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General Practitioners
Defence Fund

BMA



Conference of Representatives of Local Medical Committees Agenda

18 and 19 May 2017

Edinburgh International Conference Centre,
The Exchange, Edinburgh EH3 8EE.



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Conference of Representatives of Local Medical Committees

Agenda

To be held on

Thursday 18 May 2017 at 9.30am

Friday 19 May 2017 at 9.00am

At the Edinburgh International Conference Centre, The Exchange, Edinburgh EH3 8EE

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)

Hal Maxwell (Ayrshire)

Rachel McMahon (Cleveland)

Emmanuel Owoso (Swansea)

Uzma Ahmad (Walsall)

Roberta King (Dorset)

Elliott Singer (Newham)

NOTES

Under standing order 18, in this agenda are printed all notices of motions for the annual conference received up to noon on 13 March 2017. Although 13 March 2017 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 – Daniel Hodgson - 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 12 May 2017**.

LMC CONFERENCE ELECTIONS

The following elections will be held on Thursday 18 May and Friday 19 May 2017.

Elections held under standing orders:

Chair of conference

Chair of conference for the session 2017-2018 (see standing order 72 - nominations to be handed in no later than **12 noon Thursday 18 May**).

Deputy chair of conference

Deputy chair of conference for the session 2017-2018 (see standing order 73 - nominations to be handed in no later than **9.30am Friday 19 May**).

Seven members of the GPC

Seven members of the GPC for the session 2017-2018 (see standing order 74 - nominations closed at **5.00pm on Tuesday 9 May**).

Seven members of the conference agenda committee

Seven members of the conference agenda committee for the session 2017-2018 (see standing order 75 - nominations to be handed in no later than **1.00pm on Thursday 19 May**).

Other elections held with consent of Conference:

Co-option of doctor within 5 years of qualification

Co-option of an early career GP to the GPC for the session 2017-2018 – nominations to be handed in no later than **1.00pm Thursday 18 May**

Deputy chair of LMC England conference

Deputy chair of LMC England Conference for the session 2017-2018- nominations to be handed in no later than **12 noon Thursday 18 May**.

Five members of LMC England conference agenda committee

Five members of the LMC England conference agenda committee for the session 2017-2018- nominations to be handed in no later than **9.30am on Friday 19 May**.

Schedule of business
Thursday 18 May 2017

Item	Time
Opening business	9.30
Annual report by the Chair of GPC	10.00
Debate: Core funding and the formula Occupational health Indemnity Regulation	10.30 10.30 10.40 10.50 11.10
Report by the Chair of Sessional subcommittee	11.30
Debate: Sessional GPs Pensions Core GP contract	12.00 12.00 12.10 12.20
Charities	12.50
Lunch	13.00
Parallel sessions: Themed debates Members may choose which session to attend, see pages 15 - 41 <ul style="list-style-type: none"> • Bridging the Gap (Rationing) p16 • Contractual Status / Risk / Individual Survival p21 • Working at Scale p24 • GPFV / Urgent Prescription for General Practice p29 • Workload p35 • QOF p39 	14.00
Debate: Forms and fees Other motions Interface with A&E Primary – Secondary care interface – transfer of work Primary care support England (Capita) Premises	16.00 16.00 16.10 16.40 16.50 17.00 17.10
Contingency	17.20
Close	17.30

Schedule of business
Friday 19 May 2017

Item	Time
Question the UK Executive Team	9.00
Debate: GPC representation GP trainees and training Appraisal and revalidation	9.30 9.30 9.50 10.20
Report by the Nation Chairs	10.40
Debate: Northern Ireland Sustainability and Transformation plans	11.10 11.10 11.20
Soapbox	11.40
Lunch	12.30
Report by the Chair of GPDF	13.30
Debate: APMS Clinical records E-referrals CQC EU Nations Other motions (2)	13.50 13.50 14.00 14.10 14.20 14.30 14.40
Contingency	14.50
Output and debate from parallel discussions	15.00
Debate: Prescriptions	16.30
Chosen motions	16.40
Close	17.00

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 2016-2017) and GPC News (..) of the 2016 Annual Conference of Local Medical Committees as approved by the Chair of conference in accordance with the provision of standing order 87.

STANDING ORDERS

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

There are some housekeeping matters to enable the change of the two day UK conference into a one day UK event, with the setting up of the new England LMC conference. The Chair of Conference will seek permission of conference to enact some new procedures, including describing how some England only elections will be held. These are by necessity outside the standing orders, but designed to enact the will of conference, and conference's permission will be sought after explanation before the Report of the Agenda Committee.

REPORT OF THE AGENDA COMMITTEE

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

ANNUAL REPORT

10.00

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

- * 6 KENT: That conference believes that core GP funding continues to be under resourced and the current funding formula is not fit for purpose on the grounds that it does not adequately reflect the exponential increase in demand and activity in core primary care.
- 6a BUCKINGHAMSHIRE: In light of the government ruling that every visitor to England has a right to free GP care, conference demands that practices should be reimbursed for the cost of treating temporary residents and those seeking immediately necessary treatments.
- 6b BUCKINGHAMSHIRE: That conference reasserts that the current Carr-Hill formula is unfair and unacceptable and
- (i) notes the move of QOF and other payments worsens the inequality of funding for practices with a Carr-Hill factor of <1
 - (ii) does not accept the refusal of government to resolve the inequitable funding of practices because it is 'too difficult'
 - (iii) insists that the base line for Carr-Hill or its successor is 1 for every patient registered with a practice and any weightings for additional need be added to this
 - (iv) presses the GPC to negotiate an equitable resolution in the next year.
- 6c BRO TAF: That conference calls on the UK government to increase the fee per patient yearly given to GPs to provide GMS, as the current remuneration is unsustainable due to rising costs.
- 6d WALTHAM FOREST: That conference recognises that any funding formula for general practice will result in areas being deprived of funding whilst the overall budget remains insufficient to meet patient needs.
- 6e AVON: That conference thanks GPC England for the joint guidance they produced with NHSE, recognising the challenges involved in caring for atypical populations. It encourages GPCE to continue to campaign for better funding for young people's health and in particular for university practices.
- 6f GLASGOW: That conference believes careful consideration has to be given to the balance of the funding formula between deprived patients, remote and rural patients, elderly patients and those patients not in any of these groups who may face their funding being eroded.
- 6g CORNWALL AND ISLES OF SCILLY: This conference believes that one size does not fit all and demands the GPC negotiates fairer funding for remote and rural areas, which are unscaleable.
- 6h LEEDS: That conference believes that without increased funding to partnerships, general practices will cease to be viable, and the extra work and leadership provided by GP partners will be lost to the NHS, with very serious consequences to the inhabitants of UK.
- 6i NORTH YORKSHIRE: That conference instructs GPC to ensure that adequate funding is negotiated for primary care to provide a safe service.
- 6j BIRMINGHAM: That conference believes that the general practice funding formula increasingly fails to adequately recognise the needs of elderly and frail patients and the associated GP workload and urges GPC to rectify this.

- * 7 AGENDA COMMITTEE PROPOSED BY THE SESSIONAL GP SUBCOMMITTEE OF THE GPC: That conference:
- (i) condemns the woeful provision of occupational health services for GPs
 - (ii) demands a comprehensive funded occupational health service for all GPs on a performers list
 - (iii) demands a comprehensive funded occupational health service for all GP practice staff
- 7a THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference calls on the GPC to insist that no GP on the performer's list should have to separately fund occupational health services and GPC should lobby NHSE and commissioners to ensure that the service specifications for occupational health is equitable for all GPs.
- 7b LEEDS: That conference condemns the woeful provision of occupational health services for GPs and:
- (i) believes NHS England should be ashamed and held to account at their failure to commission an acceptable service which results in general practice staff being put at risk
 - (ii) directs GPC to negotiate a comprehensive service accessible for all practice staff.
- 7c ISLINGTON: That conference demands that occupational health services are provided and funded, for all practice employees by NHSE.

- * 8 NOTTINGHAMSHIRE: That conference is becoming increasingly concerned with a trend of GPs being refused the renewal of their indemnity cover by the medical defence organisations leading to a worsening of the GP workforce crisis. We implore the GPC to:
- (i) negotiate with the MDOs to change the rules that they do not have to give reasons for refusals to the GP
 - (ii) request that an appeals process is put in place to allow a right of reply for the individual GPs involved
 - (iii) call upon the government to make alternative arrangements possible when the usual firms will not or cannot supply indemnity or provide an overreaching indemnity cover in the form of a 'national indemnity scheme'.
- 8a DERBYSHIRE: That conference calls upon the medical defence organisations to be more transparent in how they perceive the level of risk in general practice and primary care to be changing and how this translates into the setting of individual GPs subscription levels.
- 8b KINGSTON AND RICHMOND: That conference believes that:
- (i) the escalating costs of indemnity for general practitioners is significantly contributing to workforce shortages in primary care
 - (ii) indemnity organisations should be transparent about their risk criteria in terms of individual general practitioners subscriptions, and provide an individual breakdown of these for each subscriber each year
 - (iii) NHS England should create a level playing field in terms of indemnity costs for undertaking NHS service between general practitioners and those doctors working in organisations covered by CNST.
- (Supported by Croydon and East Sussex)
- 8c DEVON: That conference believes some GPs are being inappropriately penalised with disproportionately high premiums for their medico-legal indemnity insurance and asks the GPC to investigate these anomalies.
- * 9 CLEVELAND: That conference, regarding medical indemnity for GPs:
- (i) welcomes the contribution towards rising costs recently negotiated in England
 - (ii) believes that the contractual uplift to practices in England has been insufficient to cover the actual rise in indemnity costs
 - (iii) believes that direct reimbursement of direct costs would be preferable to reimbursement via practices based on list size
 - (iv) insists on the negotiation of full reimbursements of all indemnity costs
 - (v) demands that any future reimbursement schemes are extended to include all 4 nations, and non-GMS general practice work.
- 9a BUCKINGHAMSHIRE: That conference welcomes government recognition that excessive indemnity costs are a significant barrier to GP recruitment and retention, and requests GPC to negotiate full direct reimbursement of GP indemnity costs incurred while providing NHS services.
- 9b GATESHEAD AND SOUTH TYNESIDE: That conference insists that medical insurance indemnity payments should be fully reimbursed in their entirety to individual GPs in the first instance, which would lead naturally to a national scheme that benefits both doctors and patients.
- 9c LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference calls upon the GPC to negotiate full reimbursement of the indemnity subscription with NHSE.
- 9d MID MERSEY: That conference demands that NHS England fully indemnifies GPs.

9e	<p>DERBYSHIRE: That conference:</p> <ul style="list-style-type: none"> (i) welcomes the element of uplift to the global sum in the 2017-18 contract changes which is badged to account for increases in medical indemnity fees (ii) welcomes the implication that NHS England recognises that the medical indemnity fees are one of the major drivers of the general practice workforce crisis (iii) asserts that the mechanism whereby hugely variable medical indemnity fee increases are reimbursed to practices by a way of a global sum increase is inherently inequitable.
9f	<p>THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:</p> <p>That conference asks GPC England to negotiate indemnity reimbursements to be paid directly to each individual practitioner on the performer's list rather than being paid to practices.</p>
9g	<p>BOLTON: That conference appreciates the partial reimbursement to cover the rise in indemnity insurance costs agreed in the 2017/18 contract. However, conference believes that the exorbitant costs of indemnity insurance is accelerating the exit of doctors from general practice and that general practitioners deserve parity of cover with consultants in secondary care, at similar costs.</p>
9h	<p>CUMBRIA: That conference believes that the spiraling cost of indemnity cover has an even more adverse impact on locums in that their only source of reimbursement is through increasing charges and asks GPC to pursue NHSE for a national solution that recognises the unique position of locums.</p>
9i	<p>NORFOLK AND WAVENEY: That conference asks GPC to pursue negotiations on a better way to indemnify the GP workforce against increasing claims without bankrupting individual GPs or the NHS.</p>
9j	<p>GLOUCESTERSHIRE That conference calls on the GPC to work with the MDOs to end the practice of the minimum number session charge for out-of-hours work since this minimum discourages those GPs who might otherwise provide vital extra capacity at peak times.</p>
9k	<p>DORSET: That conference asks GPC to demand that NHS England rectifies its oversight in the GPFV in failing to provide any compensation for indemnity inflation for out of hours GPs ASAP.</p>

- * 10 KENT: That conference is concerned about the complexities of the complaints and regulatory systems faced by GPs and asks the GPC to investigate the impact on the GPs affected and negotiate simplification of the current processes.
- 10a MID MERSEY: That conference deplores the current NHS investigating process in primary care and believes that practices and individual clinicians are left unsupported throughout this process.
- 10b SANDWELL: That conference calls on the GPC to work with the GMC and NHSE to minimise the number of multiple investigations of single initial complaints.
- 10c MID MERSEY: That conference asks GPC to ensure that NHS investigators:
- (i) meet the standards outlined in the NCAS document 'How to conduct a local performance investigation'
 - (ii) are regularly assessed and only approved to undertake this work after their own standards have been found to be acceptable.
- 10d AVON: That conference believes that the Parliamentary and Health Services Ombudsman is not fit for purpose and believes that it:
- (i) is deeply prejudicial to general practitioners in its approach to dealing with patient complaints
 - (ii) has little understanding of general practice or the pressures general practitioners work under
 - (iii) has no mechanism to allow appeal or redress against the decisions it makes
 - (iv) should be relieved of any role in connection with the GP complaints process.
- 10e WIRRAL: That conference believes that the way GP performance concerns are managed presently is unfair, unjust and unrealistic; and demands that GP performance should be measured against that of busy, practical, everyday GPs rather than against those unachievable unrealistically high standards/ performance of the 'perfect GP about to sit an exam with half hour appointments' as is done presently.
- 10f SOMERSET: That conference believes the arrangements for GPs to join or rejoin the profession are now completely unfit for purpose and, as a first step, asks GPC to press for a merger of the national medical performers list and the General Medical Council GP register.
- * 11 LINCOLNSHIRE: That conference requests that GPC advises on a realistic action plan to:
- (i) provide appropriate value for money mechanisms to give practices constructive feedback
 - (ii) stop inappropriate anonymous feedback systems which allow for trolling and cyber-bullying
 - (iii) ensure feedback and research reports are promulgated appropriately and used to enhance services.
- 11a BARKING AND HAVERING: That conference believes that anonymous complaints should neither be published nor used for rating a practice.
- 11b BARKING AND HAVERING: That conference believes that anonymous complaints made on NHS Choices are derogatory in manner and as they do not publish the responses only demoralises staff.
- 11c BRADFORD AND AIREDALE: That conference is dismayed that malicious and unsubstantiated comments about GP practices are allowed to stand on the NHS choices website whether or not they are truthful and demands that this is changed.
- 11d WORCESTERSHIRE: That conference believes that action is needed to protect practices and individual team members from 'trial by Facebook' and that the regulations should permit the removal of patients who publicly pillory their GP via social media despite being asked to desist.

QUESTION THE CHAIR OF SESSIONAL SUBCOMMITTEE

11.30

Receive a report from the Chair of Sessional GPs subcommittee, Zoe Norris
Followed by a Q&A session from the floor

Members of conference may ask questions from the indicated microphones of the chair of the Sessional GPs subcommittee

SESSIONAL GPs

12.00

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| * | 12 | SUFFOLK: That conference believes GPs are being lost from the workforce unnecessarily, because there is no systematic approach to keeping in touch with freelance GPs and supporting them and tasks GPC with ensuring that government funds, and supports the setting up of national and local solutions. |
| | 12a | NORFOLK AND WAVENEY: That conference asks GPC to improve communication with sessional GPs by: <ul style="list-style-type: none">(i) government policies and priorities that are disseminated from NHSE should be sent directly to all GPs on the performers list(ii) the current mode of cascading information via practices results in ad hoc dissemination of important documents(iii) the current official ways of transmission of information are not available to sessional GPs who work only as locum GPs(iv) the uneven dissemination of information risks disenfranchising sessional GPs and eventually risks alienating this section of the workforce crisis. |
| | 12b | CUMBRIA: That conference believes that locum GPs are often missed out of vital communications from NHSE, the Patient Safety Agency and CCGs and this places them at personal risk and calls on GPC to negotiate with NHSE for a national communications strategy to secure adequate communication of guidelines and patient safety communications to locums. |

PENSIONS

12.10

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| * | 13 | AGENDA COMMITTEE TO BE PROPOSED BY SOMERSET: That conference instructs GPC to enter into urgent discussions on NHS pensions to ensure that: <ul style="list-style-type: none">(i) the paperwork for locum GPs is simplified on to a single form(ii) disincentives to GPs to remain in the scheme are removed(iii) all GPs providing NHS services are allowed to be part of NHS pension schemes(iv) all GPs may choose to superannuate less than 100% of their NHS earnings |
| | 13a | SOMERSET: That conference instructs GPC to enter into urgent discussions with the Department of Health on NHS pensions so that anomalies in the system affecting general practice are eliminated, ensuring in particular that: <ul style="list-style-type: none">(i) the paperwork for locum GPs is simplified on to a single form(ii) disincentives to senior GPs to remain in the scheme are removed(iii) Limited Liability Partnerships are allowed to offer NHS pensions(iv) blocks preventing subcontractors in working in new models of care from offering NHS pensions are removed. |
| | 13b | 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. |
| | 13c | DEVON: That conference calls on the government to improve the pension arrangements for GPs over a certain age to incentivise them to continue to practice for a few more years to fill the impending workforce crisis until the promised extra GPs complete their training. |

- 13d GLOUCESTERSHIRE: That conference believes the current NHS pension arrangements for locum GPs are inefficient and waste a significant amount of NHS administrative resource and therefore calls for:
- (i) the GPC to negotiate the necessary changes to allow the replacement of the current (locum A, B and solo) forms with a single annual online form per employer/locum
 - (ii) the establishment of a simple electronic payment system allowing monthly or annual direct debits
 - (iii) recognition that, as likely net contributors, locum doctors are valuable members of the NHS pension scheme and should be treated as such
- 13e AYRSHIRE AND ARRAN: That conference demands that all four UK governments urgently negotiate at a national level to make superannuation for OOH GP work optional thereby encouraging more GPs to work out of hours to help alleviate the workforce crisis.
- 13f BUCKINGHAMSHIRE: That in the light of the recent and successful judges case in the high court over age discrimination in changes to GP pension arrangements, conference instructs GPC with BMA to explore a similar challenge on behalf of GPs.
- 13g BRADFORD AND AIREDALE: That conference asks the government, and chancellor, to acknowledge that recent punitive changes to the NHS pension scheme have hastened the early retirement of senior GPs who are urgently needed on the frontline of primary care. For younger GP principals, the new pensions system actively disincentivises people to take on additional funded NHS roles.

CORE GP CONTRACT

12.20

- * 14 WALTHAM FOREST: That conference demands that GPC develops a definitive list of what is included in the core contract to enable practices to focus NHS resources on delivering essential services.
- 14a HULL AND EAST YORKSHIRE: That conference is concerned that many GPs are asked to provide unfunded services to their patients and asks GPC to urgently define what is a non-essential service as per the general medical services contract and provide robust guidance on how GPs can safely withdraw from providing these services.
- 14b NORTH AND NORTH EAST LINCOLNSHIRE: That conference is concerned that many GPs are asked to provide unfunded services to their patients and asks GPC to urgently define what is a non-essential service as per the general medical services contract and provide robust guidance on how GPs can safely withdraw from providing these services.
- 14c SANDWELL: That conference calls on the GPC to work to reduce the non-clinical burden on practices, by clearly defining GMS core contract work and declaring practices to be AQP for non-core work.
- 14d LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference calls upon GPC to finally define core GP services.
- 14e NORTHUMBERLAND: Accountable care organisations are built on the concept of clarity of clinical pathways and roles. It is imperative that for the stability of primary care within the new models of working, that the core services of primary care are clearly defined.
- 14f BRENT: That conference accepts that the time has come to finally consider exactly what is classified as GMS core, and what constitutes an additional service and calls upon GPCE to produce guidance accordingly, to support the English LMCs in their local commissioning arrangements.

CONTINGENCY

CHARITIES

12.50

Dain Fund

- 15 Receive: Report by the Chair of the Dain Fund (Dr Mike Downes).

Claire Wand Fund

- 16 Receive: Report by the Chair of the Claire Wand Fund (Dr Russell Walshall)

Cameron Fund Annual General Meeting

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

LUNCH

13.00

These debates are being conducted under SO 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.

The agenda committee has received a number of motions grouped under some general topics, and after consideration believes that conference would be best served by a more open debate on the first day with feedback to conference on the second day.

The format of the session is that a GPC lead will introduce the topic then we will spend approximately an hour discussing the issue & finish with half an hour to collate what we want to take back as feedback and what motions may go to conference for voting. Motions arising from these debates, and reports to conference, will be considered on Friday afternoon from 3pm.

These sessions will all run in parallel at the same time. Members of conference can each attend whichever session they choose, though LMCs with multiple representatives should attend a mixture of the sessions.

The Agenda Committee has designed these sessions to be attended in full. Moving between sessions is discouraged after they start.

BRIDGING THE GAP (RATIONING) – THEMED DEBATE 1 (TD1)

The funding allocated to NHS services is insufficient to meet the needs and wants of the population. This impacts on our day to day lives as clinicians, and within our LMCs. How can we manage within these funding constraints?

Members of conference and observers will be asked to consider, but are not restricted to, the following key questions:

- should we use clinical or financial criteria to prioritise services? Which is more important?
- how should we manage local policies that contradict national guidelines?
- is patient education a priority? Do they need education as to how to use services more effectively?
- should we have an open debate with the public about services that are not currently funded? Who should lead this debate – the government, the commissioners, the medical profession, or someone else?
- is it possible for the NHS to survive with insufficient government resources? Should we look at alternative funding solutions, or co-payments?

BRIDGING THE GAP (RATIONING) – MOTIONS

TD1-1	NORTH YORKSHIRE: That conference believes that CCGs should not impose blanket treatment thresholds especially where these are specifically against NICE guidance
TD1-2	NORTH YORKSHIRE: That conference calls for greater transparency around rationing.
TD1-3	NORTH YORKSHIRE: If CCGs and the government fail or decline to discuss rationing with the public then conference believes that GPs have the right to do so.
TD1-4	GLASGOW: That conference believes that the rising workload in the NHS is unsustainable and that urgent action by the government is required to address patients' expectations and what the NHS can reasonably deliver to the public.
TD1-5	NORTH YORKSHIRE: That conference believes NHS rationing is inevitable. NHSE and government will not discuss this due to the political implications. The GP profession demands that GPC shows some genuine leadership and engage the country in discussion on what should be rationed.
TD1-6	NORTH YORKSHIRE: That conference believes that the governments need to be fully transparent to the public regarding significant local differences in NHS funding in primary care, driven by political effect, not health economical needs, which accelerates health care inequalities and maintains a post code lottery, that puts well-being and potentially lives at risk.
TD1-7	NORTH YORKSHIRE: That conference believes that primary care and the wider NHS are in crisis due to a lack of funding and in the absence of government engagement with the public on this matter, GPC has a duty to bring this to the country's attention and highlight the true severity of the situation so the public can begin meaningful dialogue about what they want their future NHS to look like, and would wish to see funded through general taxation.
TD1-8	WALTHAM FOREST: That conference challenges the government to have an open and honest public debate on what the NHS can actually afford to fund.
TD1-9	AYRSHIRE AND ARRAN: That conference calls on the Scottish Government to hold a public debate about the principals of 'realistic medicine' thus clarifying what areas of healthcare will be funded by the NHS.
TD1-10	<p>NOTTINGHAMSHIRE: That conference believes some CCGs put prescribing cost savings ahead of appropriate clinical behaviour and so, to avoid a post code lottery, suggests that the:</p> <ul style="list-style-type: none"> (i) prescribing budgets for all CCGs nationally are taken over by NHSE and costs are met centrally (ii) government fully fund the cost of clinical pharmacists for all GP practices.
TD1-11	CAMBRIDGESHIRE: That conference calls on the GPC to lobby the government to instruct NICE not to limit their considerations to factors such as QALYs but to also take account of the costs to the health economy as a whole when making recommendations.
TD1-12	<p>CAMBRIDGESHIRE: That conference believes that GPs:</p> <ul style="list-style-type: none"> (i) provide clinical opinions with limited resources (ii) have a capacity to err, which is innate in human experience (iii) protect patients by only referring when a clinical need exists to minimise the risk of harm from over-investigation and over treatment, the benefit of which has never been fully recognised.
TD1-13	BEDFORDSHIRE: That conference calls for GPC to work with the Department of Health to develop a more rational approach to prescription charges and in particular to the exemptions policies which are anomalous and unfair.
TD1-14	<p>NEWCASTLE AND NORTH TYNESIDE: That conference believes that charging patients for NHS prescriptions:</p> <ul style="list-style-type: none"> (i) contradicts the principle that health care should be funded out of general taxation and be free at the point of need (ii) makes the extension of payments by patients such as co-payments, fees for GP NHS services, or fines for patients more likely (iii) should be abolished in England.

