

**GPDF**

General Practitioners  
Defence Fund

**BMA**



# 2016 Conference of LMCs Agenda

19 and 20 May at the Mermaid Centre, London



British Medical Association  
[bma.org.uk](http://bma.org.uk)







# Agenda

To be held on

**Thursday 19 May 2016** at 9.30am

**Friday 20 May 2016** at 9.00am

At The Mermaid Conference & Events Centre, Puddle Dock, Blackfriars, London EC4V 3DB

## Chair

Guy Watkins (Cambridgeshire)

## Deputy

Chair Mary O'Brien (Dundee)

## Conference Agenda Committee

Guy Watkins (Chair of Conference)

Mary O'Brien (Deputy Chair of Conference)

Chaand Nagpaul (Chair of GPC)

Stuart Blake (Edinburgh)

Christopher Browning (Suffolk)

Hal Maxwell (Ayrshire)

Helena McKeown (Wiltshire)

Rachel McMahon (Cleveland)

Stephen Meech (Kent)

Emmanuel Owoso (Swansea)

## Notes

Under standing order 18, in this agenda are printed all notices of motions for the annual conference received up to noon on 14 March 2016. Although 14 March 2016 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the secretary prior to the conference, or handed in, in writing, at as early a stage of the conference as possible.

The agenda committee has acted in accordance with standing 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 the GPC as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.

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

Under standing order 21, 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 series of major issue debates.

Attached is a ballot form for chosen motions.

The ballot closes at **noon on Friday 13 May 2016**.

## Schedule of business

### THURSDAY 19 MAY 2016

Item	Time
Opening business	09:30
Annual report by the Chair of GPC	10:00
Themed debates:	
Funding of General Practice	10:20
Workload in General Practice	11:00
General Practice Workforce	11:40
Empowering Professionalism	12:20
Lunch	13:00
Parallel discussion groups	14:00
Information management and technology	16:15
Seven day GP service	16:40
Urgent care	16:50
Junior doctors' dispute	17:00
Contingency	17:20
Close	17:30

### FRIDAY 20 MAY 2016

Item	Time
Response of the profession	09:00
Premises	10:40
Overseas patients	10:50
GP locums	11:00
Medical certificates and reports	11:10
Soapbox	11:20
Charities	12:20
Lunch	12:30
Chosen motion section	13:30
Themed debate – GPC Reform Task Group	15:10
Close	17:00

## Elections

The following elections will be held on Thursday 19 May and Friday 20 May 2016.

### **Chair of conference**

Chair of conference for the session 2016-2017 (see standing order 72 – nominations to be handed in no later than **12 noon Thursday 19 May**).

### **Deputy chair of conference**

Deputy chair of conference for the session 2016-2017 (see standing order 73 – nominations to be handed in no later than **9.30am Friday 20 May**).

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

Seven members of the GPC for the session 2016-2017 (see standing order 74 – nominations closed on Monday 9 May).

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

Seven members of the conference agenda committee for the session 2016-2017 (see standing order 75 – nominations to be handed in no later than **1.00pm on Thursday 19 May**).

## Return of Representatives

**9.30**

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

## Minutes

2. Receive: Minutes (AC19 2014-2015) of the 2015 Annual Conference of Local Medical Committees as approved by the Chair of conference in accordance with the provision of standing order 87.
3. Receive: Summary (GPC News 6, 2015-16) of the 2015 Special Conference of Local Medical Committees.

## Standing orders

4. 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

5. THE CHAIR (on behalf of the agenda committee): That the report of the agenda committee be approved.
6. AGENDA COMMITTEE: That conference, in order to facilitate its own policy of asking the GPC to ensure adequate representation on GPC of LMC representatives within their first five years post CCT, agrees to hold a ballot during conference to enable the Chair of the Representation Sub-Committee to identify the most suitable GP to co-opt (to have the full voting rights of any GPC member) for the forthcoming session. Candidates must be Representatives of LMCs at this conference, and must have gained their CCT after 19 May 2011. Only representatives at Conference will be entitled to vote.

## ANNUAL REPORT

**10.00**

7. THE CHAIR: Report by the Chair of GPC, Dr Chaand Nagpaul.

## THEMED DEBATES (Please see Annex 1) 10.20 – 13.00

The remainder of this morning's session will be conducted under Standing Order 54 – Major Issue debates.

At the Special Conference in January four main themes were debated, calling for the negotiation of a Rescue Package for General Practice, and since then GPC have produced and published their [Urgent Prescription for General Practice](#). We have received a large number of motions for this Conference covering the same ground.

We are therefore holding four Major Issue Debates this morning.

1020 to 1100	Funding of General Practice
1100 to 1140	Workload in General Practice
1140 to 1220	General Practice Workforce
1220 to 1300	Empowering professionalism

The structure of the debate in each of these sections will be the same.

A member of the GPC executive team will introduce the debate (SO 54.3).

The Agenda Committee has produced in the Agenda Pack **Annex 1** for each debate the current GPC policy (as set out in the *Urgent Prescription*), relevant recent Conference policy, and motions submitted for consideration at this conference (marked A or AR as appropriate under SO 25/26).

Subsequent speakers will be called by the Chair from those who have indicated a wish to speak using speaker slips (54.5) – to facilitate this, speakers will be asked to describe in as few words as possible the area they wish to address on the Major Issues speaker slip.

Members of Conference will be given only **one** minute to address conference to allow as many as possible to speak (54.5).

The Chair of GPC and the introductory speaker may reply to the debate for up to two minutes (54.6 and 54.7).

After the debate (54.8) voting representatives at conference will be invited to indicate on a scale of 1 (not at all) to 6 (completely), using the electronic voting pads supplied, the extent to which they support current GPC policy in this.

Further to this indication of opinion, LMC representatives are also invited to indicate on the Major Issues Chosen Motion form any motions they believe should be debated to form new policy in this area. Motions will be debated, in order of priority, as time allows, on Friday morning.



**PARALLEL DISCUSSION GROUPS (Please see Annex 2) 14.00 – 16.10**

The start of the afternoon session will be held in parallel sessions. There are nine parallel sessions and each member of conference may attend three.

The Agenda Committee has listened to calls for some policy areas to be debated in a way less constrained by the wording of motions, and believes that some topics may be better debated in conversation around the key issues. The Agenda Committee also notes that some areas of interest key to GPs, LMCs and the GPC are not easily submitted as motions, and in response to requests have broadened the areas for debate accordingly.

Parallel sessions are designed to help members of conference Listen, Challenge, and Learn. An invited member of conference with specific expertise, who has agreed to introduce the topic, for no more than ten minutes, will then facilitate questions and debate and will lead parallel sessions. Speaker slips will not be used.

Members of conference and others will be able to view a record of the parallel sessions afterwards.

Parallel sessions may not form new policy directly, but motions arising from parallel sessions may be debated on Friday morning as representatives are invited to indicate any motions they wish to choose, after the sessions.

The Agenda Committee will confirm the timetable and room allocations after members of conference have indicated which session they would like to attend to try and facilitate choices where possible, and to reduce traffic between sessions.

Sessions run between  
1400 and 1440  
1445 and 1525  
1530 and 1610

Plenary starts again in the main auditorium at 1615.

#### Topics

- A Training and support for a new GP workforce
- B Listening to and learning from our diverse workforce
- C Mitigating risk in funding and developing GP Premises
- D How devolution in Manchester has radically changed thinking
- E Experience of creating an extended primary care team in Wessex
- F Professionally supported regulation – Preparing for a post-CQC world
- G Helping GPs to work at the top of their game
- H GP networks – promoting sustainable practice through collaboration
- J Responding to new contractual initiatives in New Models of care

In **Annex 2** the Agenda Committee has listed the motions submitted to Conference that it considers are best dealt with within these parallel sessions. Some sessions do not have relevant motions.

After the parallel sessions LMC representatives are also invited to indicate on the Parallel Session Chosen Motion form any motions they believe should be debated to form new policy. Motions will be debated, in order of priority, as time allows, on Friday morning.

**DEBATE (Please see Annex 3)****16.15**

The Agenda Committee has prioritised the following motions for debate. For ease of reference only those prioritised are listed here – the more complete and familiar presentation of the Agenda detailing the other motions in the brackets is included at **Annex 3** for reference.

**INFORMATION MANAGEMENT AND TECHNOLOGY****16.15**

8. AGENDA COMMITTEE to be proposed by Hull: That conference believes that GP IT needs fully funded:
  - (i) improved support services
  - (ii) fast and reliable broadband connections
  - (iii) scanning, digitising and shredding of paper records
  - (iv) interoperability
  - (v) a fit for purpose national primary care IT specification
  
9. AGENDA COMMITTEE to be proposed by South Staffordshire: That given the rise of multi-agency integrated digital care records and patient access to their own records, conference:
  - (i) requires the transfer of data controller status from individual primary care provider organisations
  - (ii) requests particular consideration of the needs for confidentiality of adolescents and vulnerable adults
  - (iii) advises patients should be given their paper notes for safekeeping
  - (iv) calls for a national Data Sharing agreement
  - (v) demands that the workload implications are addressed.

**SEVEN DAY GP SERVICE****16.40**

10. SUFFOLK: That conference believes that the current emphasis on 7-day working is a political push for the unachievable particularly in the light of the continued under-resourcing of primary care and insists that the 7-day mantra be abandoned and any additional resource available should be used to enhance the weekend emergency cover services.

**URGENT CARE****16.50**

11. AGENDA COMMITTEE to be proposed by Dorset: That conference is concerned by the lack of integration between the out-of-hours GP care providers with each other and in-hours GP services and calls for:
  - (i) a radical redesign and integration of all current out of normal hours services
  - (ii) an integrated IT system across all out-of-hours providers
  - (iii) work that comes to a practice after 6pm to be directed to OOH services
  - (iv) an out-of-practice daytime visiting service
  - (v) community urgent care centres which patients can access when their practices have no more capacity for same day access.

**JUNIOR DOCTORS DISPUTE****17.00**

12. AGENDA COMMITTEE to be proposed by Shropshire: That conference is appalled at the government's handling of the junior doctor's dispute and
- (i) strongly condemns the imposition of the new unsafe and unfair contract on junior doctors
  - (ii) believes that the imposition of the new junior doctors contract will cause irreparable damage to the NHS and patient care by destroying doctors' morale and losing the goodwill of hard working staff
  - (iii) confirms support for the junior doctors and calls on the GPC to set out what steps practices can take to demonstrate this.

**CONTINGENCY****17.20****CLOSE****17.30**



**RESPONSE OF THE PROFESSION (Please see Annex 4)****9.00 – 10.40**

After the submission deadline for motions to conference, NHS England published the [General Practice Forward View](#).

Taken together with the Urgent Prescription for General Practice published by the GPC scheduled for debate on the first day of conference, these two documents reflect the conversation to date between the GPC and NHSE on the so called rescue package demanded at the January Special conference.

Between 0900 and 1040 on Friday morning the Agenda Committee has arranged a Major Issue debate to debate and agree the profession's response to the General Practice Forward View, in the light of GPC and Conference policy and our debate the previous day.

The Agenda Committee has considered a large number of motions be included in this Major Debate, and these are in **Annex 4**.

The Agenda Committee anticipates that many of these published motions may have been overtaken by the publication of the General Practice Forward View, and expects a number of motions to be submitted by LMCs in response to this publication under the New Business rule SO63.6

The Agenda Committee will therefore detail how this debate will be handled, and how the response of Conference will be measured (with the possibility of forming new conference policy under S054.8) in the Supplementary Agenda at the start of Conference.

**DEBATE (Please see Annex 5)****10.40**

The Agenda Committee has prioritised the following motions for debate. For ease of reference only those prioritised are listed here – the more complete and familiar presentation of the Agenda detailing the other motions in the brackets is included at **Annex 5** for reference.

**PREMISES****10.40**

13. KENT: That conference believes that NHS Property Services is not fit for purpose and has:
- (i) failed in its mandate 'to provide a quality service to its tenants'
  - (ii) failed in its core value 'caring – helping the NHS to deliver better and more sustainable clinical care and services'
  - (iii) not been made accountable for its mismanagement and lack of action
  - (iv) demanded charges that are unrealistic, unaffordable and destabilising to practices.

**OVERSEAS PATIENTS****10.50**

14. EAST SUSSEX: That conference believes that overseas visitors should be able to attend UK general practitioners but:
- (i) this should only be on a private fee-paying basis
  - (ii) any fees paid should be retained in full by the general practice
  - (iii) it remains open to the government to offer NHS care free to overseas visitors at walk-in-centres, urgent care centres, and accident and emergency departments, and patients can be offered these alternatives.

**GP LOCUMS****11.00**

15. AGENDA COMMITTEE to be proposed by the Sessional Subcommittee: That conference affirms that locum GPs are an essential part of the GP workforce and in this current workforce crisis:
- (i) rejects the principle that the Department of Health can unilaterally fix a market price for services
  - (ii) rejects compulsory reporting by practices of locum payments
  - (iii) affirms that practices and locum GPs should be allowed to mutually agree terms and conditions
  - (iv) rejects any attempt to cap the fees charged by GP locums
16. DERBYSHIRE: That conference requests our profession to come together to agree a fair and reasonable cap on GP locum fees. (Motion will fall and not be debated if (iv) of Agenda Committee motion is passed)

**MEDICAL CERTIFICATES AND REPORTS****11.10**

17. AGENDA COMMITTEE to be proposed by Scottish Conference of LMCs That conference calls for:
- (i) an extension of self-certification for illness from 7 to 14 days
  - (ii) a change in legislation to allow other health care professional such as midwives, allied health professionals and nurse practitioners to complete 'fit notes' for patients.

**SOAPBOX****11.20**

18. Soap box is held under Standing order 57:
- 57.1 A period shall be reserved for a 'soapbox' session in which **representatives** shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
  - 57.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
  - 57.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
  - 57.4 GPC (UK) members shall not be permitted to speak in the soapbox session.

**CHARITIES****12.20**

19. Dain Fund  
Receive: Report by the Chair of the Dain Fund (Dr Stephen Bill Strange).
20. Claire Wand Fund  
Receive: Report by the Chair of the Claire Wand Fund (Dr Jane Wand).
21. Cameron Fund Annual General Meeting  
Receive: Report by the Chair of the Cameron Fund (Dr Stephen Linton).



**CHOSEN MOTION SECTION****13.30 – 15.10**

LMC Representatives have had three chances to choose motions for debate to allow new policy to be formed.

Motions chosen for debate may be formal C motions (chosen from the agenda in advance of conference under SO27), or motions chosen from the Major Issue debate and from the Parallel Sessions during conference. Motions included in the Supplementary Agenda may also be chosen during conference.

Motions will be debated under normal conference debating rules, in order of chosen priority, as time allows. LMCs who submitted motions chosen will be invited to propose the motion for conference.

The Agenda Committee has allocated 1330 to 1510 for these debates under SO29.

The list of the motions to be debated will be published at the start of the Friday morning session to allow preparation.

**THEMED DEBATE – GPC REFORM TASK GROUP** **15.10**  
**GENERAL PRACTITIONERS COMMITTEE, LMC CONFERENCE,**  
**GENERAL PRACTITIONERS DEFENCE FUND (Please see Annex 6)**

From 1510 the Agenda Committee has scheduled a Major Issues debate (under SO54) for the conference to debate the report of the GPC Reform Task Group.

The report of the task group, and a commentary, has been published to Conference after the submission deadline for motions to conference.

The Agenda Committee received a number of motions regarding the operation of the GPC, Conference, and GPDF prior to the publication of the Task Group Report, and these are in **Annex 6**

The Agenda Committee considers these motions to be best considered within a Major Issues debate, but is also anticipating the possible submission of new business motions (SO63.6) may also later be included.

The format of this debate will be:

Hamish Meldrum, Chair of the GPC Reform Task Group, will introduce the debate (SO 54.3).

Subsequent speakers will be called by the Chair from those who have indicated a wish to speak using speaker slips (54.5) – to facilitate this speakers will be asked to describe in as few words as possible the area they wish to address on the Major Issues speaker slip.

Members of Conference will be given only **one minute** to address conference to allow as many as possible to speak (54.5).

The Chair of GPC and the introductory speaker may reply to the debate for up to two minutes (54.6 and 54.7).

After the debate (54.8) voting representatives at conference will be invited to indicate on a scale of 1 (not at all) to 6 (completely), using the electronic voting pads supplied, the extent to which they support different policy areas within the GPC Reform task group report. It is important that Conference has an opportunity to express an opinion on all aspects of the report, whilst recognising the decision making authority of different bodies for different recommendations as detailed in the report.

**CONTINGENCY** **16.50**

**CLOSE** **17.00**

## PART TWO (Please see Annex 7)

We then have a further **Annex 7** that will include A/AR motions, and the Part 2 motions (under SO20)



**THEMED DEBATE – FUNDING OF GENERAL PRACTICE  
FAIR AND SUSTAINABLE FUNDING AND RESOURCES**

**10.20  
ANNEX 1**

- Problem:** The percentage of NHS funding spent on general practice has fallen from 10.4% in 2005/6 to 7.4% in 2014/15, leaving practices receiving an average of only £141 per patient to deliver a year of general practice care. This means general practice has an effective funding deficit of at least £2.5bn.
- Impact:** General practice does not have sufficient funds for workforce, premises or services to meet the growing needs of patients and this is undermining the safety of care delivered.
- Actions:**
- Government must commit to incremental recurrent funding in general practice, to reach a minimum of 11% of NHS spend. This would require funding the current deficit of at least £2.5bn in addition to the £8.3bn spent on general practice in England in 2014/15 and £9.8bn spent across the UK. This funding commitment will require a rebalancing of NHS resources to where care is delivered, in the context of care moving out of hospital.
  - Provision of an immediate stabilisation fund for general practice to provide emergency support to vulnerable practices at risk of closing, or where safe patient care is significantly compromised.
  - Establish a healthcare resilience task force within each CCG or locality area to provide support to vulnerable or at risk practices, which could include the provision of management resources, clinical input, proactive support, eg for unfilled vacancies, project management support or technology support which could be called upon at short notice for a practice in crisis. This should be developed in liaison with LMCs and needs to operate in a non-threatening and non-judgemental culture to support openness.
  - Increases in indemnity insurance costs for all primary care practitioners should be fully reimbursed or paid for by NHS England, and steps taken to introduce a sustainable system of indemnity for those working in primary care comparable with clinicians working in secondary care.
  - The funding allocation formula for practices should fairly reflect the workload of practices, including activity common to all practices that is not related to the demographics of the patient population.
  - Practices serving atypical populations should be supported through dedicated bespoke funding allocations.
  - A long term mechanism should be agreed to calculate and fully fund practice expenses including direct reimbursement of expenses incurred specifically to deliver NHS services.

## THEMED DEBATE – FUNDING OF GENERAL PRACTICE

### These motions are relevant Policy

(from the Special Conference)

That conference notes that practices currently provide a year of care for an average of £141 per patient and believes that this is wholly inadequate to provide a safe, sustainable and responsive service that meets the growing needs of their patients and therefore calls on governments to ensure that all practices receive at least £200 per patient per year.

That conference supports patients' requirements for safe and sustainable services which can only be delivered by stable general practices and therefore requires that the GPC rejects annual contract renegotiations and such a contract will be subject to genuinely independent financial review only.

That conference demands that the reimbursement of GP expenses must be properly and fully funded if practices are to continue to function and remain open.

That conference believes, in order to provide safe and sustainable services in general practice, separate contractual arrangements are needed for care for residents of nursing homes, residential care homes and similar institutions and medical certification of illness and travel advice and immunisation.

That conference, in order to address the current recruitment crisis, demands the government writes off a proportion of new GPs' student loans for each year of service, at five yearly intervals.

That conference calls for a "buyer of last resort" scheme to be established for privately owned or rented GP premises to safeguard practices where the financial risk associated with the premises threatens viability.

### Relevant Policy from Annual Conference 2015

That conference believes that current funding is threatening the viability of many practices and what is needed is:

- (i) reimbursement of net expenses
- (ii) a halt to the demise of seniority payments
- (iii) an immediate increase in resources to reflect the increase in consultation rates.

That conference believes that the current formula based core contract is unfit for purpose:

- (i) in that it fails to recognise the ever increasing demand for access and complex care associated with model 21st century general practice
- (ii) in that it fails to incentivise the expansion of primary care needed to cope with the vision set out in the NHS Five Year Forward View
- (iii) and should be replaced by a payment by activity contract which directly links workload to resource.

That conference calls on the Departments of Health to move more funding into core contract baselines in order to:

- (i) allow more strategic planning at a local surgery based level
- (ii) allow clinicians more time with their patients rather than scrabbling to achieve piecemeal funding streams
- (iii) avoid endless submission of plans, audits and reports to achieve individual funding streams.

That conference notes that many practices impacted by the removal of MPIG are feeling abandoned by government and the GPC and calls on the GPC to:

- (i) ensure that government understands the consequent reduction in frontline services and access for patients
- (ii) offer greater support to practices that are losing income to ensure patient services are not jeopardised,
- (iii) focus on negotiating a change in the formula such that weighting is only used to increase funding for those practices with populations considered to be more in need, rather than reducing it for others.



**THEMED DEBATE – FUNDING OF GENERAL PRACTICE**

- T1-1 CITY AND EAST LONDON: That conference insists that the share of the NHS budget that is allocated to general practice is:
- (i) immediately restored to 11% and
  - (ii) increased to 25% over the next five years.
- T1-2 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that you can have any two of fast, cheap or quality under current NHS funding arrangements and that the public needs to choose which two it prioritises or else acknowledge that investment is needed to achieve all three.
- T1-3 BRADFORD AND AIREDALE: That conference believes that piloting new ways of working with only short term funding is damaging as it raises expectations which are doomed to be dashed and rejects pilots without a commitment to long term funding.
- T1-4 EALING, HAMMERSMITH AND HOUNSLOW: That conference, in light of all the evidence that the Five Year Forward View has failed in its stated objective to 'stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas', demands the GPC seek a moratorium on all new government initiatives until that objective has been achieved to the satisfaction of the Annual Conference of LMCs.
- T1-5 HULL AND EAST YORKSHIRE: That conference believes that most local enhanced services and local authority-commissioned public health services are underfunded because they are not properly costed and by continuing to provide these services GPs reduce the profitability of their practices and asks the GPC to design a costing template to assist practices in evaluating the viability of taking on extra services.
- T1-6 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that most local enhanced services and local authority commissioned public health services are underfunded because they are not properly costed and by continuing to provide these services GP, and by virtue of that, reduce the profitability and viability of their practices and asks the GPC to design a costing template to assist practices in evaluating the viability of taking on extra services.
- T1-7 COVENTRY: That conference calls on NHSe to fully reimburse practices for the time and money spent on processing registrar payments and patient record transfers, both the result of poor contract negotiation at the time of hiving off PCSS.
- T1-8 LEEDS: That conference believes that in order for practices to remain sustainable and patients to continue to receive an acceptable general practice service a core GMS contract with ring-fenced funding must be provided to practices when working with a multispecialty community provider.

- T1-9 BRADFORD AND AIREDALE: That conference demands that as a result of the development of New Models of Care and a more diverse primary care workforce that:
- (i) entitlement to re-imburement for maternity/paternity/adoption leave is extended to all health professionals employed by GP practices and federations
  - (ii) this is fully funded by NHSE at an appropriate level for each role.
- T1-10 KENT: That conference insists that the GPC:
- (i) secure a commitment from government that spending on primary care increases to at least 12% of the total NHS spend
  - (ii) secures an agreement to suspend all further PMS redistribution and MPIG erosion
  - (iii) produces a nationally agreed and costed menu of 'GMS plus' services
  - (iv) act on its mandate to seek a new national core contract which links payment to activity.
- T1-11 BRADFORD AND AIREDALE: That conference believes that a system in which secondary care is funded predominantly by payment per episode of care and primary care is funded for open ended care on a capitation basis can only lead to any ever reducing share of NHS funding going to primary care with a consequent increase in overall NHS costs. An increase in the proportion of funding that is activity based and funding that is quality based would make general practice more sustainable.
- T1-12 LEEDS: That conference believes that the implementation of the review of the Carr-Hill formula:
- (i) could seriously destabilise practices
  - (ii) should only be done through differential uplifts to funding and not cutting the resources of some practices to fund others.
- T1-13 NORTHAMPTONSHIRE: That conference welcomes the small changes made in this year's contract to try and stabilise general practice, but now look to urgently receiving the significant amount of investment needed to secure and develop our service.
- T1-14 LEEDS: That conference believes that the underfunding of general practice is a fundamental cause of the current workload and workforce crisis which is undermining safety and sustainability of practices and impacting on the quality of care provided to patients and demands that:
- (i) government set a target for commissioners that 11% or more of the NHS budget should be invested in general practice
  - (ii) NHS England and CCGs should ensure 11% or more of the £3.8bn provided to the NHS in the Spending Review should be invested in general practice in 2016/17
  - (iii) NHS England and CCGs should make clear commitments to make above inflation annual real terms increases in investment for general practice and be held to account to deliver this.
- T1-15 MID MERSEY: That conference believes that nurse revalidation will have a considerable impact on general practice and asks the GPC to ensure it is properly resourced.
- T1-16 CARDIFF AND VALE OF GLAMORGAN DIVISION: That conference on the General Practice Committee of the BMA to negotiate a scheme where GPs are reimbursed for their indemnity for all NHS work, rather than Crown Indemnity.

- T1-17 SOUTH CENTRAL REGIONAL COUNCIL: That conference instructs GPC to investigate and report on the recent PMS contract reviews, such report to include:
- (i) identification of the financial loss to PMS practices
  - (ii) identification of how monies lost from PMS have been redistributed by investment in general practice locally
  - (iii) identification of the circumstances whereby some practices have been able to retain historic funding.
- T1-18 BIRMINGHAM: That conference believes that a doubling of funding is now the minimum required to save general practice and calls on GPC to negotiate this as part of the Special Conference rescue package, in order to ensure both an appropriate increase in global sum together with contractual changes to deliver additional explicit funding for
- (i) each GP partner
  - (ii) extended partnership models
  - (iii) direct reimbursement of all employed clinical and support staff, CQC registration fees and medical indemnity costs
  - (iv) extending the scope of direct premises reimbursements.
- T1-19 BEDFORDSHIRE: That conference calls on GPC to negotiate with the Government a system of financial supports or other inducements to make partnership in general practice a more attractive option for newer/younger GPs
- OR
- Conference calls on GPC to use GPDF surpluses to create a system of financial supports to make partnership in general practice a more attractive option for newer/younger GPs
- T1-20 NORTH YORKSHIRE: That conference believes that whilst the public still values general practice most highly amongst NHS services, the government should reflect this by increasing funding and resources accordingly.
- T1-21 NORTH YORKSHIRE: That conference believes primary care will not survive the internal market of the NHS and conference demands that:
- (i) primary care funding is no longer linked to secondary care spend in CCG budgets
  - (ii) payment by results is urgently reviewed with a block secondary care contract imposed to encourage austerity and living within a budget
  - (iii) resource released by reducing administration of the internal market is utilised to restore the funding previously transferred from primary care budgets to support failing foundation trusts.
- T1-22 LIVERPOOL: That conference believes that as a result of the Health and Social Care Act, following the transfer of primary care support services to Capita, NHS England has effectively transferred additional administrative work and governance to practices without providing any resources and instructs GPC to negotiate additional resources into general practice to account for this unresourced, transferred work.

- T1-23 BUCKINGHAMSHIRE: That conference commends the Kings Fund report which concluded that for the NHS to maintain its historic share of GDP there should be an additional £16 billion in the budget, and therefore insists that
- (i) the governments must increase the funding of general practice by a minimum of £2 billion in the next 12 months
  - (ii) funding for essential and additional services must be based on a minimum 11% of the NHS budget
  - (iii) all future funding must take into account the needs of an ageing population and the exponential growth of those with long term conditions
  - (iv) any government or local initiative/vanity project must be fully funded in addition to existing monies.
- T1-24 BUCKINGHAMSHIRE: That conference believes the Carr-Hill formula results in unacceptable variations in practice funding and
- (i) insists that there be no weighted capitation, with every practice being paid a realistic global sum payment for every registered patient
  - (ii) that identified factors known to increase the workload above the provision of normal general practice, should be addressed by additional funding.
- T1-25 GLASGOW: That conference, in the light of the recent findings of research published in the British Journal of General Practice, calls upon GPC negotiators to ensure that the huge difference in premature multi-morbidity across the social spectrum is taken into account in the allocation of funding and resources for general practice.
- T1-26 GLASGOW: That conference expresses concern that, whilst spending on the NHS has been increasing in the past decade, the vast majority of this funding has been absorbed into acute services and hospitals and the percentage of total spend as GP funding has been decreasing, and calls on:
- (i) government to urgently increase the funding to general practice to at least 2005/06 levels (9.78%)
  - (ii) GPC to work with the Scottish Government to direct any new investment into funding for general practices and primary care services and staff.
- T1-27 AVON: That conference deplores the fact that the portion of NHS spend on primary care is to fall yet again. It calls on the GPC to negotiate an immediate reversal of this trend and for primary care to receive a 20% share of the total NHS spend.
- T1-28 DEVON That conference observes that if government and the public desire a GP service based on 'wants' rather than 'needs' then this requires a future proofed funding mechanism that delivers:
- (i) a global funding envelope of £280 per weighted patient per year for 2016-17
  - (ii) an automatic annual uplift for medical inflation which is CPI plus 3%
  - (iii) an automatic national activity uplift matching any annual increase in UK patient contacts to an equivalent annual increase in UK global funding value
  - (iv) an automatic increase of the global funding value by 40% in the event of 7 day routine working.
- T1-29 DEVON That conference demands that all increases in expenses due to the Living Wage be fully reimbursed.

- T1-30 AVON: That conference calls for CQC fees to be based on a per patient capitation rather than a flat fee per practice.
- T1-31 AVON: That conference agrees that whilst home visits are an essential part of British general practice, they are unsustainable with the current funding structure and the crisis affecting general practice. Conference therefore calls on the GPC to negotiate with NHS England to ensure that there is:
- (i) appropriate bespoke funding to ensure that every practice is able to field a dedicated visiting doctor for at least part of every working day
  - (ii) recognition and acceptance by NHSE that it is not a patient's right to have a home visit but should be a clinical decision made by a doctor
  - (iii) agreement that GPs can genuinely refuse to visit patients who are not genuinely house bound, without fear of complaint or action for breach of contract.
- T1-32 DEVON That conference notes that the Carr-Hill formula is based on data collected almost 15 years ago and is now out of date and calls for an updated formula that takes account of modern factors that impact upon general practice workload.
- T1-33 LAMBETH: That conference calls for at least 25% of the NHS budget to be spent on general practice to achieve the aims of the 5 Year Forward View.
- T1-34 BRENT: That conference notes the increasing demands on general practice and calls upon GPC to:
- (i) insist that new practice or federation work is resourced on an episode basis with up front overheads' funding
  - (ii) demand an appropriate global sum increase to reflect that practice population consultation rates have increased
  - (iii) initiate a public facing campaign to raise awareness of how hard GPs are working for patients and how inadequately this work is resourced
  - (iv) call for an end to 'all you can eat buffet' type GP work: out of hospital schemes; post hospital discharge
  - (v) negotiate an agreed funding mechanism for all reports related to statutory and other functions under previous collaborative arrangements.
- T1-35 SCOTTISH CONFERENCE OF LMCs: That conference:
- (i) believes the care patients need should be free at the point of delivery
  - (ii) believes because of the ever increasing demand and inadequate funding, general practice and the NHS may not survive
  - (iii) is concerned that short term funding is leading to a fragmentation of care that is difficult to access, confusing to navigate and demands longer term decision making and funding.
- T1-36 SCOTTISH CONFERENCE OF LMCs: That conference is concerned about the creation of intermediate care beds in the community and asks that:
- (i) appropriate remuneration is offered to practices looking after these patients
  - (ii) general practitioners looking after these patients have access to the full medical records
  - (iii) there are alternatives put in place to manage delayed discharges.



