SOMERSET: That conference asserts that the avoiding unscheduled admissions enhanced service has had a minimal effect on reducing admissions because other agencies cannot or will not use the agreed care plans. It should therefore be replaced.

59d LEWISHAM: That conference believes that financial incentives to reduce referral rates create an unacceptable conflict of interest between GPs and their patients and exposes both parties to significant risk.

59e LEWISHAM: That conference demands that general practice should not be asked to manage the excessive attendance at unscheduled care sites.

59f GREENWICH: That conference demands that the GPC should, when negotiating with NHS England in relation to direct enhanced services, ensure that the:

- (i) specification clearly sets out what practices are expected to do to fulfil the requirements set out in the specification
- (ii) interpretation of the specification and any associated guidance is made explicit by both the GPC and NHS England before they are launched; and
- (iii) interpretation of the specification and guidance cannot be changed arbitrarily in the year.

59g AYRSHIRE AND ARRAN: That conference believes that short lived, under resourced enhanced services are of limited value and would welcome the development of long-term appropriately resourced, funding streams to resource any services which health boards and their equivalent in the other UK countries wish to commission from practices which are over and above 'core services'.

This year the Agenda Committee received a large number of motions for consideration relating to the working of the GPC and GPDF, as well as about Conference itself.

Clearly these are fundamental bodies; with GPC representing the profession and GPDF (General Practice Defence Fund) collecting the voluntary levies from LMCs to fund the GPC, national political structures and, indeed, conference itself. The conference of LMCs is the major political meeting of general practice and as such has a remit to ensure that it serves its representatives.

Over the last few months the GPDF has been working closely with the GPC, and in conjunction with some LMC secretaries, on a design project, looking at some of the matters raised in these motions, as well as other potential responses to the changing and challenging world in which we all operate.

Some LMC representatives also attended workshops on joint GPC / LMC working at the LMC secretaries' conference at the end of last year, and GPC members have had two similar opportunities for debate.

However, now it is *your* chance to be heard. All of you.

At last year's LMC conference the Agenda Committee was tasked with exploring different ways of working at conference, and this year was asked to run a session, of up to two hours, under temporary standing orders to trial alternative ways of working.

The Agenda Committee believes that the motions submitted, together with the other parallel work over the last few months, are important - and that **the voices of all conference members are vital in ensuring that the future structures of our profession meet their needs.**

We are therefore spending 90 minutes in breakout groups before lunch. Members of conference will be allocated to different groups but don't worry as, all groups are considering the same subjects. Please help us with a difficult logistical task by attending the group allocated to you.

The Agenda Committee also appreciates the roles within our LMCs that our invited conference observers have: they may be observers here, but many of these colleagues work full time for LMCs and are an integral part of our joint working. We are therefore **inviting all LMC observers** also to attend a separate breakout group, considering the same questions offered to conference members.

Each breakout group will have:

- an external facilitator
- a member of the agenda committee
- a member of the GPC secretariat.

Each group is asked to consider the following three questions (and only the following three questions!), and for each question to offer no more than three priorities.

- (1) What should LMCs be delivering for GPs over the next few years?
- (2) What should the GPC/GPDF be delivering for GPs and LMCs over the next few years?
- (3) What should Conference be delivering for GPs, LMCs, and the GPC over the next few years?

The Agenda Committee will then collate these priorities into motions to be debated, and potentially passed as policy, later on Friday afternoon. Please consider the motions already submitted by LMCs, set out below, when considering your priorities. Groups that do not manage to stick to the questions will be unlikely to have the opportunity of forming policy today. Detailed reports from each group will be written up later to ensure that the discussions are captured and help in this restructuring.

We want to capture diversity where it reflects true differences, consensus where it exists, and form policy where it helps to set direction. We are asked to focus on what *outcomes* the profession needs; if structural change is later proposed conference will, as ever, have a voice as the most representative body for all GPs.

As with all changes to conference, the Agenda Committee will seek feedback to help us learn from the experience. For the technically minded, these breakout groups will be conducted under standing orders 1-16, 36, 42, 82 and 86, all others being suspended for the duration of the session.

- 60 COVENTRY: That conference believes that support for LMCs by the GPC has been insufficient recently, and requires the GPC to:
- (i) provide timely and competent advice on all areas where otherwise LMCs would need to develop local advice with the risk of inconsistency and increased cost to all GPs
  - (ii) develop a tracking system for enquiries made by individual LMCs which is available to the requesting LMC online
  - (iii) develop a database of enquiries from LMCs to the GPC and the replies given, to be available to all LMCs online.
- (Supported by SANDWELL)
- 61 WARWICKSHIRE: That conference believes that support for LMCs by the GPC has been insufficient recently, and requires the GPC to:
- (i) provide timely and competent advice on all areas where otherwise LMCs would need to develop local advice with the risk of inconsistency and increased costs to GPs
  - (ii) develop a tracking system for enquiries made by individual LMCs which is available to the requesting LMC online
  - (iii) develop a database of enquiries from LMCs to the GPC and the replies given, to be available to all LMCs online.

- 62 WORCESTERSHIRE: That conference believes support for LMCs by the GPC has been insufficient recently, and requires the GPC to:
- (i) timely and competent advice on all areas where otherwise LMCs would need to develop local advice with the risk of inconsistency and increased cost to all GPs
  - (ii) developing a tracking system for all enquiries made by individual LMCs which is available to the requesting LMC online
  - (iii) develop a database for enquiries for LMCs to the GPC and the replies given, to be available to all LMCs online.
- 63 SOUTH STAFFORDSHIRE: That conference believes that support for LMCs by the GPC has been insufficient recently, and requires the GPC to:
- (i) provide timely and competent advice on all areas where otherwise LMCs would need to develop local advice with the risk of inconsistency and increased cost to all GP
  - (ii) develop a tracking system for enquiries made by individual LMCs which is available to the requesting LMC online
  - (iii) develop a database of enquiries from LMCs to the GPC and the replies given, to be available to all LMCs online.
- 64 NORTH STAFFORDSHIRE: That conference believes that support for LMCs by the GPC has been insufficient recently, and requires the GPC to:
- (i) provide timely and competent advice on all areas where otherwise LMCs would need to develop local advice with the risk of inconsistency and increased cost to all GPs
  - (ii) develop a tracking system for enquiries made by individual LMCs which is available to the requesting LMC online
  - (iii) develop a database of enquiries from LMCs to the GPC and the replies given, to be available to all LMCs online.
- 65 SHROPSHIRE: That conference believes that support for LMCs by the GPC has been insufficient recently, and requires the GPC to:
- (i) provide timely and competent advice on all areas where otherwise LMCs would need to develop local advice with the risk of inconsistency and increased cost to all GPs
  - (ii) develop a tracking system for enquiries made by individual LMCs which is available to the requesting LMC online
  - (iii) develop a database of enquiries from LMCs to the GPC and the replies given, to be available to all LMCs online.
- 66 SOLIHULL: That conference believes that support for LMCs by the GPC has been insufficient recently, and requires the GPC to:
- (i) provide timely and competent advice on all areas where otherwise LMCs would need to develop local advice with the risk of inconsistency and increased cost to all GPs
  - (ii) develop a tracking system for enquiries made by individual LMCs which is available to the requesting LMC online
  - (iii) develop a database of enquiries from LMCs to the GPC and the replies given, to be available to all LMCs online.
- 67 HIGHLAND: That conference is troubled by the number of GP practices still at risk of closure and asks GPC to give further support to LMCs who are witnessing this.
- 68 AVON: That conference calls upon the GPC to reinforce the statutory representational and negotiating roles of LMCs particularly in this time of rapid political change and with the increasing profile of any qualified provider (AQP).
- 69 AVON: That conference asks GPC, that in the light of the demands and expectations currently being faced by LMCs that it recognises their needs and provides a timely and locally appropriate response to support LMCs deal with the issues being encountered.
- 70 CORNWALL AND ISLES OF SCILLY: That conference demands more support for regional LMC structures.
- 71 CHESHIRE: That conference believes that the GPC should move resources from the centre to sub regional areas to help with the increasing prospect of local contract negotiations.
- 72 HERTFORDSHIRE: That conference calls on GPC to work more collaboratively with LMCs in the production of guidance for grass roots general practices.
- 73 KENT: That conference requests that in order to help support LMCs in enabling meaningful collaborative working between practices the GPC should provide funding for:
- (i) legal advice
  - (ii) business registration
  - (iii) start up fees
  - (iv) training for LMC staff.
- 74 MID MERSEY: That conference congratulates the GPC on its renewed efforts to enhance GPC / LMC axis.
- 75 DEVON: That conference asks that if the new government proposes any new legislation or a White Paper relating to NHS reorganisation the GPC will use its influence within the BMA to ensure any changes are voted on by GPs before policies move too far down the political tracks to be practically halted.
- 76 NORFOLK AND WAVENEY: That conference asks GPC to ensure that all contract information and enhanced services are shared with practices promptly in the New Year to enable appropriate planning and decision making.
- 77 NOTTINGHAMSHIRE: That conference, recognising that effective local leadership is essential for the successful development of our profession and continued improvements in primary care:
- (i) believes it necessary to develop a new breed of GP leader to guide GP provider organisations and help deliver new models of care
  - (ii) calls upon GPC to identify and describe the qualities applicable to the different types of GP leaders which our profession requires and make a case for financial support needed to develop them
  - (iii) believes that, given appropriate financial support, LMCs should be willing and able to identify, cultivate, and organise these new GP leaders and ensure that they adopt a value base appropriate to their roles.

- 78 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that LMCs would benefit from the development of e-learning programmes for LMC members.
- 79 DERBYSHIRE: That conference commends the GPC on its publication Quality first: managing workload to deliver safe patient care and requires GPC to continue its general efforts in this direction but more specifically:
- (i) to take up with the other branches of practice committees the issue of workload dumping onto general practice
  - (ii) to co-ordinate and promulgate intelligence from LMCs about successful schemes and strategies introduced locally to prevent workload dumping
  - (iii) to construct a standard education resource about workload dumping and acceptable professional behaviours for delivery to GP audiences, hospital doctor audiences, GP trainees and NHS managers
  - (iv) to construct a document which will allow practices to calculate their charges for undertaking dumped workload including guidance on enforcing payment by trusts which continue to dump workload on general practice
  - (v) consider the preparation of test cases on workload dumping for judicial review.
- 80 EAST MIDLANDS REGIONAL COUNCIL: That conference commends the GPC on its publication "Quality first: managing workload to deliver safe patient care" and requires GPC to continue its general efforts in this direction and specifically:
- (i) to take up with the other branches of practice committees the issue of inappropriate and unfunded workload transfer onto general practice, which then causes cost to the GP personally and not to the NHS
  - (ii) to co-ordinate and promulgate intelligence from LMCs about successful schemes and strategies introduced locally to prevent "workload dumping"
  - (iii) to construct a standard education resource about mutually agreed, appropriate transfer of workload including acceptable professional behaviours, for delivery to GP audiences, Hospital Doctor audiences, GP trainees and NHS managers
  - (iv) to construct a document which will allow practices to calculate their charges for undertaking unfunded inappropriately transferred workload including guidance on enforcing payment by trusts which continue to transfer this workload on general practice
  - (v) consider the preparation of test cases on unfunded inappropriate transfer of workload for judicial review.
- 81 LIVERPOOL: That conference believes that information from GPC is usually very helpful and informative but could be even more beneficial if it was produced and disseminated earlier.
- 82 CORNWALL AND ISLES OF SCILLY: That conference believes that the current structure of GPC is unwieldy and is in urgent need of reform.
- 83 SOMERSET: That conference requires GPC to ensure that voluntary (national) levy paying practices get value for money by:
- (i) establishing its own website and database, accessible to lay LMC officers
  - (ii) reducing its membership to a suitable size for a working committee
  - (iii) supporting regional clusters of LMCs to match NHS England area teams
  - (iv) changing its constitution so voting GP members are elected by levy paying practices and not any other organisation.
- 84 CUMBRIA: That conference believes that GPC and LMCs need to change to be fit for purpose for modern general practice if they are to remain the voice of general practice by:
- (i) diversification in the use of the levy to support the new needs of general practice in areas such as HR, education and occupational health
  - (ii) support for the imminent vast changes in the role of the GP to face the expectations of patients
  - (iii) support federations and GP networks.
- 85 CORNWALL AND ISLES OF SCILLY: That conference that GPC is unwieldy and unresponsive to the needs of general practice and:
- (i) demands that it reform and decrease in size
  - (ii) responds much more timely
  - (iii) develops a regional structure to help support increased regional negotiation
  - (iv) has a website completely separate to the BMA website which is unfit for purpose.
- 86 DEVON: That conference asks that prior to entering into national negotiations the LMC list server is used to collate views from LMCs regarding proposed changes to GMS / PMS and nationally specified enhanced services.
- 87 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference is concerned that LMCs are not representative of the current demographic of grass roots GPs. Conference therefore calls on LMCs to encourage representations of GP trainees / First 5 members by providing a co-opted seat for these members.
- 88 DEVON: That conference is aware that the GPDF runs with millions of pounds in reserve so at a time when GP practice income is falling in real terms it would seem reasonable to ask the GPDF to:
- (i) review the need for such a seemingly high level of reserve
  - (ii) set a realistic and justifiable level for those reserves
  - (iii) agree a mechanism such as a negative budget or rebate to practices if the current level of reserve cannot be justified.
- 89 OXFORDSHIRE: That conference believes that LMCs hand over about 5p per patient voluntary levy annually (an annual income of £3.8m), but have very little control of how this is used to benefit levy payers, a situation that has to change in future.
- 90 COVENTRY: That conference concerned that the GPC was reticent in opposing co-commissioning and, in effect, gave it tacit approval.
- 91 MID MERSEY: That conference believes in English votes for English policies and that it is time for English LMCs to have an annual conference.

- 92 CORNWALL AND ISLES OF SCILLY: That conference believes that the LMC conference in its current format is outdated and not fit for purpose and urges GPC to change the format and function of conference to ensure it is fit to support the future needs of the profession.
- 93 CAMBRIDGESHIRE: That conference regrets that so many motions submitted this year, including this one:
- (i) are about what has happened in the past rather than look to the future
  - (ii) demand things in a way the best LMCs gave up years ago, after finding cooperation works better
  - (iii) reflect or repeat what we have been saying for years
  - (iv) fail to help the GPC prepare for next year, or to work better with LMCs for GPs
  - (v) are designed to get chosen for debate by a conference system desperately in need of further reform.
- 94 DEVON: That conference encourages speakers to avoid using the following phrases as they denigrate the potential power of these proceedings:
- (i) "it's going to happen anyway"
  - (ii) "we are better helping shape the future rather than complaining about it"
  - (iii) "the government will do whatever they want"
  - (iv) "privatisation of the NHS is awful" (without mentioning that almost all GP surgeries are privately run enterprises)
  - (v) "I am opposing the motion because it simply does not go far enough".
- 95 BRO TAF: That conference requests GPC and the Agenda Committee to prevent motions appearing on the conference agenda whose only intention is to promote a personal political point.
- 96 ROTHERHAM: That conference requests that, in future when motions are not prioritised for debate because the agenda committee considers that policy is already determined, the current policy is stated in the conference agenda.
- 97 DEVON: That conference alters the rules regarding emergency speaker slips to be more like the challenge system commonly operating in major sporting fixtures (such as tennis and cricket) such that if the chairperson:
- (i) judges that the emergency speaker slip has been used entirely appropriately then it is not removed from the representative and so can be used again later in the conference
  - (ii) deems the emergency speaker slip to have been used inappropriately it is withdrawn from the delegate as under the current rules.
- 98 BRO TAF: That conference requests GPC chair(s) of committee to refrain from directing conference to accept or reject any motion.
- 99 DEVON: That conference asks all speakers to declare whether he / she has any other roles within healthcare provision or purchasing and if so then before addressing conference they should ensure their:
- (i) other roles are written on their speaker slip
  - (ii) speech opens with statements of fact regarding other roles and their own perceived potential conflicts of interest if they exist
  - (iii) other roles are written on the screen behind the speaker and remain in view throughout their time addressing conference.
- 100 LIVERPOOL: That conference believes that the Conference of LMCs should once again return to the BT Convention Centre in Liverpool, the Gold Award winning 'Best UK Conference Centre' for the third year running, following the successful Annual Conference of LMCs in 2012.
- 101 BRO TAF: That conference approves Cardiff, the capital city of Wales, as the venue for the 2016 UK LMC Conference.
- 102 SOMERSET: That conference believes that the BMA in its current form can no longer represent the interests of all doctors, and should now be divided into separate primary and secondary care representative bodies.