TD1-15	DERBYSHIRE: That conference calls upon the GPC Executives and the Department of Health to implement a campaign to inform organisations and the public about what is appropriate to request from GPs in the light of the current workforce crisis.
TD1-16	BEDFORDSHIRE: That conference calls on GPC to press for a national information campaign aimed at all NHS providers and commissioners to inform them that winter occurs in December, January and February each year.
TD1-17	DERBYSHIRE: That conference demands that GPC England Executive attempts to engage with NHS England to identify those areas of work that GPs are incentivised to do that have no or poor evidence bases and to explain to the public that they will no longer be provided as NHS services.
TD1-18	MANCHESTER: That conference believes the nation should be educated to access health care services responsibly, with particular attention to reducing expectation of prescriptions for minor or self-limiting conditions.
TD1-19	CORNWALL AND ISLES OF SCILLY: This conference believes that 'non-means tested free at the point of care' is an unsustainable healthcare model for an aging population and calls on the <ul style="list-style-type: none"> (i) medical profession to show leadership about this issue as MPs clearly will not (ii) GPC to encourage proper public discussion via the media about the pros and cons of alternative models to meet the health needs of the UK.
TD1-20	GLOUCESTERSHIRE That conference believes the government needs to be honest about what sort of health service it is willing to pay for.
TD1-21	HERTFORDSHIRE: That conference calls on government to be explicit with the public about what is affordable and will continue to be free at the point of care.
TD1-22	NORTHERN IRELAND CONFERENCE OF LMCs: That conference instructs GPC to ensure that any changes to the GP contract will include measures to manage demand such as co-payments.
TD1-23	BARNET: That conference instructs the GPC to initiate a full open debate with the GP community regarding whether practices should start directly charging patients for GP services, which services should be available on the NHS and which services should only be available by payment of a fee.
TD1-24	BRADFORD AND AIREDALE: That conference believes that any patient wishing to access routine primary care outside core hours should be self-funding. In a climate where the NHS and individual CCGs are looking at what services should not be included under NHS provision, this should be high on the list.
TD1-25	SHROPSHIRE: That conference believes attempts to increase GP capacity by extending opening hours or using other health professionals has failed, and proposes that the emphasis must now switch from increasing capacity to reducing demand and that the most effective way to do this would be to introduce a token 'charge' for GP consultations (with a mechanism to reimburse the elderly and those on low income).
TD1-26	AVON: That conference calls upon the government to mount a national public health awareness campaign to encourage patients to take more responsibility for the management of their own health with the object of reducing the workload demand on general practice.
TD1-27	CLEVELAND: That conference insists that the UK governments must put much greater resources into patient education and that they should: <ul style="list-style-type: none"> (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.
TD1-28	AYRSHIRE AND ARRAN: That conference insists that the four UK governments: <ul style="list-style-type: none"> (i) need to be more honest and open with the public in terms of the limited resources available (ii) should support self-care and empowerment of individuals to seek advice/care from other sources of service provision through national campaigns/media initiatives rather than primary care being portrayed as the first port of call for minor, self-limiting and social care issues.

TD1-29	<p>BIRMINGHAM: That conference urges GPC to take steps to secure the delivery of an ongoing demand management programme for general practice including:</p> <ul style="list-style-type: none"> (i) public information (ii) patient education (iii) advice to health, social care and other partners.
TD1-30	<p>GLOUCESTERSHIRE That conference believes there should be a coordinated national campaign to educate patients on self-management and alternative points of care</p>
TD1-31	<p>WIGAN: That conference questions whether there is sufficient evidence to show that patient self-care can truly relieve the pressure of demand for GP/general practice contact. It asks the GPC to take an evidence based position on this and not to allow un-evidenced supposition to dull its demands for practice funding.</p>
TD1-32	<p>CORNWALL AND ISLES OF SCILLY: This conference believes that “care should be free at the point of access” is strangling the 21st Century NHS and should be replaced with “no one should be prevented from receiving the care they need through poverty”.</p>
TD1-33	<p>KENT: That conference demands the BMA/GPC, acknowledging the low level of health spend as a percentage of GDP in the UK, launches a public debate to openly discuss the limitations on healthcare provision and rationing decisions that need to be made and are currently being enacted by CCGs.</p>
TD1-34	<p>LIVERPOOL: That conference believes that the GPC and BMA should work to actively dispel the myth that the NHS is unaffordable and promote the fact that the NHS is the most cost-efficient universal health care system in the world.</p>
TD1-35	<p>NEWCASTLE AND NORTH TYNESIDE: That conference believes that charging patients may have a negative and destabilising impact on NHS primary care and requests the GPC to do further work to highlight the unforeseen effects.</p>
TD1-36	<p>DERBYSHIRE: That conference exhorts the Department of Health to instigate a national debate on what:</p> <ul style="list-style-type: none"> (i) the public want from general practice (ii) patients with diagnosed health problems want from general practice
TD1-37	<p>CORNWALL AND ISLES OF SCILLY: That conference believes that the current policy of promising with one hand and then taking away with the other is resulting in a primary care service that is now at breaking point to the detriment of both patient care and the NHS. PART 2</p>
TD1-38	<p>WILTSHIRE: That conference contends that NHS general practice has become financially unviable in many areas and:</p> <ul style="list-style-type: none"> (i) instructs GPC to give practices advice on how to 'go 100% private' (ii) asks GPC to negotiate terms under which NHSE would support those patients who cannot afford to pay per consultation (iii) insists that all UK permanent residents have a right to NHS care which includes NHS prescriptions and instructs GPC to negotiate the availability of NHS prescriptions to patients of private GPs (iv) insists that private GPs should have access to NHS secondary care referrals for their patients.
TD1-39	<p>NORTH YORKSHIRE: That conference demands GPC to make steps to convert general practice into a private service.</p>
TD1-40	<p>NORTHAMPTONSHIRE: That conference demands that the GPC urgently looks at alternatives NHS provision of primary care and produce robust legal and financial advice on viable alternatives within the next six months.</p>
TD1-41	<p>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:</p> <ul style="list-style-type: none"> (i) legal consultation for premises funding (ii) scoping a system of itemised billing for services in a manner similar to our dental colleagues.

TD1-42

BUCKINGHAMSHIRE: That conference believes that:

- (i) attempts to negotiate improved funding and support for primary care have failed to mitigate the crisis that faces general practice
 - (ii) given the current attitude and lack of support demonstrated by politicians in power towards GPs, further negotiations are very unlikely to be fruitful, and
- calls upon the BMA and GPC to develop, publish and widely distribute to all practices, alternative contract and income consultation plans, which will include a private primary care service.

CONTRACTUAL STATUS/RISK/INDIVIDUAL SURVIVAL - THEMED DEBATE 2 (TD2)

The independent contractor model has long been the norm in General Practice. In recent years however, for a variety of reasons, many GPs are not keen on becoming partners any longer. New GPs are opting to either locum or be salaried; while a considerable number of older GPs are turning their backs on partnerships, resulting in many Practices struggling to recruit partners and some folding up.

The objective of the themed debate will be to consider the inherent issues in this rather complex situation, and come up with some ideas. While we would be looking at the pros and cons of the various models, the main aim is not to affirm that one model is better than the other. Rather, we should perhaps be examining ways that we could work together for the continuing benefit of our patients and the enhancement of our professional satisfaction and fulfilment.

Representatives will be asked to consider but are not restricted to, the following key questions:

- has the independent contractor model reached the 'end of the road'?
- is a full salaried model realistic and or desirable?
- what is the future of the locum model of work?
- is list based practice a gold standard?
- how can we guard against divide and rule?
- how should we work to protect and promote what matters to the profession?
- how could the independent contractor model be protected or promoted?

CONTRACTUAL STATUS / RISK / INDIVIDUAL SURVIVAL – MOTIONS

TD2-1	HAMPSHIRE AND ISLE OF WIGHT: That conference affirms in the value of the partnership model and advises that the governments should invest to allow partners and salaried GPs to provide a comprehensive primary care service free at the point of delivery.
TD2-2	HERTFORDSHIRE: That conference believes in light of the future workforce actively choosing non-principal contractual models, GPCUK should be preparing a workstream to investigate and mitigate the profession for a post-partnership environment.
TD2-3	DERBYSHIRE: That conference instructs GPC England Executive to produce a SWOT analysis of changing to an entirely salaried general practice service.
TD2-4	HAMPSHIRE AND ISLE OF WIGHT: That conference believes the NHS cannot afford a solely employed model of general practice.
TD2-5	WILTSHIRE: That conference warns that patient continuity will fail under a solely salaried service and that once continuity is completely lost that general practice will provide less value for money. (Supported by Dorset)
TD2-6	WILTSHIRE: That conference warns that an entirely employed model and the loss of the partnership model would be devastating for the NHS.
TD2-7	NORFOLK AND WAVENEY: That conference believes a robust and well-resourced partnership model for general practice is better for the NHS than a salaried service.
TD2-8	NORFOLK AND WAVENEY: That conference believes there are serious flaws in the current independent contractor status and seeks a new model which will support new models of care.
TD2-9	SOUTHWARK: That conference rejects the practice model whereby a minority of GPs hold a practice contract on the basis that: <ul style="list-style-type: none"> (i) fellow GPs' autonomy is compromised (ii) the vocational aspect of general practice is diminished (iii) the earning potential of GPs is restricted in an already financially unstable system.
TD2-10	CITY AND HACKNEY: That conference believes that GPC should represent equally partners and non-partners when discussing new models of care.
TD2-11	AVON: That conference believes that the very survival of LMCs is under threat by new models of care and requests that the GPC ensure: <ul style="list-style-type: none"> (i) new contractual arrangements include a provision for payment and collection of levy payments (ii) GPs do not lose their only independent, statutory representation (iii) an improved system for identifying and supporting locum GPs (iv) private providers are under the same obligation to fund LMC levies as current NHS providers.
TD2-12	HAMPSHIRE AND ISLE OF WIGHT: That conference believes that GP partnerships have reached their maximum risk capacity and that in order to innovate and transform, we must enable risk to be shared whilst ensuring that local GPs retain control of the system. (Supported by Dorset)
TD2-13	CAMBRIDGESHIRE: That conference believes that as a result of an ever increasing workload, the profession needs better ways of managing risk and calls on the GPC to help practices ease this burden.
TD2-14	OXFORDSHIRE: That conference believes that constructing partnerships and future GP providers on a skill mix model using a range of new GP like performers places an indemnity and monitoring burden on those who hold the contract and calls on those constructing future contracts to recognise this in their design and negotiations.
TD2-15	WILTSHIRE: That conference believes the NHS cannot afford a solely employed model of general practice.

TD2-16	<p>AVON: That conference recognises that partnership is in danger of becoming a non-viable business model for general practice. It calls upon government to be:</p> <ul style="list-style-type: none"> (i) open and transparent about, its plans for the future of general practice (ii) accountable for providing appropriate resource to enable general practice to thrive.
TD2-17	<p>THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:</p> <p>That conference considers new models of care and demands GPC to ensure that any employment contracts are equitable for all types of GPs regardless of their current contractual status.</p>
TD2-18	<p>DORSET: That conference affirms the value of the partnership model and asks the government to invest to allow partners and salaried GP's to provide a comprehensive primary care service free at the point of delivery.</p>
TD2-19	<p>DORSET: That conference warns that an entirely employed model and the loss of a partnership model would be devastating for the NHS.</p>
TD2-20	<p>EAST SUSSEX: That conference believes:</p> <ul style="list-style-type: none"> (i) general practitioners should be rewarded for making a long-term commitment to working within practices, either as partners or as salaried colleagues (ii) continuity of patient care is good quality patient care (iii) general practitioners working as locums fulfil a valuable role in ensuring a flexible workforce (iv) the increasing number of general practitioners who choose to work as locums is symptomatic of the challenges faced by general practice. <p>(Supported by Croydon)</p>

WORKING AT SCALE – THEMED DEBATE 3 (TD3)

Further to the recent GPC conference of Working together to sustain General Practice, motions submitted have expressed the views that independent general practices have had their day and that a move to being part of integrated providers of primary care is now inevitable. Themes that have been expressed in motions received so far include:

- GPs should remain within the NHS
- necessity of flexibility of working
- the future of general practice is being damaged by the processes around contracting for and working to scale
- new models of care require adequate resource
- need to see evidence base that 'at scale' working provides better outcomes than traditional practice based contracts
- national vs local contracts & contract holding vs working to contract
- issues around multi-speciality community provider (MCP) contracts:
 - level of bureaucracy
 - lack of protection for individual contract holders to the liability from the implications of pooled budgets
 - preservation of the tenure of GMS and PMS contracts
 - lack of focus on patient care and standards of service
- need for the GPC to produce a clear, concise practical guide to its implementation of these different contract models.

WORKING AT SCALE – MOTIONS

TD3-1	SOMERSET: That conference believes that the transition from small independent general practices to integrated providers of primary care is now inevitable and that GPC needs to recognise this and structure its support for GPs and practices appropriately.
TD3-2	HAMPSHIRE AND ISLE OF WIGHT: That conference believes GPs should remain within the NHS but via 'at scale working' and with the ability to choose to be an independent contractor, salaried GP or have a portfolio career and change this at any stage of their career.
TD3-3	DORSET: That conference believes that GP's should remain within the NHS but via at scale working but that they should be able to be flexible as to whether this is delivered either via an employed or independent contractor model.
TD3-4	WILTSHIRE: That conference believes that the future of general practice is being damaged: <ul style="list-style-type: none"> (i) by the processes for bidding for working at scale (ii) by the application process and allocation to receive GPFV funding (iii) and that under investment in existing NHS general practice is a deliberate policy choice.
TD3-5	DORSET: This conference supports working at scale and new models of care but insists that it is adequately resourced in terms of both leadership and management's support and therefore mandates the GPC to demand this from NHSE.
TD3-6	WILTSHIRE: That conference supports working at scale and new models of care but insists that it is adequately resourced both in terms of leadership and management support.
TD3-7	WIGAN: That conference questions the compatibility of Service Delivery Footprints introduced in connection with at scale, place based, integrated working, with a consistent delivery of care across a practice's registered population.
TD3-8	BRADFORD AND AIREDALE: That conference believes that, whilst 'general practice at scale' is the mantra of the government and CCGs, flexibility, reactivity and the ability to provide continuing care to our patients are essential attributes to providing excellent care in general practice. These attributes will be reduced or lost, if GPs are pressured into working at scale.
TD3-9	TOWER HAMLETS: That conference believes that GP hubs: <ul style="list-style-type: none"> (i) do very little to ease the overall workload pressures in general practice (ii) threaten the future of general practice as more and more services are subsumed into them (iii) should be rejected by general practice.
TD3-10	TOWER HAMLETS: That conference is gravely concerned that the direction of travel of general practice is away from nationally negotiated GMS contracts to 'at scale' APMS contracts and untested organisations such as MCPs.
TD3-11	GLOUCESTERSHIRE: That conference would like to see the evidence that clusters of 30,000 patients are any better served than those by traditional General practice.
TD3-12	DORSET: That conference believes that the bidding process to allow practices to work at scale is detrimental to the future of individual practices.
TD3-13	WILTSHIRE: That conference demands a choice of contracts for general practice in order to get the best deal for patients and doctors.
TD3-14	NORTH YORKSHIRE: That conference recognises and accepts that we cannot prevent traditional general practice from dying a slow painful death because of the government's agenda, so focus should shift to looking at different business models for how 30,000 GPs will earn a living in a future health service.
TD3-15	DORSET: That conference believes that allied health professionals have the potential to save general practice from disaster: <ul style="list-style-type: none"> (i) if they are providing additional capacity (ii) if they are under the operational control of general practice (iii) and asks GPC to support the introduction of these professionals into general practice.

TD3-16	<p>HAMPSHIRE AND ISLE OF WIGHT: That conference believes that allied health professionals have the potential to save general practice from disaster, but only if:</p> <ul style="list-style-type: none"> (i) they are providing additional capacity (ii) they are under the operational control of general practice (iii) ending employment liability is not held by GP partners (iv) contracts are held by MCPs.
TD3-17	<p>BOLTON: That conference believes there is a clear conflict of interest when Acute and Foundation Trusts are running primary care services which could impact on their income and general practice is better placed to run primary care services due to an intimate knowledge of the local community.</p>
TD3-18	<p>DORSET: This conference believes that practice mergers can offer an answer to the current crisis by improving retention of doctors, promoting energy, enthusiasm and flexibility and creating a feeling of empowerment and therefore asks GPC to negotiate financial and managerial support for them from NHSE.</p>
TD3-19	<p>WILTSHIRE: That conference believes that practice mergers offer an answer to the current crisis in general practice and:</p> <ul style="list-style-type: none"> (i) improve retention of all doctors (ii) promote creative energy and enthusiasm (iii) promote flexibility of working (iv) allow greater control over destiny.
TD3-20	<p>WILTSHIRE: That conference with regard to practice mergers, believes that the cost of merging should be fully funded in keeping with the GP Forward View.</p>
TD3-21	<p>CAMDEN: That conference demands that GPC negotiates with government new funding and support to develop collaborative groups such as primary care homes / neighbourhoods / CHINs and that these initiatives will not commence until appropriate funding and infrastructure is in place.</p>
TD3-22	<p>SCOTTISH CONFERENCE OF LMCs: That conference:</p> <ul style="list-style-type: none"> (i) believes that patients should be able to self-refer to a wider range of allied health professionals within primary care (ii) insists that waiting times to see allied health professionals in primary care should be no greater than that to see a GP.
TD3-23	<p>GLOUCESTERSHIRE That conference holds that funding aimed at 30,000 clusters will not help general practice anything like as well as direct payments to practices.</p>
TD3-24	<p>HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the headlong rush to transformation including the emphasis on hubs is in danger of throwing the baby out with the bathwater by damaging practice based care and continuity for patients.</p>
TD3-25	<p>HAMPSHIRE AND ISLE OF WIGHT: That conference believes hubs should be available to all patients at a locality level but that attendance must only be via the GP practice with which the patient is registered.</p>
TD3-26	<p>DORSET: That conference believes that hubs should be available to all patients at a locality level but that attendance should be via GP practices and asks GPC to support local schemes along these lines.</p>
TD3-27	<p>HERTFORDSHIRE: That conference recognises that working at scale can bring financial and practical challenges for practices that have been largely underplayed by commissioners in the rush to promote collaborative working, and calls on GPC to do more to support practices to address these challenges.</p>
TD3-28	<p>LAMBETH: That conference opposes initiatives to promote 'working at scale' on account of its lack of evidence base; and calls upon GPCE to campaign for investment to be diverted from such vanguards back into practice contract baselines.</p>
TD3-29	<p>SOUTHWARK: That conference rejects the government's preferred model of general practice provision at scale and has significant concerns that this model will lead to a greater iniquitous divide between contract holding GPs and GPs working under a contract of employment.</p>

TD3-30	LIVERPOOL: That conference believes that in view of the recent National Audit Office report on integrating health and social care failing to provide better outcomes for patients or any compelling evidence of saving money or reducing admissions, GPC calls on the government to avoid a headlong rush into integration as a way of compensating for a lack of proper funding of social and health care.
TD3-31	SHROPSHIRE: That conference welcomes initiatives and funding to encourage employment of alternative clinicians to help ease the workforce crisis in general practice, but calls upon the government to ensure clearer recognition of their role with the introduction of dedicated professional representative bodies and indemnity.
TD3-32	<p>AGENDA COMMITTEE: That this conference with respect to multi-speciality community provider (MCP) contracts:</p> <ul style="list-style-type: none"> (i) believes that they are over bureaucratic (ii) believes that they do not protect individual contract holders liability from the implications of pooled budgets (iii) believes that they do not preserve the tenure of GMS and PMS contracts (iv) believes that they lack focus on patient care and standards of service (v) asks GPC to produce a clear, concise practical guide to its implementation
TD3-33	DORSET: That conference believes that if allied health professionals are to work in general practice then enduring employment liability and contracts should be held by MCPs.
TD3-34	GATESHEAD AND SOUTH TYNESIDE: That conference believes that in order to facilitate working at scale, the new multi specialty community provider contract should not have an arbitrary time limit, which places it at risk of being subject to retendering after a fixed period of time. Furthermore, practices entering into such a contract should have a guaranteed right of return to a GMS contract if they so wish.
TD3-35	LEEDS: That conference is alarmed at the number of practices that have closed in the last year and believes this is a direct result of the failure of government to invest in general practice, address dangerous levels of workload and enable the recruitment of sufficient staff and demands that urgent action is taken to address this crisis.
TD3-36	GLASGOW: That conference believes that list based general practice remains the most best way to deliver primary care and that the new staff employed to support general practices need to be attached and based in GP practices.
TD3-37	DORSET: That conference believes that for the voluntary MCP contract to work bureaucracy must be minimised and barriers removed and asks GPC to support local groups as they work towards it.
TD3-38	<p>KENT: That conference feels that the multi specialty community provider contract framework does not go far enough in:</p> <ul style="list-style-type: none"> (i) protecting the liability of individual contract holders from the implications of pooled budgets (ii) preserving the tenure of GMS and PMS contracts (iii) protecting GPs from further unfunded work being transferred from secondary care.
TD3-39	<p>WILTSHIRE: That conference agrees that in order for the voluntary MCP contract to be a successful way to deliver primary care it:</p> <ul style="list-style-type: none"> (i) willing GPs must be resourced to drive it forward (ii) there must be adequate communication with all parties (iii) there must be a minimum of bureaucracy and barriers.
TD3-40	DORSET: That conference believes that the voluntary MCP contract could work if it places the patient at the centre and maximises benefits and minimises risks and therefore asks GPC to produce a clear, concise practical guide to its implementation.
TD3-41	<p>SOUTH STAFFORDSHIRE: That conference worries about the implications of the new MCP contract on the autonomy of GPs and asks:</p> <ul style="list-style-type: none"> (i) for an open debate about the partnership v salaried GP model (ii) that the BMA takes a strong stand against any move towards the fully-integrated MCP model, until general practice itself is sustainable and until such a time that the alternative offer provides more security of tenure (perpetuity) and stability for GP colleagues and primary care health teams.

TD3-42	SOMERSET: That conference believes that the government's attempts to force GP practices into rigid national MCP or PACS contracting models by refusing to amend the rules on access to the NHS pension scheme and on VAT exemption to allow local flexibility are a serious threat to GP sustainability and urges GPC to redouble efforts to resist them.
TD3-43	<p>WILTSHIRE: That conference:</p> <ul style="list-style-type: none"> (i) abhors the way the government has circumvented our GPC negotiators with its invitation-only voluntary contract negotiating panel (ii) instructs the GPC to produce a clear, concise LMC, stepwise, practical guide to the implementation of the MCP voluntary contract.
TD3-44	<p>LEEDS: That conference believes that the MCP contract arrangements developed by NHS England</p> <ul style="list-style-type: none"> (i) will lead to the end of the independent contractor system for general practice (ii) will lead to the vast majority of GPs working as employees of larger organisations (iii) will ultimately lead to a worse rather than better service for patients (iv) are not the best way for practices that want to improve community based services (v) should not be promoted to practices as the primary way to work at scale.
TD3-45	SHROPSHIRE: That conference believes the development of hubs and multi-speciality community providers may dilute the unique selling point of GPs – their personal relationship with their patient and the continuity of care that this ensures.
TD3-46	LEEDS: That conference believes that employed GPs working in MCPs should be offered the equivalent of an NHS consultant contract with national terms and conditions, and directs GPC to develop such a contract with NHS England.
TD3-47	LEEDS: That conference believes that the requirement to put MCP contracts out to tender will inevitably lead to multinational companies running MCP organisations and directs GPC to make the public aware of the impact of this change to their GP service.
TD3-48	<p>HULL AND EAST YORKSHIRE: That conference accepts that MCPs and ACOs are being considered by some GPs. However, we are worried that these focus mainly on contracting and have very little information on patient care and standards of service. We ask GPC to:</p> <ul style="list-style-type: none"> (i) provide guidance on how GPs locally can ensure that high standards of patient care and good governance can be incorporated into the contracts that are being developed (ii) lobby CCGs to ensure that general practice is appropriately involved at the heart of the decision making processes of these new structures. <p>(Supported by North and North East Lincolnshire)</p>
TD3-49	<p>HULL AND EAST YORKSHIRE: That conference is worried about the lack of clarity in the MCP contract about premises and asks GPC to address this.</p> <p>(Supported by North and North East Lincolnshire)</p>
TD3-50	CITY AND HACKNEY: That conference believes that the GPC should negotiate with the Department of Health to ensure that at scale providers, such as MCPs, should employ GPs on a standard salaried contract.
TD3-51	<p>SCOTTISH CONFERENCE OF LMCs: That conference:</p> <ul style="list-style-type: none"> (i) believes that patients should be able to self-refer to a wider range of allied health professionals within primary care (ii) insists that waiting times to see allied health professionals in primary care should be no greater than that to see a GP.
TD3-52	NORTHAMPTONSHIRE: That conference insists federations and MCPs must demonstrate that they are value for money, fit for purpose and sustainable whilst reducing the workload of GPs.

GP FORWARD VIEW/URGENT PRESCRIPTION FOR GENERAL PRACTICE – THEMED DEBATE 4 (TD4)

In January 2016, the Special LMC Conference instructed GPC to negotiate a rescue package for general practice. GPC identified a number of actions required to provide a sustainable future for general practice, and published “Our Urgent Prescription for General Practice”. This was followed by the subsequent publication of “General Practice Forward View” by NHS England.

12 months have now passed since these documents were published, but is general practice being rescued? Are sufficient measures being implemented to ensure safe and sustainable care for our patients? Can we be confident for the future of NHS general practice?

The Agenda Committee has received a number of motions expressing views and opinions on what has (or hasn't) happened over the last 12 months, what still needs to be achieved, and what actions require to be taken to deliver the desired results.

Given the range of issues to be debated, the Agenda Committee has concluded that the most constructive way to address these issues is to hold an open debate on the first day of Conference, with appropriate feedback to all members of Conference at a plenary session the following day.

The format of the open debate will include an introduction by the Chair of GPC, approximately 60 minutes of debate on the issues, and approximately 30 minutes to collate feedback to be delivered the following day.