- T1-37 SHROPSHIRE: That conference believes that general practice in the UK is struggling to cope with ever-increasing demand and that, in the absence of significant additional resources (and using the example of how a 5p plastic bag charge can dramatically change behaviour), believes the introduction of a token charge for GP consultations now needs to be considered – before the 'jewel in the crown of the NHS' fails.
- T1-38 LOTHIAN: That conference recognises that palliative and end-of-life care in the community is an increasing workload, and a very valuable use of our time, but should be properly and separately resourced both:
- (i) financially and
  - (ii) in terms of expanded community nursing teams with palliative care expertise.
- T1-39 OXFORDSHIRE: That conference believes that given the inadequate NHS funding of general practice, patients will only get the full range of services they wish from GPs when the current constraints on charging registered patients are removed and practices are allowed to charge for services that are not provided on the NHS. It calls on the GPC to renegotiate the wording of Regulation 24 and schedule 5 so that this can happen.
- T1-40 OXFORDSHIRE: That conference believes that to ensure funding follows activity, temporary resident work should revert to being funded as item of services activity as it was under the Red Book.
- T1-41 BARKING AND HAVERING: The conference believes that the GPC should negotiate that indemnity and CQC costs are paid directly and centrally by the NHS to help to cap the cost and reduce the burden of escalating costs of running GP surgeries in and out of hours.
- T1-42 SCOTTISH CONFERENCE OF LMCs: That conference demands the provision of additional resource to allow general practitioners time to complete the requirements of appraisal and revalidation.
- T1-43 AVON: That conference calls on the government to introduce a system of patient fees for access to primary care.
- T1-44 WILTSHIRE: That conference recognises that indemnity fees are rising excessively and demands direct reimbursement from NHS England, to include:
- (i) those fees paid on behalf of salaried colleagues by their employers, and
  - (ii) the fees paid on behalf of other practice clinicians.
- T1-45 NORTH YORKSHIRE: That conference believes that the restriction on charging patients, particularly for non-commissioned services represents a restriction on trade and may be a breach of competition law, therefore it instructs GPC and if necessary GPDF to commence a legal challenge to the continued inclusion of this clause in our contract.

- T1-46 SUFFOLK: That conference notes the year-on-year fall in publicly reported GP income over the last five years leading to instability in the delivery of primary care and calls upon the GPC to seek a dedicated meeting with the Secretary of State for Health and to report openly to the profession the outcome of that meeting to:
- (i) point out that mechanisms in place for maintaining stability of the profession and its income, particularly the DDRB, are clearly failing in their role
  - (ii) discuss paths of remedy for this situation
  - (iii) seek a guarantee that it is the intention of the Department that rises in expenses which are beyond the control of the profession are demonstrably fully remunerated in future pay rounds.
- T1-47 DERBYSHIRE: That conference:
- (i) demands that, if the Care Quality Commission (CQC) is to continue inspecting general practice, any increases to its fees to the sector should not exceed 1% per annum for as long as public sector pay restraint continues at this level
  - (ii) demands that the government produces an impact assessment of the transaction costs of cycling money from the Treasury through the Department of Health, NHS commissioners and NHS providers to the CQC as compared to direct funding of the CQC by the Treasury.
- T1-48 WIRRAL: That conference believes the present GP contract is unfit for purpose and
- (i) recommends that an 'activity based contract' might attract more funding into general practice
  - (ii) suggests that the capitation fee should be like a retainer which pays for up to a certain number of consultations per year, such as 6 per year, which is the national average consult rate
  - (iii) recommends that there is an extra NHS payment to the practice of £25 per consult with either the GP or nurse in excess of the national average consult rate.
- T1-49 BEXLEY: That conference calls for a move towards a truly national contract for GPs with equity being ensured by having a single rate of PMS premium available to both PMS and GMS practices with a defined list of costed services for practices to choose from on top of core funding agreed between the BMA and NHS England.
- T1-50 GREENWICH: That conference believes that the current PMS review will see a reduction in investment in GP services despite all the reassurances contained within the proposals from NHS England.
- T1-51 NORFOLK AND WAVENEY: That conference believes that primary care can no longer be free at the point of delivery and asks GPC to produce a discussion document looking at the risks and benefits of co-payment systems.
- T1-52 BEDFORDSHIRE: That conference calls on GPC to negotiate with government a new deal for GPs based on the principles of the 'Red Book' payment system.
- T1-53 CITY AND EAST LONDON: That conference demands GPC lobbies for general practice budgets to be removed from the control of the government.

- T1-54 SOUTH STAFFORDSHIRE: That conference demands that the government stops 'privatisation by stealth' and that:
- (i) private providers are stopped from undermining general practice at every opportunity
  - (ii) if the government is incapable of adhering to the principle of NHS 'free at the point of care', then it must be honest about that, with the introduction of limited charges, for non-essential GP or A&E attendances.
- T1-55 DERBYSHIRE: That conference reasserts its commitment to a national health service that is universal, comprehensive, funded from general taxation, free at the point of contact and based on the needs of the individual and calls upon the electorate to make it clear to politicians whether it supports such an ideal.
- T1-56 NORTH YORKSHIRE: That conference demands a substantial increase in CCG primary care budgets to address the significant proportional erosion of funding over recent years in order to resolve the current crisis experienced in general practice.
- A** T1-57 ROCHDALE AND BURY: That conference urges the government to freeze CQC fees in a volatile sensitive period with general practice.
- A** T1-58 BRADFORD AND AIREDALE: That conference demands that a new activity based contract is negotiated as the current funding model is accelerating the demise of general practice.
- A** T1-59 SHROPSHIRE: That conference believes a change to payment by activity must now be considered for general practice, not least to reduce the currently unfunded transfer of work from secondary care.
- A** T1-60 CAMDEN: That conference insists that government needs to understand, that GP practices are doing more and more work for less and less money and thus:
- (i) conference believes this situation is not sustainable, and
  - (ii) instructs the GPC to negotiate a sensible and equitable payment by activity solution.
- A** T1-61 EAST SUSSEX: That conference calls for the cost of CQC registration fees paid by practices to be a fully reimbursable annual expense.
- A** T1-62 BROMLEY: That conference has no confidence in CQC and deplores the unreasonable increase in CQC fees which have been proposed.
- A** T1-63 MANCHESTER: That conference believes future contract negotiations regarding the removal of QOF ensure that all funding is moved to the core contract and there is no further performance monitoring of indicators.
- A** T1-64 BRADFORD AND AIREDALE: That conference calls on the GPC to negotiate a five year plan for funding as a move away from short term funding is needed so that financial stability can be provided.
- A** T1-65 GATESHEAD AND SOUTH TYNESIDE: That conference believes that the NHS has no secure future unless there is a committed cross party agreement, long-term planning and realistic investment that is allowed to extend beyond any parliamentary lifetime.

- A** T1-66 CITY AND EAST LONDON: That conference believes the current PMS contract re-negotiations, which are resulting in levelling down of PMS contracts over a very short period of time, risks making these practices financially unviable and must be halted.
- A** T1-67 AVON: That conference calls for the GPC to negotiate on a robust itemised fee-for-service contract for primary care, rather the current unsustainable block contract.
- A** T1-68 LEEDS: That conference believes that indemnity costs should be fully paid by NHS England for all GPs on the national performers list, with equivalent arrangements for GPs elsewhere in the UK.
- A** T1-69 NORTH YORKSHIRE: That conference believes that the Department of Health should fund crown indemnity for all primary care contacts.
- AR** T1-70 HERTFORDSHIRE: That conference believes that the formula for determining whether a practice is entitled to locum reimbursement for sickness absence is too high and prevents many practices from receiving the vital support they need at times of difficulty and calls on GPC to negotiate a revision to the formula in Section 16.4(c) of Part 4 of the Statement of Financial Entitlements.
- AR** T1-71 CITY AND EAST LONDON: That conference believes that the costs incurred in employing locums to cover periods of maternity and paternity leave should be fully reimbursed by NHSE and that all discretionary components should be withdrawn.
- A** T1-72 DEVON That conference demands that if more care is to be delivered outside of hospitals then:
- (i) specific targets must be set to ensure health commissioners move resources to where they are most required
  - (ii) government needs to instruct all health commissioners to increase enhanced service spending by 10% every year.
- A** T1-73 CAMDEN: That conference notes the alarming rise in indemnity costs for all GP's; principals and sessionals and urges GPC to urgently intervene and help recoup such exorbitant costs.
- A** T1-74 HARINGEY: That conference supports the GPC for negotiating an indemnity reimbursement element to the uplift for the GP contracts 2016/17 and insists that this should continue in all future contracts.
- A** T1-75 NORTHERN IRELAND CONFERENCE OF LMCs: That conference insists GPC negotiates a mechanism for proper reimbursement of expenses including indemnity for GPs.
- A** T1-76 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That GPC acts urgently to:
- (i) insist that the MDOs recognise that the inexorable rise in indemnity costs is placing future service provision by GPs at risk as they can no longer afford to cover indemnity costs appropriate to their role(s)
  - (ii) that a similar support mechanism for practice expenses that is in the global sum funding and uplift 2016/17 is also provided for freelance/locum GPs, particularly those engaged in out of hours service provision.

- AR** T1-77 AVON: That conference applauds and appreciates the work of the GPC executive in successfully negotiating contact changes for 2016-17 which will help to protect GP income.
- A** T1-78 WILTSHIRE: That conference believes that the cost of CQC registration for practices:  
 (i) should not rise  
 (ii) and that the proposals for several fold increases are outrageous  
 (iii) and any cost of CQC registration should be fully reimbursed.
- A** T1-79 CAMDEN: That conference notes that good quality health care comes at a price, in order to continue providing such care equitably:  
 (i) GDP spend on health care needs to increase  
 (ii) the proportion of spend in general practice needs to increase and calls upon GPC to work alongside the BMA to lobby the government to achieve this.
- A** T1-80 LAMBETH: That conference recognises the need to address increasing workload and demands that the GPC negotiates a contract based on activity in common with the rest of the health service.
- A** T1-81 MERTON, SUTTON AND WANDSWORTH: That conference is concerned about the increasing workload being placed on practices without adequate funding.
- A** T1-82 LAMBETH: That conference instructs the GPC to negotiate more funding for primary care to ensure that the demand from patients can be met.
- A** T1-83 MANCHESTER: That conference believes all future nationally commissioned work is not agreed unless there is appropriate funding/ resources to support delivery.
- A** T1-84 SURREY: That conference believes general practice should not undertake any NHS services unless they are appropriately funded.
- A** T1-85 NEWCASTLE AND NORTH TYNESIDE: That conference welcomes the extra investment in general practice, but believes it falls far short of what is needed, and demands that this government demonstrates a meaningful commitment to general practice by investing at least 11% of the NHS budget in general practice.
- A** T1-86 LOTHIAN: That conference insists that GMS funding streams should clearly account for the added and rising workload relating to multi-morbidity, whether it occurs in the elderly, or prematurely in the socio-economically deprived.
- A** T1-87 LINCOLNSHIRE: That conference recognises that the special conference supported the resourcing of general practice at a level of at least £200 per patient per year. Conference calls on GPC to make this a priority in their discussions with government; but that the level of funding for general practice is addressed as a percentage of the entire NHS budget; and not less than 11% and at a level which will never allow the NHS resource to fall below 10% of GDP.
- A** T1-88 LOTHIAN: That conference insists that GMS funding streams should be sufficiently weighted to account for the costs of providing medical care to residential homes.



- A** T1-89 LOTHIAN: That conference insists that, in order to maintain safety and ensure equity, a revised contract should adequately resource appointments requiring a translator and ensure provision of sufficient and rapid access to translator services.
- A** T1-90 NORTH YORKSHIRE: That conference recognises that despite a generally increasing health care demand and need, core primary care continues to deal with 90% of NHS contacts and so should receive no less than 10% of the total NHS budget.
- A** T1-91 HERTFORDSHIRE: That conference notes that the UK spends proportionately less on health care than other countries in the EU and calls on GPC to repeatedly point this out to government and call for increased investment in the NHS.
- A** T1-92 CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS AND REGIONAL COUNCILS: That conference calls upon the BMA to lobby the government to spend at least 11% of the NHS budget in general practice.
- A** T1-93 YORKSHIRE REGIONAL COUNCIL: That conference believes that the Quality and Outcomes Framework should end by April 2017 for all practices and the funding fully invested in to global sum/PMS baselines to enable practices to continue to deliver high quality care but without the micromanagement of the current scheme.
- A** T1-94 HAMPSHIRE AND ISLE OF WIGHT: That conference calls on the UK government to increase NHS funding as percentage of GDP to at least that of the European average GDP, and to increase the proportion of the NHS budget allocated to general practice back to at least 2004 levels.
- A** T1-95 OXFORDSHIRE: That conference believes that the current GP capitation funding is a block contract that works against practice viability by encouraging workload transfer from many NHS and non-NHS organisations.
- A** T1-96 NORTHAMPTONSHIRE: That conference deplores the use of the term 'cost efficiencies' when this actually means:  
(i) cuts in funding to general practice  
(ii) unfunded new work being imposed on practices  
(iii) increasing the 'hidden deficit' of partners' income in practices.
- A** T1-97 LEEDS: That conference believes that the current crisis in health and social care is a direct result of inadequate funding and calls on the government to commit to match or exceed the average % GDP spent on health and social care made by comparable European countries.

**THEMED DEBATE – WORKLOAD IN GENERAL PRACTICE**  
**REDUCING WORKLOAD TO ENSURE DELIVERY OF SAFE AND HIGH**  
**QUALITY CARE**

**11.00**

- Problem:** Consultation rates and numbers have dramatically increased. The needs of many patients have become much more complex, with many being less confident to manage self-limiting conditions. Additionally, increasing amounts of work have moved from secondary care to general practice, often inappropriate and unfunded, and the bureaucratic burden on practices and practitioners has increased.
- Impact:** Workload pressures are undermining the safety of care to patients, with 93% of GPs reporting that heavy workload has negatively impacted on the quality of patient services. 9 in 10 GPs believe that the 10 minute consultation is inadequate to meet patients' needs. 34% of GPs are considering retiring in the next five years, and 17% of GPs are considering less than full-time working due to workload pressures, hence reducing GP capacity further.<sup>2</sup>
- Actions:**
- Set a national standard for a maximum number of patients that GPs, nurses and other primary care professionals can reasonably deal with during a working day to maintain delivery of a safe and high quality service.
  - Establish locality hubs to which practices can refer urgent patients when they have reached the capacity threshold for safe care on any given day. These hubs will not be walk-in-centres, but services that practices can refer to when required. Their primary purpose will be to provide the support necessary for a sustainable service at practice level. See Locality hubs for further information. These hubs can ultimately:
    - become centres for training, development and recruitment
    - host much of the wider primary healthcare team
    - organise care home provision
    - control and cost care being moved into the community from hospitals and other sources.
  - Provide organisational development funding and support to enable collaboration between practices and others within their locality, including the development of practice networks and multispecialty community organisational arrangements, building on current GMS/PMS contracts. Such networks can be used to:
    - support individual practices with workload, including the development of locality hubs
    - encourage sharing of back office functions and administrative support
    - expand services in primary care, with the managed transfer of care out of hospital
    - develop the general practice and primary care workforce, aligning the diversity of the GP profession with local identity
    - develop sustainability.
  - Ensure GPs and other practice team members are enabled to routinely offer 15 minute consultations or longer where necessary for patients with greater needs such as complex or multiple morbidity. This may result in a waiting list for routine appointments in the interests of patient safety. To mitigate this, NHS England and

commissioners can expand capacity by resourcing locality hubs, skill-mix, manage demand, and commission direct access to other providers in order to release GP capacity

- Optimising the care of patients in their own home:
  - dedicated community nursing teams fully integrated with GP practices, to provide case management of frail elderly patients including being the first point of contact for appropriate home visits.
  - CCGs to arrange patient transport services for appropriate patients to attend GP surgeries, as is currently the case for similar patients accessing hospital outpatient clinics
  - expansion of community nursing independent prescribing to avoid contacting a GP for the sole purpose of issuing a prescription
  - CCGs to commission specialist and multi-professional rapid response teams or similar to support early discharge of patients. This will help to avoid inappropriate demands on GPs, and will serve patients' needs with timely dedicated support
  - hospitals to directly arrange community nursing, rehabilitation or social support in the community for patients being discharged from hospital.
- Separate contractual arrangements, such as a new Directed Enhanced Service or multi professional contract, for dedicated care of patients in nursing and residential homes, and frail elderly housebound patients, providing significant new funding to enable the creation of multi-professional teams and appropriate specialist input to better meet the needs of this group of patients.
- Establish a national list of services that are not included in core GMS which practices can choose if they wish to provide, with pricing benchmarks nationally set that can be locally adapted according to any variations.
- Stem inappropriate clinical and bureaucratic workload shift onto GP practices, including the following:
  - define a specification for appropriate, related internal hospital referrals, eg a rheumatologist to a pain clinic, with the practice to be copied in
  - ensure that hospital initiated investigations are followed up and actioned by the requesting clinician, including communicating with the patient, in keeping with the recent NHS England guidance
  - hospital clinicians to use HFP10s and be enabled to use an electronic prescription service for the initiation and ongoing prescribing of specialist medication – ending the current inappropriate workload and clinical governance risk of GPs prescribing outside their competence and for clinical decisions for which they are not responsible
  - hospital practitioners prescribing a full course of treatment when initiated in outpatient clinics
  - enable community nursing teams and other allied health professionals to be trained and accredited to prescribe independently, and to make appropriate direct referrals where appropriate (eg to an incontinence nurse or social services)
  - end employers of community nurses insisting on patient specific directions for items that have been prescribed

- introduce pathways for granting permission for low priority procedures to be streamlined, including appeals procedures that do not necessarily involve the GP
  - hospital practitioners to issue fit notes for patients at discharge or in out-patient clinics for full duration of recovery
  - enable patients to contact hospital clinicians directly for queries relating to their clinical management in hospital, rather than being redirected to their GP
  - enable patients to book all transport to hospital appointments directly with the service without the need to involve the practice
  - enable hospital doctors to directly book investigations using a commissioned and resourced community phlebotomy service as opposed to asking the GP to do so
  - information about all patient contacts being sent electronically or added directly to the patient record within 48 hours of a patient being seen
  - ensure that discharge processes from secondary care are always followed and that community support for the patient has been arranged by the hospital where needed prior to discharge
  - and able to take on the additional clinical responsibility and workload and is additionally resourced.
- Ending inappropriate workload shift with effective CCG commissioning, to be taken forward locally with the support of LMCs:
    - LMCs, practices and CCGs should coordinate local strategies, including electronic service alerts via templates on clinical systems for CCGs to take action
    - CCGs should put in place troubleshooting staff to address problems of inappropriate workload shift flouting local commissioning agreements, to avoid practices incurring bureaucratic time
    - all hospitals should provide a dedicated GP helpline to address primary/secondary care interface problems
  - Universal access to and promotion of Pharmacy First (or other minor ailment) schemes, including the provision of medications without charge for patients who are exempt from prescription charges.
  - Enable patients exempt from NHS prescription charges to directly access products such as gluten-free products, other food supplements, dressings, appliances and stoma products without the need for GPs to prescribe these items, with appropriate regulatory changes made to make this possible.
  - End the GP role in assessing the eligibility for bus passes, parking badges, housing, gym membership and other similar non-NHS work and ensure that this work is commissioned from an appropriate source by the requesting organisation, eg the local authority or CCG.
  - Clear definition, funding and enforcement of payment of all collaborative services.

## THEMED DEBATE – WORKLOAD IN GENERAL PRACTICE

### Policy from the Special Conference

That conference, gravely concerned by the intensity at which GPs are working, believes that current working practices may be a risk to patients' care and GPs' health, and calls for GPC to campaign for safe working practices such as:

- (i) an increase in the duration of routine GP appointments to at least 15 minutes
- (ii) a restriction of patient contacts per day to a level comparable to other EU countries

### From Conference 2015

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

That conference, recognising the increasing mismatch between workload and available GP and practice workforce, calls on the governments and NHSE to work with the GPC to urgently define

- (i) what is and is not included in GP essential services
- (ii) what work can be postponed or abandoned if a practice is unable to recruit sufficient staff to deliver all services safely
- (iii) what patients and public can and cannot expect from GP service in crisis.



## THEMED DEBATE – WORKLOAD IN GENERAL PRACTICE

- T2-1 SOMERSET: That conference asserts that rising demand and falling resources mean patient safety can no longer be guaranteed in NHS general practice, and asks GPC to open negotiations with the government to
- (i) define the contents and scope of the core primary care contract
  - (ii) acknowledge that additional work will require additional resources
  - (iii) consider how public demand for health care can be better managed.
- T2-2 DEVON That conference instructs GPDF to fund research into decision fatigue in general practice in order to provide an evidence base for a safe workload.
- T2-3 CITY AND EAST LONDON: That conference instructs GPC to define a safe number of daily patient contacts and when this has been exceeded instruct practices to record the excess in order to inform government and the public of the work done by GPs which goes beyond safe limits.
- T2-4 GATESHEAD AND SOUTH TYNESIDE: That conference believes that a task force needs to be set up to examine how to control patient demand in a primary care setting so that:
- (i) workload can be brought to reasonable levels
  - (ii) inappropriate attendances at A&E and walk-in centres is reduced
  - (iii) there is a reinforcement of self-care for individuals.
- T2-5 BEDFORDSHIRE: That conference is concerned that it seems to have become accepted that GPs' working conditions are so crushing and deforming that GPs need to be taught to be resilient and demands that GPC tells NHS England that resources should be put in to changing working lives for the better rather than changing people to be more hard-hearted.
- T2-6 WELSH CONFERENCE OF LMCs: GPs are on their knees and the next generation are being scared off and many GPs are forced to accept ever growing lists until they surrender their contract in despair:
- (i) we need GPC to define and agree with the government a manageable safe workload
  - (ii) introduce measures to stop GPs being forced to take patients above this level
  - (iii) need to empower GPC to find urgent solutions to what GMS work can be safely stopped or suspended to try and rescue the struggling GP workforce

With an aging population and ever expanding treatments, scarce GP services need to be protected and used wisely.

- T2-7 AYRSHIRE AND ARRAN: That conference is concerned by the current workload in general practice and believes that this is both unsustainable and is acting as a disincentive to those who might otherwise consider a career in general practice. Conference calls on GPC to work with relevant bodies to reduce the workload managed in general practice by:
- (i) creating a mechanism for patients to self-refer to professions allied to medicine including but not limited to physiotherapy, podiatry and counselling
  - (ii) increasing the number of pharmacists working in general practice who can deal with medication reviews and repeat prescriptions
  - (iii) stopping the need for re-referrals to secondary care where patients have been discharged following failure to attend appointments
  - (iv) exploring mechanisms for triaging patients prior to them being appointed to see a GP.
- T2-8 SHROPSHIRE: That conference:
- (i) believes the bureaucratic workload in UK general practice to be excessive, unnecessary and unsustainable, and
  - (ii) calls on the government to mandate a 'pause' in appraisal, revalidation, CQC inspections and other workload that does not contribute directly to patient care.
- T2-9 SHROPSHIRE: That conference recognises that the strain on GPs attempting to deliver high quality healthcare to their patients with inadequate resources is such that all GPs should be signed off work for 'stress'.
- T2-10 SHROPSHIRE: That conference believes that, unlike hospitals and particularly A&E departments whose workload is documented in detail, lack of statistical evidence of the true workload faced by GPs may make our case less compelling and calls for a reintroduction of a comprehensive national data collection in general practice.
- T2-11 WIRRAL: That conference demands that government recognise that GPs do a HUGE amount of 'sweeping up' for the NHS and:
- (i) insists that this extra work is acknowledged by secondary care and politicians
  - (ii) demands that it is properly funded and that a mechanism of funding such work is found immediately.
- T2-12 AVON: That conference has no confidence in NHS England because it has:
- (i) incrementally increased the workload of primary care without providing additional funding
  - (ii) persistently failed to actively support practices who experience difficulty with staffing and funding
  - (iii) persistently attempted to introduce APMS contracts when partnerships change or collapse
  - (iv) little or no local knowledge now that it's geographical footprint has changed and it is therefore wholly insensitive to local needs
  - (v) has been made aware of the parlous state of general practice time and time again but has continued to compound the problem rather than make any meaningful attempt to assist.
- T2-13 LANCASHIRE PENNINE: That conference believes that the introduction of nurse revalidation is an unnecessary and ineffective process for ensuring high quality of nursing standards and places an additional burden on practices through its impact on nurse retention and practice workload.

- T2-14 SCOTTISH CONFERENCE OF LMCs: That conference is concerned about the creation of intermediate care beds in the community and asks that:
- (i) appropriate remuneration is offered to practices looking after these patients
  - (ii) general practitioners looking after these patients have access to the full medical records
  - (iii) there are alternatives put in place to manage delayed discharges.
- T2-15 WILTSHIRE: That conference believes we no longer have capacity to visit patients at home and wants patients without means of transport to be provided with NHS transport to GP surgeries.
- T2-16 CITY AND EAST LONDON: That conference instructs GPC:
- (i) as a matter of urgency to define safe working for GPs
  - (ii) to instruct GPs to stop registering patients if their working practices are out with the definition of safe working.
- T2-17 HERTFORDSHIRE: That conference calls on GPC to insist that NHS England proactively supports practices in areas that are struggling to recruit clinical staff by working with CCGs to allow list closures across entire towns or areas where this is necessary for patient safety and to prevent the domino effect.
- T2-18 DERBYSHIRE: That conference notes with alarm the unprecedented crisis in general practice workforce and workload and:
- (i) urges the government to make it clear to the English electorate what services can be provided by general practice under these circumstances, and in what timescales
  - (ii) urges the government to make it clear to the English electorate the difference between what general practice could deliver in an ideal world and what it can deliver in the real world
  - (iii) warns the government that the current burden of over-regulation and reporting requirements takes up so much of the limited time available to general practitioners and their staff that patients may not be receiving the clinical care they deserve.
- T2-19 WILTSHIRE: That conference believes:
- (i) the current GP service is unsustainable
  - (ii) the current on demand service is unsustainable
  - (iii) we no longer have capacity to visit patients at home.
- T2-20 DORSET: That conference believes:
- (i) the current GP service is unsustainable
  - (ii) the current on demand service is unsustainable
  - (iii) believes we no longer have capacity to visit patients at home.
- T2-21 HAMPSHIRE AND ISLE OF WIGHT: That conference believes:
- (i) the current GP service is unsustainable
  - (ii) the current on demand service is unsustainable
  - (iii) we no longer have capacity to visit patients at home.
- T2-22 GLASGOW: That conference believes that the fee payable to GPs for completion of personal independence payment reports should reflect the time spent by GPs completing these extensive reports and calls on GPC to negotiate a significant increase to the current fee of £35.

- T2-23 LEEDS: That conference is concerned at the increasing numbers of practices struggling to provide a safe and sustainable service and insists that in order to protect patients practices are enabled to self declare a safety alert when they have reached capacity on any specific day and can then direct patients to alternative service providers such as a walk-in centre or A&E.
- T2-24 WEST SUSSEX: That conference believes that in order to provide safe and sustainable care, general practices should be able to:
- (i) set a maximum limit to the number of patients that can register at a practice, and
  - (ii) should be able to do so without requesting their commissioners permission.
- T2-25 GLOUCESTERSHIRE: That conference believes general practice's ability to focus on people who are unwell and on those with chronic conditions would be enhanced by removing some tasks (eg contraception, antenatal care, vaccinations, dementia screening, unplanned admissions case management, travel advice and routine patient requested health checks) or by moving them to a separate service or services.
- T2-26 DORSET: That conference asks all GPs to embrace some change in our working practices so that we can work smarter rather than harder and continue to shine as the Jewel in the Crown of the NHS.
- T2-27 DORSET: That conference recognises that 10 minutes is not long enough for a consultation with a patient with complex needs and
- (i) instructs the GPC to look at ways of extending the average consultation time to 15 minutes
  - (ii) asserts 20 minute appointments should now be standard practice.
- T2-28 MID MERSEY: That conference believes that the work involved in practices responding to NHSE investigations is often onerous and calls on the GPC to ensure it is properly remunerated, particularly where the outcome of an investigation is that there is no case for the practice to answer.
- T2-29 CONFERENCE OF HONORARY SECRETARIES OF BMA DIVISIONS AND REGIONAL COUNCILS: That conference believes that in order to preserve patient safety, the BMA should undertake an immediate and necessary workload analysis that can define safe limits of working in general practice.
- T2-30 HERTFORDSHIRE: That conference notes with gravity the mounting number of practices closing and on the brink of financial collapse, and calls upon NHS England with the government to agree to the following measures as an immediate and necessary emergency rescue package until at least the end of this Parliament:
- (i) a review of appraisal and revalidation requirements with a view to simplification and support of practitioners
  - (ii) appraisals to take place at intervals of twenty four months and revalidations to take place each decade
  - (iii) NHSE to pay for nationwide contract with an online appraisal toolkit.

- T2-31 HERTFORDSHIRE: That conference notes with gravity the mounting number of practices closing and on the brink of financial collapse, and calls upon NHS England with the government to agree to the following measures as an immediate and necessary emergency rescue package until at least the end of this Parliament:
- (i) a moratorium on QOF for the remainder of 2016/17 with payments to practices based upon 2015/16 returns
  - (ii) a moratorium on DESs for the remainder of 2016/17, with payments to practices based upon 2015/16 returns
  - (iii) area team bursaries to contribute to employed GP staff costs where GP vacancies threaten practice viability
  - (iv) emergency 'amnesty' fund whereby practices who wish to hand back GMS contract to NHSE may do so without incurring prohibitive costs or risk of bankruptcy
  - (v) annual rise in share of NHS budget to a minimum of 20%.
- T2-32 CAMDEN: That conference believes that in order to preserve patient safety, the BMA should undertake an immediate and necessary workload analysis that can define safe limits of working in general practice.
- T2-33 TAYSIDE: That conference believes that individuals who have spent significant portions of their medical careers working night shifts should, in light of the health risks and consequent reduced life expectancy associated with night shift working, be entitled to retire from the NHS Pension scheme five years earlier than the normal pensionable age without detriment to their earnings.
- T2-34 DERBYSHIRE: That conference reiterates that medicine is not a free good and provision of medical services must be through just and equitable contracts that reward skill, effort, risk and responsibility.
- T2-35 SUFFOLK: That conference suggests that a contract promising an 'all-you-can-eat' delivery model of primary care, free at the point of delivery and on fixed funding, is unsustainable in any framework and should not be the starting point for any negotiations.
- T2-36 NORTHAMPTONSHIRE: That conference insists that GP's must have the option to cease to provide services that lie outside the contract (where these are inadequately resourced) so as to protect the quality and safety of overall care.
- T2-37 MID MERSEY: That conference considers the new deal for general practice to be neither 'new' nor a 'deal'.
- T2-38 MID MERSEY: That conference demands that the GPC urgently negotiates a new contract for general practice before general practice is completely decimated.
- T2-39 LIVERPOOL: That conference believes that patients with real health care needs value continuity of care over rapid access and that GPC must ensure that in any future contract negotiations, continuity of care is prioritised as an outcome for practices rather than ever extending hours, hence valuing need over convenience.
- T2-40 LOTHIAN: That conference asserts that, if we are to move to different models of access and new electronic approaches, GPs should be funded for every email initiated by a patient to which they respond.