**LUNCH**

**12.30**



- 103 **AGENDA COMMITTEE to be proposed by WILTSHIRE: That conference believes that current funding is threatening the viability of many practices and what is needed is:**
- (i) a guaranteed average net remuneration
  - (ii) reimbursement of net expenses
  - (iii) a halt to the demise in MPIG
  - (iv) a halt to the demise of seniority payments
  - (v) an immediate increase in resources to reflect the increase in consultation rates.
- 103a WILTSHIRE: That conference believes that with general practice in the state it is, family doctors need a:
- (i) guaranteed average net remuneration
  - (ii) reimbursement of net expenses,
  - (iii) halt to the demise of MPIG
  - (iv) halt to the demise of seniority payments.
- 103b DEVON: That conference notes the current funding envelope for general practice is:
- (i) below the free market rate
  - (ii) incentivising GPs to avoid becoming partners in practices
  - (iii) causing the closure of financially unviable surgeries often in remote areas with no hope of mergers
  - (iv) risking the medical care of more remote communities whose surgeries are closing
  - (v) in need of an immediate increase in resources.
- 103c CUMBRIA: That conference believes that the future of isolated rural practice is untenable because of big falls in income due to GMS / PMS rationalisation and falls in dispensing profits and calls on the government to recognise through appropriate resources the vital nature of isolated rural practice.
- 103d WALTHAM FOREST: That conference demands that the UK government and local authorities reconsider the resources that remain unchanged year on year despite the fact that consultation rates have doubled in primary care which is now impacting on patient care.
- 103e SOUTHWARK: That conference believes that general practice must have a substantial increase in money to cope with the real increase in demand.
- 103f EAST SUSSEX: That conference believes that without substantial investment UK general practice will wither and die.
- 103g SOUTH CENTRAL REGIONAL COUNCIL: That conference notes that:
- (i) recent changes to the funding of general practice is only serving to increase the speed at which individuals exit GP partnerships
  - (ii) recent changes, and particularly the loss of the Minimum Practice Income Guarantee (MPIG), have irrevocably damaged some practices;
  - (iii) the abolition of seniority payment is damaging recruitment of partners, amongst a great many other reasons for difficulties in recruitment.
- We therefore call for a fundamental rethink of general practice funding arrangements.
- 104 **KENT: That conference believes that the current formula based core contract is unfit for purpose:**
- (i) in that it fails to recognise the ever increasing demand for access and complex care associated with model 21st century general practice
  - (ii) in that it fails to incentivise the expansion of primary care needed to cope with the vision set out in the NHS Five Year Forward View
  - (iii) and should be replaced by a payment by activity contract which directly links workload to resource.
- 104a DEVON: That conference calls upon the government to recognise that healthcare consumption in general practice by patients over the age of 85 rises dramatically and to address this by:
- (i) producing a funding formula that fairly reflects this truth
  - (ii) providing additional funding to resource this fact.
- 104b AYRSHIRE AND ARRAN: That conference believes that there is a significant workload attached to care home patients over and above the normal services general practitioners provide for their patients and instructs GPC and SGPC to negotiate adequate resources in any contract negotiations for this patient cohort.
- 104c CITY AND EAST LONDON: That conference is relieved that the Carr Hill Formula is to be reviewed to take into account other factors such as deprivation. Conference is appalled that it has taken 11 years to review a formula that was flawed at its inception and demands that systems are put in place to allow new evidence to be taken into account and resolve any further errors in the formula in a more timely manner.
- 104d BEDFORDSHIRE: That conference instructs GPC to negotiate the value of the core contract in order to pay practices in a way that recognises the complexity and hard work undertaken.

- 104e WILTSHIRE: That conference believes that there should be a single contract for GP services and that this should be based on an item of service payment.
- 104f BEDFORDSHIRE: That conference believes that there is insufficient recognition of the enhanced workload for patients with multiple comorbidities and instructs GPC to negotiate a 'frail patient index' which fully recognises this workload.
- 104g SHEFFIELD: That conference believes the national contract for general practice:
- (i) remains unfit for purpose
  - (ii) fails to provide an adequate framework for funding support.
- 105 **AVON: That conference calls on the Departments of Health to move more funding into core contract baselines in order to:**
- (i) allow more strategic planning at a local surgery based level**
  - (ii) allow clinicians more time with their patients rather than scrabbling to achieve piecemeal funding streams**
  - (iii) avoid endless submission of plans, audits and reports to achieve individual funding streams.**
- 105a DEVON: That conference asks the new government to ensure:
- (i) that every practice is paid at £75 per patient immediately thus improving funds in underfunded practices and ending the nonsensical historic differences
  - (ii) extra funding is added to this figure as per previous list weight adjustments for age, deprivation, rurality.
- 105b NORTHAMPTONSHIRE: That conference insists that core funding of general practice is made both equitable to all practices and to a level that makes general practice a financially viable and attractive career.
- 105c WALTHAM FOREST: That conference believes that successive governments' attempts to run the NHS like a poorly managed convenience shop is detrimental to the health of the nation. It requests that the GPC develop alternative funding models that stabilise the NHS and reverse the current trend of destabilisation and fragmentation.
- 105d WORCESTERSHIRE: That conference believes that the current fragmented and disjointed claims system is putting unnecessary pressure on practice managers who are struggling to cope and that this system needs to be urgently simplified.
- 105e SOUTHWARK: That conference believes that the funding of core services per weighted patient in each CCG should be the same for all contractors in that CCG area and not dependent on the type of contract be it GMS, PMS or APMS between contractor and NHSE.
- 105f LAMBETH: That conference notes the increasing complexity and duration of consultations in delivering essential and additional services, believes that core funding should be increased to £100 per annum per patient and requests GPC to negotiate this.
- 105g BRENT: That conference notes the increased number of consultations required to be undertaken by GPs over the past five years under the core contract and calls upon the GPC to negotiate for a corresponding increase in the global sum.
- 105h DEVON: That conference calls on the government to scrap the numerous recent incentive schemes and provide more investment to stabilise the profession and make it a more attractive option for life.
- 105i LIVERPOOL: That conference believes that the increased fragmentation and unpredictability of funding for general practice is adversely affecting the ability of GPs to improve services for patients as they are forced to spend large amounts of time writing proposals on 'innovative' ways to spend the money and carrying out non-evidence based box ticking to prove how it has been used.
- 105j LIVERPOOL: That conference believes that the increasing fragmentation of funding into primary care is adversely affecting the ability of general practice to improve and react to challenges of the 21st Century.
- 105k NORTHAMPTONSHIRE: That conference feels that the current insurance premium / capitation fee per patient no longer reflects the professional cost of the number of both face to face consultations and administrative case reviews that now take place in modern general medical practice.
- 105l NORTH YORKSHIRE: That conference recognises that whilst involving GPs in commissioning, new integrated care pathways, secondary to primary care shift of work and all the other innovations is important, core general practice involving day to day acute and chronic medical care, is being neglected and de-funded.
- 105m HERTFORDSHIRE: That conference deplores the fact that the increased tendency for payment to general practice to be based on what is measurable has led to an obsessive focus on data collection at the expense of patient centred care.

- 106 **LEEDS: That conference believes the use of the Prime Minister's Challenge Fund to fund extended hours and seven day services is:**  
**(i) undermining GP out-of-hours services**  
**(ii) stretching an already over-stretched service more thinly and risks undermining core general practice services**  
**(iii) not the best use of NHS resources**  
**(iv) not sustainable.**
- 106a EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the launch of non-recurrent initiatives such as the Prime Minister's Challenge Fund that create unrealistic, inflated and contradictory patient expectations of general practice, without the necessary sustainable means to meet them and demands that such initiatives should be treated as pilots that will not be rolled out without a robust evaluation and evidence of patient need/clinical appropriateness, improved patient care, and supporting recurrent resources including training, IT premises, funding and workforce.
- 106b LANCASHIRE PENNINE: That conference believes that the proliferation of new initiatives and pilots such as Prime Ministers Challenge Fund dilutes the resources available to provide core general practice, particularly in competing for scarce GP manpower.
- 106c SHEFFIELD: That conference believes, with reference to the Prime Minister's Challenge Fund, some challenges should not be risen to.
- 106d MID MERSEY: That conference believes that the Prime Ministers Challenge Fund is merely a political window dressing which has led to inequality of access.
- 107 **HERTFORDSHIRE: That conference notes that many practices impacted by the removal of MPIG are feeling abandoned by government and the GPC and calls on the GPC to:**  
**(i) ensure that government understands the consequent reduction in frontline services and access for patients**  
**(ii) offer greater support to practices that are losing income to ensure patient services are not jeopardised,**  
**(iii) focus on negotiating a change in the formula such that weighting is only used to increase funding for those practices with populations considered to be more in need, rather than reducing it for others.**
- 107a LEEDS: That conference condemns NHS England's failure to support GMS practices who have lost the most through the cut to MPIG funding and calls on them to take urgent action to address this.
- 107b CITY AND EAST LONDON: That conference believes the loss of MPIG funding is having a devastating impact on many practices and:  
(i) believes it seriously jeopardises the viability of many practices  
(ii) deplores the damage this is having on the delivery of services to patients  
(iii) criticises the inadequate support for affected practices  
(iv) asks that government ensures any reviews to NHS funding formulae for GP practices are undertaken in a timely way and contain allowances for deprivation to reflect the particular needs and circumstances of local populations.
- 107c CITY AND EAST LONDON: That conference believes that NHSE has not been transparent in its calculation of projected practice losses due to the phasing out of MPIG. Conference demands that NHSE makes public the methods used and what measures were taken to assess the impact of those methods on practices and areas.
- 107d CITY AND EAST LONDON: That conference is appalled that NHSE have been challenged on the calculations they have used to identify which practices are eligible for MPIG reprieve money but have not responded to the specific challenges. Conference demands that NHSE either accept or reject these challenges, giving valid reasons, by the end of June 2015.
- 107e AVON: That conference calls for the withdrawal of MPIG to be halted, in the face of increasing surgery closures nationally, and the disproportionate damage being done to practices with unusual populations, such as rural, inner city, student or non-English speaking.
- 107f AVON: That conference accepts that the loss of MPIG has had a disproportionately negative impact on practices with unusual populations, such as rural, inner city, student or non-English speaking.
- 107g AVON: That conference calls on GPC to negotiate fairer funding for practices serving complex or unusual populations, following the loss of MPIG, to avoid the threat of bankruptcy, closure, and the disenfranchising of vulnerable populations.
- 107h AVON: That conference calls on GPC to ensure that MPIG is not withdrawn until alternative funding arrangements are put in place, to prevent the collapse of services caring for some of our most challenging and vulnerable populations.

- 108 **AGENDA COMMITTEE to be proposed by DEVON: That conference believes, with respect to data governance, that:**
- (i) the Health and Social Care Act and the Data Protection Act are frequently at odds with each other and should be amended
  - (ii) when GPs are required to share information for patient care they should be indemnified if a data breach occurs within the requesting organisation
  - (iii) the era for general practices to be the data controllers for patient records has passed and this responsibility should lie with NHS England
  - (iv) GPs should have control over who has remote access to their IT systems
  - (v) GPC should set up a national approval process for data sharing agreements.
- 108a DEVON: That conference believes with respect to data governance:
- (i) the Health and Social Care Act and the Data Protection Act are frequently at odds with each other and should be amended
  - (ii) when GPs are required to share information for patient care they should be indemnified if a data breach occurs within the requesting organisation.
- 108a DEVON: That conference believes that the era for general practices to be the data controllers for patient records has passed and this responsibility should lie with NHS England.
- 108b SCOTTISH CONFERENCE OF LMCs: That conference insists that whether GPs remain data controllers or not, they should have control over who has remote access to their IT systems and so help preserve patient confidentiality.
- 108c HILLINGDON: That conference notes the proliferation of data sharing agreements and:
- (i) deplores the time needed by practices and LMCs in assessing and approving these
  - (ii) calls upon GPC to set up a national approval process
  - (iii) requires that those advising on data sharing show some understanding of information governance, data protection and the overriding need for patient confidentiality.
- (Supported by HARROW)
- 108d DEVON: That conference believes the government should indemnify and be responsible for any liability GPs and their practices might be subject to if they agree to allow patient data to be shared via care.data or the Medical Interoperability Gateway (MIG).
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- 109 **AGENDA COMMITTEE as proposed by MID MERSEY: That conference, with respect to information technology:**
- (i) insists that GPC negotiate the continuation of funding of SMS text reminders from clinical systems
  - (ii) instructs GPC to negotiate that mobile, upgradeable IT for patient systems should be part of the core offer for practices
  - (iii) demands that all GPSoC software is accessible by single log-on using the NHS Smartcard
  - (iv) deplores the delay to implementation of the GP2GP 'large message' solution
  - (v) demands that the Summary Care Record should be a comprehensive record of information from all providers of health.
- (v) RM
- 109a MID MERSEY: That conference demands that the Summary Care Record should be a comprehensive record of information from all providers of health.
- 109b BEDFORDSHIRE: That conference insists that GPC negotiate the continuation of funding of SMS text reminders from clinical systems.
- 109c BEDFORDSHIRE: That conference instructs GPC to negotiate that mobile, upgradeable IT for patient systems should be part of the core offer for practices.
- 109d COVENTRY: That conference despairs at the requirement to use multiple log-ons to access centrally provided software and demands that all GPSoC software is accessible by single log-on using the NHS Smartcard.
- 109e COVENTRY: That conference deplores that the delay to implementation of the GP2GP 'large message' solution is causing patient records to be degraded and creating significant additional workload for practices and demands that the GPC ensures its roll-out is prioritised and is completed within the next six months for all GP2GP compatible systems.
- 109f COVENTRY: That conference notes that the failure to provide centrally provided and funded remote access to clinical systems condemns housebound patients to a lower quality and higher risk service, and demands that the GPC negotiates the provision of this.
- 109g COVENTRY: That conference believes that the devolution of SMS commissioning to CCGs will result in a patchy service disadvantaging deaf and other patients and demands that it revert to a nationally provided service.
- 109h LANCASHIRE COASTAL: That conference:
- (i) welcomes the NHS digital strategy to improve patient care
  - (ii) condemns the move by NHS England to withdraw the SMS patient text messaging service as short sighted
  - (iii) believes devolving funds for SMS messaging to CCGs will lead to areas of England where the SMS messaging service will be withdrawn
  - (iv) call for NHS SMS text messaging to be fully funded centrally.
- 109i BEDFORDSHIRE: That conference believes that everyone should have a single, online medical record in the control of the patient and calls on the GPC to campaign for this.

- 109j DEVON: That conference strongly believes that patient care and safety would be significantly enhanced if on registering with a new practice a full transfer of all previous electronic GP records were available at a click and calls on the government to make this happen by the end of the 2015 calendar year.

## PRIMARY AND SECONDARY CARE INTERFACE

14.40

- 110 **NORTH YORKSHIRE: That conference believes that meaningful collaboration between primary and secondary care cannot happen whilst secondary care is paid for by payment by results and primary care is paid on a block contract.**
- 110a BRADFORD AND AIREDALE: That conference believes that a system in which secondary care is funded predominantly by payment per episode of care and primary care is funded for open ended care on a capitation basis can only lead to an ever reducing share of NHS funding going to primary care with a consequent increase in overall NHS costs.
- 111 **HAMPSHIRE AND ISLE OF WIGHT: That conference demands that hospital trusts be made aware that all local GP practices are under exceptional pressure at present, because of:**
- (i) rising patient expectations
  - (ii) the increasing tendency of hospitals to discharge patients precipitately
  - (iii) the growing trend of hospitals to ask GPs to do tasks that until recently was the responsibility of hospitals
  - (iv) commissioners insistence that GPs must jump through every increasing hoops before referring patients to hospitals
  - (v) patients seen in A&E who are then told to see their GP immediately when not indicated or appropriate.
- 111a SOUTH CENTRAL REGIONAL COUNCIL: That conference notes the ever-increasing demands on general practice and:
- (i) calls upon colleagues working in secondary and community care to cease passing unfunded work to general practice
  - (ii) calls for an ending of the culture of general practice as a sump for other services' work.

## CO-COMMISSIONING

15.00

- 112 **AGENDA COMMITTEE as is proposed by DERBYSHIRE: That conference believes co-commissioning:**
- (i) must be adequately resourced
  - (ii) must exclude performance management of GPs
  - (iii) must tackle and reassure regarding potential conflicts of interest
  - (iv) will further reduce the influence of member practices on CCGs
  - (v) will be made unworkable through conflicts of interest and so calls for GPC to advise GPs not to participate in its implementation.
- 112a DERBYSHIRE: That conference:
- (i) believes that level three co-commissioning (delegated commissioning authority) by CCGs is inevitable
  - (ii) is gravely concerned that CCGs will not have sufficient resources to undertake commissioning of primary, secondary and community care
  - (iii) is concerned that there will always be a perception of conflicts of interest if a co-commissioning CCG attempts to transfer resources along with workload from secondary to primary care
  - (iv) reminds CCGs that they are membership bodies comprised of their constituent practices and that constituent practices tell the CCG what to do and not vice versa.
- 112b EAST MIDLANDS REGIONAL COUNCIL: That conference:
- (i) believes that level 3 co-commissioning (delegated commissioning authority) by CCGs is inevitable
  - (ii) is gravely concerned that CCG's will not have sufficient resources to undertake commissioning of primary, secondary and community care
  - (iii) is concerned that there will always be a perception of conflicts of interest if a co-commissioning CCG attempts to transfer resources along with workload from secondary to primary care
  - (iv) reminds CCGs that they are membership bodies comprised of their constituent practices and that constituent practices tell the CCG what to do and not vice versa.
- 112c WALTHAM FOREST: That conference abhors that general practice is being judged and performance managed under co-commissioning. Conference insists that general practice is performance managed outside the sphere of the CCG.
- 112d MID MERSEY: That conference believes that CCGs who undertake delegated commissioning should never be allowed to performance manage their colleagues because of conflicts of interest.
- 112e NORFOLK AND WAVENEY: That conference believes that conflict of interests is often cited as a reason not to change the way in which we provide or commission care. As GPs we are experts in managing conflicts of interest and as long as they are transparent and properly managed they should not be a bar or a 'usual excuse' to allow GPs to decide what is right for their patients.
- 112f BEDFORDSHIRE: That conference believes that co-commissioning will introduce a level of conflict of interest which will make it unworkable and calls on the GPC to advise GPs not to participate in its implementation.

