

**GPDF**

General Practitioners  
Defence Fund

**BMA**

# Special LMC conference 2016

To decide what actions are  
needed to ensure GPs can deliver  
a safe and sustainable service

## Agenda

30 January 2016  
Mermaid Centre, London



British Medical Association  
bma.org.uk

# Special Conference of Representatives of Local Medical Committees

## Agenda

To be held on

**Saturday 30 January 2016** at 10.30am

At the Mermaid, Puddle Dock, Blackfriars, London EC4V 3DB

**Chair** Guy Watkins (Cambridgeshire)

**Deputy Chair** Mary O'Brien (Tayside)

### **Conference Agenda Committee**

Guy Watkins (Chair of Conference)

Mary O'Brien (Deputy Chair of Conference)

Chaand Nagpaul (Chair of GPC)

Stuart Blake (Edinburgh)

Christopher Browning (Suffolk)

Hal Maxwell (Ayrshire)

Helena McKeown (Wiltshire)

Rachel McMahon (Cleveland)

Stephen Meech (Kent)

Emmanuel Owoso (Swansea)



## NOTES

Under standing order 18, in this agenda are printed all notices of motions for the special annual conference received up to noon on 18 December 2015. Although 18 December 2015 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the secretary prior to the conference, or handed in, in writing, at as early a stage of the special conference as possible.

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

Under standing order 21, the agenda committee has grouped motions or amendments which cover substantially the same ground, and has selected and marked in bold one motion or amendment in each group on which it is proposed that discussion should take place.

	Motions	Time
Opening business	1 – 4	10.30
Workload	5 – 6	11.20
Workforce	7 – 10	12.00
Lunch		1.00
Speaker – Maureen Baker		2.00
Future of the NHS	11 – 12	2.10
Regulation	13 – 14	
Premises	15	
Funding	16 – 18	3.20
Indemnity	19	4.10
Solutions	20	4.30
Close		5.30

## RETURN OF REPRESENTATIVES

10.30

- 1 THE CHAIRMAN: That the return of representatives of local medical committees (SC3) be received.

## STANDING ORDERS

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

## REPORT OF THE AGENDA COMMITTEE

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

## REPORT FROM CHAIR OF GPC

- 4 THE CHAIRMAN: Report by the Chair of GPC, Dr Chaand Nagpaul.

## WORKLOAD

11.20

- 5 **AGENDA COMMITTEE to be proposed by WILTSHIRE: That conference, gravely concerned by the intensity at which GPs are working, believes that current working practices may be a risk to patients' care and GPs' health, and calls for:**
- (i) increase in the duration of routine GP appointments to at least 15 minutes
  - (ii) restriction of patient contacts per day to a level comparable to other EU countries
  - (iii) outlawing of unsafe 12 hour days
  - (iv) reduction in maximum hours per week to 48
  - (v) reduced core hours.
- 5a WILTSHIRE: That conference is gravely concerned by the intensity at which GPs are working and:
- (i) believes that current working practices may be a risk to patients' care
  - (ii) asserts that 12 hour days GP days are unsafe
  - (iii) calls for a restriction on patient consultations per day to a level comparable to other EU countries
  - (iv) demands that there is an urgent freeze on non-essential work for practices unable to recruit without a penalty that threatens the practice viability.
- 5b WILTSHIRE: That conference is aware that across Europe other generalists usually have longer consultations and fewer patient interactions in a working day and believes that having as many patient contacts as UK general practitioners do is:
- (i) currently unsustainable
  - (ii) potentially dangerous for patients
  - (iii) unhealthy for GPs' health and well-being
  - (iv) that demand needs to be controlled via a national mechanism such as managing patient expectations to sustain general practice.
- 5c SHROPSHIRE: That conference believes that comparison with the rest of Europe suggests that UK general practitioners having more than 25 patient contacts a day are operating under adverse circumstances and possibly putting themselves and their patients at risk
- 5d DORSET: That conference recognises that 10 minutes is not long enough for a consultation with a patient with complex needs and
- (i) instructs the GPC to look at ways of extending the average consultation time to 15 minutes
  - (ii) asserts 20 minute appointments should now be standard practice.
- 5e THE GPC: That GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That, in light of the increasing medical complexity and multi-morbidity managed in general practice, conference calls on GPC to campaign to increase the duration of routine GP appointments to 15 minutes.
- 5f HEREFORDSHIRE: That conference demands that the government must introduce a mechanism whereby general practitioners can move to provide longer consultations for all patients as the current system of GPs providing 10 minute appointments is clinically unsafe.
- 5g CAMBRIDGESHIRE: That conference notes that while consultation rates have risen, consultation times have not, and calls on the GPC to demand the resources needed to give patients the longer consultation times they need.
- 5h WORCESTERSHIRE: That conference demands that the government must introduce a mechanism whereby general practitioners can move to provide 20 minute consultations as the norm for all patients in the next 2-3 years, as the current system of GP's providing 10 minute appointments is clinically unsafe.