- T2-41 CLEVELAND: That conference demands that the requirement for home visits should be removed from the core GP contract.
- T2-42 CARDIFF AND VALE OF GLAMORGAN DIVISION: That conference is gravely concerned that the current level of workload in general practice may be a risk to patient care and calls for:-
- (i) proper resourcing of primary care to meet the increasing demands of the population;
  - (ii) practices to be able to self-declare as safety alert when they have reached capacity;
  - (iii) development of incentives to promote retention of doctors in the UK;
  - (iv) a decrease of bureaucratic workload that has no benefit to patient care delivery.
- T2-43 NOTTINGHAMSHIRE: That conference calls on government to acknowledge that it is necessary and desirable for them to agree with the GPC and the RCGP a definition of core general practice which:
- (i) forms the basis of a national contract and funding arrangements governing essential services across the four nations
  - (ii) offers no barrier to innovation or to additional work being undertaken by GPs where funded appropriately
  - (iii) can be revised on an ongoing basis systematically as clinical practice and the needs of society evolve, on the basis of professional consensus.
- T2-44 DEVON That conference instructs GPC to negotiate a separate national intermediate care contract.
- T2-45 SHEFFIELD: That conference believes that care planning should be the responsibility of the integrated care team tailored to the individual patient, and not a bureaucratic box ticking, paper exercise taking up GPs' time unnecessarily.
- T2-46 DERBYSHIRE: That conference does NOT believe that the NHS is safe in this government's hands and warns the general public that their GP service faces extinction within five years unless radical changes acceptable to the profession are made.
- T2-47 COVENTRY: That conference believes that the new system for transfer of Lloyd George envelopes is not fit for purpose due to:
- (i) unresourced additional workload
  - (ii) information governance issues.
- T2-48 GLOUCESTERSHIRE: That conference seeks recognition by the government of the present crisis in general practice and that this recognition must lead quickly to a 'back to basics' approach within general practice with the aim of:
- (i) putting priority on continuity of care
  - (ii) extending nominal appointment times to 15 minutes
  - (iii) reducing considerably the level of micro management currently imposed
  - (iv) providing extra funding beyond the capitation fee if patients exceed six appointments a year
  - (v) reducing practice boundaries to safe limits.



- T2-49 NORTHAMPTONSHIRE: That conference rejects the new deal promised by the Secretary of State for Health which is too little, too late and offers nothing to reverse the decline in the number of doctors in general practice; does not reduce workload and does not provide for a sustainable service in the future.
- T2-50 NORTHAMPTONSHIRE: That conference demands that the health secretary stops and thinks before suggesting new gimmicks and services, such as one minute e-consultations, that he has no idea about whilst telling us that there is no more money and we must do more for less.
- T2-51 MID MERSEY: That conference believes the Health Secretary should abandon his plans for “Eight days a week” in favour of “Let it be”, “With a little help from his friends” on the GPC.
- T2-52 HERTFORDSHIRE: That conference believes to curb excess self-limiting inappropriate demand on primary care is to place a nominal charge on the GP consultation, which will be reimbursed upon later individual application.
- T2-53 BEDFORDSHIRE: That conference believes that today’s GP has to deal with minor ailments for which earlier generations would never have visited their GP and conditions which were previously dealt with in secondary care and calls for
- (i) funding and manpower to follow the patients from secondary care into general practice
  - (ii) resources to ensure that practices are able to safely separate urgent cases from routine care
  - (iii) education in self-care for minor illnesses to be widely taught at every opportunity in schools, A&E and GP practices
  - (iv) pharmacists to receive training in red-flag symptoms in minor illness so they can be more confident in their advisory role with patients.
- T2-54 ISLINGTON: That conference recognises and acknowledges the levels of unfunded work moving from secondary to primary care and the government should insist that such services are funded by the hospital making the referral of services.
- T2-55 SOUTHWARK: That conference notes that failed discharges place immense pressures on the GP workforce which is already struggling with the demand- capacity deficit and demands that hospitals which have a high rate of failed discharges be included in CQC inspections.
- T2-56 MID MERSEY: That conference believes that general practice is becoming increasingly complicated and requests the GPC to measure the volume, intensity and quality of GP work so that the relentless annual increase in workload can be quantified.
- T2-57 DERBYSHIRE: That conference calls for the statutory introduction of ‘Pharmacy First’, or similar, schemes across the United Kingdom to cover all products with an over the counter licence and for paragraph 39 of schedule 6 of the National Health Service (General Medical Services) regulations 2004 and corresponding paragraph in the PMS, APMS and Scottish, Welsh and Northern Irish regulations to be amended accordingly.

- T2-58 GATESHEAD AND SOUTH TYNESIDE: That conference believes that the completion of care plans for avoiding admissions and dementia are too bureaucratic, time consuming and take GPs away from patient care. Conference calls for:
- (i) them to be made simpler
  - (ii) to be completed by other properly resourced personnel where appropriate
  - (iii) evidence to be produced to show their usefulness
  - (iv) their removal from performance targets.
- T2-59 BUCKINGHAMSHIRE: That conference requests GPC to recommend what is a safe and sustainable daily workload for a GP, taking into account that in Europe the average GP manages 25 patient contacts per day.
- A** T2-60 HERTFORDSHIRE: That conference calls upon the GPC to work with the RCGP, PHE and HMG in launching a national awareness campaign for self-care and responsibility of use of general practice services and resources.
- A** T2-61 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that the government must commit new funding to establish evidence-based patient education programmes and government must focus on:
- (i) self-management of minor illness
  - (ii) appropriate use of NHS services
  - (iii) working with the NHS to encourage patients to manage their own health.
- A** T2-62 WAKEFIELD: That conference believes that the unfunded and unplanned transfer of work from secondary to primary care should cease.
- A** T2-63 AVON: That conference deplores the constant and increasing shift of unresourced work from secondary to primary care, which is causing extreme hardship for general practitioners. It calls on the GPC to mount a national campaign to ensure that:
- (i) this behaviour by secondary care is exposed and stopped
  - (ii) work already transferred is appropriately costed and primary care compensated accordingly.
- A** T2-64 ROCHDALE AND BURY: That conference recognises the unacceptable work load generated by acute hospital trusts booking centres when no appointments are available and patients are sent back to their GP to re-refer and urges GPC to address this.
- A** T2-65 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference calls on GPC to insist that the BMA is recognised as having negotiating rights for all GPs being offered contracts to work for new NHS organisations such as MCPs, PACs, ACOs, federations of GP practices and super surgeries and that these contracts should be:
- (i) developed proactively with advice from BMA
  - (ii) based on nationally accepted terms, conditions and pay scales as for other NHS doctors
  - (iii) and therefore includes consideration of the BMA salaried model contract or hospital consultants contracts where applicable
  - (iv) the contracts should recognise all previous public sector GP work which is superannuable under the NHS pension scheme as continuous service regardless of employer (GMS, PMS, APMS, etc).

- A** T2-66 CLEVELAND: That conference insists that the UK governments must put much greater resources into patient education and that they should;
- (i) start from early school years
  - (ii) encourage self-management of minor illnesses and an understanding of the commoner red flag symptoms
  - (iii) teach people how to access healthcare in an appropriate and timely manner
  - (iv) give a realistic understanding of the expectations that people should have about the NHS within a finite resource system.
- A** T2-67 HULL AND EAST YORKSHIRE: That conference believes that the government must commit new funding to establish an evidence-based patient education programme and government must focus on:
- (i) self-management of minor illness
  - (ii) appropriate use of NHS services
  - (iii) working with the NHS to encourage patients to manage their own health.
- A** T2-68 GLASGOW: That conference calls on health boards to implement systems that will allow patients to rebook themselves after missing appointments without requiring another GP referral.
- A** T2-69 WILTSHIRE: That conference is aware that across Europe other generalists usually have longer consultations and fewer patient interactions in a working day and believes that having as many patient contacts as UK general practitioners do is:
- (i) currently unsustainable
  - (ii) potentially dangerous for patients
  - (iii) unhealthy for GPs' health and well-being
  - (iv) that demand needs to be controlled via a national mechanism such as managing patient expectations to sustain general practice.
- A** T2-70 NORFOLK AND WAVENEY: That conference believes deprivation of liberty safeguarding legislation as currently written it is causing unnecessary anguish for relatives, increased GP workload and problems for care homes, and calls for GPC to exert influence to accelerate the planned review.
- A** T2-71 LAMBETH: That conference believes that there is an increase in the number of patients who attend A&E and their GP with minor ailments that could be self medicated and calls on national policy makers to provide patients with more information regarding self-help and the correct pathways to access health care.
- A** T2-72 ROCHDALE AND BURY: That conference urges this government to educate the public in the appropriate use of the health service to avoid waste.
- A** T2-73 DERBYSHIRE: That conference reminds the government that over the years GPs have, given the right tools and incentives, always been willing to innovate and change but that change and innovation requires resource, investment, time and, a clear long term strategy free of micro management.
- A** T2-74 DERBYSHIRE: That conference asserts that the 2015/16 GMS contract changes in England barely scratch the surface of the changes that are required to save general practice.

- A** T2-75 ENFIELD: That conference believes that CCGs should work with hospital trusts to ensure that GPs and practitioners do not have to pick up hospital administration and secretarial work and demands this be enshrined in any future contract.
- A** T2-76 NORTHAMPTONSHIRE: That conference demands that the commissioners stop bolting on new initiatives to our contracts, however worthy, before sufficient resources are provided to do that new work.
- A** T2-77 ISLINGTON: That conference recognises the impact of CQC visiting practices and the amount of workload costs and preparation is diverting time and resources from providing quality services/care to patients.
- A** T2-78 NORTH YORKSHIRE: That conference believes that the current recruitment / retention crisis in general practice will continue to deteriorate unless significant steps are taken to challenge the expectation that we will continue to absorb more work with insufficient additional funding.
- A** T2-79 GLASGOW: That conference believes the future of general practice needs to be protected by an agreement on what it is reasonable to expect a GP to do in their working day.
- A** T2-80 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
In light of the increasing medical complexity and multi-morbidity managed in general practice, this conference calls on GPC to campaign to increase the duration of routine GP appointments to 15 minutes.
- A** T2-81 ROCHDALE AND BURY: That conference recognises the unacceptable workload generated by the public failing to attend hospital and community appointments resulting in a waste of scarce GP resource in re-referring
- A** T2-82 HERTFORDSHIRE: That conference notes with interest Mary McCarthy's findings from the UEMO (European Union of General Practitioners) and calls upon the GPC executive team to work with NHS Employers in using a maximum number of patient contacts per day to determine safe levels of workload to improve quality of care and make general practice viable again.
- A** T2-83 CORNWALL AND ISLES OF SCILLY: That conference believes that the workload in general practice is unsafe and unsustainable and calls upon GPC to define a safe working day for GPs.
- A** T2-84 SOUTH ESSEX That conference calls upon GPC to urgently consult and agree a national definition of safe working limits for general practice.

## THEMED DEBATE – GENERAL PRACTICE WORKFORCE AN EXPANDED WORKFORCE IN AND AROUND THE PRACTICE

11.40

- Problem:** In the last decade the number of hospital consultants has increased by 48%, while GP numbers have increased by only 14%, and since 2009 the number of GPs per head of population has declined. GP training posts are not being filled, and increasing numbers of older GPs are planning to retire. There is a similar recruitment and retention crisis in practice nursing, with a fall of community nurses of 38%. Further, there are increasing numbers of GP partner vacancies, adding often unmanageable workload burden on a smaller pool of partners.
- Impact:** The reduced capacity of the general practice and community workforce leads to increased workload burdens, increased practitioner burnout, delays in access to appointments, and care that is fragmented or potentially unsafe being provided. All these factors lead to a vicious circle, impacting further on morale, recruitment and retention. Governments' attempts to resolve some of these issues through the use of APMS contracts has often made the situation worse, not better.
- Actions:**
- While there are inadequate numbers of GPs currently, there needs to be use of skill-mix built within and around the framework of the GMS/PMS contract, to support GP pressures, ensure retention of the current GP workforce, while creating definitive solutions to improve recruitment to expand the GP workforce.
  - A step change in GP recruitment initiatives with a clear and credible plan to recruit more GPs.
  - Immediate resources to fund an expanded and comprehensive primary care team to reduce and relieve GPs' workload, including fully funded clinical professionals to work directly with practices, including pharmacists, mental health practitioners, advance nurse practitioners, physiotherapists, medical assistants and physician associates.
  - Direct access to services to avoid GP first point of contact, eg:
    - extended scope practitioner eg direct access physio
      - specialist nurses for chronic diseases (eg diabetes, epilepsy, rheumatoid)
      - mental health services
      - Pharmacy First and minor ailment schemes
      - health visitors
      - district nursing services.
  - Establish closer links between community pharmacists and practices where this can support GP workload.
  - Commission a comprehensive and nationally defined community nursing team to support and work with each practice in an integrated manner.
  - Expand the number of hospital based clinicians delivering care in the community working in partnership with primary care clinicians.

- Dedicated funding to support GPs to develop portfolio careers and specialist skills to improve recruitment and retention, eg an individual professional development budget that a GP could use over the 5 year revalidation cycle
- Establish training hubs for enhanced training for practice managers and other practice staff.
- Further reduce the bureaucratic burdens of the returner scheme.
- Improve the investment in and promote the retainer scheme.
- Encourage permanent GP practice placements with inducement schemes.
- Alongside the model GMS salaried GP contract, develop a nationally defined employed GP contract modelled on the hospital consultant contract for those GPs working for other providers or GP led organisations.
- Investing in the GP out-of-hours service to enable an expanded and sustainable clinical workforce, addressing issues such as additional indemnity costs. This would also support the development of a clinically appropriate integrated seven-day *urgent care* service.

## THEMED DEBATE – GENERAL PRACTICE WORKFORCE

The following motions are already the policy of LMC Conference;

### 2016 Special Conference

That conference, in respect of physicians' assistants;

- (i) is concerned that they will distract attention from the inadequate numbers of GPs and registrars
- (ii) is concerned that they will not decrease GP workload
- (iii) is concerned that they will increase referrals, investigations and prescribing
- (iv) demands that they require their own medical indemnity cover.

### 2015 Annual Conference

That conference believes that general practice is experiencing the biggest workforce crisis since its inception and calls upon the newly elected government to take action to ensure that:

- (i) GP funding, recruitment and retention are addressed as its first priority for the NHS
- (ii) GPs who are leaving the profession early are supported to stay in practice
- (iii) all those wishing to return to the profession are fully supported and encouraged to do so
- (iv) the contribution of all GPs to the delivery of NHS services is valued regardless of their contractual status.
- (v) general practice is supported as an integrated progressive career from medical school right through to retirement.

That conference congratulates NHS England in its intention to reduce the barriers to accessing the induction and refresher scheme, and asks GPC to insist that:

- (i) these are not confined to under doctored areas
- (ii) GPs are funded to undergo the scheme at no less than the pay scale of a trainee GP
- (iii) practices who supervise these GPs receive funding commensurate with the GP trainers' grant.

That conference welcomes UK trained GPs who wish to return to practice in the NHS after a period working abroad and:

- (i) seeks assurances that all efforts are made to reduce the barriers to their re-integration into the NHS
- (ii) asks that returning GPs need not all be subjected to full induction and refresher training
- (iii) demands that certain overseas qualifications be recognised by the NHS
- (iv) demands that outreach appraisal programmes be available for these GPs while working abroad
- (v) demands that a financial resettlement programme be created to incentivise GPs to return from working abroad.

That conference is concerned by the decline in GP training applications and calls on GPC and the RCGP to increase efforts to recruit GP trainees by:

- (i) ensuring GP trainees are provided with adequate support for increasing workload pressures
- (ii) increasing funding for trainers to enhance the quality of GP training
- (iii) vigorously opposing plans to cut the pay of GP trainees
- (iv) implementing strategies to improve student perceptions of general practice.



That conference:

- (i) recognises that list based general practice has been shown to be the most effective way of delivering primary healthcare to patients
- (ii) insists that the partnership model of general practice remains viable for those that wish to work within it
- (iii) warns that any movement towards the formation of larger general practice organisations should not be allowed to destroy the continuity of care that exists in general practice
- (iv) urges GPC to resist changes which risk forcing GPs into larger general practice organisations.

That conference asks the GPC to act urgently to mitigate the financial risk to the 'last man standing' in practices such as a change in partnership model to limited liability partnerships and to explore and negotiate mechanisms with government to stabilise general practice in a locality where sudden practice closures are likely to have occurred.

That conference believes that there should be one central body that oversees performer's lists to avoid multiple, time consuming bureaucratic applications by GPs to so many different bodies for the same thing.

That conference condemns the recent changes that will affect GP pensions:

- (i) which will mean retention of senior general practitioners will be increasingly difficult
- (ii) which is likely to further discourage new recruits to the profession
- (iii) which will hasten the demise of general practice
- (iv) which will be to the detriment of patient care
- (v) and calls on GPC to work with governments to address the situation.

**THEMED DEBATE – GENERAL PRACTICE WORKFORCE**

- T3-1 DERBYSHIRE: That conference calls for the urgent incorporation of contingency planning for large numbers of patients being left without general practice services at very short notice into all NHS emergency preparedness and resilience planning.
- T3-2 HULL AND EAST YORKSHIRE: That conference believes that practice managers are vital to the success of general practice and that:
- (i) GPC should endeavour to work alongside a nationally recognised institution to facilitate tailored qualifications in practice management
  - (ii) GPC should promote excellence in practice management.
- T3-3 HIGHLAND: That conference calls on GPC to investigate the indemnity costs associated with the delegation of tasks to healthcare workers and to look at how the burden on GPs could be eased.
- T3-4 NORTHERN IRELAND CONFERENCE OF LMCs: That conference demands the Department of Health to have an active and realistic strategy of how to retain general practitioners of 55 years and over, to enable the continuity of care and maintain practice structures and ensure patient safety.
- T3-5 ROTHERHAM: That conference acknowledges the workforce crisis is threatening safe and sustainable general practice service and calls on the government to implement a scheme for reimbursement of 70% of total staff costs to GP practices immediately to save general practice.
- T3-6 GLOUCESTERSHIRE: That conference:
- (i) supports the Public Accounts Committee's finding that NHS England appear to have been complacent about general practice's ability to cope with the increase in demand caused by rising public expectations and the needs of an ageing population, many of whom have multiple health conditions
  - (ii) having seen no change in this complacent attitude, demands a far more robust plan for general practice before it has to be replaced by a more expensive private option.
- T3-7 GLOUCESTERSHIRE: That conference believes the root cause of the current crisis is a loss of morale in primary care and urges that steps be taken to improve it.
- T3-8 BRADFORD AND AIREDALE: That conference believes that in order to facilitate the use of skill mix in general practice, the current reimbursement of locum fees for sickness and maternity cover should be extended to all clinical front line consulting staff, including nurse practitioners, clinical pharmacists, physicians assistants and other providers of patient consultations.

- T3-9 GLOUCESTERSHIRE: That conference is very alarmed to hear of nurse shortages and insists that:
- (i) the introduction of nurse appraisals be halted until a proper evaluation of medical appraisal has taken place has been properly evaluated, specifically as to whether it
  - (ii) the bursary schemes for student nurses be restarted as a matter of urgency
  - (iii) more nurse training be spent seeing patients on hospital wards
  - (iv) more nurse training should be spent in primary care as well as with GP practice nurses
  - (v) the upgrading of health care assistants to registered nurses be made a smooth and easy transition.
- T3-10 SURREY: That conference believes that GP partnerships represent:
- (i) a long term investment in the healthcare of local communities
  - (ii) continuity of care for patients facing a confusing multiplicity of providers
  - (iii) a cost-efficient way of delivering NHS primary care.
- T3-11 EALING, HAMMERSMITH AND HOUNSLOW: That conference notes that there is a recruitment crisis in general practice, not only of GPs, but also ancillary staff, and calls on government to fund:
- (i) training of current practice staff, and
  - (ii) general practice sufficiently to allow practices to offer salaries at the right level to attract the right quality of staff.
- T3-12 LAMBETH: That conference confirms that practice nurses are an integral part of a practice team and demands that the GPC negotiates:
- (i) investment in schemes to support practice nurse training
  - (ii) more ring fenced funding to Community Education Provider Networks (CEPNS) to support training for primary care (nurses, pharmacists, HCAs).
- T3-13 BEDFORDSHIRE: That conference calls on GPC to negotiate with government a payment which underlines the importance of partners, similar to the Basic Practice Allowance.
- T3-14 SUFFOLK: That conference believes that the current emphasis on 7-day working is a political push for the unachievable particularly in the light of the continued under-resourcing of primary care and insists that the 7-day mantra be abandoned and any additional resource available should be used to enhance the weekend emergency cover services.
- T3-15 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference acknowledges disagreements over the independent contractor status and instructs GPC to:
- (i) survey the career intentions of GP trainees and young GPs to determine whether independent contractor status will be viable in the future
  - (ii) explore ways of maintaining independent contractor status whilst offering new GPs the protected career development opportunities, time for management and clinical leadership and guaranteed employment rights that hospital contracts provide
  - (iii) explore how we may move towards a service involving regional NHS primary care organisations that employ salaried GPs on NHS contracts.

- T3-16 SALFORD AND TRAFFORD: That conference believes an enquiry should be instigated by the BMA into indemnity costs; how increases are calculated and how they impact on workforce numbers.
- T3-17 NORTH YORKSHIRE: That conference believes that general practice is at risk of collapse due to the combined effects of excess workload, workforce pressures and under-resourcing.
- T3-18 BUCKINGHAMSHIRE: That conference, in the light of the workforce crisis, accepts the need for a greatly extended practice team, but insists that the government provides indemnity for all non-doctor clinicians added to the teams.
- T3-19 WILTSHIRE: That conference recognises the need for more carers to provide care in the community and:
- (i) welcomes a commitment to care workers receiving a living wage and supports measures aimed at increasing the number of paid care workers
  - (ii) recommends care workers receive NHS terms and conditions of service
  - (iii) calls for care workers to be considered key workers and given advantageous deals on housing.
- T3-20 WILTSHIRE: The conference demand action on a strategy for retaining experienced general practitioners within the GP workforce, which should specifically include:
- (i) re-instatement of seniority payments or equivalent funding
  - (ii) amendments to the NHS pension scheme to incentivise GPs to remain in practice
  - (iii) voluntary exit interviews for GPs who are retiring or moving out of the UK
  - (iv) reduced bureaucracy for the GP returners scheme.
- T3-21 COVENTRY: That conference calls on Jeremy Hunt to deliver the 5000 additional GPs as promised.
- T3-22 DEVON That conference asks the BMA pensions negotiators to seek a sufficiently incentivised pension tax reimbursement scheme in order to stem the haemorrhage of experienced GPs retiring early.
- T3-23 NORFOLK AND WAVENEY: That conference believes that the workforce crisis is getting worse rather than better and will lead to unsafe levels of primary care in certain areas of the UK and calls on GPC to negotiate:
- (i) safe doctor: patient ratio definition
  - (ii) a clearer practice list closure mechanism
  - (iii) safe working hours definition.
- T3-24 SHROPSHIRE: That conference believes that in order to solve the recruitment crisis in general practice the government must ensure sufficient university places to provide clinical staff to run the NHS, and ensure employment conditions suitable to retain them in the UK.

- T3-25 NORTHAMPTONSHIRE: That conference tells the government that it needs to find a way of reducing the number of retirements from general practice and encouraging retired doctors back into practice by:
- (i) providing full indemnity cover
  - (ii) ending CQC inspections
  - (iii) removing imposed protocols, guideline and proformas that insult the professionalism of doctors
  - (iv) making 15 minute appointments the standard
  - (v) removing the requirement for annual appraisals
  - (vi) reinstating seniority payments.
- T3-26 HERTFORDSHIRE: That conference calls upon the government to facilitate the return of UK qualified GPs from overseas with a comprehensive recruitment package including:
- (i) financial assistance with relocation fees
  - (ii) facilitation of the process of getting onto the Performer's List
  - (iii) acceptance of existing enhanced DBS or equivalent for initial six months
  - (iv) acceptance of existing local appraisal documentation for initial six months
  - (v) ability to join a partnership without prior approval from CQC.
- T3-27 LOTHIAN: That conference maintains that, in order to deliver a safe and sustainable service, general practitioners require much stronger community nursing teams to play a significantly greater role in managing long term conditions, and provide first-line assessment of nursing and care home patients.
- T3-28 NORFOLK AND WAVENEY: That conference demands that Health Education England produce and fund sufficiently robust training and career structures for practice reception staff, practice nurses, nurse practitioners, physician associates and pharmacists to enable a truly multi-disciplinary primary care team.
- T3-29 BEDFORDSHIRE: That conference is insulted and shocked by the Chief Executive of Health Education England's suggestion that hospital consultants could end their career in general practice and calls on GPC to ensure that those in charge of the education and training of future doctors understand what GPs do and why their training takes so long.
- T3-30 HERTFORDSHIRE: That conference notes that there are still some older GPs who enjoy the job and are not ready to retire, and calls on GPC to actively seek out and work with these valuable colleagues to harness their experience and skills as inspiration and support for other GP colleagues.
- T3-31 SOMERSET: That conference believes that a 'perfect storm' of government failures has led to the current GP crisis, and asks GPC to press NHSE to describe exactly how it is going to provide a safe primary care service without a medical workforce trained for or willing to do the job?

- T3-32 BUCKINGHAMSHIRE: That conference recommends that as part of the rescue package for general practice, government funds an expanded general practice workforce to include
- (i) advanced nurse practitioners
  - (ii) mental health nurses and counsellors
  - (iii) MSK extended scope practitioners and physiotherapists
  - (iv) pharmacists
  - (v) emergency care practitioners.
- T3-33 BUCKINGHAMSHIRE: That conference believes that should the workforce crisis remain unresolved, regulations will have to be changed to remove the right of the public to have direct access to a GP.
- T3-34 LINCOLNSHIRE: That conference agrees that the UK needs at least ten thousand more GPs to fill the workforce shortfall in general practice, and that recruitment from overseas will help to fill this shortfall. Conference thus calls for
- (i) HEE, RCGP, GMC and NHSE to reduce bureaucracy which is a barrier to overseas recruitment
  - (ii) the recruitment process to be funded by NHSE who have made a commitment to recruit more GPs.
- T3-35 NOTTINGHAMSHIRE: That conference:
- (i) supports the development of extended primary care teams to ease GPs' workload burdens and give them more time for patients
  - (ii) calls on government to provide the additional resource needed to support the recruitment, training, and employment of these additional staff on a recurrent basis.
- T3-36 DEVON That conference notes that 'return to practice' requirements are ad hoc and poorly funded and therefore demands a fully funded, remunerated and codified recruiting programme to enable thousands of excellent GPs of working age to return to work in the NHS.
- T3-37 CITY AND EAST LONDON: That conference notes that current working conditions in the NHS are causing workforce shortages in primary care with GP working abroad or retiring and medical students not considering primary care an attractive career option and demands the GPC negotiates with government, a package incentivising GP recruitment and retention.
- T3-38 LAMBETH: That conference recognises the difficulties in recruitment to general practice and recommends meeting the career aspirations of our colleagues by adding a salaried option to deliver primary care services.
- T3-39 CITY AND EAST LONDON: That conference:
- (i) recognises the unprecedented workforce crisis in general practice
  - (ii) believes that the introduction of physicians assistants is a distraction from the real solutions which are needed to save general practice while doing nothing of substance to prevent the haemorrhage of GPs from the NHS
  - (iii) instructs GPC to oppose the government's introduction of physicians' assistants into general practice.

- T3-40 NORTHUMBERLAND: That conference recognises that indemnity fees, even at 'average' levels are making part time working for locum GPs potentially non-viable and asks GPC to:
- (i) continue urgent efforts to resolve the whole indemnity issue
  - (ii) seek an interim solution that will prevent loss from the profession of this valuable group of practitioners.
- T3-41 LEEDS: That conference believes that in order for practices to deliver a safe and sustainable service there is an urgent need for a significant expansion of the general practice workforce which should include:
- (i) fully funding a pharmacist for every practice that wants one
  - (ii) fully funding an expansion of the number of practice nurses through measures equivalent to the 'Ten Point Plan' for 5000 additional GPs
  - (iii) fully funding an expansion of the number of healthcare assistants
  - (iv) fully funding an expansion of GP support staff capable of reducing the administrative burden carried by GPs such as dealing with hospital correspondence and prescription requests
  - (v) greater support and training for practice managers.
- T3-42 BRO TAF: That conference requests the GPC to counter the unhelpful rhetoric from the UK Governments and associated bodies which promotes the myth that other health professionals will provide the answer to the recruitment and sustainability crisis in general practice.
- T3-43 AVON: That conference calls on the GPC to:
- (i) stop colluding with government in attempting to find inappropriate solutions for the crisis within general practice such as federations and mergers
  - (ii) stop colluding with government in attempting to find inappropriate solutions for the crisis within general practice such as substituting the dwindling GP workforce with alternative health care professionals including nurses, pharmacists and PAs
  - (iii) focus on providing appropriate funding and recruitment to general practice so that the service can be appropriately staffed by doctors.
- T3-44 MID MERSEY: That conference believes that the days of independent contractor status are coming to an end and it is time to seriously consider a salaried service and asks the GPC to engage in a constructive and focused manner to explore this option.
- T3-45 BROMLEY: That conference should discourage use of APMS contracting as such contracts do not provide continuity of care and effective succession planning and instead such contracting should only be limited to under-doctored areas with an option to revert back to GMS/ PMS over a given period of time if considered to be in the best interests of patient care.
- T3-46 SOUTHWARK: That conference believes that partnerships that are doing well have little incentive to take on further partners, and incoming doctors are more likely to be employed as sessional doctors which can create an unfair hierarchy.
- T3-47 DERBYSHIRE: That conference reminds the government of the mathematical certainty that an extension of the breadth and depth of general practice services at weekends will mean a diminution on weekdays unless the number of appropriate primary care clinicians is increased by 40%.



