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General Practitioners  
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# 2018 Conference of England LMC Representatives Agenda

23 November at the Mermaid Centre, London



British Medical Association  
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# Agenda

## To be held on

**Friday 23 November 2018** at 9.30am  
At the Mermaid London, Puddle Dock, London EC4V 3DB

## Chair

Rachel McMahon (Cleveland)

## Deputy Chair

Shaba Nabi (Avon)

## Conference Agenda Committee

Rachel McMahon (Chair of Conference)  
Shaba Nabi (Deputy Chair of Conference)  
Richard Vautreay (Chair of GPC England)

Miriam Kay Ainsworth (Avon)  
Katie Bramall-Stainer (Hertfordshire)  
Roberta King (Dorset)  
Brian McGregor (North Yorkshire)  
Elliott Singer (Waltham Forest)

## Notes

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 21 September 2018. Although 21 September 2018 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 – Jacqueline Connolly – 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 orders to prepare the agenda. A number of motions are marked as those which the agenda committee believes should be debated within the time available. Other motions are marked as those covered by standing orders 25 and 26 ('A' and 'AR' motions – see below) and those for which the agenda committee believes there will be insufficient time for debate or are incompetent by virtue of structure or wording. Under standing order 20, if any local medical committee submitting a motion that has not been prioritised for debate objects in writing before the first day of the conference, the prioritisation of the motion shall be decided by the conference during the debate on the report of the agenda committee.

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

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

Under standing order 20, the agenda committee has grouped motions or amendments which cover substantially the same ground and has selected and marked one motion or amendment in each group on which it is proposed that discussion should take place. Under standing order 28, the agenda committee has scheduled a major issue theme debates.

Attached is a ballot form for chosen motions. The ballot closes at **noon on Friday 16 November 2018**.

## Conference of England LMCs elections

The following elections will be held on Friday 23 November 2018.

### Chair of conference

Chair of conference for the session 2018-2019 (see standing order 63) – nominations to be submitted no later than **10.00am Friday 23 November**.

### Deputy chair of conference

Deputy chair of conference for the session 2018-2019 (see standing order 64) – nominations to be submitted no later than **12.00 Friday 23 November**.

### Five members of LMC England conference agenda committee

Five members of the England conference agenda committee for the session 2018-2019 (see standing order 65) – nominations to be submitted no later than **13.00 on Friday 23 November**.

## Schedule of business

**Friday 23 November 2018**

Item	Time
Opening business	9.30
GP at Hand	10.10
Clinical	10.30
Themed debate – Partnerships	11.20
Partnerships	12.20
Working at scale	12.30
<b>LUNCH</b>	<b>13.00</b>
Regulation	14.00
Practice based contracts	14.20
Workload	14.40
GP retention	15.00
Education and training	15.10
Information management and technology	15.20
Funding	15.40
Premises	16.30
Pensions	16.40
Primary Care Support England (PCSE)	16.50
Chosen motions	17.00
Closing business	17.20
<b>CLOSE</b>	<b>17.30</b>

**OPENING BUSINESS****9.30****RETURN OF REPRESENTATIVES**

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

**STANDING ORDERS**

- 2 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the standing orders (appended), be adopted as the standing orders of the meeting.

**REPORT OF THE AGENDA COMMITTEE**

- 3 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the report of the agenda committee be approved.

**ANNUAL REPORT****9.50**

- 4 THE CHAIR: Report by the Chair of GPC England, Dr Richard Vautrey.

**GP AT HAND****10.10**

- \* 5 AGENDA COMMITTEE TO BE PROPOSED BY NORTH YORKSHIRE:  
That conference with regard to the Secretary of State for Health and Social Care:
- (i) welcomes NHS England's independent evaluation of GP at Hand service
  - (ii) is shocked and dismayed by his flagrant endorsing of the GP at Hand model within the Babylon headquarters
  - (iii) calls upon him to publicly retract his comments that GP at Hand was "good for NHS patients, clinicians... and relieved pressure on other NHS services" until such a time as the report commissioned by his own ministerial department is completed
  - (iv) calls upon him to ensure that existing software used by GPs works appropriately first before continuing to promote GP at Hand
  - (v) cannot have confidence in him if he continues to demonstrate his ignorance of the value, worth and function of general practice by his support for a virtual system incapable of providing holistic care.
- 5a NORTH YORKSHIRE: That conference believes the new Secretary of State for Health has adequately demonstrated his ignorance of the value, worth and function of general practice by his support for a virtual system incapable of providing holistic care and consequently has no confidence in his ability to lead the health service in its current state of crisis.
- 5b AVON: That conference wishes to remind the new Secretary for Health that just because he has a GP at Hand, he cannot continue to squeeze and underinvest in English general practice in the same way his predecessor crushed our profession.

- 5c NORTH AND NORTH EAST LINCOLNSHIRE: That conference calls on the new secretary of state for health and social care, with his interest in IT, to ensure that existing software used by GPs works appropriately first before continuing to promote Babylon's 'GP at Hand' as the solution to relieve pressures on GP services!  
(Supported by Hull and East Yorkshire LMC)
- 5d AVON: That conference wishes to remind the new Secretary for Health that the essential element of continuity of care provided by general practice cannot be replaced by an App.
- 5e AVON: That conference is shocked and dismayed by the Secretary of State for Health and Social Care, flagrantly endorsing the GP at Hand model within the Babylon headquarters; a model which cherry picks fit patients and threatens the viability of GP practices.
- 5f CAMBRIDGESHIRE: GPC England welcomes NHS England's independent evaluation of Babylon's GP at Hand service, and calls upon the Secretary of State for Health & Social Care to publicly retract his comments that GP at Hand was "good for NHS patients, clinicians... and relieved pressure on other NHS services" until such a time as the report commissioned by his own ministerial department is completed.
- 5g HAMPSHIRE AND ISLE OF WIGHT: That conference recognises the possibilities that artificial intelligence and IT advances such as the use of apps to access medical services have a value in the 21st century general practice but it comes at huge expense implications that must be considered and met before the next time the Secretary of State reaches for his phone in his pocket.
- 5h WALTHAM FOREST: That conference is concerned about the potential destabilising effect on general practice of artificial intelligence health providers and is astounded that the new Secretary of State for Health has been so public in his support for one single private provider.
- 5i DEVON: That conference welcomes the new Secretary of State for Health's interest in digital mediums for delivery of health care and requests that IT capabilities are made available to all practices who wish to deliver healthcare in this way.
- \* 6 AGENDA COMMITTEE TO BE PROPOSED BY REDBRIDGE: That conference believes that the rise of out of area alternate primary care providers:
- (i) has the potential to destabilise the local health economy, threatening the viability of the current model of general practice
  - (ii) urges the government to halt the roll out of these models before it has considered the impact on primary care
  - (iii) requires the government to reassess the benefits of online consulting to the patients
  - (iv) instructs the GPC to insist that all providers must offer and deliver a full range of services, equitably, to all patient groups without any exceptions based on age, sex and morbidity or technological competence
  - (v) calls for the abolition of the out of area registration clause in the GMS contract.



- 6a REDBRIDGE: That conference believes that the rise of Internet access to out of area alternate primary care providers undermines the gatekeeping role and;
- (i) has the potential to destabilise the local health economy, threatening the viability of the current model of general practice.
  - (ii) urges the government to halt the roll out of these models before it has considered the impact on primary care
  - (iii) requires the government to reassess the benefits of online consulting to the patients.
- 6b TOWER HAMLETS: That conference instructs the GPC to insist that all providers must offer and deliver a full range of services, equitably, to all patient groups without any exceptions based on age, sex and morbidity or technological competence.
- 6c NEWCASTLE AND NORTH TYNESIDE: That conference calls for the abolition of the out of area registration clause in the GMS contract.
- 6d NORFOLK AND WAVENEY: That conference believes that the current regulatory arrangements for online providers:
- (i) risks causing disintegration in the provision of GP services
  - (ii) poses risks to the workforce both individually and as a system
  - (iii) causes and exacerbates financial risks to practices by cherry-picking patients
  - (iv) has posed risks to patients.
- 6e HERTFORDSHIRE: That conference urgently asks GPC when renegotiating a future England GMS contract, to draw clear lines in the sand around disruptive digital technologies, ensuring that NHS practices will not be decimated by privately supported digital companies on NHS contracts making use of loopholes in the regulations.
- 6f MERTON: That conference calls upon the government to recognise that providing more apps or other forms of digital access will not benefit those who are most vulnerable eg the elderly, the visually impaired and those with significant mental or learning difficulties and that reliance on these may increase health inequalities.
- 6g BEDFORDSHIRE: That conference believes that GPs, who examine nearly every patient, are bewildered as to how an app can perform this function.
- 6h WEST PENNINE: That conference believes Babylon is a solution that provides a technology based service to its patients but does not fulfil the requirement of universal care for all and risks to destabilise other GP practices and CCGs by cherry-picking those with less needs, leading to widening health inequalities. The NHS is for people and we should ensure technologies such as this are made available for ALL patients.
- 6i SOMERSET: That conference recognises that patients should have a free choice of provider of NHS services for consultation and supply of medication but deplores the lack of a level playing field when:
- (i) NHS England threatens contractors with breach of contract notices when they seek to counteract predatory marketing by private online providers
  - (ii) current BMA advice on professional behaviour forces contractors to fight with one hand tied behind their backs

(iii) marketing by some online providers amounts to prescription direction and this should be insisted on by GPC in discussions with NHS England.

- 6j WOLVERHAMPTON: That conference believes whilst the use of technology in delivery of healthcare is welcomed, because the Babylon and GP at Hand systems are permitted to exclude health delivery and planning for complex and chronic cases, the funding they receive from the NHS should be reduced by an inverse Carr-Hill type of funding formula, to be devised centrally, to reflect their ability to cherry pick the easier cases, so that resources are not diverted away from the mainstream NHS, which picks up all the complicated and resource heavy cases, to avoid disadvantaging the other parts of the NHS and the diminution of scarce public funds and conference urges GPC to develop such a funding formula in conjunction with the Department of Health.
- 6k LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon to GPC for practices to have the same contract for online services as new practices.
- 6l HARINGEY: That conference mandates GPC to create a level playing field for GP practices to be able to provide virtual GP services which must include resources to invest in modern technology, funding and training.
- 6m NORTHAMPTONSHIRE: That conference demands that patient registration for general practice services must be inclusive for all and for all types of consultation contact.
- 6n BIRMINGHAM: That conference demands the abolition of the out of area registration regulation which is discriminatory, divisive, fragments the delivery of holistic GP care and lends itself to exploitation for commercial gain by allowing practices to cherry-pick healthy, low workload patients.
- 6o TOWER HAMLETS: That conference calls for the abolition of the Out of Area Registration Clause in the Patient Choice Scheme part of the GMS contract.
- 6p HERTFORDSHIRE: That conference calls on GPC England, when negotiating contractual changes, to abolish the current out of area registration regulations.

## CLINICAL

10.30

- \* 7 AGENDA COMMITTEE TO BE PROPOSED BY HAMPSHIRE AND ISLE OF WIGHT: That conference believes that due to gaps in commissioning GPs are being encouraged to work beyond their competencies in a number of clinical areas and calls on GPC England to:
- (i) ensure that no GP is pressurised by NHS England into prescribing medication outwith their competence due to failures of NHS England specialist commissioning
  - (ii) call on the GMC to amend their guidance on Trans Healthcare as their current guidance is in neither patients nor doctors best interests
  - (iii) negotiate for safe and effective secondary care high risk medical monitoring for patients with eating disorders to be available in all parts of England

(iv) ensure appropriate services are commissioned for the management of substance misuse

- 7a HAMPSHIRE AND ISLE OF WIGHT: That conference believes GPs are being encouraged to work beyond their competencies in prescribing specialist medication for gender identity issues and calls on GPC England to work on guidelines with NHS England.
- 7b DERBYSHIRE: That conference asserts that the management of all substance abuse, which includes prescription and OTC medication, is a specialist service and not part of the GMS contract and instructs GPC to advise NHS England and RCGP accordingly.
- 7c HAMPSHIRE AND ISLE OF WIGHT: That conference notes that the GMC's guidance on Trans Healthcare as it applies to GPs prescribing unlicensed medication is at odds with the duties of a doctor as set out in Good Medical Practice. We believe that no GP should be pressurised into prescribing medication outwith their competence due to failures of NHS England specialist commissioning. We call on the GMC to amend their guidance on Trans Healthcare as their current guidance is in neither patients nor doctors best interests.
- 7d BEDFORDSHIRE: That conference believes
- (i) That it is unacceptable for Eating Disorder Services to expect and to try to force GPs to provide the intensive and high risk medical monitoring needed for Anorexia Nervosa patients and
  - (ii) that safe and effective secondary care medical provision for patients with eating disorders should be available in all parts of England.
- 7e GLOUCESTERSHIRE: That conference is alarmed at the lack of a consultant led eating disorders service across the UK, and insists on a properly organised service that includes ECG and blood monitoring either within the service or commissioned with a suitably qualified clinician (rather than left with the GP).
- 7f LINCOLNSHIRE: That conference notes with great concern the increase in mortality associated with opiate prescriptions in the USA, and in wishing to prevent a similar epidemic in the UK, look to NHS England to do everything to prevent this including the local monitoring of opiate prescribing recommendations from Pain clinics and post surgical procedures for non tumour patients.
- 7g MANCHESTER: That conference notes that despite the increasing desire of the profession to identify and manage prescription drug dependence, there continues to be a lack of resources to help manage these patients in primary or secondary care, and calls on NHS England to correct this without further delay.
- 7h NOTTINGHAMSHIRE: That conference recognises that a number of clinical areas are neglected by CCGs causing patients default to GP care. Examples include gender re-assignment, eating disorders, and autism in adults.

We call on the government to:

- (i) make it compulsory for CCGs to ensure that services are commissioned for all these complex problems
- (ii) that any such services are provided in a timely fashion with a maximum permitted wait for treatment in the same manner as other services.

- \* 8 AGENDA COMMITTEE TO BE PROPOSED BY SEFTON: That conference remains concerned by the introduction of barriers which block GPs from making clinically appropriate referral to secondary care colleagues, so conference instructs GPC to:
- (i) give guidance on the actions they should take when referrals pathways are created requiring GPs to undertake work or actions outwith of their agreed contracts before being able to refer
  - (ii) tackle the surfeit of referral templates and protocols which are resulting in a subtle transfer of workload from secondary to primary care
  - (iii) publicise that CCG referral management schemes and procedures of low clinical value are only about cost cutting and rationing
  - (iv) negotiate with NHS England and government the need to agree an England wide list rather than have postcode lottery decisions.
- 8a SEFTON: That conference remains concerned by the introduction of barriers which block GPs from making clinically appropriate referral to secondary care colleagues. Conference instructs GPC to prepare detailed guidance for LMCs and GPs on:
- (i) the actions they should take when referrals pathways are created requiring GPs to undertake work or actions outwith of their agreed contracts before being able to refer
  - (ii) the actions that they should take when confronted by local referral pathways which block access to nationally funded NHS services
  - (iii) write to all CCG chairs and chief executives reminding them that it is entirely appropriate for a GP to refer a patient for a specialist opinion.
- 8b NORTH YORKSHIRE: That conference believes CCG referral management schemes and procedures of low clinical value are only about cost cutting and rationing, and instructs GPC England to:
- (i) publicise this wherever appropriate
  - (ii) negotiate with NHS England/government the need to agree an England wide list rather than have Postcode lottery decisions
  - (iii) in the absence of any success following the above discussion with NHS England/government, to start a public debate with regards to what the NHS can afford on their behalf to highlight the negative impact and outcomes of their NHS funding decisions.
- 8c BRENT: That conference regrets that GPs do not have reliable access to appropriate professional advice on child mental health and calls upon GPC to work with commissioners and professional bodies to ensure that requests for professional advice cannot be rejected, particularly where there are safeguarding concerns.
- 8d HAMPSHIRE AND ISLE OF WIGHT: That conference deplores the increased general practice workload and delayed patient care caused by the unprecedented rise in individual funding request requirements and calls upon CCGs to:
- (i) limit and reduce the number of situations where individual funding must be applied;
  - (ii) streamline the process to reduce delay for patients and the administrative burden on staff involved;
  - (iii) stop using the process to unfairly ration care for certain patient groups to their detriment, eg the obese awaiting orthopaedic procedures for arthritis who struggle to lose weight as a result of their limited mobility.
- (Supported by Bath and North East Somerset, Swindon & Wiltshire)

- 8e SHROPSHIRE: That conference insists that general practitioners retain the right to refer patients to hospital for an opinion and advice and that, while willing to comply with electronic and proforma based systems, must be assured that referrals will not be rejected because arbitrary criteria are not met or a proforma is incomplete.
- 8f NOTTINGHAMSHIRE: That conference calls for an end to acute trusts insisting that referrals must be made through different proforma, and allows a sensible clinical letter from one highly trained health professional to another.
- 8g DERBYSHIRE: That conference calls upon GPC to tackle the surfeit of referral templates and protocols which are resulting in a subtle transfer of workload from primary to secondary care.
- 8h WORCESTERSHIRE: That conference deplores the use of protocols and proformas by CCGs that actually seek to restrict patient care for financial reasons and requests that GPC should press for the misuse to cease.
- 8i NEWHAM: That conference deplores the continued dumping of secondary care work onto general practice and demands that secondary care is responsible for arranging any investigations required for secondary care to provide advice to general practice or in advance of any secondary care appointments.
- 8j NEWHAM: That conference insists that CCGs commission and fund appropriate services to ensure that there is no increase in GP workload if a community or secondary care service is decommissioned.
- 8k COVENTRY: That conference demands that GPC ensures that with the imposition of the contractual requirement for all referrals to be eReferrals, general practitioners are not forced to use a wide range of proformas. Imposition would increase rejected referrals and effectively lead to the rationing of secondary care services due to bureaucratic hurdles. This would enable CCGs to ration secondary care whilst making it the responsibility of the GP to explain this to patients and face all the subsequent fall out.
- 8l NOTTINGHAMSHIRE: That conference calls for an end to acute trusts insisting that referrals must be made through different proforma, and allows a sensible clinical letter from one highly trained health professional to another.
- 8m NEWHAM: That conference deplores the continued dumping of secondary care work onto general practice and demands that secondary care is responsible for arranging any investigations required for secondary care to provide advice to general practice or in advance of any secondary care appointments.

- \* 9 AGENDA COMMITTEE TO BE PROPOSED BY HAMPSHIRE AND ISLE OF WIGHT: That conference states, general practice is NOT an emergency service and calls upon GPC England to:
- (i) condemn those ambulance services who downgrade calls from GP practices for emergency ambulance, thereby putting seriously unwell patients at risk due to delay in response times
  - (ii) address the mission creep in out of hours general practice in providing stop-gap, unsafe emergency care to plug deficiencies in our under-funded ambulance service
  - (iii) demand an evaluation of 111 in England to ensure value for money and appropriate signposting to other services
  - (iv) declare that the diversion of GPs or practice staff to immediately attend local emergencies in place of ambulance staff is a misuse of primary care resources.
- 9a HAMPSHIRE AND ISLE OF WIGHT: That conference condemns those ambulance services who downgrade calls from GP practices for emergency ambulances, thereby putting seriously unwell patients at risk due to delay in response times.
- 9b DERBYSHIRE: General practice is NOT an emergency service. Conference calls on GPC to address the mission creep in OOH general practice in providing stop-gap, unsafe emergency care to plug deficiencies in our under-funded ambulance service.
- 9c SEFTON: That conference duly commends the work of ambulance services in England and recognised the challenges upon them, but it is unacceptable that increasingly ambulance service request/expect GP practices to fill in gaps in ambulance service provision by responding to local emergencies in their neighbourhood to apply immediate care i.e. defibrillation, etc, or to accept de-prioritisation of emergency calls made from GPs because of their presence with the patients(s). Conference instructs the GPC to write to all medical directors of ambulance services in England to:
- (i) impress upon them that GPs are not clinically responsible for not contracted for, the provision of clinical supervision required by patient management protocols developed by ambulance services
  - (ii) declare that GPs are not an adjunct of emergency services and that the diversion of GPs or practice staffs to immediately attend local emergencies in place of ambulance paramedic staff is a misuse of primary care resources.
- 9d DORSET: That conference calls for a full evaluation of NHS 111 as it continues to mis-direct patients and overload already stretched NHS services.
- 9e HAMPSHIRE AND ISLE OF WIGHT: That conference demands an evaluation of 111 in NHS England to ensure value for money and appropriate signposting to other services:
- (i) its role in health system care should be to improve efficiency and relieve workload in other services, not to add to it
  - (ii) proposals around direct booking into general practice are poorly thought through, without resource and probably inappropriate in the majority of cases
  - (iii) it will poorly integrate with practice working where triage systems already exist often in a more robust way.