Representatives are not restricted in the issues they choose to discuss, but may wish to consider:

- is general practice being allocated sufficient new money?
- is enough new money actually reaching general practice?
- are there issues relating to implementation and what could be done differently?
- has there been any impact on the onerous workload in general practice?
- will the proposals deliver safe and sustainable levels of workload in future years?
- has the recruitment and retention crisis in general practice been adequately addressed?
- is the “General Practice Forward View” fit for purpose?
- will the “General Practice Forward View” rescue general practice if delivered in full?
- will full delivery of “Our Urgent Prescription for General Practice” provide safe and sustainable patient care?
- what further steps do representatives wish to be taken by government?
- what else should be done by GPC?
- how should individual general practitioners respond?
- is there still a need to consider appropriate forms of action, and would this be effective or counter-productive?

GP FORWARD VIEW / URGENT PRESCRIPTION FOR GENERAL PRACTICE – MOTIONS

- TD4-1 HERTFORDSHIRE: That conference has no confidence in the General Practice Forward View as it has
- (i) failed to make any impact into the recruitment and retention crisis facing general practice
 - (ii) failed to deliver any resources necessary to transform and sustain primary care
 - (iii) failed to make any inroad into the unmanageable daily workload within general practice
- TD4-2 LAMBETH: That conference agrees that:
- (i) the funding announced as part of the GPFV is insufficient for the purposes of sustaining general practice
 - (ii) that it is a disgrace that the allocated 16/17 monies have not reached a majority of practices by mid March 2017
 - (ii) the spring budget confirms that the government has no intention of stabilising or supporting general practice
- and calls on conference:
- (iii) to declare the GPFV unfit for purpose
 - (iv) to mandate GPCE to consider how in light of (iii) it will revise its urgent prescription and take this forward.
- TD4-3 WORCESTERSHIRE: That conference believes that so far the GP Forward View has done almost nothing to solve the GP crisis and request GPC continue to push for decent funding to implement our urgent prescription for general practice policy.
- TD4-4 LEEDS: That conference believes the promised funding of £2.4bn in the GP Forward View is being delivered too slowly and demands that NHS England dramatically increase the speed of investment to solve the crisis in general practice that is a reality now.
- TD4-5 MID MERSEY: That conference believes that the monies promised in the GPFV are not being delivered and asks the GPC to hold the government to account.
- TD4-6 BUCKINGHAMSHIRE: That conference has no confidence in the likelihood of the GPFV rescuing current general practice as
- (i) it fails to provide any uplift to the funding of essential and additional services
 - (ii) funding eg for transformation is inequitable for differing areas in the country
 - (iii) it requires practices to waste time funding bids which fit all the required criteria but do not result in any payments
 - (iv) the funding envelope is too small and investment by 2020 is too late.
- TD4-7 EALING, HAMMERSMITH AND HOUNSLOW: That conference regrets that the GPFV 'rescue package' for English general practice was too little, too late, and that the reduction in QOF targets has been replaced with equally onerous pressures on practices to undergo whole system transformation and accept yet more secondary care 'leftward shift' of clinical work without adequate resources, and calls upon GPCUK/E to negotiate for ring fenced funding for general practice backfill to enable local leaders to consider, canvas and potentially implement local working at scale arrangements.
- TD4-8 SOUTHWARK: That conference has no confidence in the GPFV to address the dire recruitment and retention challenges facing the profession; and calls upon GPCE to collaborate with the RCGP in applying pressure to government in addressing this.
- TD4-9 BRADFORD AND AIREDALE: That conference acknowledges that the implementation of the GP Forward View has been far too slow, overly bureaucratic for practices and that realistically there has been no change in day to day front line services or support for GPs and other primary care professionals. This cannot be tolerated, and the government needs to act immediately to back up their offer of support with improved funding for primary care.
- TD4-10 NORTH YORKSHIRE: That conference believes that the GPFV is failing to offer what promised and has not provided stability to general practice.

TD4-11	WILTSHIRE: That conference believes that GPs have jumped through every hoop set up by NHS England and the devolved governments but are not seeing any benefits and demands that the money promised to the devolved nations and in England within the GPFV needs to begin flowing immediately.
TD4-12	HAMPSHIRE AND ISLE OF WIGHT: That conference believes that GPs have jumped through every hoop set up by NHS England but are not seeing any benefits and demands that the money promised within the GPFV needs to begin flowing immediately.
TD4-13	DORSET: That conference believes that GPs have jumped through every hoop set up by NHSE but the money promised within the GPFV has not begun to flow and therefore calls on GPC to challenge the LATs to provide transparency and demonstrate where the money has gone.
TD4-14	DORSET: That conference calls for the funding promised in the GPFV to start flooding into general practice. Of and when this occurs, realistic timescales must be given in order to properly draw up plans to effectively and efficiently utilise this public money.
TD4-15	DERBYSHIRE: That conference is dismayed at the timing surrounding the implementation of the GP Forward View, noting that nothing happened for many months after the publication of the documents and then CCGs were issued with very detailed guidance on a return to NHS England that, they were required to make within a two week timescale.
TD4-16	BEDFORDSHIRE: That conference believes that while GPFV was always “too little, too late”, NHS England’s failure to expedite most of the measures in the document has had the reverse of its intended effect: morale has fallen, more practices are handing back their GMS contracts and GPs close enough to retirement have decided it’s time to hang up their stethoscopes.
TD4-17	<p>THE GPC: That the GPC seeks the views of conference on the following motion: That conference strongly supports GPC England in its demand that NHS England guarantees:</p> <ul style="list-style-type: none"> (i) that all monies announced as part of the GP Forward View (GPFV), including the £171 million transformation funds, is new money for general practice and not recycled from other parts of the existing spend on GP services (ii) that any funding within the GPFV not spent in any given financial year is not lost to general practice (iii) to underwrite the GPFV monies for GPs in areas where the CCGs are in deficit or financial difficulties and where this threatens local funding of GPFV commitments (iv) that all funding promised to general practice within the GPFV will not be spent/lost/subsumed into any other healthcare sector, nor be returned to nor retained by the Treasury.
TD4-18	SURREY: That conference supports the work of GPC in ensuring monitoring of the implementation of the GP Forward View proposals within CCGs and by NHS England local Offices.
TD4-19	LANCASHIRE COASTAL: That conference believes that GPC should call on the government to recognise that general practice nationally is grossly underfunded and that sections of the service are at imminent risk of collapse, and further calls on the GPC to recruit the public in support of immediate remediation by significantly increasing funding and reducing demand.
TD4-20	OXFORDSHIRE: That conference believes that the fundamental cause for the crisis in general practice is the growing gap between resources for core services and demand on practices. Conference therefore mandates GPC to make involvement with further government initiatives dependent upon the government acting to restore core funding to a level that makes general practice sustainable.
TD4-21	<p>BIRMINGHAM: That conference requests the GPC to hold NHS England and the Department of Health to account for full delivery of the:</p> <ul style="list-style-type: none"> (i) GP Forward View, and (ii) urgent prescription for general practice.
TD4-22	CENTRAL LANCASHIRE: That conference believes that the comments by the prime minister in January 2017 about the service offered by GPs to their patients demonstrates a complete lack of understanding of the crisis that primary care is facing and instructs GPC to seek an assurance from the prime minister that general practice is indeed at the core of the success of the NHS the service and will be funded accordingly.

TD4-23	WIGAN: That conference requests the GPC to demand of the Prime Minister that she publicly recognises the work undertaken by GPs and their teams in providing first line healthcare. That she acknowledge that GP principals typically work on average 11-12 hour days and when not providing extended hours surgeries at weekends, spend this time reviewing discharge letters and care plans etc.
TD4-24	GREENWICH: That conference demands that GPFV funding be allocated directly to individual practices so that it will have a tangible effect at the individual practice level
TD4-25	DEVON: That conference calls for funding to be streamlined so that government investment into general practice is directed into the global sum rather than into separate tranches that may be difficult to access.
TD4-26	BIRMINGHAM: That conference believes GPC should negotiate an adequate global sum rather than allowing the GPFV to dangle increasingly complicated and out of reach carrots that do not deliver and have no impact on workload or patients' quality of care.
TD4-27	BRENT: That conference: <ul style="list-style-type: none"> (i) deplores the lack of progress in releasing GPFV funds into general practices, and (ii) calls upon GPCE to negotiate with NHSE incorporating the remainder of the GPFV funds from 1 April 2018 into practice baselines, as practices are ideally placed to identify how to use monies in their patients' best interests.
TD4-28	HERTFORDSHIRE: That conference believes if the government is truly in favour of a forward view for the survival of general practice, the outstanding monies ring fenced for this purpose should be put directly into practice baselines from April 1st 2018 to enable providers to provide, commissioners to commission, and call an end to the immoral waste of time and energies that has encapsulated the GPFV deckchair rearrangement exercise since its announcement in April 2016.
TD4-29	BRENT: That conference believes with the benefit of hindsight, that the outcomes negotiated by GPCUK for general practice in 2016 fell far short of the necessary requirements to see the sustainability of safe NHS general practice, and that the changes to the 2017-2018 contract do not fully address this issue and now calls for GPC E to investigate how best to seek a mandate from the profession in England to legally apply utmost pressure to the government to alleviate the unsafe working conditions that English GPs now face.
TD4-30	TOWER HAMLETS: That conference observes that regarding Motion S20 from the January 2016 Special Conference of LMCs: <ul style="list-style-type: none"> (i) motion S20 was passed with a large majority at LMC special conference 2016 (ii) general practice continues to be under resourced and to suffer from an unprecedented workforce crisis (iii) GPC chose not to enact motion S20 (iv) this conference demands that GPC ballot GPs as to whether they would be prepared to collectively close their lists in response to this crisis.
TD4-31	AVON: That conference is dismayed at the failure of the GPC to act upon the mandate to explore industrial action granted to them by the emergency conference of January 2016. It therefore formally requests that GPC England follows the lead taken by its Northern Irish counterpart and to grow a backbone.
TD4-32	DONCASTER: That conference demands a written apology from the GPC in recognition of the failure of GPC and NHSE to produce and deliver a rescue package mandated by the Emergency Conference of LMCs in 2016, thereby contributing through inaction to the closure of a number of practices across the UK. (Supported by Sheffield and Rotherham)
TD4-33	CAMBRIDGESHIRE: That conference welcomes the GP Forward View investing in general practice but regrets how the funds have become over-managed, underspent and driven by the year end.

TD4-34	<p>EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the delay in allocating resilience funding to general practice and conflating the supporting vulnerable practices ring fenced funding with the GPFV resilience programme, and:</p> <ul style="list-style-type: none"> (i) demands that NHSE and CCGs act swiftly to relieve pressure on practices who are in imminent danger of closing and (ii) calls for resilience monies to be directed urgently to relieve the current staffing crisis in practices.
TD4-35	<p>GLOUCESTERSHIRE That conference is very concerned that resilience moneys have merely funded an army of 'change managers', care navigation and coding trainers, legal purveyors and mediators rather than properly and directly resourcing practices.</p>
TD4-36	<p>ISLINGTON: That conference requires LMCs to be fully involved in assuring the allocation of GP Forward View monies.</p>
TD4-37	<p>HAMPSHIRE AND ISLE OF WIGHT: That conference finds that Local Area Teams are currently acting as a roadblock to the flow of resources in the NHS and calls on LATs to provide transparency, identify the funding and demonstrate the delivery of the GPFV to local general practices.</p>
TD4-38	<p>DERBYSHIRE: That conference regrets the non-recurrent nature of several of the funding streams in the GPFV, given that they are designed to plug workforce gaps, not to generate extra income.</p>
TD4-39	<p>NOTTINGHAMSHIRE: That conference welcomes any new investment into general practice but contends that there is a real risk that the delivery of the GPFV will be greatly hampered and proposes that:</p> <ul style="list-style-type: none"> (i) NHS England is requested to directly inform practices of all schemes via their own website and directly via email (ii) NHS England provides transparency over the use of funding allocated with regular reports at regional level of spend against scheme (iii) GPC lobbies NHS England to ensure that any underspend against the allocated funding is made available to practices to spend on a fair shares basis.
TD4-40	<p>HAMPSHIRE AND ISLE OF WIGHT: That conference believes:</p> <ul style="list-style-type: none"> (i) that the 5YFV has significantly benefitted neither GPs nor their patients (ii) is not the charter for general practice that conference unanimously voted the government should be challenged to sign (iii) if such a charter had been produced the recent political attacks on general practice would have been mitigated.
TD4-41	<p>LEEDS: That conference:</p> <ul style="list-style-type: none"> (i) is gravely concerned about the unacceptable waiting times for children and adults with mental health problems to access psychological therapies (ii) sees little or no sign of an increase in the number of mental health therapists promised both in the GP Forward View and Implementing the Five Year Forward View for Mental Health (iii) believes that the failure to invest in mental health services has a detrimental impact on patients, families and carers, GP practices, the wider NHS and social care system and society as a whole (iv) demands that the government does more than simply speak of parity of esteem for mental health services, but instead properly and urgently invests in an expanded and sustainable mental health service.
TD4-42	<p>LEEDS: That conference believes that the GP Forward View pharmacy scheme should provide sustainable, recurrent funding to enable an increase in the deployment of pharmacists within practices, and should not be limited to a reducing amount over three years.</p>

TD4-43	<p>LEEDS: That conference believes the current workload pressure in general practice is unsafe and unsustainable and:</p> <ul style="list-style-type: none"> (i) that the UK government is ultimately responsible for this and should take responsibility for any harm that patients suffer as a result (ii) that a rapid expansion in the general practice workforce is required to deal with this (iii) demands that sustained and significant investment above the commitments made in the GP Forward View must be made available to support an expansion of the general practice workforce as a matter of urgency (iv) calls for further investment in practice premises to enable practices to provide increased space for an expanded workforce to deliver services to patients.
TD4-44	<p>COVENTRY: That conference believes practices looking to establish new models of working (such as docman management at a distant site) in primary care should expect robust and clear support from NHS England, the CQC and the indemnity providers to accept and endorse these changes as part of the ten high impact areas.</p>
TD4-45	<p>DORSET: That conference asks GPC to demand that NHS England stops imposing ridiculous timescales for practices to submit bids for funding. More haste, less speed?</p>
TD4-46	<p>WORCESTERSHIRE: That conference believes that the rhetoric from NHS England at a national level is not being matched by delivery on the ground with respect to the GP crisis.</p>
TD4-47	<p>GLASGOW: That conference insists that the additional investment that has been announced for primary care and GP services should be spent on actual services that will reduce general practice workload and not to relieve secondary care or health board pressures.</p>
TD4-48	<p>MID MERSEY: That conference believes that general practice is working at capacity and cannot continue without additional significant financial input.</p>
TD4-49	<p>NORFOLK AND WAVENEY: That conference believes the current resilience funding for practices is too little, too late and poorly targeted to help practices teetering on the edge of survival.</p>
TD4-50	<p>LEEDS: That conference is alarmed at the number of practices that have closed in the last year and believes this is a direct result of the failure of government to invest in general practice, address dangerous levels of workload and enable the recruitment of sufficient staff and demands that urgent action is taken to address this crisis. PART 2</p>
TD4-51	<p>LANCASHIRE COASTAL: That conference believes that NHSE needs to urgently revise the current GP workforce plans as there are grave concerns that the current national plans to increase the number of GPs in England is failing, the workforce crisis in general practice is worsening rapidly and is destabilising the ability of the NHS to deliver the 5 year forward view.</p>
TD4-52	<p>WALTHAM FOREST: That conference notes with regard to the NHS GP health services:</p> <ul style="list-style-type: none"> (i) conference applauds the creation of the NHS GP health services but questions why it took so long to create this service (ii) instructs GPC to negotiate with the NHS a protected funding stream for this service to guarantee its existence in perpetuity.

WORKLOAD – THEMED DEBATE 5 (TD5)

Further to the recent GPC conference and other work on managing workload, many motions have been submitted. GPs remain concerned about the safety of patients, the quality of care and the personal impact on GPs themselves faced by ever increasing workload pressures.

The key questions are:

- how far has the BMA quality first agenda reached and helped practices, and how can it be built on?
- how far have recent developments in the standard hospital contracts delivered improvements?
- how far can workload be limited by professional control over the amount of work we are able to do, and if so how?
- does the profession wish to see external mandated limits on safe workload, and how might that work?

WORKLOAD – MOTIONS

TD5-1	<p>AGENDA COMMITTEE TO BE PROPOSED BY SHEFFIELD: That conference recognises the excessive workload burden on UK general practice and:</p> <ul style="list-style-type: none"> (i) commits the GPC to explore and agree with NHS UK a safe limit to the number of consultations taken each day by a general practitioner (ii) believes that the GPC should revisit the delivery of the demand of the Socialist Charter for Health 1965 the “the family doctor must have a working day which leaves him/her some time for leisure”
TD5-2	<p>SHEFFIELD: That conference recognises the excessive workload burden on UK general practice and commits the GPC to explore and agree with NHS England a safe limit to the number of consultations taken each day by a general practitioner. (Supported by Barnsley, Doncaster and Rotherham)</p>
TD5-3	<p>LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference calls upon the GPC to define what is the maximum number of patient contacts in a working day.</p>
TD5-4	<p>BEDFORDSHIRE: That conference believes that GPC should revisit and negotiate the delivery of the demand of the Socialist Charter for Health 1965 that “the family doctor must have a working day which leaves him/her some time for leisure”.</p>
TD5-5	<p>SHROPSHIRE: That conference accepts the general practice is in crisis and suggests, for the safety of patients and doctors, it should be recognised that twenty five consultations a day may be enough.</p>
TD5-6	<p>SCOTTISH CONFERENCE OF LMCs: That conference recognises that workload in general practice is at a critical level and is potentially compromising patient and clinician safety and demands that urgent action is required immediately to address this problem.</p>
TD5-7	<p>CAMDEN: That conference calls on GPC to:</p> <ul style="list-style-type: none"> (i) lobby the government to publicly state that 15 minute GP appointments should be the minimal standard recognising the increased age and complexity of the patients we serve, and that for many patients far longer appointments are required to enable general practice to safely manage the large-scale transfer of work from secondary to primary care (ii) negotiate an increase in GP funding to enable sufficient resources to fund 15 minute GP appointments.
TD5-8	<p>BEDFORDSHIRE: Article 24 of the declaration of human rights states “everyone has the right to rest and leisure, including reasonable limitation of working hours”. Currently as numbers of GPs are falling, list sizes rising and workload increases many GPs are working well beyond such hours. Conference calls for GPC to negotiate terms which recognise this basic and essential right.</p>
TD5-9	<p>SOUTH STAFFORDSHIRE: That conference believes that GP workload is no longer sustainable and demands that the BMA negotiates a GMS contract which:</p> <ul style="list-style-type: none"> (i) restricts patient contacts to no more than 25 per day between contracted working hours (ii) extends all routine/booked GP appointments to 12 minutes as a minimum (iii) ensures that GPs are only responsible for work that it generated by GPs and not third parties.
TD5-10	<p>SANDWELL: That conference calls on the GPC to unilaterally declare that in the interests of patient safety and quality, a GMS session will consist of 13 consultations per session in 2018, falling to 9 consultations, each of 15 minutes duration by 2020:</p> <ul style="list-style-type: none"> (i) nine such sessions per week should be provided for every 1500 patients (ii) experienced practitioners, who have the personal capacity to safely deliver additional consultations, should be commissioned to do additional consultations, in their own practice or in a hub (iii) this will adequately recompense high performing GPs and allow adequate remuneration for additional GPs for those principles who otherwise risk burn out.
TD5-11	<p>NORFOLK AND WAVENEY: That conference recognises general practice can build the opportunities to develop GP services and ensure that it is an attractive and flexible career path for doctors and nurses but only if there is a clear recognition of workload implications and subsequent robust long-term contracts.</p>

TD5-12	NORFOLK AND WAVENEY: That conference asks GPC to determine a workload to what a GP can safely undertake in a day without affecting the health and well-being of their patients or themselves. This should include all work including face to face, telephone consults and visits as well as clinical paperwork, form filling and CQC/appraisal work. Education should be factored in.
TD5-13	YORKSHIRE REGIONAL COUNCIL: 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 local hub, a walk-in centre or A+E.
TD5-14	BIRMINGHAM: That conference requests that BMA commissions research into decision fatigue in general practice and its potential impact on patient safety.
TD5-15	GLASGOW: That conference believes that due to the current workforce crisis and the rising workloads in general practice that every and each GP practice is vulnerable.
TD5-16	GLOUCESTERSHIRE That conference believes, with regret, that general practice is close to or suffering from a humanitarian crisis in many parts of the UK.
TD5-17	DERBYSHIRE: That conference requires the GPC England Executive to engage with NHS England to devise a simple model and mechanism for: <ul style="list-style-type: none"> (i) general practice or groups of general practices to declare when demand exceeds capacity (ii) setting out how the NHS and social care services should respond when general practice or groups of general practice declare that demand exceeds capacity.
TD5-18	DERBYSHIRE: That conference notes the regular declarations of 'black alert' by hospitals when they are full and can accept no more patients and demands that a similar system of alerting exist for general practice and conference instructs BMA Council and the GPC to initiate such a system with or without government cooperation.
TD5-19	MANCHESTER: That conference agrees that the usual length of appointments for all GPs should be 15 minutes
TD5-20	BUCKINGHAMSHIRE: That conference insists that GPs must be given the legal right to control their workload to ensure safe care of patients.
TD5-21	NORFOLK AND WAVENEY: That conference believes that workload pressures are at the very heart of recruitment difficulties and early retirements and calls on GPC to negotiate: <ul style="list-style-type: none"> (i) fully funded extended primary care teams to include pharmacists, physiotherapists and physician associates (ii) safe workload and time limits for the benefit of both GPs and patients alike (iii) reduction in administrative burden of appraisals, revalidation and CQC inspections (iv) full training and better remuneration of receptionists so they become 'care navigators'.
TD5-22	WILTSHIRE: That conference calls for a funded educational campaign: <ul style="list-style-type: none"> (i) for the general public to enable patients to manage their own health (ii) including the management of minor illnesses to be included within the national curriculum.
TD5-23	DORSET: That conference believes that the government should fund public health education to enable patients to look after their own health and also that this education should be part of the national curriculum.
TD5-24	LIVERPOOL: That conference believes that the constant push by the Department of Health for same day access to care to satisfy demand management is interfering with the ability of GPs to maintain continuity of care for patients with complex needs, to the detriment of the quality of care, and, increasing costs and time required to provide that care.
TD5-25	CORNWALL AND ISLES OF SCILLY: This conference believes that unless workload is limited there is no future for a national GP contract.
TD5-26	OXFORDSHIRE: That conference believes that given the current mismatch between demand and resources in the GMS contract, home visits should be limited to the bed bound and terminally ill, and calls on the GPC to devise and then negotiate a way of achieving this.

TD5-27	<p>EAST SUSSEX: That conference:</p> <ul style="list-style-type: none"> (i) notes the increasing burden of work placed upon out-of-hours GP services due to overload of in-hours GP services (ii) acknowledges the consequent increased blurring of boundaries between in-hours and out-of-hours GP services (iii) calls for out-of-hours GP services to be properly funded in order to maintain adequate and sustainable rota commitments (iv) calls for out-of-hours element of GP indemnity payments to be reduced (v) calls for the provision of commonality of computer systems between in-hours and out-of-hours GP services.
TD5-28	<p>CENTRAL LANCASHIRE: That conference believes that an over emphasis on access in the evenings and weekends sacrifices safety through continuity of care with a patient's own practice and detracts from the need to invest in improving access during core hours which is vitally required to avoid patients seeking other sources of medical help.</p>
TD5-29	<p>THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:</p> <p>That conference believes that housebound patients requiring home visits should be obliged to register at the surgery closest to their home.</p>
TD5-30	<p>BARKING AND HAVERING: That conference believes that practices are struggling to cope with increasing demand while no action exists for DNAs (did not attend) against patients.</p>
TD5-31	<p>OXFORDSHIRE: That conference believes that in current circumstances of inordinately long GP working days, home visiting all but the bed bound and terminally ill is no longer possible, and calls on the GPC to devise and negotiate a new system that uses GP time more wisely</p>
TD5-32	<p>NORTH STAFFORDSHIRE: That conference believes that:</p> <ul style="list-style-type: none"> (i) unless patient demand is urgently curtailed general practice is unlikely to survive, with dire consequences for the NHS as a whole (ii) the disinvestment in public health spending is at odds with the government's desire to promote healthy lifestyles and does nothing to stem patients' demands on the GP's workload, and urgently needs to be reversed and strengthened (iii) the GPC should demand that our government urgently develops a structured and sustained national campaign to improve health literacy and self-care, which stretches from cradle to grave and which amongst others encompasses a more prominent role for health education in schools and access to an NHS self-care app for all (which has resulted in a 12% reduction in GP consultations in The Netherlands within 2 years).
TD5-33	<p>BARNET: That conference recognises that the current unsurmountable pressures on general practice are destabilising general practice and that GPC should fully support general practices in refusing to engage in schemes, such as care closer to home networks (CHINS) and quality improvement support teams (QISTS), that are insufficiently resources and have no evidence that they improve the stability of practices.</p>
TD5-34	<p>CAMBRIDGESHIRE: That conference in light of the ever increasing workload and to keep patients safe, calls on the GPC to define the number of patients, based on list size, that can be safely managed by a practice in any one day.</p>
TD5-35	<p>HAMPSHIRE AND ISLE OF WIGHT: That conference believes that general practitioners impose on themselves too much responsibility for the welfare of the NHS at huge personal cost, and</p> <ul style="list-style-type: none"> (i) should concentrate on their duties to patients (ii) should support those with true responsibility for the NHS only to the extent that this does not harm the care of our patients (iii) should engage our patients fully in holding to account those responsible for the current state of the NHS.
TD5-36	<p>GLASGOW: That conference recognises that workload in general practice is at a critical level and is potentially compromising patient and clinician safety and demands that urgent action is required immediately to address this problem.</p>

QOF AND GP FUNDING – THEMED DEBATE 6 (TD6)

General practice has been chronically under resourced. The current GMS Contract has been in place since 2004 and the economic conditions under which this contract was negotiated have drastically changed. Simon Stevens has suggested that QOF, which was an integral part of the 2004 GMS contract, has reached the end of its useful life.