- 5i SOUTH STAFFORDSHIRE: That conference calls upon the GPC to:
- (i) restore work-life balance to the profession by implementing the UK Working Time Regulations (WTR) for "ALL" general practitioners
  - (ii) introduce a workload monitoring system that records time spent working outside contracted hours
  - (iii) develop a banded payment mechanism, that recognises and compensates GPs, for the intensity and duration of work carried out during unsociable hours
  - (iv) negotiate a new deal contract that protects patients from overtired doctors, by reducing the maximum hours worked per week to 48.
- 5j BIRMINGHAM: That conference recognises that GP practices in Denmark are highly motivated and provide high quality general practice based on a 9am to 4pm core working day with appropriate out of hours services and directs GPC to negotiate shorter core hours for general practice to improve both patient safety and workforce morale.
- 5k CLEVELAND: That conference;
- (i) is concerned by the excessive hours being worked by many GPs
  - (ii) believes that GMC requirements to work only when safe to do so always over-ride any contractual obligations
  - (iii) believes that a safe maximum sessional workload for GP contractors should be urgently defined
  - (iv) calls on the GPC to urgently develop a range of supportive solutions for practices in whom excessive GP working hours have been identified.
- 5l WAKEFIELD: That conference believes in the interests of patient safety the number of patient contacts GPs can have in one session should be limited.
- 5m NORTHERN IRELAND NORTHERN: That conference recognises that the current GP workload is unsafe for both doctors and patients and calls for a national contract to limit workload to a safe level.
- 5n BRO TAF: That conference asks government to recognise that present day patient consultations by general practitioners are very complex, the 10 minute consultation time is insufficient and we need:
- (i) more general practitioners and more consultation times for patients in order to improve continuity of care
  - (ii) to rationalise complex secondary care work being dumped on GPs.
- 5o AYRSHIRE AND ARRAN: That conference delivers the government a warning. Due to chronic underfunding and overwhelming demand, the workload pressure is putting the health of the current workforce at risk. If the government does not act NOW, there will be no health service.
- 5p WORCESTERSHIRE: That conference insists that the government must introduce limits on the number of patients that it is safe for a GP to see in each clinical session.
- 5q HEREFORDSHIRE: That conference insists that the government must define and introduce safe limits on the number of patients a primary care clinician can see in a session.
- 5r SANDWELL: That conference calls on the GPC to unilaterally declare that, in the interest of patient safety and quality, a GMS GP session will consist of 13 consultations. Nine such sessions should be provided for every 2000 patients. Experienced practitioners who have the personal capacity to safely deliver additional consultations should be commissioned to do so or be able to charge commissioners at full rate. This will bring sanity to GPs' lives, adequately recompense high performing GPs and allow adequate remuneration to employ additional GPs for those principals who otherwise risk burnout.
- 5s HERTFORDSHIRE: That conference notes with interest Mary McCarthy's findings from the UEMO and calls upon the GPC executive team to work with NHS Employers in using a maximum number of patient contacts per day to determine safe levels of workload to improve quality of care and make general practice viable again.
- 5t CROYDON: That conference believes practices should be encouraged to cap their list sizes in order to deliver a safe and sustainable service.  
*(Supported by Croydon, Kingston & Richmond, Surrey, East Sussex and West Sussex)*
- 5u CENTRAL LANCASHIRE: That conference believes that general practice is not waving but drowning in a crisis of unsustainable workload that threatens patients' safe treatment and the health of the workforce which needs to be averted NOW, otherwise politicians will have to face the consequences of avoidable suffering and needless deaths.  
*(Supported by Lancashire Coastal, Lancashire Pennine and Cumbria)*
- 5v NORTH ESSEX: That conference believes there will be no solution to the crisis facing general practice until the following actions are taken, and asks that GPC take responsibility for initiating this plan:
- (i) GPC leads a nationwide campaign to ensure that the workload of practices is limited to a level which is considered to be safe for both patients and practitioners
  - (ii) LMCs are supported to encourage and defend practices which follow safe practice guidance
  - (iii) practices are given the necessary tools and support to work only within their safe workload limits
  - (iv) NHS England commits to reducing local micro management and unnecessary bureaucracy and CCGs commission services which will address any surplus demand across the locality
  - (v) patient groups at a national and local level are given full information on this plan of action.
- 5w LIVERPOOL: That conference believes that a safe and sustainable service for patients with ever increasing complex needs and multiple morbidities, can only be secured by improving the quality of life and working environment for GPs; this can only be achieved by seeing fewer patients with longer consultation times working alongside an enhanced multi-disciplinary primary care team.