## THEMED DEBATE – PARTNERSHIP

11.20

*The Partnership Themed Debate will be conducted under standing order 50. The motions submitted by LMCs that the Agenda Committee considers are best covered by this themed debate are included in the agenda here, and are numbered TD 1 to TD 12.*

*The Agenda Committee have invited Dr Nigel Watson (Independent Chair of the GP Partnership Model Review) to provide a brief introduction to the debate, as well as a summary of his work thus far, to compliment his [interim report which is available here](#).*

*The themed debate will cover any aspects relating to partnership generally, and the GP Partnership Model Review specifically.*

*All members of conference may take part in this debate by speaking from the microphones in the hall, rather than from the podium, when called by the Chair, with a speaker time limit of one minute per speaker.*

*At the conclusion of the debate a representative of the Chair of GPC England will have the opportunity to respond to the debate, followed by Dr Nigel Watson.*

*The response of members of conference to the debate will then be measured by a test of support of the following statements, written by the agenda committee, using a 1-6 button vote.*

1. *The partnership model: small, large or in networks, is the only model of primary care that the profession will support.*
2. *There should be financial incentives solely available to partners.*
3. *A funded training scheme for GPs wishing to become partners is essential.*
4. *An expanded multi-professional team will support GP partners, reducing the need for an increase in core GMS funding.*

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| TD1 | <p>SURREY: That conference:</p> <ul style="list-style-type: none"> <li>(i) reaffirms its support for the GP partnership model of delivery of primary medical services</li> <li>(ii) urges that any acceptable outcome of the current GP Partnership Review includes a direct financial uplift in GMS Global Sum and/or PMS Global Sum Equivalent.</li> </ul>   |
| TD2 | <p>HAMPSHIRE AND ISLE OF WIGHT: That conference believes that non-GP partners can bring valuable skills and experience to GP partnerships and commends this approach.</p>  |
| TD3 | <p>LANCASHIRE COASTAL: That conference believes:</p> <ul style="list-style-type: none"> <li>(i) that the potential move away from the partnership model of general practice is a leap into the unknown at a time of critical change in both health care and the wider nation as a whole</li> <li>(ii) it is not the model that is broken, but the failure by successive governments to invest in staff, training and premises</li> <li>(iii) that adequately staffed and funded GP partnerships are the potential saviour of the NHS.</li> </ul> |

- TD4 KENT: That conference calls for the BMA/GPC to create a template 'Model Partnership Agreement' to give clarity and confidence to potential new partners.
- TD5 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference wants to keep the partnership model and notes there is a decrease in newly qualified GPs wanting to take up partnerships. To promote partnerships we mandate GPC to work with relevant bodies to help salaried doctors experience partner responsibility whilst being adequately remunerated.
- TD6 MERTON: That conference calls upon the government to strengthen genuine continuity of care in general practice by substantially increasing resources for the attraction and retention in GP principals
- TD7 DORSET: That conference believes that the commissioning by Jeremy Hunt of the GP Partnership Review was overdue but nevertheless is very welcome. Many problems have been identified with potential solutions and conference calls on GPC England to ensure that the government recognises this report and that it is implemented with the utmost urgency for the sake of our patients and general practice.
- TD8 DORSET: That conference acknowledges the excellent work done so far on the 'GP Partnership Review' and looks forward to implementing its recommendations.
- TD9 CLEVELAND: That conference supports NHS England in launching a review of both partnership model and GP premise, and:  
(i) insists on meaningful engagement across the entire general practice profession  
(ii) backs consideration of all suggestions and recommendations however politically uncomfortable or radical some may feel  
(iii) insists that the agreed outcomes are properly resources to ensure success.
- TD10 TOWER HAMLETS: That conference believes that holistic general practice, with continuity of care, from the cradle to the grave is the bedrock of the NHS.
- TD11 BROMLEY: That conference believes that greater resource and support should be given to protecting the current GP partnership model.
- TD12 NORTHAMPTONSHIRE: That conference demands the reinstatement of the basic practice allowance to support the partnership model of general practice.



**PARTNERSHIPS****12.20**

- \* 10 AGENDA COMMITTEE TO BE PROPOSED BY CAMBRIDGESHIRE: That conference calls on GPC England to reduce the inherent risks in the current partnership model that are alienating GPs and pushing experienced GPs into early retirement by negotiating with the government to:
- (i) introduce a form of Limited Liability into the partnership model for contract holders
  - (ii) recognise the financial burden of taking on a partnership by seeking full reimbursement of necessary costs incurred in providing NHS premises
  - (iii) require NHS England to cover staff redundancy costs in the case of list dispersal.
  - (iv) ensure NHS England is obligated to take over the lease of a collapsed practice and act as a tenant of last resort
  - (v) introduce a statutory cap to the liability which can befall a contractor who finds themselves in the position of being “last partner standing”.
- 10a CAMBRIDGESHIRE: That conference calls on GPC England to reduce the inherent risks in the current partnership model that are alienating GPs and pushing experienced GPs into early retirement by negotiating with the government to;
- (i) introduce a form of Limited Liability into the partnership model for GMS-contract holders
  - (ii) recognise the financial burden of taking on a partnership by seeking full reimbursement of necessary costs incurred in providing NHS premises
  - (iii) require NHS England to cover staff redundancy costs in the case of list dispersal.
- 10b BUCKINGHAMSHIRE: That conference believes the financial liabilities upon partners put in the situation of being “last man standing” is unsustainable, unfair and represents an individual level of risk found nowhere else in the NHS, and mandates GPC to negotiate:
- (i) that NHS England be obligated to take over the lease of a collapsed practice and act as tenant of last resort
  - (ii) a statutory cap to the liability which can befall a contractor who finds themselves in the position of being “last man standing”.
- 10c WORCESTERSHIRE: That conference believes the level of clinical and financial risk held personally by GP partners is now unsustainable and demands that GPC seek to negotiate meaningful reductions as part of next year’s GMS contract review.
- 10d AVON: That conference urges discussions with NHS England to allow practices to be given the option of choosing to become a Limited Liability Partnership, with guarantee that if they do they will be able to renew their existing GMS or PMS contract.
- 10e GLOUCESTERSHIRE: That conference, in order to improve recruitment prospects by limiting future partners’ exposure to the risks currently engendered by the present partnership model, requests that general medical services contracts be allowed to be held by legal structures other than partnerships, this to include limited liability partnerships or limited companies.

**WORKING AT SCALE****12.30**

- \* 11 WALTHAM FOREST: That conference believes that working at scale is just one potential solution for the GP crisis and instructs GPC to:
- (i) robustly defend a practice's ability to explore other solutions
  - (ii) challenge NHS England when any practice feels coerced into working at scale
  - (iii) negotiate with NHS England to prevent Local Improvement Schemes (LiS) being offered on a population basis rather than to individual practices.
- 11a KENT: That conference demands the funding of practice based services should be bottom up not top down so that
- (i) funding is routed via practices
  - (ii) the system of funding federations to sub-contract to practices terminates.
- 11b EALING, HAMMERSMITH AND HOUNSLOW: That conference believes that no amount of transformation, efficiency savings and working at scale will help with the current crisis without additional recurrent investment into primary care.
- 11c CAMBRIDGESHIRE: That conference calls on the GPC England when negotiating contract changes to:
- (i) protect the plurality and diversity of models through which general practice is delivered, rather than favouring one model
  - (ii) commit to promoting continuity of care over access
  - (iii) recognise that bigger does not always mean better when looking at the various models for delivering primary care
  - (iv) ensure that contracts do not contain any terms that directly or indirectly discriminate against smaller practices.
- \* 12 AGENDA COMMITTEE TO BE PROPOSED BY NORTH ESSEX: That conference, with regard to Integrated Care Systems:
- (i) demands LMCs are recognised in all potential "ICS" GP Integration agreements as the legitimate representative organisation for general practice
  - (ii) believes they are yet another national scheme based on little or no evidence of benefit
  - (iii) demands they cannot be established without robust documentary evidence demonstrating a significant level of practice support
  - (iv) demands practices should not be financially disadvantaged by declining a voluntary ICP contract.
- 12a NORTH ESSEX: That conference asks GPC to ensure that LMCs are recognised in all potential "ICS" GP Integration agreements as the legitimate representative organisation for general practice.
- 12b NORTH ESSEX: That conference instructs GPC to ensure that practices who choose not to take up the offer of a voluntary ICP Contract do not suffer any financial detriment including retaining equitable access to all funding streams associated with the nationally negotiated GMS Contract.

- 12c HERFORDSHIRE: That conference ask the GPC to negotiate that primary care at scale within integrated care systems should be given the opportunity to horizontally integrate rather than default to a vertical integration with a hospital trust.
- 12d BERKSHIRE: That conference expresses deep concern over the introduction of Integrated Care Systems (ICS) and believes they are yet another national scheme based on little or no evidence of benefit, and:
- (i) calls on GPC to request NHS England provide the evidence base for the formation of these systems
  - (ii) calls on GPC to ensure that practice participation in such systems is voluntary and non-contractual
  - (iii) mandates GPC to negotiate a minimum level of new funding for practices who participate in these systems.
- 12e NORTH ESSEX: That conference instructs GPC to ensure that Integrated Care Systems cannot be established without robust documentary evidence demonstrating a significant level of practice support.
- 12f CITY AND HACKNEY: That conference:
- (i) deplores the absolute lack of transparency and accountability of STP/ACO/ICS Boards in failing to release sufficient information relation to transformation plans
  - (ii) opposes further transformation until STP/ICS plans have been properly exposed to the public, peer scrutiny and debate
  - (iii) condemns the situation whereby CCGs across the country are being forced to comply with ICS/ACS/STP plans by NHS England withholding critical funding unless CCGs fall into line
  - (iv) demands that as a matter of national interest, STP/ICS plans be subjected to independent audit by the National Audit Office before enactment.

**LUNCH****13.00****REGULATION****14.00**

- \* 13 AGENDA COMMITTEE TO BE PROPOSED BY WAKEFIELD: That conference believes CQC visits add an unnecessary burden to the GP workload, contributing to the current workforce crisis, and demands:
- (i) a minimum interval of five years between visits for practices achieving 'good' in the last five years
  - (ii) a minimum 14 day notice period prior to a practice inspection, unless serious safety concerns have been raised
  - (iii) removal of the requirement for DBS checks for every change in practice registration status, instead accepting inclusion on the national performers' list as adequate proof
  - (iv) GPC England clarify where the responsibility lies in following up patients who choose not to accept invitations to national screening programmes
  - (v) GPC England work with the CQC and Health and Safety Executive in absolving practices being censured for premises safety issues where the Landlord is responsible for rectification.

- 13a WAKEFIELD: That conference believes CQC visits add an unnecessary burden to the GP workload contributing to current workforce crisis and stress.  
That conference demands the CQC should work with the practices to improve the standards of care and make visits and inspections a more supportive role.  
That conference demands:
- (i) no more frequent visits than every five years for practices achieving 'good' in the last five years
  - (ii) the CQC must give a minimum 2 weeks' notice to practices unless serious safety concerns have been raised.
- 13b KENT: That conference demands that the CQC remove the requirement for DBS checks for every change in practice registration status and accept inclusion in the performers list as standard proof.
- 13c HAMPSHIRE AND ISLE OF WIGHT: That conference instructs GPC to examine the desirability and feasibility of the CQC developing a Memorandum of Understanding with the Health and Safety Executive such that premises issues which are the responsibility of the landlord can be rectified despite reluctance of the landlords to ensure the safety of the premises and for which CQC currently censures practices despite this being outwith their control.
- 13d WALTHAM FOREST: That conference is concerned that during inspection visits CQC is asking practices what they are doing about patients who are not taking up screening programmes and requires GPC to clarify the responsibility of the GP in following up these patients.
- 13e NORTHAMPTONSHIRE: That conference demands that small practices are given centralised support to help manage increased regulations such as from CQC
- 13f NORTH YORKSHIRE: That conference believes that CQC continues to make excessive demands on practices at a time when resilience, financial stability and morale is low within the profession and demands such over-regulation is curtailed immediately.
- \* 14 MID MERSEY: That conference directs GPC to work to ensure that there is effective independent oversight and review of NHS England performance management procedures in primary care, including performance investigations and the functions of Performance Advisory Groups and Performers List Decision Panels.
- 14a CUMBRIA: That conference believes that decisions about the future career of doctors going through performance committees (PAG and PLDP) is too often made on an arbitrary basis and calls for a level of clarity and consistency when deciding the level of sanction or remedial action to apply.
- 14b MANCHESTER: That conference agrees an overhaul of the existing performance management of GPs is required following the blurring of boundaries and confusion with the various agencies who undertake different aspects; and asks for clarification on which areas of performance are undertaken by whom, using which standards.

- 14c HAMPSHIRE AND ISLE OF WIGHT: That conference believes that in the interest of natural justice GPs should have the option to properly defend himself or herself in person as part of the NHS England complaints procedure.
- 14d MID MERSEY: That, given the operation and impact of NHS England performance reviews in primary care, conference asks GPC to request and collate examples of harmful consequences for GPs and practices arising from inappropriate handling of NHS England investigations, and to obtain senior legal opinion regarding any concerns identified.
- 14e MID MERSEY: That under GDPR regulations GPs have the right to access all personal data held about them by NHS organisations, such as NHS Regional Directorates (including any previously 'confidential' appraisal documentation), and Conference requests that GPC explores ways to help LMCs to facilitate and enable all GPs in requesting such information, to be printed and supplied at the cost of the data controller
- 14f WORCESTERSHIRE: That conference is alarmed that NHS Performance Advisory Groups do not require the attendance of an LMC representative in order to be quorate and demands that:
- (i) LMC representatives are present when GP performer cases are discussed
  - (ii) protection is given to GPs who run Special Allocation Schemes as they are more likely to receive vexatious complaints
  - (iii) whistleblowers are kept informed and updated about outcomes of their cases
  - (iv) when a complaint is not upheld, any record of the complaint be removed from the retained record of that doctor.
- 14g MID MERSEY: That conference insists that, with regards to NHS England performance procedures in primary care:
- (i) there must be clarity about what procedures apply
  - (ii) there must be clarity about what standards GPs and practices are required to achieve
  - (iii) such standards must be based on typical real-world achievements by GPs and practices.
- 14h COVENTRY: That conference expresses concern about the creeping culture of over regulated Performance management and complaints and insists that:
- (i) there should be information available to GP representatives of the breakdown of cases appearing before the Performance Advisory Group committees as there is suspicion that inappropriate cases are now reaching this level
  - (ii) LMC representation should not be restricted for GPs appearing before PAG hearings.
- 14i HAMPSHIRE AND ISLE OF WIGHT: That conference expects that NHS Performance Investigations in general practice should be conducted according to the published NCAS guidance 'how to conduct a local performance investigation'.
- 14j MID MERSEY: That conference considers that the dual roles of NHS England case investigators in primary care performance investigations of both collecting evidence and of making judgements based on evidence must be separated

**PRACTICE BASED CONTRACTS****14.20**

- \* 15 AGENDA COMMITTEE TO BE PROPOSED BY OXFORDSHIRE: That conference believes core funding for general practice has been eroded to the point that it is now unsustainable and unsafe, and
- (i) that annually negotiated adjustments to the GMS contract is a method of negotiation which is failing to address the crisis in general practice
  - (ii) mandates GPC England to negotiate a recurrent global sum uplift at least over and above inflation
  - (iii) calls on NHS England to issue multi-year contracts to general practice to ensure funding stability over the medium-term to support practices to invest and develop
  - (iv) proposes that payments for enhanced services are index linked
  - (v) mandates GPC England to negotiate a wholesale new GMS contract.
- 15a OXFORDSHIRE: That conference believes the current GMS contract is not fit for purpose, and:
- (i) that annually negotiated adjustments to the GMS contract is a method of negotiation which is failing to address the crisis in general practice
  - (ii) mandates the GPC to negotiate a wholesale new GMS contract.
- 15b BUCKINGHAMSHIRE: That conference believes core funding for general practice has been eroded to the point that it is now unsustainable and unsafe, and therefore mandates GPC to negotiate a recurrent global sum uplift at least over and above inflation.
- 15c AVON: That conference calls on NHS England to issue multi-year contracts to general practice to ensure funding stability over the medium-term to support practices to invest and develop.
- 15d KENT: That conference proposes that payments for enhanced services are index linked.
- 15e WIRRAL: That general practice can no longer operate financially with an out of date system which largely pays GP practices for the number of patients registered. We demand an urgent overhaul of the GP contract which reflects the increased consultation rate and shift of work from secondary into primary care.
- 15f LAMBETH: That conference:
- (i) notes the rising rates of consultations with GPs and hence GP workload
  - (ii) deplores the multiplicity of complex funding streams under the GPFV and other initiatives which do not compensate for this increased workload
  - (iii) demands that GPC negotiate adequate investment in the core contract.

**WORKLOAD****14.40**

- \* 16 AGENDA COMMITTEE TO BE PROPOSED BY SHROPSHIRE: That conference, mindful of the clinical risks of excessive workload, believes that:
- (i) an assessment of a GP's commitment should be based on total hours worked rather than sessions
  - (ii) the core contracted hours should be reduced to 08.00 hours – 18.00 hours
  - (iii) a limit of 1500 patients per WTE GP should be set as standard.
- 16a SHROPSHIRE: That conference believes a limit to list sizes would be safer for both doctors and patients and that a limit of 1500 patients per WTE GP should be set as a standard.
- 16b NOTTINGHAMSHIRE: That conference is concerned that the term 'full time equivalent' (FTE) or 'whole time equivalent (WTE) based on current calculations is no longer fit for purpose when describing GP work. It follows that the use of the term 'part-time' should not be used for those who work less than 8-9 sessions when they are working for more than 37.5 hours and demands that the GPC:
- (i) conducts a review on how GP work is accounted for and valued
  - (ii) adopts as its view that a session no longer is an appropriate unit to calculate GP time in.
- 16c SHROPSHIRE: That conference, mindful of the clinical risks of excessive workload, believes that GP practices should have an agreed limit on the number of consultations one doctor should be expected to undertake each day.
- 16d LEEDS: That conference believes it is unsafe to expect any GP to work longer than 10 hours a day on a regular basis and therefore calls for the contracted core hours for GMS and PMS practices to be 8:00 to 18:00.
- 16e SANDWELL: That conference urges the GPC to accept, in the interests of patient safety and quality:
- (i) a reasonable GMS session should consist of 13 consultations per session in 2019, falling to nine consultations, each of 15 minutes duration by 2021 and nine such sessions per week should be provided for every 1500 patients
  - (ii) practitioners who have the personal capacity to safely do so, should be commissioned to do additional consultations, in their own practice or in a hub.
- 16f HEREFORDSHIRE: That conference agree that unsustainable workload is a major factor in the current GP crisis and safe working limits are essential to ensure safety for both doctors and patients.
- 16g NORTHAMPTONSHIRE: That conference demands that a national standard maximum cap be instituted on patient registration per full time GP.