The themed debate will be to consider how we best utilise QOF funding, whether or not the current GMS contract is still fit for purpose and if a new contract was negotiated what would the key principles be that the profession would want adopted within this.

Representatives will be asked to consider but are not restricted to, the following key questions;

- has QOF reached the end of its useful life?
- should QOF money be reallocated into core funding? If so, would this help to stabilise general practice?
- what are the positive outcomes from QOF? How do we preserve these? Should there continue to be monitoring of these areas?
- do we need a new national contract to replace the current GP contracts? If so, should a new contract:
 - be based on activity or capitation?
 - only nationally negotiated KPIs? If so, within the financial constraints how do we address local issues?
 - reintroduce the principle of a Basic Practice Allowance?

QOF AND GP FUNDING - MOTIONS

TD6-1	<p>LEEDS: That conference:</p> <ul style="list-style-type: none">(i) agrees with Simon Stevens that QOF has reached the end of its useful life(ii) insists that all QOF funding should remain within the GMS/PMS contract to support core activity(iii) believes that computer system prompts should be retained to support clinical decision making and long-term condition management(iv) believes that any future data extraction should be to support professionally-led peer review and not a new pay for performance scheme.
TD6-2	<p>BRADFORD AND AIREDALE: That conference demands a commitment that any alternative funding to QOF stays accessible to practices independent of size and preferably through reinvestment in the global sum.</p>
TD6-3	<p>GATESHEAD AND SOUTH TYNESIDE: That conference believes that QOF has now spent its usefulness and should be removed entirely and all the funding reallocated into the global sum.</p>
TD6-4	<p>GATESHEAD AND SOUTH TYNESIDE: That conference insists that services that are offered on a voluntary basis for practices to take up such as QOF, enhanced services etc. should not be used as a means to measure the performance of GPs and practices by appraisal systems, CQC and NHS England.</p>
TD6-5	<p>AVON: That conference believes that QOF is now outmoded and out dated. It has become a distraction from the provision of targeted care to those who most need it and that funding for chronic disease management should all be moved into the global sum.</p>
TD6-6	<p>MANCHESTER: That conference agrees QOF funding should go into core practice funding with the aim of supporting long term conditions.</p>
TD6-7	<p>LEEDS: That conference believes that the system of maintaining a database of indicators that are no longer in QOF (INLIQ) should end and calls for a new professionally supported arrangement for extracting data to enable GP peer quality reviews.</p>
TD6-8	<p>BRADFORD AND AIREDALE: That conference believes QOF should not be scrapped. Instead it should be improved, expanded and made compulsory. General practice funding is far too reliant on capitation via the global sum and QOF combines both payment for quality and payment for activity and as such should be supported.</p>
TD6-9	<p>NOTTINGHAMSHIRE: That conference believes the relevance of QOF has greatly deteriorated as a tool to drive up quality and calls for its abolition and the transfer of funding into the global sum.</p>
TD6-10	<p>NORTHERN IRELAND CONFERENCE OF LMCs: That conference calls on GPC to renegotiate the GP contract in order to preserve a safe and effective general practice service within the NHS.</p>
TD6-11	<p>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.</p>
TD6-12	<p>MID MERSEY: That conference believes that the government has failed to respond to the ever increasing complexity of patients being treated in general practice and demands a comprehensive review of the GP contract to reflect this increased workload.</p>
TD6-13	<p>LAMBETH: That conference rejects any form of locally negotiated key performance indicator in practice contracts save for the national core contract.</p>
TD6-14	<p>BEDFORDSHIRE: That conference calls on GPC to negotiate for the Basic Practice Allowance, or similar, to be reintroduced.</p>
TD6-15	<p>BEDFORDSHIRE: That conference believes that the reintroduction of the Basic Practice Allowance (or similar) should happen as a matter of urgency as an incentive/inducement to both existing and potential GP partners and that this would be far more effective than any of the measures of the GPFV.</p>
TD6-16	<p>NORFOLK AND WAVENEY: That conference believes that the GMS contract is no longer fit for purpose and instructs GPC to negotiate a different payment model based on activity.</p>

- TD6-17 BEDFORDSHIRE: That conference believes that the ethos behind the BPA from 1966 would do more for general practice than the 5YFV.
- TD6-18 LEWISHAM: That conference demands that the GPCUK executive team explores the creation of a new minimum practice income guarantee as a future method of securing funding for general practice to guarantee partners a protected income stream
- TD6-19 WEST PENNINE: That conference believes a payment per contact system could be the way to address the imbalance in primary care funding.

*	18	AGENDA COMMITTEE TO BE PROPOSED BY MID MERSEY: That conference, in relation to non-contractual letters and reports: (i) believes the workload associated with reports requested by the DWP is disproportionate to the fee received, and demands that this be urgently reviewed (ii) demands that collaborative arrangements are honoured (iii) demands a review of the reimbursement associated with the copying of records to reflect the true cost (iv) asks the GPC to publish advice for GPs on the potential medico-legal dangers of 'fit to participate in...' forms (v) requires that the public be clearly informed regarding documentation that is not part of the GP contract.
	18a	MID MERSEY: That conference notes with concern the growing trend of local authorities to expect general practitioners to write reports without remuneration where these were previously funded under the collaborative arrangements and calls on the GPC to: (i) lobby for a change in attitude towards paying for such reports (ii) produce guidance in the form of a list of such activities (iii) attempt to negotiate the re- instatement of the collaborative arrangements.
	18b	LOTHIAN: That conference believes that the workload associated with PIP documentation is disproportionate in terms of the fee received and demands that this be urgently reviewed.
	18c	CUMBRIA: That conference believes that the reimbursement associated with the copying of records are out of date and do not reflect the true cost of this function and instructs GPC to make representations to the appropriate authorities to have these reimbursements revised.
	18d	DEVON: That conference asks the GPC to publish advice for GPs on the potential medico-legal dangers of completing the increasing number of 'fit to participate in' forms.
	18e	GLOUCESTERSHIRE That conference requires the public to be clearly informed regarding documentation that is not part of the GMS contract in order to avoid wasting patient and professional time.
	18f	LOTHIAN: That conference demands, in terms of our social security bureaucracy, that: (i) no letter should be requested of GPs for a benefits decision without government funding for it (ii) other health professionals closely involved with the patient should be allowed to contribute to DWP documentation (iii) it be considered that the current system increases inequalities by relying on GPs serving the most deprived patients to shoulder the biggest unresourced burden for reports.
	18g	WELSH CONFERENCE OF LMCs: That conference believes the requirement for supporting medical evidence from applicants GPs in benefits applications is either scrapped in its entirety or funded properly via collaborative fees and not at the expense of often vulnerable patients.
	18h	DERBYSHIRE: That conference instructs Council to sort out and modernise the 'collaborative fees' structure in respect of work done by doctors on behalf of local authorities.
	18i	BUCKINGHAMSHIRE: That conference insists that general practice is not a 'free good' for every organisation or government department wanting a medical report, certificate, occupational health service, or attempting to off-load medico-legal responsibilities, and requests GPC to publicise this to relevant organisations.
	18j	LINCOLNSHIRE: That conference calls upon GPC and GPDP to support legal action against local authorities who do not fulfil their responsibilities under the collaborative arrangements by refusing to reimburse the costs of GPs who participate in safeguarding processes.
	18k	ISLINGTON: That conference insists the GPC negotiates to ensure practices are paid appropriately for work undertaken to support fit to work appeals.

18l	HERTFORDSHIRE: That conference believes the department of work and pensions disability assessment is not fit for purpose, creates an egregious and onerous burden of bureaucracy for the GP, and calls upon GPCE to negotiate for a reasonable fee schedule for GPs in cases of preparing evidence for appeals.
18m	LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference calls upon NHSE to provide funding and remuneration for GPs to produce reports for child protection meetings/conferences with immediate effect and to be negotiated locally.
18n	AVON: That conference calls on the GPC to ensure that the government takes steps to reverse the trend for institutional misuse of GPs' time, by halting the practice of inappropriate requests for GP letters from various agencies.
18o	EALING, HAMMERSMITH AND HOUNSLOW: That conference calls on the department for work and pensions to reform the current system of assessment for personal independence payments (PIP) which is undermining the welfare of patients and increasing the workload of GPs and demands the following: <ul style="list-style-type: none"> (i) DWP gives serious weight to long term sickness certificates issued by GPs when assessing eligibility for PIP, thereby reducing appeals and unfunded workload and time away from acute care for GPs by placing value on the professional advice issued by the GP in the MED3 with regard to long term sickness and suitability of work (ii) GPCE negotiate a fee structure with DWP to fund additional workload for the GP in cases of appeal (iii) DWP pays a fee to the GP for ALL further information required should a patient appeal a DWP decision.
18p	MANCHESTER: That conference should work with the NHS to reduce the 'get a note from your doctor' culture.

OTHER MOTIONS (1)

16.10

*	19	HERTFORDSHIRE: That conference notes with alarm the 2016 revisions to recertifying letters of competence in IUCD fitting and SDI fitting and removal and <ul style="list-style-type: none"> (i) believes these changes will have a dramatic effect on doctors able to continue offering this service (ii) believes that the changes discriminate against locum and freelance GPs (iii) believes that this will have a detrimental effect on female patient choice and access to LARC provision (iv) calls upon GPCUK urgently to meet with colleagues from the faculty of reproductive and sexual health certification unit to address this.
	19a	KENSINGTON, CHELSEA AND WESTMINSTER: That conference notes with regret the changes to the recertification on doctors wishing to renew their LARC letters of competence from the FRSH, and how this practically will challenge sessional and locum doctors from being able to continue to provide these essential services to their female patients.
*	20	AGENDA COMMITTEE PROPOSED BY DEVON: That Conference requests the criteria for categorisation as a 'violent patient' be expanded to include unacceptable behaviour outside the practice.
	20a	DEVON: That conference asks the GPC to address the anomaly of a patient only qualifying to be categorised as a 'violent patient' if they have demonstrated violent behaviour within their own GP surgery irrespective of unacceptable behaviour during out of hours clinical interactions.

- 20b NORTH STAFFORDSHIRE: That conference believes that:
- (i) the current protection provided to practice staff from violent patients is inadequate and urgently needs to be addressed
 - (ii) the need for a patient to have committed or threatened a violent act against the practice before they can be considered a danger to and be excluded from the practice and referred to the violent patient scheme is naive in the extreme
 - (iii) the GPC should seek new clear guidance from NHSE which strengthens protection of GP surgery staff and acknowledges that patients who have committed a violent crime outside the practice potentially pose a similar danger inside the practice, and where appropriate should be accepted on the violent patient scheme.
- * 21 CITY AND HACKNEY: That conference insists that as independent contractors, GPs should be permitted to provide and directly charge their registered patients for treatment not available on the NHS.
- 21a CORNWALL AND ISLES OF SCILLY: This conference calls on the GPC to lobby government to change legislation and allow GP's to provide non-NHS private services to their registered patients.
- 21b NORFOLK AND WAVENEY: That conference asks GPC to look into the feasibility and change in regulations to allow GPs to charge their own patients for services no longer covered by local NHS contracts.
- 21c HAMPSHIRE AND ISLE OF WIGHT: That conference believes that in order for the independent contractor status to survive it needs to be released from the restraint of trade of the GMS contract and demands that this is renegotiated.
- 21d DORSET: That conference believes that in order for the independent contractor status to survive it needs to be released from the restraints to private provision from the GMS contract and demands that this is renegotiated.
- 21e NORTH YORKSHIRE: That conference believes that, as practices are getting larger and with no new money coming into primary care, we should instruct GPC to advise a change to the ban on offering services not available on the NHS to their own patients.
- 21f NORTHUMBERLAND: It is outdated and perverse that GPs cannot provide services privately to their registered patients and one which disproportionately disadvantages rural and elderly populations. General practice should have the opportunity to develop as a truly commercial entity and this conference calls on the GPC to amend urgently the regulations that prohibit provision of services to the registered list.
- 21g SOMERSET: That conference believes that the GMS contract restrictions on the provision of non NHS services to the registered patients of a practice are hopelessly out of date and calls on GPC to seek an urgent revision of them as part of the NHS sustainability and transformation process.

INTERFACE WITH A&E

16.40

- * 22 AGENDA COMMITTEE TO BE PROPOSED BY NORFOLK AND WAVENEY: That conference:
- (i) celebrates the hard work and professionalism of colleagues working in emergency medicine
 - (ii) understands that hospitals are under a great deal of pressure at this time
 - (iii) demands that the government withdraws its assertion that the overcrowding of A&E departments is due to general practice
 - (iv) does not support the move to redirect A&E patients to general practice
 - (v) instructs GPC to oppose the placing of GPs in A&E departments as this will further destabilize primary care
- 22a NORFOLK AND WAVENEY: That conference instructs GPC to oppose the placing of GPs in A&E departments as this will further destabilise primary care.

22b	DERBYSHIRE: That conference celebrates the hard work and professionalism of colleagues working in emergency medicine and roundly condemns and totally refutes any suggestion that the capacity problems in hospital emergency departments are the results of acts errors or omissions by GPs.
22c	REDBRIDGE: That conference demands that Teresa May backs up her statement regarding GP availability causing the increase in AE attendances with robust evidence or in the absence of this formally apologises to the profession.
22d	BARNET: That conference is appalled by the suggestion that GPs are in any way responsible for the catastrophe of overcrowding in secondary care.
22e	WANDSWORTH: That conference demands that the government withdraws its assertion that the overcrowding of A&E departments is due to general practice.
22f	GLASGOW: That conference does not support the move to redirect A&E patients to general practice.
22g	WEST PENNINE: That conference believes provision of emergency and urgent care services should be reviewed. (i) putting GPs in A&E is not a helpful solution (ii) 111 calls should be dealt with by a clinician (iii) serious consideration should be given to making A&E a referrals only service (iv) the continued imposition of the four hour target is counter productive.
22h	DERBYSHIRE: That conference asserts that, following the Chancellor's budget announcement of additional funding to place GPs in A&E departments: (i) this fails to recognise the immediate crisis in general practice (ii) with a diminishing GP workforce this is a misguided use of funding (iii) this funding should be directed to supporting the GP workforce in practices.
22i	SUFFOLK: That conference observes that A&E departments are busy because the health system itself is busy and the patients are sick. Conference laments the initiative to place GPs in A&E, noting that the existing GP workforce is stretched, that new vacancies are unlikely to be filled and that this is a fragmentation of primary care; it calls on GPC to negotiate that this new funding be streamed through existing core General Practice instead.
22j	CAMBRIDGESHIRE: That conference whilst acknowledging the crisis in A&E departments this winter, regrets that the government's solution shows a complete lack of understanding of the workforce crisis within general practice and calls upon the GPC to ensure that these solutions do not disrupt the staffing of current in-hours general practice services.
22k	GLASGOW: That conference understands that hospitals are under a great deal of pressure at this time but rejects any suggestion that GPs should be doing more in the community to avoid sending patients into hospital.
22l	NORFOLK AND WAVENEY: This conference believes that front-ending the 111 service with non-clinically trained call handlers who have direct access to booking out of hours appointments has increased pressure on out of hours services and has reduced the effectiveness of that service to respond to the genuine urgent cases.
22m	DEVON: That conference asks the government to reverse its decision to employ GPs to see patients in A&E as: (i) this directly counters GPs efforts to encourage patients not to attend hospital (ii) investing the money directly into GP practices might be a better solution to the A&E problems.
22n	YORKSHIRE REGIONAL COUNCIL: That conference notes the planned investment announced in the Spring budget of £100m to enable a GP to be present in every A+E in England and:- i) believes this will lead to an increase in patients attending A+E; ii) believes this will further undermine the GP recruitment and workforce crisis; iii) demands that investment is made in to general practice to increase capacity to meet patients urgent care needs in the community rather than A+E.

- 22o MERTON: That conference demands that the government and political leaders stops blaming GPs for the lack of NHS investment and resources and acknowledges that
- (i) GPs offer a full 24/7 service, either through the provision of practice-based or OOH-based medicine
 - (ii) the difficulties facing our A&E colleagues is not the fault of general practice.

PRIMARY SECONDARY INTERFACE – TRANSFER OF WORK

- * 23 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference directs the GPC to seek a clear definition of the clinical work being transferred from secondary care into the community and:
 - (i) formally classify this as intermediate care
 - (ii) ensure that GPs are properly remunerated for performing this new clinical role
 - (iii) must robustly resist any further demand on general practice without guaranteed transparent funding
 - (iv) insists that prior to any shift of service from secondary to primary care, the appropriate community services are put in place to manage the increase in workload
 - (v) support practices to reject work which is not appropriately commissioned or suitably funded.
- 23a DEVON: That conference directs the GPC to seek a clear definition of the exponentially increasing clinical work being transferred from secondary care into the community and:
 - (i) formally classify this as intermediate care
 - (ii) ensure that GPs are properly remunerated for performing this new clinical role.
- 23b GWENT: That conference demands that targets are placed on primary care organisations with regard to transfer of resources to primary care and general practice.
- 23c HARROW: That conference calls upon:
 - (i) primary care commissioners to ensure that specialist work outside of practices core contractual requirements is appropriately commissioned, taking full account of GP workload, and is resourced at a rate which enables a sustainable shift from secondary to primary care
 - (ii) practices to reject work which is not appropriately commissioned or sustainably funded.
- 23d DERBYSHIRE: That conference demands that NHS England urgently makes accountable to both primary and secondary care new money to fund adequate resources, both people and technology, to facilitate appropriate clinician to clinician communication between the two sectors.
- 23e WALTHAM FOREST: That conference insists that prior to any shift of services from secondary to primary care, the appropriate community services are put in place to manage the increase in workload.
- 23f CAMDEN: That conference recognises that, while there has been a large increase in the number of hospital consultants over the last 10 years, the number of GPs has barely changed and insists that no further work is transferred from secondary to primary care until the 5,000 extra GPs are in post.
- 23g NORTH YORKSHIRE: That conference believes that general practice cannot absorb any further transfer of work to the community via proposed STPs and that GPC must robustly resist any further reorganisation of primary care without guaranteed transparent funding.
- 23h EALING, HAMMERSMITH AND HOUNSLOW: That conference calls upon CCGs when seeking to commission traditionally secondary care services from primary care, to undertake in collaboration with their LMC a full impact and needs based assessment on local practices including examining local workforce pressures and ensure appropriate and reasonable financial recompense is made to practices in the interests of patient and practitioner safety.
- 23i DEVON: That conference wishes to call the government’s attention to the National Audit Office report about the Better Care Fund, which reaffirms GPs serious concerns about transferring some hospital services and care into the community and indicates that this approach does not tangibly improve patient outcomes, does not reduce emergency hospital admissions nor does it save money.

23j	NORFOLK AND WAVENEY: That conference calls upon GPC to insist that adequate primary and community care is fully funded and already in place prior to any shifts in work from secondary to primary care as outlined in STP plans and that GPFV is the driver for 'transformation' rather than need to bail out secondary care debt.
23k	KENSINGTON, CHELSEA AND WESTMINSTER: That conference calls upon CCGs when seeking to commission traditionally secondary care services from primary care, to undertake in collaboration with their LMC a full impact and needs based assessment on local practices including examining local workforce pressures and ensure appropriate and reasonable financial recompense is made to practices in the interests of patient and practitioner safety.
23l	NORFOLK AND WAVENEY: That conference believes that the transfer of work to general practice from the acute sector is likely to increase further which means that there must be a more robust framework to recognise this workload. Currently there are many ad hoc local enhanced service arrangements which only partly recognises this transfer of workload by some CCGs.
23m	NORFOLK AND WAVENEY: That conference believes that any new work must be fully funded by NHSE/ CCGs from transformation funds and not just PMS monies.
23n	NORFOLK AND WAVENEY: That conference instructs GPC to design a framework which recognises the workload and cost implications of transfer of work to general practice. To ensure that such workload is recognised and appropriately remunerated.
23o	KENT: That conference insists that CCGs should properly enforce secondary care contractual obligations that protect primary care from the shift of inappropriate workload.
23p	GLASGOW: That conference is concerned that rising pressure on secondary care services will increasingly impact on general practice workloads.
23q	BARNET: That conference refuses to support community care integration until CCGs and health boards adequately support effective community services.

PRIMARY CARE SUPPORT ENGLAND (CAPITA)

17.00

* 24	AGENDA COMMITTEE TO BE PROPOSED BY LEEDS: That conference believes Capita's management of Primary Care Service England has been shambolic and: <ul style="list-style-type: none"> (i) demands that the support services for general practice must be returned to being delivered by an NHS organisation (ii) demands that GPs are compensated appropriately for any financial losses and extra work done by primary care, due to its incompetency (iii) demands that NHSE take urgent action to resolve any outstanding payment issues relating to LMCs (iv) is dismayed by the inability of PCSE to produce an accurate performers list (v) believes the public needs to be fully informed about the financial damage to the tax payer and the risk to the medical profession.
24a	LEEDS: That conference believes that LMCs have been badly let down by Capita/PCSE and demand that NHS England take urgent action to resolve any outstanding payment issues relating to LMCs.
24b	LEEDS: That conference believes Capita's management of Primary Care Service England has been shambolic and demands that the support services for general practice must be returned to being delivered by an NHS organisation.
24c	CAMBRIDGESHIRE: That conference believes that, in the interests of patient safety, an accurate performers list must be maintained and, being dismayed by the inability of PCSE to produce one, believes that NHS England is acting unlawfully by allowing this situation to persist.
24d	MID MERSEY: That conference believes that the current arrangements for access to the National Performers List held by CAPITA is not fit for purpose.

24e	NORTH YORKSHIRE: That conference believes the public needs to be fully informed about the financial damage to the tax payer and the risk to the medical profession as well as the health of patients caused by the apparent inadequacy and lack of competence of Capita, the sole provider for primary care support services framework over the last two years
24f	<p>AVON: That conference believes that the NHSE procurement process has been an unmitigated disaster, as highlighted by the awarding of contracts to providers such as Capita. In order to ensure NHS providers and patients do not suffer any further:</p> <ul style="list-style-type: none"> (i) it should be scrapped or reformed urgently (ii) contracts should never be awarded to the cheapest, but to the safest and most competent provider.
24g	NEWCASTLE AND NORTH TYNESIDE: That conference believes that NHS England would have been more popular if the '£250 for Capita' had been accompanied by a promise that NHS Commissioners would in future exclude the company from bidding for NHS contracts.
24h	<p>SUTTON: That conference agrees that:</p> <ul style="list-style-type: none"> (i) the PCSE services provided by Capita are not fit for purpose (ii) that the £3m recurrent money announced in the recent GMS contract changes for 17/18 to account for the increase in practice workload relating to records transfer is insufficient as it does not take into account the extra workload caused due to delays around the Performers List and other services provided by Capita; and (iii) calls upon the GPC to negotiate full cost reimbursement for practice work caused by the failing of Capita. <p>(Supported by Lambeth)</p>
24i	BRADFORD AND AIREDALE: That conference recognises the significant impact the outsourcing of the primary care services has had on general practice, and calls on the GPC to demand compensation from Capita to recompense general practice for the time and workload involved.
24j	<p>KENSINGTON, CHELSEA AND WESTMINSTER: That conference:</p> <ul style="list-style-type: none"> (i) has no confidence in Capita's complaints procedures and the ability of Capita to resolve GP payments issues arising from complaints, and (ii) calls upon GPCE to negotiate a reasonable outcome and reimbursement of lost practice income from the failures of the PCSE Capita contract.
24k	<p>DERBYSHIRE: That conference:</p> <ul style="list-style-type: none"> (i) condemns the shoddy arrangements made by the government to outsource back office functions of the NHS to private contractors for the provision of services such as the administration of GP provider and performer lists, the transfer of GP patient records, the administration of sessional doctor pension payments and GP trainee HR functions (ii) instructs the BMA and the GPC to pursue both the government and the contractors for full recompense for the financial losses or extra work incurred by doctors as the result of such defective or inadequate arrangements (iii) demands that the government in future NHS outsourcing projects not only takes into account the past track record of bidders but also invite stakeholders onto the selection panel.
24l	<p>HERTFORDSHIRE: That conference deplores the ongoing chaos caused by the transfer of support services to Capita and calls on GPC to</p> <ul style="list-style-type: none"> (i) insist that PCSE does not pursue any list cleansing exercises until all the outstanding issues relating to the transferred services have been resolved (ii) ensure practices receive adequate compensation for the additional work caused to them.
24m	LIVERPOOL: That conference believes that GPC must press for a change to the Performers List regulations on the grounds that Capita and NHS England have been unable to process GP changes to the Performers List in a timely fashion, thus preventing some GPs who are fully able, to practice elsewhere in the United Kingdom, from working as GPs in England.