- 5x HERTFORDSHIRE: That conference believes that population demographics and morbidity make longer consultation times and lower lists essential for the sustainability of patient/doctor satisfaction within general practice and that investment in practices must be directed to achieve this without any consequent financial penalty.
- 6 **AGENDA COMMITTEE to be proposed by BUCKINGHAMSHIRE: That conference believes, in order to provide safe and sustainable services in general practice, separate contractual arrangements are needed for:**
- (i) home visits
  - (ii) care for residents of nursing homes, residential care homes and similar institutions
  - (iii) medical certification of illness
  - (iv) travel advice and immunisation
- 6a BUCKINGHAMSHIRE: That conference believes that in the absence of adequate funding, GP services can no longer be sustained unless:
- (i) home visits are no longer provided by GP surgeries
  - (ii) the care for residents of nursing homes, residential care homes and other similar institutions are no longer provided by GP surgeries.
- 6b KENT: That conference believes that a separate service for home visiting be established which would allow GPs to focus on surgery workload.
- 6c CLEVELAND: That conference concludes that the unprecedented demands on general practice mean that a practice provided home visiting service is no longer sustainable, and calls for the appropriate contractual changes to reflect this.
- 6d DEVON: That conference recognises the huge burden of work involved in caring for patients in residential and nursing homes and calls for the current 1.4 weighting to the GP baseline payment to be significantly increased.
- 6e NOTTINGHAMSHIRE: That conference believes that to eradicate the burden of certification requests for non-medical purposes, PCOs should be instructed to appoint local certification officers with authority to access patient records with consent when responding to such requests using a suite of nationally provided forms, their services to be paid for by charges determined by nationally agreed tariffs.
- 6f KENT: That conference demands that the responsibility for certification of fitness to work is removed from GPs and that:
- (i) patients can self certify for up to 14 days
  - (ii) employers are required to use an occupational health service for certification beyond 14 days
  - (iii) that the DWP establish their own means for determining fitness for benefits.
- 6g WAKEFIELD: That conference feels that travel advice and immunisation should be removed from the GP contract and provided elsewhere as it absorbs a disproportionate amount of time that could be used in treating patients who are actually ill.
- 6h BUCKINGHAMSHIRE: This conference instructs the GPC to define essential or core primary care duties and services as soon as possible and:
- (i) identify appropriate levels of funding for these core primary care duties and services
  - (ii) negotiate with government/NHSE what essential services will cease if there is inadequate funding to provide safe and effective patient care
  - (iii) demand that the governments address the constant form filling and bean-counting required for payment of all on core activities, such as enhanced services and other contracts, which diverts attention away from patient care
- 6i HERTFORDSHIRE: That conference believes that general practice is unsustainable in its current fixed fee open-ended contract commitment and calls on GPC to negotiate a new contract that more closely reflects and pays for the work expected from general practice.
- 6j KENT: That conference demands a definition of core and non-core work and:
- (i) that the relentless drive for access over continuity is stopped
  - (ii) ensures that administrative activities such as safeguarding reports and ESA forms are adequately reimbursed.
- 6k CORNWALL AND ISLES OF SCILLY: That conference believes that the time has come to define what is meant by core general practice.
- 6l COVENTRY: That conference believes that the current level of workload in general practice is not safe or sustainable. We therefore call on the GPC to look at funding mechanisms that recognise and adequately fund work that is outside of the core GMS contract.
- 6m LEEDS: That conference believes that in order for practices to deliver a safe and sustainable service to all their patients
- (i) increased and dedicated funding should be provided to support the care of patients in nursing and residential homes
  - (ii) patients in nursing homes should receive the majority of their care from a specialist multi-disciplinary service and not their GP.
- 6n SOMERSET: That conference believes that the time has come to define what is meant by core general practice.  
*(Supported by Cornwall)*
- 6o GLOUCESTERSHIRE: That conference requires the excessive workload of general practitioners to be alleviated by one or more of the following measures:
- (i) defining what services can be regarded as outside the core contract
  - (ii) supporting GPs who decide to provide only those core services
  - (iii) encouraging the NHS to set a fair rate for non-contractual work
  - (iv) limiting seven day opening to the provision of urgent care only.