- T3-48 AVON: That conference, in the light of the persistent undermining by government of the current model, calls on government to state their precise, clear plans about their future intentions for primary care, and whether they envisage a service fronted and staffed by GPs, or by other healthcare professionals.
- T3-49 BEDFORDSHIRE: That conference laments the loss of many older GPs through early retirement and calls on the GPC to negotiate the re-instatement of seniority payments or equivalent funding for those GPs within ten years of state pension age.
- T3-50 AYRSHIRE AND ARRAN: That conference urges all four UK governments to address the superannuation issues associated with OOH work which is proving to be a disincentive for many experienced GPs to continue working out-with daytime practice.
- T3-51 KENT: That conference notes with concern the consequences of final pay control on practices and asks:
- (i) this be publicised to practices and the wider NHS
  - (ii) the GPC investigates how these consequences can be mitigated
  - (iii) the BMA to negotiate a solution with the NHS Pensions Agency.
- AR** T3-52 SEFTON: That conference calls upon NHS England to heed the findings of recent studies into why GPs are leaving the profession early and to respond in the first instance by
- (i) providing a robust and fully funded occupational health service for general practice
  - (ii) fund and promote a mentorship support scheme for newly appointed GPs to counter feelings isolation
  - (iii) address the 'bully culture' 'that really permeates management in the NHS'.
- A** T3-53 HIGHLAND: That conference asserts that the personal health and wellbeing of doctors should not suffer from unrealistic professional obligations, and therefore asks GPC to
- (i) identify ways to improve the support available around absence from the workplace;
  - (ii) push for the governments to ensure that efforts are directed towards maintaining workforce health in areas that are experiencing excessive pressures;
  - (iii) continue to push for GPs and their staff to have access to a centrally funded, high-quality occupational health service.
- A** T3-54 ROCHDALE AND BURY: That conference urges GPC to seek solutions to the current crises facing the profession by GPs leaving over the next 5 years
- A** T3-55 AYRSHIRE AND ARRAN: That conference in the light of the current workforce difficulties calls for a UK wide performers list for GPs to allow greater workforce mobility.
- A** T3-56 NORTH YORKSHIRE: That conference believes that the current workforce crisis will get worse unless more measures are taken to educate and empower patients so that increasing demand is channeled to the right person in the right place and at the right time.

- A** T3-57 ROCHDALE AND BURY: That conference believes the way in which the government is handling the NHS Pension scheme will lead to a mass exodus of members currently in the scheme.
- A** T3-58 NORTHERN IRELAND CONFERENCE OF LMCs: That conference believes that the benefits of independent contractor status still outweigh the negatives and insists that this is retained in contract negotiations.
- A** T3-59 ROTHERHAM: That conference believes there is no substitute for the experience and knowledge of senior GPs. The threat of losing this cohort of GPs due to the loss of seniority payments is a threat to delivering a safe and sustainable general practice service and demands they be reinstated immediately.
- A** T3-60 BRADFORD AND AIREDALE: That conference believes that the quickest and simplest way to aid with retention of senior GPs is to stop the withdrawal of seniority payments and reverse the changes that have been made.
- A** T3-61 LAMBETH: That conference believes that workforce planning is too short term and is not managed effectively at present with the result that there are insufficient numbers of GPs and practice nurses to support primary care.
- A** T3-62 GLASGOW: That conference wishes to remind the rest of the NHS that practice nurses are employed by GPs to assist in providing services under the GP contract and are not in practice to provide community nursing services.
- A** T3-63 NORFOLK AND WAVENEY: That conference calls upon GPC to negotiate a replacement for seniority payment to recognise experience and commitment in an effort to retain GPs active within general practice and avoid further reductions in the GP workforce.
- A** T3-64 BORDERS: That conference believes that the changes to the lifetime allowance and annual allowance in pensions, is and will, lead to a loss of experienced GPs and some flexibility must be introduced to aid recruitment and retention.
- A** T3-65 NORFOLK AND WAVENEY: That conference believes that the current workforce crisis in primary care is having a detrimental effect on recruiting young doctors into general practice.
- A** T3-66 NORFOLK AND WAVENEY: That conference believes the government's pension reforms and reduction in seniority payments has driven an entire generation of doctors to retire early or cut back their commitments exacerbating the current workforce problems.
- A** T3-67 LEEDS: That conference is alarmed at the GP workforce crisis and insists that NHS England and Health Education England do far more to reduce the bureaucracy of the GP returners scheme to enable more GPs to return to UK general practice.

- A** T3-68 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that the government no longer engages in proper workforce planning and that an additional 5,000 GPs is a political figure plucked out of the air and does not recognise the numbers intending to retire or emigrate, and calls upon the government and HEE to increase the numbers of places in medical schools to satisfy the future needs of medical workforce in the UK.
- A** T3-69 HULL AND EAST YORKSHIRE: That conference believes that the government no longer engages in proper workforce planning and that an additional 5,000 GPs is a political figure plucked out of the air and does not recognise the numbers intending to retire or emigrate, and calls upon the government and HEE to increase the numbers of places in medical schools to satisfy the future needs of medical workforce in the UK.
- A** T3-70 DORSET: That conference recognises that British trained GPs currently working overseas could be a valuable part of the future primary care workforce in this country and suggests:
- (i) there are clear and consistent criteria for returners facilitating easy access onto performers lists
  - (ii) appraisal and other performance measures undertaken in other countries are recognised for revalidation in Britain
  - (iii) there is no requirement for returning to this country for annual appraisal but encouragement for appraisal to be validated appraisal to be undertaken abroad
  - (iv) that the GPC should scrutinise the processes involved in returning to our workforce and ensure they are made as conducive as possible.

**THEMED DEBATE – EMPOWERING PROFESSIONALISM** **12.20**  
**REDUCING THE REGULATORY BURDEN OF CQC**  
**REDUCING BUREAUCRACY AND DUPLICATION TO EMPOWER PROFESSIONALS**

- Problem:** The process of CQC registration and inspection duplicates work already done by other bodies, is disproportionate and costly in time and resource, is not evidence based, is demoralising and therefore is not fit for purpose.
- Impact:** The 2016 BMA survey showed that 8 out of 10 GP practices report that preparing for a CQC inspection resulted in a reduction in time available to care for patients.<sup>6</sup> Almost 9 out of 10 GP practices said that on the day of the CQC inspection, staff had to reduce GP services available for patients. Three quarters of practices reported that staff suffered from significantly increased stress in preparing for and undergoing inspections, but only 1 out of 10 (11%) regarded their final CQC rating as a fair assessment.
- Actions:**
- Replace the current flawed and erroneous content and pattern of CQC visits and ratings, with targeted assessments of essential quality assurance processes where supported by evidence of risk of patient safety.
  - End the duplication of the current CQC registration process and NHS England managed national performers list and performance management arrangements, with a single slimmed down cost-effective process funded by NHS England not practices.
- Problem:** The increased bureaucratic burden created to assess, performance manage and regulate general practice has dramatically increased in the last decade, costing significant amounts both in lost clinical time with patients and financial resource for the NHS and practitioners.
- Impact:** The burden of unnecessary bureaucracy has disempowered professional clinicians and undermined their morale, added unnecessarily to practice and NHS management workload, resulted in significant duplication, misled patients, and wasted millions of pounds that could have been better spent on direct patient care.
- Actions:**
- End the Quality and Outcomes Framework and invest the unweighted resource in the core GMS/PMS contract, developing in its place a professionally-led system that encourages and celebrates quality of care delivered and is not linked to financial targets.
  - End the Avoiding Unplanned Admission enhanced service and invest the unweighted resource in the core GMS/PMS contract to enable practices to care for vulnerable patients without the added and unnecessary bureaucracy of this scheme.
  - Review the bureaucracy and frequency of the appraisal process and reduce so-called 'mandatory' training requirements.
  - Provide at least half a day of protected funded time every month for all GPs and practice staff to engage in learning and professional development.
  - End the annual cycle of GP contract negotiation and provide stability of contract to practices.
  - Reduce the bureaucracy involved in moving between the nations' performers lists, particularly when working in border areas.

## THEMED DEBATE – EMPOWERING PROFESSIONALISM

The following motions are already the policy of LMC Conference;

That conference believes that over regulation and monitoring of the profession has eroded morale and had an adverse effect on the sustainability of general practice, and:

- (i) opposes any increase in the fees demanded of practices by the Care Quality Commission and demands that all fees be fully reimbursed
- (ii) demands that GPC actively campaigns to abolish the regulation of general practice by the CQC
- (iii) demands that GPC produces realistic proposals for an effective peer led quality assurance scheme for General Practice based on criteria that improve patient care and safety
- (iv) calls on GPC to explore all options by which GP practices could lawfully withdraw from engaging with the Care Quality Commission.

### 2016 Special conference

That conference insists that new models of care must be based on:

- (i) personalised care being delivered to patients by general practices supported by extended primary health care teams
- (ii) a registered list of patients
- (iii) an adequately resourced, safe and sustainable national core GP contract
- (iv) cherishing and building on the independent contractor model

That conference:

- (i) recognises that appraisal and revalidation consume time that general practitioners could use for direct patient care
- (ii) calls for the appraisal and revalidation requirements to be reviewed and simplified
- (iii) calls for appraisal to return to being a formative process
- (iv) calls for the frequency of appraisals to be reduced.

That conference calls upon the GPC to negotiate Crown Indemnity for all GP work, both in and out of hours, in all NHS working environments, with immediate effect.

### 2015 Annual Conference

That conference:

- (i) believes that the GMC is creating a climate where doctors practice in fear for their registration
- (ii) demands that GPs being investigated for alleged misdemeanours should be presumed innocent until proven otherwise
- (iii) demands that the GMC implement the recommendations of the independent report by Sarndrah Horsfall, 'Doctors who commit suicide while under GMC fitness to practise investigation'.

That conference with respect to the current complaints system for general practice:

- (i) believes it has been undermined by the fragmentation of the NHS resulting from the Health and Social Care Act
- (ii) believes it is letting GPs, practices and patients down
- (iii) believes that it would benefit from a step for mediation in the process
- (iv) calls on the GPC to conduct a review of decisions and findings of the Health Service Ombudsman in relation to GPs
- (v) asks the GPC to work with NHS England to revise it.

That conference believes that professional regulation of doctors needs to be separate from the regulation of other professions and providers, and protected from political interference, and therefore calls for the GMC to remain independent.

That conference:

- (i) believes that appraisal has become a workload burden for GPs
- (ii) believes that appraisal is no longer a formative experience for most GPs
- (iii) believes that appraisal is being made far more arduous and bureaucratic than is required by GMC
- (iv) believes that appraisal poses particular difficulty for sessional GPs to obtain evidence for their various roles
- (v) calls on GPC to ensure that appraisal returns to a much more valuable process for GPs.

That conference deplores the bureaucratic and incompetent nightmare of the CQC, and demands that it is decommissioned forthwith and that the funding is reinvested in frontline services.

That conference requests that the Secretary of State ensures that GP regulation and inspection:

- (i) is focused
- (ii) is relevant to clinical outcomes
- (iii) does not demoralise, denigrate or draw resources away from actually delivering healthcare.

## THEMED DEBATE – EMPOWERING PROFESSIONALISM

- T4-1 CITY AND EAST LONDON: That conference believes that if general practice fails the NHS will fail.
- T4-2 NORTHERN IRELAND CONFERENCE OF LMCs: That conference rejects a national definition of safe practice for general practitioners as it is incompatible with independent contractor status.
- T4-3 SALFORD AND TRAFFORD: That conference believes that as the panoply of regulatory bodies monitoring general practice inform each other of any knowledge of a complaint, they should also share with each other when they decide not to progress a complaint.
- T4-4 SHROPSHIRE: That conference believes that GP appraisal should be performed by their GP peers, and if recruitment of sufficient doctors to perform this is inadequate then the rate paid for each appraisal by NHSE should increase to reflect the importance of the role.
- T4-5 MID MERSEY: That conference believes that the general public needs to be properly educated in how to use general practice and asks the GPC to explore all necessary steps required to achieve this.
- T4-6 BEDFORDSHIRE: That conference believes that GP's indemnity fees should be capped and calls on the GPC to work to effect this.
- T4-7 GLOUCESTERSHIRE: That conference, while noting that discussions about medical insurance for GPs and other staff are taking place, insists that in the meantime the medical defence organisations return to their mutuality roots and therefore revert from the current varied underwriting decisions to a cover per whole time equivalent GP, and pro rata thereof.
- T4-8 DORSET: That conference believes that with the increasing blame and claim culture, complaints against GPs are having a demoralising effect on our work force and result in increasing workload and stress for GPs and their practice managers. We call on the BMA and NHS England to provide greater support in dealing with the significant administrative burden and negative psychological impact that complaints cause to all those involved.
- T4-9 BEDFORDSHIRE: That conference no target, ranking, dashboard or payment relating to individuals or practices should be based on metrics which do not have full exception coding provided.
- T4-10 CITY AND EAST LONDON: That conference demands an end to work being imposed on general practice by NHSE which is unfunded and un-negotiated, for example, the requirement for practices to ensure a patient has had a colposcopy appointment issued when referred directly by the cytology labs. Ensuring a patient has an appointment should remain with the referrer and all changes must be negotiated and discussed and not just imposed.
- T4-11 BEDFORDSHIRE: That conference believes that there should be centralised, government funded indemnity for GPs against all possible risks to their practice – not only lawsuits but also ombudsman etc. – and calls on GPC to work to effect this.



- T4-12 NORTH YORKSHIRE: That conference recognises that the huge increases in medical indemnity premiums year on year are unsustainable, and to help rein in these exorbitant rises the GPC must lobby for legislation that limits lawyers that encourage patients to sue doctors on a no win - no fee basis.
- T4-13 LIVERPOOL: That conference believes that GPs must strive towards providing 20 minute appointments for the management of patients with more complex needs, to at least maintain the holistic and broad role of the family GP, and to prevent burnout and compassion fatigue.
- T4-14 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that general practice is still one of the best jobs in the world and we need government and GPC to make a public commitment to support GPs to deliver a high quality service.
- T4-15 NORTH YORKSHIRE: That conference calls for a change in legislation to enable GPs to be included on the specialist medical register; the difficulty at the moment is that GPs are not seen as specialists.
- T4-16 DERBYSHIRE: That conference demands that any new contract for GP services to the public be comprehensive and simple so that practices do not have to spend time making multiple claims for payments from multiple funders.
- T4-17 WIGAN: That conference exhorts the GPC to urgently engage with NHS England and medical defence bodies to devise an affordable indemnity scheme for general practice.
- T4-18 DERBYSHIRE: That conference:  
(i) asserts that the 2004 GP contract is no longer fit for purpose  
(ii) instructs GPC to initiate negotiations with NHS England regarding a new contract based on principles acceptable to the profession.
- T4-19 ROCHDALE AND BURY: That conference urges GPC to expedite a solution to the ongoing problems caused by the cost of medical indemnity for GP's.
- T4-20 BUCKINGHAMSHIRE: That conference as part of the 'rescue package', presses the GPC to urgently publish a list of procedures and services that are not part of contracted essential and additional services  
(i) which should be implemented nationally  
(ii) and that practices providing these services should be given additional payments  
(iii) and would advise practices undertaking these services without additional funding to consider giving notice of terminating the services.
- T4-21 BIRMINGHAM: That conference calls on GPC to publicly advise every practice that in order to continue to safely provide essential services to currently registered patients they must now consider contractual measures to reduce workload, including, as a priority, declining to register new patients whilst formally applying for practice list closure.

- T4-22 DERBYSHIRE: That conference asserts that the emotional blackmail of general practitioners by politicians, the NHS, journalists and opinion formers, to obtain NHS services from GPs without proper reward or reimbursement of expenses incurred, using the arguments that 'patients will suffer/what about your dedication and vocation?' are those of the morally and intellectually bankrupt in the context of a wealthy nation such as the United Kingdom.
- T4-23 KENT: That conference calls for a media campaign to inform the public that:
- (i) the current GP workload is unmanageable and unsafe
  - (ii) the shortage of GPs is threatening services right now
  - (iii) patients should be encouraged to cherish their practices as a limited resource
  - (iv) patients are encouraged not to book appointments for non-medical reasons.
- T4-24 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference instructs GPC to urgently address the rising costs of medical indemnity for general practitioners, and to take action to minimise the direct financial cost of indemnity to GPs and GP practices. This conference calls for the GPC to explore options including but not limited to:
- (i) GP indemnity to be funded centrally
  - (ii) GPs to be given crown indemnity
  - (iii) GP per session indemnity to be capped nationally.
- T4-25 WILTSHIRE: That conference deplores the rise of the CQC demands for payment from practices and demands that GPC co-ordinates a mass campaign of non-payment.
- T4-26 GLASGOW: That conference remains disappointed that the culture of 'get a letter from your doctor' continues to be an administration requirement from organisations in both public and private sectors before patients can access services and calls on the Scottish and UK Governments to:
- (i) promote and encourage a common sense approach that removes the 'need' for a GP letter
  - (ii) reaffirm their commitment to reducing bureaucracy in general practice
- T4-27 WEST MIDLANDS REGIONAL COUNCIL: That conference urges the BMA to support legislative change that requires the General Medical Council to reformat the Medical Register such that general practitioners are treated equally with doctors in other specialties and are listed as specialists in their own right.
- T4-28 DERBYSHIRE: That conference instructs GPC to produce a series of brief educational leaflets describing the obligations and limits of general practitioners working the NHS aimed at
- (i) NHS managers
  - (ii) social services
  - (iii) hospital doctors
  - (iv) MPs
  - (v) others.

- T4-29 KINGSTON AND RICHMOND: That conference believes the GPC should:
- (i) more robustly make the case for general practice in the national media
  - (ii) make it clear that negative and unjustified media comments are damaging to general practice.
- T4-30 LAMBETH: That conference believes that there is a need to manage patients' expectations as many patients' complaints are a consequence of unrealistic expectations and instructs the GPC to produce a marketing/communications plan with the aim of managing patients' expectations.
- T4-31 SCOTTISH CONFERENCE OF LMCs: That conference remains disappointed that the culture of 'get a letter from your doctor' continues to be an administrative requirement from organisations in both public and private sectors before patients can access services and:
- (i) maintains that there should be a central, accessible, 'plain English' website outlining which documents, certificates and letters patients are/are not entitled to on the NHS
  - (ii) calls on the Scottish and UK Governments to promote and encourage a common sense approach that removes the 'need' for a GP letter.
- T4-32 HIGHLAND: That conference believes in working environments where people feel dignified and demands that GPC explore how contractual arrangements might:
- (i) better protect staff in general practice in dealing with patients who request testing or treatments that are not supported by guidelines, are not medically indicated, or which may even be potentially harmful;
  - (ii) avoid unnecessary exposure of staff to the harmful effects that occur when patients repeatedly exhibit behaviour that is aggressive, abusive or intimidating.
- T4-33 NEWCASTLE AND NORTH TYNESIDE: That conference, whilst recognising some merits of patient care plans, needs to appreciate the workload involved, and although they could be an important management tool in appropriate circumstances, should not be performance driven, without due regard for clinical priorities.
- T4-34 NORTHERN IRELAND CONFERENCE OF LMCs: That conference petitions the government as follows:
- (i) general practice must be saved, in order that the NHS itself can survive
  - (ii) general practice in the UK has for decades been the envy of the world, but is now imperilled as never before, and an emergency package of measures is vital.
- T4-35 AYRSHIRE AND ARRAN: That conference calls for wider recognition and understanding of the crisis facing general practice amongst the public, our NHS colleagues and politicians.
- T4-36 MID MERSEY: That conference deplores the recent unjustifiable 14% escalation in the CQC's annual subscription of 14% and asks the GPC to ballot all general practices about refusing to pay en masse.

- T4-37 MANCHESTER: That conference believes that if the current workload crisis is not adequately addressed, GPs should symbolically resign from their 'gatekeeper' role in rationing NHS care and concentrate only on providing safe and effective care for the patient in front of them. This may include:
- (i) not engaging with referral management schemes that are primarily about reducing numbers of referrals or deflecting them to cheaper services
  - (ii) not engaging with medicines management schemes that are primarily about drug acquisition cost
  - (iii) refusing to do unpaid work when there are secondary care tariff based services that could take this on, eg phlebotomy, spirometry, ABPMs, ECGs, shared care prescribing, etc
  - (iv) recognising when the daily safe capacity of the GP practice has been reached and then signposting patients to an appropriate alternative.
- T4-38 CITY AND EAST LONDON: That conference believes that the presence of 'employment coaches; in GP surgeries could compromise the integrity of doctors and undermine trust in their relationship with patients.
- T4-39 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference believes that increasing workload and lack of resource represents a significant threat not only to the health and wellbeing of practitioners but to the ability of general practice to deliver high quality care. It instructs the GPC consider all actions available, including industrial action, in order to ensure a sustainable future for general practice services for patients.
- T4-40 DEVON That conference believes that the consequences of the CQC system of grading demonstrate that:
- (i) the true aim of CQC is to influence patient behaviour in choice of practice rather than to provide public assurance on standards
  - (ii) CQC outcomes need to be revised to a binary pass / fail grading.
- T4-41 LIVERPOOL: That conference believes that the future of general practice rests with having a much enhanced multi-disciplinary team to support GPs, so that GPs can concentrate on managing those patient with complex needs and requests GPC to negotiate an equitable rate to the global sum to encourage, and facilitate the development of a fully enhanced multi-disciplinary team.
- T4-42 GLASGOW: That conference welcomes the publication of the Scottish Chief Medical Officer's report "Realistic Medicine" in starting a conversation with clinicians on how doctors can reduce the burden and harm to patients from over-investigation and over-treatment.
- T4-43 NORTH STAFFORDSHIRE: That conference believes that current patient demand can no longer safely be met by the current GP workforce and that the government needs to
- (i) recognise and acknowledge this
  - (ii) indemnify the associated professional risks for those working in this unsafe clinical environment
  - (iii) invest in appropriate patient education to mitigate the effects of uncontrolled government and media stoked healthcare demand
  - (iv) as a duty of care to its own NHS GP medical staff, pursue all avenues to decrease the unsustainable pressures on general practice
  - (v) devise a back-up alternative system of primary care for when general practices completely collapse in certain areas.

- T4-44 BRADFORD AND AIREDALE: That conference acknowledges the need to use all forms of media to raise awareness of the current threats to primary care, primarily the funding gap, recruitment crisis and burgeoning workload. Modern and social media platforms provide a great opportunity to inform the general public of these current issues and highlight the importance of supporting general practice.
- T4-45 AVON: That conference calls for immediate action to address the recruitment crisis facing primary care by:
- (i) reducing the onerous nature of revalidation on GPs who have retired
  - (ii) promoting the benefits of primary care as a specialty choice
  - (iii) giving tangible incentives for senior GPs to remain within the profession
  - (iv) making changes to the pension structure to encourage GPs to remain within the workforce.
- T4-46 SOMERSET: That conference instructs GPC to use all its endeavours to ensure that the public understands that the constant corrosive criticism of GP services from parts of the daily press is a significant contributor to the rapidly deteriorating GP workforce position in much of the country.
- T4-47 BUCKINGHAMSHIRE: That conference requires the GPC to invest in a major media and public relations campaign to inform the public of the general practice crisis. This will include
- (i) a major investment in a high-end media strategy utilising leading industry experts in public relations, branding and advertising to inform the campaign
  - (ii) an increased investment in press office functions to enable high intensity, high quality press releases to promote our campaign message and to rebuff any negative government or press statements
  - (iii) a coordinated high-end national promotion campaign in general practice surgeries with the aim that every patient entering a general practice surgery leaves it fully informed of the current crisis.
- T4-48 NORTH YORKSHIRE: That conference believes that despite all the problems, the role of the GP is the best job in the NHS and new GPs, who will be the saviours of the profession, are welcomed and will be supported to continue UK general practice as the envy of the rest of the world who are worse off than the UK but have better weather.
- T4-49 DORSET: That conference believes that with the increasing blame and claim culture, complaints against GPs are having a demoralising effect on our work force and result in increasing workload and stress for GPs and their practice managers. We call on the BMA and NHS England to provide greater support in dealing with the significant administrative burden and negative psychological impact that complaints cause to all those involved.
- T4-50 WILTSHIRE: That conference agrees with the Secretary of State for Health that GPs are 'the jewel in the crown' of the NHS:
- (i) and asks him to demonstrate his accolade by reducing the regulatory burden and micro management of services provided by GPs to restore the high trust low bureaucracy principle GPs signed up for
  - (ii) demands an end to the triple jeopardy of three regulators for English GPs with the GMC, the CQC and Quality Improvement teams from NHS England.

- T4-51 NORFOLK AND WAVENEY: That conference demands GPC negotiates an appropriate reduction in the burden of appraisal and revalidation for GPs who work part time to encourage GPs who may otherwise have retired completely to support and ensure a safe and sustainable NHS.
- T4-52 NORFOLK AND WAVENEY: That conference believes that appraisals should be conducted by fellow professional peers and not devolved to non-GPs.
- T4-53 DERBYSHIRE: That conference demands that in view of the current critical workforce crisis and extended working days the following measures be enacted immediately:
- (i) TWO yearly appraisal system with no more than three appraisals in a six year period plus an RO recommendation = revalidation
  - (ii) CQC be abolished
  - (iii) the current extended hours DES be abolished and the money returned to the global sum or the PMS baseline and that any replacement scheme be funded from entirely new money.
- T4-54 DERBYSHIRE: That conference calls for:
- (i) a rationalisation and reduction of the multiple jeopardies faced by GPs and practices
  - (ii) the abolition of the power of the health ombudsman to require a practice to pay financial compensation when a finding of clinical error has been made.
- T4-55 GLOUCESTERSHIRE: That conference:
- (i) is appalled that in many areas 10% of GPs are annually being taken to the Professional Advisory Group (PAG), many for problems caused by illness, overwork or systems failure within the NHS (and through no fault of their own)
  - (ii) demands that PAG assessments be halted forthwith
  - (iii) demands the suspension of anything but the most serious referrals until a faster, less stressful, peer review screening process is in place.
- T4-56 MID MERSEY: That conference believes that the process of whistle blowing in general practice is in need of urgent reform and is nothing but hot air and remains deeply concerned about the welfare and future of whistle blowers.
- T4-57 HERTFORDSHIRE: That conference believes that the revalidation system causes unnecessary stress to GPs due to lack of communication between Responsible Officers and the GMC which can result in GPs receiving emails suggesting incorrectly that they have not been revalidated and calls on GPC to insist that the GMC and NHS England resolve this situation.
- T4-58 HERTFORDSHIRE: That conference views with dismay the further devaluing of the appraisal process by the introduction of non GP appraisers and urges the GPC to fight to retain the value of formative, personal, peer review based appraisals.

- T4-59 BERKSHIRE: That conference believes patient safety is paramount and hence asks government to
- (i) recognise that GPs spend so much time ‘fire-fighting’ clinical demand that there is scant capacity left to deal with anything else
  - (ii) fund protected time so GPs can bring the quality improvements projects of their CCGs to reality, achieve standards set by CQC and have time for professional interaction and maintaining their knowledge
  - (iii) fund tools and support services that facilitate GPs engagement with regulatory systems and professional development
  - (iv) work with GPs to make regulatory measures and activities better focused, meaningful and time efficient.
- T4-60 WILTSHIRE: That conference believes that we are the most over-regulated GPs in the world and demands action to stop our exposure to triple jeopardy.
- T4-61 HULL AND EAST YORKSHIRE: That conference believes that all NHS and local authority services should be covered by Crown Indemnity and protection of a doctor’s good name and professional standing should remain with the defence organisations.
- T4-62 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that all NHS and local authority commissioned services should be covered by crown indemnity and the protection of a doctor’s good name and professional standing should remain with the defence organisations.
- T4-63 NORFOLK AND WAVENEY: That conference instructs GPC to undertake an appraisal of indemnity premiums for scheduled, unscheduled care, and the impact of multi-disciplinary working, and to consider the options available to the profession including the introduction of crown indemnity.
- T4-64 AVON: That conference instructs GPC to call for an urgent review of the way this country manages medical negligence cases in an effort to move to a system of no fault compensation, as practiced, for example, in New Zealand.
- T4-65 BEXLEY: That conference:
- (i) remains concerned by the current medical indemnity system of the three defence unions
  - (ii) notes with concern that insurance premium costs appear to be rising annually yet services remain ‘discretionary’ after the deduction of subscriptions; and
  - (iii) calls for conference to support the movement of GPs to crown indemnity cover on par with that of hospital doctors.
- T4-66 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference condemns the Health Minister’s proposal of one minute video consultations and calls on GPC to insist that new technology must ease the unsustainable pressures on general practice, and to reject any technologies that add to them.