- 112g CAMBRIDGESHIRE: That conference questions how an organisation can be accountable to its members at the same time as holding them to account, and regrets that GPs will inevitably take more of a back seat role in supposedly clinically led CCGs as a consequence of co-commissioning.
- 112h DEVON: That conference believes co-commissioning will result in significant professional and ethical problems for GPs who sit on CCG boards because two hats on one head will always lead to a conflicted point of view no matter how many guidelines are written.
- 112i HERTFORDSHIRE: That conference is concerned that co-commissioning is being thrust on to CCGs too quickly and calls on GPC to ensure:
- (i) its administration and delivery is adequately resourced
  - (ii) the existing commissioning role of CCGs is not impaired
  - (iii) any new locally designed incentive scheme is subject to consultation and approval by the LMC
  - (iv) adequate time is allowed for CCGs to work out how to manage conflicts of interest without damaging general practice.
- 112j NORTH YORKSHIRE: That conference believes the current model of GP board membership CCGs is already under threat because of conflict of interest and recruitment and retention issues and will be further compromised by the co commissioning agenda.
- 112k NORTH WEST REGIONAL COUNCIL: That conference notes the large number of CCG members who may have a personal financial interest in decisions made by the CCG. In addition to declaring any interest it is important that anyone with an interest is excluded from discussions where they may personally benefit.

## ASK THE EXECUTIVE TEAM

15.10

## BREAKOUT GROUP MOTIONS

15.30

## MEDICAL CERTIFICATES AND REPORTS

16.00

- 113 **AGENDA COMMITTEE as proposed by HAMPSHIRE AND ISLE OF WIGHT: That conference:**
- (i) **is concerned about the recent ruling requiring GPs to report all deaths of residents in care homes subject to Deprivation of Liberty Safeguards (DOLS) to the coroner for inquests and calls on the GPC to resolve this**
  - (ii) **notes that considerable amount of GPs' time is taken up completing reports requested by insurance companies and other agencies and requests the GPC to address this unrealistic demand**
  - (iii) **believes that collaborative fees are now a mess which needs to be resolved nationally.**
- 113a HAMPSHIRE AND ISLE OF WIGHT: That conference deplores the recent ruling on the requirement to report all deaths of residents in care homes subject to DOLS to the coroner for inquests and calls upon the GPC to negotiate on an amendment to the legislation forthwith.
- 113b GLOUCESTERSHIRE: That conference is dismayed that since 2008 coroners have demanded reports from GPs yet the GPs have had no right to adequate or appropriate payment for the work involved, and calls on the GPC to seek correction of this injustice.
- 113c HERTFORDSHIRE: That conference believes that insurance companies should not be asking for copies of patients' records in lieu of reports and demands that GPC:
- (i) clarifies the situation with the Information Commissioners Office
  - (ii) provides practices with clear guidance about how to respond to these requests.
- 113d MORGANNWG: That conference reminds the governments and public bodies in the UK that many of their demands for reports and certificates from GPs that come via the patient use up valuable surgery appointments that should be available for seeing and treating the sick.
- 113e ROCHDALE AND BURY: That conference the GPC to address the unrealistic expectations of GPs from third parties, when seeking medical information.
- 113f WORCESTERSHIRE: That conference believes the various payments previously covered by so called collaborative arrangements are now a mess and need to be resolved nationally.
- 113g KENT: That conference is concerned that the collaborative fee payments have failed in some parts of the UK and demands immediate reinstatement.

- 114 **AGENDA COMMITTEE as proposed by DERBYSHIRE: That conference notes the catastrophic retention crisis in the primary care workforce and demands that NHS England immediately restores a fully funded and accessible occupational health service for GPs and their staff, including:**
- (i) **bespoke mental health and psychological support**
  - (ii) **equity of access for freelance/locum GPs.**
- 114a DERBYSHIRE: That conference notes the catastrophic retention crisis in the primary care workforce and demands that NHS England immediately restores a fully funded, comprehensive and accessible occupational health service for GPs and their staff as one way of addressing this crisis.
- 114b CUMBRIA: That conference believes that GPs are extremely vulnerable to stress related illness, burnout and risk in the current climate of general practice and should be offered ready access to bespoke mental health and psychological support before they experience catastrophic breakdown.
- 114c THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference calls on the GPC to ensure that all freelance / locum GPs are entitled to free occupational health services.
- 114d AVON: That conference is concerned that the increasing workload and stress in primary care has put the health and wellbeing of general practitioners at serious risk and:
- (i) deplores the uncaring and underhand way that government has devalued and virtually destroyed occupational health services for GPs
  - (ii) calls on the GPC to demand a fully funded and comprehensive occupational health service for all GPs and their staff
  - (iii) calls on the GPC to extract a public apology from government, for treating general practitioners in this way.
- 114e CLEVELAND: That conference calls on NHS England to recognise the increasing loss of GPs from the workforce due to work related stress and demands that there is national provision of a general practice wellbeing service offering mentoring and psychological interventions in order to aid retention.
- 114f BRADFORD AND AIREDALE: That conference deplores the changes in occupational health provision and calls for them to be reversed immediately.
- 114g DEVON: That conference deplores the unilateral action of removing the funding and support for the primary care occupational health service and asks for an immediate increase in practice expenses to enable the same level of cover, previously provided, to ill or seriously stressed people working for the NHS in primary care.
- 114h DEVON: That conference calls upon NHS England to reverse its decision to reduce funding for an Occupational Health Service as the lack of occupational support of the NHS workforce is contributing to the early retirement of general practitioners and the resultant workforce crisis.
- 114i SALFORD AND TRAFFORD: That conference believes that it is vital for there to be care taken of the mental and physical health of GPs currently working in general practice with a fully functioning, funded, national scheme.
- 114j NORFOLK AND WAVENEY: That conference calls on GPC to ensure appropriate occupational health support is available to all GPs.
- 114k CORNWALL AND ISLES OF SCILLY: That conference that the proposed changes to GP occupational health services are a disgrace and will:
- (i) lead to the deterioration in the mental and physical health of many GPs
  - (ii) damage recruitment and retention.
- 114l EDGWARE AND HENDON DIVISION: That conference finds that it is indefensible that GP's and their staff have no access to occupational health services equivalent to other NHS staff, and demands that all NHS staff are given equal access to occupational health services.
- 114m NORTH WEST REGIONAL COUNCIL: That conference deplores the removal of occupational health provision for primary care staff including GPs in the reorganisation following the health and social care act and demands
- (i) that the funding previously allocated to this service is urgently re-identified and restored
  - (ii) that occupational health services are freely available for all GPs and their staff;
  - (iii) that the irrational policy of only providing occupational health services for those GPs facing performance procedures is recognised as too little and too late;
  - (iv) that timely and rapid access to appropriate mental health services must form an integral part of such occupational health provision.
- 114n EAST MIDLANDS REGIONAL COUNCIL: That conference notes the catastrophic retention crisis in the primary care workforce and demands that NHS England immediately restores a fully funded, comprehensive and accessible occupational health service for GPs and their staff as one way of addressing this crisis.

- 115 **BUCKINGHAMSHIRE:** That conference believes that:
- (i) it is unacceptable that government repeatedly ignores and overrides the recommendations of the DDRB (Doctors’ and Dentists’ Review Body)
  - (ii) by ignoring (even only once) the recommendations of the DDRB, government has fatally undermined the credibility of the independent review process
  - (iii) the GPC and BMA alienate members by continuing to submit evidence to the DDRB or to cooperate with the DDRB reviews
  - (iv) the GPC and BMA need to return to direct negotiations over pay, contracts and conditions with the NHS and use all lawful approaches to dispute-resolution including strike action where appropriate.

**PENSIONS**

- 116 **AGENDA COMMITTEE as proposed by EAST SUSSEX:** That conference condemns the recent changes that will affect GP pensions:
- (i) which will mean retention of senior general practitioners will be increasingly difficult
  - (ii) which is likely to further discourage new recruits to the profession
  - (iii) which will hasten the demise of general practice
  - (iv) which will be to the detriment of patient care
  - (v) and calls on GPC to work with governments to address the situation.
- 116a EAST SUSSEX: That conference notes that recent changes in pension arrangements mean retention of senior general practitioners will be increasingly difficult, to the detriment of patient care.
- 116b NORFOLK AND WAVENEY: That conference believes the profession has been unfairly penalised by the changes to the NHS pension scheme. Particularly affecting those younger GPs who will have to pay more in contributions whilst working longer for a lower pension. This is likely to further discourage new recruits to the profession.
- 116c CORNWALL AND ISLES OF SCILLY: That conference believes that the recent changes to pension LTA will hasten the demise of general practice.
- 116d GLASGOW: That conference is concerned that the recent changes to the NHS superannuation scheme and taxation on pensions has had a negative effect on GP retention and calls on GPC to work with devolved governments to ameliorate the situation.
- 116e BUCKINGHAMSHIRE: That conference condemns the further reduction in pension life time allowance which can only aggravate the exodus of GPs in their 50s and asks GPC to bring this to the attention of all relevant ministers.
- 116f MANCHESTER: That conference believes that the terms of the current NHS Pension Scheme have affected GP retention.
- 116g DEVON: That conference acknowledges that the announced reduction in the pension’s lifetime allowance will push the current workforce crisis to cataclysm, and calls on the government to address urgently the general practice workforce collapse.
- 116h SEFTON: That conference recognises that a significant factor in the current GP manpower crisis is the pressure on GPs to retire. The successive reduction in Pension Life Time Allowance is a considerable inducement to retire and the recent announcement that it is to fall further is inimical to GP retention. Conference calls upon the GPC to engage with the NHSE and Treasury to eliminate the negative impact of these measures.
- 116i DERBYSHIRE: That conference demands that the government revisits as a matter of extreme urgency the changes to pension rules which are resulting in large numbers of GPs retiring earlier than they had originally planned and their skills being lost to the NHS.
- 116j DEVON: That conference request that the GPC negotiate a special case for GPs to back date a return to the original life time allowance of £1.8m as a means to retain senior GPs within the superannuation scheme and thus retain them in practice to help ease the recruitment crisis.



**PUBLIC HEALTH****16.40**

- 117 **CAMBRIDGESHIRE:** That conference believes that public health campaigns often appear to be politically motivated rather than evidence based, can damage the public's perception of their GP, and should be planned in conjunction with the GPC.
- 118 **AYRSHIRE AND ARRAN:** That conference requests government to develop and implement strategies to promote patient self-care and appropriate use of precious NHS resources.
- 118a **AVON:** That conference requests that the Department of Health provide increasing patient education resources so that minor illnesses can be better managed through self-care.
- 118b **BEDFORDSHIRE:** That conference believes that patient education is needed to avoid A&E attendance and admission, and calls on the GPC to ensure there is a national advertising campaign.
- 118c **DEVON:** That conference calls for a concerted and effective public health campaign to help patients manage their own minor illness and reduce demand for antibiotics.
- 118d **WILTSHIRE:** That conference asks the GPC to put pressure on the government to educate the general public regarding:  
(i) what is not a suitable problem to bring to their GP, and  
(ii) that the NHS is for patients' needs, not patients' wants.
- 118e **KENT:** That conference insists that the national curriculum includes compulsory health education in schools in order to promote:  
(i) self-care and self-reliance  
(ii) responsible use of NHS resources  
(iii) health and social care as attractive career options.
- 118f **BEDFORDSHIRE:** That conference believes that minor illness education should be part of the national curriculum.

**OTHER MOTIONS 2****16.50****CONTINGENCY****16.55****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 used as a reference or reaffirmation by 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 119. HIGHLAND: That conference is concerned about the impact that welfare reform has had on people across the UK, particularly in the context of rising inequality.
- A 120. MORGANNWG: That conference notes with concern the mounting sickness periods in the population as a result of the immense impact of the government's social policies.
- A 121. BUCKINGHAMSHIRE: That conference is appalled that the government refuses to recognise general practice as a specialism and insists that it remedies this forthwith.
- A 122. SHROPSHIRE: That conference believes that GPs in the UK should be recognised as specialists in family medicine as is the case in the rest of Europe. This would provide a timely reminder to our hospital colleagues and the general public and could help correct the negative image of general practice currently promulgated by the national media.
- AR 123. NORFOLK AND WAVENEY: That conference asks GPC to work with NHSE to ensure all commissioning decisions are medically evident, a good use of NHS money and will work in practice.

#### WORKLOAD

- A 124. CAMBRIDGESHIRE: That conference congratulates the GPC on the publication of their document entitled 'Quality first: managing workload to deliver safe patient care' that puts in black and white what LMCs have been advocating for years.

#### PRIMARY CARE WORKFORCE

- A 125. SCOTTISH CONFERENCE OF LMCs: That conference:
- (i) deplores the fragmentation of the primary care team and believes that this decreases efficiency and threatens the quality of service to patients
  - (ii) insists that if GPs are to maximise their potential in providing medical care in the community, the primary care team must be based around the practice
  - (iii) calls on health boards to support GP practice based teams.
- A 126. AYRSHIRE AND ARRAN: That conference deplores the destruction of the primary care team and calls on GPC and SGPC to campaign for community staff such as community nurses and health visitors to be practice attached.
- A 127. DUMFRIES AND GALLOWAY: That conference deplored the fragmentation of the primary care team and believes that this decreases efficiency and threatens quality of service to patients.

#### GP EDUCATION AND TRAINING

- A 128. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the current remuneration for a GP trainer is inadequate and derisory. It urges the GPC to work with HEE and develop a more fit for purpose remuneration package that takes into account the time, effort and responsibility the role requires.
- A 129. NORTHERN IRELAND CONFERENCE OF LMCs: That conference calls on RCGP to review the trainee e-portfolio in order to alleviate the burden on trainers who are already under significant pressure in their daily practice.
- AR 130. GLASGOW: That conference calls for appropriate funding for continuing professional development to be built into any future GP contract.

- A 131. COUNTY DURHAM AND DARLINGTON: That conference is concerned about the continued disparity in pass rates between international medical graduates, British non-white graduates and British white graduates in MRCGP examinations (Membership of Royal College of General Practitioners).
- A 132. COUNTY DURHAM AND DARLINGTON: That conference calls upon RCGP and HEE to inform the potential applicants of the disparity in pass rates between international medical graduates, British non-white graduates and British white graduates in MRCGP examinations (Membership of Royal College of General Practitioners).
- A 133. DARTFORD GRAVESEND AND MEDWAY DIVISION: That conference proposes that in time of recruitment crisis GP training should stay at three years duration and not extended to four years.

## ACCESS

- A 134. MANCHESTER: That conference believes the role of general practice is to deliver equitable services to people who wish to consult because they are ill or believe themselves to be ill, not to police UK borders.
- A 135. CITY AND EAST LONDON: That conference is alarmed that after a motion was passed at last year's LMC conference that GPs should have no role in acting as agents of border control, that there are now pilot schemes where GPs are being asked to check patients' EHIC cards for eligibility to NHS care. Conference restates its opposition to any involvement of general practice in policing patients' immigration status and calls for the cessation of these pilots. Conference calls on the GPC to issue clear guidance that GPs should not involve themselves in any aspect of policing immigration status.
- A 136. WALTHAM FOREST: That conference is amazed that GPs are now being asked to be undertake the work of immigration officers in checking people's right to receive NHS care. Conference demands that the government simplifies the procedure and that this removes any onus on GPs to be checking immigration status.
- A 137. HARINGEY: That conference believes that access to GP services through longer working days and seven-day-a-week working is a distraction from the problems of general practice resources which must be addressed in order to provide services in core hours.
- A 138. NORTH YORKSHIRE: That conference demands that the drive towards 8-8 / 7 day working should be resisted given the current recruitment and retention crisis and level of demand and workload in general practice.
- A 139. MID MERSEY: That conference believes that an 8-8 7 day a week provision of care is an unrealistic demand on a demoralised, depleted and ageing profession.
- A 140. BEDFORDSHIRE: That conference is dismayed by the continual emphasis on seven day, 8am to 8pm routine GP services and calls on the GPC to make it clear that:
- (i) the counter-productive implications have not been ignored
  - (ii) it dilutes core and existing services
  - (iii) it is not deliverable or economical, and
  - (iv) that 8am to 8pm opening, seven days a week is purely political spin.

## CCGS

- A 141. BARNET: That conference insists CCGs must become answerable to their membership about decisions made on their behalf.
- A 142. BRADFORD AND AIREDALE: That conference believes that membership of CCGs should not be compulsory for doctors wishing to work as partners in general practice.

## PREMISES

- AR 143. KENT: That conference asserts that NHS Property Services Ltd has a profound conflict of interest when acting as both landlord and adviser to NHS England about premises issues, and calls for this arrangement to be discontinued.