**GP RETENTION****15.00**

- \* 17 SOMERSET: That conference agrees with NHS England that it is important to keep experienced GPs working in primary care and:
- (i) urges GPC to negotiate an incentive scheme with NHS England to acknowledge the expertise of senior doctors
  - (ii) that this should be through a new system of seniority payments based on years of service.
- 17a BRADFORD AND AIREDALE: That conference calls on NHS England to re-establish a seniority scheme with an investment of new money with the aim of encouraging GPs to delay early retirement.
- 17b BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference insists that any GP over the age of 60 doing at least four sessions a week for 30 years or more of clinical work should be given a £25,000 thank you.
- 17c COVENTRY: That conference supports exploring effective ways of retaining GPs over the age of 50 to prevent the haemorrhaging of experience and the weakening of support to younger GPs. We mandate the GPC to lobby NHS England to:
- (i) seek to expand and publicise the GP retainer scheme and increase the funding for both GPs and the practice
  - (ii) consider the reintroduction of a seniority payment to GPs who continue as a partner
  - (iii) review the appraisal and revalidation system to avoid GPs 'timing' their retirement to avoid the onerous process of revalidation.
- 17d GLOUCESTERSHIRE: That conference believes and reminds the government that the only guaranteed way to recruit and retain GPs is by significantly improving GPs' pay and conditions.

**EDUCATION AND TRAINING****15.10**

- \* 18 AGENDA COMMITTEE TO BE PROPOSED BY SANDWELL: That conference believes that access to protected learning and professional development for GPs, allied health professionals, practice managers and staff are vital to maintain quality care and requests that GPC England:
- (i) negotiates a separate ring-fenced budget to fund these sessions in addition to GMS or CCG provision
  - (ii) applies what influence it can to ensure that appropriate material is included in the core curriculum for allied professionals
  - (iii) negotiates a fully funded GP mentoring programme be set up by Health Education England (HEE).
- 18a SANDWELL: That conference believes that access to protected learning and professional development sessions for GP's are vital to maintain quality care and request the GPC negotiate a separate, ring-fenced budget to fund these sessions, in addition to existing GMS or CCG provision.
- 18b HARROW: That conference recognises that medical assistants and care navigators are an asset to the primary care team and calls upon GPC to negotiate for further workforce and education funds to be made available for upskilling, to enable them to further address GP workload pressures.



- 18c SUFFOLK: That conference considers that the generic curriculum followed by nurses and pharmacists in training ill-equips them for work in general practice. At a time when an increasing number of those in allied professions are likely to find a career in primary care, English GPC is requested to apply what influence it can to ensure that appropriate material is included in the courses.
- 18d NORFOLK AND WAVENEY: That conference calls upon GPC to negotiate greater support for practice managers in the form of training and resources to help lead local transformational change.
- 18e DORSET: That conference believes that all GPs should have a regular mentor to facilitate a return to a healthy workforce and therefore maintain high quality care and calls on GPC England to establish a fully funded scheme.
- 18f LEWISHAM: That conference whilst supporting practice development through quality improvement work, requires practice time to be appropriately resourced to deliver this.

## INFORMATION MANAGEMENT AND TECHNOLOGY 15.20

- \* 19 AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference insists that IT infrastructure must:
- (i) provide proper function for clinical use by practices before introducing political wants such as WiFi for patients
  - (ii) meet basic standards agreed with the GPC for connectivity and speed
  - (iii) provide appropriate recompense to practices for failure
  - (iv) include the full reimbursement of practice costs incurred by system and provider changes including the purchase of systems and services for any proposed future working at scale environment
  - (v) include a penalty clause in all future NHS IT contracts securing funding for any unforeseen workload required of general practice following a system failure.
- 19a CLEVELAND: That conference insists that IT infrastructure must:
- (i) provide proper function for clinical use by practices before introducing political wants such as WI-FI for patients
  - (ii) meet basic standards agreed with the GPC for connectivity and speed
  - (iii) provide appropriate recompense to practices for failure.
- 19b WEST SUSSEX: That conference:
- (i) notes the increased workload required of GP practices following identified NHS IT failures
  - (ii) that the workload must be appropriately recompensed by NHS England
  - (iii) future NHS IT contracts should include a penalty clause securing funding for such future workload, if required.
- 19c NORFOLK AND WAVENEY: That conference asks GPC to negotiate reimbursement of system change costs if incurred by practices in the proposed retendering by NHS Digital of a new framework which will replace the outgoing GP Systems of Choice framework and enable the purchase of systems and services fit for a future working at scale environment.

- 19d AVON: That conference is fed up with recurrent IT failures by third parties that result in risk and extra workload for our surgeries and we call on GPC to negotiate a national compensation package when these failures occur.
- 19e KENT: That conference calls for GPs to be properly reimbursed when called upon to remediate IT failures caused outside of practice systems.
- 19f LEWISHAM: That conference whilst supporting the use of digital technology, requires practices to be protected from clinical risk and negative outcomes related to the use of third-party diagnostic and signposting apps.
- 19g WALTHAM FOREST: That conference supports the integration of new technologies into general practice and insists that:
- (i) new funding should be identified to fund this
  - (ii) individual practices should be able to determine the solution that suits their and their patient's need
  - (iii) digital access is included in practice capacity data
  - (iv) any unintended consequence on vulnerable groups of patients are mitigated for.
- 19h LAMBETH: That conference does not believe that NHS Digital has either the capacity or required skills to develop an NHS app as ordered by the Secretary of State and calls upon the project to be abandoned before millions of public funds are wasted on attempting to develop an app, when there are already good apps available to patients which meet their needs.
- 19i NORTH ESSEX: That conference calls on GPC to ensure that the definition of what constitutes core GP IT equipment is updated to reflect new working arrangements thereby ensuring that CCGs retain responsibility for meeting the full cost of system purchases, upgrades, support and cyber security.
- 19j NORTH ESSEX: That conference calls on GPC to ensure that there is adequate investment in baseline IT services before GPs are expected to use more digital aids and complex high data sites and services.
- 19k WAKEFIELD: That conference supports the development of national integrated IT systems between primary care and between primary care and secondary care in order to create a 21st century health service.
- 19l LEEDS: That conference calls on NHS England to make a significant increase in investment in IT to enable:
- (i) the full digitalisation of patients' paper (Lloyd George) records
  - (ii) all practices to be able to offer smart phone consultations when clinically appropriate
  - (iii) all practices to be provided with demand management systems to be used by patients accessing their practice
  - (iv) regular software and hardware upgrades.

- 19m NOTTINGHAMSHIRE: That conference recognises the need for accurate and timely record keeping as well as the need to work efficiently using the NHS resources at hand. IT systems that take up to 20 seconds to open a patient record, to provide acute medication, to review a letter or clinical result even on a 'good day' are now wasting a disproportionate amount of clinical time. Conference demands that:
- (i) government is lobbied for a massive investment in fast, secure IT provision as a matter of urgency
  - (ii) the current complex landscape of general practice IT is simplified to reduce the need for multiple systems, log-ons, passwords etc.
- 19n LAMBETH: That conference insists that the current GP IT systems are not fit for purpose and instructs GPC to negotiate with NHS England:
- (i) a 5 year IT investment plan
  - (ii) a programme to update practice hardware so that the systems can manage current and future processing demand
  - (iii) each consulting room to have two monitor screens to allow viewing of multiple systems at the same time
  - (iv) each practice to have its own dedicated access to HSCN with an agreed minimum bandwidth which is reviewed annually
  - (v) each practice to be migrated onto Voice Over Internet Protocol (VOIP) within 2 years with a dedicated internet connection as a minimum standard.
- 19o BEXLEY: That conference believes that it is essential for the current out-dated operating systems and IT infrastructure of general practice to be reviewed and improved to lay the groundwork for greater technological advances and that this occurs before any further investment is made in the alternative digital healthcare model.
- 19p MID MERSEY: That conference calls for the GPC 'Information management, technology and information governance' policy group to liaise with NHS Informatics and GP clinical system suppliers to consider the development of artificial intelligence solutions to support and improve the management of clinical results in general practice.

## FUNDING

15.40

- \* 20 AGENDA COMMITTEE TO BE PROPOSED BY AVON: That conference, with regard to procedures of limited clinical value:
- (i) calls for proper, evidence-based evaluation of all treatments given this title, taking into account the cost consequences of not providing treatment
  - (ii) calls for an end to acute trusts and CCGs insisting on prior approval being sought before referral for procedures of 'limited clinical value'
  - (iii) welcomes the NHS England consultation on procedures of limited value but demands that the evidence base for its implementation is approved by all stakeholders, including consultants, GPs and the public
  - (iv) believes that many CCGs are inappropriately using the concept of "procedures of limited clinical value" to simply save money.

- 20a AVON: That conference is gravely concerned about the principle of INNF (Interventions not normally funded) which are applied differently across the country, causing unfairness and inequality and the de-professionalisation of GPs and consultants alike. It calls for proper, evidence based evaluation of all treatments given this title, taking into account the cost consequences of not providing treatment in terms of the:
- (i) longer term physical and mental suffering of patients who are denied treatment
  - (ii) additional burden on primary care in terms of extra consultations for explanation of why treatment has been denied, ongoing management of the condition for which treatment had been sought.
- 20b WORCESTERSHIRE: That conference believes that many CCGs are inappropriately using the concept of “procedures of limited clinical value” to simply save money and demands that GPC lobby NHS England to implement a genuine validated national scheme not open to local abuse.
- 20c NOTTINGHAMSHIRE: That conference calls for an end to acute trusts and CCGs insisting on prior approval being sought before referral for procedures of ‘limited clinical value’.
- 20d AVON: That conference welcomes the NHS England consultation on procedures of limited value to reduce the postcode lottery existing between different CCGs but demands that the evidence base for its implementation is approved by all stakeholders, including consultants, GPs and the public.
- 20e TOWER HAMLETS: That conference believes that programmes such as “London Choosing Wisely” are a cover for rationing NHS care and:
- (i) that the way to ensure equity of access to treatments is to fund the NHS properly
  - (ii) calls on the GPC to insist that decisions about patients should be clinically and not financially driven
  - (iii) calls on GPC to oppose such programmes.
- 20f KENT: That conference deplores the postcode lottery for procedures such as IVF and vasectomies and calls for a nationally agreed and publicised ‘Ration Book’.

***At the 2017 UK Conference, the following motion was passed – “That conference instructs the GPC to produce a discussion paper outlining alternative funding options for general practice, including co-payments.” A paper on funding models for general practice was produced. Here is the weblink to the [BMA website](#) and a [link to the discussion paper](#).***

- \* 21 KENT: That conference recognises the dire state of general practice and demands a co-payment model.
- 21a CAMBRIDGESHIRE: That conference, notes the success of the introduction of a nominal charge resulting in the reduction of demand for plastic carrier bags in England and calls on GPC England to lobby for similar measures to be introduced in respect of GP consultations to reduce the ever increasing demand that fuels the current unsustainable workload.

- 21b HERTFORDSHIRE: That conference wishes to see the abolition of the prescription charge in England, and instead supports a nominal charge upon making a patient-initiated GP surgery appointment, to be reimbursed on a means-tested basis as a means of controlling unmitigated demand.

## DDRB

- \* 22 LEEDS: That conference:
- (i) welcomes the DDRB prioritising general practice in its 2018 report
  - (ii) condemns the government for failing to implement the 4% award in full
  - (iii) condemns the government for failing to provide practices with sufficient funding to pay their staff the equivalent of the Agenda for Change award made to other NHS staff
  - (iv) believes the failure of the government to properly invest in general practice will make recruitment and retention of GPs harder
  - (v) calls on the government to establish a truly independent pay review body for doctors, which binds them to award the recommendations made, in the same way that applies for MPs' pay.
- 22a NORTHAMPTONSHIRE: That conference demands that the government is legally bound in future to accept in full the Doctors and Dentists Review Body recommendations, in the same way as MPs awards are accepted.
- 22b SURREY: That conference deplores the failure of the government to implement in full the DDRBs 2018/19 recommendations for general practitioners.
- 22c DERBYSHIRE: That Conference would like to know what is the point of the DDRB if it's recommendations are wilfully ignored by Government.
- 22d SEFTON: That conference deplores the action of the Secretary of State for Health and Social Care in meddling with the DDRB's inadequate pay recommendations for GPs to make them less remunerative. It calls upon GPC in future to use the example of this year's direct negotiations with NHS Employers on GP expenses to secure an extension of collective bargaining to GP pay.
- 22e GLOUCESTERSHIRE: That conference deplores the government's failure to fully adopt the DDRBs 4% recommendation for GPs and respectfully points out that this decision does not encourage an already demoralised, shrinking workforce.
- 22f WAKEFIELD: That conference condemns the continued underfunding of general practice reflected in the government's decision not to fully implement the last DDRB recommendation for doctors.
- 22g HAMPSHIRE AND ISLE OF WIGHT: That conference believes that as the government ignores the recommendations of all public sector pay review bodies, except that charged with determining pay of members of Parliament, that future pay awards should be matched to the award made to MPs.
- 22h HERTFORDSHIRE: That conference asks GPC to negotiate a definitive independent pay review body that the government cannot ignore.

- 22i NOTTINGHAMSHIRE: That conference deplores the decision of the government to decline to follow the DDRB in this year's funding round and calls on the GPC to continue to seek for fair funding for general practitioners before we all take early retirement.
- 22j NOTTINGHAMSHIRE: That conference deplores the decision of the government to decline to follow the DDRB in this year's funding round and calls on the GPC to continue to seek for fair funding for general practitioners before we all take early retirement.
- 22k DERBYSHIRE: Conference notes that GPs are retiring at a rate of knots, and that the workforce is diminishing rather than growing, at a time where the work load continues to rise. Conference demands that the GPC make this very clear to the Department of Health, and demands that GPs cannot be expected to do any more, unless there is a substantial increase in income in line with DDRB recommendations.
- 22l HAMPSHIRE AND ISLE OF WIGHT: That conference condemns the government's actions with regards to the DDRB recommendations on GP pay.
- 22m HAMPSHIRE AND ISLE OF WIGHT: That conference calls for reform of the DDRB, returning to the principles as set out in the recommendations of the Pilkington Royal Commission, with the requisite skills and expertise of membership required to properly determine the remuneration of the profession.
- 22n LAMBETH: That conference wholly deplores the actions of the Department of Health/NHS England in not upholding and adhering to repeated recommendations by the DDRB regarding doctors pay, and instead giving derogatory pay awards that do nothing to help with recruitment and retention of the depleted NHS workforce.
- 22o LIVERPOOL: That conference believes that GPs in England are dismayed that the 45th DDRB has not been implemented in full, with effect from 1 April 2018, by NHS England.
- 22p WORCESTERSHIRE: That conference believes that it is unacceptable for the government to ignore the recommendations of the Doctors' and Dentists' Review Body and acknowledges the detrimental effect on GP morale, recruitment and retention.

## PREMISES

16.30

- \* 23 AGENDA COMMITTEE TO BE PROPOSED BY KENT: That conference insists NHS Property Services, a wholly owned subsidiary of the Department of Health and Social Care:
- (i) is destabilising general practice through unilateral increases in service charges
  - (ii) should immediately withdraw the demands for these unsubstantiated and unfair service charges
  - (iii) should pay compensation to the affected GPs for the expense and distress caused by the dispute over service charges
  - (iv) is recognised by NHS England as an NHS body.

- 23a KENT: That conference is outraged that NHS Property Services, which is wholly owned by Department of Health, is destabilising general practice by attempting to unilaterally increase service charges for its GP tenants, and demands that:
- (i) NHS Property Services immediately withdraws the demands for these unsubstantiated and unfair service charges and pays compensation to the affected GPs for the expense and distress caused by this dispute
  - (ii) NHS England recognises NHS Property Services as an NHS body and invests in these premises as part of the NHS estate.
- 23b REDBRIDGE: That conference demand urgent action regarding the ongoing issue of service charges for practices in premises leased from community health partnerships or NHS property services and insist that:
- (i) service charges are justified
  - (ii) NHS Property Services is required to provide a detailed breakdown of all service charges.
- 23c CAMBRIDGESHIRE: That conference calls on GPC England:
- (i) to recognise the stress the imposition of new service charges, lacking in transparency, is placing on partners providing services from buildings managed by NHS Property Services
  - (ii) to express no confidence in the board of NHS Property Services and to call for the resignation of the Chairman of the Board and Chief Executive Officer.
- 23d DERBYSHIRE: That this conference instructs the GPC and the BMA to press for NHS Property Services to become an NHS body.

## PENSIONS

16.40

- 24 NORFOLK AND WAVENEY: That conference believes that following the identification of GP pension earning discrepancies that:
- (i) NHS England's management of GP pensions has been wholly unacceptable
  - (ii) NHS England must rectify any discrepancies as a matter of urgency
  - (iii) NHS England must pay compensation to any GP who has been affected.

## PRIMARY CARE SUPPORT ENGLAND (PCSE) 16.50

- \* 25 BUCKINGHAMSHIRE: That conference believes that the way Capita Primary Care Support England has mismanaged the GP pension scheme is unacceptable, falling well below expected professional standards and calls:
- (i) for Capita to be stripped of its PCSE contract immediately
  - (ii) on the GPC to issue a formal complaint regarding Capita PCSE to the Pensions Ombudsman
  - (iii) on GPC to demand that any workload or time commitment required on the part of GPs and practices to correct these errors will be financially compensated for.

- 25a SOMERSET: That conference has no confidence in the present provider of Primary Care Support England despite repeated reassurances of improvement from despite repeated contract breaches by NHS England and believes that the current pensions debacle to be the final straw and so:
- (i) calls for its contract to be terminated and taken back into the public sector
  - (ii) demands that the present provider indemnifies the NHS against costs of rectifying the results of its inefficiencies rather than being allowed to walk away.
- 25b HAMPSHIRE AND ISLE OF WIGHT: That conference is appalled (although not surprised) that mistakes have been made by Capita with respect to their handling of GP pension contributions and demands that any and all additional costs incurred by GPs as a result of this are met in full by NHS England.
- 25c NORTH YORKSHIRE: That conference believes that Capita is failing to meet service requirements and demands that NHS England finally strips it of the contract to manage PSCE functions including pensions.
- 25d CLEVELAND: That conference, in respect of NHS England's contract with Capita to provide 'support' to primary care:
- (i) notes that NHS England has £60 million of savings as a result of this contract
  - (ii) demands an immediate payment to practices, individual GPs and LMCs to compensate them for the shambolic service thus far
  - (iii) insists on the immediate reinstatement of names case managers, with specific email and telephone contacts
  - (iv) demands an independent complaints process, with meaningful and timely responses
  - (v) requires on going financial compensation to practices, individual GPs and LMCs from NHS England until a functioning support service is provided.
- 25e KENT: That conference, following the Public Accounts Committee report into Capita, calls for:
- (i) Capita to return primary care support services to local provider
  - (ii) Capita not be awarded any further NHS contracts
  - (iii) an independent judicial review into the procurement and monitoring of Capita's NHS contracts and management of GP pensions.
- 25f AVON: That conference condemns the inadequate service that is being offered by Capita regarding pensions and performers lists and urges GPC to seek financial redress for those affected.
- 25g NORTHAMPTONSHIRE: That conference demands the abolition of the contract with Capita.

**CHOSEN MOTIONS**

**17.00**

**CLOSE**

**17.30**



# Conference of England LMC Representatives

## **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. The Agenda Committee in consultation with the GPC Chair proposes acceptance of a large number of 'A' and 'AR' motions to enable them to be transferred to the GPC. A and AR motions and the procedure for dealing with them are defined in standing orders.