24n	<p>SEFTON: That conference declares that:</p> <ul style="list-style-type: none"> (i) Primary Care Support England is incompetent (ii) the refusal of NHS England to disclose details of whether and how it evaluates the performance of PCSE, is a disgraceful concealment of this incompetence (iii) the privatisation of these services has failed and NHS England should bring them back into in-house provision forthwith.
24o	<p>MID MERSEY: That conference believes that Capita:</p> <ul style="list-style-type: none"> (i) is not fit for purpose and (ii) demands that its contract with the NHS be withdrawn with immediate effect (iii) demands that GPs are compensated appropriately for extra work due to its incompetency.
24p	<p>LEEDS: That conference believes that locum GPs have been badly let down by Capita/PCSE and demands that NHS England take urgent action to resolve pension statement issues and to compensate any locum GP who loses out as a result of management failings.</p>
24q	<p>LANCASHIRE PENNINE: That conference believes that the recent experience of outsourcing core NHS administrative services to Capita was ill conceived, very poorly planned and implemented, and asks GPC to make the strongest representations to NHSE that such an experience of total failure of service should never be repeated.</p>
24r	<p>DERBYSHIRE: That conference demands that the individuals, both commissioners and providers, who have been ultimately responsible for the shambles that has been the PCSE procurement be identified and held publicly to account.</p>
24s	<p>LIVERPOOL: That conference believes that unless Capita and NHS England can confirm that a GP's final pension will not be adversely affecting by Capita's inability to process NHS pension contributions from GPs in the month that they have be paid to Primary Care Support England, compensation must be paid to those GPs for the inability of PCSE to properly and efficiency administer the collection of pension contributions.</p>
24t	<p>LAMBETH: That conference agrees that:</p> <ul style="list-style-type: none"> (i) the PCSE services provided by Capita are not fit for purpose (ii) that the £3m recurrent money announced in the recent GMS contract changes for 17/18 to account for the increase in practice workload relating to records transfer is insufficient as it does not take into account the extra workload caused due to delays around the Performers List and other services provided by Capita; and (iii) calls upon the GPC to negotiate full cost reimbursement for practice work caused by the failing of Capita. <p>(Supported by Sutton)</p>
24u	<p>DARTFORD GRAVESEND & MEDWAY DIVISION: That conference recommends that the government look into the debacle about capita and pensions for new GPs joining a practice.</p>
24v	<p>SOUTH CENTRAL REGIONAL COUNCIL: That conference is dismayed by the continued failures of the private outsourcing firm Capita to deliver its contract for the provision of Primary Care Support Services and believes:</p> <ul style="list-style-type: none"> (i) that patients and practitioners have been put at unnecessary and avoidable risk as a result of these failures (ii) that practices should be fully compensated for these failings; (iii) that NHS England should consider stripping Capita of its contract unless its performance meets the required standards (as originally commissioned) within an agreed timeframe.
24w	<p>GLOUCESTERSHIRE That conference calls for a full investigation of the procurement of primary care services in England and demands the resignation and possible prosecution of those who recklessly set up such a poor and dangerous procurement process.</p>

- 24x NOTTINGHAMSHIRE: That conference is appalled at the gross incompetence of Capita in managing the transition of PCSE services and seeks to mitigate the damage by:
- (i) lobbying NHS England to make payments to practices for monies still due to them
 - (ii) requesting that NHS England (not Capita) sends regular updates to practices about its progress on all areas of activity handed over to Capita and accepts responsibly for clear failings in the service delivery.

PREMISES

17.10

- * 25 AGENDA COMMITTEE PROPOSED BY LOTHIAN: That this conference believes that our national negotiators must urgently address the significant threats many practices currently face in relation to their premises, including:
 - (i) the issues of 'last person standing'
 - (ii) lack of investment
 - (iii) unfair service charges
 - (iv) unfair rent reviews
 - (v) coercion of practices in national health service property services buildings into signing unfavourable leases.
- 25a LOTHIAN: That conference believes that our national negotiators must urgently address the significant threats many practices currently face in relation to their premises.
- 25b LOTHIAN: That conference demands that all health boards and authorities should act as guarantors for leases for GP premises in order to encourage partners to sign the leases, support recruitment and retention, and avoid the 'last person standing' scenario.
- 25c DORSET: That conference believes that by removing the risk implications of last man standing a career in primary care will be more appealing to younger GPs.
- 25d HAMPSHIRE AND ISLE OF WIGHT: That conference believes that removing the risk implications of last man standing will increase attractiveness to younger GPs and demands our GPC Executive negotiators and our Trade Union with negotiating rights for GPs to pursue a national solution to the last man standing issue of premises liability.
- 25e WILTSHIRE: That conference calls on our GPC executive negotiators and our trade union with negotiating rights for GPs to pursue a national solution to the last man standing issue of premises liability.
- 25f SHROPSHIRE: That conference is dismayed the NHS has not solved the 'last man standing' issue, leaving GPs vulnerable to personal insolvency as leaseholders for practice premises delivering NHS care and calls upon the government to assume liability when practices are forced to close.
- 25g NORTH STAFFORDSHIRE: That conference believes that the:
 - (i) financial risk associated with holding a GMS contract and being the last man standing is exacerbating the premature retirement of GPs and in doing so it precipitates the very situation (of being the last man standing) GP partners are trying to avoid
 - (ii) financial risk associated with the last man standing scenario hampers recruitment of new GP partners
 - (iii) financial risk associated with the last man standing scenario has an adverse effect on the sustainability of general practice
 - (iii) GPC should enter into urgent negotiations with the Department of Health to agree on a scheme that underwrites the risks for GP partners associated with a last man standing scenario
 - (iv) GPC should provide practices with a detailed options appraisal on existing legal arrangements which may mitigate against the risks to GP partners of the last man standing scenario.
- 25h SHROPSHIRE: That conference considers the difficulty of practicing good medicine from poor premises to be self-evident and asks that investment in the general practice estate is a long overdue priority.

25i	<p>HULL AND EAST YORKSHIRE: That conference believes that the funding of £900 million as part of the Estates and Technology Transformation Fund is inadequate and poorly managed by NHS England. We demand that NHS England:</p> <ul style="list-style-type: none"> (i) immediately reinvests any unspent funds in to general practice (ii) at least doubles the funding to secure a future proof premises and technology infrastructure for general practice. <p>(Supported by North and North East Lincolnshire)</p>
25j	<p>MID MERSEY: That conference calls on the GPC to ensure that CHP management charges in LIFT buildings are paid for by NHS England and not by general practitioners.</p>
25k	<p>AVON: That conference deplores the proposed massive hikes in service charges by NHS Property Services affecting practices based in health centres, previously run by NHS estates, which could render 10% of practices nationally becoming unsustainable. Conference calls on the GPC to do much more to fight against these unfounded changes.</p>
25l	<p>DERBYSHIRE: This conference notes that the single shareholder of NHS Property Services (NHSPS) is the Secretary of State for Health in England and that NHSPS and agencies acting in its name are:</p> <ul style="list-style-type: none"> (i) seriously threatening the financial viability of many NHS GP practices (ii) causing massive psychological distress and managerial work for GP partners diverting them away from caring for the sick (iii) behaving very badly as landlords in a manner unbecoming of either a publicly quoted company, or as one of Her Majesty's Secretaries of State.
25m	<p>TOWER HAMLETS: That conference notes the large rises in service charges for practices in NHSPS and that these increases are often demanded without proportionate increases in the level of service received by the practice. This conference demands that GPC ballot all practices in NHSPS premises as to their willingness to take part in a collective boycott in paying services charges until NHSPS agree an acceptable and transparent national protocol for agreeing the level of service charge payments.</p>
25n	<p>CITY AND HACKNEY: That conference demands that the NHS needs to fund property and estates appropriately; profits made from property services should be reinvested in NHS property and should not be used as income for the Treasury.</p>
25o	<p>HERTFORDSHIRE: That conference believes that the current process for rent reviews is neither fair nor reasonable and calls on GPC to negotiate with NHS England a fairer, quicker and slicker process in order to allow general practice to be stable and sustainable for the future.</p>
25p	<p>GREENWICH: That conference condemns the excessive service charges being imposed on practices by NHSPS, which risk undermining the stability of practices and are potentially ruinous</p>
25q	<p>KENT: That conference strongly condemns the Secretary of State for Health, as the sole shareholder of National Health Service Property Services, for putting practices at risk by demanding unreasonable service charges and demands that NHSPS immediately withdraws the demands for charges which are threatening practices with closure.</p>
25r	<p>EALING, HAMMERSMITH AND HOUNSLOW: That conference notes the extraordinary rise in practice premises fees and rent reviews, and calls upon GPCUK/E (where relevant) to negotiate a rapid resolution to this crisis which is rendering many practices financially insolvent.</p>
25s	<p>BRENT: That conference notes the destabilisation to practices caused by the inadequate reimbursement of rent review costs and calls upon GPCE to negotiate with NHSE and NHSPS to:</p> <ul style="list-style-type: none"> (i) clarify the process and (ii) negotiate the resourcing of reasonable premises service charges through adequate practice reimbursements.
25t	<p>MANCHESTER: That conference deplores the slow speed at which NHS estates companies are working to agree leases and business arrangements with practices.</p>
25u	<p>LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference calls upon the GPC to negotiate a reasonable tariff with NHS England which can help GP in NHS property use more space at efficient costs to provide more services.</p>

25v	KENT: That conference condemns NHS England for using the estates and technology transformation fund infrastructure investment to coerce practices in national health service property services buildings into signing unfavourable leases, and demands that this investment is made available to these practices without further delay.
25w	NORTHUMBERLAND: That conference calls for <ul style="list-style-type: none"> (i) a national solution to the lease issue, and that the current national lease is effectively a blank cheque for the lawyers (ii) extension of the deadline for reimbursement of SDLT and transitional relief given the slow pace of developments – most of which delay has been due to non-response of NHSPS.
25x	NORTHUMBERLAND: That conference calls for the GPC to make clear to the public that financial resource being diverted to resolution of the lease issue, and increase in service charges, is a loss to direct patient care.
25y	CAMBRIDGESHIRE: That conference condemns the raiding of the Estates and Technology Transformation Fund and the constant introduction of new obstacles designed to prevent and delay practices accessing what is left of the funding.
25z	NORTHUMBERLAND: That conference calls for the GPC to intervene in dealings with NHSPS on the basis that <ul style="list-style-type: none"> (i) the current situation threatens viability for some practices (ii) practices are unable to mitigate any financial loss due to prohibition of truly ‘commercial’ behaviour (iii) there is marked inequity of impact, the greatest effect being in areas with greater health centre stock ie frequently relating to deprived populations.

CONTINGENCY

17.20

CLOSE

17.30

QUESTION THE UK EXECUTIVE TEAM

09.00

Members of conference may ask questions from the indicated microphones of the 4 GPC chairs and the GPC England executive

GPC AND REPRESENTATION

09.30

- * 26 AGENDA COMMITTEE PROPOSED BY THE SESSIONAL GP SUBCOMMITTEE OF THE GPC: That conference calls for changes to the current system of election of GPC members to:
- (i) increase the number of regional representatives and reduce the number of members elected from both the conference of representatives of local medical committees and the BMA annual representative meeting
 - (ii) have regional representatives elected by local medical committees
 - (iii) limit the number of consecutive terms served by GPC members
 - (iv) have proportionate representations of GP principals, salaried GPs and locum GPs
 - (v) have proportionate representation to mirror the genders of the constituent members of the profession.
- 26a THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference believes the proposal changes to the constitution of the GPC will be unable to guarantee greater diversity and more representativeness without limits on the number of consecutive terms for GPC seats.
- 26b AVON: That conference believes that the Meldrum reforms have not fulfilled their intended purpose to make GPC more accountable to LMCs. It calls on the GPC to change the current system of election of GPC members to increase the number of regional representatives, nominated and elected by LMCs and to decrease the number of posts elected by LMC conference and the ARM.
- 26c CUMBRIA: That conference believes that the membership of GPC should mirror the constituent members of the profession with proportionate representation of salaried, locum, principals and gender.
- 26d NORTH YORKSHIRE: That conference agrees that there is not enough influence from younger GPs on the fundamental changes occurring in primary care that they will have to live and work with.

GP TRAINEES AND TRAINING

09.50

- * 27 AGENDA COMMITTEE TO BE PROPOSED BY THE GP TRAINEES SUBCOMMITTEE: That conference, in respect of under and post-graduate medical training and recruitment in general practice:
- (i) requires greater investment in medical school placements in general practice
 - (ii) insists that all foundation programmes starting within the next 12 months must include a dedicated general practice placement
 - (iii) insists that all GP training schemes starting within the next 12 months must be at least 4 years in length, with a minimum of 24 months spent within general practice
 - (iv) believes that Broad Based Training should be a mandatory gateway
 - (v) calls for health education bodies to significantly increase their funding for GP education to ensure training practices are properly incentivised for the essential work of training.

27a	THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: That conference believes that broad based training should be a mandatory gateway to GP training with GP training reduced to two years in practice.
27b	EDGWARE & HENDON DIVISION: That conference believes that significantly greater exposure to general practice is necessary both in undergraduate and postgraduate training, to reflect the volume for NHS care provided in general practice, and which is expanding given changes in patterns of care and population demographics.
27c	CLEVELAND: That conference, in respect of post-graduate medical training: (i) insists that all GP training schemes starting from August 2018 must be at least 4 years in length, with a minimum of 24 months spent in general practice (ii) insists that all foundation programmes starting from August 2018 must include a dedicated general practice placement.
27d	HARINGEY: That conference believes that training in general practice should be shaped to meet the demands of changing NHS working patterns.
27e	LOTHIAN: That conference calls upon the government to mandate an assurance that all foundation doctors are offered a community-based placement as part of their two-year programme.
27f	SCOTTISH CONFERENCE OF LMCs: That conference believes that mandatory experience of working in general practice for all foundation year doctors would improve working at the primary secondary care interface to the benefit of patient care.
27g	LIVERPOOL: That conference believes that if the government genuinely wants to develop the GP workforce, there needs to be a greater investment in medical school placements, in general practice.
27h	LOTHIAN: That conference supports the Medical Schools Council report 'By choice not by chance - supporting medical students towards future careers in general practice' and calls upon the government to implement its recommendations.
27i	BIRMINGHAM: That conference believes that in light of the GP recruitment crisis, GPC should seek an urgent review by the Department of Health of the case for a fully funded fourth year of general practice training.
27j	DEVON: That conference calls for Health Education England to significantly increase their funding for GP education to ensure training practices are properly incentivised for the essential work of training the desperately needed high quality GPs for the future.
* 28	AGENDA COMMITTEE TO BE PROPOSED BY NORFOLK AND WAVENEY: That conference believes that the future of general practice is contingent on qualitative and fully subscribed vocational training schemes. It therefore requests GPC to work with RCGP and the government to: (i) replace the £20,000 inducement payment for unattractive areas with paying off students debts for all GP registrars (ii) Increased investment in training facilities and trainers (iii) reduction in examination fees (iv) make training more geared towards preparing trainees to become partners and principals (v) incentivise practices to accept and support FY1/FY2 posts.

- 28a NORFOLK AND WAVENEY: That conference believes that the salvation of general practice depends on robust and attractive vocational training schemes and calls on GPC lobby for:
- (i) reform of the £20,000 inducement payment for unattractive areas
 - (ii) replace it with paying off student loan debt
 - (iii) make sure it applies to all scheme participants even if they didn't need an inducement to apply to that area
 - (iv) increased investment in training facilities and trainers to make schemes attractive
 - (v) reduction in exorbitant compulsory examination fees
 - (vi) making it financially more attractive for practices to support FY1/FY2 posts in general practice.
- 28b BEDFORDSHIRE: That conference believes that the GP trainee eportfolio is no longer fit for purpose, and calls on GPC to work with the RCGP to produce a training scheme that:
- (i) is a reasonable length
 - (ii) discriminates adequately between competent and non-competent candidates
 - (iii) prepares trainees to become principals and partners rather than just train them to pass the MRCGP.
- 28c BEDFORDSHIRE: That conference asks GPC to acknowledge the increased workload of TPDs and to negotiate a deal to appropriately recompense them and trainers for the additional work that is now expected of them.
- 28d BRADFORD AND AIREDALE: That conference asks the government to say what measures it intends to introduce to make speciality training (especially in primary care) more attractive to young doctors given the recent marked fall in FY2 doctors applying for speciality training.

- * 29 COVENTRY: That conference believes that the new contract for GP trainees will have the following negative consequences:
- (i) practices will drop out of GP training
 - (ii) trainees will be less well prepared to become career general practitioners
 - (iii) the increased intake to general practice will become more difficult to realise
 - (iv) there will be increasing reluctance of trainers to take LTFT trainees.
- 29a SOUTH CENTRAL REGIONAL COUNCIL: That conference believes that with respect to the new GP trainee contract:
- (i) it will not prepare trainees for the reality of life as a general practitioner;
 - (ii) the proposed timetable is unrealistic and will reduce opportunities for contact with trainers, not enhance them;
 - (iii) it will not deliver the degree of training and experience necessary for the award of CCT;
- We therefore call on the BMA to renegotiate the contract to deliver a more realistic training programme which will fully prepare GP trainees for life as a General Practitioner, whatever their final career objectives.

APPRAISAL AND REVALIDATION

10.20

- * 30 WILTSHIRE: That conference welcomes the findings of the Pearson Review into revalidation and looks forward to working with patients on its development.
- 30a HAMPSHIRE AND ISLE OF WIGHT: That conference notes the recommendations of the report by Sir Keith Pearson on appraisal and revalidation and:
- (i) welcomes the message to ROs that appraisal and revalidation should not include lots of their special little demands
 - (ii) confirms its lack of support for appraisal by non-clinicians
 - (iii) supports the development and dissemination of the benefits of doctor appraisal to patients rather than a wholesale reorganisation
 - (iv) looks forward to working with patient representatives on how patient feedback can be a useful professional developmental tool rather than an unregulated Trip Advisor style feedback.

- 30b WILTSHIRE: That conference is alarmed that the issue of remediation slipped from view in the governments' approach to appraisal and revalidation and notes Sir Keith Pearson's acknowledgement of the time needed for doctors' appraisal and demands the resourcing of professional development and remediation should once more have a central position in the discussions.
- 30c DORSET: That conference welcomes the findings of the Pearson Review and looks forward to working with patients on its development.

- * 31 KENT: That conference insists that, in order to preserve the integrity and value of the reflective process, GP trainee portfolios and appraisal toolkits should be confidential and protected from use in litigation
- 31a LAMBETH: That conference:
 - (i) maintains the principle that NHS GP appraisals are confidential
 - (ii) that prospective employers cannot seek information contained therein save for confirming that an individual is in good standing with such a process
 - (iii) deplores the stance taken by a GMC representative at a recent meeting for appraisal leads in London, that the idea of sharing appraisal summaries with prospective employers was in any way acceptable.
- 31b CENTRAL LANCASHIRE: That conference believes that the value of the appraisal scheme as a formative process of learning and development is being placed in jeopardy by the threat of disclosure of privileged information to lawyers pursuing negligence claims from such appraisals and performance committees and measures should be introduced by NHSE to safeguard such information.

REPORT BY THE NATION CHAIRS

10.40

32 SCOTLAND

Receive report from the Chair of Scotland, Alan McDevitt

33 WALES

Receive report from the Chair of Wales, Charlotte Jones

34 NORTHERN IRELAND

Receive report from the Chair of Northern Ireland, Tom Black

- * 35 GPC TO BE PROPOSED BY NORTHERN IRELAND CONFERENCE OF LMCs: That conference believes that the people of Northern Ireland have been seriously let down by the failure to invest in general practice and demands that the top priority of any incoming government for Northern Ireland must be to invest in general practice by at least the equivalent investment that has been made in England, Scotland and Wales.
- 35a NORTHERN IRELAND CONFERENCE OF LMCs: That conference thanks Dr Tom Black for his unwavering leadership and support of the profession during these challenging times of crisis.
- 35b AVON: That conference offers its congratulations to Northern Ireland GPC and to our colleagues in Northern Ireland who have had the courage to stand up to a bullying government and to tell them that enough is enough. We stand with them and wish them well in the turbulent months ahead.
- 35c BUCKINGHAMSHIRE DIVISION: That conference extends its full support to the GPs of Northern Ireland for their robust defence of the provision of safe care to their patients.
- 35d NORTHERN IRELAND JDC That this conference supports our GP colleagues as they continue their fight for survival in Northern Ireland, and calls for immediate support.

- * 36 AGENDA COMMITTEE TO BE PROPOSED BY MID MERSEY: That conference believes that the Sustainability and Transformation Plans are fundamentally flawed, and:
- (i) believes that they are undemocratically appointed QUANGOs that do not represent the public or profession
 - (ii) condemns them as an attempt to dismantle the NHS
 - (iii) asserts that they will only increase the postcode lottery
 - (iv) believes they will stimulate further division between organisations despite intending to promote integrity
 - (v) the only possible outcomes are cuts in services and/or increases in waiting times.
- 36a MID MERSEY: That conference:
- (i) believes that STPs are undemocratically appointed QUANGOs that do not represent the public or profession
 - (ii) condemns STPs as an attempt to dismantle the NHS.
- 36b NOTTINGHAMSHIRE: That conference questions the concept of sustainability and transformation plans and asserts that they will only increase the post code lottery and even potentially stimulate further division between organisations despite intending to promote integration.
- 36c DERBYSHIRE: That conference is gravely concerned that the spirit of the cooperation envisioned in Sustainability and Transformation Plans seemed to evaporate when CCGs tried to negotiate the 2017/18 contracts with Acute and Community Trusts.
- 36d COVENTRY: That conference believes that Sustainability and Transformation Plans (STPs) have been developed in many areas with limited general practice input to the planning process. By prioritising a move from secondary to primary care as a delivery site, they overestimate the ability of the primary care workforce and venues to deliver a new raft of care without seriously destabilising core delivery of the GMS contract.
- 36e DERBYSHIRE: That conference asserts that many Sustainability and Transformation Plans are unsustainable and unachievable especially in relation to the:
- (i) potential inability to recruit and train the planned numbers of GPs and other professionals into primary care
 - (ii) potential inability to release funding from secondary care to enable transformation to occur within primary care.
- 36f GATESHEAD AND SOUTH TYNESIDE: That conference believes that the Sustainability and Transformation Plans are fundamentally flawed due to the chronic underfunding of the NHS, huge cuts to social care budgets and the exposure of the huge gaps in funding that they are trying to close.
- 36g GATESHEAD AND SOUTH TYNESIDE: That conference believes that the Sustainability and Transformation Plans cannot possibly be attained due to:
- (i) the lack of engagement of appropriate front-line clinicians
 - (ii) the unattainable assumptions that they are based upon eg 15% reduction in emergency admissions
 - (iii) the complete lack of honesty to the general public regarding the reality and nature of the problem
 - (iv) that the only possible outcomes are cuts in services and/or increases in waiting times.
- 36h CORNWALL AND ISLES OF SCILLY: This conference believes that STPs are simply a way to cut services without the public realising their NHS is being dismantled.
- 36i NORFOLK AND WAVENEY: That conference believes that the STP is a sticking plaster over a gaping wound and that is being set up to fail to allow privatisation of large sections of health and social care provision.
- 36j HERTFORDSHIRE: That conference recognises that the outcomes of the 44 STP plans throughout England will effectively expedite the demise of the NHS.

36k	LINCOLNSHIRE: That conference proposes that forcing health economies to save money through Sustainability and Transformation Plans is a ruse to hide the fact that the Government has chronically underfunded the NHS, and calls for a vote of no confidence in their current health policies. (Supported by East Midlands)
36l	LAMBETH: That conference affirms well-resourced general practice as being fundamental to a successful and efficient NHS, and that therefore the lack of strategic involvement or resource into general practice as laid out in the 44 STP plans for England will not achieve the £22bn savings promised, but expedite the end of the English health and social care system.
* 37	<p>AGENDA COMMITTEE TO BE PROPOSED BY AVON: That conference instructs the GPC to negotiate with the Department of Health that STPs must, without exception, ensure that:</p> <ul style="list-style-type: none"> (i) GPs and particularly LMCs are an integral part of any STP Board structures and negotiation committees (ii) STP programme directors are admonished and removed from office if they fail to consult LMCs (iii) real investment is made in general practice and primary care to produce the cost savings associated with less reliance on secondary care (iv) any targets or timescales applied must be clinically appropriate, not financially or politically driven (v) no further cuts are made to secondary care services without a thorough assessment of local population growth trends and short, medium and long term projections of patient needs.
37a	<p>AVON: That conference is gravely concerned about the way STPs are being used as a smoke screen to justify swinging cuts to NHS funding in all parts of England.</p> <p>It instructs the GPC to warn the Department of Health that STPs must, without exception, ensure that:</p> <ul style="list-style-type: none"> (i) GPs and particularly LMCs are an integral part of any STP negotiation (ii) STP programme directors are admonished and removed from office if they fail to consult LMCs (iii) real investment is made in general practice and primary care, which will inevitably lead to cost savings if there is less reliance on secondary care.
37b	BEXLEY: That conference demands that LMCs have a seat on local STP boards to enable general practice to have a voice in the strategic development of future community based services/new models of care
37c	<p>CLEVELAND: That conference, when considering integrated working such as the Sustainability and Transformation Plans in England;</p> <ul style="list-style-type: none"> (i) welcomes closer professional working between primary and secondary care teams (ii) believes that initial additional financial investment is essential (iii) insists that any targets or timescales applied must be clinically appropriate, not financially or politically driven (iv) demands meaningful engagement and consultation with professional representative groups such as LMCs and LNCs.
37d	<p>EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the cuts to secondary care funding proposed in the STP plans which threaten the viability of vital NHS services and:</p> <ul style="list-style-type: none"> (i) calls on the government to allocate and ring fence additional funding to support and sustain general practice provision and premises (ii) demands that no further cuts are made to secondary care services without a thorough assessment of local population growth trends and short, medium and long-term projections of patient needs (iii) calls on NHSE to assure the viability of general practice to take on this work before proceeding with any further transfer of work from secondary care.
37e	<p>DONCASTER: That conference does not recognise the authority of Sustainability and Transformation Plan leaders, whom having been selected by the colour of their school tie, have no representative mandate and therefore calls on GPC to help define the management structure of STPS with clarity on how GPs are appropriately represented.</p> <p>(Supported by Rotherham and Barnsley)</p>

- 37f WEST SUSSEX: That conference believes:
(England Specific)
- (i) all Sustainability and Transformation Plan Boards should have at least one LMC representative present
 - (ii) STP Boards should be required by NHS England to demonstrate engagement with local general practitioners and not merely local CCGs.
- 37g SOMERSET: That conference recognises that the development of Sustainability and Transformation Plans and accountable provider organisations will reduce the importance and influence of clinical commissioning groups, and requires GPC to consult with LMCs and produce a policy on how the voice of GPs will be clearly heard by the new organisations.
- 37h HAMPSHIRE AND ISLE OF WIGHT: That conference, with regards the Sustainability and Transformation Plans in England:
- (i) is appalled by emerging sums spent on management consultants that could have been spent on patient care
 - (ii) rejects blanket policy referral management schemes
 - (iii) demands that hospital are not deliberately set against general practice
 - (iv) condemns plans that simply accept a reduction in GP numbers without incentivising and addressing GP workload and capacity
 - (v) calls on NHS England to reject STPs that ignore their own NHS England recommendation to invest 15-20% of Sustainability and Transformation Fund allocations on general practice.