## NEW MODELS OF CARE

- A 144. HERTFORDSHIRE: That conference agrees that small practices still have a place within modern general practice, and calls on GPC to remind government at every opportunity that this is the case.
- A 145. REDBRIDGE: That conference demands that the profession supports smaller GP practices to be sustainable in the future and enable them to provide continuity of quality care to patients.
- A 146. MID MERSEY: That conference recognises the important role of small and single handed practices in supporting and improving health outcomes in the NHS.
- A 147. SOUTHWARK: That conference believes that GP care is cost effective, holistic, personalised and what patients want.

## OTHER MOTIONS 1

- AR 148. NORFOLK AND WAVENEY: That conference calls for any changes to QOF or other terms in service to have at least a one year notice period to enable proper planning processes and resource relocations to take place.
- A 149. WEST PENNINE: That conference believes we need to encourage the GPC to encourage the government to recognise pre diabetes as a clinical entity. If QOF continues in its current form, they should campaign for inclusion in health checks.
- A 150. AVON: That conference deplores the target driven culture of today's primary care and believes that whilst some are useful and appropriate:
- (i) they have become so numerous that they are now out of control
  - (ii) it has become difficult to distinguish those that are useful from those that are a waste of time and resources
  - (iii) many are used inappropriately to criticise and humiliate general practitioners
  - (iv) the GPC should negotiate forthwith for the abolition of the majority of them.
- AR 151. HERTFORDSHIRE: That conference is dismayed over further disruption of primary care support services and:
- (i) despairs at the loss of efficient, effective and productive providers in the pursuit of political dogma
  - (ii) deplores the disproven assurances of NHS England that "these changes will not affect the service you receive"
  - (iii) regrets the burden in general practice that the loss of long term relationships will inevitably bring.
- A 152. COUNTY DURHAM AND DARLINGTON: That conference believes that any system for firearms licensing that relies on a pre- or post- grant notification is flawed.
- A 153. COUNTY DURHAM AND DARLINGTON: That conference recommends the police should be provided with a medical report for all applicants for firearms licenses at the beginning of the licensing process and that if GPs provide such a report they should be paid for doing so.
- A 154. COUNTY DURHAM AND DARLINGTON: That conference calls on the GPC to campaign for legislative change to allow development of a robust firearms licensing process.
- A 155. LANCASHIRE COASTAL: That conference condemns the insistence by NHS England to offer short term APMS contracts when PMS or GMS contracts are renewed and believes GMS contracts should be offered in order to provide stability for patients in their on-going care.
- AR 156. REDBRIDGE: That conference rejects fundamental changes of general practice which erode the concept of family doctors. These changes result in an undermining of the personal care and the continuity of care which is most valued by patients. Conference insists that the loss of the concept of the family doctor will never be agreed by the profession.
- A 157. DORSET: That conference believes that women are under-represented in medical politics and positive steps should be taken to remedy this as soon as possible.
- A 158. GLASGOW: That conference believes that the relentless negative media portrayal of general practice has significantly damaged both the morale of the profession and its recruitment and calls for media editors and politicians to publicise the positive aspects of general practice.
- A 159. DEVON: That conference believes that GP's should not be criticised in the media for prescribing too many antibiotics on one day and not prescribing enough antibiotics on the next day.
- A 160. CAMBRIDGESHIRE: That conference demands that the GPC work with the BMA media relations team to produce more robust responses to the persistent drivel and inaccuracies seen in the press.
- A 161. ROCHDALE AND BURY: That conference urges GPC to heighten media engagement to inform the public on service constraints.
- A 162. HERTFORDSHIRE: That conference deplores the bureaucracy regarding the replication and duplication of DNACPR forms and instructs GPC to negotiate for a unified, transferable UK wide form, accepted by all ambulance trusts, area teams, CCGs and GP practices.

## REGULATION, MONITORING AND PERFORMANCE MANAGEMENT

- AR 163. ROCHDALE AND BURY: That conference urges the GPC Executive Team to address the double registration for GP's by the GMC and the performers list.
- A 164. EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the inappropriate use of secondary care infection control and other premises standards by inspectors assessing general practice premises, which is causing unnecessary anxiety and expense for practices that are already under considerable strain and demands that the current premises inspection standards are withdrawn and new standards are negotiated which are fit for purpose.
- A 165. MID MERSEY: That conference believes infection control audits carried out in primary care need to reflect the nature of primary care.

- A 166. THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee: That conference demands NHS England follow the example of the devolved nations in recognising that locum / freelance GPs are an important part of the GP workforce and reintroduce the funding for participating in annual appraisal.

## CLINICAL AND PRESCRIBING

- A 167. HULL AND EAST YORKSHIRE: That conference deplores the increasing problems with unavailability of medications due to supply chain problems, which has significant negative impact both in terms of patient care and GP workload. Conference requests that GPC presses for urgent high level Department of Health action to address this issue.
- AR 168. HULL AND EAST YORKSHIRE: That conference insists that NICE, when advising on quality standards or guidelines, must take into account the implications for GP workload, and that the NHS, in accepting any NICE guidance, must make an explicit commitment to pay, with new funding, for any additional GP workload involved.
- A 169. MID MERSEY: That conference believes that there is no justification for patients suffering from any hormone deficiency condition to receive all medications free of charge.
- AR 170. DERBYSHIRE: That conference believes that the local variability of access for GPs to investigations such as CT, MRI, isotope scan etc., is whole unacceptable, wasting money and resources, putting patients' lives at risk and wasting the talents of experienced clinicians.
- AR 171. LANCASHIRE PENNINE: That conference believes that some NICE guidelines have little chance of being implemented as they do not give sufficient consideration to the ability of the service to deliver in the light of severe manpower constraints.
- AR 172. DEVON: That conference believes GPs in England and Northern Ireland should have free access to the drugs and therapeutics bulletin in the same way that their colleagues in Scotland and Wales do.
- AR 173. LIVERPOOL: That conference believes that GPC should encourage more GP representation on to NICE guidance review panels as recent recommendations (with corresponding targets) from NICE guidance have been widely perceived as controversial and impractical for GPs to implement.
- AR 174. CITY AND EAST LONDON: That conference has concerns regarding NICE and demands:
- (i) more GPs are involved in developing the NICE guidelines and that they are appropriately remunerated for this role
  - (ii) NICE review their processes and guidelines and ensure that their guidelines are relevant, achievable and realistic in UK clinical practice
  - (iii) that NICE considers the impact of the implementation of their guidelines on both general practice and patients.
- A 175. AYRSHIRE AND ARRAN: That conference calls on the government to provide support and resource to those practices who wish to provide a service to help their patients to self-test and self-manage their own anticoagulation.
- A 176. SHROPSHIRE: That conference believes the current prescription charge exemption regulations are illogical, discriminatory and in need of revision, with particular attention to the anomalous omission of major chronic diseases such as asthma and the blanket exemption from payment for all prescribed medication not just the qualifying condition.
- A 177. BUCKINGHAMSHIRE: That conference believed that erratic non-availability of some medications causes considerable inconvenience to patients, GPs and pharmacists and calls on government to put measures in place to ensure that such events are rare and devise a national alerting system (listing currently non-available medication) for GPs
- A 178. SOUTHWARK: That conference is concerned regarding the extra workload involved in providing prescriptions for dosset boxes and calls upon the GPC to discuss this with the PSNC Pharmaceutical Services Negotiating Committee to reach a pragmatic solution.
- AR 179. LEWISHAM: That conference calls for an end to prescribing incentive schemes based purely on cost savings because they fracture the GP / patient relationship; and calls upon the commissioning bodies to endorse schemes that promote safe evidence-based prescribing.
- A 180. BUCKINGHAMSHIRE: That conference is increasingly concerned by the number of medicine shortages reported by patients and pharmacists:
- (i) as the resulting need to switch to an alternate drug can be detrimental to a patient's wellbeing
  - (ii) as this causes delay in patients receiving the medicines they need, while wasting a considerable amount of patient and doctor time
  - (iii) and insists that the Department of Health ensure that GPs are informed of all relevant drugs shortages.
- AR 181. HULL AND EAST YORKSHIRE: That conference is concerned about the potential adverse effects on society and individuals of pharmaceutical intervention for patients whose cardio-vascular risk factors are within the norm for their age.

## DISPENSING

- A 182. HERTFORDSHIRE: That conference believes that the rules pertaining to the setting up of new pharmacies, which have the consequence of stopping practices from dispensing to their own patients, removes patient choice and calls on GPC to negotiate a change in the regulations to remove this unfair ruling and allow competition between pharmacies and local practices.
- A 183. NORFOLK AND WAVENEY: That conference believes dispensing practices offer a preferred and better integrated service for patients and all practices should be allowed to dispense to their patients irrespective of local pharmacy provision.

## FUNDING FOR GENERAL PRACTICE

- A 184. NORTHAMPTONSHIRE: That conference demands that any transfer of work to GPs should only occur when adequate additional resources are provided up front and in full to cover that work.
- A 185. DUMFRIES AND GALLOWAY: That conference believes that effective transfer of workload from secondary to primary care can only be achieved by increasing the proportion of total NHS spend in primary care.
- A 186. GWENT: That conference believes that, just as you cannot fit a quart into a pint pot, neither can further services be delivered within the existing funding envelope for primary care and additional work will require adequate additional resource.
- A 187. WOLVERHAMPTON: That conference believes if routine GP care is to be provided 8am – 8pm seven days a week it can only be provided by extra funding to be agreed with the profession.
- A 188. ENFIELD: That conference believes the current rate of transfer of work from secondary to primary care without additional resources for primary care to undertake extra work is unsafe and unsustainable.
- A 189. DEVON: That conference believes that 'intermediate care' is not primary care and should be paid for appropriately as this will enable recognition and appropriate remuneration for the many GP practices who are now doing secondary care work in the community.
- A 190. DEVON: That conference deplores the continuing lack of funding for general practice and primary care and notes that specialised commissioning is now receiving more funds than primary care.
- A 191. BEDFORDSHIRE: That conference believes that the NHS can probably afford what patients need but not what patients want and calls on GPC to demand that government is honest about rationing.

## INFORMATION MANAGEMENT AND TECHNOLOGY

- AR 192. WEST PENNINE: That conference believes funds should be made available to allow patients to access their medical records.
- A 193. MID MERSEY: That conference believes that the proposed model for patient access to their full medical records will give rise to increased workload in general practice and will not be in the best interests of patients.
- A 194. MID MERSEY: That conference believes that potential damage caused to patients by having access to their entire GP medical records outweighs the advantages and should be discouraged.
- AR 195. GLASGOW: That conference recognises that IT functionality is vital in enabling practices to deliver high quality care to patients and demands increased investment to support and develop GP practice IT.
- AR 196. GLASGOW: That conference believes that the sharing of specified electronic patient information between different services can improve the patient journey and care.
- A 197. SUFFOLK: That conference with respect to the Electronic Prescription Service (EPS):  
(i) notes that this is not available for dispensing practices  
(ii) expresses concern at the disadvantage to patients and dispensing doctors  
(iii) demands that the necessary IT functionality and hardware to enable dispensing practices in England to use the EPS be provided and funded by the NHS  
(iv) calls upon the GPC/Joint GP IT committee to negotiate an appropriate package.
- A 198. KINGSTON AND RICHMOND: That conference notes the importance of properly supporting IT services within practices.
- AR 199. GRAMPIAN: That conference insists that IT provision in general practice must be fit for purpose and appropriately funded to ensure that we can work efficiently and safely in the care of our patients.

## PRIMARY AND SECONDARY CARE INTERFACE

- A 200. GRAMPIAN: That conference feels that if we are to fulfil our potential as out of hospital expert generalists, GPs must be given full access to appropriate hospital investigations without the delaying step of outpatient referral.
- A 201. NORFOLK AND WAVENEY: That conference supports no additional secondary care workload being passed onto primary care without clearly identifying the funding and resource implications to enable appropriate commissioning.
- A 202. DERBYSHIRE: That conference believes that letters about patients from hospitals to GPs should be required to meet national standards in how they convey information, especially medication that has been stopped and started, and in timeliness.



- A 203. SOMERSET: That conference asserts that, with regard to correspondence from hospitals:
- (i) when hospital doctors send copies of highly technical letters to patients, they, rather than the GP should be responsible for explaining them to the patient
  - (ii) the inability of hospital patient administration systems to address letters to a named GP generates unreasonable work in primary care and is a serious risk to patient safety
  - (iii) timeliness of correspondence should be a central element of the contracts drawn up by commissioners, not an optional extra.
- A 204. SURREY: That conference believes hospital discharge summaries should be timely, relevant, and every patient discharged from hospital should have one.
- A 205. NORFOLK AND WAVENEY: That conference believes communication between secondary and primary care is exemplified by the quality of discharge summaries, highlighting this as important factor for better patient care.
- A 206. DEVON: That conference believes that GP referral screening centres must not be allowed to interfere with a GP referral without a clinician in the centre having a professional conversation (verbal or electronic) with the referrer.
- AR 207. CAMBRIDGESHIRE: That conference believes that CCG referral management policies, and associated exceptional case funding application processes, are often unreasonable, and therefore demands that the GPC produce guidelines to help CCGs respect the professionalism of GP referrers
- A 208. DERBYSHIRE: That conference believes that the blocking of inter-consultant referrals does not result in a more efficient health service and calls for it to end.
- A 209. ROTHERHAM: That conference instructs GPC and the GPC executive team to remove obstructions to appropriate GP referral and resist any new ones.
- A 210. DUMFRIES AND GALLOWAY: That conference believes that when a GP is considering referral of a patient for acute admission to hospital, that the clinical needs of the patient take precedence over concerns over targets.
- A 211. SCOTTISH CONFERENCE OF LMCs: That conference believes that when a GP is considering referral of a patient for acute admission that the clinical needs of the patients take precedence over concerns over targets.
- A 212. MORGANNWG: That conference:
- (i) welcomes various initiatives by ambulance trusts and services to reduce the inappropriate use of ambulance transport
  - (ii) demands an extension of the ambulance service to provide transport to GP premises for those patients whose medical condition prevent them from being safely transported by taxi or by public transport.
- A 213. DYFED POWYS: That conference accepts that while there is a reduction in the number of GP hours available, the decision about which primary health professional is appropriate to address the patient's problem should be decided by the primary care team and not the patient.
- A 214. CORNWALL AND ISLES OF SCILLY: That conference believes that the workload shift from secondary care into in general practice is causing a workload crisis and demands the government negotiate a workload solution for practice with the GPC in order to ensure it remains sustainable.

## CO-COMMISSIONING

- AR 215. HERTFORDSHIRE: That conference deplores the waste of resources caused by the dismantling of PCTs only to recreate them three years later through co-commissioning.
- AR 216. EASTERN REGIONAL COUNCIL: That conference deplores the waste of resources caused by the dismantling of PCTs only to recreate them three years later through co-commissioning.

## MEDICAL CERTIFICATES AND REPORTS

- A 217. HAMPSHIRE AND ISLE OF WIGHT: That conference insists that if coroners expect a report from GPs in order to assist the coroner in his legal duties, then that report cannot be provided on the basis of zero resource and GPs should be able to charge a reasonable fee for such reports.
- A 218. NOTTINGHAMSHIRE: That conference, in the light of the impact of the Coroners and Justice Act on GPs' workload in some areas of the country, is greatly concerned at the absence of consistency among HM Coroners in interpreting the Act's provisions, and calls upon the GPC to discuss these concerns directly with the Ministry of Justice and the Chief Coroner.

## PENSIONS

- AR 219. AVON: That conference notes with alarm that non-core services, provided by any qualified provider, are unlikely to be superannuable under the NHS pension scheme in the future and calls on the GPC to negotiate with the Department of Health to protect the position of doctors in this respect.
- AR 220. AYRSHIRE AND ARRAN: That conference asks the four UK governments to make superannuation payments for income from OOH be made optional.

- A 221. SOUTHWARK: That conference calls upon GPC to negotiate with NHSE to ensure that payments received by practices for work done by federated groups of practices are superannuable. (Supported by LAMBETH and SOUTHWARK)
- A 222. LAMBETH: That conference calls upon GPC to negotiate with NHSE to ensure that payments received by practices for work done by federated groups of practices are superannuable. (Supported by LAMBETH and SOUTHWARK)
- A 223. DEVON: That conference recognises that LMCs were established by an Act of Parliament and have been an integral part of general practice since long before the establishment of the NHS and as a result:  
(i) all LMC employees should, by right, have access to the NHS pensions scheme  
(ii) LMC staff should be given an option to make pensionable their proven LMC salaries for the last five years and make appropriate back-payments on that basis.
- A 224. HERTFORDSHIRE: That conference believes that practices owe a duty of respect to all doctors and calls on GPC to do more to ensure that locum GPs should:  
(i) be regarded as valuable additions to the workings of a practice  
(ii) be paid on time  
(iii) have their pension contributions paid appropriately.
- A 225. LIVERPOOL: That conference believes that the current pension arrangements for GPs are discriminatory against GP locums and calls upon the GPC to enter into discussion with the NHS Pensions Agency to ensure that the families of GP locums do not lose out from the death in service benefit purely because of death occurring between two different locum jobs.