#### CLINICAL

- |          |    |  |
|----------|----|--|
| <b>A</b> | 26 | WEST PENNINE: That conference tasks GPC to demand NHS England sets a level playing field during the flu vaccination season, resulting in fairer distribution and availability of flu vaccines to GP Practices and pharmacies.  |
| <b>A</b> | 27 | GLOUCESTERSHIRE: That conference demands that the Electronic Prescribing System (EPS) be introduced urgently for dispensing doctors, to ensure that rural patients get access to the same service as their urban counterparts.   |
| <b>A</b> | 28 | EAST SUSSEX: That conference requests GPC to negotiate a nationally agreed DNAR template for use across England, and agreed national protocols for its implementation.   |
| <b>A</b> | 29 | WORCESTERSHIRE: That conference demands that: <ul style="list-style-type: none"> <li>(i) dispensing doctors should be entitled to the same reimbursement for IT for the Electronic Prescription Service (EPS) as pharmacists</li> <li>(ii) the GPC to negotiate full funding for EPS for dispensing doctors by NHS England.</li> </ul> |

#### PRIMARY/SECONDARY INTERFACE

- |          |    |   |
|----------|----|---|
| <b>A</b> | 30 | DEVON: That conference recognises the increasing amount of clinical work falling into the gap between primary and secondary care and asks the GPC to formally define this as Intermediate Care within any new contract negotiations with NHS England.   |
| <b>A</b> | 31 | MERTON: That conference calls for an integrated and connected health service with a commitment to delivering care in the community with adequate and supported care organised by a primary health care team.  |
| <b>A</b> | 32 | LANCASHIRE PENNINE: That conference believes that understanding and mutual respect between consultants and GPs is hindered by workload pressures and calls on the BMA to promote national and local programmes to facilitate networking and understanding between the two branches of medicine. |
| <b>A</b> | 33 | KENT: That conference believes that communications to primary care should be paperless.   |
| <b>A</b> | 34 | KENT: That conference demands that any clinical pathways, protocols or service changes which have an impact on general practice are agreed by GPC or LMCs before implementation.  |

- A** 35 LEWISHAM: That conference believes that general practice needs to be perceived as an equal partner in integrated healthcare systems, rather than a conduit for work and risk that other parties are reluctant to take on.
- A** 36 DEVON: That conference is concerned that in an attempt to reduce hospital bed occupancy in some areas of England palliative care patients are being discharged into nursing homes and community hospitals as temporary residents forcing GPs to take on important end of life care without the appropriate funding and resources.
- A** 37 DEVON: That conference is aware that in some areas two week wait does not mean what it says and demands NHS England step in to enforce this when required.
- A** 38 REDBRIDGE: That conference calls for an end to the continued squeeze on health and social care budgets and that government realises that innovation, primary care at scale and joint working across health and social care cannot in itself be successful in delivering the government's health and social care agenda without adequate resources, financial, educational, clinical and managerial.
- AR** 39 HERTFORDSHIRE: Given the level of morbidity in nursing homes, conference urges GPC to negotiate for the NHS to commission a multi-disciplinary care service, overseen by a community geriatrician, for patients in nursing homes.
- AR** 40 BRADFORD AND AIREDALE: That conference demands that all hospitals, including single specialty ones such as psychiatry, should provide primary care services for their in-patients and not expect this to be done by local general practices as part of their PMS/GMS contracts.

## WORKING AT SCALE

- A** 41 LEEDS: That conference believes for primary care networks to function they must be provided with recurrent funding for:
- (i) GP leadership
  - (ii) all practices to engage in its activities
  - (iii) practice manager involvement
  - (iv) administrative support.
- A** 42 NORTH YORKSHIRE: That conference demands that for general practice to integrate with other services and work at scale it requires recurring funding thereby allowing organisation development and a resilient community based management structure to become the new norm.
- A** 43 REDBRIDGE: That conference calls for an end to the continued squeeze on health and social care budgets and that government realises that innovation, primary care at scale and joint working across health and social care cannot in itself be successful in delivering the government's health and social care agenda without adequate resources, financial, educational, clinical and managerial.
- A** 44 EALING, HAMMERSMITH AND HOUNSLOW: That conference demands that if GP at Scale is to be successful then the NHS England needs to ensure that there is adequate recurrent funding made available to pay for these organisations to exist and that GP practices should not be funding such initiatives which are the chosen direction of NHS England.

- A** 45 HAMPSHIRE AND ISLE OF WIGHT: That conference calls for the GPC to negotiate that the New Care Models be adequately funded and properly re-numerate GP's for their involvement.
- A** 46 LAMBETH: That conference demands that if the drive is to merge practices as part of the working at scale agenda:  
 (i) additional resources and investment must be provided to enable clinical leadership engagement with the process  
 (ii) ring-fenced resources, including backfill for clinicians, is essential.
- A** 47 HERTFORDSHIRE: That conference values continuity of care and the registered list above passing trends for provision at scale: which lacks long term evidence of both improvements in patient care and practitioner morale alike.
- AR** 48 GLOUCESTERSHIRE: That conference is not surprised that continuity of care has been scientifically shown to provide a greater life expectancy and requests that the importance placed on primary care networks be thoroughly and scientifically evaluated and continuity of care maintained before all practices are coerced into adopting this method of working.
- AR** 49 NORFOLK AND WAVENEY: That conference asks for GPC guidance in dealing with the emergence of large super-practices and GP federations in order that LMCs may effectively represent general practice and individual GPs.

## COMMISSIONING/STPS

- A** 50 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that GPs have no contractual responsibility for outbreak management, including mass prescribing for prophylaxis, and that this task is a responsibility of Public Health England. Conference instructs GPC to take all steps necessary to ensure that GPs are not coerced into undertaking this inappropriate work.
- A** 51 DERBYSHIRE: The conference demands that GPC inform NHS England that their short-term approach to balancing the books in year, is a profoundly short-sighted approach to funding that risks patient safety and results in commissioning decisions that have the potential to cost substantially more in future years.
- A** 52 BRENT: That conference condemns the underfunding of care for long term conditions in primary care and calls upon commissioners to ensure patient safety by adequately funding appropriate services and care pathways in general practice.
- A** 53 DEVON: That conference demands that engagement of STPs with general practice is not seen as lip service by ensuring there is specific funding within their budgets for GP representatives to attend meetings at all levels within their developing management structures.
- A** 54 MORECAMBE BAY: That conference believes that commissioners see the primary care estate as a free good and have ignored the need to develop the estate as part of the strategic Integrated Care Partnership intentions to transfer services out of hospital.

- A** 55 DERBYSHIRE: That conference calls upon GPC to highlight to NHS England and patients that whilst there is some protection of core GP funding, QIPP schemes that take funding away from secondary care and community services risks general practice picking up the shortfall to maintain patient safety.
- A** 56 DERBYSHIRE: That conference believes that the funding for care in the community is inadequate and that:
- (i) patients are suffering
  - (ii) general practice cannot be the safety net for deficiency in provision of services.
- AR** 57 DERBYSHIRE: The conference deplores the use of emotional blackmail and coercion by CCGs as means to compel general practice to provide unfunded, non-contractual work and calls upon GPC to empower GPs to say 'no'.
- AR** 58 SOMERSET: That conference deplores the cuts forced upon local government to sexual and other public health services and:
- (i) acknowledges that this is putting more pressure on already overstretched practice teams
  - (ii) instructs GPC to call out this unacceptable but entirely predictable result of the fragmentation of health services, and
  - (iii) instructs GPC to reiterate demands for properly funded public health services as being essential to a civilised, modern society.
- AR** 59 KENT: That conference urges the GPC to investigate ways of preventing the deleterious knock-on effects on practices neighbouring those that have access to greater CCG resources because they are failing.

## REGULATION

- A** 60 SURREY: That conference believes in the light of the successful appeal by Dr Bawa Garba, has no confidence in the GMC as a professional regulator.
- A** 61 CLEVELAND: That conference seeks a change to the Regulations to enable GPs on the Performers List in Scotland, Wales or Northern Ireland to work for up to eight weeks in England from the date that they have submitted an application for the England Performers List, or, if longer, such other period as the application takes to be approved.
- AR** 62 OXFORDSHIRE: That conference believes the multiple jeopardy system of complaints against GPs within the NHS is iniquitous, onerous and disproportionately punitive, and:
- (i) believes the system of allowing multiple simultaneous complaints to be made in parallel promotes a blame culture within the NHS
  - (ii) calls on GPC to work with stakeholder agencies to develop a streamlined and fair hierarchical pathway for GP complaints
  - (iii) calls on GPC to demand a system which allows vexatious complaints to be identified as such and more easily refuted.

- AR** 63 MANCHESTER: That conference notes the increasing numbers of ‘complaints’ submitted to NHS general practice surgeries that have no justification based on the NHS contract held by the surgery, published professional standards, or requirements under the Health and Social Care Act and:
- (i) is concerned that responding to these ‘complaints’ takes resources away from patient care and negatively affects the morale of doctors and other surgery staff
  - (ii) has no confidence in the NHS complaints process
  - (iii) calls for a complete overhaul of the NHS complaints process.
- AR** 64 NORFOLK AND WAVENEY: That conference believes that NHS Choices patient feedback is demoralising rather than constructive and calls on GPC to negotiate changes to protect practices and individuals from ill-founded criticism.
- A** 65 CLEVELAND: That conference asserts that the time take to process Performers List applications in England in England is unacceptably long and exacerbates the workforce crisis; conference therefore demands a maximum allowance time target of six weeks and that this be no longer than the time taken in the other UK countries.

## PRACTICE BASED CONTRACTS

- A** 66 NORTHAMPTONSHIRE: That conference demands that general practices have the right to close their patient list when they consider that they have reached capacity to deliver safe patient care.
- A** 67 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon GPC to define core and non-core GP services.
- A** 68 NORFOLK AND WAVENEY: That conference instructs the GPC negotiating team that they cannot allow our core GMS contract opening hours to go beyond 8-6.30 Monday to Friday.
- AR** 69 NORTHAMPTONSHIRE: That conference demands that the process for closing lists is simplified, made transparent and not at the arbitrary judgement of NHS England.
- AR** 70 HERTFORDSHIRE: That conference believes that, where a practice is handing back its GMS contract, the money currently made available for the procurement and delivery of new APMS contracts (including caretaker contracts) should be made available to local practices to take over the running of the practice terminating its contract, under their existing GMS contract.
- AR** 71 SURREY: That conference believes commissioner approval should not be required for a GP contractor to close their list [under the current regulations] for a cumulative maximum period of six months in any two years.
- AR** 72 BIRMINGHAM: That conference believes that GP out of hours services:
- (i) should remain defined as Primary Medical Services
  - (ii) should not be separated into a collection of sub-specialist services under the title of “urgent care”
  - (iii) should principally be aimed at supporting GP practices in providing appropriate patient access to primary medical services at all times.

- AR** 73 MID MERSEY: That conference believes it is wrong that practices do not receive a quarterly payment for newly registered patients who die before the end of a quarter and that this particularly disadvantages practices providing palliative care for patients in the end stages of life and asks GPC to negotiate a quarterly payment for patients in this final period that is at least proportionate to the number of weeks lived prior to death.

## WORKLOAD

- AR** 74 LEICESTER, LEICESTERSHIRE AND RUTLAND: The conference considers that GP appointments are increased from 10 to 15 minutes as a minimum.
- AR** 75 WEST SUSSEX: That conference:
- (i) believes GP workload is unsustainable
  - (ii) demands a cap on the number of patient consultations that can be undertaken by each GP per working day is introduced
  - (iii) that commissioners are responsible for providing NHS services to patients requiring same care once the cap is reached.
- AR** 76 KENT: That conference demands a GP contract which sets a safe daily limit of all patient contacts with
- (i) overflow being funded/provided by additional/enhanced services
  - (ii) the ability for practices to declare a black alert and close to further activity.
- AR** 77 HARINGEY: That conference supports GPC to demand an end to the “all you can eat buffet” view of general practice propagated by the Department of Health and NHS England and calls for the recognition of the increased workload in general practice by increased investment into the global sum.
- AR** 78 BEXLEY: That conference with regards to sick certification:
- (i) notes that a large proportion of time is spent in general practice preparing sick notes for the benefit of DWP
  - (ii) notes that most patients with ongoing chronic issues need occupational health assessment to assess their fitness to work
  - (iii) recognises that GPs are not trained to do this work and there can be untoward medico-legal consequences of signing a sick note when it can be considered fraudulent
  - (iv) requires sick notes for chronic conditions be removed from the GP remit
  - (v) requires hospital teams to fulfil their contractual obligation and generate sick notes for patients under their care.

## EDUCATION AND TRAINING

- A** 79 SEFTON: That conference calls upon the GPC to engage with the GMC and HEE to agree a reduction of the bureaucratic burden on appraisers of conducting GP appraisal(s)
- A** 80 KENT: That conference proposes that GP trainees should be primarily based in general practices with shorter secondments to secondary care for specialist experience.

- A** 81 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference is concerned that junior doctors are burning out and struggling with their workload. With the King’s fund announcing qualified GPs work on average 3.5 days we call upon GPC to work with relevant bodies to:
- (i) allow trainees to work at less than full time for any reason
  - (ii) allow trainees to work at any percentage with appropriate notice
  - (iii) encourage the filling in of exception reporting for heavy workloads.
- A** 82 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference mandates that GPC England to work with relevant bodies to ensure that all Foundation Year doctors have a placement in the community as required by the Collins report.
- A** 83 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference recognises that ways of working in GP have changed, and that full time equivalent hours are often worked in less than 5 days. This conference calls on GPC to recognise that:
- (i) such arrangements can be used in training.
  - (ii) work schedules can be more reflective of post CCT working through consolidation of clinical sessions to reduce the number of days worked whilst maintaining contractual hours.
- AR** 84 HERTFORDSHIRE: That conference notes with concern, examples where GPs working in secure environments are being asked by employers to forward their NHS GP appraisal outputs as a reference tool and test of competence, conference:
- (i) believes this is a gross misuse of the appraisal process and that there are no such requirements for outputs to go to new employers, and
  - (ii) calls on the GPC to work with NHS England and employers in insuring appropriate appraisal systems are in place with community providers employing GPs in particular roles, and that these are appropriate, reasonable and resourced.

## FUNDING

- A** 85 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon GPC to negotiate a change in the GP contract to allow GPs to charge their patients for services not supplied by the NHS including minor surgery not provided by the NHS, acupuncture where not provided by the NHS and flu vaccinations to patients that are not entitled to a NHS flu vaccination.
- A** 86 OXFORDSHIRE: That conference mandates GPC to negotiate the contractual freedom for GPs, as independent contractors, to provide and directly charge their registered patients for treatment not available on the NHS.
- A** 87 NORFOLK AND WAVENEY: That conference asks GPC to renegotiate the GP contract to allow practices to charge their own registered patients for services not included in this contract.



- A** 88 HAMPSHIRE AND ISLE OF WIGHT: That conference instructs GPC to end the anomaly whereby general practitioners are unable to provide services privately to their registered list due to the constraints of the GMS contract.  
(Supported by Bath & North East Somerset, Swindon & Wiltshire)
- A** 89 LEEDS: That conference believes general practice will be the foundation on which other NHS services are developed within NHS England's long-term plan and therefore insists that general practice is prioritised for funding from the £20bn committed by government.
- AR** 90 BEDFORDSHIRE: Given that in 2017 conference resolved that it 'insists that as independent contractors, GPs should be permitted to provide and directly charge their registered patients for treatment not available on the NHS' we now call on GPC England to make this a key issue in negotiations for the GMS contract.
- AR** 91 DEVON: That conference requests that GPC ensures that NHS England proactively invests in general practice in areas on the brink instead of waiting until contracts are handed back.

## PREMISES

- A** 92 NORTHAMPTONSHIRE: That conference insists that serious consideration be given to the appalling state of some primary care estate and that pressure is brought to bear centrally to properly fund it.
- A** 93 NORTHAMPTONSHIRE: That conference insists that NHS England arranges to buy practice premises off struggling partners who are unable to continue to practice.

## PENSIONS

- A** 94 SOMERSET: That conference believes that sessional doctors should enjoy the same NHS Pension rights as the rest of the workforce and in particular death in service benefits.

## GENERAL DATA PROTECTION REGULATIONS (GDPR)

- A** 95 WOLVERHAMPTON: That Conference believes with the Data Protection Act 2018 removing the ability to charge up to £50 for the provision of Medical Records, the extra costs incurred by practices in providing such records should now be matched by an uplift in funding from NHS England and that GPC should assess the extra costs to practices and negotiate with NHS England to secure such funding to bridge the gap.
- A** 96 HILLINGDON: That conference is concerned about the increase cost to practices in implementing GDPR and instructs the GPC to negotiate an increase in the global sum to negate this cost.
- A** 97 GATESHEAD AND SOUTH TYNESIDE: That conference directs the GPC to enter into negotiations with NHS England to remunerate practices for the additional unresourced work arising from GDPR, in particular the burden of subject access requests.

- A** 98 MID MERSEY: That conference believes that providing data following a Subject Access Request under General Data Protection Regulations should be cost neutral.
- A** 99 NORTH ESSEX: That conference instructs GPC to devise a national assurance process with NHS England that ensures all Data Sharing Agreements are GDPR compliant, have a legal basis and are ethically sound before being circulated to practices.
- A** 100 GATESHEAD AND SOUTH TYNESIDE: That conference believes that the role of data controller is no longer compatible with modern general practice because:
- (i) the time and financial resources taken up by this activity impede the ability of practices to deliver clinical care
  - (ii) it causes an unacceptable risk to individual practices who may inadvertently breach regulations
  - (iii) the role would be better taken over by a dedicated team at NHS England allowing practices to concentrate on clinical care.
- A** 101 BEDFORDSHIRE: That conference feels that the problems around processing medical records for the many people who can and do request them creates impossible burdens for the dwindling numbers of GPs who are already overworked and calls for GPC England to put the case to the government to relieve GPs of the role of data controllers for medical records, or call for provision of centralised clinically trained staff to check records for third party references or clinically sensitive information.

## NHS ENGLAND

- A** 102 NORTH ESSEX: That conference requests GPC ensures that NHS England Area Teams provide a named person to address any patient safety concerns raised by patients or LMCs in order to alleviate increasing problems caused by blurred lines of accountability between NHS England and CCGs.
- A** 103 NORTHAMPTONSHIRE: That conference supports the benefits of small local GP surgeries, and calls on NHS England to publicly support their survival in view of the comments of Dr Arvind Madan in his previous role.
- A** 104 AVON: That conference is appalled by the comments of the recently resigned Director of Primary Care for NHS England and demands that NHS England makes a public statement in support of small practices.
- A** 105 HERTFORDSHIRE: That conference asks GPC to celebrate general practice in all its shapes and sizes, as it is precisely this individuality which enables practices to continue to provide world class primary care tailored to their unique populations. GPC cannot allow NHS England to undermine this very essence of primary care.
- A** 106 HAMPSHIRE AND ISLE OF WIGHT: That conference notes that NHS England does not publish their own complaints procedures for individuals or organisations that wish to make a complaint about NHS England. We believe in the interests of transparency that this complaints procedure should be given equal prominence to their publication of the procedure for complaints against GPs.

- AR** 107 LAMBETH: That conference calls upon all policy decisions made by NHS England/Department of Health to be properly founded on an evidence based rationale, rather than the latest ideas and whims of the Secretary of State.

## INDEMNITY

- A** 108 KENT: That conference calls for regulation of the MDOs and demands:
- (i) transparency from MDOs in the processing of applications and calculation of indemnity fees
  - (ii) independent and unified appeal process for doctors whose application for indemnity cover is rejected.
- A** 109 DERBYSHIRE: That conference believes that with an increasingly mobile workforce and salaried GP indemnity often being paid by practices, conference is concerned about the impact of the requirement for run-off cover for claims based indemnity which could leave both practices and GPs with inadequate medical indemnity. Whilst a state backed indemnity scheme is pending, we urge GPC to create some robust guidance on this issue for practices.
- A** 110 AVON: That conference is dismayed about the lack of information about the state funded indemnity scheme for GPs, which is due to commence in April 2019. It requests the GPC to seek reassurance and public confirmation from government that the scheme will commence on time and as planned.
- A** 111 HAMPSHIRE AND ISLE OF WIGHT: That conference demands the issue of indemnity is sorted once and for all.
- A** 112 CLEVELAND: That conference welcomes the state backed indemnity scheme expected to commence in April 2019 and requires:
- (i) clarity on the content of the scheme several months prior to its implementation
  - (ii) adequate run off cover for those who have recently left NHS general practice
  - (iii) a scheme which is equitable to all GPs, regardless of their current indemnity provider
  - (iv) a scheme which ensures adequate cover for all practice staff and trainees working within practices.

## GPC/GPDF/LMCS/CONFERENCE

- A** 113 CHESHIRE: That conference recognises the need to ensure that all locally agreed levies are collected and forwarded to LMCs whatever the future primary medical services contractual relationships may be.
- A** 114 MANCHESTER: That conference agrees GPC should provide formal feedback on actions taken as a result of carried motions from the previous conference.