SOAPBOX

11.40

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.

LUNCH

12.30

QUESTION THE CHAIR OF GPDF

13.30

Receive a report from the Chair of GPDF, Stewart Kay
Followed by a Q&A session from the floor

Members of conference may ask questions from the indicated microphones of the chair of the GPDF

APMS

13.50

- * 38 HERTFORDSHIRE: That conference mandates the GPDF to seek an expert QC opinion to challenge the notion that only APMS contracts may be awarded when procuring general medical services.
- 38a TOWER HAMLETS: That conference instructs the GPC to oppose further APMS contracts and to legally challenge NHS position of only tendering for APMS contracts.
- 38b HERTFORDSHIRE: That conference calls on GPCE to support LMCs in legally challenging NHS England in its refusal to award new GMS contracts where this is clearly in the best interests of patient care.

CLINICAL RECORDS

14.00

- * 39 AGENDA COMMITTEE TO BE PROPOSED BY COVENTRY: That conference asserts the vital importance of efficient clinical records, and so requests that:
 - (i) all patient's clinical information are held digitally in an approved NHS system
 - (ii) all clinical information are transferred digitally between practices
 - (iii) all current paper records should be stored centrally.
- 39a COVENTRY: That conference believes that it is essential that the entirety of a patient's clinical information is held digitally in an approved NHSE system that must be able to be transferred to subsequent GPs digitally without any requirement for paper print outs.
- 39b BRADFORD AND AIREDALE: That conference calls on the need for paper medical records to be stored centrally to reduce the unnecessary workload burden on general practice, processing and storing paper medical records when all current relevant patient medical information is now computerised.
- 39c DERBYSHIRE: That conference notes that the move to a paperless NHS is far from complete and is, in the interim, increasing the amount of paper in the system, leading to an urgent need for a national solution to an increasing record storage problem.
- 39d DEVON: That conference calls for the government to mandate the IT providers to provide inter-communicability between GP IT systems within the next 12 months.
- 39e DEVON: That conference, given the serious problems experienced this year with transfer of medical notes, calls for the creation of a specific fund from within NHS Digital to enable practices to start digitalising their medical records as soon as possible.

E-REFERRALS

14.10

- * 40 AGENDA COMMITTEE PROPOSED BY WIRRAL: That conference asserts that the notion of exclusive e-referrals is bad for patient safety, and therefore demands:
 - (i) implementation of 100% mandated e-referrals is postponed until the NHS is adequately resourced
 - (ii) all queries from patients concerning e-referrals must be directed to the appropriate hospital, not the GP.
- 40a WIRRAL: That conference believes that the letter sent to patients from the NHS e-referral service creates unnecessary workload for GPs by advising them to contact their GPs in cases where they do not have password; and demands that this letter should be reworded to direct enquiries to the Service or the appropriate hospital.
- 40b GLOUCESTERSHIRE That conference believes that restricting referrals to electronic only, is likely to be extremely dangerous for patient care and significantly increase the bureaucratic burden on general practice.
- 40c GLOUCESTERSHIRE That conference rejects any notion of 100% mandated electronic secondary care referrals by 2018 or at any time until the NHS is properly resourced.

CQC

14.20

- * 41 MANCHESTER: That conference has no confidence in CQC and agrees the need to:
 - (i) develop guidance to support and empower GP practices to challenge the process and inspections
 - (ii) support GP practices through the appeals process
 - (iii) ensure CQC processes are open and transparent and reduce bureaucracy
 - (iv) ensure inspections are evidence based and relate to the contract of the practice and what they are commissioned to provide.
- 41a LIVERPOOL: That conference believes that CQC assessments of GP practices are too variable, and too dependent upon the personalities of the assessing team, and requests that GPC works more closely with CQC to ensure that CQC assessments of GP practices are uniform and appropriate.
- 41b SEFTON: That conference believes that the CQC is exceeding its statutory remit of ensuring that providers meet the 'essential' standard of safety and quality. It instructs the GPC to:
 - (i) review the currently published CQC guidance for GP providers and identify where current CQC policy advice exceeds the remit of essential safety and quality
 - (ii) review the currently published CQC guidance for GP providers and identify areas where current CQC policy advice exceeds a GP's current GMS contractual and or statutory obligations
 - (iii) provide practical support and guidance to practices which receive 'requires improvement' or 'inadequate' ratings from the CQC owing to expectations in excess of essential standards of safety and quality.
- 41c OXFORDSHIRE: That conference believes that CQC inspections should only examine areas where clear primary care based evidence exists and there should be a focus on patient care outcomes and not on process and protocols.
- 41d REDBRIDGE: That conference requires CQC to develop an open and transparent complaints and appeal process to ensure that inspectors/inspection teams are accountable for the reports they produce.
- 41e MERTON: That conference demands that:
 - (i) CQC be made accountable for unacceptable variability between inspections
 - (ii) individual inspectors be publicly ranked by feedback from those they have inspected.

41f	HERTFORDSHIRE: That conference continues to be dismayed by CQC's apparent inconsistency, subjectivity and pettiness in passing judgement on practices and calls on GPC to negotiate a regulatory system that is fit for purpose.
41g	LANCASHIRE PENNINE: That conference believes that there is far too much variability in the inspection regimes of CQC with individual inspectors allowed to bring their own prejudices and priorities into the inspection regime and calls on the CQC to introduce measures to improve standardisation and challenge rogue inspectors.
41h	WEST PENNINE: That conference believes GPC/ CQC liaison needs to be given more authority. CQC standards should be subject to review and agreement with relevant professional bodies.
41i	WIRRAL: That conference notes that CQC inspection, as it is currently done, rather than being supportive: <ul style="list-style-type: none"> (i) is challenging, aggressive and over-bureaucratic in nature (ii) undermines the resilience of general practice and jeopardises patients' care (iii) is another unnecessary layer of regulations to general practice (iv) is of no advantage, and should be stopped with immediate effect.
41j	KINGSTON AND RICHMOND: That conference believes CQC inspection teams should only include general practitioners who are currently on the Medical Performers List, to ensure those inspecting general practices retain relevant experience in terms of this role.
41k	NOTTINGHAMSHIRE: That conference notes the inconsistencies of the CQC inspection approach and urges the GPC to take a more active role in supporting practices, through their LMCs, who feel that they are victims of this.
41l	MID MERSEY: That conference has no confidence in the CQC's proposed Insight Reports and calls upon the GPC to demand a halt in their implementation.
41m	DERBYSHIRE: That conference calls upon the CQC to stand by its previous announcement that practices currently rated good or outstanding will be subject to a much less intensive and burdensome inspection regime going forward.
41n	NORFOLK AND WAVENEY: That conference seeks GPC to negotiate a change in CQC classification. CQC was designed to identify and rectify unsafe practice, therefore categories should be good/needs improvement or unsafe. Inspections could be simplified in line with this. CQC's role is not to 'award' status as that is a role belonging to the RCGP which rewards those exhibiting excellence.
41o	HERTFORDSHIRE: That conference thanks the GPCE for successfully negotiating financial recompense for CQC fees, but calls on GPCE to now focus its negotiation around practices in receipt of 'good' or 'outstanding' reports to have their inspection interval increased.
41p	AVON: That conference congratulates GPC England on their successful negotiation of new contract for 2017/18 and in particular with regard to the full reimbursement for CQC fees. It encourages GPCE to build on their success by pushing for a move to less frequent inspections for good or outstanding practices eg a five yearly cycle.
41q	LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference feels that the CQC should be put into 'special measures' across all standards.
41r	DERBYSHIRE: That conference calls upon the English Department of Health to align its inspection regime of general practice with that currently employed in Wales.
41s	CAMBRIDGE HUNTINGDON & ELY DIVISION: That conference requests that the BMA provide advice and support to General Practitioners to video record CQC inspections to ensure the accuracy of CQC reports.
41t	LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference feels that the CQC should be put into 'special measures' across all standards.

EU NATIONALS

14.30

- * 42 SEFTON: That conference believes that EU nationals working in the NHS should be granted an immediate right of UK residence. The uncertainty which is now being caused by the political hesitancy on this matter is detrimental to the stability now and in the immediate future of the National Health Service. It calls upon the GPC to:
 - (i) undertake and publish a detailed survey of general practice to establish the numbers of staff who are affected by uncertainty of residence in the UK
 - (ii) campaign for an early and positive decision by government on the right of EU nationals working in general practice and the wider NHS, to remain in the UK.
- 42a HULL AND EAST YORKSHIRE: That conference is concerned that the 'BREXIT' plans by the UK government do not spell out the options for GPs from the EEA working in the United Kingdom and calls on the GPC to:
 - (i) ensure that GPs from the EEA working in the UK are secured the right to continue to remain and work in the UK after the United Kingdom exits the European Union
 - (ii) vehemently oppose any plans by the UK government to repatriate these GPs back to Europe.
(Supported by North and North East Lincolnshire)

OTHER MOTIONS (2)

14.40

- * 43 REDBRIDGE: That conference requires the UK Visa Bureau to add general practitioners to the UK shortage occupation list.

CONTINGENCY

14.50

OUTPUT AND DEBATE FROM PARALLEL SESSIONS

15.00

The Agenda Committee will publish more detail on how this session will be run on Friday morning to help members of conference prepare for the session.

- * 44 AGENDA COMMITTEE TO BE PROPOSED BY NORTHERN IRELAND: That conference demands that NHS prescriptions are no longer available for:
 - (i) over the counter medications
 - (ii) food products.
- 44a NORTHERN IRELAND CONFERENCE OF LMCs: That conference demands that 'over the counter' preparations are no longer available on NHS prescriptions.
- 44b LOTHIAN: That conference believes that GPs should not be involved in the prescription of food.
- 44c LEEDS: That conference is concerned that GPs are being put in unacceptable situations by CCGs that are trying to restrict the prescription of products that are available to buy, such as paracetamol, ibuprofen and gluten-free foods, and calls on the departments of health and other relevant bodies, to make the necessary legislative changes to protect GPs and to develop a consistent approach to this issue across the UK.
- 44d CLEVELAND: That conference demands a change in the regulations such 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.
- 44e BEDFORDSHIRE: That conference calls on GPC to call for a central policy with regard to the prescribing of medications which are available in cheap generic versions over the counter. Currently there is a postcode lottery as to if and how much is prescribed according to CCG policies.
- 44f BEDFORDSHIRE: That conference calls on GPC to negotiate to have gluten-free foods removed from the list of medications prescribable on an FP10 and replaced with a voucher system for those on low incomes.
- 44g AVON: That conference believes that GP prescriptions for many over the counter medications are putting immense pressure on GP access which is already under strain. It is also disempowering patients to self-care and, instead, engendering doctor dependency for many self-limiting minor ailments. Conference proposes:
 - (i) GPs have the freedom to deny over the counter prescriptions requests for self-limiting illnesses, without the threat of breach of contract
 - (ii) all over the counter prescriptions are banned under NHS prescribing rules
 - (iii) pharmacies are given the authority to dispense suitable quantities of otc analgesia or other treatments for those on a repeat prescription
 - (iv) a national public health awareness campaign to encourage patients to take more responsibility for the management of their own health.

CHOSEN MOTIONS

16.40

Motions chosen for debate (chosen from the agenda in advance of conference under SO27), may be chosen from motions in Part 2 of the Agenda, and this year, also from motions grouped in the Agenda under the parallel session major debates.

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.

CLOSE

17.00

Conference of Representatives of Local Medical Committees

Agenda: Part II

(Motions not prioritised for debate)

PART TWO

CLINICAL (PRESCRIBING, DISPENSING AND PHARMACY)

45. SCOTTISH CONFERENCE OF LMCs: That conference, in relation to firearms:
- (i) regrets guidance that puts an obligation on GPs to facilitate licence applications
 - (ii) believes GPs should only be asked for the applicants' medical information and that it is the responsibility of the police service to determine the suitability of an individual to hold a firearms licence
 - (iii) believes the manner in which the new certification was introduced to practices, was confusing and disruptive and continues to present professional risk and vulnerabilities to general practitioners.
46. GLASGOW: That conference believes that in cases of firearms license applications, GPs should only be asked for the applicants' medical information and it is the responsibility of the police service to determine the suitability of an individual to hold a firearms licence.
47. COUNTY DURHAM AND DARLINGTON: That conference:
- (i) agrees that firearms licensing authorities should have access to independent relevant medical information to assess the suitability of applicants to hold a firearms licence
 - (ii) agrees that GPs are best placed to provide this information
 - (iii) calls on the GPC to campaign for legislative change to make this a statutory requirement with an appropriate mechanism to ensure that GPs are paid for undertaking this work
 - (iv) agrees that GPs have no role in assessing the medical suitability of applicants to hold a firearms licence.
48. SCOTTISH CONFERENCE OF LMCs: That conference believes that a community based phlebotomy service, accessible to both primary and secondary care services are not funded through GP income, would lead to significant reductions in GP workload and improved clinical governance, with results able to go directly to the requesting clinician.
49. WILTSHIRE: That conference condemns the ongoing medication switches GPs are being asked to do as one brand becomes cheaper than another as a potential safety issue and inconvenience to the patient and a source of unnecessary workload and complaints to the GP.
50. NORTH AND NORTH EAST LINCOLNSHIRE: That conference acknowledges that some GP practices are now beginning to work collaboratively in larger organisations. We therefore call on the GPC to work with the Dispensing Doctors Association to secure the dispensing rights of GP practices in this new world for general practice.
51. GLOUCESTERSHIRE That conference congratulates the doctors who reported to the relevant authorities, the manufacturers of previously cheap drugs whose prices inexplicably were hiked up but
- (i) insists that the NHS should be far more eager to report or investigate such issues itself in future
 - (ii) insists that all reparations should go back to the NHS and not to the Treasury.
52. GLOUCESTERSHIRE That conference is dismayed that a high proportion of all referrals to child and adolescent mental health services are rejected, and demands that at least 95% of referrals be accepted.
53. LIVERPOOL: That conference believes that since NHS England has commissioned pharmacists as well as GPs, to provide seasonal influenza vaccinations, GPs are being left to vaccinate the housebound and patients with more complex needs, against seasonal influenza; GPC should now negotiate the fee being paid to GPs to reflect the difficulty of vaccinating such patients.
54. SOMERSET: That conference believes that the competitive market for the provision of flu immunisation has adversely affected relationships between general practice and community pharmacy at a time when the professions need to be working together, and calls on GPC to seek a collaborative arrangement that remunerates both parties appropriately. PART 2
55. LIVERPOOL: That conference believes that supplies of vaccine for seasonal influenza should now be procured centrally, in a similar manner for all other vaccines that are used for any national vaccination campaign.

56. GLASGOW: That conference is concerned about the negative impact of significant increases in the cost of some generic medications has on both practice prescribing budgets and on patient care.
57. CAMBRIDGESHIRE: That conference believes that the GPC needs to publish guidance about the consequences of private online prescribing.
58. SANDWELL: Drug shortages, wholesale changeovers, patient preferences and confusion over 'generic brand names' is both dangerous and arduous for practices. Conference calls on the GPC, to make clear to CCGs, NHSE and Department of Health that additional prescribing work purely for economic reasons is not a GMS service. It should therefore be subject to commissioning as a service like any other.
59. NORFOLK AND WAVENEY: That conference asks GPC to negotiate with the government to unify pricing arrangements for generic drugs so there is no difference between multiple manufacturers and single license holders, as the latter have led to exorbitant price rises for commonly prescribed generic products with significant costs to the NHS.
60. LINCOLNSHIRE: That conference believes that CCG led use of branded generics should be stopped as it:
 - (i) is unsafe, as brand names can cause prescription errors and cause patient confusion
 - (ii) does not save money, as repeated changes to brand inflate administrative costs.
61. MID MERSEY: That conference believes that whilst repeat dispensing is useful for some patients it:
 - (i) can create extra unnecessary workload within practices
 - (ii) benefits pharmacies more than most patients
 - (iii) should not be seen or promoted as a default position for repeat prescribing.
62. MID MERSEY: That conference believes that the introduction of an enhanced service for pharmacists to give influenza vaccinations will lead to practices ordering less Influenza vaccinations in future leaving some patients vulnerable.
63. MID MERSEY: That conference believes that the introduction of an enhanced service for pharmacists to give Influenza vaccinations was poorly thought through and has been detrimental to GP / pharmacist relations without significantly increasing vaccination uptake.
64. TAYSIDE: That conference demands that GPC negotiates a mechanism with community pharmacists that drug substitutions due to supply problems that do not involve a change of drug, should be made by the community pharmacy without demanding a new script from the GP practice.
65. TAYSIDE: That conference believes that the continued inefficient use of general practice resource required to re-issue alternative medication due to stock shortage is inappropriate and calls on chief pharmaceutical officers to work with GPC to enable pharmacists to automatically make appropriate substitutions when required.
66. LIVERPOOL: That conference believes that with increasing pressures on the prescribing budget, GPC should be working with the Department of Health to alter the prescribing and dispensing regulations to insist that when a GP prescribes a generic medicine, the pharmacist must dispense the cheapest possible version of that medicine without the need for the GP to repeatedly change the medicine to yet another branded generic.
67. BOLTON: That conference believes that high quality care is being delivered in many localities in general practice, which is reducing waste and costs to the NHS. This should be recognised good practice, encouraged and data should be shared between CCGs to improve general practice on a national level.
68. MID MERSEY: That conference believes that an enhanced service for pharmacists to give influenza vaccinations could work to the benefit of patients if pharmacists were not permitted to vaccinate until the end of November and were contractually obliged to signpost to general practitioners before this time.
69. LOTHIAN: That conference, recognising the growing number of complex patients in the community, calls upon our governments to work on a standardised frailty assessment using primary care data to deliver resource where it is most needed.
70. LAMBETH: That conference asserts:
 - (i) the evidence base around screening programmes is variable
 - (ii) hence key performance indicators around national screening targets are not appropriate in local contract negotiations.

71. **A** MID MERSEY: That conference:
- (i) believes that prescribing for gender reassignment requires specialist support and is not a GP contract activity
 - (ii) asks that general practitioners only undertake this activity after GPC has negotiated with NHS England and that CCGs commission this service as an enhanced service.
72. **AR** CLEVELAND: That conference, in respect of fitness to work certification:
- (i) demands an extension in the period of self-certification to at least 14 days within 12 months of this conference
 - (ii) demands a change in legislation to allow allied health professionals and nurse practitioners to complete 'fit notes' for patients within 12 months of this conference
 - (iii) insists that the workload associated with issuing Med3 certificates should be removed from GPs completely by April 2018.
73. **A** GLOUCESTERSHIRE That conference is concerned that the current level of prescription drug manufacturer supply problems is becoming dangerous in addition to wasting valuable NHS time and demands that the department of health take immediate action.
74. **A** HERTFORDSHIRE: That conference agrees that practices should continue to be able to refer babies for serology following complete Hepatitis B immunisation and calls on GPC to ensure that this work is not pushed back to practices.
75. **A** NORTHUMBERLAND: That conference calls for the GPC to ensure that there is a solution to allow dispensing practices to nominate themselves by EPS as previously agreed; and thus meet the targets agreed by the GPC in the new 2017-18 contract.
76. **AR** TAYSIDE: That conference calls on all four nation governments and health boards to ensure that public health departments provide hands on support to primary care in the event of significant local outbreaks of infectious disease.
77. **A** GLASGOW: That conference demands that secondary care and mental health clinics have access to either a hospital pharmacy or a community prescription pad so that GPs are not the default service for all urgent or same day prescriptions coming from clinics.

PRIMARY-SECONDARY CARE INTERFACE – TRANSFER OF WORK

78. WILTSHIRE: That conference recognises the training and experience that goes into the decisions doctors make with their patients when referring patients to specialist services and:
- (i) deplores blanket policy referral management schemes
 - (ii) believes blanket referral management schemes undermine GPs' professional integrity
 - (iii) calls on GPCUK to publicise tick-box referral management schemes as rationing
 - (iv) recognises that the NHS is as good as it is through the good will of its staff and that GPs are not to blame for under investment which is a deliberate policy choice
 - (v) believes that our comprehensive NHS is becoming a safety net service with UK patients not getting the equivalent routine care to countries with similar GDPs.
79. NOTTINGHAMSHIRE: That conference rejects the notion of prior approval referrals and requests that the GPC ensures that the CCGs accept all medico-legal risk that goes with such commissioning decisions; the GP has discharged their duty of determining the need and acting on it appropriately.
80. MERTON: That conference demands that practices are not obliged to assist hospitals in piloting new processes to monitor and collect payment from overseas patients who are not eligible for free NHS treatment. (Supported by Wandsworth)
81. WORCESTERSHIRE: That conference believes that general practitioners are the best clinicians to decide the quality and quantity of information provided to them following out-patient appointments or hospital discharge and GPC should develop 'discharge forms' to facilitate this.

82. DONCASTER: That conference recognises the expense and workload burden associated with referring NHS patients to secondary care for the provision of cheap and readily available medical devices and calls upon GPC to attempt to negotiate a mechanism by which GPs can source, provide and charge their registered NHS patients for the provision of such devices.
(Supported by Rotherham)
83. DERBYSHIRE: That conference:
- (i) notes with grave concern the deteriorating ambulance service response times for 'GP urgents'
 - (ii) deplores attempts to massage ambulance response times by telephoning the GP just before the target is breached to ask for extra time (thus avoiding target failure)
 - (iii) resents the 'third degree' to which health care professionals are subjected when ordering an urgent ambulance and insists that the government implements the "Health professionals" protocol which exists in the system
 - (iv) demands that GPs representatives are meaningfully consulted and involved in forthcoming system redesign.
84. SOUTHWARK: That conference believes the loss of a clinically-led NHS has contributed to the inevitable demise of the NHS and that it is too late to regain control.
85. WELSH CONFERENCE OF LMCs: That conference demands that GP's are not to be regarded as an emergency service and used as a substitute to attend an emergency because of a failure of the ambulance service to respond appropriately.
86. COVENTRY: That conference believes that the multiple initiatives in recent years have repeatedly failed to stem the tide of increasing workload in both primary and secondary care and that it is time to do the one thing that will actually make a difference to the ailing NHS – that is a concerted, whole-hearted and sustained investment in traditional practice based primary care. Conference affirms that this model of delivering healthcare, despite massive underinvestment in recent years, still remains the most cost-efficient and solvent provision within the NHS. We call on government, NHSE and CCGs to commission directly with practices using additional ring-fenced money to provide extra in-house clinics and to provide pro-active home visiting to the frequent users of healthcare resources, using practice employed staff. Failure to invest properly in practice based community care is causing failure across the entire NHS.
87. DERBYSHIRE: That conference demands that sexual health and family planning services in England are brought back from the local authority control to the National Health Service.
88. BROMLEY: That conference demands that LMCs be involved in any attempts to reconfigure and/or extend community mental health services; and that account be taken of remuneration, workload and training implications for GPs and practice staff.
89. KENT: That conference believes, given the current parlous state of the NHS, the difficulties we have in recruitment, and following the example set by the GMC, that private health insurance be provided by the government as an employment benefit to all frontline NHS primary care staff.
90. NORTH YORKSHIRE: That conference believes that the department of health must urgently review their manpower as well as leadership on all levels to attract the indeed most competent and able MPs from across all parties, who are not tied to or influenced by a political background and agenda, that is clearly counter-productive to the NHS.
91. BEDFORDSHIRE: That conference:
- (i) believes that the NHS needs to be more joined up in the way it works, and
 - (ii) calls on the GPC to push for a policy which would ensure different parts of the NHS would be incentivised to work to common objectives.
92. BEDFORDSHIRE: That conference believes that the:
- (i) purchaser-provider split was invented to add the benefits of competition and evolution to the NHS but the way it has been implemented, it simply adds complexity to the process
 - (ii) The provider/commissioner split has had its days, and
- calls on GPC to press the government to confirm if they propose to make the purchaser-provider split truly competitive or to drop it entirely.