- T4-67 ROTHERHAM: That conference believes the increasing costs for CQC registration should actually be spent on improving GP services and not on incompetent processes. We call on the GPC to explore all options for GP practices to completely withdraw from engaging with CQC and pursue this via judicial review if needed.
- T4-68 WILTSHIRE: That conference believes that medical indemnity is a significant deterrent to GPs working and instructs the GPC to pursue with the possibility that the indemnity market is not open enough to competition with appropriate bodies such as the Competitions and Markets Authority and the Financial Conduct Authority.
- T4-69 AYRSHIRE AND ARRAN: That conference demands:
- (i) an end to the external measurement of quality, eg CQC, within practices
  - (ii) the development of a professional peer led framework to support practices in providing and maintaining quality of patient care.
- T4-70 OXFORDSHIRE: This conference believes that CQC and appraisal/ revalidation are of dubious value and have opportunity costs which are partially responsible for preventing a GP workforce in short supply from providing the clinical care patients require.
- T4-71 NORTH YORKSHIRE: That conference demands that CQC is asked to justify and validate its standards.
- T4-72 SOMERSET: That conference asks GPC to press the Care Quality Commission to produce evidence that its inspection regime is cost effective, and to demonstrate how its inspections and associated reports and practice ratings have led to a measurable reduction in actual patient harm.
- T4-73 BUCKINGHAMSHIRE: That conference expects the regulatory scheme which should replace CQC will:
- (i) be fully resourced by NHS England
  - (ii) be proportionate in its expectations and standards for general practice
  - (iii) negotiate and agree suitable inspection intervals and regulatory standard with GPC, accepting advice from RCGP.
- T4-74 GATESHEAD AND SOUTH TYNESIDE: That conference believes that time spent by GPs in proving their accountability is unnecessary and soul destroying. Whilst there has to be some accountability, it has now gone too far and become onerous and unnecessary.
- T4-75 NORTHUMBERLAND: That conference acknowledges that a well-informed, consistent, and professional inspection system could be formative, constructive and supportive for general practice. If CQC is to continue there should be:
- (i) public acknowledgement that the system is not fit for purpose, and has in many instances caused extreme and unnecessary distress to practices and caused unnecessary distress and concern to patients
  - (ii) a public apology/statement of the shortcomings from CQC
  - (iii) action by CQC to work with primary care to produce a regime that is fit for purpose
  - (iv) published clear standards and requirements that are not open to interpretation

- T4-76 DEVON That conference notes that:
- (i) proper inspection and regulation of general practice is good for doctors and good for patients
  - (ii) in the light of 'intelligent monitoring' and vast hikes in fees the current management of CQC has failed abjectly in its responsibility to run a proper inspection regime
  - (iii) current CQC functions relating to primary care could be better delivered if overseen by LMCs.
- T4-77 HERTFORDSHIRE: That conference notes with gravity the mounting number of practices closing and on the brink of financial collapse, and calls upon NHS England with the government to agree to the following measures as an immediate and necessary emergency rescue package until at least the end of this Parliament:
- (i) a review of CQC processes and inspections to simplify and support practices
  - (ii) a moratorium on CQC inspections until a review is carried out into the over-regulation of primary care and the evidence base surrounding improved quality outcomes of such inspections, with self-declaration measures in the interim.
  - (iii) a freeze on 2014 CQC fee schedule.
- T4-78 HULL AND EAST YORKSHIRE: That conference believes that general practice is still one of the best jobs in the world and we need government and GPC to make a public commitment to support GPs to deliver a high quality service.  
**(Supported by NORTH and NORTH EAST LINCOLNSHIRE)**
- T4-79 SALFORD AND TRAFFORD: That conference believes that if this government truly believes what it says, "that general practice is the jewel in the crown of the NHS" that it is time it started treating GPs and their staff as the precious commodity they are.
- T4-80 MID MERSEY: That conference believes that the standard of clinical note keeping required today makes fifteen minute appointments insufficient in general practice.
- T4-81 CLEVELAND: That conference calls on the profession as a whole to portray the positive aspects of general practice to publicise it as a worthwhile career option.
- T4-82 WILTSHIRE: That conference believes that it would be professionally advantageous for GPs to be renamed 'consultants in primary care'.  
**(Supported by DORSET, HAMPSHIRE and ISLE OF WIGHT)**
- T4-83 HAMPSHIRE AND ISLE OF WIGHT: That conference believes GPs as individuals have net earnings, not profits, and that this term should be preferred in all contracts and commentaries.
- T4-84 WILTSHIRE: That conference believes that currently
- (i) GPs are being proletarianised
  - (ii) GPs are being de-professionalised.
- T4-85 COVENTRY: That conference believes that the GPC should mandate that the term mandatory is banned and should produce guidance regarding what competencies are expected of GPs and how they can demonstrate these.  
**(Supported by WORCESTERSHIRE)**

- T4-86 SHROPSHIRE: That conference believes recognition of UK general practitioners as specialists in family medicine (as is the case in Europe) would improve GP status and morale which, in turn, would have a positive effect on recruitment and retention.
- T4-87 LEWISHAM: That conference believes that in order to challenge perception amongst professionals and patients, general practitioners should be able to call themselves 'consultants in primary care'.
- T4-88 WOLVERHAMPTON: That conference believes the great strength of the GMS contract has been the fact that it is centrally negotiated. It is now time to rein in all the locally negotiated bolt on services for central negotiation to strengthen the GMS contract and general practice.
- T4-89 SUFFOLK: That conference views the continued under-resourcing of primary care combined with the lack of willingness of the government to listen to our professional bodies as a perfect storm threatening the very existence of the whole NHS. Without an immediate and meaningful change in government policy in these areas the profession is likely to be forced to concentrate on matters of immediate patient safety only at the expense of all other work. Conference instructs GPC to leave the government in no doubt on this matter.
- T4-90 CLEVELAND: That conference believes the GPC could learn from the example of The Netherlands in their dealings with the Departments of Health and specifically demands;
- (i) a tougher negotiating stance
  - (ii) a refusal to co-operate with any imposed box ticking or targets
  - (iii) stability of GP income, rather than cycles of boom and bust.
- T4-91 DEVON That conference:
- (i) is appalled at the cavalier and often deliberately misleading use by politicians and enthusiasts alike of medical statistics
  - (ii) would welcome the formation of a body to be a watchdog for statistical abuse operating in a similar role to the Office for Budget Responsibility which regulates political economic statements
  - (iii) asks the GPDF to commission a fully funded, academically based, and entirely independent parallel 'Office for Medical Statistics Responsibility' as a respected neutral arbiter of 'medical facts'.
- T4-92 GREENWICH: That conference believes that the more the government reduces the income and increases the workload of practices the less likely are QIPP plans to work.
- T4-93 LOTHIAN: That conference maintains that there should be a central, accessible, 'plain English' website for patients / organisations / employers outlining which documents, certificates and letters they are / are not entitled to on the NHS.
- T4-94 KENT: That conference demands that schools are:
- (i) required to refer to the advice on Public Health England's website when determining a child's fitness to attend school
  - (ii) reminded annually that no form of certification is needed to support absence from school or offer mitigation for performance in exams
  - (iii) only to signpost pupils or parents to be checked by their GP when acting under guidance approved by PHE and/or the local LMC.

- T4-95 CLEVELAND: That conference believes that the profession lacks a comprehensive objective for the future of general practice, and demands this is published by the GPC within 12 months.
- T4-96 EALING, HAMMERSMITH AND HOUNSLOW: That conference calls on the GMC and NHSE to:
- (i) promote a more consistent approach to GP appraisals, and
  - (ii) requests that responsible officers clarify the interpretation of the appraisal guidelines and communicate this clearly to GPs, and
  - (iii) adopt an approach that promotes clinical effectiveness rather than adds bureaucratic demand.
- T4-97 LEEDS: That conference believes that in order to reduce the bureaucratic burden on practices and to improve services to patients NHS England must insist that all hospital services:
- (i) have in place easily accessible systems to enable patients to manage their appointments and to contact the specialist responsible for their care without the need to involve their GP
  - (ii) stop advising patients to ask their GP for a letter to expedite their appointment.
- T4-98 DERBYSHIRE: That conference is very concerned that, in this electronic age, failures of timely communication between secondary care and primary care remain commonplace and
- (i) asserts that this is a patient safety issue, especially when prescribing issues are involved
  - (ii) reminds GPC and other branches of practice committees of motion 73 of the annual conference of LMCs 2014
  - (iii) asserts that improved communication will save the time of patients, general practice and hospital clinical and their support staff.
- T4-99 NORTH STAFFORDSHIRE: That conference believes:
- (i) that S2(4) of the Law Reform (Personal Injuries) act 1948 should be repealed to allow compensation to purchase NHS care, supporting the NHS rather than harming it
  - (ii) there should be a cap on future care costs and earning costs for more fair distribution of compensation
  - (iii) that the current cost of GP medical indemnity is unsustainable, harming patient care through decreasing the workforce and in particular, harming the GP partner role where its burden especially falls.
- T4-100 HAMPSHIRE AND ISLE OF WIGHT: That conference demands a unifying charter for safe and sustainable practice that:
- (i) reflects the outcomes of our deliberations in the face of the current crisis, and
  - (ii) the government should be challenged to sign it.
- (Supported by DORSET AND WILTSHIRE)**
- A** T4-101 AYRSHIRE AND ARRAN: That conference calls for an immediate end to the unresourced work that comes to general practice from secondary care.
- A** T4-102 HERTFORDSHIRE: That conference recognises that list closure is a last resort for most practices and asks GPC to ensure NHS England supports list closure applications as a positive way for practices to manage their lists.

- A** T4-103 LOTHIAN: That conference recognises that the interface of primary and secondary care is commonly dysfunctional leading to difficulties in patient care and believes that there needs to be nationally defined and nationally enforced systems to ensure that GPs are no longer 'delegated' routine secondary care work including onward referrals to other specialties.
- AR** T4-104 NOTTINGHAMSHIRE: That to help deliver the requirements of the GPCs 'Quality First' document, conference calls on the government to give primary care commissioning organisations a set of objectives by which they will seek to prevent the unresourced transfer of work from secondary care to general practice and discourage inappropriate use of GPs time by patients and third parties.
- A** T4-105 CUMBRIA: That conference believes that the over regulation, monitoring and reporting arrangements for general practice
- (i) presents multiple layers of jeopardy to GMC, CQC, Ombudsman, NHSE, CCG HealthWatch et al,
  - (ii) is a bureaucratic and unnecessary overhead that is crippling practices
  - (iii) and that the GP profession should only be accountable to one organisation.
- A** T4-106 ROCHDALE AND BURY: That conference deplores the way in which CQC has differing standards in undertaking GP practice visits.
- A** T4-107 BROMLEY: That conference believes that a national policy is sought to address the growing 'dumping' on general practice from secondary care, which includes but is not limited to:
- (i) ordering and chasing investigations under the care of secondary care colleagues,
  - (ii) referral onwards to other secondary care colleagues and
  - (iii) referral for patients not attending appointments/ having appointments cancelled.
- A** T4-108 REDBRIDGE: That conference recognises
- (i) that the shift of work from secondary to primary care creates a significant clinical risk and that
  - (ii) GPs should not be expected to prescribe medication that should be managed in secondary care.
- A** T4-109 SOUTHWARK: That conference deplores the time and resources taken up by general practice in having to re-refer patients who do not attend scheduled outpatient appointments or having to refer patients at the request of secondary care clinicians and demands that the GPC negotiates that a solution be put in place to resolve this.
- A** T4-110 HERTFORDSHIRE: That conference applauds NHS Scotland's decision to abandon QOF and pool resources into the global sum, and in the interests of efficiency and the protection of core GP services for the population of England calls upon NHS England to agree to the same.
- A** T4-111 LEEDS: That conference believes that QOF should end and the funding fully invested in to global sum/PMS baselines to enable practices to continue to deliver high quality care but without the micro management of the current scheme.

- A** T4-112 NORFOLK AND WAVENEY: That conference calls upon GPC to negotiate a cessation in requests from schools for confirmation of absence for the sole purpose of maintaining schools truancy ratings.
- A** T4-113 SOMERSET: That conference notes that the cost of medical indemnity insurance has continued to increase rapidly, and for some practitioners may soon be unaffordable, and therefore demands that GPC start negotiations with NHSE and the NHSLA seeking to include all clinical work done under any NHS contract in a nationally funded indemnity scheme.
- A** T4-114 SUFFOLK: That conference believes that the current CQC primary care inspection regime is unwieldy and unfit for purpose. Conference requests that GPC negotiate a more proportionate monitoring scheme for GP practices and insists that this is funded centrally in full.
- A** T4-115 NORFOLK AND WAVENEY: That conference believes that current system of CQC primary care inspection is not conducive to good and safe patient care.
- A** T4-116 BRADFORD AND AIREDALE: That conference believes that the CQC inspection regime in its current form is not fit for purpose and calls for the CQC inspection regime to be rationalised to support modern general practice in a resource constrained environment with less emphasis on bureaucratic tick box requirements and protocols.
- A** T4-117 DERBYSHIRE: That conference demands that:
- (i) routine inspections of general practice by the Care Quality Commission (CQC) should be abandoned, at least until the general practice workforce crisis has been resolved to the satisfaction of the profession
  - (ii) unannounced inspection of general practices by CQC should not be triggered by otherwise un-investigated complaints about the clinical practice of individual clinicians.
- A** T4-118 GLASGOW: That conference considers it inappropriate delegation of work and a waste of GPs' and patients' time for secondary care doctors to tell patients to see their own GP for onward referral to other specialties and calls on our clinical colleagues in hospital to follow GMC guidance and refer patients appropriately to other specialties.
- A** T4-119 AVON: That conference calls on the government to address the constant form filling and bean-counting required for payment of activities such as enhanced services and other contracts, which diverts attention away from patient care.
- A** T4-120 MID MERSEY: That conference believes that it is time for crown indemnity to be extended to cover general practice.
- A** T4-121 ROCHDALE AND BURY: That conference despises the way in which CQC visits are undertaken leading to significant clinical time withdrawn from patient care.
- A** T4-122 MERTON, SUTTON AND WANDSWORTH: That conference reiterates its stance that incentives to practices to reduce referrals are not appropriate.

- A** T4-123 WILTSHIRE: That conference believes that there are too many impediments to returning to general practice or moving easily between the four nations and instructs the GPC to negotiate for a single UK performers list.
- A** T4-124 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference calls upon GPC to unequivocally support and promote, with LMCs, that sessional GPs have equity of access to, and support for any training for CQC and employer requirements across regions.
- A** T4-125 SOMERSET: That conference asserts that GP professional appraisal is rapidly moving from being a supportive exercise to another performance management tool and, in the absence of any evidence of its value in this respect, appraisals should take place once every two years.
- A** T4-126 GREENWICH: That conference demands the GPC to negotiate an 'emergency brake' on the unfunded shift of workload from secondary to primary care, the target driven administrative burden, and the bullying tactics of over-regulation.
- AR** T4-127 SOMERSET: That conference asks GPC to enter into discussions with NHS England to ensure that GP Performance processes can remain sufficiently localised for meetings to be of an acceptable length for full consideration of all cases, and also to ensure that participants are aware of local conditions and circumstances that are likely to be relevant to the case.

## PARALLEL DISCUSSION GROUPS

## Annex 2

## TRAINING AND SUPPORT FOR A NEW GP WORKFORCE

- P1-1 NORTH YORKSHIRE: That conference is concerned that all surviving GPs in 10 years' time will need to be fluent in complex non-clinical skills and attitudes, such as larger-scale leadership ability, a reasonably competitive business sense and a broader management competence, which are currently not specifically part of the usual curriculum in medical school or GP training. There is an urgent need to integrate a systematic and structured investment into these skills now.
- P1-2 HERTFORDSHIRE: That conference laments the loss of many older and more experienced GP partners which is depriving younger partners of the mentorship and support that the older generation of GPs benefitted from and calls on GPC to explore mechanisms of replacing this unofficial resilience training through funded mentorship programmes.
- P1-3 BRADFORD AND AIREDALE: That conference believes that the current MRCGP Clinical Skills Assessment in its current form is not fit for purpose and calls for it to be more reflective of modern general practice, with less emphasis on obtaining a pristine psychosocial history and inclusive of multiple patient presenting complaints within one appointment.
- P1-4 ROCHDALE AND BURY: That conference recognises the current pressures faced by general practice but urges GPC to educate junior doctors in embarking on a career in general practice.
- P1-5 BRADFORD AND AIREDALE: That conference supports the need for leadership training for GPs and calls on NHSE to provide funding and support for GPs to attend leadership training if they so wish. There are formal leadership training schemes in the other devolved nations but not in England. Training opportunities may be aimed at First 5 GPs but should also be available to GPs at other stages of their careers.
- P1-6 HULL AND EAST YORKSHIRE: That conference believes that the current GP training programme does not adequately prepare trainees for the current environment in general practice and calls on the GPC to:  
(i) push for the inclusion of resilience training for all junior doctors  
(ii) promote evidence-based forms of stress relief to all junior doctors  
(iii) engage with LMCs to provide a mentoring scheme for First5 GPs in each geographical area to support them in their practice.
- P1-7 CORNWALL AND ISLES OF SCILLY: That conference believes that general practice needs a clearer career structure and calls upon GPC to design a career pathway for newly qualified GPs.



- P1-8 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference believes that burnout is a serious issue for GPs, and GP trainees, which is impacting on recruitment and retention. We call on the GPC and LMCs to work with training practices, training schemes, and post-graduate health education organisations to:
- (i) ensure the framework GP trainee contract is implemented for every GP trainee to better address work-life balance and ensure safe care for patients
  - (ii) ensure training practices are adequately funded to be able to provide good supervision and training
  - (iii) ensure GP trainees receive the two structured educational and one independent study sessions per week as stated in the framework contract
  - (iv) introduce a system of mandatory monitoring of GP trainee working hours and educational sessions to ensure GP trainees are not routinely working beyond the 40 hours a week stated in the framework contract.
- P1-9 AYRSHIRE AND ARRAN: That conference understands that there are reports of some GP trainees working in excess of the 10 four hour sessions specified in the GP trainee framework contract and calls on GPC to work with relevant organisations to:
- (i) ensure the GP trainee framework contract is being followed
  - (ii) ensure GP trainees receive the two structured educational (including day release) and one independent study per week stated in the GP trainee framework contract
  - (iii) introduce a mechanism to monitor GP trainee working hours and educational sessions.
- P1-10 DORSET: That conference believes that there should be the creation of a postgraduate GP fellowship grade in order to promote career development and encourage retention of newly qualified GPs.
- P1-11 HAMPSHIRE: That conference believes that there should be the creation of a postgraduate GP fellowship grade in order to promote career development and encourage retention of newly qualified GPs.  
**(Supported by ISLE OF WIGHT AND WILTSHIRE)**
- P1-12 NORFOLK: That conference demands separate funding of GP fellowship schemes to enable young doctors leaving VTS schemes to progress their careers in a safe and sustainable manner and not be lost to general practice.  
**(Supported by WAVENEY)**
- P1-13 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference calls on GPC to work with the relevant bodies to develop more academic and fellowship opportunities for GPs and GP trainees in order to improve recruitment and retention.
- P1-14 KENT: That conference demands that GP trainees who have failed their final exams but are assessed as still trainable should be:
- (i) enabled to work as a staff grade GP for a defined time
  - (ii) supported educationally
  - (iii) protected by the BMA model contract
  - (iv) paid more than a physician's associate.

- P1-15 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the requirement for new GP trainers to acquire a Postgraduate Certification in Education (PGCE) is seen as an impediment to becoming a GP trainer on account of the time required and inadequate funding.
- P1-16 AYRSHIRE AND ARRAN: That conference is concerned by the decline in applications to GP training over recent years and believes that there is an impending workforce crisis. Conference calls on GPC to work with relevant bodies in order to:
- (i) increase the amount of time medical students spend in general practice during medical school
  - (ii) introduce a mechanism to incentivise medical schools who have high numbers of students entering general practice
  - (iii) increase the number of foundation trainees with general practice placements
  - (iv) promote the benefits of a career in general practice to potential applicants
  - (v) increase the attractiveness of general practice to potential applicants.
- P1-17 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference is concerned by the decline in applications to GP training over recent years and believes that there is an impending workforce crisis. Conference calls on GPC to work with relevant bodies in order to:
- (i) increase the amount of time medical students spend in general practice during medical school
  - (ii) introduce a mechanism to reward medical schools who have high numbers of students entering general practice.
  - (iii) increase the number of foundation general practice placements.
  - (iv) promote the benefits of a career in general practice to potential applicants.
  - (v) increase the attractiveness of general practice to potential applicants.
- P1-18 SEFTON: That conference demands that NHS England:
- (i) delivers on its commitment to creating a 3250 GP training places in general practice
  - (ii) provides a bursary of £5k for each doctor in training who elects to complete GP training.
- P1-19 NEWCASTLE AND NORTH TYNESIDE: That conference demands that general practitioners are added to the 'shortage occupation list', which would have the dual benefit of alleviating normal stress on current non-EU trainees, but also may make general practice more attractive to prospective trainees from outside the EU.
- P1-20 NOTTINGHAMSHIRE: That conference believes that in order to make good its pledge to recruit an additional 5,000 GPs the government should ensure that:
- (i) all medical students are required to spend a minimum of six months in general practice prior to qualification
  - (ii) all foundation year doctors experience a mandatory placement in general practice
  - (iii) additional resources are found to remunerate GP practices hosting these placements.

- P1-21 DERBYSHIRE: That conference recognises that other safety critical industries budget for their qualified workforce to spend around 25% of their paid time in training but the NHS does not and demands that this situation be remedied.
- P1-22 DEVON That conference instructs GPC to negotiate the establishment of an individual training fund for every doctor on the GP Performers' List to be used to pay for CPD work over each five year revalidation cycle.
- P1-23 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference instructs GPC to negotiate with LETBs and other relevant bodies to secure national and regional funding for GPs to take approved study leave and to pay for the necessary locum cover.
- P1-24 ROCHDALE AND BURY: That conference believes this government needs to do more to enlighten students to embark on a career in general practice.
- P1-25 SHROPSHIRE: That conference believes that UK medical schools should now restrict the number of places offered to applicants from overseas in the belief that applicants from the UK are more likely to remain and work in the NHS.
- P1-26 GLOUCESTERSHIRE: That conference wishes to see an increase in the number of medical school places.
- P1-27 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference decries the disparity in medical student funding between secondary and primary care and calls upon the GPC to:  
(i) recognise that further investment in primary care is essential to promoting and attracting medical students to the specialty  
(ii) acknowledge that much needed increases in capacity will not happen without increases in funding and support for practices  
(iii) urgently work with relevant stakeholders to appraise funding costs of medical students within the primary care setting.
- P1-28 NORTH WEST REGIONAL COUNCIL: That conference calls on the BMA to work with relevant bodies to develop more academic and fellowship opportunities for GPs and GP trainees to help improve recruitment and retention.
- P1-29 BRADFORD AND AIREDALE: That conference demands a commitment, in a time of ever increasing clinical demand, that time is continued to be protected and funded for practice learning and development for one afternoon on a monthly basis with associated funding for out of hours cover to enable this and the content of this time should be at the practice's discretion.
- P1-30 LANCASHIRE COASTAL: That conference believes that special consideration needs to be given to relaxing the current rigidity that forces a young medical trainee to make their career choice at an early stage and impedes a subsequent change.

- P1-31 AYRSHIRE AND ARRAN: That conference is concerned that the MRCGP Clinical Skills Assessment (CSA) is only held in London. This results in a significant financial disadvantage for GP trainees who have to travel significant distances and disrupts exam preparation. Conference calls on GPC to work with RCGP to:
- (i) mitigate the financial disparity of attending the CSA exam for GP trainees travelling long distances
  - (ii) investigate establishing additional venues across the UK where candidates can sit the CSA.
- P1-32 AYRSHIRE AND ARRAN: That conference is concerned by the lack of funded time available to general practitioners for both continuing professional development and service development and calls on GPC to work with the four governments and primary care organisations for increased funding and protected time for:
- (i) continuing professional development for general practitioners
  - (ii) general practitioners to work on local service developments.
- (Supported by GPC TRAINEE SUBCOMMITTEE)**
- P1-33 SOMERSET: That conference believes that recent changes in the matching of GP training applicants and training posts from a regional to a national arrangement will increase inequality between more and less popular schemes, risks further destabilisation of general practice, and needs to be reconsidered.
- P1-34 CAMDEN: That conference is appalled by the pass results shown by the new fast track GP returners induction exam and calls on the GPC to liaise with key stakeholders to improve this process as a priority.
- P1-35 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference denounces the unjustified examination fees charged by the RCGP to trainees and demands that the college urgently provides a transparent account of the exam fee breakdown.
- P1-36 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference condemns the RCGP for the lack of tangible reform of ePortfolio which continues generate an unjustifiable workload for trainers and trainees to the detriment of GP training nationally.
- P1-37 NORTHERN IRELAND CONFERENCE OF LMCs: That conference calls on the RCGP to review the current trainee eportfolio to ease the burden on trainers and trainees that are under significant pressure from their daily practice.
- A** P1-38 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference believes that the junior doctors' contract negotiation issue has shown that the profession is strongest when it works together. We call on GPC to work with LMCs to encourage more GP trainees to become involved in the work of LMCs and the BMA.

- A** P1-39 NORTH STAFFORDSHIRE: That conference believes that the government for England should seriously consider and cost-benefit analyse a staggered system for writing off student debt for junior doctors who choose general practice as a career, in order to facilitate workforce retention and improvement. This will be especially important going forwards for those medical students in current year four and below of training, who will have huge cumulative debts and a strong system induced incentive to emigrate en masse.
- A** P1-40 BEDFORDSHIRE: That conference notes the need to attract more trainees into general practice and calls on GPC to negotiate a system of financial support for students on the condition they commit to a minimum period in general practice on the completion of studies.
- A** P1-41 MERTON, SUTTON AND WANDSWORTH: That conference supports the BMA's expressions of concern regarding the proposed changes to the Tier 2 work visa route which could lead to a loss of many UK trained doctors and affect general practice.
- A** P1-42 BRADFORD AND AIREDALE: That conference believes that GP training should better prepare trainees for partnership with a stronger focus on business and medico politics.
- A** P1-43 SCOTTISH CONFERENCE OF LMCs: That conference, in light of the direction of the future GMS contract and vision for general practice, re-affirms its support for a minimum of four year GP training for all GP trainees and that this training is of high quality and relevant rather than allowing workforce shortages in secondary care to be filled.
- A** P1-44 NORTH YORKSHIRE: That conference acknowledges the importance of GPs in senior leadership roles and in order to achieve this there should be:
- (i) more emphasis given to leadership in the GP registrar curriculum
  - (ii) better defined pathways for registrars or younger GPs who are keen to pursue such roles.

**LISTENING TO AND LEARNING FROM OUR DIVERSE WORKFORCE**

- P2-1 LANCASHIRE COASTAL: That conference believes that imaginative and flexible ways must be found to allow GPs to maintain clinical expertise and confidence when they are unable to work in the current extremely demanding roles of most salaried and partner GPs; if this is not done we risk losing highly trained GPs who will never return to general practice.
- P2-2 CLEVELAND: That conference fully supports GP principals, salaried and locum GPs working together in a mutually supportive way and believes that:
- (i) we must respect the variety of working patterns that doctors choose
  - (ii) the time has come to put all contractual differences aside.
- P2-3 SOUTHWARK: That conference demands that in order to assist in enhancing the morale of sessional GPs and increasing staff retention among sessional GPs:
- (i) guidance be developed by the GPC that allows sessional GPs opportunities to take up specialist interests roles and other generic and Leadership roles that directly contributes to the transformation of primary care
  - (ii) local or even national measures be negotiated by the GPC and introduced to ensure there is equity in pay between salaried GPs who have a similar skill base.
- P2-4 SOUTHWARK: That conference believes that if the division of principal GPs and sessional GPs is to remain there must be a model of work that allows greater equality of respect, workload, and some parity of pay.
- P2-5 HERTFORDSHIRE: That conference believes that the GPC Executive Team be mandated to negotiate a contractual model of general practice provision for use in employed GP positions within ACOs/vanguard sites whereby practitioners have a model salaried contract which rewards experience and expertise; encourages career development whilst not penalising career breaks (for eg parental or sickness leave) and allows GPs to run their local models of care on a sessional basis employed by their PCO/NHSE.
- P2-6 LIVERPOOL: That conference believes that for many GPs, being an independent contractor is not their preferred contractual arrangement and that GPC should pro-actively develop adequately funded alternative contractual arrangements.
- P2-7 SOUTHWARK: That conference believes that being deprived of autonomy or any sense of ownership within the general practice setting can lead to many sessional GPs being demotivated and that this needs to be better addressed by the GPC.
- P2-8 SOUTHWARK: That conference believes that entrepreneurship is usually a model that should be commended but acknowledges that while restricting partnership in practices encourages entrepreneurship this can be at the expense of sessional GPs.
- P2-9 SOUTHWARK: That conference believes that the GPC should strive to find a means to ensure more equality of autonomy, respect and income across all GPs, particularly in relation to partners versus salaried doctors.

- P2-10 BRADFORD AND AIREDALE: That conference believes that every effort should be made to secure employment in the UK for GPs completing training including but not limited to inducements and action to encourage trainees to take substantive posts rather than work as locums.
- P2-11 TAYSIDE: That conference acknowledges that the BMA salaried model contract has protected GPs against unfair terms and conditions since its inception and urges GPC to negotiate with UK government health departments:
- (i) a contract and associated terms and conditions of service suitable for all GPs in salaried roles regardless of employer
  - (ii) a requirement to make the offer of this contract, or more favourable, a requirement on anyone wishing to employ a GP in a salaried post
  - (iii) negotiate a formal pay scale that that both incentivises recruitment but also rewards retention of these doctors within the NHS.
- P2-12 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference believes that performers list administration should also collate all mandatory certificates required for practice and act as a single point of contact so that practices can check from one source that those doctors on the performers list have up to date certificates, therefore avoiding excessive administration which is onerous for both sessional GPs and GP practices.
- A** P2-13 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference recognises and asserts that for the future development of general practice in the new and evolving NHS structures, sessional GPs have a vital role to play and are to be actively encouraged, provided with equity of access to and support for the development of special interests including roles in leadership.
- A** P2-14 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference actively encourages CCGs to:
- (i) recognise the value of engaging with sessional GPs, particularly as a solution to conflict of interest issues
  - (ii) that when engaged in revisions to the constitution, they ensure that references to GPs specifically include sessional GPs.

**MITIGATING RISK IN FUNDING AND DEVELOPING GP PREMISES**

- P3-1 NORTHUMBERLAND: That conference believes the model of personally owned premises is no longer fit for purpose and is one of the factors exacerbating the recruitment crisis in primary care. In cases where the situation is genuinely threatening continuing viability of surgeries, there should be a:
- (i) publicly funded scheme to take over ownership of premises
  - (ii) realistic national primary care estates strategy.
- P3-2 SOUTH ESSEX DIVISION: That conference requests BMA to ensure that adequate resources are made available to ensure satisfactory premises for Primary Health Care.
- P3-3 LINCOLNSHIRE: That conference recognises that federation and integration of practices and services is the only source of providing sustainable services to patients. This cannot happen as many current general practice premises are not fit for providing 21st century primary care services. Conference therefore calls on the GPC to discuss with government as a matter of urgency:
- (i) to consider a fair mechanism for the purchase of GP owned premises from them
  - (ii) to invest in new premises and infrastructures fit for future models of care which are wholly owned by the NHS.
- P3-4 HERTFORDSHIRE: That conference calls upon HMG, as part of its immediate and necessary rescue package for general practice, to underwrite all loans to new partners buying into practice premises.
- P3-5 NORFOLK AND WAVENEY: That conference believes the plethora of project initiatives such as the Prime Minister's Challenge Fund is wasteful in terms of time and workforce resources and disruptive to patient care.
- P3-6 CROYDON: That conference believes the administration of the Primary Care Infrastructure (now Transformation) Fund has been shambolic.
- P3-7 DEVON That conference is appalled that most infrastructure fund monies from year 1 went unspent and demands that government launches an enhanced scheme with increased funding and the removal of red tape to ensure the money is spent.
- P3-8 LAMBETH: That conference acknowledges the reports in PULSE that the Prime Minister's Challenge Fund is being paid for in part by monies previously allocated to the GP premises development fund and:
- (i) totally opposes this reallocation of these monies while improvements to current premises are required
  - (ii) calls on the GPC to demand of policy makers that this reallocation of monies is ceased immediately.
- P3-9 NORTHAMPTONSHIRE: That conference insists that practices need a 'facilities allowance' to be fully rewarded for all the added costs of providing modern primary care facilities, beyond a rental income and payment for the provision of medical services, to cover:
- (i) the financial risk of building and maintaining a practice facility
  - (ii) the cost of providing management functions
  - (iii) the risks involved in employing and managing staff
  - (iv) the time and cost of increasing regulation, monitoring and reporting.