## SESSIONAL GPs

- A** 115 NORTH YORKSHIRE: That conference instructs GPC to demand that CCGs demonstrate their engagement with sessional/locum GPs working in their area. This engagement should at the very least include:
- (i) establishing direct communication of updates/bulletins/ local developments with sessional/locum GPs via CCG email distribution lists
  - (ii) inviting sessional/locum GPs to CCG educational events
  - (iii) providing equitable access to mandatory training for sessional/ locum GPs
  - (iv) offering equitable opportunities for learning and development to sessional/locum GPs as they would to GP partners for personal development
  - (v) allowing sessional/locum GPs to contribute to local general practice via the CCG even if they are not aligned with a practice by inviting them to local development events and advertising CCG roles to them.

## WORKFORCE

- A** 116 DERBYSHIRE: That conference believes that with general practice transforming to create new models of care, the make-up of our practice workforce is changing. We ask GPC to negotiate with NHS England to ensure that the SFE for sickness cover and maternity leave extends to all allied health professionals as a matter of urgency.
- A** 117 BRADFORD AND AIREDALE: That conference instructs that policy makers should prioritise improving GP continuity of care over extended access as there is mounting evidence in the past year that this is a more cost-effective way of achieving positive health outcomes including improved mortality, patient satisfaction and reduced A+E admission.
- A** 118 NORFOLK AND WAVENEY: That conference believes that the current Improved Access pilot scheme poses risks to the supply of clinical staff to both in-hours and OOHs by spreading a depleted workforce even more thinly and asks for a proper impact assessment.
- A** 119 DERBYSHIRE: That conference is deeply concerned that with 2020 less than 18 months away rather than achieving a net increase of 5000 new GPs, recent figures have shown both Headcount and FTE numbers are continuing to drop.
- A** 120 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon the poor performance of the International GP recruitment scheme and the waste of valuable research. Conference calls upon GPC to negotiate transfer of resources local initiatives to ease workload.
- A** 121 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon the GPC to make the process easier and simpler for GPs returning back to the UK, as currently they are finding the paperwork and retraining involved a challenge
- A** 122 GLOUCESTERSHIRE: That conference is dismayed at the large sums of money spent on trying to recruit overseas doctors yet failing to prioritise recruitment and retention of GPs who have been trained and are often well-established in the UK.

- A** 123 NORFOLK AND WAVENEY: That conference asks GPC to hold the government to account for the promised provision of 5000 extra whole time equivalent GPs by 2020.
- A** 124 REDBRIDGE: That conference, having welcomed the previous Secretary of State’s announcement of 5000 extra GPs are dismayed that at present there are 1000 fewer and move that the current Health Secretary take urgent action to address the significant workforce issues facing general practice.
- A** 125 KINGSTON AND RICHMOND: That conference believes comprehensive NHS Occupational Health Services should be available to all staff working in GP practices

## GPFV

- A** 126 SURREY: That conference has no confidence in the GP Forward View as the vehicle to provide the required investment needed to safeguard the future of NHS general practice.
- AR** 127 DERBYSHIRE: That conference notes GPCs own report of GPFV which showed a multitude of deficiencies, hoop jumping and failure to deliver promised funding. This affirms conference’s previous vote of no confidence in the GPFV. Conference therefore asks again for GPC to declare that the GPFV has failed.
- AR** 128 HEREFORDSHIRE: That conference agree that the GP Forward View has yet to deliver any substantive investment direct to practices to allow the expansion of the professional teams needed to provide primary care services fit for the future.
- AR** 129 AVON: That conference calls on NHS England to make it mandatory that CCGs publish transparently and accurately how GP Forward View monies are being spent or wasted.
- AR** 130 GREENWICH: That conference believes that the aspirations of the GP Forward View have not materialised, with most practices not seeing any significant benefits on the ground; to make general practice sustainable we need funding which is directed to practices, who should also be involved in how resources are used.
- AR** 131 NORTH YORKSHIRE: That conference believes given the ongoing failure of the GPFV to provide the much needed lifeline directly to general practice and the failure of adequate improvements being achieved within the last year, conference demands that GPC England publicly dissociate itself from GP Forward View.

# Conference of England LMC Representatives

## **Agenda: Part II**

(Motions relevant to UK LMC Conference)

## Agenda: Part II (Motions relevant to UK LMC Conference)

This section of the part 2 agenda contains motions that the England Agenda Committee felt pertained to UK-wide issues and would therefore benefit from debate at the UK LMC Conference. If your LMC has a motion in this section, it is strongly recommended that you re-submit your motions to the UK LMC Conference. **The deadline for submission of motions is 8 January 2019**

### CLINICAL

- 132 GLOUCESTERSHIRE: That conference recognises the importance of dispensing to rural general practices and urges that practice resilience be improved by:
- (i) maintaining a fair dispensing fee
  - (ii) reducing, or eliminating, clawback.
- 133 GLOUCESTERSHIRE: That conference is dismayed that the life expectancy of UK citizens is less than that for comparable nations and calls on the BMA to urgently find out why.
- 134 AVON: That conference deplores the lack of government funds to provide support for the increasing numbers of vulnerable people who are struggling to cope with mental health issues and conference calls upon the GPC to make representations to the Government minister with responsibility for mental health to provide increased resources for the care of patients with mental health issues.
- 135 NORFOLK AND WAVENEY: That conference believes the proposed ban concerning selling energy drinks to those under 16 years old doesn't go far enough in combatting a major public health problem.
- 136 GLOUCESTERSHIRE: That conference, in order to provide equity to patients, seek to change the regulation which prevents some rural patients in merged practices from receiving dispensing services from their GPs even after they have changed their home address.

### PRIMARY/SECONDARY INTERFACE

- 137 HAMPSHIRE AND ISLE OF WIGHT: That conference believes it should be a professional obligation for hospital doctors to introduce themselves by full name and job title when answering bleeps to assist communication with GPs.
- 138 LIVERPOOL: That conference believes that the NHS should continue to offer a comprehensive, free at the point of contact, service across England.

## COMMISSIONING

- 139 LEEDS: That conference believes that the separation of public health from the NHS has led to increased bureaucracy both nationally and locally, and unacceptable funding cuts that have been damaging for patients' health and undermined practices' ability to offer comprehensive services to their patients and therefore calls for this failed policy to be reversed.
- 140 LAMBETH: That conference  
 (i) deplores previous and planned cuts to the Public Health Budget  
 (ii) asks the BMA to lobby the government to bring smoking cessation services, sexual health services and substance misuse services in England back into the control of NHS England and/or CCGs.
- 141 BRADFORD AND AIREDALE: That conference demands that patients who attend A+E due to alcohol intoxication should be invoiced with a means tested charge to be used to fund public health campaigns regarding the dangers of drinking to excess.

## REGULATION

- 142 SHROPSHIRE: That conference acknowledges the legal hurdles to creating a single professional register but demands that the GMC now makes a public statement recognising that GPs are specialists in family medicine and starts the process necessary to change the current regulations.
- 143 GLOUCESTERSHIRE: That conference insists that GPs are specialists in primary care and calls on the GMC to recognise this equivalence in status.
- 144 COVENTRY: That conference insists that GPs are regarded as Specialists and General Medical Experts. Furthermore there is appreciation that we are best placed to make clinical decisions tailored to our individual patients and that there is a recognition that strict adherence to an increasing plethora of Guidelines is not always in the best interests of patients.
- 145 HULL AND EAST YORKSHIRE: That conference is still concerned about the implications of the Bawa Garba case and what it means for appraisal and revalidation for GPs. We call on the BMA to provide clear and concise information about the actions that GPs can take to ensure that they do not fall foul of the necessary regulations.  
 (Supported by North and North East Lincolnshire)
- 146 KENT: That conference believes the title of GP be replaced with the title of Consultant in Community Medicine.
- 147 WIRRAL: That the professional title 'GP' has had much mud thrown at it by the media and politicians. It has become an old fashioned title and in the eyes of some become synonymous with a poor service and mistakes. It's time to rename/relaunch our arm of the profession and call ourselves 'Primary Care Physicians'.



- 148 DERBYSHIRE: That conference demands that in this increasingly litigious society, GPC challenge the assumption by MDO/CQC/GMC that responsibility for following up missed out patient appointments and investigations always defaults to GPs, ignoring the responsibility that patients should accept themselves.
- 149 BEDFORDSHIRE: In relation to hearings by GMC, coroners and the courts which relate to alleged negligent behaviour by healthcare workers, conference believes that it should be mandatory that evidence of stress levels, overload and systemic problems related to the delivery of care to the patient(s) in question are presented to the hearing, and that evidence on these matters cannot be ruled as inadmissible.
- 150 CUMBRIA: That conference believes that the GMC needs to improve its sensitivity, timeliness and general handling of trivial cases being referred to GMC as the end result is often a demoralised and demotivated GP who has yet another reason to leave the profession.
- 151 KENT: That conference notes with concern the increasing distance between the GMC and the medical profession and calls for the GMC to be publicly funded.
- 152 KENT: That conference believes the GMC executive should be elected by doctors.
- 153 KENT: That conference instructs that the statutory standard of proof required by GMC and any other local authorities to find a charge against a doctor should be 'beyond reasonable doubt' rather than the present 'balance of probabilities'.
- 154 KENT: That conference proposes that the GMC be more transparent and:  
(i) inform doctors whenever a complaint is made against them  
(ii) cease the practice of indefinitely retaining records of complaints that do not meet the threshold for investigation.
- 155 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
We welcome the recent high-court judgement allowing Bawa-Garba to work as a doctor again but feel the original charge was wrong. We call upon the BMA to continue to work with the relevant bodies to push for a change in the law for gross manslaughter negligence to reflect the Scottish law.
- 156 NORTH YORKSHIRE: That conference is anxious that GPC is actively involved in the preparations for the proposed introduction of medical examiners for death certification from April 2019 to avoid a collapse of the management and logistics of death certification.

## EDUCATION AND TRAINING

- 157 KENT: That conference calls on the GPC to renegotiate remuneration for GP educators.
- 158 BRADFORD AND AIREDALE: That conference demands that government bans advertising unhealthy food to children, improves nutritional education in schools and medical schools and makes healthy food more affordable
- 159 BIRMINGHAM: That conference requires GPC England to resist any post-Brexit attempt to remove or weaken the GP Vocational Training Regulations.

## INFORMATION MANAGEMENT AND TECHNOLOGY

- 160 NORTH AND NORTH EAST LINCOLNSHIRE: That conference is concerned about the emergence of various IT solutions that are non-evidence based, untested and poorly regulated. The conference believes that:
- (i) this is having a negative effect on patient care
  - (ii) IT solutions should be tested and approved at least in line with other medical and surgical interventions
  - (iii) the IT developers should be held responsible legally and financially if these result in adverse outcomes for patients
- (Supported by Hull and East Yorkshire LMC)
- 161 LAMBETH: That conference:
- (i) believes that algorithms should be regulated
  - (ii) demands that online consultation tools should be subject to an appropriate regulatory framework
  - (iii) demands that there should be agreed governance structures and clarity of liability for adverse incidents arising from use of online consultation tools
  - (iv) demands that online consultation systems be subject to independent evaluation of effectiveness before NHS bodies procure them for practices
  - (v) demands that GPC support general practices in refusing to implement such algorithms unless and until acceptable regulation and liability agreements are in place.
- 162 AVON: That conference urges GPC to work with NHS England to develop a regulatory approval and harm monitoring regime, as exists for drug interventions, for mobile and web based applications that are designed for use by patients and which may be interpreted as giving specific medical advice to the individual without consultation with a clinician.
- 163 AVON: That conference calls on the government to legislate for proper regulation of healthcare apps. Medicines require extensive assessment before being declared safe for patient use. The same stringent requirements should be required for apps that are intervening in patients' health.

## FUNDING

- 164 BATH AND NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference supports that the patient should have the right to top up basic NHS care with their own funds where this care is deemed to be in the interest of the patient and asks that GPC England demands action from NHS England.
- 165 BATH AND NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference supports that the patient care should be quality over equality and can be achieved by the patient being able to top up the cost of basic NHS care and asks that GPC England demands action from NHS England.

## PENSIONS

- 166 CLEVELAND: That conference, in respect of GP pensions in England:
- (i) demands the reinstatement of an annual statement of contributions, to be sent to every member of the scheme
  - (ii) requires clarity as to the effective processes to resolve any discrepancies in contributions
  - (iii) requires clear guidance as to the role of the Pensions Ombudsman
  - (iv) demands the modernisation of the Forms A and B system for locums into a fully electronic system.
- 167 SOMERSET: That conference believes that the work of LMC staff is NHS work and therefore they should be allowed to join the NHS Superannuation Scheme.
- 168 GLOUCESTERSHIRE: That conference believes the current NHS Pension arrangements for locum GPs are inefficient and waste a significant amount of NHS administrative resource and therefore calls for the:
- (i) GPC to negotiate the necessary changes to allow the replacement of the current (Locum A, B and Solo) forms with a single annual online form per employer/locum
  - (ii) establishment of a simple electronic payment system allowing monthly or annual direct debits.

## GENERAL DATA PROTECTION REGULATIONS (GDPR)

- 169 NOTTINGHAMSHIRE: That conference deplores the imposition of GDPR on the profession in the area of subject access requests without regard to the resources needed to comply with the legislation and:
- (i) urges GPC to negotiate a fair price/reimbursement for the extra workload involved
  - (ii) demands that the BMA to negotiates an exemption for the provision of medical records
  - (iii) that GPC highlights the harm this legislation is causing not only financially but also in worsening relationships between doctors and solicitors as requests for medical records now increase along with SARs being misused.
- 170 NORTHAMPTONSHIRE: That conference insists that practices are able to charge for the administrative cost of note checking and handling under GDPR access requests.

- 171 SOMERSET: That conference deplores the use of GDPR to make general practice a free photocopying and postal service for lawyers and it:
- (i) profoundly regrets the current BMA advice which reinforces this approach
  - (ii) urges the GPC to take appropriate action, including funding a test case if necessary, to establish case law to prevent this injustice in perpetuity.
- 172 NORFOLK AND WAVENEY: That conference asks GPC to negotiate with government for a change in GDPR regulations to allow practices to recover costs incurred in copying records for patients and their legal representatives.
- 173 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon the GPC to agree with the ICO a definitive policy so that practices are not taken advantage of in relation to SAR requests from third party.
- 174 DERBYSHIRE: That conference demands that GPC works urgently with NHS England, the Information Commissioner's Office, the Law Society and the Association of British Insurers to remove, reduce or mitigate the significant additional unfunded work that has landed in general practice as a consequence of the introduction of the Data Protection Act 2018 which included GDPR legislation.
- 175 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon GPC to provide a definitive policy to define excessive within SAR requests
- 176 LEEDS: That conference believes the government has failed to appreciate the impact the introduction of GDPR would have on practices and calls for a much more robust approach to support practices and protect patients from the actions of those using subject access requests to obtain patient information inappropriately.
- 177 LIVERPOOL: That conference believes that solicitors are using GDPR regulation in a manner that was not intended and calls upon GPC and the BMA to clarify with the Information Commissioner that solicitor requests for copies of medical records in relation to claims does not fall within the definition of a Subject Access Request.
- 178 LANCASHIRE COASTAL: That conference believes that the stimulation of SARRS requests as a result of the GDPR is destroying general practice and calls on GPC, NHS England and the Information Commissioner to develop a set of guidelines as to what is a reasonable and proportionate response and what is 'excessive.'
- 179 DEVON: That conference demands that general practice be exempt from the multiple requests for information legislated by GDPR as this is creating unnecessary work and unfunded work in general practice taking clinicians and staff away from time that could be better spent on patient care.

## GPC/GPDF/LMCS/CONFERENCE

- 180 KENT: That conference urges the GPC to establish a committee to represent the needs of small rural and semi-rural practices in these days of urbanisation and federation.
- 181 HERTFORDSHIRE: That conference has no confidence that the BMA is adequately financially supporting the work of GPC at this time of crisis in general practice and calls upon the BMA to correct this.
- 182 DORSET: That conference requests all LMCs produce a code of conduct for their members.
- 183 HAMPSHIRE AND ISLE OF WIGHT: That conference, despite repeated calls, notes that the package of reforms promised to conference as a package (the Meldrum reforms) have yet to be implemented in full and demands that GPC deliver the reforms that conference were promised.
- 184 MANCHESTER: That conference agrees that following the mysterious decision to include GPC as part of the BMA that clarity is sought as to what the GP Defence Fund levy is used for and suggests that until this information is forthcoming and all the necessary due diligence checks are undertaken that LMCs withhold the GP Defence Fund levy.

## SESSIONAL GPs

- 185 AVON: That conference asks GPC England to recognise the plurality of roles taken up by GPs in England, which may include working regularly for a clinical commissioning group or NHS England and demands that their employment rights are negotiated in a similar way to the model salaried GP contract.
- 186 CITY AND HACKNEY: That conference believes that GPs working regularly in non-practice roles, such as for Clinical Commissioning Groups and NHS England, should be protected by employment law, and calls upon GPC England to create model terms and conditions for this group of GPs.
- 187 AVON: That conference believes that GPs working regularly in non-clinical NHS roles, such as for clinical commissioning groups and NHS England, should be protected by employment law, and calls upon GPC England to create model terms and conditions for this group of GPs.
- 188 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference believes that GPs working in non-clinical roles should be represented by the GPC, and calls upon GPC England to create model terms and conditions for this group of GPs.
- 189 KENT: That conference calls for an amendment of the BMA salaried contract for salaried GPs who are GP educators that ensures adequate standardised remuneration.
- 190 HAMPSHIRE AND ISLE OF WIGHT: That conference calls on the BMA to establish a standing committee for sessional GPs.

## WORKFORCE

- 191 NORTH YORKSHIRE: As stress levels amongst GPs remain at high levels conference calls upon the GPC to:
- (i) source or develop an appropriate short survey tool to measure and classify work related stress amongst GPs
  - (ii) encourage every GP on a UK performers list to anonymously complete the survey annually
  - (iii) collect and evaluate the findings and trends
  - (iv) publish and promote the results to the general public and the profession
  - (v) ensure that GPs who identify themselves to be at critical levels and/or high risk based on their personal survey score have access to effective, free and confidential professional support throughout the country.
- 192 NOTTINGHAMSHIRE: That conference acknowledges the fantastic work being provided for our own health as GPs by many services across the country including by LMCs. Furthermore, it calls on the NHS to provide core funding for this to continue and spread throughout the UK in order to support the profession and prevent further burnout and loss of GPs.

## BREXIT

- 193 NORFOLK AND WAVENEY: That conference believes that a no-deal Brexit will cause damage to primary care through:
- (i) shortages of medicines and vaccines
  - (ii) reduction in EU doctors able and willing to work in the NHS
  - (iii) financial market effects leading to a more costly NHS
  - (iv) leaving Euratom which regulates the import and export of radioactive and nuclear materials including medical radio-isotopes used to treat cancer, materials which cannot be produced in the United Kingdom.
- 194 WIRRAL: That conference believes:
- (i) the prospect of Brexit has harmed the NHS and the wider economy, exacerbating health inequalities and deleteriously affecting other social determinants of health
  - (ii) Brexit itself shall cause much worse damage to the NHS, the economy and social determinants of health
  - (iii) prior to the 2016 referendum, there was no clear model for Brexit and the people who voted to leave the EU were a 'broad church' including many who believed that Britain could retain membership of the customs union and the single market
  - (iv) prior to the 2016 referendum, undeliverable promises/false claims were made that encouraged people to vote for Brexit who would now feel differently
  - (v) there should be a second referendum/'People's Vote' on the final Brexit deal.
- 195 LEWISHAM: That conference believes that given the risks posed to patient care by Brexit and EU departure, a mandate for a second UK referendum on the proposed deal or no deal scenario is required.

- 196      BERKSHIRE: That conference calls on GPC to make the Secretary of State aware of the severe negative impact Brexit is having on recruitment and retention of overseas staff in general practice and the very real risk to the safe delivery of services to patients this poses.