93. HILLINGDON: That conference deplores proposals to merge CCGs as undermining local sovereignty and threatening the ability of CCGs to take the initiative to make decisions for local people, and calls for the immediate withdrawal of such plans.
94. NORTHUMBERLAND: That conference calls for an end to the practice of service development, the funding for which is short term, and which are then deemed to be part of core services by commissioners. Examples include IUS fitting, now commissioned by public health and no longer available (in some areas), for non-contraceptive indications. This leads to inequity of access for patient and financial consequences for practices.
95. CAMBRIDGESHIRE: That conference believes that GPs helping CCGs make clinical commissioning decisions:
- (i) are hampered by national constraints
 - (ii) often have to deal with misinterpretations of the meaning of conflicts of interests
 - (iii) would be helped if integrated decisions could be made across primary and secondary care to make the best use of available funds.
96. SOMERSET: That conference, in light of the recent BMJ article (2017; 356:j84) confirming that continuity of care reduces hospital admissions, believes that the political pressure for 7 day routine access to general practice will
- (i) reduce access for patients to familiar GPs during the normal working week
 - (ii) prioritise trivial work at the expense of long term condition management
 - (iii) profoundly affect recruitment of GPs to already struggling out of hours services
 - (iv) confuse patients by adding new and poorly co-ordinated access routes into healthcare
 - (v) increase pressure on hospital beds
 - (vi) not deliver value for money
- and therefore urges GPC to make these points directly to the public in a concerted information campaign.
97. CUMBRIA: That conference believes that "thank you" is an underused term between colleagues.
98. CORNWALL AND ISLES OF SCILLY: This conference believes that gain share agreements are divisive and will adversely affect the doctor patient relationship.
99. WEST PENNINE: That conference believes local authorities should be held financially responsible for the NHS costs incurred where social care provision delays a patient discharge.
100. SHROPSHIRE: That conference condemns the practice of requesting signed authorisation from GPs to indemnify the work of non-doctor clinicians from community and secondary care trusts and requires these organisations to establish mechanisms for supporting their own doctors.
101. SHROPSHIRE: That conference believes reorganisation does not, of itself, provide an improvement of services and that, particularly in the health service, stability and consistency are desirable qualities.
102. DORSET: That conference calls upon the GPC to end fragmented out of hours urgent care and develop an efficient joined up, single point of access service for urgent primary care services to avoid duplication of effort and financial wastage using one method of technology/computer system and one joint workforce.
103. SOMERSET: That conference notes that with the progressive evolution of GPs into community elderly care physicians, unless the growing deficiency in access to support services in the community is addressed by STPs with an urgent transfer of financial and human resources, it will no longer be possible for GPs to work within the requirements of their GMC registration without referring such patients for hospital care.
104. CORNWALL AND ISLES OF SCILLY: This conference demands that agencies that reject a referral from a GP are responsible for writing to the patient to explain their reasons for declining the requested activity with advice on alternative options for the patient.
105. WIRRAL: That conference believes that with respect to NHS 111:
- (i) its triage ability and performance continue to be of very poor quality
 - (ii) its activities often cause confusion and lead to over-use of NHS emergency services
 - (iii) it has the potential of jeopardising patient care
 - (iv) it should therefore be disbanded with immediate effect and resources released be diverted to help struggling 999 services and A&E services.
106. A LIVERPOOL: That conference believes that NHS 111 creates more problems than it solves by being too risk averse and requires more senior clinicians to be involved at the triage stage.

107. A GLASGOW: That conference believes government should recognise the essential role of GP and nurse led primary care OOH services in the unscheduled care environment and protect these vulnerable services from unrealistic efficiency savings which compromise the ability to deliver safe and effective care.
108. A SCOTTISH CONFERENCE OF LMCs: That conference believes that when referring to secondary care:
- (i) it is unacceptable to receive 'back to referrer' as an outcome being utilized as a means to manage out-patient workload
 - (ii) highly skilled extended GP team members' referrals should be accepted to give us equity with secondary care staff.
109. A GLASGOW: That conference condemns the use of back to referrer outcomes by secondary care as means to manage out-patient workload.
110. A AVON: That conference deplores the continuing wholesale disregard for the NHS standard contract by secondary care, which continues to seek to pass excessive quantities of work to general practice. Work for which secondary care is funded within tariff and for which general practice is not. It calls upon the Department of Health to:
- (i) ensure that clinicians and managers from both secondary care and the CCGs are properly educated in terms of their responsibilities under the NHS standard contract
 - (ii) introduce sanctions for trusts who are in breach of the NHS standard contract
 - (iii) ensure that general practice is allowed to invoice trusts whenever such breaches occur and that payment of such invoices is properly enforced
 - (iv) ensure that practices are properly supported by CCGs and NHS England when they legitimately reject unfunded work.
111. A SOUTHWARK: That conference demands that CCGs' performance management of the six requirements for hospitals in the 2016/17 NHS Standard contract is monitored, to ensure that the avoidable extra workload for GPs is being reduced and that hospitals are challenged as appropriate when found not to be compliant with those requirements.
112. A CAMBRIDGESHIRE: That conference welcomes the new requirements added to the hospital standard contract but regrets that some specialities persist in refusing to take referrals from GPs, issuing guidance instead, and calls on the GPC to consider ways of addressing this patronising practice.
113. A BARNET: That conference demands that GPs are no longer used as the dumping ground for work from secondary care as well as any other organisation that just expects the 'GP to sort'.

CONTRACTS AND REGULATION

114. CAMBRIDGESHIRE: That conference calls on the GPC to negotiate a national change to ensure that, in the event of a complaint from a patient, GPs are not criticised for adhering to a CCG's limited prescribing formulary and can expect support from the CCG during the complaints process.
115. EALING, HAMMERSMITH AND HOUNSLOW: That conference notes the failure of some local commissioners to adequately provide for patients and thus place local GPs in the inevitable invidious position of either facing censure via the GMC, or financial penalties for their practice, and calls upon GPCUK to publicise such examples and work with the GMC in following the advice as set out in good medical practice.
116. HERTFORDSHIRE: That conference calls upon GPCUK to enter into negotiations with NHSE to halt plans for routine GP access outside core contract hours until a thorough local needs assessment has been undertaken to see if this is affordable to the relevant CCGs.
117. LEWISHAM: That conference calls upon the GPC to collate evidence in relation to the effects of 7 day working on practices and an evidence based need assessment on whether this policy is needed, and will have the desired effect rather than wanted on account of political expedience.

118. REDBRIDGE: That conference demands, with regards to seven day working, that Teresa May provides a public report on:
- (i) her understanding of the current provision of GP OOH services
 - (ii) the evidence outlining the need for 7 day routine GP services
 - (iii) the impact assessment on the effect 7 day working would have on Monday to Friday GP services
 - (iv) the workforce requirements and plan for training and recruitment that would be needed to implement the policy.
119. SUFFOLK: That conference notes that successor schemes to those funded by the prime minister's challenge fund stipulate that GP appointments be provided outside the normal working day and on a pre-bookable basis ie for routine matters. Such additional appointments have little chance of reducing A&E attendance and Conference calls on GPC to negotiate that this money be routed through core general practice instead.
120. LIVERPOOL: That conference believes that GPC must strongly resist plans, currently under consideration by government, to expect GPs to establish whether a patient registering at a GP practice should be charged for NHS services.
121. LIVERPOOL: That conference believes that GPC must strongly resist plans, currently under consideration by government, to extend the charging of overseas visitors and migrants, into primary care.
122. ROTHERHAM: That conference instructs the GPC to make it clear to their negotiating partners that annual contract negotiations are no longer appropriate.
123. LEWISHAM: That conference demands, where local PMS contracts are being negotiated, that the PMS premium is used to fund non-core work that is currently unfunded and non resourced.
124. NEWHAM: That conference requests that the provision of all travel advice, medications and vaccinations is added to the schedule of services in the GMS Regulations for which charges can be made.
125. NEWHAM: That conference instructs GPC to negotiate with the Department of Health the removal of all travel advice, medications and vaccinations as an NHS service.
126. NORTH YORKSHIRE: Conference calls on the GPC to press for a review of the funding of CQC registration and inspections in primary care, and pending this, a halt to the planned rises in fees faced by practices in the current climate of reduced practice incomes.
127. SUFFOLK: That conference welcomes the initiative to set up a dedicated process to ensure reimbursement for CQC and indemnity payments, it notes that existing mechanisms are set up which should have delivered this reimbursement and that the need for alternative consideration acknowledges the failure of those mechanisms. Conference calls on GPC to explore with government the detail of that failure and the reasons for it; to quantify the financial loss attributable to that failure over the last 10 years and to invite government to make restitution.
128. LEEDS: That conference believes CQC is an expensive bureaucracy that should be rated as 'inadequate', put in special measures and its funding transferred to the NHS to support patient care.
129. TOWER HAMLETS: That conference notes the rise in annual CQC registration fees from £1952 to £4526 for single location practices of between 5001 and 10,000 patients. Conference believes that this is an outrageous waste of NHS money which should be spent on patient care. Conference instructs GPC to:
- (i) expose this widely in the media; and
 - (ii) demand that government intervene to reverse these increases forthwith.
130. ENFIELD: That conference requires GPC to negotiate with NHSE for the full reimbursement of any charges required for general practices to provide services to NHS patients to include CQC, GMS, MDO, NHSPS and any other regulatory body.
131. MID MERSEY: That conference believes that NHS England should define the minimum level of indemnity insurance required by a doctor to work as a general practitioner.
132. DORSET: That conference believes that there should be provision for indemnity for all allied health care professionals working in general practice and asks GPC to enter into a dialogue with relevant indemnity agencies to facilitate this.

133. AVON: That conference, whilst welcoming the proposals by the Department of Justice to consider capping legal fees in some clinical negligence cases, believes that the only way to regain control of medical indemnity costs is to introduce a system of 'no fault compensation'. It therefore requests that the GPC and the BMA lobby the government to make this change.
134. HERTFORDSHIRE: That conference acknowledges that the financial situation of the NHS necessitates GPCUK negotiating a change to the relevant regulations and contracts that
- (i) prevent practices from offering GMS services privately to their NHS registered patients
 - (ii) prevents practitioners from prescribing to their NHS registered patients on a private prescription
135. DERBYSHIRE: That conference urges the ARM of the BMA to show solidarity with GP colleagues and to adopt the LMC Conference policy that the GPs should be allowed to charge their own patients for work that is not commissioned by the NHS in their locality.
136. LEEDS: That conference believes that planned rises in the government's UK National Living Wage may have an impact on practice expenses in the future and directs the BMA to review this as part of its process of calculating expenses rises for GP practices.
137. DERBYSHIRE: That conference notes that the current system of medical report procurement for drivers applying for a vocational ('HGV/PSV') licence is riddled with holes, because the applicant with something to hide can see ANY doctor for the report and thus conceal adverse factors and consequently another Glasgow bin lorry accident is not a case of if, but when, BMA Council is instructed to lobby the Department for Transport accordingly.
138. BUCKINGHAMSHIRE: That conference requests that in any BMA negotiations which would have an impact on GP workload or income, the GPC must be included and have significant involvement.
139. BUCKINGHAMSHIRE: That conference continues to believe that it is iniquitous that commercial and multinational companies providing general practice and other NHS services are outwith the Freedom of Information Act (FOI)
- (i) as this prevents scrutiny of their NHS funding streams to ensure comparable funding with other practices
 - (ii) as this excludes them from IR35 issues for employing locums
 - (iii) and instructs the GPC to lobby government and the ICO to resolve this inequitable situation.
140. NORFOLK AND WAVENEY: That conference recognises the detrimental effect of
- (i) the general dissatisfaction in the medical profession which is a direct result of government policy and mismanagement
 - (ii) that short term piecemeal funding initiatives leads to long-term uncertainty
 - (iii) the funds from clinical care for patients ending in the pockets of meeting attendees, paper production and private consulting companies.
141. DERBYSHIRE: That conference demands that in light of the 9% rise in national insurance for the self-employed that the GPC insist that there is a commensurate rise in GP income, on top of any rise in the global sum.
142. MERTON: That conference demands that officers of NHSE be held accountable in the event of failure to adhere to agreements.
143. HAMPSHIRE AND ISLE OF WIGHT: That conference calls for GPCUK to ensure that local medical committees represent the employment rights for GPs:
- (i) irrespective of employment status
 - (ii) irrespective of whether a GP provides NHS general practice or private general practice.
144. BARNET: That conference agrees that it should be mandatory for PMS practices to follow the BMA standard contract, including arrangements for maternity pay and protected CPD time to address the inequity in employment terms and conditions between PMS and GMS practices which could be contributing to the recruitment crisis in PMS practices.
145. SHROPSHIRE: That conference calls upon the NHS to reimburse those GPs whose individual income has been top-sliced for years to fund the seniority scheme, in the expectation that it would be returned to them as seniority payments in the latter stages of their career, who will now lose out significantly as these payments are phased out.

146. AVON: That conference calls for the GPC to negotiate on behalf of PMS practices now that a national contract is in place. This is to ensure no practice is disadvantaged by local commissioning pressures likely to arise in the next few years in response to efficiency savings pressure.
147. DERBYSHIRE: That conference calls upon the GPC to determine what amount in the GMS global sum represents the expense of practices of paying the LMC levy.
148. GLOUCESTERSHIRE That conference calls for a levy on any organisation that seeks to mitigate their liability by including words to the effect of 'please consult your GP' in their written advice to their customers, such levy to then be used to support front line primary care.
149. GLOUCESTERSHIRE That conference believes it is now time that goodwill be chargeable on the sale or transfer of practices, thus bringing the regulations into line with equivalent business practice.
150. DORSET: That conference asks GPC to demand that HMRC classifies self-employed GPs working out of hours as such and thus benefit from the ensuing tax breaks they are entitled to.
151. CAMBRIDGESHIRE: That conference recognises that general practice exists in a societal environment of escalating demand and workload, increasing risk aversion, increasing litigation and decreasing tolerance of uncertainty, and calls on the GPC to
- (i) encourage NHS management and politicians to acknowledge the role of GPs in managing uncertainty and the burden of risk as the vital foundations of an affordable health service
 - (ii) urge regulators ,when making judgments, to appreciate the challenging circumstances in which risk is managed by GPs
 - (iii) explain to commissioners that if GP referrals had increased by the same percentage as indemnity costs, the NHS would have collapsed.
152. OXFORDSHIRE: That conference believes that the widening gap between government funding and the costs of consistent high quality health care is such that practice income can no longer be solely dependent on state provision. Conference therefore mandates the GPC to renegotiate an explicit list of what can no longer be considered core GP services for the NHS, and to provide an evaluation of options for practices to benefit from additional non-state funding streams, negotiating contractual changes to facilitate this and, in so doing, allow patients a choice to access to services that the state is no longer able to provide.
153. CLEVELAND: That conference demands that each of the GPC negotiating teams, in respect of negotiations over funding:
- (i) refuse to agree to any funding streams that are recycled whereby the same pot of money buys new work
 - (ii) object to the auditing of defunct QOF indicators and enhanced services
 - (iii) insist that all new monies to support general practice should go straight into the global sum.
154. SOMERSET: That conference asserts that with falling numbers of GPs and the adoption of multi-professional primary care teams it is no longer possible for doctors to have full medico-legal responsibility for patient care, and that non-medical clinicians should be responsible for the consequences of their actions.
155. BROMLEY: That Conference demands that CCGs put in place robust measures to monitor new community services and other contracts that are awarded to new private sector and other providers to ensure that workforce levels are adequate and the quality of care maintained for patients to the same degree of scrutiny as is afforded to those holding GMS/PMS contracts
156. NORTH YORKSHIRE: The deterioration of general practice is unrecoverable and conference instructs GPC to work towards a new contract that is not reliant on new models of care.
157. CORNWALL AND ISLES OF SCILLY: This conference demands the end to an open-ended GP contract as it is undeliverable and unsafe.
158. NORFOLK AND WAVENEY: That conference instructs GPC to resist all attempts to extend the contractual working week to 7 days until the promised extra 5000 GPs are in place and the current 5 day GMS contractual week has returned to a robust and sustainable position.
159. WILTSHIRE: That conference calls for provision of indemnity for all Allied Health Care Professionals working autonomously to provide NHS primary care.

160. DORSET: That conference believes that there should be provision for indemnity for all allied health care professionals working in general practice and asks GPC to enter into a dialogue with relevant indemnity agencies to facilitate this.
161. MERTON: That conference demands that the government acknowledges that general practice offers far more than just reaching 'targets' and that much vital work goes unrecognised.
162. BRADFORD AND AIREDALE: That conference notes the dramatic success of the '5p plastic bag tax' showing that significant behavioural changes can be brought about by seemingly trivial stimuli. Conference request the GPC to negotiate for GPs to be permitted to levy a maximum 20p charge for all surgery appointments and home visits. This should be treated as cash income for practices with no requirement to report centrally. Exceptions if any would be entirely at the discretion of the GP.
163. CUMBRIA: That conference believes, in the light of recent research on the benefits of continuity of care to our patients, particularly the most vulnerable in society, that the government's plans to increase evening and weekend access should be immediately reviewed and subject to a detailed cost benefit analysis because implementation of this policy moves general practice in a direction which erodes, not enhances, continuity of care for patients and this will have untold long term effects upon the nation's health and wellbeing.
164. DORSET: That conference asks GPC to demand that NHS England provide clarity over the integration of extended access and urgent care service provision to avoid duplication of effort and financial wastage.
165. A KENT: That conference insists that, to reduce inappropriate workload in primary care, CCGs should robustly commission services from secondary care providers which include
- (i) issuing of fit notes
 - (ii) supply of medication on discharge and from outpatients
 - (iii) taking responsibility for following up their investigations
 - (iv) timely communications to primary care.
166. A WEST PENNINE: That conference believes some practices would benefit from becoming limited companies.
167. A AVON: That conference believes that, in order to preserve the partnership model of general practice, a change in legislation is required to allow the use of Limited Liability Partnership (LLPs) for the delivery of general practice. GPC is requested to negotiate to allow LLPs to:
- (i) contract with the NHS to provide GP services
 - (ii) allow access the NHS pension scheme
 - (iii) secure the financial position of the last man standing.
168. A NORTH YORKSHIRE: That conference recognises the issue of attracting new GPs into partnerships particularly in light of surgery closures around the country and suggests that contracts may be held by those who operate with limited liability
169. A BRADFORD AND AIREDALE: That conference calls on the GPC to negotiate with the government a halt to the implementation of 8-8 seven day working until the current 8-6.30 Monday to Friday service is appropriately resourced and for the government to provide independent evidence that extending the current primary care service will lead to improved patient care.
170. A DEVON: That conference calls on the Department of Health to recognise that there is good evidence from pilot studies conducted over the last 12 months that there are no significant benefits to the health of patients or the health economy from GPs offering a routine 8am – 8pm service 7 days a week and therefore this political policy should be abandoned.
171. A MID MERSEY: That conference calls upon the government to ensure a sustainable viable 5 day routine general practice before introducing 7 day routine general practice.
172. A BARNET: That conference will not agree to deliver 12 hour a day services every day until there is good evidence that there is a clinical need AND guaranteed funding to support it.
173. A MID MERSEY: That conference expresses its confidence in a nationally negotiated GMS contract.

174. A DONCASTER: That conference demands that GPC recognise change fatigue in general practice as a result of annual contract negotiations which is causing perpetual uncertainty and therefore resolves to reduce the frequency of negotiations with representatives of the Department of Health with a view to delivering detailed and long term plans for general practice.
(Supported by Sheffield, Rotherham and Barnsley)
175. A GATESHEAD AND SOUTH TYNESIDE: That conference applauds GPC in negotiating the reimbursement of CQC fees for 2017/18 and insists that reimbursement of CQC fees should be continued in the long term.
176. A DERBYSHIRE: That conference welcomes the introduction of practice reimbursement of CQC fees but suggests that significant savings in transaction costs could be achieved if the money was passed directly from the Treasury to the CQC, rather than having to be transferred through multiple layers of administration.
177. A THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference believes that in order to assist LMC representation of all GPs, GPC must ensure that data collection on main clinical contractual status takes place via the Revalidation Management system, and following consent, is shared with LMCs.
178. A DERBYSHIRE: That conference congratulates the GPC England Executive on achieving various positive changes in the 2017/18 GMS contract changes but agrees with the chairman of GPC England that changes to the contract alone will not solve the crisis facing general practice.
179. AR WALTHAM FOREST: That conference insists that the GPC will not agree any contractual changes to implement seven day working without:
(i) at least 40% increase in core practice funding
(ii) identification of the workforce to service the additional hours.
180. AR SOMERSET: That conference asserts that particularly in view of the recent decision by the Lord Chancellor to reduce the personal injury discount rate, the present arrangements for clinical indemnity in primary care are no longer sustainable and therefore asks GPC to press for a move away from personal indemnity protection to system based cover.
181. AR LEEDS: That conference notes that appraisers have not had an increase in remuneration for over five years and directs GPC to negotiate with NHS England an increase to appraiser payments.
182. GLOUCESTERSHIRE That conference is concerned at the dwindling number of GP owned surgery premises and requests the GPC to investigate and promote ways to increase GP owner occupation.

EDUCATION, TRAINING AND WORKFORCE

183. SUFFOLK: That conference believes GPs are being lost from the workforce unnecessarily, because there is:
(i) no access to funded careers advice and guidance
(ii) inadequate access to funded coaching and mentoring
(iii) a lack of tailored educational and professional support for GPs temporarily unable to work for health reasons, but not yet eligible for the induction and returners scheme
(iv) no access to IT training or re-training for GPs who are not attached to a specific practice and tasks
GPC with ensuring that government funds, and supports the setting up of national and local solutions to these problems.
184. NORFOLK AND WAVENEY: That conference calls upon GPC to negotiate a significant incentive for senior GPs to remain within general practice

185. NOTTINGHAMSHIRE: That conference recognises that partnership as a career model is becoming less attractive and calls for this to be addressed in the following ways:
- (i) lobby the government to massively increase investment into premises development
 - (ii) call upon the GPC to look at new models of career development to enable general practice to be the enticing exciting career we all know it can be
 - (iii) GPC leads with a positive publicity campaign to help counterbalance the negative media attention that general practice has faced over the last 12 months and more.
186. SUTTON: That conference demands that the requirements to be a GP trainer should be standardised across all the health education bodies.
187. LEEDS: That conference:
- (i) thanks all GPs and their practice teams for their hard work, dedication and for doing their best for their patients despite the growing pressures on funding, workload and workforce
 - (ii) condemns all those in senior leadership positions in government and other national bodies who, through their comments and actions, attempt to scapegoat GPs for the wider problems in the NHS or undermine the morale of GPs and those who work with them in general practice.
188. AVON: That conference believes that, given the push to diversify the GP workforce, that the 2018/19 GP contract should include provision of sickness and maternity pay for nurses and allied health professionals, such as emergency care practitioners, physiotherapists and pharmacists, employed directly by practices for the purpose of supporting the delivery of new models of care.
189. LEEDS: That conference believes that the lack of investment in community nursing is having an impact on practice workload, and the ability of GPs and community services to properly and safely manage their patients at home, and calls on NHS England and national governments to address this situation as a matter of urgency.
190. AVON: That conference deplores the government's lack of action on the continuing workforce crisis in general practice. It:
- (i) censures the government for its failure to ensure that GP recruitment is sufficient to address the acute shortage of GPs in general practice
 - (ii) challenges the government to explain how with the present shortage of GPs its promise to the public of seven day access to GPs will occur
 - (iii) demands that the government explains why it has decreased funding to general practice
 - (iv) demands that the government remedies immediately the ongoing serious funding deficiencies in primary care
 - (v) calls upon government and NHSE to reaffirm publicly that general practice is the cornerstone of the NHS.
191. SCOTTISH CONFERENCE OF LMCs: That conference believes that training courses should be funded and much readily available for:
- (i) GP nurse practitioners
 - (ii) practice nurses.
192. NORFOLK AND WAVENEY: That conference believes that the withdrawal of seniority has had a catastrophic effect on workforce retention and government ambitions for 5000 extra doctors in general practice. The plug is leaking at a greater rate than the NHS tap can fill the workforce bath.
193. DEVON: That conference recognises in order to retain the GP workforce there needs to be quick and significant incentives introduced to persuade older GPs to continue to practice.
194. CITY AND HACKNEY: That conference believes that the Department of Health is not doing enough to retain older doctors and demands for a review of pensions, seniority payments and the bureaucracy of appraisal and revalidation so as to encourage senior GPs to remain in practices.
195. AYRSHIRE AND ARRAN: That conference is aware that the burden of appraisal is a barrier to retention of the older GP workforce and calls on GPC to work with the RCGP, the GMC and the appropriate educational bodies to develop a simpler and less burdensome model for this group of doctors.