## Agenda: Part II

### (Motions not prioritised for debate)

#### GOVERNMENT

226. BRO TAF: That conference calls on GPC to insist that the government repeals the 1974 Venereal Disease Regulations.
227. NORTH STAFFORDSHIRE: That conference believes that the lack of a clear and coherent medium to long-term strategy and vision in the NHS:
- (i) does nothing to support the development of a workforce and infrastructure needed to deal with ever increasing demand in primary care
  - (ii) undermines it's cost-effectiveness and is wasteful
  - (iii) causes CCGs to issue short-term contracts in an attempt to chase NHSE politically driven targets
  - (iv) stifles innovation
  - (v) means that many CCG and NHSE initiatives, contracts and their associated targets are never properly evaluated, and no lessons are learned as a result of this
  - (vi) will lead to an ever increasing workforce and capacity crisis in primary care
  - (vii) puts patient safety and quality of care at risk
  - (viii) and tasks the GPC to seek a national 3-5 year agreement for the GP contract, rather than annual round of wasteful changes
  - (ix) and tasks the GPC to support a national campaign to ensure that the NHS is run without any political interference
  - (x) and tasks the GPC to ensure that CCGs are truly independent in setting their local healthcare agendas and spending priorities, so that they are not hamstrung by central dictat.
228. WILTSHIRE: That conference recognises that GPs should follow the government's policies and priorities and to that end practices should:
- (i) have protected time for preparation for and indulgence in CQC inspections
  - (ii) have protected time for reading and discussing every guideline which could be relevant in general practice
  - (iii) have protected time interfacing with social care and third sector organisations
  - (iv) have protected time for revalidation
  - (v) stop seeing patients completely to allow time for (i)- (iv)above.
229. OXFORDSHIRE: In line with the forthcoming publication of general practitioners incomes, conference calls on the Secretary of State for Health for England to mandate the publication (at the same time, in the same publications) the total NHS remunerated salaries, including publicly funded pension contributions, received by all executives, senior managers and management consultants, employed by CCG's, NHS England and the Department of Health.
230. OXFORDSHIRE: That conference condemns the hypocrisy of David Cameron and George Osborne for renegeing on their commitment to openly publish their income tax declaration, whilst holders of public office.
231. BERKSHIRE: That conference calls for all golden helloes and severance payments received by the Secretary of State for Health in England, all executives and senior managers employed by CCG's, NHS England and the Department of Health be openly published in the same publications as that of general practitioners annual salaries.
232. BERKSHIRE: That conference calls on the Secretary of State for Health in England, all executives and senior managers employed by CCG's, NHS England and the Department of Health to take cuts in pay in proportion to that experienced by the average GP, during the tenure of the present government.
233. HAMPSHIRE AND ISLE OF WIGHT: That conference is tired of our patients and general practice being on the receiving end of 'unintended' consequences' every time there is a health care delivery system change and conference suspects that some of these consequences are indeed intentional and thus should be subject to the proper democratic process.
234. ROCHDALE AND BURY: That conference urges the government to address the lifespan variation across the North / South divide with additional investment.
235. LIVERPOOL: That conference believes that GPC is looking forward to working in close collaboration with the new government to enhance and develop general practice and primary care to deliver cost effective high quality care that is publically funded and free at the point of care as well as further develop the expert generalism model delivered from practices by a fully staffed, trained and supported GP and associated clinical workforce.
236. WALTHAM FOREST: That conference has grave concerns that the policy of segmentation will cause further confusion and disarray leading to worsening of patient health outcomes. It demands that the government recognise the benefit of the expert generalist, is explicit in this support and stops undermining general practice.
237. WIRRAL: That conference believes that:
- (i) the NHS Health and Social Care Reforms have NOT produced the anticipated benefits for patients and may have made National Health Services worse
  - (ii) the architects and enthusiasts for such reform should resign from political or high managerial office forthwith.

238. COVENTRY: That conference believes that the devolution of the total Health and Social Care budgets to local councils portends the end of a National Health Service and further removes any responsibility for the NHS from the Secretary of State for Health.
239. DEVON: That conference believes that the Health and Social Care Act 2012 will soon be pronounced a 'dead duck' and welcomes this.
240. HARINGEY: That conference demands that the NHS and Department of Health laces primary care at the heart of its work as primary care undertakes 90% of work in the health service which would collapse without it.
241. GLOUCESTERSHIRE: That conference believes the people of the UK will never forgive the government that brings about the collapse of general practice and calls on the GPC to increase and improve communications to support general practice as much as possible.
242. SOUTH STAFFORDSHIRE: Whilst welcoming the No more games campaign conference instructs GPC to campaign against further demoralisation of general practice and demand that government stops:
- (i) blaming GPs for everything, including the crisis in A&E
  - (ii) using the NHS for political gains
  - (iii) adding stress to GPs by transferring unresourced work from secondary care
  - (iv) raising false patient expectations about GP access and opening hours
  - (v) the negative media campaign against general practice making it unattractive to new doctors
  - (vi) initiating and then criticising GP payments such as the dementia incentive which we never asked for misleading the public that GPs are overpaid.
243. DEVON: That conference believes that any MP who advises doctors to consult astrological charts prior to treating patients should stick to their day job(s) and highly paid directorships.
244. LEEDS: That conference recognises that as a result of campaigning by the BMA GP committee, general practice was a major issue in the general election campaign, and now calls on the new secretary of state for health in England to work constructively with GPC to:
- (i) make significant and sustainable long-term investment in to core general practice
  - (ii) increase the number of GPs in training
  - (iii) increase investment in GP premises
  - (iv) reduce bureaucracy, box-ticking and micro-management
  - (v) support the development of general practice.
245. AVON: That conference deplores the governments scapegoating of GPs and in particular primary care for the recent acute bed crisis in hospitals which is not due to lack of primary care provision but due to the lack of acute beds in the UK.
246. NEWCASTLE AND NORTH TYNESIDE: That conference believes that there should be a restoration of the duty of the Secretary of State to deliver a comprehensive NHS in England and to have powers of intervention in any part of the NHS (including foundation trusts).
247. NORFOLK AND WAVENEY: That conference asks GPC to seek a national enquiry on the wasted billions spent on the Health and Social Care Act failure.

## WORKLOAD

248. COVENTRY: That conference believes that whilst welcoming the GP workforce collaborative ten point plan believes this will fail unless job satisfaction and workload improve and demands that the GPC must make these the core of current and future negotiations.
249. SCOTTISH CONFERENCE OF LMCs: That conference believes that the current increased usage of A&E departments, often for minor medical complaints is mirrored in general practice where spiralling demand against a background of static manpower resources has been fuelled by politically stimulated consumerist attitudes.
250. AYRSHIRE AND ARRAN: That conference believes the ongoing use of general practice 'as the service of last resort' when other services are under pressure is contributing to the difficulties faced by general practice and calls for urgent government action to stop this happening.
251. WORCESTERSHIRE: That conference believes the latest reorganisation of NHS England will lead to increased chaos and bureaucracy and directly worsen primary care workload.
252. NORFOLK AND WAVENEY: That conference notes that the NHS promotes physical activity and a healthy lifestyle as important in a person's health and wellbeing both physically and mentally:
- (i) the current workload of GPs heightens the risk that GPs often neglect themselves
  - (ii) the increased risk of burnout with current work and stress levels is leading to increased early retirements
  - (iii) stressed and tired doctors pose a risk to patient safety.
253. NORTHAMPTONSHIRE: That conference demands the right for all patients to be able to register with the doctor of their choice without regard to the capacity and workload of the practice concerned.
254. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference proposes, legislation could be passed to enable practices to charge patients for failing to attend booked appointments with a GP or other clinician employed by the practice. Systems can be established to ensure patients with valid reasons or circumstances are exempt from such charges. These charges would help the public appreciate the value and cost of NHS GP services and reduce the number of wasted appointments. Legislation could be passed to enable this - NHS orthodontists have made similar charges for years. The experience of orthodontists has been that charges are rarely imposed as failure to attend rates are minimal in practice with a policy of fines and where waiting room notices explain the fines, and the reason for them.

## PRIMARY CARE WORKFORCE

255. DERBYSHIRE: That conference is of the opinion that Public Health England as currently constituted places the registered medical practitioners it employs in an impossible situation with regard to their medical registration and their obligations as doctors.
256. NORTH STAFFORDSHIRE: That conference recognises the now inevitable short to medium term severe shortfall in GP numbers, the excessive pressures on those GPs still working and the genuine risk of general practice patient cover simply shredding for a significant population, putting lives at risk through no prescriptions, no-one for secondary care to liaise with and no actual general practice access. This could happen anywhere in the UK through a combination of retirement, illness, failed recruitment and burnout and then a ripple effect as neighbouring practices folded under the enforced area team allocation strain, leaving a geographical hole that could not be filled. This is every LMCs' and responsible officer's worst nightmare.
257. NOTTINGHAMSHIRE: That conference welcomes the '10 point plan' for general practice as a not to be missed opportunity to bring consistency and stability to education, training, recruitment, retention, and workforce planning in general practice, and believes:
- (i) that to develop a GP practice workforce which is sustainable and fit for the future, an agreed percentage of the health education budget should be ring-fenced in perpetuity for general practice
  - (ii) appropriate local structures should be established to oversee and deliver GP workforce development in every locality
  - (iii) wherever possible LMCs should be encouraged, either individually or collectively, to lead, direct or actively participate in such structures, be they local training hubs or local improvement collectives.
258. DEVON: That conference believes that in order to improve our critical workforce issues nationally:
- (i) the returners scheme should be overhauled completely and UK trained GP's returning to work in the UK should undergo fast track re-accreditation
  - (ii) that the recent arrangements for MDO fee supplementation for GPs working out-of-hours does nothing to retain hardworking GPs in OOH services and should therefore be extended and improved
  - (iii) a robust and effective national system for occupational health services for GPs should be provided.
259. HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the current expectations to work up to six months unpaid in order to return to general practice following a career break or work abroad falls within the legal definition of slavery and should be robustly challenged.
260. NORTH ESSEX: That conference calls on the GPC to explore the feasibility of the distribution of GPs being managed again by a national body to aid recruitment in traditionally under doctored areas and ensure a more equitable spread of general practice expertise.
261. DORSET: That conference deplores the concept of 'physicians associates' assistants' if they are to become a cut priced version of general practitioners.
262. NORFOLK AND WAVENEY: That conference notes that funding and workforce deficiencies in certain specialities has led to cases presenting in the emergency setting and a resultant increased clinical and clerical workload for primary care with unfair media denigration of GPs clinical skills.
263. WIGAN: That conference believes that the 'more with less' approach to the neglect of developing capacity in general practice is eroding the ability of GPs to be effective gatekeepers to health services. Increasing need and 'help seeking' behaviour on the part of the population together with expectations to 'find and treat' is overwhelming general practice. The failure to ensure that supply of GPs reasonably equates with demand for them is a key factor in dissuading trainees from pursuing a career in general practice and those who have trained, from becoming principals in general practice. Vertically integrated models of care delivery do not address this and may exacerbate it.
264. GLASGOW: That conference believes that it is time to consider rebranding GPs as primary care consultants to reflect their expanding role in the community, increase respect and classify GPs as leaders of the patient's medical care in the community.
265. WIRRAL: That conference accepts that the title 'general practitioner' for doctors in our branch of medicine is obsolete; it is synonymous in the minds of patients, politicians and the media with poor care, medical mistakes and the NHS's failings and we should be rebranded 'consultants in primary care'.
266. CORNWALL AND ISLES OF SCILLY: That conference that the term GP should be abolished in favour of the title primary care consultant.
267. SHEFFIELD: That conference supports a friends and family test for GPs and their staff to assess the appeal of general practice as a career.
268. HERTFORDSHIRE: That conference calls on GPC to ask the profession to think about its recent experience of general practice and ask "how likely are you to recommend a career in general practice to friends and family?"
269. BRADFORD AND AIRESDALE: That conference believes the GPC should embrace the 'Friends and Family test' and survey all general practitioners with the question "Would you recommend a career in general practice, as it is now, to your friends and family?"
270. HERTFORDSHIRE: That conference welcomes the £10 million fund to reduce early GP retirement, but notes that of more pressing concern is the number of young women leaving the profession and asks GPC to:
- (i) prioritise with utmost urgency a review of funding arrangements for maternity leave provisions for GPs irrespective of contractual status
  - (ii) negotiate fully funded retainer and returner schemes throughout the UK
  - (iii) work with NHS England and the RCGP to help GPs to rejoin the workforce without having to jump through onerous hoops.
271. DEVON: That conference believes the only way to solve the current GP manpower problem is to get more men rather than asking the increasing proportion of female GPs to work longer and harder.

272. HAMPSHIRE AND ISLE OF WIGHT: That conference believes part time working is destroying continuity of care and should be discouraged.
273. OXFORDSHIRE: That conference believes that the standard presentation of NHS111 reports includes so much clutter in the form of multiple negative answers to questions that reading each document is a difficult task, with resultant unnecessary clinical risk. It calls on government to amend the report template so that it conveys the most important information in a much more readable way.
274. NORFOLK AND WAVENEY: That conference believes that despite the large increase in secondary care consultants there has not been the desired increase in productivity and if this shift in workforce was targeted to primary care it would be more effective to manage healthcare.
275. GLOUCESTERSHIRE: That conference is very alarmed both at the detail that has been demanded in the Workforce Minimum Data Set and also at the short time being allowed to complete it and so:
- (i) questions the expected validity and benefits of the survey
  - (ii) wonders why more extensive use is not being made of existing workforce data
  - (iii) seeks the withdrawal of the Workforce Minimum Data Set.
276. THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee:  
That conference believes that support networks and targeted educational sessions for sessional GPs are vital in the retention of this mobile and flexible part of the workforce and calls upon GPC to insist Health Education England includes this in their workforce strategy.
277. AYRSHIRE AND ARRAN: That conference deplores the deskilling of the community nursing team and calls on GPC and SGPC to make it clear to the four UK governments that this trend needs to be reversed urgently.
278. GLASGOW: That conference demands that any medical equipment required for a 'shift in care' to the community is supplied and maintained by the board or department making that change.
279. DEVON: That conference wishes to clearly state that:
- (i) without adequate funding 'care in the community' equates to 'poor care for all and no care for some'
  - (ii) the proportion of NHS resources spent in the community has fallen steadily over 20 years
  - (iii) the government should introduce a legal enforceable directive for commissioners to double their spend in the community over the next five years.
280. CORNWALL AND ISLES OF SCILLY: That conference that the inexorable rise in workload in primary care is responsible for the current recruitment problems in general practice and demands the government urgently negotiate a fit for purpose workload and workforce solution with GPC.

## GP EDUCATION AND TRAINING

281. LINCOLNSHIRE: That conference urges Health Education England to urgently address the recruitment and retention crisis in general practice by:
- (i) reducing the financial and workload burden of returner schemes
  - (ii) ensuring that all foundation doctors spend at least four months in general practice
  - (iii) incentivising training in specialties which are under-subscribed, such as general practice.
282. CAMDEN: That conference believes that movement of GP education from deaneries to local education training boards (LETBs) fails to provide meaningful primary care training for GPs because LETBs are dominated by trusts which are service driven and place emphasis on junior service delivery jobs rather than general practice roles. Conference demands that GP education should be led by primary care trainers in the interests of the needs of patients in general practice.
283. NORFOLK AND WAVENEY: That conference believes medical training needs to:
- (i) promote general practice from year one
  - (ii) medical school entry criteria widened to not purely focus on academic achievement of achieving 3 A\* grades
  - (iii) increase use of GPs as clinical tutors within undergraduate training with appropriate remuneration
  - (iv) greater influence of 'non-academic' GPs in undergraduate teaching and policy within the medical schools.
284. THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference believes that, in view of the current GP recruitment crisis, the RCGP must engage more with trainee groups with regard to:
- (i) sudden exam date changes
  - (ii) reducing the high costs of membership, subscription and exam fees
  - (iii) exploring an alternative to the much maligned RCGP e-portfolio used in GP training.
285. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that for those candidates who repeatedly fail the CSA but have passed the AKT and WBPA should have an alternative means of assessment available to them to help them. It urges the GPC to lobby and work with the RCGP to help develop an alternative clinical assessment medium for such candidates.
286. DERBYSHIRE: That conference declares that the activities of many deaneries, in their new incarnation as part of Health Education England, are fundamentally undemocratic, taking powers they do not possess in law, making up ex-cathedra rules concerning medical practice and generally obstructing doctors' right to peaceful enjoyment of their professional qualification. The GPC is instructed to investigate the methods of deaneries, suggest mechanisms to improve their accountability to the profession and to report back by LMC conference 2016.
287. EALING, HAMMERSMITH AND HOUNSLOW: That conference demands a recognised career structure, training and accreditation programme for practice managers, who are crucial to the sustainability of general practice.

288. WIRRAL: That conference demands that medical school intake should be expanded to fully cover the predicted need for doctors within the NHS.
289. CLEVELAND: That conference demands that there is an open and honest discussion about the consideration of publishing costs to all patients for the individual care they have received when accessing GP services in order to foster an awareness of the costs of healthcare and to encourage responsible usage of services.