- P3-10 CROYDON: That conference believes NHS England should fund any improvements identified as required within general practices following infection control inspection visits.
- P3-11 MANCHESTER: That conference believes GPC should be tackling nationally the issues of GP leases, in terms of the increasing demands for rent and non-reimbursable items.
- A** P3-12 WILTSHIRE: That conference demands a limitation to the liability of GPs who are either lease holders or owner occupiers to avoid the 'last man standing' scenario.
- A** P3-13 DERBYSHIRE: That conference asserts that confidence in the current GP system can be improved by the Treasury agreeing to underwrite the 'last person standing' scenario in a practice, subject to suitable safeguards.
- AR** P3-14 WILTSHIRE: That conference demands that NHS England or its successor contract holder organisation must take on the head lease of a GP who requests this.
- A** P3-15 WILTSHIRE: That Conference recognises the difficulties of the 'last man standing' in the provision of GP premises which causes difficulty in recruitment to general practice to the detriment of the efficient running of the service and insists that government should use the provisions already enshrined in the Premises Cost Directions (England) to take on the head lease of any GP premises on the request of the GP principal involved.
- A** P3-16 SOMERSET: That conference insists that GPC, recognising that NHSE already pays for practice premises through cost and notional rent, negotiates with NHSE that an appropriate body be made responsible for purchasing GP owned properties, or taking on the assignment of leases where this is necessary, to sustain general practice for the continued provision of acceptable patient care .
- A** P3-17 AYRSHIRE AND ARRAN: That conference given the current situation in general practice, calls on the UK governments to provide more substantive support for premises development to allow GPs to meet the demands of modern general practice.
- AR** P3-18 SOUTH STAFFORDSHIRE: That conference believes that this government has created a climate of uncertainty about the future of general practice by neglecting to invest in premises and asks that it:
- (i) prioritises the much needed upgrade to the modernisation of premises, to make them future proof for the delivery of modern, high quality care for our patients;
  - (ii) takes responsibility for head leases on newly developed premises.

## HOW DEVOLUTION IN MANCHESTER HAS RADICALLY CHANGED THINKING

NO MOTIONS

## EXPERIENCE OF CREATING AN EXTENDED PRIMARY CARE TEAM IN WESSEX

NO MOTIONS

## PROFESSIONALLY SUPPORTED REGULATION – PREPARING FOR A POST CQC WORLD

### NO MOTIONS

## HELPING GPs TO WORK AT THE TOP OF THEIR GAME

- P4-1 GLASGOW: That conference supports SGPC in negotiating a new GP contract for 2017 that will secure the future of general practice in Scotland.
- P4-2 GLASGOW: That conference welcomes the changes to the 2016/17 GP contract in Scotland and the transfer of QOF into core funding

## GP NETWORKS – PROMOTING SUSTAINABLE PRACTICE THROUGH COLLABORATION

- P5-1 NORTH YORKSHIRE: That conference should encourage the government to support the joining of small practices by protecting their existing individual income streams.
- P5-2 NOTTINGHAMSHIRE: That conference believes that to facilitate the establishment of effective practice networks and federations the NHS must:
- (i) provide dedicated funding to purchase the management and logistical support needed
  - (ii) give networks and federations the freedom to obtain that support from whomever they deem appropriate
  - (iii) remove obstacles to them taking over the commissioning of secondary care where they aspire to adopt a population based approach
  - (iv) ensure that financial support and freedom of operation are not conditional on the practices involved relinquishing the protection of their national core contracts.
- A** P5-3 NORTH YORKSHIRE: That conference demands consistent, nationally agreed funding to support general practice working at scale that includes the development and support of federations.
- A** P5-4 SURREY: That conference believes the development of GP Federations should be appropriately resourced.

## RESPONDING TO NEW CONTRACTUAL INITIATIVES IN NEW MODELS OF CARE

- P6-1 WILTSHIRE: That conference believes that 'New Models of Care' are no substitute for the lifetime doctor-patient mutual investment company of 'Old Models of Care'.
- P6-2 WILTSHIRE: That conference recognises the special place of smaller practices in the GP firmament and directs GPC to remove the 30000 patient baseline from the proposed 'voluntary' Cameron Contract which the government plan to offer.

- P6-3 NOTTINGHAMSHIRE: That conference, recognising the instructions it gave to GPC last year to negotiate a solution to the problem of rising indemnity costs, calls on GPC to redouble its efforts and ensure that any new arrangements include indemnity cover for all clinical staff employed by GPs including new grades of staff like clinical pharmacists and physician associates.
- P6-4 LAMBETH: That conference believes that in order to avoid diluting the willing, but over-stretched workforce that already exists, community schemes and hubs should be integrated with the current structures instead of services being duplicated or new ones put in place.
- P6-5 DERBYSHIRE: That conference instructs GPC to include in any new contract negotiations a right for any qualified GP to work for the NHS in England on a nationally agreed salaried contract held by NHS England or any single not-for-profit successor body.
- P6-6 CAMBRIDGESHIRE: That conference calls on the GPC to negotiate a change to the status of those who can hold a GMS, PMS or APMS contract to include LLPs and enable existing contractors adopting that status to have it recognised by NHS England via a contract variation.
- P6-7 KENT: That conference propose that:
- (i) limited liability partnerships should be able to hold GMS and PMS contracts
  - (ii) the GPC / BMA start an honest debate about what is needed for general practice to survive
  - (iii) practices should be able to offer a wider range of private medical services to their registered patients.
- P6-8 DERBYSHIRE: That conference reminds the Chancellor of the Exchequer that the planning of transformational change requires resources over and above those needed to run either the current system or the future system.
- P6-9 DERBYSHIRE: That conference warns the English electorate that the actions of the government show that it does not understand:
- (i) the effect that current health policy is having on GPs
  - (ii) that investment in general practice is the most effective use of NHS money
  - (iii) that 7/7 8-8 is not the best use of NHS resource and will cause general practice to become unsustainable
  - (iv) it does not understand that transformation takes time
  - (v) it does not understand that pilots need evaluation before national roll out of a scheme.
- P6-10 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that a new GP contract is urgently required which:
- (i) rewards innovation and new ways of working
  - (ii) allows contracts to be held by limited liability organisations, such as LLPs or Ltd companies
  - (iii) removes the liability from GPs from funding regulation by CQC and similar
  - (iv) abolishes the monopsony model of funding for general practice and permits a multi-customer model.

**(Supported by DORSET AND WILTSHIRE)**

- P6-11 SUFFOLK: That conference demands that all contractual models are constructed in a way that means they are viable in the whole of England.
- P6-12 SUFFOLK: That conference notes that traditional general practice was one of the preferred models in the five year forward plan and demands that this model remains equally attractive as any new model.
- P6-13 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the present contractual insistence on provider practices having an unlimited liability partnership presents an increasing and unacceptable financial risk to remaining partners in the present climate of underfunding, premature loss of partners due to overwork, dismal recruitment of new GPs, and is a massive disincentive to young GPs becoming partners. The GPC should seek to change the regulations to allow GPs to contract as Limited Liability Partnerships which would ameliorate these risks and encourage young GPs to become partners with the ultimate benefit to service provision and continuity to patients.
- P6-14 BIRMINGHAM: That conference believes that a strong and sustainable independent contractor model of general practice is essential but now only viable through partnership working at scale and calls on GPC to robustly champion extended partnership models as a means to ensure the survival of GP-led general practice.
- P6-15 WILTSHIRE: That conference is alarmed at the private sector taking advantage of the collapse of traditional NHS GP services with the creation of on demand uber-GP type private services and instructs the GPC to research and publicise:
- (i) the evidence that privatisation of general practice especially in England is occurring to the general public
  - (ii) that privatisation of general practice is evidenced and not an example of a conspiracy theory
  - (iii) that privatisation of general practice and working at scale especially in England is a step towards Accountable Care Organisations (ACOs)
  - (iv) that the creation of ACOs will make it easier for large NHS organisations to be bought up by private corporations.
- P6-16 NORTH YORKSHIRE: That conference believes that accountable care organisations are the death knell of modern general practice.
- P6-17 BROMLEY: That conference deplores the move towards the 'US style' accountable care organisations (ACOs) model of healthcare and 'at-scale' working without firstly addressing an underfunded primary care budget and instead calls the GPC to negotiate for longer term financial viability, workforce sustainability and steps to addressing the current workload crisis.
- P6-18 ROCHDALE AND BURY: That conference acknowledges that devolution is an opportunity to improve healthcare.
- P6-19 ROCHDALE AND BURY: That conference seeks GPC support with expertise and workforce to develop emerging neighbourhoods and local care organisations (LCOs).

- P6-20 CORNWALL AND ISLES OF SCILLY: That conference believes that many UK GPs confuse their duty to protect and care for their patients with a misplaced duty to protect the NHS. To allow a more informed and sensible debate we demand the GPC investigates some alternative models of delivering healthcare and presents them at the next LMC Conference.
- P6-21 BROMLEY: That conference completely rejects plans for integrating primary care funding with social care and council budgets (as piloted in the Manchester model), as this will take an already underfunded primary care towards breaking point.
- P6-22 SCOTTISH CONFERENCE OF LMCs: That conference:
- (i) supports the concept of GPs and others working to the top of their license and that, where there are inadequacies in the support by the extended team, work should not default back to the GP
  - (ii) believes that GPs need additional practice nursing and pharmacist resource in the practices for them to be able to take on any further extended roles in caring for complex multi-morbidities patients in the community.
- P6-23 ROCHDALE AND BURY: That conference recognises the need for change to release efficiency savings but needs to remain conscious of clinical safety for the public.
- A** P6-24 GLOUCESTERSHIRE: That Conference notes the headlong rush into 'new models of care' and asks the GPC to provide:
- (i) more opportunities for GPs to learn why and where such projects have succeeded or failed
  - (ii) better information and resource material to allow GPs to understand the implications of contract changes.
- A** P6-25 SALFORD AND TRAFFORD: That conference believes that it is surely time that NHS management recognised the need to always gain clinical evidence to inform their decision making on reconfigurations and restructuring of services and contracts.
- A** P6-26 DEVON That conference demands that 'new ways of working' must be subject to proper pilot phases with independent academic assessment.
- A** P6-27 CORNWALL AND ISLES OF SCILLY: That conference believes that in order to encourage new GPs to invest in general practice for the future legislative change is needed to allow general practice partnerships to have limited liability.
- A** P6-28 AVON: That conference calls on GPC to negotiate for GPs to hold a Limited Liability Partnership structure which allows them to have both GMS/PMS contracts.
- A** P6-29 SHROPSHIRE: That conference believes that, to mitigate the 'last man standing' issue, GP practices should now be allowed to form limited liability partnerships that would be able to hold a GMS contract and opt into the NHS pension scheme.

**DEBATE  
INFORMATION MANAGEMENT AND TECHNOLOGY****Annex 3**

- \* 8 AGENDA COMMITTEE to be proposed by Hull: That conference believes that GP IT needs fully funded:
- (i) improved support services
  - (ii) fast and reliable broadband connections
  - (iii) scanning, digitising and shredding of paper records
  - (iv) interoperability.
  - (v) a fit for purpose national primary care IT specification
- 8a HULL AND EAST YORKSHIRE: That conference believes that the current level of IT support offered by commissioners to practices is neither sufficiently robust nor responsive for the needs of 21st century general practice. Conference requests GPC to demand of GP IT contracts with providers that:
- (i) the provider must respond immediately to a failure of IT that causes a practitioner to be unable to access patient records, and a failure to restore full service within 15 minutes should be regarded as a significant incident
  - (ii) practices should have essential back-up hardware items available on site to minimise service interruption, and
  - (iii) adequate bandwidth to cover clinical systems must be compulsory, even if this requires fibre-optic broadband at increased cost.
- 8b COVENTRY: That conference believes that general practice should be a totally paperless service and that this should be supported nationally by a programme of scanning and shredding paper records.
- 8c DEVON That conference asks that the Secretary of State for Health sponsors legislation that:
- (i) will authorize the immediate transfer of the whole patient medical record to electronic form
  - (ii) will enable paper records to be destroyed or stored at government expense outside of GP practices
  - (iii) whole process of digitilisation of medical records is publically funded.
- 8d HERTFORDSHIRE: That conference calls on GPC to negotiate with NHS England to fund the digitization of all patient records to release more space for patient care.
- 8e LOTHIAN: That conference recognises that current IT is not fit for purpose and demands a national primary care IT specification, with defined minimum standards of infrastructure, in order to provide safe, multi-disciplinary patient care.
- 8f GLOUCESTERSHIRE: That conference is shocked and dismayed that the main GP systems of choice and other related software still lack proper interoperability and insists that the introduction of full interoperability be given a much higher priority in GPC negotiations in the coming years.
- 8g SUFFOLK: That conference believes GP IT provision is a critical pillar in the safe efficient provision of primary care and when this fails health practitioners and patients are put at significant risk. This is not acceptable and should be treated as a 'never' event.

- 8h NORTHUMBERLAND: That conference believes that the persisting refusal of the clinical system providers to enable full interoperability is putting patient safety at risk and demands that:
- (i) pressure is put on the IT providers to resolve the situation urgently
  - (ii) that GPC demands that commitments under previous IT strategies are honoured
  - (iii) that there is increased media coverage from the BMA of the safety and financial inefficiencies this is creating.
- 8i GLASGOW: That conference demands that IT support for practices and continuing development in the clinical software must be maintained in the new GP contract.
- 8j DEVON That conference demands that any move towards a truly paperless NHS must be fully funded.
- 8k SOUTHWARK: That conference demands that IT support which is fit for purpose be implemented in order to allow GPs to avoid wasting time dealing with IT related problems which could be better spent enhancing the health and addressing the needs of their patients.
- \* 9 AGENDA COMMITTEE: That given the rise of multi-agency integrated digital care records and patient access to their own records, conference:
- (i) requires the transfer of data controller status from individual primary care provider organisations
  - (ii) requests particular consideration of the needs for confidentiality of adolescents and vulnerable adults
  - (iii) advises patients should be given their paper notes for safekeeping
  - (iv) calls for a national Data Sharing agreement
  - (v) demands that the workload implications are addressed.
- 9a BRADFORD AND AIREDALE: Given the rise of multi-agency integrated digital care records, that conference calls for the transfer of data controller status as per within the Data Protection Act 1998 from individual primary care provider organisations to NHS England or the Secretary of State, with an appointable Caldicott Guardian responsible for primary care organisations.
- 9b SOUTH STAFFORDSHIRE: That conference deplores the inappropriate use of taxpayer's money on the NHS Connecting for Health agenda and insists that:
- (i) the government provides ring fenced technology funding to CCGs to develop their IM&T plans to enable a paper free, digital, interoperable and real-time patient record by 2020
  - (ii) the funding is provided at £2 per head of population, in addition to the existing IT budget, and not subsumed in the baseline
  - (iii) the government urgently commissions a task and finish group to review the information governance requirements around record sharing, across health and social care
  - (iv) provide GP practices with the infrastructure support and resource to facilitate the above objectives.
- 9c NORTH YORKSHIRE: Patients have access to their own records and there are undoubted benefits in enabling this to be 'online' however the rush to implement this without addressing the needs for confidentiality of adolescents and vulnerable adults will create very real risk of harm.

- 9d WILTSHIRE: That conference advises that patients should be given their paper notes for safekeeping.
- 9e GLOUCESTERSHIRE: That conference insists that the workload implications be assessed and addressed before any decision is made to introduce an all-informed electronic health system.
- 9f BEDFORDSHIRE: That conference believes that the patient record should be owned and held by the patient and calls upon GPC to work to effect this change.
- 9g COVENTRY: That conference calls on the government to produce a national Data Sharing Agreement in order to curb the proliferation of local agreements which are expedient, do not solve the problem, are often incompetent, and expose GPs to real and imminent danger of contravening Information Governance rules.
- 9h HERTFORDSHIRE: That conference calls on GPC to clarify data protection principles and requirements around safeguarding in a way that GPs can understand and use.
- 9i AYRSHIRE AND ARRAN: That conference believes the development and implementation of a single electronic patient record is long overdue and represents a significant patient safety issue which must urgently be addressed.



## SEVEN DAY GP SERVICE

- \* 10 SUFFOLK: That conference believes that the current emphasis on 7-day working is a political push for the unachievable particularly in the light of the continued under-resourcing of primary care and insists that the 7-day mantra be abandoned and any additional resource available should be used to enhance the weekend emergency cover services.
- 10a HAMPSHIRE AND ISLE OF WIGHT: That conference deplores the ill-advised, non-evidence based rush to routine seven day working in primary care.
- 10b NORFOLK AND WAVENEY: That conference believes that the government's ideological obsession with seven day working will produce a less safe and sustainable NHS until the issues of workload and workforce are addressed.
- 10c BRADFORD AND AIREDALE: In view of the fact that primary care can barely cope with current rising patient demand and workload, conference calls on the government to acknowledge that a seven day NHS will make it even more difficult to meet current demand and to therefore include mechanisms to manage public expectation within its plans for a seven day NHS.
- 10d BRADFORD AND AIREDALE: That conference believes that all the proposals for seven day working for GPs are little more than an alternative way of providing out of hours cover and demands that government stop implying that they mean that patients will be able to see their own GPs, in their own practices at weekends. Conference calls on GPC to challenge this implication at every opportunity.
- 10e LIVERPOOL: That conference believes that the concept of routine 7 day working is the rejuvenation of the tale of the emperor's new clothes and even the government needs to recognise the difference between genesis and evolution.
- 10f NORTH YORKSHIRE: That conference believes that further work on a non-evidence based seven day a week general practice model needs to be stopped before the end of 2016, before it continues to disengage clinicians, confuse the public and waste resources.
- 10g KENT: That conference believes that the government's vision of seven day routine primary care:
- (i) is unaffordable, undesirable, undeliverable and dangerous to patients
  - (ii) fails to recognise the value of continuity of care that is so critical to many patients
  - (iii) should be abandoned and the released funding invested in making existing primary care services sustainable.
- 10h SHROPSHIRE: That conference calls for the Department of Health to cease demanding routine seven day working in general practice until parliament is sitting seven days a week.
- 10i AVON: That conference confirms that general practice is not an emergency service and thus instructs the GPC to decline to engage in any discussion with the department of Health or NHS England in which the subject of Sunday working is raised.

- 10j WIGAN: That conference is appalled to learn from recent evidence before the Parliamentary Public Accounts Committee that NHS England has undertaken no financial needs assessment or planning in respect of the drive for 7 day routine working in the NHS. It call upon NHS England to adhere to evidence based policy making and to suspend the drive for 7 day routine working until it has done so.
- 10k NOTTINGHAMSHIRE: That conference, recognising the aspiration to provide seven day access to GP services, calls upon government to provide evidence that this will improve the nation's health and ensure we have the additional staff and the financial support needed to put this into effect.
- 10l LAMBETH: That conference believes that there is no evidence that providing routine 7 day access to routine primary health care improves the quality of urgent care or of health care overall and calls on the GPC to get the message across to politicians and patients that there is no evidence that routine 7 day access is a cost effective way of providing care.
- 10m BRADFORD AND AIREDALE: That conference opposes any further plans for seven day working pilots unless there are firm assurances that the financial incentives provided are sustainable and there will be an adequate workforce available to deliver them.
- 10n BROMLEY: That conference should say no to 8-8 7 days working until the underfunded budget, financial viability, workforce sustainability and the worsening workload crisis are addressed.
- 10o WALTHAM FOREST: That conference demands:
- (i) that the government does not impose 7 day working on GP practices before there are the appropriate resources in place to support practices and that
  - (ii) funding is made available to enable practices to provide adequate medical and wrap around staffing for weekend clinics.
- 10p BEDFORDSHIRE: That conference believes that the government's drive for seven day opening of general practices is misguided in confusing urgent care needs with self-limiting minor illness and chronic disease management and calls on GPC to negotiate for the establishment of adequately resourced, appropriately located, integrated community and hospital services for unscheduled care.
- 10q NORTH YORKSHIRE: 7 day working plans are ill conceived and conference believes that:
- (i) patients in the Prime Minister Challenge Fund trials have demonstrated a lack of interest in seeing a doctor they don't know at the weekend, enforcing this with the inevitable reduction in the available weekday workforce will ironically make it more difficult for them to see the doctor that they have continuity with
  - (ii) patients do express the wish for improved urgent care out of hours, and this is what should be resourced rather than the routine care that can be better and more locally provided in the normal working week.

## URGENT CARE

- \* 11 AGENDA COMMITTEE to be proposed by Dorset: That conference is concerned by the lack of integration between the out-of-hours GP care providers with each other and in-hours GP services and calls for:
- (i) a radical redesign and integration of all current out of normal hours services
  - (ii) an integrated IT system across all out-of-hours providers
  - (iii) work that comes to a practice after 6pm to be directed to OOH services
  - (iv) an out-of-practice daytime visiting service
  - (v) community urgent care centres which patients can access when their practices have no more capacity for same day access.
- 11a Motion by DORSET: That conference is concerned by the lack of integration between the various out-of-hours GP care providers (111/walk-in/GP in A&E/CCG initiatives etc) with each other, and also with their poor co-ordination and communication with in-hours GP services, to the detriment of competent, cohesive medical care. To address these issues we propose that:
- (i) an integrated IT system (for example SystemOne) is introduced across all out-of-hours providers
  - (ii) out-of-hours providers should as much as possible be planned, organised and on-going, and aware of and communicate with each other
  - (iii) enhanced salaried roles incorporating in-hours GP work with regular out-of-hours roles locally are considered.
- 11b NORFOLK AND WAVENEY: That conference believes that in many areas out of hours primary care is poorly commissioned and promotes inappropriate expectations of the NHS and calls for a radical redesign and integration of all current out of normal hours services.
- 11c NOTTINGHAMSHIRE: That conference, recognising the change in the understanding of the public's need for urgent care, and greater integration between general practice and urgent care services, calls on GPC to negotiate contractual changes to ensure that any:
- (i) work that comes to a practice after 6pm can be directed to OOH services, ensuring GPs have time complete administrative tasks within the official definition of core hours
  - (ii) request for a visit received after lunchtime visits have been completed will be directed to an appropriate daytime visiting service.
- 11d BUCKINGHAMSHIRE: That conference demands that every commissioning organisation creates and funds at least one in hours community urgent care centre which patients access when their GP practices have no more capacity for same day access.

**JUNIOR DOCTORS DISPUTE**

- \* 12 AGENDA COMMITTEE: That conference is appalled at the government's handling of the junior doctor's dispute
- (i) strongly condemns the imposition of the new unsafe and unfair contract on junior doctors
  - (ii) believes that the imposition of the new junior doctors contract will cause irreparable damage to the NHS and patient care by destroying doctors' morale and losing the goodwill of hard working staff
  - (iii) confirms support for the junior doctors and calls on the GPC to set out what steps practices can take to demonstrate this.
- 12a SHROPSHIRE: That conference:
- (i) is dismayed at the damage to recruitment and retention of doctors within the UK that will result
  - (ii) has no confidence that the NHS is safe in this government's hands.
- (Supported by WORCHESTERSHIRE, WOLVERHAMPTON and SOUTH STAFFORDSHIRE)**
- 12b KENT: That conference strongly condemns the imposition of the new unsafe and unfair contract on Junior Doctors by Jeremy Hunt and the Department of Health and believes that this will cause irreparable damage to the NHS and patient care by destroying doctors' morale and losing the goodwill of hard working staff.
- 12c KENT: That conference confirms support for the Junior Doctors and calls on the GPC to set out what steps practices can take to demonstrate this.
- 12d NORTH STAFFORDSHIRE: That conference:
- (i) is appalled at the government's handling of the junior doctors dispute
  - (ii) is dismayed at the damage to recruitment and retention of doctors within the UK that will result
  - (iii) has no confidence that the NHS is safe in this government's hands.
- 12e COVENTRY: That conference applauds Jeremy Hunt for his services to general practice including:
- (i) making hospital jobs so unpalatable that junior doctors will start to consider training to be general practitioners again
  - (ii) ensuring Australia, New Zealand, Canada, and Qatar are able to directly appreciate the high quality of British trained GPs.
- 12f DERBYSHIRE: That conference:
- (i) fully supports the junior doctors in their demand for a contract that is safe for both patients and doctors
  - (ii) deplores the government's handling of its dispute with the junior doctors.
- 12g WIGAN: That conference affirms its support for doctors in training in their campaign to resist the Secretary of State's impositions of an unsafe contract.
- 12h NORTHUMBERLAND: That conference deplores the imposition of the new junior doctors contract and
- (i) continues to support our junior colleagues
  - (ii) highlights the fact that financial penalties for changing speciality during training is likely to disadvantage those wishing to consider a career change to general practice.

- 12i HULL AND EAST YORKSHIRE: That conference believes that all GP practices must refuse to employ any junior doctor undertaking a vocational training scheme on the terms of the imposed junior doctor contract and that:
- (i) the terms of the current junior doctor contract should be used as a model contract for GP specialist trainees during their time in general practice
  - (ii) conference resents the action of the Secretary of State to unilaterally impose this contract
  - (iii) conference supports its junior doctor colleagues in the strongest possible terms.
- 12j SEFTON: That conference calls upon the Prime Minister to reshuffle without delay the current Secretary of State for Health and appoint a successor better able to engage positively with the profession in meeting the challenges facing the NHS.

## RESPONSE OF THE PROFESSION

## Annex 4

The following motion is already the policy of the LMC Conference;

That conference instructs GPC that should negotiations with government for a rescue package for general practice not be concluded successfully within 6 months of the end of this conference:

- (i) actions that GPs can undertake without breaching their contracts must be identified to the profession
- (ii) 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
- (iii) the GPC should canvass GPs on their willingness to submit undated resignations.

- R-1 BOLTON: That conference believes that if the BMA decides to request and use undated resignation letters from GPs these letters should only be used if a minimum of 30% of GPs have submitted them.
- R-2 DERBYSHIRE: That conference requires the GPC Executive, in seeking the introduction of a rescue package or packages for general practice in the United Kingdom to:
  - (i) demonstrate to the profession how it has gathered and responded to the opinions of 'grassroots' GPs
  - (ii) be open and transparent at all stages to the public and the professional about the progress being made, even if this means relaxation or abandonment of 'principled negotiation'
  - (iii) be resolute in putting to the profession all outcomes achieved or not achieved at the end of the six month period following the 2016 Special Conference of LMCs.
- R-3 DERBYSHIRE: That conference instructs the GPC to revise and review its scheme of sanctions ready to be enacted in the absence of negotiated contractual funding and policy revisions for general practice which are acceptable to the profession.
- R-24 WILTSHIRE: That Conference directs GPC to collect undated resignations from GPs to strengthen their hand in renegotiation of our contract and that GPs are encouraged to have the courage to provide such letters of resignation as the only way in which to bring the government seriously to the table.
- R-5 HAMPSHIRE AND ISLE OF WIGHT: That conference calls upon the BMA to ballot its GP members for industrial action if a fair, sustainable and modern GP contract cannot be achieved through negotiation.
- R-6 SHROPSHIRE: That conference believes the response of the government to the crisis in general practice remains inadequate and instructs the GPC:
  - (i) to now ballot general practitioners on their willingness to submit undated resignations
  - (ii) after taking relevant legal advice, to produce a report to practices on the options for taking industrial action that lies within the law.

**(Supported by SOUTH STAFFORDSHIRE, WOLVERHAMPTON and NORTH STAFFORDSHIRE)**

- R-7 HULL AND EAST YORKSHIRE: That conference believes that GPs would not offer undated resignations from their GMS/PMS contracts because of their heavy investments in their practices, but to relieve the pressure of the current crisis should resign from all:
- (i) CCG and national enhanced services contracts
  - (ii) local authority-commissioned public health services contracts, and should ask the GPC to investigate and negotiate proper and realistic funding of the core contract.
- (Supported by NORTH and NORTH EAST LINCOLNSHIRE)**
- R-8 KENT: That conference demands that, in the light of the crisis in general practice, the GPC takes immediate steps to obtain undated resignations from every GP in the country.
- R-9 AVON: That conference calls on GPC to investigate and advise on mechanisms for GPs to practise independently of the NHS, should the need arise. This should include:
- (i) legal consultation for premises funding
  - (ii) scoping a system of itemised billing for services in a manner similar to our dental colleagues.
- R-10 KENT: That conference demands that, within one month, the GPC ballots GPs on what actions they would be prepared to take without breaking their contract to ensure the safety of patients and strengthen our negotiators' position.
- R-11 DERBYSHIRE: That conference now warns the public that, in the absence of both a categorical denial and positive remedial action from the government, it appears that the government is hell bent on ending the NHS GP service by means of attrition through policies which have the effect of working GPs to the point of ill health, resignation from the service or bankruptcy caused by financially starving out GP practices.
- R-12 SUFFOLK: That conference notes the difficulties which self-employed contractors face in delivering any meaningful industrial action and that useful guidance for resolution of this problem was notably absent when the profession was last called to IA. Conference therefore calls on GPC to consider this matter and if necessary to set up a working group to produce appropriate guidance now in case this is needed in 2016.
- R-13 SUFFOLK: That conference expresses outrage that GPC appears to be on the periphery rather than at the centre of processes which may lead to the development of a new primary care contract and instructs GPC to demand full participation in all discussions from their commencement.
- R-14 WILTSHIRE: That conference has no confidence in the current Health Secretary and calls for his immediate resignation. This critical time for the NHS demands a Health Secretary with better understanding of the history of the NHS and its workings, and a more demonstrable willingness to listen to the valid concerns of those working within it.
- R-15 KENT: That conference, in light of the damage that Mr Hunt has done to the NHS, demands his resignation.

- R-16 EALING, HAMMERSMITH AND HOUNSLOW: That conference demand that the GPC provides at and to this conference:
- (i) substantial details on its proposed rescue package
  - (ii) an update on the progress of the actions agreed by January's Special Conference of LMCs in each part of motions 303.
- R-17 CENTRAL LANCASHIRE: That conference strongly believes that it is unlikely that the government will come forward with an adequate rescue package for general practice and calls on GPC:
- (i) to report to conference the progress of negotiations so far
  - (ii) to canvas the views of conference and front line GPs on the progress of these negotiations and their acceptability
  - (iii) to use these views to strengthen and empower negotiations
  - (iv) to confirm before the expiry of the 6 months the measures that GPs will be advised to follow to reduce workload and sustain safe practice
  - (v) to advise practices on the impact and next steps following mass resignations from the current NHS contract.
- R-18 BRO TAF: That conference believes the motion passed at the Special UK LMC Conference in January 2016 which reads "GPC should canvass GPs about their willingness to submit undated resignations" is unhelpful and requests GPC to undertake this only as a last resort.
- R-19 LINCOLNSHIRE: That conference recognises Motion 20 of the special conference and calls upon GPC to make clear to general practice what the rescue package actually comprises. Conference also demands that GPC advises on a realistic action plan for all practices to ensure survival such as:
- (i) cessation of all unfunded work, such as ECG, ambulatory BP etc
  - (ii) cessation of engagement in all non-primary medical clinical work ie CCG's etc.
- R-20 LOTHIAN: That conference acknowledges that in the face of an unprecedented crisis, undated resignations may be the only way forward, but also needs to consider whether a government insufficiently committed to general practice, and the NHS, may actually welcome these.
- R-21 ROCHDALE AND BURY: That conference urges GPC to dismiss the threat of seeking unsigned resignation letters from GPs as a method of forcing this government to undertaken GPC requested action
- R-22 ROCHDALE AND BURY: That conference recognises the risk of GPs leaving the BMA if similar support shown for junior doctors is not seen for general practice.
- R-23 BARNET: That conference demands GPC undertakes a survey of all GPs in England to establish their willingness to partake in forms of action in support of doctors suffering from extreme workloads.