196. DERBYSHIRE: That this conference insists that a registerable medical degree plus a CCT in general practice and ongoing postgraduate education equips GPs to do what GPs do and:
 - (i) rejects local stipulation and interpretation by NHS managers and responsible officers of that which is necessary for GPs to continue practicing, successfully complete appraisal or, achieve recommendation for quinquennial revalidation
 - (ii) rejects attempts by managers to inappropriately require GPs to repeatedly prove basic competencies and knowledge by applying criteria and tests more suited to technicians undertaking technical tasks who do not need to possess the underpinning medical patho-physiological understanding to perform their duties
 - (iii) rejects all attempts to impose multiple diplomatisation
 - (iv) requires the GPC and BMA to negotiate accordingly.
197. HERTFORDSHIRE: That conference calls upon the GPCUK to negotiate with NHSE a reduction in the frequency of appraisal and an extension to the revalidation cycle to relieve pressures on GPs and appraisal teams and allowing them to focus on direct patient care and practitioners who genuinely need support.
198. NOTTINGHAMSHIRE: That conference is concerned that swingeing cuts to Health Education England budgets demonstrates that education and training is becoming a lower priority for investment by the government.
199. DORSET: That conference calls for GPC to ensure that there are employment rights for all doctors working in primary care to be represented by a local medical committee irrespective of employment status.
200. BRADFORD AND AIREDALE: That conference recognises that appraisals are too focused on revalidation, that revalidation is a significant barrier to workforce retention and does not prevent bad medical practice. Conference therefore believes that revalidation should be abandoned and appraisals redesigned.
201. BRADFORD AND AIREDALE: That conference believes that GPs in the later stages of their careers are more likely to retire than undergo revalidation and, in the interest of retaining these GPs in NHS practice, call for the requirements for appraisal and revalidation to be removed from GPs over 55 years old.
202. HEREFORDSHIRE: That conference agrees that doctors approaching retirement who have already successfully completed one revalidation cycle should have their appraisal requirements relaxed to encourage them to remain in the medical workforce.
203. KENSINGTON, CHELSEA AND WESTMINSTER: That conference calls upon the GPCUK to negotiate with NHSE a reduction in the frequency of appraisal intervals to 24 months following a successful revalidation and subsequently extending the revalidation cycle length to 8 years to relieve pressures on GPs and allowing them to focus on direct patient care.
204. DONCASTER: That conference recognises the unflinching resolve of the general practice workforce in the face of insurmountable challenges in the NHS and calls upon the GPC to explore the possibility of annual events celebrating the success of general practice.
(Supported by Sheffield, Rotherham, Barnsley and Nottinghamshire)
205. CORNWALL AND ISLES OF SCILLY: That conference believes that unless the current administration openly acknowledges and addresses the workforce crisis in primary care that the NHS will begin to fall over within the next year.
206. SOUTH STAFFORDSHIRE: That conference deplores the bias held by the CQC and GMC against doctors, and highlights the fact that:
 - (i) doctors are no longer respected as elite professionals but viewed as a problem to be managed by politically motivated, scientifically illiterate managers who seem keen to damage the profession
 - (ii) this culture is a major factor undermining recruitment and retention.
207. NORTHAMPTONSHIRE: That conference laments that there has been no significant improvement in recruitment and retention because of the Secretary of State's inability to plan and run a stable and sustainable primary care service.
208. NORTH YORKSHIRE: Fiscal measures made the retention of current general practice unachievable and conference demands the Department of Health/government to make immediate measures to achieve longer GP careers.

209. BRADFORD AND AIREDALE: That conference requests the government to acknowledge that the promised 5000 GPs by 2020 will be woefully insufficient to replace much needed frontline staff. Given the current recruitment crisis, conference requests urgent meaningful action is needed to prevent the total collapse of NHS primary care as we know it.
210. GLOUCESTERSHIRE That conference requires that all GPs who have relevant UK experience within the last 5 years should be fast tracked when moving from the performers list of one of the 4 nations to the performers list of another.
211. NORTH YORKSHIRE: That conference believes that GPs should be renamed Consultants in General Practice to emphasise our growing expertise within this field and to increase respect within the health care system.
212. NORTH STAFFORDSHIRE: That conference believes that:
- (i) skill mix in general practice to help create additional capacity and expertise is to be welcomed
 - (ii) the role of the GP partner, as a clinician and manager being responsible for a team of healthcare workers is changing and becoming ever more complex
 - (iii) the added responsibilities of today's GP partners is preventing GPs who are not partners from joining partnerships
 - (iv) unless the partnership model is actively supported, current partnerships will cease to exist, leaving us with a salaried service only
 - (v) the GPC should seek negotiations with the Department of Health to enhance the terms of service for GP partners, in order to promote recruitment and retention
 - (vi) too little is being done to make general practice an attractive career option, and the GPC is tasked to negotiate preferential terms with the Department of Health for graduates who choose general practice above other medical career options.
213. SHROPSHIRE: That conference demands the urgent funding of a bioengineering program designed to immediately triple-clone all UK GPs, including the recently retired, in order to facilitate our Prime Minister's glorious vision of a truly 24/7 health service. The project should ideally extend to exploration of the resurrection of deceased general practitioners, though conference acknowledges that some health consumers might find zombie GPs unpalatable at first (assuming they even notice the difference.) However, we believe that public fears about human cloning and the walking dead could be swiftly allayed by the persuasive powers of the undisputedly veracious Mr Jeremy Hunt.
214. AVON: That conference, given the large numbers of highly skilled and experienced GPs who have left general practice in the last ten years, contributing to the current shortage of GPs, calls upon the government to make it easier and worthwhile for retired GPs to return to clinical practice by offering appropriate inducements.
215. BRADFORD AND AIREDALE: That conference looks at exploring ways that choosing local salaried posts can be incentivised to stabilise a diminishing GP workforce without putting further financial strain on practices, for example extra independent access to funding or benefits for GP trainees choosing to stay in local practices in their first five years of qualification.
216. SOMERSET: That conference notes that the steady flow of experienced GPs leaving the profession because of rising workload, increasing taxation and pension issues is becoming a flood, and requires GPC to enter urgent discussions with the Department of Health and press for action to find practical solutions, not based on an employment requirement, to reverse this.
217. A AYRSHIRE AND ARRAN: That conference insists that there should be nation-wide protection for doctors undertaking the hospital component of GP training to ensure that all training posts provide the necessary training which will be required in general practice and are not simply used to fill gaps in secondary care rotas.
218. A HAMPSHIRE AND ISLE OF WIGHT: That conference deplores the recent savage cuts to funding for Health Education England which will have a damaging effect on the provision of postgraduate education for GPs and asks the GPC to:
- (i) make the Department of Health aware of the effects of these cuts on GP education
 - (ii) press for re-instatement of funding to support current levels of GP postgraduate education.
219. A WILTSHIRE: That conference instructs the GPC to produce and publicise guidance to practices on how to take on apprentices in administration, reception and health care workers in GP practices.

220. A SUFFOLK: That conference notes that it costs approximately £500,000 to train up a fully qualified GP, and instructs GPC to force government to review the simple economics and to accept that increasing resources and support for the existing GP workforce is the only logical way forward, rather than promising to replace it with thousands of new extra GPs at vast expense because of the rising disillusionment, burnout and early retirement of the current workforce.
221. A GLASGOW: That conference calls on GPC to work with the GMC and national appraisal and revalidation bodies to reduce the burden of appraisal on an exhausted GP workforce through agreeing proportionate and relevant supporting evidence required for appraisal and reduction in frequency of full appraisal based on risk stratification and by reclaiming GP appraisal as a formative and supportive activity which assists GPs in their development and helps them survive in their current stressful working life.
222. A BOLTON: That conference believes that as the General Medical Council has not enforced a paperless process for appraisals, the drive from local Area Teams towards a paperless appraisal process is unfair, and may disadvantage GPs who are well versed with a paper based process. Therefore general practitioners should have the right to use paper evidence if they choose.
223. A GLASGOW: That conference calls on GPC to work with the GMC and national appraisal and revalidation bodies to reduce the burden of appraisal on an exhausted GP workforce through agreeing proportionate and relevant supporting evidence required for appraisal and reduction in frequency of full appraisal based on risk stratification and by reclaiming GP appraisal as a formative and supportive activity which assists GPs in their development and helps them survive in their current stressful working life.
224. A MID MERSEY: That conference demands that NHS England:
 (i) reviews the current appraisal process, the workload and time involved in preparation
 (ii) questions the value of such a process on a yearly basis.
225. A NORTH YORKSHIRE: That conference believes, in light of the BMA GP workload survey, that there is an ensuing workforce disaster with full time GP's retiring and less part time GP's taking up vacancies.
226. AR WILTSHIRE: That conference believes the law needs to change to address the shortage of GPs and keep up with an increasingly diverse primary care team and asks for the GPC to work with appropriate bodies to identify which roles could be done by other professionals.
227. A BARNET: That conference requires the GPC to openly and honestly assess the views of sessional GPs and the ways in which they want to work in future to encourage more salaried GPs and locums to take up partnerships to ensure the future of general practice.
228. A HERTFORDSHIRE: That conference
 (i) regrets the continued loss of experienced GPs from the workforce
 (ii) congratulates GPCE and the sessionals subcommittee for its work on the new retainer contract
 (iii) calls for the retainer scheme to be extended and expanded urgently to further improve retention of the workforce for the benefit of patients and the future of the profession.
229. A MERTON: That conference calls upon the government to face the fact that there is a significant workforce crisis affecting general practice which requires an immediate and public commitment to improving the retention of experienced general practitioners.
230. A NORTH WALES: That conference believes that at a time of medical workforce shortages in many specialities, UK government and the royal colleges should be actively looking at ways of utilising the skills of trained doctors who are refugees, and supporting them into the workforce.
231. A SHROPSHIRE: That conference praises the joint statement on GPs as specialists from the BMA and RCGP, with subsequent acknowledgment by the GMC, and urges that the legislative changes necessary to achieve recognition of GPs as specialists are enacted.

GPC / GPDF / CONFERENCE (INCLUDING REFORMS)

232. CORNWALL AND ISLES OF SCILLY: This conference believes that the GPDF has failed to defend general practice in any discernable way.
233. DEVON: That conference supports a more rapid reform of the GPDF into an organisation that will be fit for purpose and requests that greater efforts be made to make transition swift.
234. HERTFORDSHIRE: That conference notes that the total voluntary levy contribution from English LMCs to the GPDF has fallen significantly in the last year, and calls upon the chair of the GPDF board to expedite and execute in full the outcomes of the Meldrum Report which were accepted a year ago.
235. SOMERSET: That conference asserts that the failure of GPC to implement a regional representative structure for general practice has hampered efforts by LMCs to work collaboratively at the level of NHS England regional office areas, to the detriment of general practice, and expects GPC to address this failure forthwith.
236. THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:
That conference believes that:
(i) general practice is facing a crisis which will potentially end general practice as we know it quite soon
(ii) most patients, and indeed, other doctors, have no idea that this is going to happen.
(iii) GPC should implement a grassroots campaign to raise awareness with patients
237. BIRMINGHAM: That conference requests that in light of the increasing devolution of NHS England managerial and commissioning functions, GPC England develops a devolved regional structure to complement its national functions.
238. DERBYSHIRE: That conference:
(i) perceives that the GPC England Executive is less representative of, and accountable to grass roots GPs than was the old GPCUK negotiating team
(ii) calls for an urgent review of the effect of the implementation of the Meldrum Review.
239. SOMERSET: That conference believes that the General Practice Defence Fund has now accrued sufficient reserves to be able to return the voluntary levy for 2017-18 to LMCs to meet their urgent local needs, and seeks the support of GPC in achieving this.
240. ROTHERHAM: That conference instructs the GPC to prepare, for consideration at 2018 LMC Conferences, a report:
(i) describing the steps required to legally separate from the BMA and form a separate general practitioners' union
(ii) detailing if and how local union functions and protections can be transferred or extended to include local medical committees
(iii) outlining what proportion of GPC activity is funded the BMA rather than LMC organised levy contributions.
241. AVON: That conference believes the time has come to break away from the BMA and to develop a dedicated GP union, which will focus primarily on the interests and survival of general practice rather than the survival of the NHS.
242. DERBYSHIRE: That conference calls for a change to Standing Order number 5 of this conference such that LMCs are represented according to the number of patients in their area rather than the number of GPs they represent (NOTE TO AGENDA COMMITTEE - under the current system areas with the greatest recruitment difficulties may be under-represented at conference. We recognise that special arrangements may be required for remote and rural areas, such as the Highlands and Islands.)
243. BRO TAF: That conference endorses that the UK LMC Conference will be held by rotation in all four nations of the United Kingdom.
244. MID MERSEY: That conference believes that in the current climate the future of general practice is under threat and believes that the GPC is the professions only true representative.

245. ROTHERHAM: That conference instruct the GPC to create an Independent Contractors Subcommittee.
246. LEEDS: That conference believes that councils have greater respect than committees and calls on the General Practitioners Committee UK and to be renamed as the General Practitioners Council UK, and encourages other BMA branch of practice committees to follow suit.
247. WIGAN: That conference calls upon the GPC to increase its campaigning in the media to highlight the problems and pressures faced by GPs and to counter the penchant of certain national newspapers to blame GPs for problems in the funding and staffing of the hospital service.
248. HAMPSHIRE AND ISLE OF WIGHT: That conference demands a prompt survey of GP's job satisfaction working under different contractual arrangements.
249. WILTSHIRE: That conference demands a prompt survey of GPs' job satisfaction working under different contractual arrangements.
250. WOLVERHAMPTON: That conference believe in the 2017-18 contract negotiations the GPC has given in to blackmail that the package would be accepted only if practices give up their half day closing in order to qualify for the extended hours DES and that conference does not agree that GPC should accede to such tactics in future.
251. BEDFORDSHIRE: That conference asks that GPDF money be spent on a national advertising campaign about general practice to inform the public about the amount of work that general practices do for the NHS, the percentage of NHS appointments and care that takes place in general practice, and the level of funding for GP services and how it has dropped.
252. CORNWALL AND ISLES OF SCILLY: This conference demands that in its next survey GPC finds out who will be the last NHS GP responsible for turning off the lights.
253. MANCHESTER: That conference has no confidence in the BMA press office in countering negative GP publicity and calls for a unified approach.
254. AR DONCASTER: That conference remains tired of the pressure exerted by the GPC when summing up motions, thereby unduly influencing the will of LMCs and reminds the Deputy Chair of GPC of his offer in 2014 to discuss this issue again should policy leads not alter their behaviour. As such, conference resolves to seize back control over its own mind and declares an immediate cease to the practice of GPC summing up of motions. (Supported by Rotherham)
255. AR CLEVELAND: That conference mandates the Agenda Committee to ensure that future conferences are regularly held outside London in respect of:
- (i) the one day UK Conference for LMCs
 - (ii) the new English Conference of LMCs.

GP TRAINEES

256. BRENT: That conference welcomes the new retainer contract and applauds GPCE and the sessional GP subcommittee for their work, but calls for these bodies to investigate how, and to negotiate for the scheme to be extended beyond five years where there is a case for this, to further improve retention of the workforce.
257. BEDFORDSHIRE: Given that trainees no longer seem to be required to attend partners' meetings and to learn the basic principles of practice management, conference:
- (i) believes that this is a silent acknowledgement that the partnership model is in the 'palliative phase', and
 - (ii) calls on GPC to work with the RCGP to define realistic successor models for general practice.

SESSIONAL GPs

258. MANCHESTER: That conference agrees to support GP locums by:
- (i) ensuring GP practices and GP locums are free to agree terms and conditions confidentially and agreements are commercially confidential and should not be subject to compulsory reporting
 - (ii) ensuring GP locums are free to offer their services at a rate they feel is fair and reasonable and GP practices are free to engage GP locums at a rate they feel is appropriate and neither should be influenced by third parties
 - (iii) reminding GP practices that additional indemnity funds provided in the latest GMS contract negotiation is also earmarked to provide for increased costs of GP locums
 - (iv) gaining agreement that being on the Performers List is sufficient to fulfil requests for standard documentation from employing practices.

NATION SPECIFIC (ENGLAND, NORTHERN IRELAND, SCOTLAND, WALES)

259. WELSH CONFERENCE OF LMCs: That conference calls on Welsh Government to strongly argue to the UK government that immigration changes are needed to recruit more doctors for primary care from abroad.
260. WELSH CONFERENCE OF LMCs: That conference calls, in show of support to our GP colleagues across the border, on the UK population to lobby their MPs for a vote of no confidence in the Prime Minister as she has deliberately placed the blame for NHS failures at the doorstep of GPs whilst conveniently forgetting that it is the gross under-resourcing that has plunged the NHS into crisis.
261. WELSH CONFERENCE OF LMCs: That conference requests that the Welsh Government looks at an alternative mechanism to facilitate sickness certification.
262. BEDFORDSHIRE: That conference believes that the government gives the impression that it does not care about the people working in the NHS and their needs.

OTHER

263. HAMPSHIRE AND ISLE OF WIGHT: That conference believes WEXIT is the only way to make general practice great again #THEONLYWAY IS WESSEX.
264. DORSET: That conference believes # THE ONLY WAY IS WEXIT.
265. DORSET: That conference believes that NHSE's increasing habit of insisting on a short timescale for response results in a smaller chance of the response being valid.
266. OXFORDSHIRE: That conference is dismayed that NHSE has again failed to recognise that essential general practice services have an incalculable value to the NHS and country.
267. BRADFORD AND AIREDALE: That conference believes in the urgency of climate change action, and that we must strive to do our part in achieving the national target of reducing carbon emissions within the NHS by 80% by 2050 (from 1990 levels).

FUNDING

268. LEEDS: That conference believes that cuts to social care leading to reductions in home care support and a shortage of affordable care home places is one of the main causes of the rising pressures on GP practices, A+E and hospital bed capacity and calls on the Treasury to prioritise funding to enable patients to be cared for in the community with dignity and respect.

269. HAMPSHIRE AND ISLE OF WIGHT: That conference supports calls for a cross party commission into funding health and social care.
270. BARNET: That conference is appalled at successive governments using the NHS as a 'political football' and calls on the BMA to initiate a cross party NHS convention to address the future of the NHS and prevent its continued use for political gains. Conference insists that such a convention should include GP and practice staff representatives being actively involved in encouraging, influencing and contributing to the process.
271. AVON: That conference deplores the 27% cut in the public health budget and challenges the government to explain how:
- (i) this cut supports the future national agenda for health promotion and health care;
 - (ii) it will reduce morbidity and cut the primary care patient workload.
272. CORNWALL AND ISLES OF SCILLY: That conference believes that the current funding of the NHS through only general taxation is unsustainable and instructs the GPC to explore other methods.
273. NORTHAMPTONSHIRE: That conference insists any funding commitments should be independently audited, verified and published before being announced to clearly show if it is new or recycled money.
274. BUCKINGHAMSHIRE: That conference believes that
- (i) the fundamental cause of the crisis in general practice is the widening gap between resources for essential and additional services and demands made on practices
 - (ii) any involvement of GPs in further government initiatives should be dependent upon the government guaranteeing a significant uplift to the global sum to at least double the current per capita value.
275. DERBYSHIRE: That conference urges the NHS in the four UK countries to work with their GPCs to develop methodologies to identify funding gaps in primary care at practice, locality, regional and national levels.
276. DERBYSHIRE: That conference:
- (i) notes for example the increase in NHS Tariff prices for 2017-2018 in respect of patient attendance at A&E ranging from 7% to 41% according to episode
 - (ii) is unable to comprehend how general practice is expected for the seventh consecutive year to manage with only a 1% growth in resource despite a 40% growth in workload
 - (iii) insists that the GPC and BMA repeatedly highlight the fact that all general practice services, premises and staff are provided annually for less than £3 per week per person.
277. NORTH YORKSHIRE: That conference believes that primary care funding should be fixed at 10% of total NHS budget.
278. HERTFORDSHIRE: That conference congratulates GPC on forcing NHS England to adhere to the statement of financial entitlements with regards to maternity locum reimbursements and asks GPC to support practices in submitting back claims for money that was denied them in areas that insisted on applying a pro-rata cap.
279. SUFFOLK: That conference acknowledges the rising pressures in the NHS that are portrayed daily in the media, and laments the continued and irresponsibly dismissive way that Government ignores and denies the prime cause; the continued under resourcing of primary care - the NHS sector which performs 91% of the workload with just 9% of the funds. Conference insists that GPC force Government to increase resources for primary care in proportion to the workload carried, as a much more cost-efficient way to use public money and improve care to patients.
280. LANCASHIRE COASTAL: That conference believes that changes to the law to introduce the concept of criminal negligence only serve to criminalise the honest acts and omissions of GPs, promote a name and shame culture in society and reinforce the current GP workforce crisis and instructs GPC to work with NHSE to introduce systems and processes to limit the corrosive effects of this badly thought out law.
281. NORFOLK AND WAVENEY: That conference believes for the NHS and general practice to be sustainable we need greater investment in public health, well-being services, sexual health services, school-based health services and greater support for parents. Prevention remains better than cure.

282. A MERTON: That conference calls upon the government to:
- (i) recognise the value patients place in the personalised care offered by their GPs
 - (ii) accept the need for greater resources to be made available to primary care in general and specifically to general practice.

INFORMATION MANAGEMENT AND TECHNOLOGY

283. SOUTH STAFFORDSHIRE: That conference believes that the implementation of the new EU GDPR regulations will make the GPs' obligations as a data controller even more onerous and demands that:
- (i) an urgent IG reference group is created to consider all the implications for GPs and implement a policy to mitigate these
 - (ii) the BMA agrees a national Data Sharing Agreement which allows legitimate sharing of personal confidential data with third parties other than those employed by the practice.
284. CLEVELAND: That conference embraces the wider use of digital consultation technology, but reminds the UK governments that its uptake will be instead of traditional appointments, not to provide additional GP capacity.
285. BIRMINGHAM: That conference believes that full online patient access to their medical records:
- (i) is inappropriate for some patients
 - (ii) should be limited to the patient summary
 - (iii) is developed progressively according to the resources available to deliver it
 - (iv) is extended only as appropriate to individual patients.
286. WEST PENNINE: That conference demands adequate resources are made available for supporting general practice to enable responsible sharing of electronic health records with patients and carers and understanding with an appropriate explicit consent process.
287. WORCESTERSHIRE: That conference demands that GPC start negotiations to remove the liability from GPs in their role as data controllers.
288. WILTSHIRE: That conference demands that all GPs have access to computer systems which go at least fractionally faster than a drunken snail.
289. DORSET: That conference demands that GPC works to ensure that all GPs have computer systems that go at least fractionally faster than a drunken snail.
290. WAKEFIELD: That conference only supports monitoring of GP workload or activity where that monitoring is 'fit for purpose', any data gathered is analysed in a pre-agreed manner and conclusions are justifiable.
291. DERBYSHIRE: That conference reiterates that the introduction of new systems requires investment and that potential savings cannot be obtained until the new systems are embedded and the old system can be safely withdrawn.
292. AYRSHIRE AND ARRAN: That conference believes in order to work more effectively in extended multi-disciplinary teams and across the interface that:
- (i) it is important to be able to safely and securely share appropriate patient data
 - (ii) the model of the GP as the data controller may not be the best model for the future
 - (iii) GPC and the four UK governments explore different data controller options.
293. NORTHUMBERLAND: That conference condemns the discrepancy in long term planning for information technology in primary care and recognises that continued short term funding prevents true innovation and progression.
294. NORTHUMBERLAND: That this conference calls for the highly sophisticated and effective use of IT in primary care to be publically recognised; and for other NHS areas to build on this success rather than the uncoordinated development strategy seen currently.

295. MID MERSEY: That conference believes that EPS linked electronic requests for ordering repeat medication is the most efficient way of managing repeat prescribing where patients are capable of using it.

GOVERNMENT AND NHS GOVERNANCE

296. AVON: That conference believes that the government is the architect of GP stress and that they should be held accountable for the untold misery they have caused to so many members of the profession.
297. ENFIELD: That conference demands that the NHS needs a period of stability without constant restructuring.
298. LAMBETH: That conference demands:
- (i) that government lead an honest debate over which services the NHS cannot afford and should cease to provide and
 - (ii) that conference supports the GPC in leading the call for this within the wider BMA.
299. WILTSHIRE: That conference calls for the UK governments to publically acknowledge the essential role of GPs to the profession and the general public.
300. DORSET: That conference demands that the government publically acknowledges the essential role of GPs in the NHS.
301. MID MERSEY: That conference believes that the NHS is not safe in the hands of the current government.
302. MID MERSEY: That conference deplores the government's seemingly obsessive desire to reform the NHS.
303. NORTHUMBERLAND: Accountable care organisations are clinically led organisations with GPs as equal partners. Conference calls for
- (i) stability in health policy to allow safe and sustainable models to mature
 - (ii) recognition of the truly specialist nature of primary care.
304. NORFOLK AND WAVENEY: That conference requests that the Secretary of State for Health should rule on the entitlement to social care services for European citizens resident in the UK in the light of the Brexit vote.
305. LEICESTER, LEICESTERSHIRE AND RUTLAND: This conference calls upon the PM to sack Jeremy Hunt as Minister of Health for presiding over the worst time in the history of the NHS, missing targets, longer waiting lists and low morale.
306. DEVON: That conference believes the cycle of over investment followed by under investment in other years with each change of government is unhealthy for the NHS and calls on MPs to:
- (i) have a wide, non party debate on the future of the NHS
 - (ii) allow the NHS to be ruled and managed by the NHS Executive without interference from the Secretary of State for Health
 - (iii) agree a realistic long term financial projection for the NHS as guided by the Health Select Committee.
307. GLOUCESTERSHIRE: That conference states that NHS England is no longer fit to run primary care and needs to be replaced by a more competent and properly financed system.
308. BEDFORDSHIRE: That conference asks the GPC to get the government's honest opinion as to who, in 2025, will be delivering general practice (as opposed to primary care) and how.
309. NORTHAMPTONSHIRE: That conference laments that there has been no significant improvement in recruitment and retention because of the Secretary of State's inability to plan and run a stable and sustainable primary care service.
310. A SHROPSHIRE: That conference believes GPs should not be required to act as proxy border guards for the government.
311. A NEWCASTLE AND NORTH TYNESIDE: That conference believes that the requirement that GP practices check the migration status of new patients may lead to discrimination on grounds of race and religion and therefore should be opposed by the GPC.

312. A SHROPSHIRE: That conference recognises, with Professor Sir Michael Marmot, that many of the problems in the NHS are outside doctors' control and demands that the wish for a fairer and more equal society is reflected in government policy.

CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

STANDING ORDERS

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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.

Mobile phones

83. Mobile phones may only be used in the precincts of, but not in, the conference hall.

The press

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

No smoking

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

Chairman's discretion

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

Minutes

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



BMA

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LMC

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