## ACCESS

290. DORSET: That conference believes that access to urgent and emergency care should be both simplified and restricted to better enable patients to receive "the right care in the right place at the right time".
291. LEEDS: That conference believes it is essential for the future success of the NHS in England that all patients, regardless of their postcode, should be able to access a general practice service based on a nationally defined and funded core contract.
292. LEWISHAM: That conference demands that general practice should not be blamed for excessive attendance at unscheduled care sites.
293. SHROPSHIRE: That conference disputes the government's claim that keeping GP surgeries open seven days a week will improve the health of the nation and suggests that they compare UK provision with the rest of Europe. In Denmark GP surgeries not only are not open at weekends but close at 4.00pm (2.00pm on Fridays) without any evidence of detriment to the population's wellbeing.
294. NORFOLK AND WAVENEY: That conference believes that the provision of GP services 8-8 7 days a week is:
- (i) unviable
  - (ii) dangerous to the health of GPs who are already working 12 hour days
  - (iii) unsustainable
  - (iv) unaffordable
  - (v) unrealistic as not enough GPs
  - (vi) simply a political 'winner' in an election year
  - (vii) a recipe to worsen the recruitment crisis.
295. CITY AND EAST LONDON: That conference calls on the GPC to organise collective refusal of general practice to co-operate with the implementation of 48 hour access targets or seven day opening should they become government policy.
296. LAMBETH: That conference:
- (i) believes that GPs are overworked, with many already working seven day weeks, in order to staff out-of-hours services
  - (ii) believes that more work requires more resource, so the delivery of seven day, 8am to 8pm working will not be deliverable without more resource
  - (iii) calls upon GPC to demand more resource for the delivery of seven day, 8am to 8pm working.

## CO-COMMISSIONING

297. COVENTRY: That conference deplores that CCGs did not use the opportunity of investing £5 per patient as advised in 'Everyone Counts', and demands that:
- (i) NHS England requires this investment to be made in primary care in line with the 'Everyone Counts' document
  - (ii) NHS England includes a requirement that all future projects funded through this scheme are agreed by the appropriate LMC(s)
  - (iii) that GPC produces a dossier of successful schemes.
298. EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the increasing propensity of commissioners and others:
- (i) to refer to CCGs and GP federations as representatives of general practice
  - (ii) to negotiate directly with GP federations to the exclusion of LMCs, and
  - (iii) calls upon GPC to emphasis, if necessary by negotiating any necessary additional legislation, the statutory duty of all bodies to recognise and work with LMCs in all matters relating to general practices as providers.
299. CAMDEN: That conference calls upon NHS England and CCGs to:
- (i) recognise the need for GPs to maintain their clinical skills while developing their leadership roles; and
  - (ii) ensure that these roles should not be split between clinical GPs and leadership GPs therefore maintaining their skills and balance to their roles among the workforce for the benefit of general practice staff and patients.
300. NORTH YORKSHIRE: That conference should encourage CCGs to take delegated responsibility for commissioning primary care so that CCGs can facilitate GP engagement in the development of general practice that is fit for future purpose.
301. NEWCASTLE AND NORTH TYNESIDE: That conference believes that each LMC should receive monthly information and updates from NHS England, CCGs and CSUs on any services that are being commissioned by competitive tender for patients in their area.
302. NOTTINGHAMSHIRE: That conference recognises the desire of many CCGs who have opted for co-commissioning to support and invest in the local development of general practice, but insists that where such investment involves a departure from, or local variation of, nationally negotiated contractual terms (like QOF) it must be:
- (i) preceded by a formal consultation process overseen by LMCs
  - (ii) accompanied by watertight guarantees offering a 'return ticket' for practices should future political or economic circumstances deem this necessary.

303. BRENT: That conference affirms commissioners duty to consult meaningfully with LMCs on locally commissioned schemes, and calls upon commissioners to ensure that all the resource implications for practices are fully incorporated into the pricing by:
- (i) publishing a GP workload impact assessment of any reporting requirements alongside the scheme
  - (ii) avoiding additional data reporting while schemes are in progress
  - (iii) removing annual patient reimbursements which do not take into account the number of patient contacts.

## PREMISES

304. EALING, HAMMERSMITH AND HOUNSLOW: That, while conference welcomes initiatives such as the Primary Care Infrastructure Fund:
- (i) it deplores the poorly planned and resourced process and the unfortunate timing which has created GP practice frustration
  - (ii) demands that general practice support is implemented in a planned, timely fashion with prior GPC and LMC consultation to ensure it is equitable, sustainable and truly supportive of general practice.
305. BRO TAF: That conference requests GPC to ensure that the current lease used for primary care estates is altered:
- (i) to avoid practices incurring unreasonable financial strain; and
  - (i) to allow part time GPs and non GP partners to become signatories, which will facilitate and encourage the recruitment and retention of GPs.
306. DEVON: That conference believes that every patient should be seen in modern purpose built premises with adequate space and facilities as stipulated in the regulations for new premises building and to achieve this funds should
- (i) be made available to all practices for new buildings failing the above criteria
  - (ii) also be made available to provide space for the movement for secondary care work into primary care.
307. HERTFORDSHIRE: That conference is not surprised that the recent premises funding application process was as chaotically inadequate as the:
- (i) government's whole premises funding policy, and
  - (ii) GPC's achievements in securing premises investment over the last few years.
308. LANCASHIRE COASTAL: That conference opposes the future privatisation of NHS Property Services Ltd and calls for it to remain in the public sector, noting that it is currently 100% owned by the English Secretary of State for Health.
309. MID MERSEY: That conference calls upon NHSE to fully fund practices' legal costs where there is a requirement for a change in lease arrangements in LIFT buildings as a result of the NHS reorganisation.
310. EAST SUSSEX: That conference demands transparency in the objectives and actions of NHS Property Services and Community Health Partnerships and:
- (i) management of their conflicts of interest as significant landlords and simultaneous provider of technical support and advice to NHS England
  - (ii) explanation, discussion and resolution of the intended and unintended consequences of the full cost recovery model
  - (iii) rapid resolution of legacy issues
  - (iv) nationwide agreement on fair service charges.
311. LAMBETH: That conference:
- (i) expresses concern that NHSE refuses to reimburse premises costs in advance meaning that practices have to bankroll huge costs
  - (ii) calls upon GPC to negotiate a mechanism with NHSE whereby practices present the invoice for premises costs directly to NHSE who pay the premises cost directly, so the monies do not have to come through the practice, unless the practice owns the building.

## NEW MODELS OF CARE

312. DORSET: That conference believes that integrated care is the way forward – as opposed to the separation of primary and secondary care, which is unsustainable and not the best care for patients.
313. SCOTTISH CONFERENCE OF LMCs: That conference believes that, for general practice to prosper and become a more positive career option for young doctors in training, it must evolve to allow GPs to concentrate on what they uniquely can do and be fully supported by a team of other health professionals.
314. EALING, HAMMERSMITH AND HOUNSLOW: That conference demands the creation of a transformation fund for general practice that supports GPs (including sessional GPs) as well as general practice staff to prepare for the new structures, with recurrent provision for general practice provider organisations (federations / localities / networks etc) to access transformation, management, development and collaborative working funds.
315. DEVON: That conference regrets the inevitable demise of CCGs and their replacement by PACs and/or MCPs.
316. SURREY: That conference supports the principles within the Five Year Forward View that promote excellent general practice.
317. THE GPC That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee:  
That conference believes Sessional GPs should be seen as an asset by practice networks and federations and
- (i) insists they are employed/contracted by such organisations under favourable terms and conditions
  - (ii) urges networks and federations to ensure such GPs have adequate access to career progression and development
  - (iii) asks GPC to strongly promote the use of the salaried model contract by these organisations.



318. SURREY: That conference applauds the continuing efforts of general practitioners to lead developments in future healthcare delivery and that they should be supported in doing so.
319. NORTHERN IRELAND CONFERENCE OF LMCs: That conference affirms its support for a pharmacist to be employed in every practice in the UK equivalent to a full time pharmacist per average practice size.
320. NORFOLK AND WAVENEY: That conference asks GPC to push NHSE to ensure planning to design services starts at least six months in advance to ensure the specification is fit for purpose and providers have time to plan appropriately.

## GP PARTNERSHIPS

321. CENTRAL LANCASHIRE: That conference views with alarm the growing unattractiveness of being a GP principal as market forces and a shortage of GPs mean that locum costs are forced significantly higher.

## PRIVATE FEES / NHS WORK

322. EDGWARE AND HENDON DIVISION: That conference affirms that GP practices providing services under a GMS or PMS contract are NHS providers, bound by specific NHS regulations, and conference totally refutes erroneous suggestions or claims of such GP practices being 'private' providers of services in the NHS.

## CONTRACT NEGOTIATIONS

323. MID MERSEY: That conference is dismayed that fit notes are unfit for purpose and calls on the GPC to negotiate urgent reforms.
324. BEDFORDSHIRE: That conference instructs GPC to negotiate the removal from the GMS contract of the requirement to carry out a visit when appropriate.
325. HERTFORDSHIRE: That conference instructs GPC to focus its negotiation efforts to ending the purchaser provider split and improving collaboration.
326. SOUTH ESSEX: That conference instructs GPC to only engage in formal negotiations about a change to the Carr-Hill formula within the context of a full review of current and future trends in overall general practice funding, workload and its workforce.
327. AYRSHIRE AND ARRAN: That conference seeks recognition for the non-clinical work in practice and calls for negotiation of a new contract for general practice to remunerate these 'supporting clinical activities' in the same manner as our consultant colleagues.
328. LAMBETH: That conference believes that the publication by HSCIC of the mean GP income is wrong and misleading in many ways and calls on the GPC to demand that the HSCIC excludes premises costs, that practices have a chance to confirm and validate the information before it is published and that practices are able to add explanatory notes.
329. SOMERSET: That conference requires GPC to seek urgent discussions with NHS England about the GP contract with a view to:
- (i) ensuring that whenever a current GP contract is given up, area teams can use whichever contract vehicle is most appropriate, not just APMS
  - (ii) replacing current PMS and GMS with a single new national contract (GPMS)
  - (iii) more closely defining the content of the contract to explicitly exclude transferred secondary care work
  - (iv) allowing greater flexibility for current GMS and PMS contract holders to take different forms, including limited liability partnerships and community interest companies
  - (v) supporting contract holders to work co-operatively to ensure the sustainability of local primary care.

## NHS 111

330. CUMBRIA: That conference believes that the communication from 111 is of such a standard it should be used as a template for all NHS communications.
331. DEVON: That conference suggests that anyone wishing to attend A&E should be required to phone NHS111 first.

## OTHER MOTIONS

332. BRADFORD AND AIREDALE: That conference believes that the Quality and Outcomes Framework in the 2004 contract succeeded, where other funding mechanisms have failed, by rewarding GPs and practices who provided better care with higher funding, and as such the GPC should work to support a national QOF rather than let it be disbanded.
333. NORTHAMPTONSHIRE: That conference demands that all harebrained ideas and initiatives are passed through a bovine waste filter and exposed to a reality check before they are announced to the media and the wider public.
334. HARINGEY: That conference demands that the NHS and Department of Health places primary care at the heart of its work as primary care undertakes 90% of work in the health service which would collapse without it.

335. DEVON: That conference would like to know what happened to the following and have they all gone to the same place:
- (i) clinical senates
  - (ii) Andrew Lansley
  - (iii) Lord Lucan.
336. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is extremely worried about the negative impact that coroners court procedures can have on the health and well-being of a practitioner. It urges the GPC to work with the relevant authorities and help bring about a more consistent and structured approach to such proceedings which are fair and proportionate. In particular it asks the GPC to help ensure that no more than two family members are allowed to question the doctor.
337. AYRSHIRE AND ARRAN: That conference believes that where geographically practical, nursing homes should be aligned to single GP practices thereby enhancing communication, continuity of care and cost efficiency.
338. DEVON: That conference suggests that the new government should adopt one of the following as their anthem for the NHS:
- (i) we don't know where we're going, we don't know where we've been
  - (ii) you can't always get what you want to
  - (iii) help!
  - (iv) or an alternative as suggested from the floor.
339. GWENT: That conference believes in dragons, Dumbo and Dumbledore, that all politicians have the best interests of the NHS at heart and, now that the general election is pasFt, eagerly awaits the delivery of the funding windfall that will revive the service.
340. SUFFOLK: That conference would like to remind NHS England that Christmas, Easter and bank holidays occur predictably in each and every year and calls upon them to ensure that robust plans are in place early enough for bank holidays to avoid a repeat of the last minute request for practices to open over Easter 2015.
341. GREENWICH: That conference abhors the bullying actions of NHSE which are often at financial cost to practices while it repeatedly fails to deliver on its obligations with no sanction.
342. WEST PENNINE: That conference believes awareness should be raised around the benefits and risks of using social media in primary care.
343. GLASGOW: That conference believes that sanctions imposed by Job Centre Plus are a blunt tool and often cause harm.
344. DEVON: That conference asserts that:
- (i) GPs should be allowed to publicise freely all 'self-referral' NHS services that are available within a locality, and that
  - (ii) GPs who do so should not be vilified by clinicians at NHS England, who through their vilification simply demonstrate how out of touch they are with the realities of life.
345. WILTSHIRE: That conference notes that failing banks were rescued by the Treasury because they were deemed 'too big to fail' and demands that practices at risk of failing financially are offered equivalent financial bail-outs.
346. DEVON: That conference expresses concern at the current rapid turnover of NHS management staff and calls on the government to
- (i) incentivise CCGs and NHS England to allow managers to remain within, and therefore learn properly, a given remit
  - (ii) introduce financial incentives for managers to remain within their given remit.
347. DEVON: That conference demands that the government introduces legislation to force the operators of prospective nursing and residential homes, as part of their application process, to:
- (i) consult with local health agencies regarding capacity
  - (ii) demonstrate that their application can be sustained without negative impact on health services being delivered to the existing population
  - (iii) agree with local practices that those practices have capacity to manage the highly dependent patients that will be transplanted into the practice area.
348. LAMBETH: That conference:
- (i) expresses concern regarding the outsourcing of primary care support services, both nationally (PCS) and locally (CSUs)
  - (ii) notes the approved suppliers list for local primary care support services (CSUs) but stresses the need for the quality criteria to include pay and conditions for employed staff
  - (iii) demands that the national primary care support services are made accountable and are required to attend GPC and / or LMC meetings to be questioned on performance.
349. KENT: That conference instructs the GPC to support sessional GPs to establish locum chambers.
350. HERTFORDSHIRE: That conference calls on GPC to
- (i) remind the media of its social responsibility to encourage and promote general practice for the benefit of the population rather than continuing to undermine it through negative reporting
  - (ii) ensure that it delivers as strong and persuasive message regarding the dire situation facing general practice as that produced by the College of Emergency Medicine which has focused media attention on the lack of resources in A&E.

351. DERBYSHIRE: That conference notes the dissonance in tone and attitude of the mass media concerning the competence and confidence in general practitioners when compared with the more scientific data from formal reputable surveys and therefore:
- (i) can only conclude that there is a government inspired malevolent media campaign against GPs
  - (ii) encourages responsible journalists to be more critical in evaluating data from all sources before building a story.
352. DEVON: That conference asks the BMA to set up workshops for medical journalists so they can learn the important difference between Relative and Absolute Risk Reduction and encourage them to always quote both in any medical news stories.
353. DEVON: That conference calls on the new health secretary to launch a joint campaign with the BMA and RCGP to promote the standing of general practice to the British public.
354. DEVON: That conference requests that due to the national media's wilful manipulation of, or downright refusal to accept, the messages that GPC are sending out the GPC should consider commissioning full page advertisements in the national press.
355. NORFOLK AND WAVENEY: That conference believes that the GPC should be more pro-active in its media 'spin' to promote the excellence of general practice and appear on national media more often.
356. SOUTHWARK: That conference calls upon the GPC to launch a public campaign to raise awareness concerning the challenges facing general practice including:
- (i) an increasing workload arising from increasing requests from secondary, social care and other services
  - (ii) ineffective IT systems that do not migrate the necessary referral forms to general practice systems
  - (iii) high levels of sickness absence arising from overwork and low morale
  - (iv) a loss of practice managers and GP trainees from the profession because it is currently perceived to be an unattractive career
  - (v) out-of-hours (OOH) services are at risk because GPs are too overworked to do shifts.
357. GLOUCESTERSHIRE: That conference believes the practice of medicine has moved too far from being an art and too far towards being a science and asks the GPC to explore ways to reverse this trend.
358. COVENTRY: That conference believes that Dr Nagpaul has set the sartorial bar at a level unlikely to be surpassed which is only matched by his excellent orations.
359. AVON: That conference applauds the BMA's decision to host a debate in 2015 on physician assisted suicide and now calls on the BMA to schedule further debate on the ethics of life-prolonging treatment in circumstances where it will not enhance and indeed may harm the quality of life.
360. NOTTINGHAMSHIRE: That conference, while being actively supportive of the principles behind safeguarding legislation:
- (i) is concerned that Health and Social Care institutions have fallen victim to a debilitating obsession with safeguarding, which is causing them to make unrealistic and unnecessary demands of GPs at a time when they are already struggling to meet the healthcare needs of their patients
  - (ii) requests the GPC to investigate and report on this development and urges all interested parties to apply legislative requirements with reasonableness and common sense.
361. HERTFORDSHIRE: That conference is sorely disappointed that despite this being conference policy for several years, GPC has failed to ensure adequate funding for safeguarding in general practice and calls on GPC to listen to conference on this issue.
362. BEDFORDSHIRE: That conference instructs the GPC to develop and negotiate a brief, simple, universal form for safeguarding in order to better protect children and vulnerable adults.
363. LIVERPOOL: That conference believes that our current safeguarding policies in relation to sexual abuse are manifestly failing and children cannot be adequately protected unless the problem is addressed at source; this includes identifying those at risk of becoming perpetrators, allowing people to seek help without being immediately criminalised and putting in resources to looking at what, if any, therapies might be beneficial.
364. SOMERSET: That conference asserts that 'complex care' is the role that GPs are trained, experienced and support in providing, and that inventing other pathways is wasteful and fruitless.
365. CENTRAL LANCASHIRE: That conference believes that at a time of increasing genuine demand on GP's time, a wholly unnecessary extra burden is being imposed by the fragmentation of services being commissioned along dis-integrated patient pathways, leading to increased risk of elements of services being missed and forcing GPs to make less efficient use of their time, acting as the referral link or gap-filling when they could be seeing patients in need of medical care.
366. DEVON: That conference encourages GPs not to jump on the first train leaving the 'NHS policy and ideas' station before they know exactly where it is going and this could be achieved by:
- (i) incentivising different ideas in different parts of the country
  - (ii) avoiding previous central management strategy of 'one size fits all, first on get the best seats'
  - (iii) making decisions based on well researched evidence rather than how many have boarded the train because it looked to be a financially good idea at the time.
367. GWENT: That conference believes in the concept of public service and that some services are too important to be left to the vagaries of the market place, with the NHS at the top of the list of such services.