- R-24 CITY AND EAST LONDON: That conference believes that general practice is at breaking point and that despite repeated warnings from the profession and from other bodies, government initiatives have been totally inadequate and fail to address the immediate need to prevent widespread collapse of the system. Conference therefore demands that the GPC takes immediate action to survey the profession:
- (i) as to what level of industrial action they would be prepared to take
  - (ii) as to their willingness to submit undated resignation letters to the BMA.
- R-25 CITY AND EAST LONDON: That conference following the Special Conference of LMCs in January instructs GPC to immediately survey the profession on their attitude to taking industrial action should a dispute arise between GPs and the government.
- R-26 CITY AND EAST LONDON: That conference following the Special Conference of LMCs in January instructs GPC to immediately survey the profession as to what level of industrial action they would be prepared to take if we entered into a dispute with government.
- R-27 EALING, HAMMERSMITH AND HOUNSLOW: That conference calls on the GPC to follow up the momentum of the Special Conference with a clear and publicised plan for how to get general practice out of the hole it is now in.
- R-28 CITY AND EAST LONDON: That conference instructs GPC to ballot the profession as to whether they would be prepared to stop registering patients due to currently unmanageable workload.

DEBATE  
PREMISES

## Annex 5

- \* 13 KENT: That conference believes that NHS Property Services is not fit for purpose and has:
- (i) failed in its mandate 'to provide a quality service to its tenants'
  - (ii) failed in its core value 'caring – helping the NHS to deliver better and more sustainable clinical care and services'
  - (iii) not been made accountable for its mismanagement and lack of action
  - (iv) demanded charges that are unrealistic, unaffordable and destabilising to practices.
- 13a DERBYSHIRE: That conference has no confidence in the ability or desire of NHS Property Services or Community Health Partnerships to ensure that every patient will eventually have access to appropriate, fit-for-purpose health care properties for all aspects of their healthcare that cannot be delivered at home.
- 13b NORTHUMBERLAND: That conference acknowledges the growing evidence that the actions of NHS Property Services are destabilising practices and that:
- (i) the increase in premises related costs should be assessed at national level, in particular where these costs are not reimbursed
  - (ii) the consequent reduction in finance available for direct clinical care should be made clear to the public
  - (iii) that revised service charges are frequently excessive, and represent poor value for money for the services involved
  - (iv) that the GPC continues urgently to seek a resolution that is fair and equitable.
- 13c NOTTINGHAMSHIRE: That conference:
- (i) condemns NHS Property Services and their counterparts, Community Health Partnerships, for their abject failure to calculate accurately and apportion fairly to GP tenants the pass through costs of their buildings and demonstrate value for money in both rental and facilities management costs
  - (ii) calls on the government to take immediate steps to transfer responsibility for primary care estates back to the NHS.
- 13d NOTTINGHAMSHIRE: That conference calls for an immediate moratorium on payments of disputed bills for rental and pass through costs in NHS Property Services or LIFT buildings pending the establishment of a government task force involving the GPC to apportion to costs to GP tenants on a fair, rational, and transparent basis.
- 13e MID MERSEY: That conference deplores attempts by the Community Health Partnership to impose unreasonable increases in LIFT building charges whilst ignoring practice's existing lease terms and calls on the GPC to challenge their actions.

## OVERSEAS PATIENTS

- \* 14 EAST SUSSEX: That conference believes that overseas visitors should be able to attend UK general practitioners but:
- (i) this should only be on a private fee-paying basis
  - (ii) any fees paid should be retained in full by the general practice
  - (iii) it remains open to the government to offer NHS care free to overseas visitors at walk-in-centre, urgent care centres, and accident and emergency departments, and patients can be offered these alternatives.
- 14a HAMPSHIRE AND ISLE OF WIGHT: That conference believes that overseas patients should be charged for the care they receive in primary care unless covered by reciprocated arrangements.
- 14b OXFORDSHIRE: That conference believes that (European Law permitting) the regulations on temporary resident registration should be altered to ensure foreign visitors with non-emergency problems are only eligible for private GP care.

## GP LOCUMS

- \* 15 That conference affirms that locum GPs are an essential part of the GP workforce and in this current workforce crisis:
- (i) rejects the principle that the Department of Health can unilaterally fix a market price for services
  - (ii) rejects compulsory reporting by practices of locum payments
  - (iii) affirms that practices and locum GPs should be allowed to mutually agree terms and conditions
  - (iv) rejects any attempt to cap the fees charged by GP locums
- 15a THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:  
That conference recognises and affirms that freelance/locum GPs are an essential part of the GP workforce in this current workforce crisis:
- (i) demands that the principle that the Department of Health can unilaterally fix a market price for services, in this case indicative rates for freelance/ locum GP services, is rejected
  - (ii) further rejects the onerous reporting by practices of any payments over the maximum indicative rate
  - (iii) affirms that practices and locum GPs should be allowed to mutually agree terms and conditions for services provided, without this external inference
  - (iv) rejects Department of Health policies that could accentuate the GP workforce retention crisis.
- 15b NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that the governments' approach to capping locum fees in general practice will be unworkable because:
- (i) locum supply is tight
  - (ii) good locums are worth a premium
  - (iii) locums are self-employed and are entitled to set their own fees, and
  - (iv) it contravenes this government's commitment to a free market economy.

- 15c NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes the indicative/enforced locum pricing caps will result in destabilisation of practice cover, and thus add to the workload burden of existing principals and salaried GPs, that a similar situation has already occurred in secondary care since the introduction of a cap, and that practices should be free to engage locum GPs on mutually agreed terms.
- 15d CLEVELAND: That conference absolutely rejects any attempts to introduce a cap on the fees charged by GP locums.
- 15e LIVERPOOL: That conference believes that NHS England’s plans to provide indicative locum rates for GP locums will not address the workload crisis and asks GPC to consider the effects of non-cooperation with NHS England.
- 15f CAMDEN: That conference recognises the contributions of all GPs including locum GPs and rejects to record any data as per NHSE request to report payments to locums over a maximum indicative rate.
- \* 16 DERBYSHIRE: That conference requests our profession to come together to agree a fair and reasonable cap on GP locum fees.
- 16a ROTHERHAM: That conference believes that the current exorbitant fees charged by GP locums are a disgrace to the profession, and are partly responsible for the demise of general practice in some areas. We call for a unanimous stance against gold-digging locums and agencies to limit their costs, thereby encouraging more doctors to take up substantive posts and partnerships.
- 16b AVON: That conference calls upon the GPC to explore the removal of locums from the primary care workforce and have them centrally contracted to provide a flexible and cost-effective resource to provide continuity of service.
- 16c SOLIHULL DIVISION: That conference deplores the current recruitment and retention crisis in General Practice, and believes that locum indicative rates are detrimental to the sustainability of General Practice, and we call upon the Department of Health to abandon the concept.

## MEDICAL CERTIFICATES AND REPORTS

- \* 17 AGENDA COMMITTEE to be proposed by the Scottish Conference of LMCs: That conference calls for:
- (i) an extension of self-certification for illness from 7 to 14 days
  - (ii) a change in legislation to allow other health care professional such as midwives, allied health professionals and nurse practitioners to complete 'fit notes' for patients.
- 17a SCOTTISH CONFERENCE OF LMCs: That conference calls for a change in legislation to allow other health care professionals such as midwives, allied health professionals and nurse practitioners to complete 'fit notes' for patients.  
**(Supported by AYSHIRE AND ARRAN)**
- 17b AYRSHIRE AND ARRAN: That conference calls for an extension of self-certification for illness from 7 to 14 days.  
**(Supported by SCOTTISH CONFERENCE OF LMCs)**
- 17c HULL AND EAST YORKSHIRE: That conference believes that the current system of sick certification is not fit for purpose and that GPs should not be asked to make decisions on a patient's fitness to work and that(
- (i) the period of self-certification should be extended to 10 working days
  - (ii) any fit note beyond the period of self certification should only be issued by an independent occupational health clinician.

## SOAPBOX

- 18 AGENDA COMMITTEE: Soap box is held under Standing order 57:
- 57.1 A period shall be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
  - 57.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
  - 57.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
  - 57.4 GPC (UK) members shall not be permitted to speak in the soapbox session.

## CHARITIES

### Dain Fund

- 19 Receive: Report by the Chair of the Dain Fund (Dr Stephen Bill Strange).

### Claire Wand Fund

- 20 Receive: Report by the Chair of the Claire Wand Fund (Dr Jane Wand)

### Cameron Fund Annual General Meeting

- 21 Receive: Report by the Chair of the Cameron Fund (Dr Stephen Linton)

## THEMED DEBATE – GPC REFORM TASK GROUP

(Please see Annex 6)

### GENERAL PRACTITIONERS COMMITTEE

Annex 6

- T5-1 MID MERSEY: That conference believes it is time for the GPC to be reformed so that it can be truly a representative body for general practice.
- T5-2 BEDFORDSHIRE: That GPC should communicate its vision for where GPC is going in the future and what GPC is for.
- T5-3 MID MERSEY: That conference believes that the GPC's role in representing general practice is vital to the development of a safe and sustainable service into the future but it must adapt urgently to changing times and provide increased support to LMCs on a regional basis.
- T5-4 BEDFORDSHIRE: That GPC should develop and make available a number of resources to support LMCs to lead general practice to a sustainable future.
- T5-5 SOMERSET: That conference notes that whilst local medical committees have been adapting their form and function to meet the evolving needs of practices, GPC is not similarly responsive to the needs of LMCs. Conference therefore requires the GPC to take action with the BMA to:
- (i) reinstate regional liaison officers to work with LMCs
  - (ii) develop an effective regional organisation with local groups of LMCs
  - (iii) reduce the size of GPC England to a make an effective committee
  - (iv) provide a website that is fit for purpose
  - (v) establish an effective presence on social media, notably Twitter.
- T5-6 ROCHDALE AND BURY: That conference believes that the current GPC infrastructure is outdated and needs to have locality presence at county level.
- T5-7 HERTFORDSHIRE: That conference demands that GPC shows leadership by utilising some of its resources to host workshops and seminars to celebrate the good, innovative work that is going on throughout the UK to achieve high quality, sustainable primary care services as a way to support the spread of good practice.
- T5-8 BEDFORDSHIRE: That conference demands that GPC shows leadership by utilising some of its resources to:
- (i) host a number of workshops and conferences around the country
  - (ii) celebrate the good, innovative work that is going on throughout the UK to achieve high quality, sustainable primary care services
  - (iii) support the spread of good practice.
- T5-9 BRADFORD AND AIREDALE: That conference believes that the most important role of LMCs and the GPC is to support GPs in their roles as providers of primary medical services. Conference believes that support of GPs who take on other roles for example as commissioners or as providers of services other than primary medical is secondary and the amount of resource expended should reflect this.

- T5-10 LIVERPOOL: That conference believes that GPC membership should reflect the GP workforce by ensuring that there is proportional representation on GPC, especially taking into account the contractual status and gender of the GP workforce.
- T5-11 LEEDS: That conference believes GPs within five years of completing GP training should be represented on GPC and calls for at least two seats on GPC to be reserved for these GPs.
- T5-12 KENT: That conference has no confidence in the GPC to negotiate an appropriately remunerated GP contract.
- T5-13 DORSET: That conference asks the BMA to redefine the GPC representative regions so that they relate to current NHS / LMC organisational structures.
- T5-14 ROCHDALE AND BURY: That conference seeks clarification from GPC on their position where CCG chairs are also GPC representatives on how they can remain free of conflict when attending GPC meetings.
- T5-15 HERTFORDSHIRE: That conference is appalled that the report on the work carried out by selected LMC senior officers in 2014 – 15 has never been published, suggesting that this was a complete waste of time and resources, and demands:
- (i) that the report written is published immediately
  - (ii) a full explanation as to why it was rejected by GPC representatives and wasn't implemented.
- T5-16 BEDFORDSHIRE: That conference is appalled that the work carried out by selected LMC senior officers (in 2014 – 15) was a complete waste of time and resources and demands:
- (i) full transparency
  - (ii) that the report written is published immediately
  - (iii) a full explanation as to why it was rejected by GPC representatives and wasn't implemented.
- T5-17 ROCHDALE AND BURY: That conference acknowledges that having GPC representation from across the country in London on a monthly basis is a waste of scarce financial resource.
- T5-18 MANCHESTER: That conference believes future contract negotiations should be concentrated around solutions to the areas of crisis, ie estates, list issues (closure and expansion), workforce, workload, etc and the GPC Executive should lead the profession in finding solutions.
- T5-19 HERTFORDSHIRE: That conference instructs GPC to be more proactive in funding court cases in order to test whether the GMS contract is being applied fairly.
- T5-20 AVON: That conference, in the light of the new 'national' PMS contract published by NHS England, demands that the GPC
- (i) no longer hides behind the mantle of 'local negotiation' when it comes to discussion about PMS matters
  - (ii) involves itself in discussion with NHS England forthwith
  - (iii) informs all PMS practices that it is now prepared to negotiate on their behalf at a national level, as the contract is now to be a national standard contract.

**LMC CONFERENCE**

- T5-21 NOTTINGHAMSHIRE: That conference, in considering the future function of conference in light of the recommendations of the GPC task group report, earnestly hopes that less time will be spent in future debating motions, and more in general discussion and policy themed workshops.
- T5-22 MID MERSEY: That conference believes that the Conference of LMCs has become an elaborate talking shop which delivers little benefit to GPs' everyday working lives and its form and structure needs urgent and radical reform.
- T5-23 CORNWALL AND ISLES OF SCILLY: That conference believes that conference is no longer fit for purpose.
- T5-24 GLOUCESTERSHIRE: That conference remains concerned at the relative inflexibility of the current format of the Conference of LMCs and, whilst supporting the Agenda Committee and acknowledging with credit the huge demands placed upon them, believes:
- (i) believes that motions are submitted too far in advance of the meeting
  - (ii) believes that relative tweaking of motions should be allowed during the debate by the proposer
  - (iii) believes that the soapbox and roving microphone sessions often provide better insight than many of the current debates which, being uncontroversial, too often have little or no proper debate
  - (iv) believes that emergency speaker slips have a useful function, allowing instant reaction where there is no other method of doing so
  - (v) questions whether the current entirely predictable implosion of general practice could have been fought against far earlier and more robustly under different conference arrangements
  - (vi) believes, and is concerned, that some conference policies are ignored by the GPC even though properly debated and agreed by Conference (Ref payments by results and charging for flu and other non IOS charges).
- T5-25 ROCHDALE AND BURY: That conference believes that the current format of LMC conferences is outdated and should be replaced with a conference that :
- (i) provides a platform to share good practice
  - (ii) provide an opportunity to educate and inform attendees by GPC negotiators
  - (iii) share innovation and new services.
- T5-26 DEVON That conference demands that standing orders should be changed so that in future each chair of subcommittee gives a ten minute verbal report following which conference gives an 'approval rating' on the subcommittee's performance via electronic voting.
- T5-27 MID MERSEY: That conference believes that there needs to be urgent reform of the Conference of LMCs to ensure that the voice of the LMCs is properly heard above and before that of the GPC.



- T5-28 MID MERSEY: That conference believes that at the Conference of LMCs, GPC representatives should:
- (i) not be allowed to propose motions
  - (ii) not be invited to speak for or against motions unless they truly have specialist knowledge of the subject.
- T5-29 DEVON That conference requests that the Agenda Committee for the 2017 Conference reinstate the tradition of making the last motion of the Conference humorous in nature as:
- (i) it reminds us that in a financially constrained NHS laughter is a cheap and very effective medicine
  - (ii) satire is one of the most effective political weapons conference has at its disposal
  - (iii) it will bring a smile to the face of those watching next year's conference from Australia.
- T5-30 DEVON That conference is sick of people abusing the emergency speaker (pink) cards and demands a change to standing orders to give discretion to the Chair to:
- (i) allow a delegate to retain her/his emergency speaker card where their contribution has genuinely been one of information
  - (ii) fine a delegate £100 to be given to the Cameron Fund where the emergency speaker card has been used inappropriately to make a speech.
- T5-31 MID MERSEY: That conference demands clarity regarding the process of calling speakers for and against conference motions.
- T5-32 NOTTINGHAMSHIRE: That conference in considering the future function of conference hopes that, in the interests of clarity in policy setting, all motions debated will be single stem.
- T5-33 LEEDS: That conference, noting both the rapidly changing medico political agenda and the need to be more cost-effective:
- (i) believes the current pattern of a single two day annual Conference of LMCs is not fit for purpose nor good value for money
  - (ii) believes the current practice at this conference of holding a large number of short debates should end and alternative more effective ways of conferring together and setting policy should be tested
  - (iii) resolves that an annual UK conference of LMCs should be held for one day each year and, following the example set by LMCs in Northern Ireland, Scotland and Wales, a conference of LMCs in England should be held on a separate day at another time in the year
  - (iv) believes that the annual LMC Secretaries conference should also be reviewed as part of any changes to the Annual Conference of LMCs.
- T5-34 MORGANNWG: That conference believes that the National Conference of LMCs is the wrong forum at which to discuss issues pertaining exclusively to England and that the GPC should explore options which avoid wasting the time of GPs from the devolved nations.
- T5-35 BEDFORDSHIRE: That conference calls on GPC to change the way in which the Annual Conference of LMCs is organised and run.

- T5-36 BRADFORD AND AIREDALE: That conference believes that in a time when we and all our colleagues are under huge financial pressure that an extravagant conference dinner is an inappropriate use of time and money, and does not give the impression we would wish. Conference calls for the dinner be cancelled in future and consideration be given to organising or allowing a programme of fringe events, to extend the value of conference to attendees.
- T5-37 DEVON That conference believes the funds spent on conference dinner could be better spent. SHROPSHIRE: That conference believes that the January Special Conference of LMCs wasted the opportunity to respond to the calls from grass roots GPs for swift improvements in primary care conditions or effective industrial action.
- T5-38 NOTTINGHAMSHIRE: That conference in considering the future function of conference, insists that standing orders be revised in future to ensure that the agenda committee comprises only GPs who are not also members of GPC and who are still in clinical practice.

### GENERAL PRACTITIONERS DEFENCE FUND (GPDF)

- T5-39 HULL AND EAST YORKSHIRE: That conference believes that the GPDF Board should prepare an options appraisal for consideration by LMCs that seeks to address the issues identified as being in need of change with the GPDF to reduce costs and increase efficiency and respond to the real needs of LMCs and the doctors they represent and further requests that future levies must be subject to a full and frank discussion on their use.
- T5-40 LEEDS: That conference believes LMCs should be the constituency of GPDF and not members of GPC and calls for appropriate changes to the constitution of GPDF to enable this.
- T5-41 HERTFORDSHIRE: That conference notes that some LMCs are finding it increasingly difficult to justify sending thousands of pounds of GPs' money to the GPDF each year and calls on GPC to take immediate action to
- (i) allow LMCs to bid to use some of its existing reserves for the direct and immediate support of struggling practices
  - (ii) give examples of how the fund has been used for the betterment of general practice
  - (iii) provide regular updates to LMCs about the size of the GPDF and how it is being used
- T5-42 ROCHDALE AND BURY: That conference recognises that GP's donate voluntary levies to GPDF but now expects action from GPDF by utilising these funds to support the profession.
- T5-43 ROCHDALE AND BURY: That conference believes that GPDF needs to utilise financial resource to support the evolution of New Models of Delivery around the country.
- T5-44 SOMERSET: That conference is disappointed by the ineffectiveness of BMA and GPC campaigns intended to bring the critical state of general practice into the public eye, and instructs GPC to negotiate with the GPDF the release of sufficient funds to resource effective publicity in national broadcast and print media.

**PART TWO  
WORKLOAD****Annex 7**

- 22 MERTON, SUTTON AND WANDSWORTH: That conference acknowledges that practices should not be held accountable nor penalised where PPGs are not fully operational due to lack of patients wishing to engage with PPGs.
- 23 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the role of the GP is being eroded. GP's and their practices are the cornerstone of the NHS determining the way it functions and is therefore one of the main reasons it scores so well in the commonwealth fund assessments of healthcare systems across the world. Unless significant investment in training and resource is increased this cornerstone will collapse with inevitable consequence. We cannot afford as a society a secondary care driven service. If politician really do believe in an NHS let them show that in a more meaningful way.
- 24 NORTH YORKSHIRE: That conference believes that it is not justified or sustainable, that the average earnings of a salaried GP are now about half of the average income of a GP partner; so, increased guidance and support on this, eg through an updated model-contract for salaried GP needs to be considered.
- 25 DERBYSHIRE: That conference support the move by Stephen Dorrell, Norman Lamb and Alan Milburn to set up a cross party commission to review the future of the NHS and social care in England.
- 26 WILTSHIRE: That conference instructs the GPC to define the limits of the responsibilities of a GP:
- (i) and enforce these boundaries
  - (ii) refuse any transfer of work from secondary care without an additional and accepted agreement.

**EMPOWERING PROFESSIONALISM**

- 27 CITY AND EAST LONDON: That conference calls on the GPC to instruct practices to boycott this initiative:  
<http://dpac.uk.net/2016/02/why-were-opposed-to-jobs-on-prescription-donoharm/>
- A** 28 NORFOLK AND WAVENEY: That conference calls for improved collaborative working with other craft committees within the BMA to support each other and develop a sustainable professionally led NHS.
- A** 29 CITY AND EAST LONDON: That conference:
- (i) reaffirms that GPs:
    - (a) must continue to have a unique gatekeeper role within the NHS
    - (b) have highly specialised diagnostic skills and
    - (c) are extremely good value for money
  - (ii) reaffirms that GP consultations are complex and cannot be reduced to algorithms to enable safe delegation to non-medically trained call handlers
  - (iii) calls upon the GPC to insist to government that, on the grounds of patient safety, GPs should be the first point of contact for triage in primary care.

## SEVEN DAY GP SERVICE

- 30 GLOUCESTERSHIRE: That conference considers the government must recognise that understaffed practices are at risk of collapsing due to increasing work load performed by ever fewer clinicians, and in particular that:
- (i) general practice is struggling to retain and recruit doctors
  - (ii) the majority of patients do not want 7-day access and therefore to ease pressure on general practice continued roll-out of the scheme should cease
  - (iii) the time taken to train a GP and the reluctance of graduates to become GPs means that promises of 5,000 extra GPs by 2020 are unachievable
  - (iv) money would be better spent on supporting GPs than on schemes that may sound good in theory but which in practice complicate further the delivery of services and do not necessarily reduce the pressure on general practice
  - (v) until adequate numbers of clinicians have been recruited and trained there is no point in introducing services that are supposed to improve health care but really take staff from an already shrinking pool
  - (vi) enthusiasm to join the profession is inversely affected by media denunciations and the converse may also prove true.

## JUNIOR DOCTORS DISPUTE

- 31 DEVON That conference believes GPC and BMA could have been much more effective in their attempts to point out misuse of statistics by Secretary of State for Health.
- 32 GLOUCESTERSHIRE: That conference strongly supports the junior doctors in their very reasonable requests for safety and fairness in their contract and demands that junior doctors are treated more humanely in general practice as well including:
- (i) an end to the possibility of being posted for medical placements anywhere in a wide deanery area, many miles from friends and loved ones
  - (ii) an immediate working party to reduce the burgeoning behemoth of the e-portfolio, and indeed to examine the need for its very existence
  - (iii) that portfolio careers should be more welcomed and incorporated in GP training, to also include spells of training overseas
  - (iv) an end to the link between the Royal College of General Practitioners and the Clinical Skills Assessment Applied Knowledge Test
  - (v) that any annual appraisal should be between 9 and 13 months of the Certification of Completion of Specialist Training and no sooner unless in exceptional circumstances
  - (vi) that the terms and conditions for maternity and paternity leave be made equitable between hospital training and general practice placements.
- 33 BRADFORD AND AIREDALE: That conference believes that failure to support the junior doctors will herald the end of the NHS and will push GPs into private service.

## PUBLIC RELATIONS

- 34 DEVON That conference is dismayed that the public are not fully aware that the NHS is now consistently the best health service in the world as measured by the Commonwealth Fund and demands that the Government runs a high profile campaign to demonstrate to the British public the world-beating standards of healthcare available to them free at the point of delivery.
- 35 SALFORD AND TRAFFORD: That conference believes a financial disincentive is needed to ensure that more patients keep their booked appointments with GPs and their staff in general practice.
- 36 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference is horrified by the so called 'Hunt Effect', by which patients are put off accessing care on a weekend due to the perception that the NHS does not function then. We call on GPC to:
- (i) instigate a public campaign to highlight that the NHS already provides 24/7 care, including primary care.
  - (ii) condemn the Health Secretary for harming patients through dangerous rhetoric.

## OVERSEAS PATIENTS

- A 37 CITY AND EAST LONDON: That conference demands that the government should not require GPs to charge overseas patients for appointments and acknowledges that:
- (i) current procedures would not enable practices to check the residential status of patients
  - (ii) it is not the place of general practice to undertake the work of the immigration services.

## PENSIONS

- 38 DEVON that conference instructs the BMA pensions negotiators to explore with the NHSPS a change to regulations to allow a GP to choose to superannuate less than 100% of their NHS earnings and allowing the percentage to be decided by the GP on an annual basis.

## SESSIONAL GPs

- 39 DORSET: That conference believes that 50 hours of annual CPD recommended for revalidation is a reasonable goal and therefore asks the GPC to negotiate to decrease the allowance for over 200 hours of study leave currently in the model contract for salaried doctors to a similar reasonable amount.
- 40 WILTSHIRE: That conference believes the BMA has guidelines and a standard contract for non-principal GPs but these are little known and in reality not followed by many practices. This Conference believes that the difficulties in recruitment and retention of salaried GPs would be reduced if all practices were to publicise and implement the BMA standard contract.

- 41 SOUTHWARK: That conference acknowledges that although the taxpayer funds NHS doctors, the control of employment is under the jurisdiction of established partners rather than sessional doctors and that in order to make the system fair all doctors should have the right to be principals as a first choice.

## URGENT CARE

- 42 DERBYSHIRE: That conference calls for a national standard to be set to require ambulance services to regard as targets the time frame requested by GPs who have assessed patients needing unplanned admission to hospital.
- A 43 SOMERSET: That conference believes NHS 111 has been a dangerous failure and must be replaced as soon as feasible by a clinically managed service that is fully integrated with existing clinically led emergency and unscheduled care services.
- A 44 CITY AND EAST LONDON: That conference maintains its concerns about 111 and that its triaging methods are:  
(i) putting patients' lives at risk  
(ii) placing unacceptable levels of pressure on GP practices.

## PATIENT SAFETY

- 45 SOMERSET: That conference asks GPC to ensure that the disproportionate damaging effects of current NHS changes on rural populations are properly recognised, noting that the loss of a small country practice when the nearest alternative is many miles distant may have serious clinical consequences for vulnerable patients.
- 46 WEST PENNINE: That conference demands that health promotion screening questions and their answers are confidential and should be exempt from the requests of insurance reports as are HIV and genetic screening results.

## MEDICAL CERTIFICATES AND REPORTS

- 47 CITY AND EAST LONDON: That conference is extremely concerned that despite the appalling record of first ATOS and now Maximus in delivering fair fitness to work assessments that there are pilots in which job centre 'employment coaches' are being based in GP surgeries.

## WORKFORCE

- 48 BRADFORD AND AIREDALE: Increasing the number of physician associates, advanced nurse practitioners and extended scope pharmacists and physiotherapists has been identified as a partial solution to the GP workforce crisis. Once these professionals have completed their initial clinical training, considerable resources are needed to support their postgraduate training in primary care and enable them to operate as a productive member of the workforce. At

present, the time, cost and risk of this training is entirely borne by the GP practices that employ them. There is no structured postgraduate training and practices are required to meet significant indemnity costs during this process. We call on NHS England and Health Education England to calculate the cost of postgraduate training for new workforce entrants and compensate GP surgeries appropriately.

## NEW MODELS OF CARE

- 49 ROCHDALE AND BURY: That conference asks the government to allow clinicians to redesign the way healthcare is delivered without micro management from clinical commissioning groups

## INFORMATION MANAGEMENT AND TECHNOLOGY

- 50 BEDFORDSHIRE: That conference calls on GPC to work for the shutting down of the NHS Choices website.
- 51 HARINGEY: That conference calls upon GPC to explore the legal and contractual consequences of non-engagement with Patient Online.
- 52 COVENTRY: That conference deplores that the Department of Health and NHS England continue to give low priority to IT schemes that would improve GP workload, and insists that within six months all:
- (i) controlled drugs are added to repeat dispensing and electronic prescribing software
  - (ii) GPSoC accredited clinical software systems have the large message solution enabled.
- 53 COVENTRY: That conference believes that any NHS Scheme to provide WiFi services to patients in practices must be fully resourced by the NHS including providing registration and/or log-on support, and all protocols and arrangements for restricting access.
- 54 GLOUCESTERSHIRE: That Conference is appalled that the Audit Commission found the cost of the GP Extraction Service (GPES) was £45 million as of March 2015 and:
- (i) believes that the money would have been much better spent supporting general practices
  - (ii) notes that GPES was still unable to extract claims for flu and pneumococcal immunisations recently
  - (iii) notes with grave concern that GPES is still unusable for practices with a shared database
  - (iv) wishes that practices unable to use GPES for any item of work should be fairly reimbursed for the extra expense in manually searching for services properly delivered
  - (v) is concerned that GPES is being used to extract data for other agencies such as the Department of Work and Pensions for non-medical reasons and asks the GPC to investigate the implications of this.

- A** 55 NORTHUMBERLAND: With increasing numbers of practice closures, large numbers of records require transfer. Current unreliability and restrictions on file size for this to be completed via GP2GP, render the service virtually useless. Conference demands that:
- (i) pressure is put on the IT providers to resolve the situation
  - (ii) that the risk to patient safety is recognised.
- A** 56 GLASGOW: That conference deplores the continuing use by third parties of subject access requests for commercial reasons despite the Information Commissioners Office's recent ruling on the appropriateness of using a patient's medical record in this manner and calls for a clamp down on such activities.

## GP LOCUMS

- AR** 57 TAYSIDE: That conference acknowledges that locum GPs are both a major and expanding proportion of the general practice workforce and urges GPC, the BMA and GPDF to work towards a solution for funding them to attend BMA events without financial detriment as they do for practice based GPs and doctors from other branches of practice.
- AR** 58 DORSET: That conference asks the LMC to ensure all member practices provide an up-to-date, useful locum pack and necessary paperwork and clinical equipment for every locum who works at their surgery.
- A** 59 DORSET: That conference calls the GPC to recommend that all practices provide induction packs for locums and agree a formal contract prior to engagement of services to ensure both parties expectations are understood and adhered to.
- A** 60 SEFTON: That conference calls upon the GPC to investigate and redress the situation of locum GPs who are denied superannuation death in service benefits if they are between engagements at the time of decease.
- A** 61 NORTHERN IRELAND CONFERENCE OF LMCs: That conference believes that the bereaved families of locum doctors should not be denied death in service payments just because their locum husband/wife/father/mother died on a day they were not booked to work.