# Conference of England LMC Representatives

## **Agenda: Part II**

(Motions not prioritised for debate)



## Agenda: Part II (Motions not prioritised for debate)

### CLINICAL (PRESCRIBING, DISPENSING AND PHARMACY)

- 197 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon GPC to investigate the agreement of the shared care agreement drugs.
- 198 COVENTRY: That conference believes the preparations for the flu immunisation campaign for 2018-9 have been chaotic, tardy and give advantage to pharmacies over general practice by providing earlier, guaranteed supply of vaccine. That this has potential to lead to the later vaccination of vulnerable groups of patients and a higher level of risk within the community if there is an outbreak of influenza this season.
- 199 CLEVELAND: That conference is concerned that the Department of Health has mandated the use of a quadrivalent influenza vaccine that is accessible through one national supplier only and who is unable to meet demand and believes this should be formally investigated by the Competition and Markets Authority.
- 200 HARROW: That conference regrets that the current approach to medicines optimisation has potential to negatively impact on the patient-doctor relationship and calls upon NHS England to seek a longer-term strategic approach which is both clinically effective and cost-effective.
- 201 AVON: That conference deplores the mechanism by which NHS England is imposing restrictions on over the counter medicines, which places GPs in direct conflict with patients, and demands that these medications are placed on a national blacklist if their use is to be curtailed.
- 202 CLEVELAND: That conference, in respect of the “grey list” for prescribing:
- (i) believes that GPs are being exposed to unacceptable medico-legal risk
  - (ii) insists on a change to the regulations that mandate GPs to provide a prescription when clinically appropriate
  - (iii) demands its abolition.
- 203 CLEVELAND: That conference demands a review of prescription charges in England, to specifically include:
- (i) the extension of the conditions eligible for medical exemption
  - (ii) a cap on the maximum charge to each individual patient in one year.
- 204 NOTTINGHAMSHIRE: That conference deplores the continuing neglect of mental health service provision in primary care and calls on the NHS to urgently redress this for the health of the nation.
- 205 DERBYSHIRE: That conference asserts that the rolling out of a paper-based end of life care form, when there are at least as good IT solutions, is a retrograde step, risks putting patients at harm. Conference demands that this issue is addressed at a national level.

- 206 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference notes the challenges in accessing healthcare and the considerably worse health outcomes for children and adults with autism. We note that there are some simple approaches which can help with access and improving healthcare for this group and their families. We mandate GPC to work with relevant stakeholders to explore and develop simple standards and policies which can be adopted by practices to ensure good practice.
- 207 MID MERSEY: That conference believes that all patients with a diagnosis of autism should have access to specialist treatment, not just to diagnostic services.
- 208 AVON: That conference criticises the government’s tardy response through NHS England Public Health in providing an adequate and timely response to the measles outbreak and for placing default responsibility for dealing with outbreaks on general practice and conference calls upon the government to provide additional resources to PHE and to general practice to enable them to cope adequately with infectious diseases control and in particular measles.
- 209 BEDFORDSHIRE: That conference welcomes proposals to make QOF more appropriate to different populations and local needs but calls on GPC England to ensure that:
- (i) total funding available for QOF is released from central funds to CCGs and is strictly ring-fenced
  - (ii) any alternative proposals, while taking into account local needs and differing targets for different subpopulations, don’t make it impossible to collect meaningful comparative data on shifts in overall management of chronic diseases.
- 210 LEEDS: That conference believes that spirometry is not part of essential services and all CCGs should commission spirometry services to support the diagnosis and management of patients with respiratory disease.
- 211 ISLINGTON: That conference is concerned that the implementation of the current GP contract has created a cohort of frail patients for whom:
- (i) there is little/no strong evidence based guidelines
  - (ii) the management requires a multi-disciplinary approach outside the capacity of routine general practice
  - (iii) the result will be future commissioning intentions based upon a varied interpretation of the current contract and funding levels.
- 212 HAMPSHIRE AND ISLE OF WIGHT: That conference notes the increasing demands on GPs to complete funding forms for NHS continuing healthcare funding for patients approaching end of life and believes that:
- (i) GPs are not best placed to complete these forms
  - (ii) is not the purpose of CHC funding
  - (iii) diverts funding away from patients who should qualify for CHC funding under the national framework
  - (iv) reflects underfunding of end of life care needs.

- 213 HERTFORDSHIRE: In light of the use of disclaimer statements relating to private GP prescriptions from online GPs, Conference calls upon GPC to:
- (i) ensure that full responsibility rests with the prescribing private GP
  - (ii) challenge the validity of disclaimer statements
  - (iii) negotiate that private GP prescribing is in accordance with local CCG prescribing guidance for the area where the patient lives when it is expected or likely that the NHS GP is to continue a prescription.
- 214 NOTTINGHAMSHIRE: That conference believes the relevance of QOF has greatly deteriorated as a tool to drive up quality and calls for its abolition and the transfer of funding into the global sum, albeit with an element of performance management to ensure ongoing 'quality.'
- 215 NOTTINGHAMSHIRE: That conference sees unnecessary work being put to GPs that could be handled more quickly and appropriately. An example that we wish GPC to address is of overseas patients losing/ forgetting to bring their medications.  
We demand that the GPC pushes for a change to allow patients to access pharmacies to replace previously issued medication rather than have to do so via the GP.
- 216 HERTFORDSHIRE: That conference believes that all GMC registered doctors (whether Private or NHS) should have the right to issue any medication on a FP10 (subject to local or national guidelines) to any UK citizen or person qualifying for NHS treatment.
- 217 SUFFOLK: That conference requests GPC England to consider whether the scattering of Pharmacy2U leaflets experienced recently in some areas could be considered to be a form of 'direction of prescriptions' and thus in contravention of the Pharmaceutical Regulations.

## PRIMARY/SECONDARY INTERFACE

- 218 NORTH YORKSHIRE: That conference believes that 'aligned incentive contracts' between CCGs and trusts, having been developed with the main aim of reducing deficits and activity, risk further destabilising general practice and instructs GPC England to nationally negotiate to ensure:
- (i) no further additional shift of work from secondary to primary care that is not fully funded and resourced
  - (ii) general practice is involved in discussions regarding how these new contracts will change local care pathways
  - (iii) primary care is not adversely impacted by the pre-allocation of CCG funding to service these contracts.
- 219 LINCOLNSHIRE: That conference believes that the changes to the standard NHS hospital contract have not been implemented by Trusts or enforced by CCGs, and thus calls upon the GPC to:
- (i) meet with consultant, SAS, and Junior doctors committees to remind them of their duties under this contract
  - (ii) remind consultants, SAS, and junior doctors that breaching this contract is unprofessional and thus a GMC matter
  - (iii) request that the GMC writes to all consultants, SAS, and junior doctors to remind them of their responsibilities under the contract
  - (iv) meet with NHS England & NHS Improvement to remind them of their roles in enforcing the contract
  - (v) write to all CCGs to remind them of their role in enforcing the contract.

- 220 BRENT: That conference deplores the inappropriate shift of clinical risk from clinicians in secondary and community services to GPs and calls upon commissioners to ensure that the clinician who first finds risk in a patient is required to mitigate that risk rather than pass the risk on to the GP.
- 221 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers what happens to services stopped due to funding cuts and how practices are supported in communicating these to patients that then always end up at GPs practices demanding the services.
- 222 NORTH YORKSHIRE: That conference believes that in order to minimise unnecessary hospital admissions and the costs associated with this:
- (i) there should be better access to specialist advice and same day outpatient review
  - (ii) we call upon the government to increase staffing to provide a designated triage doctor
  - (iii) to offer booking into emergency clinics with the relevant speciality.
- 223 HARROW: That conference denounces any shift in responsibility for the care of patients with long term conditions which is unresourced, or inappropriate, and calls on commissioners to remain vigilant to increased clinical risks and breaches of the standard hospital contract.
- 224 DORSET: That conference calls for secondary care to permanently switch off all “copy to GP” results.
- 225 KENT: That conference negotiates a schedule and mechanism of payment to individual practices for breaches of the hospital contract which impose work on general practice.

## WORKING AT SCALE

- 226 COVENTRY: That conference believes that NHS England in compelling practices to work collaboratively at scale is forging an overall plan to achieve by stealth the development of a salaried GP service with loss of the GMS contract and the demise of the partnership model of general practice, and calls upon GPC to:
- (i) ensure all funding is made available to all practices and not dependant on being part of a collaborative group of practices
  - (ii) proactively support practices of all sizes
  - (iii) ensure CCGs are not allowed to issue only new contracts as APMS but still allow GMS
  - (iv) ensure that working at scale plans are developed by Practices rather than mandated by CCGs.

## COMMISSIONING/STPS

- 227 LINCOLNSHIRE: That conference recognises the significant cuts to funding that Public Health England has suffered and deplores the transfer of Public Health workload onto already overburdened general practices that this has caused, and calls upon government to reinstate funding to Public Health departments so that they can carry out the work that general practices are not commissioned to do.

- 228 KINGSTON AND RICHMOND: That conference believes all Public Health England initiatives should be 'sense-checked' before release by the GPC

## REGULATION

- 229 BRADFORD AND AIREDALE: That conference calls on GPC to demand that NHS England stop asking CCGs to encourage GPs to break their terms of service via national "guidance" and instead negotiate the appropriate amendments to the regulations and SFE
- 230 BEDFORDSHIRE: That conference believes that there should be a 'GMC for healthcare managers' with powers to impose sanctions on NHS managers up to, and including, depriving them of the right to work in the NHS, so that NHS managers are liable for the impact of the systems they have set up or for bullying behaviour or repeated incompetence.
- 231 MID MERSEY: That conference is concerned that the increasing control and regulation by the NHS on GP's who work as self-employed independent contractors (for example, particularly those GPs working in premises owned by the NHS) may actually mean that they are deemed to be working as NHS employees, and directs GPC to obtain expert advice on how best to approach this issue for the benefit of such doctors.
- 232 KENT: That conference agrees that the Secretary of State for Health should have significant previous experience of working in the NHS prior to appointment.

## PERFORMANCE

- 233 NORTH ESSEX: That conference requests that GPC initiate urgent discussions with regulatory bodies, commissioners and defence organisations with the aim of addressing their conflicting and competing demands that are placing GPs in an increasingly untenable working environment.
- 234 KENT: That conference:  
(i) deplores the Parliamentary and Health Ombudsman's proposal that GPs need to advise which guidelines they followed in the event of a complaint  
(iii) and demands the BOLAM principle be applied.

## EDUCATION AND TRAINING, INCLUDING GP TRAINEES

- 235 MANCHESTER: That conference finds the proliferation of “mandatory training” increasingly imposed upon GPs is becoming a tiresome burden on their personal time and states that:
- (i) first and foremost GPs are professionals able to determine their individual learning and training needs without imposition by any external agencies
  - (ii) where it is agreed that such training is to be provided (for example as part of a local initiative agreed with the LMC/CCG/Federation/practices etc.) it should be resourced appropriately
  - (iii) when such training is developed it should be targeted at the learner in content and time required to complete – no-one enjoys a “clickersize”.
- 236 SUFFOLK: That conference recognises the mandatory element in adult and child safeguarding but abhors the arbitrary interpretation which often leads to burdensome local requirements for GPs and requests GPC England to explore what is legally required and arrange for guidance to be provided which encapsulates this core requirement.
- 237 EAST SUSSEX: That conference requests GPC to negotiate a nationally agreed set of mandatory training requirements that will meet both i) CQC Inspection and ii) NHS Appraisal requirements.
- 238 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers the way GP training schemes are currently organised with trainees getting very limited time in GP with very short working hours breeding a population of young doctors not equipped to take up partnership responsibilities and hence adding to recruitment crisis as all want to just locum.
- 239 BERKSHIRE: That conference believes the GP Appraisal system is due for review and calls on GPC to engage with the GMC to initiate this.
- 240 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
We welcome the increase in medical student numbers and the creation of new medical schools. We ask to work with relevant bodies to ensure:
- (i) parity of payment with secondary care for undergraduate placements
  - (ii) ensure we increase capacity and not use current GP training places
  - (iii) increase the capacity to train GPs and practices to trainer status.
- Academic GP is an important and relevant career for trainees we must work with relevant bodies to ensure there is pay parity with secondary care academic doctors.
- 241 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference notes that retention of GP trainees is essential for recruitment to post-CCT GP posts. With this in mind, we believe that facilitating LTFT working with a flexible approach is essential, which may require simple solutions such as term-time working and ‘step-up, step-down’ working patterns.

- 242 NOTTINGHAMSHIRE: That conference notes with great concern the wide-spread cuts by Health Education England (HEE) to GP Specialty Training Programme admin support, in many cases over 50% reductions in funding with effect from 1 April 2019. These cuts pose a very real threat to the ongoing quality of the training programmes and sustainability of them which will directly negatively impact the number of trainees going on to move into mainstream general practice in England. Conference demands that:
- (i) HEE is lobbied to pause on their plans to make these admin support cuts until the start of 2020/21 to allow for the local systems to plan for continuity of support even if this has to be delivered at a lower cost
  - (ii) In the event that the plans cannot be halted, underspends in other primary care initiatives (such as GPFV including international GP recruitment) are diverted to make up for the gaps that these cuts would produce at least until the beginning of 2020/21 to allow for planning of sustainable programmes at a lower cost.
- 243 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference notes that GP trainees in hospital settings are frequently used to plug rota gaps in overstretched services, rather than focus on education and training of the individual. We deplore this situation and call for:
- (i) publication of dedicated GP trainee exception reports for both educational and service time for all hospital placements
  - (ii) detailed exit interviews to collate feedback on individual hospital posts and how to improve them specifically for GP trainee development
  - (iii) lead employers and the GMC to withdraw GP trainees from posts that provide little educational value.
- 244 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference is aware of the significant contribution administrative support staff make to GP trainees' training programs and is appalled by Health Education England's (HEE) decision to cut over 50% of their funding. We call on GPC to lobby HEE to halt their planned funding cuts.
- 245 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference asks that they consider making minor alignment part of the curriculum or primary and secondary schooling
- 246 KENT: That conference believes that pressure on general practice is not confined to winter and seeks ways of reducing such pressure such as reducing the frequency of appraisal.
- 247 NORTH ESSEX: That conference instructs GPC to agree a process with NHS England whereby all patient feedback obtained as part of the appraisal process is:
- (i) framed in a way that properly takes account of the constraints within which GPs operate
  - (ii) ensures feedback to GPs is shared in the right environment with a trained professional thereby facilitating reflection and identified learning
  - (iii) prevents GPs from being used as scapegoats for the failings of the system.

- 248 KENT: That conference recognises that GP appraisal is onerous and has not been shown to improve patient care, reduces GPs time and availability for patient care, and should be scrapped as it currently stands.
- 249 THE GPC: That the GPC seeks the views of conference on the following motion from the GP Trainees subcommittee:  
That conference asks GPC to encourage the completion of trainee exception reports by:
- (i) lobbying the college and other relevant bodies to award CPD points to work schedule review meetings
  - (ii) working with other stakeholders to promote work schedule review meetings as evidence of QI work that can be included in appraisals.
- 250 SUFFOLK: That conference instructs GPC England to reopen dialogue with NHS England about the potential for misuse of the recently adopted NHS England Low Volume GP Clinical Work Guidance paper, specifically in the context of disability, related sickness absence or any of the other protected characteristics such as pregnancy or maternity leave, as set out in the Equality Act 2010; in order to ensure that unlawful discrimination is not condoned, mindful of NHS England's Public Sector Equality Duties as per Section 149 of the Equality Act 2010.

## INFORMATION MANAGEMENT AND TECHNOLOGY

- 251 WIGAN: That conference condemns:
- (i) the lack of clarity and diligence which allows digital online providers of GP services to lead subscribers to unknowingly deregister from their extant GP practice
  - (ii) the lack of regulatory control which allows provider of this kind to register themselves off shore and to escape CQC and other regulations.
- Conference calls upon GPC to pursue and secure a tighter regulatory framework applying to these specific providers.
- 252 BEDFORDSHIRE: That conference believes that many GPs might be happy to be replaced by an app but would want to be shown who provides the indemnity for such an app.
- 253 SURREY: That conference believes that:
- (i) IT innovation offers opportunities to facilitate patient consultations
  - (ii) the GP core contract capitation payment arrangements must support the wider use of IT within general practice.
- 254 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers GP online communications are a risk to NHS GPs
- 255 GLOUCESTERSHIRE: That conference notes with concern the insistence of NHS IT portals to have to regularly change passwords, insists that a well crafted password that doesn't require writing down is a more secure entity and calls on the NHS to stop the requirement for frequent changing of passwords.



- 256 COVENTRY: That conference insists that the use of facsimile machines for the purpose of referring patients to other services within the NHS is stopped as is not compliant with GDPR and potentially compromises practices. These services must provide a secure email to receive the communication or referral, and disseminate that to practices
- 257 BRADFORD AND AIREDALE: That conference demands that there is an increase in funding to support the development and implementation of technology to help patients self-manage their own chronic illness.

## FUNDING

- 258 GLOUCESTERSHIRE: That conference believes that specialists in primary care should be able to have similar private working arrangements to all other specialists in secondary care.
- 259 NOTTINGHAMSHIRE: That conference deplores the massive funding of secondary care compared with primary care and calls for a disproportionate funding increase to mitigate or solve the:
- (i) premises problem
  - (ii) recruitment problem
  - (iii) retention problem.
- 260 LIVERPOOL: That conference believes that charging for GP appointments is not the answer to reducing demand or increasing investment in general practice.

## PREMISES

- 261 NOTTINGHAMSHIRE: That conference has lost all confidence in NHS Property Services (NHSPS) and feels that they are not fit for purpose. Conference demands that:
- (i) NHS Property Services should be disbanded
  - (ii) property owned by NHS Property Services should be owned by the NHS locally
  - (iii) clinical leadership should be heavily involved in determining how these NHS Property Services assets are utilised.
- 262 BOLTON: That conference believes there is an urgent requirement for an estates strategy:
- (i) practices are in urgent need of clear and transparent guidance on how to access funding to improve existing buildings
  - (ii) there is regional differences on how funding is made accessible to practice.
- 263 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers improvement on NHS property premises.
- 264 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference, in recognition of the difficulties that some practices have had with toxic loans, complex or unfair leasehold arrangements and other financial issues asks GPC England to:
- (i) request a national assessment of the impact of financial arrangements within practices for loans, leases and other financial commitments, with particular focus on the impact that these have on GP staff morale, premises maintenance and/or renewal and succession planning;

- (ii) supports the provision of a central fund that can be accessed by practices in urgent needs of expert financial advice on the recommendation of their LMC, CCG or NHS England;
- (iii) practices with toxic loan arrangements or other punitive contract arrangements to have priority in accessing any available funding.

## PENSIONS

- 265 BEDFORDSHIRE: Because GPs in their early 50s are being advised that, due to the annual allowance and lifetime allowance, their best option is to reduce the number of sessions they work in order to avoid effectively being taxed twice on their pension pots – creating a situation the opposite of what is needed if we are to stop the haemorrhage of experienced GPs, conference calls on GPC England to ask government to look urgently at the pensions situation.
- 266 WIGAN: That conference notes with dismay the failure to increase recruitment of GPs in any appreciable number from overseas sources to provide relief in the short and medium for the GP manpower crisis. It calls upon GPC to engage with NHS England, Secretary of State, and Treasury to seek a special dispensation from the pension funding disincentives which apply to older GPs who desire to remain in active non locum practice.
- 267 LEEDS: That conference believes that with increasing pressures and burnout, general practitioners should be able to receive their full pension at 55 years old without abatement and that such a change would lead to an expansion of the workforce by increasing entry into general practice from medical graduates.
- 268 DORSET: That conference for HMRC to admit that the changes to the NHS pension scheme with respect to annualisation of employee contributions are discriminatory and unfair. As such they should be scrapped immediately and the additional monies paid refunded to those affected.
- 269 LIVERPOOL: That conference believes that salaried GP pension contributions would be better paid direct by the employing practice to the pensions agency, as the practice does for all other salaried staff, rather than have the monies collected via the Exeter System, as the process for paying via Primary Care Support England is cumbersome, inefficient, and invariably inaccurate.