368. GWENT: That conference deplores the piecemeal privatisation of parts of the NHS, believes that the service works best as a unified whole and insists that those services that are purchased from large private companies are effectively commissioned within the NHS umbrella as soon as possible.
369. NEWCASTLE AND NORTH TYNESIDE: That conference believes that the large proportion of NHS contracts that have been won by commercial companies since the 2012 Health and Social Care Act represent real privatisation of the NHS under the 2010-2015 coalition government.

## REGULATION, MONITORING AND PERFORMANCE MANAGEMENT

370. AVON: That conference calls on the GPC to clarify the rules governing payments to GPs while they are suspended from the performers list, pending investigation into their performance and while conditionally included during a period of retraining.
371. GLOUCESTERSHIRE: That conference calls on the GPC to negotiate improvements to NHS Choices so that it becomes fair and fit for purpose:
  - (i) only registered patients or previously registered patients of the practice should be allowed to make comments
  - (ii) those commenting should be identifiable to the practice to enable comments to be followed up
  - (iii) comments should be limited to one per patient per year
  - (iv) a much greater emphasis should be placed on the risk of defamation and robust action should be taken against the perpetrator where defamation occurs.
372. WORCESTERSHIRE: That conference believes it is time for a regulatory authority with enforceable standards to be established for senior NHS managers so that they are made accountable in the same way as doctors are to the GMC.
373. HERTFORDSHIRE: That conference calls upon the GPC IT Subcommittee to work with NHS Choices in providing greater transparency for patients, the profession and public alike in reducing vexatious and unfounded comments by insisting on verifiable poster identification and the banning of anonymous remarks, be they positive or negative.
374. DERBYSHIRE: That conference, with regard to medical education and regulation, reminds the government, educators, and regulatory bodies that the NHS is not the medical profession and the medical profession is not the NHS.
375. BEDFORDSHIRE: That conference believes that the Friends and Family Test raises the unrealistic expectations of patient still further, adds nothing to the delivery of evidence-based, professional healthcare, and calls on the GPC to demand its immediate withdrawal.
376. COUNTY DURHAM AND DARLINGTON: That conference is concerned over the use of the primary care web tool as a tool for performance management by CCGs / area teams/CQC and other such bodies.
377. GATESHEAD AND SOUTH TYNESIDE: That conference believes that the exclusion of an LRC nominated representative as a quorate member on the professional advisory groups and performer's list decision panels of NHS England is a mistake and will lead to lack of confidence in the processes.
378. KINGSTON AND RICHMOND: That conference notes that visits to GP practices by Healthwatch must be consistent and planned in advance by the practice involved.
379. WAKEFIELD: That conference has no faith in the quality and aptitude of either the GP outcome standards or the GP high level indicator web tools as a means for determining the quality of general practice and are, at best, misleading.
380. THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs Subcommittee:  
That conference believes, in the interest of transparency, that NHS England should publish differences in successful revalidation rates between partners, salaried GPs, locum GPs and responsible officers.
381. HIGHLAND: That conference applauds the magnificent efforts of those healthcare workers that commit to voluntary work, with some even brave enough to help to tackle Ebola, and insists that any revalidation process must be capable of supporting such unique clinicians.
382. ROCHDALE AND BURY: That conference acknowledges the role of the GMC, but fails to understand the way it treats primary care physicians.
383. NORTHAMPTONSHIRE: That conference demands that CQC inspectors are given higher rates of pay to attract more experienced doctors away from core medical services and so drive up quality.
384. MANCHESTER: That conference believes CQC should honour its statutory agreement to involve LMCs in inspections to ensure local intelligence and support can be provided.
385. BRADFORD AND AIREDALE: That conference believes that until there is equitable funding between practices, no performance comparisons should be made, or published, by NHS England or the CQC that rank performance on an 'equitable' basis.
386. WALTHAM FOREST: That conference is concerned that the current punitive approach by organisations such as CQC prevents open reflection and learning in general practice to improve patient care. Conference demands that these reports should be used constructively to support practice development.
387. WALTHAM FOREST: That conference demands that CQC provide constructive amalgamated reports to both GPC and the government to identify areas of general practice that require investment.

388. NORFOLK AND WAVENEY: That conference demands a change to the terminology used in rating practices as 'room for improvement' and 'inadequate' fail to convey the true difficulties that individual practices face.
389. HARROW: That conference deplores the CQC's ill thought through regulations related to GP registration and their inflexible application to practice closures and caretaking arrangements, which has resulted in potential harm to patients and unnecessary disruption to general practice, and demands that the CQC work with the GPC and NHSE at a national level to establish appropriate practice support including caretaking arrangements which safeguard patient safety and access requirements while maintaining fair and reasonable treatment of GPs, practices and patients. (Supported by EALING, HAMMERSMITH AND HOUNSLOW)
390. MID MERSEY: That conference believes that there should be only one regulatory body. The profession is tired of multiple regulations and in the interests of patient safety, it further asks that the functions of the CQC should be absorbed into the GMC.
391. EAST MIDLANDS REGIONAL COUNCIL: That conference in respect of Performers List Decision Panels where a contested decision to remove a practitioner from the list is being considered:
- (i) has no confidence in NHS England's ability to handle such cases
  - (ii) believes that such cases should be dealt with by either the Tribunals Service [TS] or the Medical Practitioners Tribunal Service, with panel members who have been through a judicial appointment and training process
  - (iii) requests the GPC to open negotiations with the Department of Health and the Department of Justice to ensure that such cases are dealt with by TS or MPTS, with appropriately appointed and trained panel members.
392. Motion by DERBYSHIRE That conference, in respect of performers list decision panels where a decision to remove a practitioner from the list is being considered and where the matter is contested by the practitioner:
- (i) has no confidence in NHS England's ability to handle such cases
  - (ii) believes that such cases should be dealt with by either the tribunals' service or the medical practitioners' tribunal service and requests the GPC to open negotiations to this end with the Department of Health and the Department of Justice

## MEDICAL INDEMNITY

393. KENSINGTON, CHELSEA AND WESTMINSTER: That conference notes the rising premiums for medical defence and calls upon the GPC to meet with representatives of medical defence organisations to:
- (i) discuss the evidence base used to calculate GP premiums
  - (ii) question the cost variance between MDOs and the disparity of premiums paid by sessional GPs and principals for performing the same type of GP work
  - (iii) request that the letter of good standing required to change medical defence organisation be accurate and factual rather than a 'summary which may not be reflective'.
394. MANCHESTER: That conference believes that private medical indemnity firms should be evaluated, as:
- (i) they restrict GPs returning to work
  - (ii) they are not supportive of GPs undergoing suspension, and
  - (iii) their contracts are not always fit for purpose.

## CLINICAL AND PRESCRIBING

395. AVON: That conference deplores the fact that doctors are increasingly judged by the standards of NICE guidelines, which are in themselves questionable on occasions, rather than the tried and tested Bolam test. It calls on GPC to lobby the government to:
- (i) ensure that the Bolam Test remains the standard test for breach of duty in clinical negligence cases
  - (ii) to introduce a system of no fault compensation for victims of medical accidents.
396. AVON: That conference unequivocally supports the immediate introduction of the new meningitis B vaccine into the infant immunisation programme, and urges GPC to publicly lobby the government to rapidly conclude its negotiations with the manufacturer to prevent any further avoidable deaths.
397. WEST PENNINE: That conference believes controlled drug prescriptions should be supplied electronically.
398. DERBYSHIRE: That conference informs the public, the press and politicians that there is no magic observation or single test or scan which allows a doctor (or anyone else) to distinguish instantaneously and accurately between a person who is or is not suffering from cancer, dementia or the early prodromal stages of heart attacks, strokes, meningitis and many other conditions.
399. DERBYSHIRE: That conference recognises that cardiovascular risk assessment, the identification, management and treatment of those at risk is an important task for any service that wishes to be seen as a 'health service', but:
- (i) it doesn't just happen, and needs to be paid for, and
  - (ii) it should be undertaken at a national level, in a 'National Health Service'
  - (iii) and directs negotiators to so negotiate, even if it means an increase in the size of QOF.
400. DERBYSHIRE: That conference recognises the 2ww (two week cancer referral maximum wait to first outpatient appointment), although sometimes helpful, often means that patients who have been diagnosed as having cancer, or who are very likely to have cancer actually have to wait longer than they would have done in the past because priority is given to the management priority of seeing patients approaching the 2ww target, rather than clinical priority and:
- (i) requests the BMA to raise this again with NHS management
  - (ii) suggests that an average wait time to first outpatient appointment target may be more appropriate.

401. DERBYSHIRE: That conference notes with approval that teenage pregnancy rates in the UK have fallen to the lowest rates in over 45 years, although still the highest in Western Europe. Conference recognises that the marked fall that started in 2009 is likely to have been largely because of the emphasis on long acting reversible contraceptives (LARCs) and calls on GPC to:
- (i) negotiate the inclusion of CON002 for giving advice on LARCs back into QOF
  - (ii) negotiate that the fitting and removal of LARCs should move back into the national NHS contract as a directed enhanced service.
402. EAST MIDLANDS REGIONAL COUNCIL: That conference notes with approval that teenage pregnancy rates in the UK have fallen to the lowest rates in over 45 years, although still the highest in Western Europe, and recognises that the marked fall that started in 2009 is likely to have been largely because of the emphasis on long acting reversible contraceptives (LARCs). We therefore call on GPC to:
- (i) negotiate the inclusion of CON002 for giving advice on LARCs back into QOF;
  - (ii) negotiate that the fitting and removal of LARCs should move back into the national NHS contract as a directed enhanced service.
403. CLEVELAND: That conference calls for a much lower prescription charge, say £1 per item, to be levied on all patients with no exemptions in order to encourage patients to understand that the NHS costs money and that they need to use NHS services more responsibly.
404. LINCOLNSHIRE: That conference believes that conflicts of interest should always be declared. Conference thus promotes that whenever a doctor recommends a medication not on a local formulary, for another doctor to prescribe for a patient, any sponsorship or similar financial inducement, received by the recommending doctor in the previous two years, provided by the medication's manufacturer, should be declared in this recommendation.
405. MORGANNWG: That conference demands the availability of phlebotomy in the community to assist GPs in the management of patients with complex conditions and needs.
406. DEVON: That conference believes that following the perceived failure of this year's flu campaign following statements by the national media (including the BBC) that 'the influenza vaccine is only 3% effective':
- (i) the NHS must fund a national televised advertising campaign in September explaining the importance of a flu vaccine
  - (ii) if there is no concerted public health campaign above and beyond that normally provided then the GPC should negotiate strongly to significantly reduce the high percentage target uptakes of flu vaccination in the at risk groups.
407. DEVON: That conference agrees with the chief medical officer that the threat of antibiotic resistance is as serious as that of terrorism and we need to act now in order to prevent thousands of preventable deaths in the future by asking the government
- (i) to indemnify financially any GP sued for failure to prescribe antibiotics
  - (ii) instruct CQC, GMC and other regulators to disregard all complaints based on failure to prescribe antibiotics
  - (iii) introduce emergency powers similar to anti-terrorist legislation to achieve the above if that proves necessary.
408. LIVERPOOL: That conference believes that GPs should be spending a greater proportion of their time dealing with reactive problems, something that GPs have been trained to do and is of benefit to patients, rather than spending time and resources on wholesale indiscriminate screening, for which the evidence base is poor.
409. SHROPSHIRE: That conference believes it is illogical to inform patients that they have a life-long condition such as type 1 diabetes or epilepsy and then require them to reaffirm, every five years, that they still have the condition and asks that this anomaly be corrected.
410. CORNWALL AND ISLES OF SCILLY: That conference believes that the transfer of prescribing for all patients to general practice:
- (i) treats practices as pharmacological vending machines
  - (ii) is intrinsically unsafe
  - (iii) devolves all prescribing responsibility to primary care
  - (iv) increases workload.
411. AVON: That conference calls on GPC to negotiate a change in legislation to allow instalment prescribing of medications such as antidepressants, to minimise risk of overdose and suicide, whilst avoiding penalising the patient with multiple prescription charges.
412. KENT: That conference seeks change to the pharmacy regulations so that a pharmacist unable to supply a prescribed item gives a list of available alternatives when referring the patient back to the prescriber.
413. MORGANNWG: That conference instructs GPC to seek legal advice as to whether nurses in the community require drug administration charts to be completed by the GP when the script as dispensed carries a label with full details re dosage and administration.
414. OXFORDSHIRE: That conference believes that winter demands on general practice and A&E now justify reconsideration of offering flu immunisation to the whole UK population

## FUNDING FOR GENERAL PRACTICE

415. AVON: That conference asks GPC to negotiate increased primary care funding for young people's healthcare, such as in mental health, sexual health, and other 'Cinderella' areas of our contract. The health of our future generation is at risk from chronic underfunding, and cuts which need to be halted and reversed.
416. BRADFORD AND AIREDALE: As the proportion of old people in the UK population rises, conference demands that the H&SC budget should form a single pot, with a fixed proportion of it assigned to primary care to enable general practice to take on the additional work required to provide integrated care for vulnerable patients within this group without which their care would become increasingly fragmented.

417. COVENTRY: That conference believes that without primary care that is fit for purpose all attempts to address the pressures on A&E and secondary care will fail, primary care must have the personnel and facilities necessary to deliver the services inherent in its name. In order to do this it must be properly resourced.
418. NOTTINGHAMSHIRE: That conference views with alarm the 'Devo max' experiment currently taking place in Manchester and contends that, in deliberately blurring the distinction between NHS services which are free at the point of delivery, and social care which is increasingly means tested and paid for by recipients, it threatens the existence of the NHS as it is understood and valued by the public.
419. DERBYSHIRE: That conference highlights the inflexible thinking of NHS England when distributing resources towards policy objectives and insists that local discretion is permissible by area teams and their successors following consultation with the relevant LMC. GPC is instructed to negotiate accordingly.
420. EAST MIDLANDS REGIONAL COUNCIL: That conference highlights the inflexible thinking of NHS England when distributing resources towards policy objectives and insists that Area Teams and their successors should be empowered to respond to local need, following consultation with the relevant Local Medical Committee. GPC is instructed to negotiate accordingly.
421. DERBYSHIRE: That conference insists that where a practice list size increases rapidly, for example the acquisition of a large block of patients from a failed neighbouring practice; capitation related payments should be payable from the first day of registration and not from the first day of the next quarter. GPC is instructed to negotiate accordingly.
422. EAST MIDLANDS REGIONAL COUNCIL: That conference insists that where a practice list size increases rapidly, for example the acquisition/allocation of a large block of patients from a failed neighbouring practice, capitation related payments should be payable from the first day of registration and not from the first day of the next quarter. GPC is instructed to negotiate accordingly.
423. EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the cuts to NHSE support staff and their expertise, which has resulted in reductions in practice cash flow, resulting in increased stress and impaired morale for practice teams, and demands that NHSE provide additional funding to employ more staff to support practices.
424. GWENT: That conference:
- (i) welcomes the report of the Commonwealth Fund that shows the NHS to once again be the most cost effective health service in the developed world
  - (ii) believes that this efficiency is largely due to the contribution of primary care in the UK
  - (iii) urges governments to increase taxes to support health services and keep health care free for all citizens at the point of need.
425. GWENT: That conference notes that the average funding per patient in England would not buy a subscription to a respectable Sunday newspaper and urges the Department of Health and the Health Secretary to publicly acknowledge the fantastic job that GPs do on such a shoestring budget.
426. GATESHEAD AND SOUTH TYNESIDE: That conference believes that primary care mental health services are wholly underfunded and require considerable additional resource. This is to enable more responsive and appropriate care and to prevent escalation of need into a crisis.
427. BARNET: That conference deplores the under staffing of the NHS England payments team as:
- (i) unfair to their employees, who are in danger of burnout
  - (ii) disrespectful to practices
  - (iii) disrespectful to patients
  - (iv) undermining to patient care, as staff are called away from their core work and under resourced for their core work
  - (v) data and computer payment systems are fit for purpose and demands that NHS England urgently look at the lack of appropriately trained staff and processes of the payments teams.
428. ENFIELD: That conference demands that general practice be better resourced and supported to improve patient outcomes to reflect the part that primary care plays in patient pathways.
429. HARINGEY: That conference deplores the reduction in core funding for general practice and demands that the UK Government reconsiders its decision to remove funding for deprivation. Improved core funding is essential to the viability of general practice services.
430. NORTH STAFFORDSHIRE: That conference demands the repatriation of 2-3% of the NHS total budget to general practice, to balance the disinvestment of the last five years.
431. DEVON: That conference calls on the new health secretary to announce a doubling of resources for general practice over the life of this parliament as the only means of saving the service.
432. DEVON: That conference proposes that the government properly invests in general practice and shows courage in providing funds to stabilise the jewel of the NHS.
433. SHROPSHIRE: That conference believes it is wrong that funding arrangements in general practices allow such marked inequity that, within the same county, some practices receive four or five times the resources per patient than others.
434. EAST SUSSEX: That conference believes the current funding arrangements for general practice are:
- (i) excessively and unnecessarily complicated
  - (ii) require a disproportionate amount of practice management time
  - (iii) result in practices failing to claim for the work they undertake, thus reducing investment in general practice.