## VACCINATION AND IMMUNISATIONS

- AR** 62 MID MERSEY: That conference believes that the government is responsible for a shambolic confrontational adversarial 2015 influenza vaccination campaign which has put vulnerable patients' care at risk and damaged professional relationships and calls upon the GPC to urgently negotiate a better system for 2016 which will allow practices to deliver a safe and sustainable service and place vaccination orders with confidence, minimising financial risk.
- AR** 63 NORFOLK AND WAVENEY: That conference believes the extension of influenza vaccination to community pharmacies has not had a beneficial effect on vaccination coverage of those at risk and has been a wasteful use of resources.



- AR** 64 MID MERSEY: That conference believes that the late introduction of an enhanced service for pharmacists to deliver influenza vaccines in 2015 had a detrimental impact on GP-pharmacist relationships in many areas and calls on the GPC to work with the National Pharmacists Committee to agree reasonable standards for the 2016-17 vaccination season.
- AR** 65 MORGANNWG: That conference believes the natural home of seasonal influenza vaccination is in GP practices and that GPC should negotiate changes to existing funding arrangements, including aspirational or up-front payments, to reduce financial risk to practices and allow them to properly plan and improve uptake.
- AR** 66 LIVERPOOL: That conference believes that the contract that NHS England entered into with community pharmacies to deliver flu vaccinations is fundamentally flawed, and instructs GPC to ensure that if NHS England repeats this exercise in 2016, pharmacies are contractually obliged to report vaccinations administered to patients, to their respective GP practices, within 24 hours of administration.
- AR** 67 ROCHDALE AND BURY: That conference acknowledges the risk this government is exposing the public to by commissioning flu vaccinations with services outside general practice
- A** 68 WILTSHIRE: That conference demands an increase in the item of service fee for all vaccinations to reflect increased workload and complexity.
- A** 69 MORGANNWG: That conference believes that in line with WHO advice, the NHS should adopt universal Hepatitis B vaccination and the BMA should appeal to the JCVI to come to an implementable recommendation as a matter of urgency as this is long overdue.
- A** 70 MORGANNWG: That conference believes vaccination against Human Papilloma Virus should be 'gender-blind' and the GPC should lobby the JCVI to develop such a recommendation which is cost-effective and provides universal cover.

## CLINICAL AND PRESCRIBING

- A** 71 WELSH CONFERENCE OF LMCs: That conference deplores the regular supply shortages seen with many commonly prescribed drugs and urges government to look again at the causes of these in order to ensure that they do not continue.
- A** 72 GLASGOW: That conference welcomes the joint statements issued by the BMA's consultant committee and GPC on duty of care for hospital test results and duty of care regarding drugs recommended from outpatient clinics, and calls on the BMA to publicise this widely to all clinicians in acute and community settings.
- 73 BROMLEY: That conference supports pharmacy colleagues' campaign against NHSE's proposals to close 4000 pharmacies and replace them with hub and spoke models.

**DISPENSING**

- A** 74 BEDFORDSHIRE: That conference believes that dispensing should be available to all GPs should they wish to take on this responsibility and calls on GPC to work to effect this.
- A** 75 BEDFORDSHIRE: That conference believes that the playing field between pharmacies and dispensing practices is very uneven and that it should be levelled and calls on GPC to work to effect this.
- A** 76 NORTHUMBERLAND: That conference demands the completion of the roll out of EPS2 which will allow dispensing practices to nominate their service for electronic prescriptions.

**PRIVATE FEES/NHS WORK**

- 77 GREENWICH: That conference calls on the GPC to demand that policy makers who believe that the NHS is not sustainable without privatisation to come forward and provide evidence for their case so that an open and honest debate can take place about what can be afforded instead of enduring fragmentation by stealth.
- 78 NORTH YORKSHIRE: That conference believes that if the future of general practice lies in federations and super practices but also with increasing restriction of the treatments provided by the NHS, should all restrictions on private provision for registered patients be lapsed, as patients will be unable to access such care within their local area other than from private providers, thus restricting their choice.
- A** 79 BRADFORD AND AIREDALE: That, in view of the enhanced threat to practice funding, conference supports the principle that GPs should be able to provide private work / services to their own registered patients without having to de-register the patient from their practice list.
- A** 80 NORTHAMPTONSHIRE: That conference insists that all private insurers should use their own employees to screen requests from their private clients wishing to access private healthcare under their schemes; any NHS GP time spent on such non-NHS bureaucracy should be wholly reimbursed by the insurer.
- A** 81 WAKEFIELD: That conference believes that GPs ought to be able to charge patients for minor surgical procedures.
- A** 82 CORNWALL AND ISLES OF SCILLY: That conference believes that legislative change should be pursued to allow GPs to offer more private non-GMS services to their registered patients.
- A** 83 HERTFORDSHIRE: That conference mandates GPC to negotiate an end to the restriction on patients being charged by GPs for non-NHS services.

## PUBLIC HEALTH

- A** 84 DEVON That conference observes that:
- (i) the message that a cough for three weeks requires medical advice for possible cancer is incompatible with the message that self-limiting respiratory illness should be treated at home
  - (ii) the message that the judicious use of antibiotics is vital to stem the growth in antibiotic resistance is incompatible with the message to seek antibiotics at the earliest opportunity to avoid sudden overwhelming infection
  - (iii) government sponsorship of mutually contradictory public health information campaigns leads to increases in patient confusion, increases in GP workload with little (if any) overall public health benefits.
- 85 SHEFFIELD: That conference believes that the GP's role as the patient's advocate and gatekeeper to the health service is unsustainable because of the government driven extinction of the profession.
- A** 86 SUFFOLK: That conference believes in the current financial climate it is even more critical that government allocate resources to public health initiatives that have a robust evidence base instead of ideology. Based on this criteria health checks should be scrapped and money should be re invested to front line community services where there is proven need and which is not being appropriately met.
- AR** 87 CITY AND EAST LONDON: That conference requires an end to fragmented public health contracts and insists that contracts should cover all patients on a GP list and not just those resident in the borough.
- AR** 88 CITY AND EAST LONDON: That conference believes that there should be an end to the dumping of unfunded and inappropriate work on GP by Public Health England in the form of treatment and contact tracing of PVL infections and similar public health issues. Public Health England must continue to do this work and not delegate this down to practices who do not have either the expertise or the resources to carry out this work.
- A** 89 CITY AND EAST LONDON: That conference believes that patients receiving treatment for drug addiction should be managed holistically.
- 90 BIRMINGHAM DIVISION: That conference believes that since missed GP appointments waste time and reduce access, the GPC should campaign for the removal of restrictions on patient fines for persistent non-attendance.

## EMPOWERING PATIENTS

- 91 HIGHLAND: That conference recognises the need for effective participation of patients in healthcare, and demands that GPC explore contractual models that can reflect the significant investment of time needed from GPs and other professionals to achieve the co-production of services.
- A 92 NORTHUMBERLAND: That conference acknowledges that the current crisis in general practice will adversely affect the quality and accessibility of services, and asks the GPC to:
- (i) develop an honest campaign to inform the public of the reality of the situation
  - (ii) support individual GPs and practices where locally they need to raise such issues.

## FIRST FIVE

- 93 LAMBETH: That conference expresses the strongest concern regarding the GP recruitment challenge and demands that the GPC negotiates:
- (i) substantial financial investment in GP recruitment
  - (ii) substantial financial incentives for junior doctors doing GP training
  - (iii) substantial schemes to support the retention of newly qualified GPs in primary care
  - (iv) for absolute equity of pay between juniors doctors training to be a GP and their hospital based colleagues
  - (v) the use of schemes to recruit GPs from EU countries who have excess GPs
  - (vi) negotiates for financial or other incentives to stop GPs retiring in areas of high need.

## SUSTAINABILITY

- 94 AVON: That conference calls on NHS England to consider the sustainability of general practice and to ensure that appropriate negotiations take place with GPC when commissioning services which affect primary care, such as the inequitable funding of flu vaccinations provided by pharmacies in 2015.

## CARE IN THE COMMUNITY

- 95 DERBYSHIRE: That conference demands that health and social care services in the community are given the resources needed to do the job that the public needs.

## MEDICAL CERTIFICATES AND REPORTS

- AR** 96 GLOUCESTERSHIRE: That conference has seen little evidence that firearms possession coding or alerts are of practical use, especially when police notification systems do not appear to be working within or between forces; therefore, before the GPC recommends wide-spread firearms possession coding, further consideration is needed to address the following specific concerns that:
- (i) the risk of firearms misuse may apply to other members of the household, who should thus also be coded
  - (ii) practices should be properly compensated both for carrying out this extra work and also for taking on the considerable new risks involved.

## OTHER

- 97 HARROW: That conference regrets the withdrawal of certain contraceptive services from general practice and calls upon the GPC to:
- (i) promote the benefits of general practice provision
  - (ii) emphasise that removal of such services from general practices will deskill practitioners thereby reducing the procurement options for commissioners in future
  - (iii) argue that it is a false economy which will make access to emergency contraception far more difficult for patients and is highly likely to increase the risk of unwanted pregnancies.
- 98 LIVERPOOL: That conference believes that GPC should actively campaign to dispel the myth that the NHS is unaffordable.
- 99 LIVERPOOL: That conference believes that following NHS England's decision in 2015 to contract with community pharmacies to provide flu vaccinations, GPC should now negotiate for flu vaccines to be provided centrally as with other nationally agreed vaccination schemes.
- 100 CLEVELAND: That conference requests a change to the Regulations made under S88 of the NHS Act 2006 to restrict the prescribing for acute medical conditions of preparations that are available without a prescription.
- 101 DEVON That conference notes that the dissonance between legal rights of foreign nationals resident in the UK to different categories of NHS care is leading to a concerning increase in medico-legal risk for GPs and demands government action to align medical entitlements between primary and secondary care.
- 102 ROCHDALE AND BURY: That conference urges the GPC to highlight the current crises facing general practice with the same intensity as BMA has for junior doctors.
- 103 LEWISHAM: That conference believes that in the light of the recognition that low investment in public health ultimately causes greater NHS expenditure, public health services should be a statutory requirement of local authorities thereby avoiding the erosion of public health budgets to fund other local authority functions.

- 104 BARKING AND HAVERING: The conference believes that the BMA should demand a review of GP working hours and expectations. There should be a cap on the addition of unpaid work such as safeguarding, ESA reports, shared care work for specialist services etc.
- 105 SUFFOLK: That conference requests GPC to resist the introduction of NHS England's plan to remove patients from practice lists if they have not seen a GP in the previous five years and do not respond to a letter; the GPC should point out to NHS England that this group of patients are just as entitled to have a GP when they need one and are likely to be the demographic that does not readily respond to mail-shots and furthermore that this plan risks cutting practice incomes at a time when many practices are struggling to survive.
- 106 HIGHLAND: That conference is concerned for the welfare of all staff in general practice and asks GPC to review guidance on what services should be available and what actions may be appropriate when assessment has identified the risk of a person acting violently in a healthcare setting.
- 107 NORTH YORKSHIRE: That conference believes that in an age of evidence based medicine is it appropriate to have a Secretary of State who believes in homeopathy.
- 108 LANCASHIRE PENNINE: That conference believes that the forthcoming referendum on EU membership could have a profound impact on the future viability of the NHS and calls on GPC to undertake a full evaluation of the likely impact of the UK leaving the EU, advise doctors accordingly and raise the implications at the highest level of government.
- 109 WEST SUSSEX: That conference believes providing care to patients is of more value than attending meetings organised by a CCG.
- A** 110 BUCKINGHAMSHIRE: That conference insists that if community pharmacists are to manage minor illnesses, then regulations must be changed so that over the counter medicines used for minor illnesses
- (i) will not normally be prescribed by GPs
  - (ii) can be issued by community pharmacists without charge to those patients eligible for free NHS prescriptions.
- A** 111 LIVERPOOL: That conference believes that the introduction of more heavily market based providers under the Health And Social Care Act, will be to the detriment of the nation's health.

# Standing orders

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## Standing Order

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# CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

## STANDING ORDERS

### Conferences

#### Annual conference

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

#### Special conference

2. A special conference of representatives of local medical committees may be convened at any time by the GPC, and shall be convened if requested by one sixth, or if that is not a whole number the next higher whole number, of the total number of LMCs entitled to appoint a representative to conference. No business shall be dealt with at the special conference other than that for which it has been specifically convened.

### Membership

3. The members of conference shall be:
  - 3.1 the chairman and deputy chairman of the conference
  - 3.2 365 representatives of local medical committees
  - 3.3 the members of the GPC
  - 3.4 9 members appointed by the Scottish GPC
  - 3.5 3 members appointed by the Welsh GPC
  - 3.6 2 members appointed by the GPC (Northern Ireland)
  - 3.7 up to 5 persons entitled to attend GPC subcommittee meetings, but not otherwise members of conference; these shall be appointed by the GPC
  - 3.8 the seven elected members of the conference agenda committee (agenda committee)
  - 3.9 the regionally elected representatives of the GP trainees subcommittee, together with its immediate past chairman
  - 3.10 the elected members of the sessional GPs subcommittee of the GPC.

### Representatives

4. All local medical committees are entitled to appoint a representative to the conference.
5. The agenda committee shall each year allocate any remaining seats for representatives amongst LMCs. Allocation of additional seats shall be done in such a manner that ensures fair representation of LMCs according to the number of GPs they represent. Each year the agenda committee shall publish a list showing the number of representatives each LMC is entitled to appoint and the method of allocating the additional seats.
6. Local medical committees may appoint a deputy for each representative, who may attend, and act at the conference if the representative is absent.
7. Representatives shall be registered medical practitioners appointed at the absolute discretion of the appropriate local medical committee.
8. The representatives appointed to act at the annual conference shall continue to hold office from 15 January for 12 months, unless the GPC is notified by the relevant local medical committee of any change.



### Observers

9. Local medical committees may nominate personnel from their organisations to attend conference as observers, subject to chairman of conference's discretion. In addition the chairman of conference may invite any person who has a relevant interest in conference business to attend as an observer.

### Interpretations

10. A local medical committee is a committee recognised by a PCO or PCOs as representative of medical practitioners under the NHS Act 2006 as amended or by equivalent provisions in Scotland, Wales, and Northern Ireland.
11. 'Members of the conference' means those persons described in standing order 3.
12. 'Representative' or 'representatives' means those persons appointed under standing orders 4 to 8, and shall include the deputy of any person who is absent..
13. 'The conference', unless otherwise specified, means either an annual or a special conference.
14. 'As a reference' means that any motion so accepted does not constitute conference policy, but is referred to the GPC to consider how best to procure its sentiments.

### Motions to amend standing orders

15. No motion to amend these standing orders shall be considered at any subsequent conference unless due notice is given by the GPC, the agenda committee, a local medical committee, a constituency of the BMA's representative body, or one of the other BMA craft conferences.
  - 15.1 Except in the case of motions from the GPC, such notice must be received by the Secretary of the GPC not less than 60 days before the date of the conference.
  - 15.2 The GPC shall inform all local medical committees of all such motions of which notice is received not less than 42 days before the conference.

### Suspension of standing orders

16. Any decision to suspend one or more of the standing orders shall require a two-thirds majority of those representatives present and voting at the conference.

### Agenda

17. The agenda shall include:
  - 17.1 motions, amendments and riders submitted by the GPC, and any local medical committee. These shall fall within the remit of the GPC, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and/or the National Health Service (Scotland) Act 1978 and/or the Health and Personal Social Services (Northern Ireland) Order 1972 and any Acts or Orders amending or consolidating the same and as from time to time extended to all or any part of the United Kingdom
  - 17.2 motions, amendments and riders connected with NHS general practice from constituencies of the British Medical Association's representative body, or one of the other craft conferences convened by a standing committee of the BMA, referred by the BMA's joint agenda committee
  - 17.3 motions passed at national LMC conferences and submitted by their chairmen
  - 17.4 motions relating to the Cameron fund, Claire Wand fund and the Dain fund
  - 17.5 motions submitted by the agenda committee in respect of organisational issues only.

18. Any motion which has not been received by the GPC within the time limit set by the BMA's joint agenda committee shall not be included in the agenda. This time limit does not apply to motions transferred to the conference by the BMA's joint agenda committee. The right of any local medical committee, or member of the conference, to propose an amendment or rider to any motion in the agenda, is not affected by this standing order.
19. When a special conference has been convened, the GPC shall determine the time limit for submitting motions.

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

20. In two parts; the first part 'Part I' being those motions which the agenda committee believe should be debated within the time available; the second part 'Part II' being those motions covered by 25 and 26 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording. If any local medical committee submitting a motion included in Part II of the agenda objects in writing before the first day of conference, the transfer of the motion to Part I of the agenda shall be decided by the conference during the debate on the report of the agenda committee.
21. 'Grouped motions': Motions or amendments which cover substantially the same ground shall be grouped and the motion for debate shall be asterisked. If any local medical committee submitting a motion so grouped objects in writing before the first day of the conference, the removal of the motion from the group shall be decided by the conference.
22. 'Composite motions': If the agenda committee considers that no motion or amendment adequately covers a subject, it shall draft a composite motion or an amendment, which shall be the motion for debate. The agenda committee shall be allowed to alter the wording in the original motion for such composite motions.
23. 'Motions with subsections':
  - 23.1 motions with subsections shall deal with only one point of principle, the agenda committee being permitted to divide motions covering more than one point of principle
  - 23.2 subsections shall not be mutually contradictory
  - 23.3 such motions shall not have more than five subsections except in subject debates.
24. 'Rescinding motions': Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters 'RM'.
25. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chairman of the GPC as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.
26. 'AR' motions: Motions which the chairman of the GPC is prepared to accept without debate as a reference to the GPC shall be prefixed with the letters 'AR'.
27. 'C' motions: Prior to the conference, a ballot of representatives shall be conducted to enable them to choose motions, ('C' motions), amendments or riders for debate. Using only the prescribed form, which must be signed and received by the GPC secretariat by the time notified for the receipt of items for the supplementary agenda, each representative may choose up to three motions, amendments or riders to be given priority in debate. Chosen motions must receive the vote of at least ten representatives. The first three motions, amendments or riders chosen, plus any others receiving the vote of at least twenty representatives, shall be given priority.

28. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 44, 45, 46, 47 and 52 shall not apply and the debate shall be held in accordance with standing order 54.

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

29. Recommending to the conference the order of the agenda; allocating motions to blocks; allocating time to blocks; setting aside reserved periods, as provided for in standing orders 59 and 61, and overseeing the conduct of the conference.
30. Identifying, by enclosing within a 'black box', motions received from those local medical committees which have failed to meet their quotas to the General Practitioners Defence Fund Ltd. Before effecting this, one year's grace must be given to such local medical committees, who must have received warning that, unless the deficit is made up by 1 May after the following year, they would become subject to the 'black box' procedure.

**Procedures**

31. An amendment shall – leave out words; leave out words and insert or add others (provided that a substantial part of the motion remains and the original intention of the motion is not enlarged or substantially altered); insert words; or be in such form as the chairman approves.
32. A rider shall – add words as an extra to a seemingly complete statement, provided that the rider is relevant and appropriate to the motion on which it is moved.
33. No amendment or rider which has not been included in the printed agenda shall be considered unless a written copy of it has been handed to the agenda committee. The names of the proposer and seconder of the amendment or rider, and their constituencies, shall be included on the written notice. Notice must be given before the end of the session preceding that in which the motion is due to be moved, except at the chairman's discretion. For the first session, amendments or riders must be handed in before the session begins.
34. No seconder shall be required for any motion, amendment or rider submitted to the conference by the GPC, a local medical committee, or the joint agenda committee, or for any composite motion or amendment produced by the agenda committee under standing order 22. All other motions, amendments or riders, after being proposed, must be seconded.
35. No amendments or riders will be permitted to motions debated under standing order 28.

**Rules of debate**

36. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.
37. Every member of the conference shall be seated except the one addressing the conference. When the chairman rises, no one shall continue to stand, nor shall anyone rise, until the chair is resumed.
38. A member of conference shall address the chairman and shall, unless prevented by physical infirmity, stand when speaking.

39. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.
40. Members of the GPC, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.
41. The chairman shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.
42. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.
43. The chairman shall take any necessary steps to prevent tedious repetition.
44. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.
45. Amendments shall be debated and voted upon before returning to the original motion.
46. Riders shall be debated and voted upon after the original motion has been carried.
47. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 44, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.
48. If it is proposed and seconded or proposed by the chairman that the conference adjourns, or that the debate be adjourned, or 'that the question be put now', such motion shall be put to the vote immediately, and without discussion, except as to the time of adjournment. The chairman can decline to put the motion, 'that the question be put now'. If a motion, 'that the question be put now', is carried by a two thirds majority, the chairman of the GPC and the mover of the original motion shall have the right to reply to the debate before the question is put.
49. If there be a call by acclamation to move to next business it shall be the chairman's discretion whether the call is heard. If it is heard then the proposer of the original motion can choose to:
  - (i) accept the call to move to next business for the whole motion
  - (ii) accept the call to move to next business for one or more subsections of the motion
  - (iii) have one minute to oppose the call to move to next business.Conference will then vote on the motion to move to next business and a 2/3 majority is required for it to succeed.
50. Proposers of motions shall be given prior notice if the GPC intends to present an expert opinion by a person who is not a member of the conference.
51. All motions expressed in several parts and designated by the numbers (i), (ii), (iii), etc shall automatically be voted on separately. But, in order to expedite business, the chairman may ask conference (by a simple majority) to waive this requirement.
52. Any motion, amendment or rider referred to the conference by the joint agenda committee shall be introduced by a representative or member of the body proposing it. That representative or member may not otherwise be entitled to attend and speak at the conference, neither shall he/she take any further part in the proceedings at the

conclusion of the debate upon the said item, nor shall he/she be permitted to vote. In the absence of the authorised mover, any other member of the conference deputed by the authorised mover may act on their behalf, and if there is no deputy the item shall be moved formally by the chairman.

53. If by the time for a motion to be presented to conference no proposer has been notified to the agenda committee, the chairman shall have the discretion to rule, without putting it to the vote, that conference move to the next item of business.
54. In a major issue debate the following procedures shall apply:
  - 54.1 the agenda committee shall indicate in the agenda the topic for a major debate
  - 54.2 the debate shall be conducted in the manner clearly set out in the published agenda
  - 54.3 the debate may be introduced by one or more speakers appointed by the agenda committee who may not necessarily be members of conference
  - 54.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
  - 54.5 subsequent speakers will be selected by the chairman from those who have indicated a wish to speak. Subsequent speeches shall last no longer than one minute.
  - 54.6 the Chairman of GPC or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
  - 54.7 at the conclusion of the debate the introductory speakers may speak for no longer two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
  - 54.8 the response of members of conference to any major debate shall be measured in a manner determined by the agenda committee and published in the agenda.

#### **Allocation of conference time**

55. The agenda committee shall, as far as possible, divide the agenda into blocks according to the general subject of the motions, and allocate a specific period of time to each block.
56. Motions will not be taken earlier than the times indicated in the schedule of business included in the agenda committee's report.
57. 'Soapbox session':
  - 57.1 A period shall be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
  - 57.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
  - 57.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
  - 57.4 GPC (UK) members shall not be permitted to speak in the soapbox session.
58. Motions which cannot be debated in the time allocated to that block shall, if possible, be debated in any unused time allocated to another block. The chairman shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.
59. Not less than two periods shall be reserved for the discussion of other motions, and any amendments or riders to them, which cannot conveniently be allocated to any block of motions.

60. Motions prefixed with a letter 'A', (defined in standing orders 25 and 26) shall be formally moved by the chairman of conference as a block to be accepted without debate during the debate on the report of the agenda committee in the first session of the conference.
61. One period, not exceeding one hour, to be reserved for representatives of LMCs to ask questions of the GPC negotiating team.
62. The allocation of conference time should include a period of 'contingency time' on each day of the conference and a period for debate of chosen motion.

#### **Motions not published in the agenda**

63. Motions not included in the agenda shall not be considered by the conference except those:
  - 63.1 covered by standing orders relating to time limit of speeches, motions for adjournment or "that the question be put now" motions that conference "move to the next business" or the suspension of standing orders
  - 63.2 relating to votes of thanks, messages of congratulations or of condolence
  - 63.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association
  - 63.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned
  - 63.5 prepared by the agenda committee to correct drafting errors or ambiguities.
  - 63.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions
  - 63.7 that may arise from a major issue debate; such motions must be received by the agenda committee by the time laid down in the major issue debate timetable published under standing order 54.

#### **Quorum**

64. No business shall be transacted at any conference unless at least one-third of the number of representatives appointed to attend are present.

#### **Time limit of speeches**

65. A member of the conference, including the chairman of the GPC, moving a motion, shall be allowed to speak for three minutes; no other speech shall exceed two minutes. However, the chairman may extend these limits.
66. The conference may, at any period, reduce the time to be allowed to speakers, whether in moving resolutions or otherwise, and that such a reduction shall be effective if it is agreed by the chairman.

#### **Voting**

67. Except as provided for in standing orders 72 (election of chairman of conference), 73 (election of deputy chairman of conference), 75 (election of seven members of the agenda committee) and 76 (election of ARM representatives), only representatives of local medical committees may vote.

### Majorities

68. Except as provided for in standing order 48 and 49 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:
- 68.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC structure, or
  - 68.2 a decision which could materially affect the GPDF Ltd funds.
69. Voting shall be, at the discretion of the chairman, by a show of voting cards or electronically. If the chairman requires a count this will be by electronic voting.

### Recorded votes

70. If a recorded vote is demanded by 20 representatives at the conference, signified by their rising in their places, the names and votes of the representatives present shall be taken and recorded.
71. A demand for a recorded vote shall be made before the chairman calls for a vote on any motion, amendment or rider.

### Elections

72. Chairman
- 72.1 At each conference, a chairman shall be elected by the members of the conference to hold office from the termination of the BMA's annual representative meeting (ARM) until the end of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
  - 72.2 Nominations must be handed in on the prescribed form before 12 noon on the first day of the conference with any election to be completed by 4.00pm. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
73. Deputy chairman
- 73.1 At each conference, a deputy chairman shall be elected by the members of the conference to hold office from the termination of the ARM until the termination of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
  - 73.2 Nominations must be handed in on the prescribed form before 9.30am on the second day of the conference with any election to be completed by 12 noon. Nominees may enter on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
74. Seven members of the General Practitioners Committee
- 74.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. For six of the seats any registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, whether a member of the conference or not, is eligible for nomination providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. All GPs on the retainer scheme, and medically qualified LMC secretaries, are eligible for nomination regardless of their level of commitment to providing or performing NHS primary medical services. For the seventh seat, only an LMC representative at conference may be nominated, and that LMC representative must never have previously sat on the GPC. This LMC representative must also be a registered

medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. The members elected will serve on the GPC from the conclusion of the following ARM until the conclusion of the ARM one year thereafter.

- 74.2 Only representatives shall be entitled to vote.
  - 74.3 Nominations, election statements and photographs must be received by the GPC office seven working days before the start of the conference.
  - 74.4 Nominees may submit an election statement of no more than 50 words, excluding numbers and dates in numerical format, in a manner and format which will be specified by the Agenda Committee (that format being specified one calendar month before the start of conference). Recognised abbreviations count as one word.
  - 74.5 Nominees may also submit a photograph in a format specified by the Agenda Committee (that format being specified one calendar month before the start of conference).
  - 74.6 All nominees shall have the opportunity to take part in any hustings arranged by the agenda committee.
  - 74.7 All lists of candidates, in whatever format, shall be in random order.
  - 74.8 Elections, if any, will take place on the first day of conference and be completed by the start of the afternoon session.
  - 74.9 The GPC shall be empowered to fill casual vacancies occurring among the elected members.
75. Seven members of the conference agenda committee
- 75.1 The agenda committee shall consist of the chairman and deputy chairman of the conference, the chairman of the GPC and seven members of the conference, not more than one of whom may be a sitting member of the GPC. In the event of there being an insufficient number of candidates to fill the seven seats on the agenda committee, the chairman shall be empowered to fill the vacancy, or vacancies, by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected, and shall continue in office until the end of the following annual conference.
  - 75.2 The chairman of conference, or if necessary the deputy chairman, shall be chairman of the agenda committee.
  - 75.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by 1.00pm on the first day of the conference. Elections, if any, will take place on the second day of conference and be completed by 10.00am. With the exception of those appointed under standing order 3.7, any member of the conference may be nominated for the agenda committee. All members of the conference are entitled to vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
  - 75.4 The result of the election to the agenda committee shall be published after the result of the ARM election of GPC members is known.
  - 75.5 The two members of the agenda committee to be appointed to the joint agenda committee in accordance with article 53 of the BMA's Articles of Association shall be the chairman of the conference and the chairman of the GPC.



76. The representatives allocated to represent general practice at the BMA Annual Representative Meeting shall be members of the BMA both at the time of their annual appointment/election and throughout their term of office and shall comprise:
- 76.1 the chairman and deputy chairman of conference, if eligible
  - 76.2 the chairman of the GPC, if eligible
  - 76.3 sufficient members of conference to fill the allocation of seats, elected on a regional basis in advance of conference by those members of the conference who are members of the BMA
  - 76.4 should there be vacancies after the regional elections these shall be filled by the GPC from the unsuccessful candidates standing in those elections.
77. Three trustees of the Claire Wand fund
- 77.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. Any registered medical practitioner who is, or has been, actively engaged in practice as a general medical practitioner under the National Health Service Acts, whether a member of the conference or not, is eligible for nomination.
  - 77.2 Nominations must be handed in on the prescribed form before 1.00pm on the first day of the conference. Elections, if any, will take place on the second day of conference and be completed by 10.00am. Only representatives in attendance at the conference may vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers.
  - 77.3 Trustees will be elected on a triennial basis for a period of three years, to run from the termination of the next ARM.
78. Dinner committee
- 78.1 At each conference there shall be appointed a conference dinner committee, formed of the chairman and deputy chairman of the conference and the chairman of the GPC, to take all necessary steps to arrange for a dinner to be held at the time of the following annual conference, to which the members of the GPC, amongst others, shall be invited as guests of the conference.

#### Returning officer

79. The chief executive/secretary of the BMA, or a deputy nominated by the chief executive/secretary, shall act as returning officer in connection with all elections.

#### Claire Wand award

80. The chairman, on behalf of the conference, shall, on the recommendation of the GPC, present to such medical practitioners as may have been nominated by the trustees of the Claire Wand fund, the award for outstanding services to general practice. Such presentation shall take place at 4.00pm on the first day of the conference.

#### Motions not debated

81. Local medical committees shall be informed of those motions which have not been debated, and the proposers of such motions shall be invited to submit to the GPC memoranda of evidence in support of their motions. Memoranda must be received by the GPC by the end of the third calendar month following the conference.

**Distribution of papers and announcements**

82. In the conference hall, or in the precincts thereof, no papers or literature shall be distributed, or announcements made, or notices displayed, unless approved by the chairman.
83. Mobile phones may only be used in the precincts of, but not in, the conference hall.

**The press**

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

**No smoking**

85. Smoking shall not be permitted within the hall during sessions of the conference.

**Chairman's discretion**

86. Any question arising in relation to the conduct of the conference, which is not dealt with in these standing orders, shall be determined at the chairman's absolute discretion.

**Minutes**

87. Minutes shall be take of the conference proceedings and the chairman shall be empowered to approve and confirm them.







**LMC**

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