## PRIMARY CARE SUPPORT ENGLAND (PCSE)

- 270 NOTTINGHAMSHIRE: That conference continues to have to put up with the below par performance of PCSE which still owes money to practices and practitioners after over a year of following up. We are also aware of NHS England clawing back monies for years after their own mistakes have been made in areas such as premises, seniority etc. We have, in effect, one rule for NHS England and another for practices. This is proving difficult to tolerate when at the same time practices are being penalised for failing to claim on time when for example missing the one month deadline for claiming for childhood immunisations. We demand that:

- (i) GPC negotiates relaxing of deadlines for practice claims at least until the GPC can unequivocally state that Capita is providing an acceptable service for PCSE
  - (ii) the SFE is amended to extend the deadlines for practice claims to reflect the fact that they are overworked and often held up by PCSE, IT issues etc.
- 271 KINGSTON AND RICHMOND: That conference believes the recent advice to general practitioners regarding possible discrepancies in their PCSE pension contributions:
- (i) undermines morale within the profession
  - (ii) further damages the professions confidence in PCSE
  - (iii) must not result in any financial disadvantage to general practitioners accrued pension entitlement, and
  - (iv) that the BMA's response should be supported by a legal opinion of the adequacy of PCSEs / NHS England's response.
- 272 CLEVELAND: That conference, in respect of GP pensions in England, is concerned that some GPs may be leaving the scheme purely due to maladministration and:
- (i) insists that this issue is rectified with the relevant organisations as a matter of urgency
  - (ii) mandates the BMA to survey GPs on this matter
  - (iii) demands that the BMA increases the information provided to members
  - (iv) insists that the NHSBSA pensions agency provides all GPs with free accurate annual pension statements with explanatory notes and contact details for queries.

## GENERAL DATA PROTECTION REGULATIONS (GDPR)

- 273 WIGAN: That conference notes with concern the increase in Subject Access Requests for patient information which has followed the GDPR change. Irrespective of whether a fee can be charged, already overstretched practices are struggling under the additional administrative work this is creating. It calls upon GPC to engage with NHS England, NHS Digital, Law Society and Insurers to devise and agree an arrangement for compliance which dramatically eases the administrative burden on practices.
- 274 NORTHAMPTONSHIRE: That conference recognises that GDPR is putting practices under serious pressure and will lobby NHS England to help ease the burden.
- 275 NORTHAMPTONSHIRE: That conference demands HM Government/ NHS England takes legal responsibility for GP surgeries against litigation which might occur as a result of GDPR and data sharing with CCGs.
- 276 HAMPSHIRE AND ISLE OF WIGHT: That conference demands a national process for data sharing that is clear and GDPR compliant.
- 277 BEDFORDSHIRE: That conference believes that the NHS has no hope of getting an additional 5000/6000 GPs by 2020 unless the problem with GDPR is addressed satisfactorily.

## PRACTICE BASED CONTRACTS

- 278 NEWCASTLE AND NORTH TYNESIDE: That conference:
- (i) opposes involving general practice in checking immigration status
  - (ii) calls on GPC to insist on the removal of these questions from the GMS1 Form
  - (iii) calls on GPC to support practices who wish to cross out the supplementary questions (patient declaration for all patients who are not ordinarily resident in the UK) on the GMS1 Form.
- 279 TOWER HAMLETS: That conference:
- (i) opposes involving general practice in checking immigration status.
  - (ii) calls on GPC to support practices who wish to cross out the supplementary questions (Patient Declaration for all patients who are not ordinarily resident in the UK) on the GMS1 Form.
  - (iii) calls on GPC to insist on the removal of the declaration for all patients who are not ordinarily resident in the UK questions from the GMS 1 Form.
- 280 DERBYSHIRE: That this conference reminds NHS England, NHS managers, trusts and other commissioning bodies that
- (i) the general practitioner NHS contract is NOT an open ended block contract to provide all medical services and
  - (ii) unless a service is specified in the definition of essential or additional services, such services WILL NO LONGER be provided irrespective of any notions of “custom and practice” or “mainstreaming”
  - (iii) any such discontinued services or proposed new services can ONLY be provided subject to an agreed additional contract
  - (iv) GPC England is instructed to frequently and publicly remind commissioners and managers of these facts.
- 281 NORTH YORKSHIRE: That conference believes that health visiting should once again become part of GMS service, properly funded and with health visitors directly employed by general practice.
- 282 DORSET: That conference calls for a full evaluation of IAGPS and GP Streaming initiatives to assess whether the money would be better invested in core general practice.

## WORKLOAD

- 283 NORTH YORKSHIRE: That conference believes that workload in general practice continues to rise despite and as a result of national initiatives and demands that all new initiatives should impact assessed, costed and funded appropriately.
- 284 LINCOLNSHIRE: That conference believes that increasing patient demand, driven by irresponsible politicians, is making general practice unsustainable, and calls for politicians to be honest with the public about what can and cannot be provided by a state-funded comprehensive health service.

- 285 CENTRAL LANCASHIRE: That conference believes that an undue burden of unnecessary work is placed on GPs by the commissioning of stand-alone services from different providers which results in GPs having to cross refer between these providers in the absence of direct referral pathways.
- 286 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges looking at ways to help primary care from being everyone's dumping ground for example when the police call to report things that aren't health relevant or when a hospital clinician decides that a GP is responsible for things done in hospital!
- 287 AVON: That conference feels many CCGS are already operating with hospitals on black alert and it is clear that the system will be overwhelmed when faced with the usual winter pressures and conference calls upon the government to set out in explicit detail the funding arrangements that it has made to enable general practice and hospitals to deal with forthcoming winter pressures.
- 288 AVON: That conference asks GPC to work with Public Health England to facilitate public announcements that anticipate the effect on GPs workload and manage patient expectations, are costed for the impact on primary care workload and overall cost-effectiveness and, are attached to additional specific funding for primary care to facilitate delivery of the service.
- 289 AVON: That conference believes that IT development alone will not address the workload and workforce crisis and we call on the Department of Health to renew its efforts to explore all avenues to save general practice.

## NHS ENGLAND

- 290 ISLINGTON: That conference believes that the existing and widening gap between current social care expenditure and predicted future needs of the population is an urgent healthcare priority and that this:
- (i) compromises patient safety
  - (ii) requires GPC to demand an immediate response from the Department of Health and NHS England.
- 291 AVON: That conference is gravely concerned about the suggested appointment of Lord David Prior as the next chair of NHS England. It instructs GPC to campaign against the overtly political appointment of an individual who appears to have little knowledge or understanding of general practice and its vital importance to the NHS.
- 292 NORTHAMPTONSHIRE: That conference insists that NHS England prohibits any of their staff or associates from commenting anonymously on issues affecting primary care and will be summarily dismissed if they do so.
- 293 CENTRAL LANCASHIRE: That conference believes that there are far too many serious system failures occurring on a national basis where practices are expected to pick up the pieces and calls on NHS England to develop a national contingency plan to support practices when such incidents occur.

- 294 LIVERPOOL: That conference believes that NHS England should offer a comprehensive array of translated patient leaflets for use in patient education, public health and clinical consultations.

## INDEMNITY

- 295 BOLTON: That conference believes GPs may not be aware of the repercussions of taking up transitional benefits cover with their defence organisation:
- (i) they will have to buy run off cover for up to a maximum of seven years if they leave the scheme during this transitional period
  - (ii) they are being offered a different indemnity product, not a discount on their current arrangement
  - (iii) calls on GPC to negotiate with medical defence organisations and the government, to ensure indemnity costs are clear and transparent and do not leave GPs open to future liability.
- 296 LEICESTER, LEICESTERSHIRE AND RUTLAND: The conference considers all GPs should have crown indemnity in view of rising indemnity costs.

## GPC/GPDF/LMCS/CONFERENCE

- 297 CAMBRIDGESHIRE: That conference notes ongoing reviews over the GP funding formula, QOF, premises, partnership, and indemnity, and calls on GPC England to ballot the profession prior to agreeing GP contract changes in 2019, and that any such ballot should:
- (i) include all working GPs in England, irrespective of their contract status
  - (ii) take place once all these reviews are completed, as they are interdependent
  - (iii) take place prior to any outcomes of the various reviews being agreed, to prevent interdependent issues being dealt with sequentially.
- 298 HERTFORDSHIRE: That conference acknowledges the various consultations and reviews coming to fruition in 2019 and calls upon the GPDF to work with GPC England and, inter alia, the BMA in providing targeted financial support towards a public facing campaign to raise awareness of the perfect storm facing general practice and to galvanise patient, public and pan-professional support in advance of national contract negotiations.
- 299 SANDWELL: That conference wishes to inform the GPC that:
- (i) there has been no improvement, at all, in general practice and there appears to be no prospect of any improvement. There is, in fact, further deterioration in the safety and sustainability of general practice.
  - (ii) therefore the policy decided at the special conference in January 2016 (Motion 20) should be implemented, namely:
  - (iii) actions that GPs can undertake without breaching their contracts must be identified to the profession
  - (iv) a ballot of GPs should be considered regarding what work/services must cease to reduce the workload to ensure safe and sustainable care for patients

- (v) the GPC should canvass GPs on their willingness to submit undated resignations.
- 300 TOWER HAMLETS: That conference believes the government have no intention of listening to the medical professions repeated warnings about the demise of general practice and;
- (i) believes the public are mainly unaware of the disastrous implications of government policy
  - (ii) instructs GPC to organise a high profile event within the next three months to increase awareness of the general public to this situation
  - (iii) instructs GPC to ballot general practice on collective temporary closure of practice lists to help bring the implications of this demise into the public focus.
- 301 BIRMINGHAM: That conference believes GPC England should take steps to become more representative of its constituents.
- 302 SOMERSET: That conference believes that GPC and LMCs should take affirmative action to become more representative of the wider GP workforce.
- 303 BATH AND NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference requires the Agenda Committee to include controversial and fun motions in the first part of the agenda.
- 304 MID MERSEY: That conference requests an immediate moratorium on the use by the national media of old images of Dr Laurence Buckman at his desk when illustrating news stories about general practice.

## SESSIONAL GPs

- 305 SOMERSET: That conference recognises the great contribution made to primary care by sessional doctors, and so:
- (i) deplores the lack of financial support for appraisal and re-validation in contrast with that available to contractors through the Global Sum
  - (ii) directs GPC to negotiate an honorarium for sessional doctors to rectify this inequality.
- 306 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference condemns locum transfer fee clauses in agency contracts which require practices to pay a proportion of newly appointed salaried GPs salary to the agency if they had previously had an engagement with the practice through that agency. This disadvantages individual GPs recruitment prospects, places a financial burden on practices and fuels the general practice workforce crisis. We call on GPC to:
- (i) work with NHS England to ban the use of these clauses in general practice;
  - (ii) make individual GPs and GP practices aware that such clauses exist and provide advice on how to avoid and challenge them.

## WORKFORCE

- 307 KENT: That conference agrees that improved access 8am – 8pm 7 days per week cannot safely be achieved within current funding.
- 308 GLOUCESTERSHIRE: That conference believes that the working conditions for many GPs are now so intolerable that their health is threatened and therefore suggests that all GPs should be provided with Med3 certificates as being unfit for work unless such conditions are improved by NHS England within three months.
- 309 HULL AND EAST YORKSHIRE: That conference believes that NHS England's claims that the commissioning of extended access will create more appointments for patients in general practice is 'fake news', and:
- (i) it has been a monumental waste of public money
  - (ii) it diverted resources away from core general practice further worsening the crisis faced by the profession
  - (iii) it should be invested in core general practice.
- (Supported by North and North East Lincolnshire LMC)
- 310 NOTTINGHAMSHIRE: That conference is saddened by the falling number of GPs nationally and recognises the threat to our profession. That said, we welcome other health care professionals as part of the practice team. Conference demands that the:
- (i) GPC encourages growth in numbers of clinical pharmacists, ANPs and Physician Associates
  - (ii) burden of training and employing such practitioners does not fall entirely on general practice unless full and fair funding for this is made available.
- 311 DERBYSHIRE: That conference notes the current and predictably worsening shortage of well qualified practice nurses working in primary care and the limited exposure to practice nursing covered in the undergraduate nursing curriculum. Conference calls for all practice nurse training costs currently met by individual GP partnerships to be met by Health Education England in order that:
- (i) practice nurse training, particularly in areas of chronic disease management, become more standardised
  - (ii) when practice nurses move on to new roles, possibly in locations of greater need, their current employer is not penalised having invested in their training only for their skills to be beneficial elsewhere.
- 312 GLOUCESTERSHIRE: That conference calls for the true integration of primary health care teams, reversing the trend towards centralising allied care professionals away from primary care centres.
- 313 KENT: That conference, in order to encourage GP retention, demands that:
- (i) GPs should be rewarded for cumulative service
  - (ii) GPs should be reimbursed for overtime work carried out beyond normal agreed standard working hours
  - (iii) medical indemnity should be standardised
  - (iv) home visiting provided by a separately funded service provided by the NHS
  - (v) GPs and their families should be given private health insurance and private health club membership.



- 314 CLEVELAND: That conference, in respect of the International GP Recruitment Programme:
- (i) believes that it is on track to fail to recruit 2000 suitably qualified GPs by 2020
  - (ii) condemns the money paid to private recruitment agencies who are inexperienced in this specialist areas and have no local knowledge
  - (iii) believes the money would be better invested in retaining GPs who are already in the country, including refugee doctors
  - (iv) demands that localities or regions should have the option of using the money for their own local schemes.
- 315 HERTFORDSHIRE: That conference:
- (i) notes the failure to recruit the 5000 extra GPs promised in GPFV
  - (ii) is dismayed that the government is pressing ahead with plans for Extended Access when the workforce to deliver in-hours care is already so stretched
  - (iii) calls on GPC to get the government to suspend Extended Access at least until the GP workforce had been increased by the 5000 extra GPs promised in GPFV.
- 316 CAMBRIDGESHIRE: That conference believes that patients deserve healthy GPs and demand that GPC England:
- (i) publicly acknowledges that the current demand in general practice is posing an unacceptable risk to the physical and mental health of primary care clinicians
  - (ii) initiates a patient-facing, LMC supported campaign to engage with the public informing them of the perilous state of general practice.
- 317 NOTTINGHAMSHIRE: That conference continues to recognise that general practice is the best job in the NHS; continues to give high patient satisfaction; continues to be a profession that we are proud to part of but recognises that:
- (i) the profession is being slowly starved of resources
  - (ii) our numbers are dwindling despite record recruitment into medical schools
  - (iii) our morale is at an all-time low
- and calls on the government to recognise the harm many of their policies have done to our profession and if continued in this fashion to the health of our nation.
- 318 NORTH YORKSHIRE: That conference is convinced that the formerly promised recruitment of 5,000 additional GPs by 2020 is far off track and therefore insists the GPC is ruthless in truthfully speaking out about it to the British public and media.
- 319 WAKEFIELD: That conference supports future funding and incentives being skewed towards prioritising continuity of care within general practice as the current evolution of general practice with increased numbers of part time GPs, portfolio GPs and larger practices is endangering this.
- 320 BEDFORDSHIRE: That conference:
- (i) notes that rather than Jeremy Hunt putting the NHS on track to recruit 5000 new GPs by 2020 the number of GPs is actually falling; and
  - (ii) welcomes the new Health Secretary and fervently hopes he succeeds in revitalising general practice where Jeremy Hunt so patently failed.

- 321 MERTON: That conference calls upon the government to recognise that the ongoing and worsening recruitment crisis is indicative of the low morale in general practice.
- 322 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference asks that GPC demand Department of Health invests in schemes to encourage GPs to take up substantive positions rather than becoming GP locums.
- 323 NORFOLK AND WAVENEY: That conference asks GPC to negotiate a nationwide anonymous direct access to Practitioner Health Programme for all doctors not just GPs facing mental health difficulties.
- 324 DORSET: That conference recognises a new breed of portfolio GPs in addition to the current principal and sessional roles.
- 325 LAMBETH: That conference:
- (i) recognises the important and essential contribution general practice nurses make to primary care
  - (ii) recommends that any new GP contract including recommending a minimum pay terms and conditions structure for general practice nurses.
- 326 LANCASHIRE COASTAL: That conference believes:
- (i) that too many of the young and talented GPs in the profession hate their jobs
  - (ii) that this is not conducive to the delivery of safe, effective and efficient primary care
  - (iii) that urgent measures should be taken to look at the reasons why so many hate their jobs and identify the ramifications for recruitment and retention.
- 327 HULL AND EAST YORKSHIRE: That conference is appalled at the lack of evidence based commissioning by some CCGs and immediately calls on the NHS England to centralise commissioning responsibilities away from these CCGs!  
(Supported by the North and North East Lincolnshire)
- 328 ISLINGTON: That conference requires a commitment from NHS England and CCGs to ensure that future commissioning will be based upon the wider determinants of health and that this:
- (i) should be underpinned by increased support and funding to enable a true integration of services
  - (ii) will require better communication and involvement of patients.
- 329 NOTTINGHAMSHIRE: That conference recognises that enhanced/ locally commissioned services for many practices remain an important source of income, and the services provided are crucial for patient care. There is concern that unilateral changes to locally commissioned services are made without due process and that decommissioning decisions are made with little consultation with the profession. We urge that the GPC:
- (i) deplores moves that seek to either cease commissioning of such services or change the cost envelope for service provision without adequate consulting with the resident LMCs
  - (ii) ensures that any decommissioning or changes to funding for locally commissioned services must be made only after local discussions with the resident LMC have taken place. This could be monitored at local level by NHS England DCOs.

- 330 NORFOLK AND WAVENEY: That conference welcomes the provision of social prescribers within primary care but is concerned that because of local authority and voluntary agency funding cuts the full potential will not be achieved.

## GPFV

- 331 HARROW: That conference recognises the value of the Pharmacy in GP Scheme to partly alleviate workload strain in general practice and calls upon GPC to negotiate for a fully funded and recurrent scheme from 2020 onwards.
- 332 BERKSHIRE: That conference expects General Practice Forward View funds to be:
- (i) spent equitably across the country
  - (ii) recurrent year on year going forward
  - (iii) made available to individual practices to enable working at scale.
- 333 HARROW: That conference welcomes the GPFV allocations to date and calls upon GPC to negotiate for further GPFV allocations following 2021.
- 334 HARINGEY: That conference acknowledges the best intentions of the GPFV monies but demands that the lack of continuity in service and workforce planning resultant upon such piecemeal sums made on short term and inconsistent annual basis be reversed and there needs to be a clear, substantial and continuing commitment to invest in general practice demonstrated in the future.
- 335 LAMBETH: That conference fully endorses the recent call by the RCGP that the GPFV needs an urgent overhaul backed by an extra £2.5 billion investment to protect the future of general practice
- 336 DERBYSHIRE: That conference believes that taking into consideration the negative report of GPFV by GPC, conference instructs GPC to address the ridiculous expectation of NHS England that despite funding being released for GPFV work streams anything up to five months late that impact has to be demonstrated within that financial year.
- 337 MORECAMBE BAY: That conference believes that the Estates and Technology Transformation Fund within the GPFV has done very little to improve the general practice estate and calls on NHS England to recognise the importance of investing in individual practice premises and to develop an investment programme accordingly.
- 338 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers CCG spending resilience money for smaller practices
- 339 BEDFORDSHIRE: That conference believes that the NHS has no hope of getting an additional 5000/6000 GPs by 2020 unless the problem with GP premises is addressed satisfactorily.
- 340 SANDWELL: That conference congratulates the GPC on their decision to accept GPFV as a solution the crisis in general practice and to refuse to accept undated resignation letters etc. as per the special conference of 2016. Three years into the five year plan, the membership have no remaining concerns.

- 341 HERTFORDSHIRE: That conference:
- (i) has reached the conclusion that the GPFV is a smokescreen and that general practice is undergoing a significant intentional disruptive change, and
  - (ii) calls on the GPC to find a way to work with HMG, as this process continues, to prevent the process being as disorderly as it is at the present.
- 342 SANDWELL: That conference requires, in the event that GPFV does not solve the crisis in general practice, the GPC have in place a plan for the involution of primary care in England (ie hard GPexit).

## STANDING ORDERS

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## STANDING ORDERS

### CONFERENCES

#### Annual conference

1. The General Practitioners Committee (GPC) England shall convene annually a conference of representatives of local medical committees in England.