435. NORFOLK AND WAVENEY: That conference directs GPC to demand from the Secretary of State for Health a parity of esteem between primary care and secondary care, underpinned by a direction to NHS England to increase general practice funding percentage of total NHS funding within three years.
436. WILTSHIRE: That conference:
- (i) believes that the founding tenet of the NHS has always been that care was to be provided free at the point of use
  - (ii) believes that as long as the principle of free at the point of delivery remains sacrosanct, it does not matter who provides that care - NHS institutions, private companies or third sector enterprises
  - (iii) mandates the GPC to no longer persevere to maintain a single block NHS provider that is unsuited to the 21st Century.
437. DEVON: That conference recognises the proportion of NHS resources going to general practice has fallen from 10% to 7.5% (a reduction of 25%) over the last 25 years whilst the transfer of work out of hospitals into primary care has risen dramatically and in order to address this paradox suggests:
- (i) the motto "25 in 25" be used repetitively with managers and politicians to drive the point home
  - (ii) the GPC ask the new government to announce a costed, timetabled investment strategy to rectify this parlous state of affairs.
438. SOUTH STAFFORDSHIRE: That conference requests the GPC to be realistic and:
- (i) renegotiate our current payments structure insisting the changes are implemented in three years' time
  - (ii) understand that the current one way business relationship cannot survive with global demand on GPs affecting every aspect of their lives
  - (iii) develop an exit strategy for an independent profession truly independent of the NHS if the government cannot agree that the service is buckling under the present unreasonable and frankly childish arrangements.
439. BRADFORD AND AIREDALE: That conference calls for all future pay rises offered to very senior managers (VSMs) to mirror the real term pay reductions GPs continue to endure.
440. GLOUCESTERSHIRE: That conference suggests that some of the fines levied on banks should be used to improve NHS funding, specifically in primary care, rather than donating it all to charities.
441. CLEVELAND: That conference demands that there is an open and honest discussion about the consideration of co-payments from all patients when accessing GP services in order to foster an awareness of the costs of healthcare and to encourage responsible usage of services.
442. DORSET: That conference believes that the principle of co-payment should be allowed in the NHS.
443. CLEVELAND: That conference 'thinks the unthinkable' and encourages an open and honest public discussion by all relevant parties that the only viable way forwards for the NHS is to consider co-payments from patients or the development of an insurance based system.
444. CLEVELAND: That conference 'thinks the unthinkable' and encourages an open and honest public discussion by all relevant parties that the only viable way forward for the NHS to remain completely free at the point of access is to consider limitations on what patients can receive, such as round the clock access and hugely expensive treatments, or that the unpalatable alternative of co-payments from patients or the development of an insurance based system may need to become a necessity.
445. BRADFORD AND AIREDALE: That conference believes that access to care when needed is the greatest strength of the NHS but that free at the point of delivery is its greatest weakness: we call on conference to support a nominal charge of £10 for all GP consultations before demand completely overwhelms general practice.
446. HAMPSHIRE AND ISLE OF WIGHT: That conference deplores the blurring of general practice income streams and calls upon the GPC to negotiate clarity so that patient services can be properly resourced without being spun as general practitioner pay.
447. MORGANNWG: That conference demands GPC, with reference to the unfair situation that presently exists where British GPs are essentially paying for the face-to-face care of tourists and other 'visitors' to the United Kingdom, negotiates an IOS fee outside of the GMS allocation for all those who are entitled to seek acute medical care under reciprocal arrangements before they can return to their country of normal residence.
448. SHROPSHIRE: That conference believes the government should incorporate Directive 2011/7/EU on combatting late payment in commercial situations in the NHS contract held by general practitioners so that practices will be able to claim interest and debt recovery costs if payment has not been made more than 30 days from the date of receipt of the invoice by NHS England or its responsible agent.
449. DORSET: That conference believes that the NHS is under resourced and that it may be timely to consider a 'health tax'.
450. SALFORD AND TRAFFORD: That conference believes that funding for general practice in any integrated system needs to be safeguarded with a one-way barrier that allows additional funding in, but does not allow monies out.
451. SALFORD AND TRAFFORD: That conference believes that the removal of funding from PMS practices over a four year period is ill- judged and likely to destabilise practices. Conference suggests that extending the transition period from four to seven years, in line with MPIG transition, will give PMS practices a greater ability to retain their current staff and allow them to take on additional workload as it is transferred from secondary care.
452. SALFORD AND TRAFFORD: That conference believes that where budgets for health and social care funding are devolved it is vital to ensure that primary care allocation is safeguarded with a one-way barrier that allows additional funding in, but does not allow monies out.



453. LAMBETH: That conference opposes pooled budgets unless it can be guaranteed that the registered list will be respected.
454. NORFOLK AND WAVENEY: That conference directs GPC to demand an end to yearly politicisation of NHS funding through a commitment from the government to increase and maintain NHS funding as a percentage of GDP, at a level comparable European economies.
455. BUCKINGHAMSHIRE: That conference insists the Carr Hill formula must be abolished and:
- (i) all practices be paid a capitation fee for every registered patient
  - (ii) alternative methods found to supplement the capitation fees for patients identified as needing more than normal GP care.

## PRIMARY AND SECONDARY CARE INTERFACE

456. MID MERSEY: That conference believes that:
- (i) introduction of any qualified provider (AQP) service has led to an increase in GP workload
  - (ii) AQP service has caused some patients to receive inferior health care
  - (iii) the minimum standard for an organisation to attain AQP status should include the ability to provide basic services where needed, including appropriate follow up appointments and fit notes.
457. AYRSHIRE AND ARRAN: That conference demands that the seemingly wide-spread cancellation or postponement of secondary care clinic appointments stops now.
458. DERBYSHIRE: That conference deplores the fact that ambulance services frequently alter the service that they are prepared to offer, and require GPs to make unreasonable choices in the time frames within which patients should be transported, eg 999 or four hours, and:
- (i) insists that they should ask GPs what they believe is required of them to transport patients to hospital in a timely manner and should attempt to comply with this advice
  - (ii) insists that they should be audited on their success in delivering a service to patients based on this advice and receive appropriate feedback
  - (iii) accepts that GPs should be audited on their use of ambulance services and receive appropriate feedback on the use of the service in comparison to their peers.
459. GLASGOW: That conference believes that it is not the job of general practice to act as a personal assistant or community houseman to secondary care.
460. EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the increasing discharge of vulnerable patients with mental illness into the community without adequate preparation and demands the following:
- (i) acknowledgement that this is not a core GP function
  - (ii) prior assessment of the supporting community services
  - (iii) provision of optional training for GPs and practice staff before any scheme is launched
  - (iv) prior patient consent
  - (v) notification and agreement of the receiving GP
  - (vi) a robust, resourced and deliverable care plan agreed by all related health and social care professionals and the patients themselves, including fast track contingencies in case of deterioration/crisis
  - (vii) supporting resources such as an adequately funded and safe service (preferably a community based multi-disciplinary model, with shared care remaining with specialists) agreed by the LMC including provision of funding for the additional indemnity needed by participating GPs.
461. DUMFRIES AND GALLOWAY: That conference believes that patients deemed palliative still have a right to appropriate acute care.
462. SOMERSET: That conference believes that the growing number of 'fast track' referral expectations should be curbed on the grounds that:
- (i) they distort NHS priorities
  - (ii) some lack evidence of effectiveness
  - (iii) common symptoms such as tiredness become medicalised
  - (iv) the value of time as a diagnostic tool is lost
  - (v) the harms of over-investigation and over-diagnosis are not considered
  - (vi) they are not cost effective.
463. HAMPSHIRE AND ISLE OF WIGHT: That conference believes hospital doctors should be forced to undertake mandatory training in general practice every five years by sitting with a GP for a day.
464. OXFORDSHIRE: That conference believes that In order to reduce the inappropriate attendance at A&E departments, provision of an adequately resourced, parallel GP led minor injury unit should be introduced in all hospitals with A&E facilities.
465. NORFOLK AND WAVENEY: That conference believes that the European Working Time Restrictions have resulted in the reduction in continuity and responsibility of care for patients whilst in secondary care. This has led to poor discharge planning and communication and results in a negative impact on GPs workload.
466. NORFOLK AND WAVENEY: That conference believes respect and communication from secondary care colleagues has reduced and has a negative effect on young doctors' career aspirations in primary care.
467. CORNWALL AND ISLES OF SCILLY: That conference that the current primary and secondary care divide is destroying the NHS and calls on the government to put a stop to the internal market and enable integrated healthcare systems as they will improve patient care.

468. MORGANNWG: That conference believes that the inherently dangerous policy of the follow up not booked (FUNB) list should be resolved as a matter of urgency.
469. CORNWALL AND ISLES OF SCILLY: That conference believes that the implementation of the 'New Ways of Working' model of psychiatric care is:
- (i) causing increased workload in general practice
  - (ii) transferring and unacceptable level of risk onto primary care
  - (iii) unsafe.
470. MERTON, SUTTON AND WANDSWORTH: That conference notes with alarm the recent policy of NHSE registration departments to return misdirected hospital letters to the practice to which they had been sent expecting that they are returned to the hospital rather than using their own information to forward those letters to the correct registered GP and calls upon GPC to instruct NHS E to return to the previous system on the grounds of patient safety.
471. SOUTHWARK: That conference:
- (i) notes the exponential increase in the off-loading of work to GPs to cover early discharge, pre-operative assessment and post hospital discharge follow up requirements
  - (ii) demands that if such work is carried out in primary care, that all the resource implications are fully addressed.
472. SCOTTISH CONFERENCE OF LMCs: That conference believes that Fit to Work notes should be a mandatory component of hospital discharge documentation.

## OCCUPATIONAL HEALTH

473. GLOUCESTERSHIRE: That conference is not surprised at the low uptake of flu immunisation among staff working in general practice, and once again insists that:
- (i) a full, comprehensive occupational health service that provides appropriate immunisations be reinstated for all primary care staff
  - (ii) protection of NHS staff be included as a valid reason for immunisation under the flu programme and be matched with an appropriate fee structure.
474. DEVON: That conference notes with dismay the research showing a twenty fold increase in suicide risk among GPs in performance processes and regards the removal by NHS England of all funding for treatment as:
- (i) a potential risk to patients
  - (ii) short sighted in the middle of a workforce crisis
  - (iii) immoral
  - (iv) potentially criminal as defined by the statute relating to corporate manslaughter.

## PAY NEGOTIATIONS

475. BUCKINGHAMSHIRE: That conference is no longer surprised by the failings of the DDRB:
- (i) which admitted that it has failed over the past 10 years to ensure that GP expenses were adequately reimbursed
  - (ii) which has recommended a 1.16% uplift to practice income which will not cover the known increased expenses while increasing GP remuneration by 1%
  - (iii) and reiterates last year's policy that GPC must ensure that the DDRB is fit for purpose or otherwise seek an alternative method of negotiating GP remuneration.
476. GLASGOW: That conference is concerned that the DDRB can make pay recommendations for GPs without the detailed knowledge of how general practice is funded and managed and also without credible figures on GP practice expenses from year to year.
477. SCOTTISH CONFERENCE OF LMCs: That conference is concerned that the DDRB can make pay recommendations for GPs without the detailed knowledge of how general practice is funded and managed and also without credible figures on GP practice expenses from year to year.
478. EAST MIDLANDS REGIONAL COUNCIL: That conference agrees with the DDRB assertion, on page 'x' of the 2015 DDRB report summary, that its formula has not delivered its intended GMP pay increases for some time, and general practitioners attribute this to a failure by the DDRB to properly account for rising practice expenses despite the presence of robust data from HSCIC. The meeting instructs both the GPC and BMA Council to negotiate accordingly to rectify this error.
479. DERBYSHIRE: That conference demands that a functioning system of global practice expenses assessment and reimbursement is re-introduced without delay.
480. EAST MIDLANDS REGIONAL COUNCIL: That conference demands that a functioning system of global practice expenses assessment and reimbursement is re-introduced without delay.
481. EAST MIDLANDS REGIONAL COUNCIL: That conference expresses its solidarity with its GP colleagues who are, because of a failure of government policy fully to reimburse practice expenses since 2004:
- (i) being emotionally blackmailed into subsidising the legitimate operational costs of the NHS from their own pay
  - (ii) bearing an unfair share of the national austerity burden
  - (iii) forced to accept annual pay cuts on top of the inflationary erosion of pay
- and requires both Council and GPC to strive to quantify and present expenses data to the DDRB and HMG in time for the 2016 DDRB report.

## PENSIONS

482. BRADFORD AND AIREDALE: That conference would like to congratulate the Chancellor of the Exchequer on his announcement regarding Stamp Duty in the Autumn Statement that changed how the duty above each threshold is to be paid. No longer is duty due at a higher rate on the total value when a threshold is exceeded, but only on the amount above the threshold. Would the Chancellor like to consider the same approach for NHS pension contributions to reverse the unfair and heavy handed changes implemented within the 2015 pension scheme in order to stem the ever increasing exodus of GPs leaving the profession in lieu of early retirement and more advantageous employment abroad?
483. NORTH STAFFORDSHIRE: That conference deplores the 2015 GP NHS pension arrangements as not fit for purpose and not fit for GP retention, and together with the latest budget lifetime pension cap and annual allowance changes, are making up to 25% of GPs consider leaving the pension scheme (and some the profession). Also the long-term safety and resilience of the GP NHS pension scheme is beginning to look questionable and unable to be funded from contributions, if this occurs.
484. WAKEFIELD: That conference asks that the pension's debate be re-opened in relation to retirement age. The complexity of general practice is now such that if GPs are routinely working to 67 then their mental capacity to deal with patients could be in question.
485. ROCHDALE AND BURY: That conference urges the government to stop tinkering with the NHS pension scheme.
486. ROCHDALE AND BURY: That conference despises the double impact on the NHS pension scheme for general practitioners from an employer and employee element.
487. AVON: That conference, in the light of ever diminishing benefits of the NHS superannuation scheme, calls on GPC to negotiate with the wider BMA to provide a bespoke pension scheme for doctors that is fit for the future.
488. SCOTTISH CONFERENCE OF LMCs: That conference urges the governments to introduce flexibility to the NHS pension scheme to allow doctors to choose how much of their income they wish to be pensioned.
489. DEVON: That conference asks the GPC executive team to protect GP NHS pensions and to specifically negotiate to achieve the following:
- (i) ensure GPs remain able to defer contributions to the scheme whilst abroad and are not penalised for this on their return
  - (ii) ensure GPs remain able to defer contributions for a year or more if they wish without losing the insurance benefits the scheme provides if they continue to work within the NHS
  - (iii) enable GPs to adjust the amount of salary they submit to superannuation payments on a year by year basis
  - (iv) protect GP Pensions from further government tax grabs
  - (v) attempt to bring some consistency and common sense to the NHS GP pension scheme so that the current benefits are not eroded by having to pay our accountants vast amounts of money to explain the increasingly complex peccadillos.
490. ROCHDALE AND BURY: That conference recognises that the choice 2 option is likely to stop new healthcare staff joining the NHS pension scheme.

## PUBLIC HEALTH

491. MANCHESTER: That conference is concerned about any proposed reductions to public health spending on primary care and believes the amount of money going to public health from central government was protected as there had been a commitment to protect NHS spending for the duration of Parliament.
492. BEDFORDSHIRE: That conference calls on the GPC to campaign for certain state benefits to be dependent on engagement with public health initiatives.

# CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

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# 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.

#### 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. 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.

### 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; 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 response of members of conference to any major debate shall be measured in a manner 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 take of the conference proceedings and the chairman shall be empowered to approve and confirm them.