#### Special conference

2. A special conference of representatives of local medical committees in England may be convened at any time by the GPC England, and shall be convened if requested by one third, 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 chair and deputy chair of the conference
  - 3.2 300 representatives of local medical committees
  - 3.3 the members of the GPC England
  - 3.4 the elected members of the conference agenda committee (agenda committee)
  - 3.5 those regionally elected representatives of the GP trainees subcommittee who were elected from regions in England, together with its chair
  - 3.6 those elected members of the sessional GPs subcommittee of the GPC who were elected from regions in England.

#### Representatives

4. All local medical committees in England 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 day after conference, 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 the chair of conference's discretion. In addition, the chair 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.

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 England 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 England, the agenda committee, a local medical committee.

### **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 England, and any local medical committee. These shall fall within the remit of the GPC England, 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 any Acts or Orders amending or consolidating the same
  - 17.2 motions submitted by the agenda committee in respect of organisational issues only.
18. When a special conference has been convened, the GPC England shall determine the time limit for submitting motions.

### **The agenda shall be prepared by the agenda committee as follows:**

19. 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 24 and 25 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.
20. '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 day of conference, the removal of the motion from the group shall be decided by the conference.
21. '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.
22. 'Motions with subsections':
  - 22.1 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
  - 22.2 subsections shall not be mutually contradictory
  - 22.3 such motions shall not have more than five subsections except in subject debates.

23. 'Rescinding motions': Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters 'RM'.
24. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chair of the GPC England as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.
25. 'AR' motions: Motions which the chair of the GPC England is prepared to accept without debate as a reference to the GPC England shall be prefixed with the letters 'AR'.
26. '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 England 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.
27. 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 42, 43, 44, and 45 shall not apply and the debate shall be held in accordance with standing order 50.

#### **Other duties of the agenda committee include:**

28. 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 order 55, and overseeing the conduct of the conference.

#### **Procedures**

29. 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 chair approves.
30. 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.
31. 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 chair's discretion. For the first session, amendments or riders must be handed in before the session begins.
32. No seconder shall be required for any motion, amendment or rider submitted to the conference by the GPC England, a local medical committee, or the joint agenda committee, or for any composite motion or amendment produced by the agenda committee under standing order 21. All other motions, amendments or riders, after being proposed, must be seconded.
33. No amendments or riders will be permitted to motions debated under standing order 27.



## Rules of debate

34. 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.
35. Every member of the conference should be seated except the one addressing the conference.
36. A member of conference shall address conference through the chair.
37. 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.
38. Members of the GPC England, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.
39. The chair shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.
40. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.
41. The chair shall take any necessary steps to prevent tedious repetition.
42. 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.
43. Amendments shall be debated and voted upon before returning to the original motion.
44. Riders shall be debated and voted upon after the original motion has been carried.
45. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 42, 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.
46. If it is proposed and seconded or proposed by the chair 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 chair 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 chair of the GPC England and the mover of the original motion shall have the right to reply to the debate before the question is put.
47. If there be a call by acclamation to move to next business it shall be the chair'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.

48. 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 chair may ask conference (by a simple majority) to waive this requirement.
49. If by the time for a motion to be presented to conference no proposer has been notified to the agenda committee, the chair shall have the discretion to rule, without putting it to the vote, that conference move to the next item of business.
50. In a major issue debate the following procedures shall apply:
  - 50.1 the agenda committee shall indicate in the agenda the topic for a major debate
  - 50.2 the debate shall be conducted in the manner clearly set out in the published agenda
  - 50.3 the debate may be introduced by one or more speakers appointed by the agenda committee who may not necessarily be members of conference
  - 50.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
  - 50.5 subsequent speakers will be selected by the chair from those who have indicated a wish to speak. Subsequent speeches shall last no longer than one minute.
  - 50.6 the Chair of GPC England or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
  - 50.7 at the conclusion of the debate the introductory speakers may speak for no longer than two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
  - 50.8 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**

51. 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.
52. 'Soapbox session':
  - 52.1 A period may 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.
  - 52.2 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.
  - 52.3 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.
  - 52.4 GPC England members shall not be permitted to speak in the soapbox session.
53. 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 chair shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.
54. Motions prefixed with a letter 'A', (defined in standing orders 24 and 25) shall be formally moved by the chair 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.
55. Other periods of time may be allocated by the Agenda Committee for other purposes as indicated in the Agenda.

### Motions not published in the agenda

56. Motions not included in the agenda shall not be considered by the conference except those:
  - 56.1 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
  - 56.2 relating to votes of thanks, messages of congratulations or of condolence
  - 56.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association
  - 56.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned
  - 56.5 prepared by the agenda committee to correct drafting errors or ambiguities.
  - 56.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions
  - 56.7 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 50.

### Quorum

57. 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

58. A member of the conference, including the chair of the GPC England, moving a motion, shall be allowed to speak for three minutes; no other speech shall exceed two minutes. However, the chair may extend these limits.
59. 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 chair.

### Voting

60. Except as provided for in standing orders 63 (election of chair of conference), 64 (election of deputy chair of conference), and 65 (election of five members of the agenda committee), only representatives of local medical committees may vote.

### Majorities

61. Except as provided for in standing order 46 and 47 (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:
  - 61.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC England structure, or
  - 61.2 a decision which could materially affect the GPDF Ltd funds.
62. Voting shall be, at the discretion of the chair, by a show of voting cards or electronically. If the chair requires a count this will be by electronic voting.

### Elections

63. Chair
  - 63.1 At each conference, a chair shall be elected by the members of the conference to hold office from the termination of the conference. All members of the conference shall be eligible for nomination.
  - 63.2 Nominations must be handed in on the prescribed form before 10am on the 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.

64. Deputy chair
- 64.1 At each annual conference, a deputy chair shall be elected by the members of the conference to hold office from the termination of the conference. All members of the conference shall be eligible for nomination.
- 64.2 Nominations must be handed in on the prescribed form before 1pm on the day of the conference. 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.
65. Five members of the conference agenda committee
- 65.1 The agenda committee shall consist of the chair and deputy chair of the conference, the chair of GPC England and five members of the conference, not more than one of whom may be a sitting member of GPC England at the time of their election. In the event of there being an insufficient number of candidates to fill the five seats on the agenda committee, the chair shall be empowered to fill any vacancy 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.
- 65.2 The chair of conference, or if necessary the deputy chair, shall be chair of the agenda committee.
- 65.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by 1.00pm on the day of the conference. 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.

### **Returning officer**

66. 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.

### **Motions not debated**

67. 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 England memoranda of evidence in support of their motions. Memoranda must be received by the GPC England by the end of the third calendar month following the conference.

### **Distribution of papers and announcements**

68. 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 chair.
69. Mobile phones may only be used for conversation in the precincts of, but not in, the conference hall.

**The press**

70. Representatives of the press may be admitted to the conference but they shall not report on any matters which the conference regards as private.

**Chair's discretion**

71. 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 chair's absolute discretion.

**Minutes**

72. Minutes shall be taken of the conference proceedings and the chair shall be empowered to approve and confirm them.

## Resolutions from Conference of England LMCs 2017

In this document, the Agenda Committee has provided you with brief feedback on the resolutions from last year's conference. If you wish to seek more information regarding a resolution or area of work, please feel free to speak to one of the GPC Policy Leads, listed at the end of this appendix.

### GPC Policy Group: Commissioning and Provider Development

That conference asks GPC England to negotiate funding and statutory changes to ensure general practice can provide a strategic role in the development of new models of care and

- (i) ensure parity with other parts of the health and social care service
- (ii) ensure that they can be GP led organisations
- (iii) ensure equitable use of savings made,
- (iv) to explore other options for general practice holding core contracts **(carried as a reference)**

**Work ongoing. This is subject to current negotiations.**

That conference believes the new Integrated Urgent Care (IUC) agenda will have significant impact on primary care services and the profession has not been adequately consulted on this, and demands:

- (i) a proper impact assessment be carried out of the effect on primary care
- (ii) a proper consultation takes place between commissioning boards and LMCs
- (iii) no new service demands are imposed on already overstretched, under-resourced and understaffed primary care teams
- (iv) no staff are redirected from current service provision to support an untried and untested idea.

**Work ongoing. This has been raised with NHS England.**

### GPC Policy Group: Information Technology and Information Governance

That conference is concerned about the pressure to introduce on line consulting into general practice:

- (i) when there is no evidence that it will save time
- (ii) and believes it will decrease access to more vulnerable patients who may struggle to use the internet
- (iii) as it will add to an already unmanageable GP workload
- (iv) and calls on GPC England to make it clear to government and NHS England that GPs will not formally agree to begin on line consulting until there is clear evidence that it is beneficial to the health of patients.

**Work completed.**

That conference is concerned that with the increase in use of 'advice and guidance' by trusts on Electronic Referral System (ERS) that:

- (i) GPs will be required to take on more secondary care work without an increase in resources
- (ii) GPs will be exposed to further clinical risk
- (iii) clear guidance must be produced to clarify who holds the clinical risk
- (iv) national financial modelling is required to ensure appropriate financial resourcing of this new workload.

**Noted as policy. GPC England has delivered funding to cover this and developed guidance to address conference concerns.**

That conference requires GPC England to:

- (i) negotiate with relevant bodies on the development of a standardised overarching data sharing template and data sharing agreement format
- (ii) ensure that NHS England/CCGs recognise the importance of information governance provider development arrangements
- (iii) work to ensure that properly resourced regional information governance and data sharing support arrangements are put in place to provide expert support and advice to GP provider organisations
- (iv) appoint regional data sharing experts to provide advice and support to all LMCs on all data sharing agreement

**Work ongoing. GPC England continues to push for these.**

That conference supports the piloting of artificial intelligence health systems but insists that, prior to further rollout:

- (i) all systems need to be piloted and assessed against set national criteria
- (ii) the systems need to demonstrate a sustainable reduction in GP workload
- (iii) any system needs to fully integrate with GP clinical systems.

**Noted as policy. This has been highlighted to NHS England.**

**GPC Policy Group: Clinical and Prescribing**

That conference demands that individual CCGs should not be able to impose restrictions on prescribing and calls upon:

- (i) Department of Health to undertake a national review of prescribing regulations and entitlements
- (ii) Delegated CCGs to remove pressure on GPs to reduce or limit clinically appropriate prescribing.

**Work ongoing. GPC England responded to consultation on this issue and a few areas are subject to current negotiation.**

That conference recognises the right and responsibility of general practitioners to refer patients for specialist opinion and regarding referral management systems:

- (i) requires legal confirmation that the clinical responsibility will rest with the individual making the decision that a referral may or may not proceed
- (ii) believes they are an unacceptable barrier to patients accessing appropriate secondary care
- (iii) believes the time involved is a poor use of the GP workforce
- (iv) demands that the government takes measures to ensure that the postcode lottery these create ceases immediately
- (v) calls upon the GPC England to oppose this false economy and allow GPs as highly skilled generalists to continue to act with professional autonomy.

**Work ongoing. These points have been made to NHS England.**

### GPC Policy Group: Contracts and Regulation

That conference deplores the over-regulation of general practice and it calls upon GPC England to lobby government to:

- (i) abolish the NHS Choices reporting system
- (ii) abolish the Friends and Family test reporting system
- (iii) review the current procedure for GP complaints so that trivial complaints can be taken out of the system, as the practice time and resources they consume are disproportionate

**Work ongoing. GPC England are continuing to push NHS England to improve the way complaints are handled and share the serious concerns highlighted by conference about NHS Choices and have made this concern repeatedly known to NHSE, however they have not agreed to make a change.**

That conference asks GPC England to enter into discussions with NHS England:

- (i) to develop a new category of list closure that would allow a practice to close its list in agreement with the commissioners, and in the interest of patient safety, so that it can, for a period, decline to accept new registrations from patients who have not changed address
- (ii) to improve financial support to practices taking on patients following a list dispersal with the creation of a centrally negotiated payment per patient
- (iii) to work towards funding to practices taking on patients after a list dispersal flowing in 'real time' and not in arrears at quarter-end,
- (iv) so that commissioners must agree the terms of any list dispersal with the LMC(s) involved to ensure neighbouring practices taking on extra workload are supported appropriately and not destabilised.

### Work ongoing with NHS England.

That conference demands that the procedure be far easier for GPs to become a CQC 'registered manager', and that possession of GMC registration and placement on the Performers List alone should be sufficient requirements for this post.

### Work ongoing

### GPC Policy Group: Education, Training and Workforce

That conference demands that GPC works with NHS England to:

- (i) ensure the standards set for appraisal and revalidation are the same across the country and are not open to interpretation by individual Responsible Officers
- (ii) that appraisal remains a supportive, formative tool for professional development, in line with current RCGP guidance and not a performance management tool
- (iii) ensure that confidentiality is an integral part of the appraisal process and that performance management groups do not have the right to access an appraisal without a GP's written consent. **(carried as a reference)**
- (iv) reject any attempt by NHS England or others to introduce minimum activity levels on the Medical Performers List

**(Responsibility for this motion is shared with the Contracts and Regulation Policy Group)**

### Work ongoing



### GPC Policy Group: Workload

That conference:

- (i) believes tired doctors are potentially unsafe doctors
- (ii) calls on GPC England to issue guidance to support GPs to limit their working day to ensure patient safety
- (iii) calls on NHS England and the government, working with GPC England, to make patients aware of the importance of reducing GP workload to safe levels
- (iv) believes GPs should be supported to say “NO” without feeling guilt.

**Work ongoing. These issues have been raised with NHS England and RO. New appraisal guidance has been issued which GPs should use to reduce the workload burden of appraisal.**

That conference welcomes the recent hospital contract changes which empower GPs to reject inappropriate work from secondary care but feels it does not go far enough and demands that:

- (i) NHS England and CCGs hold secondary care providers to account for compliance with the requirements
- (ii) an identified email address is provided for every hospital to receive and act upon breaches
- (iii) GPC England negotiates with NHS England that hospitals publicise their arrangements for fulfilling their contractual obligations to patients
- (iv) GPC England works with others to introduce a formal national programme that educates clinicians joining trusts of their obligations
- (v) GPC England negotiate a tariff system which can be used to assign value and, consequently, payment to work carried out by practices, which should be done by secondary care providers.

**Work ongoing. Each of these issues are key areas of discussion being addressed in the primary-secondary interface group.**

### GPC Policy Group: Premises and Practice Finance

That conference instructs GPC England to negotiate with government:

- (i) an extension to the deadline for the reimbursement package including contributions to Stamp Duty Land Tax, VAT, legal costs and service charge management fees
- (ii) a guarantee that the ‘last man standing’ in a partnership will have the building either bought back or the remaining lease taken over by the government
- (iii) that the lease liability for non-NHS Property Services (NHS PS) should be accepted by NHS England in the same way as for NHS PS premises
- (iv) to ensure equivalent investment in partner owned premises as in purpose built and NHS Property service buildings

**Work ongoing through the Premises Review. PCDs to be published soon.**

That conference believes that Estates, Technology and Transformation Fund (ETTF) monies are not reaching sufficient numbers of practices and calls on the GPC urgently to discuss how NHS England can guarantee this money reaches practices immediately.

**Work ongoing through the Premises Review. PCDs to be published soon.**

### GP Trainees Subcommittee

That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:

That conference recognises the inconsistent out-of-hours arrangements in GP training across the country and requires GPC, through the GP trainees subcommittee, to engage with the RCGP curriculum review and HEE review of OOH to ensure that:

- (i) OOH work for GP trainees is for training and not service provision
- (ii) hours requirements for OOH work is consistent across the country
- (iii) trainees are supernumerary and supervised when managing patients in the OOH setting by a GP, and should not be expected to work as independent practitioners during their training

#### Work ongoing to address these issues with HEE.

That conference instructs the GPC to work with the RCGP to develop the GP curriculum so that trainees are taught and assessed on relevant aspects of practice management.

#### Work ongoing. This issue was reflective in the GPC England's evidence submission to the GP Partnership Model Review.

### GP Sessional Subcommittee

That conference understands the value of independent contractor status but also recognises that not all GPs desire to work in this way and calls upon GPC to:

- (i) formulate a blueprint for the future of general practice that includes a plurality of contractual types and provides meaningful support to both sessional and contractor GPs
- (ii) lobby NHS England to investigate and invest in locum chambers as a proven GP retention model (**carried as a reference**)
- (iii) ensure that locum GPs are protected from large web based platforms and locum banks which attempt to impose unfair terms of work and rates of pay.

#### Work ongoing

### GPC England Executive Team

That conference calls upon GPC England to:

- (i) make the return of the delivery of primary care support functions to the public domain a central demand in the next round of contract negotiations
- (ii) urgently address Capita's failure to correctly collect superannuation contributions in England and seek recompense for those practitioners affected
- (iii) demand that NHS England prioritise PCSE service improvement with regard to financial statements so that practices can undertake informed business planning.

#### Work ongoing. Some improvements have been made this year, however the GPC continue to have serious concerns and are working to address them.

Given the vote of no confidence in the GP Forward View at the Conference of LMCs in Edinburgh earlier this year, conference insists that GPC England negotiates improvements in the GP Forward View to ensure that money reaches practices directly without additional bureaucracy or additional workload requirements, and adequate improvements cannot be achieved within one year, GPC England must publicly dissociate itself from GP Forward View.

### **Work ongoing subject to current negotiations. The GPC have disassociated themselves from the GPFV.**

That conference deplores the imposition of the capped expenditure process (CEP) and calls on GPC to negotiate with NHS England and NHS Improvement to abandon this process because:

- (i) GP providers are already struggling to provide services within what is already a limited financial envelope
- (ii) general practice and GP service provision will necessarily and disproportionately experience the impact of this cost cutting exercise
- (iii) even with economies of scale this has the potential to destabilise general practice to the overall detriment of patient care
- (iv) the CEP is likely to significantly increase workload in general practice without any additional funding, or any consideration being given to the impact or sustainability of this transfer of work.

### **Work ongoing**

That conference believes that the rising cost of medical indemnity in England is making general practice unsustainable and adding to the workforce crisis in England, and calls upon GPC England to:

- (i) ensure that inflationary reimbursements made by NHS England are recurrent and made directly to the individual GP or practice that is paying the indemnity
- (ii) demand that the government must introduce a system of indemnity comparable with secondary care which covers all GPs on the performers list and all NHS GP practice staff.
- (iii) welcome the government's intention to provide indemnity cover to all GPs and their teams, and insists that this must be funded by new money

### **Work ongoing**

That conference, with regard to the 'GP at Hand' service launched this week and any other similar services:

- (i) deplores the use of public funds, including any GP Forward View monies, to promote inequitable access to NHS branded GP services
- (ii) demands that GPC commences urgent negotiations with the Secretary of State for Health to compensate practices from which registrations are switched for the loss of practice income incurred as a result of any patient registering with such services
- (iii) demands that the GPC seeks urgent legal advice regarding the options available and the potential for a judicial review, to challenge the decision to introduce this service.

### **Work ongoing**

## GPC Policy Leads



**Policy Group:** Clinical & Prescribing  
**Lead:** Andrew Green



**Policy Group:** Commissioning and  
Provider Development/Working at Scale  
**Lead:** Simon Poole



**Policy Group:** NHS Delivery  
**Lead:** Chandra Kanneganti



**Policy Group:** Contracts & regulation  
**Lead:** Robert Morley



**Policy Group:** Dispensing & Pharmacy  
**Lead:** David Bailey



**Policy Group:** Education, Training  
and Workforce  
**Lead:** Helena McKeown



**Policy Group:** Information Management,  
Technology & Information Governance  
**Lead:** Paul Cundy



**Policy Group:** Premises and  
practice finance  
**Lead:** Ian Hume



**Policy Group:** Representation  
**Lead:** Bruce Hughes



**Policy Group:** Workload management  
**Lead:** Matthew Mayer



**Sessional GP Subcommittee**  
**Chair:** Zoe Norris



**GP Trainees Subcommittee**  
**Co – Chair:** Zoe Greaves



**GP Trainees Subcommittee**  
**Co – Chair:** Sandesh Gulhane

**Conference of England LMC Representatives**

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