- 6p CENTRAL LANCASHIRE: That conference believes that politicians, NHS managers and patients have unreasonable and unrealistic expectations of GPs that are undermining their ability to provide safe and effective care and this needs to be remedied by:
- (i) defining in a single and coherent message the core work of a GP
  - (ii) empowering and supporting GPs to say no to work outside this core
  - (iii) not requiring a GP to undertake process work to get a tick in a box that does not impact directly on patient care
  - (iv) saying no to new work without new resources.
- (Supported by Lancashire Coastal, Lancashire Pennine and Cumbria)*
- 6q LINCOLNSHIRE: That conference call on NHS England to investigate the feasibility of a fully funded transport system to support patient movement from their home, including residential and nursing homes, for routine and emergency appointments in primary care as currently is available for appointments in secondary care.
- 6r WILTSHIRE: That conference believes we no longer have capacity to visit patients at home and wants patients without means of transport to be provided with NHS transport to GP surgeries.
- 6s SOUTH ESSEX: That conference believes there will be no solution to the crisis facing general practice until the following actions are taken, and asks that GPC take responsibility for initiating this plan:
- (i) GPC initiates a nationwide campaign to halt the rise in requests for medical letters from schools and educational establishments requiring proof of a student's illness
  - (ii) GPC initiates a nationwide campaign to engage with secondary care to highlight how patient safety is being compromised by increasing requests for GPs to review patients and investigations within less than one month after hospital discharge
  - (iii) GPC insists that the Department of Health fund an occupational health service to issue Fitness to Work certificates. Fitness to Work certificates should no longer be issued by GPs.
  - (iv) travel insurance companies are reprimanded for routinely insisting that customers request GPs to approve and document 'fitness to travel' statements in their medical records.
- 6t GLOUCESTERSHIRE: That conference believes the role of paramedics should be enhanced to include all home visiting, except terminal care visits.

- 7 **OXFORDSHIRE: That conference believes that many younger GPs currently prefer to be salaried rather than partners, and that in looking at future contractual models, the GPC Executive Team should explore all options including movement away from independent contractor status.**
- 7a MID MERSEY: That conference believes that the days of independent contractors delivering safe and sustainable general practice are coming to an end and calls upon the GPC to actively support the development of a salaried GP service.
- 7b CORNWALL AND ISLES OF SCILLY: That conference believes that the partnership model of general practice is no longer fit for purpose and calls on GPC to develop a national salaried service.
- 7c SOMERSET: That conference believes that the partnership model of general practice is no longer fit for purpose and calls on GPC to develop a national salaried service.  
*(Supported by Cornwall)*
- 7d HERTFORDSHIRE: That conference calls on the GPC to negotiate a contractual model of general practice provision at scale whereby practitioners have a model salaried contract which rewards experience and expertise, encourages career development without penalising career breaks and allows GPs to run their local models of care on a sessional basis employed by their PCO/NHSE.
- 7e SALFORD AND TRAFFORD: That conference asks GPC to explore the risks and benefits for both the health economy and the workload for individual GPs of an increasingly salaried GP service.
- 7f SALFORD AND TRAFFORD: That conference believes the concept of independent contractor status has had its day and at best is anachronistic and at worst is used as a weapon against the profession.
- 7g DERBYSHIRE: That conference instructs GPC to include in any new contract negotiations a right for any qualified GP to work for the NHS in England on a nationally agreed salaried contract held by NHS England or any single not-for-profit successor body.
- 8 **AGENDA COMMITTEE to be proposed by DORSET: That conference, in respect of physicians' assistants;**  
**(i) affirms they will be a lifeline for general practice**  
**(ii) is concerned that they will distract attention from the inadequate numbers of GPs and registrars**  
**(iii) is concerned that they will not decrease GP workload**  
**(iv) is concerned that they will increase referrals, investigations and prescribing**  
**(v) demands that they require their own medical indemnity cover.**
- 8a DORSET: That conference affirms that physicians' assistants will be a lifeline for General Practice.
- 8b SOMERSET: That conference affirms that physicians' assistants will be a lifeline for general practice.
- 8c HAMPSHIRE AND ISLE OF WIGHT: That conference affirms that physicians' assistants will be a lifeline for general practice.
- 8d WILTSHIRE: That conference affirms that physicians' assistants will be a lifeline for general practice.
- 8e NORTH WALES: That conference recognises the necessity and benefits of increasing skill mix to maintain a primary care workforce.
- 8f CHESHIRE: That conference believes that not enough is being done to address the inadequate numbers of GPs and registrars to sustain general practice and that the admission of pharmacists and physician assistants will merely distract attention from this underlying problem and lead to increased costs.
- 8g KENT: That conference is concerned that increasing the number of risk averse non-doctors will have unintended consequences which may:  
 (i) not decrease GP workload  
 (ii) increase referrals, investigations and prescribing  
 (iii) mean that medical indemnity will not cover unregulated practitioners.
- 8h SOMERSET: In the light of the persistent undermining by government of the current model, calls on government to state their precise, clear plans about their future intentions for primary care, and whether they envisage a service led and staffed by GPs or by other healthcare professionals.  
*(Supported by Avon)*
- 8i AVON: That conference, in the light of the persistent undermining by government of the current model, calls on government to state their precise, clear plans about their future intentions for primary care, and whether they envisage a service led and staffed by GPs or by other healthcare professionals.  
*(Supported by Somerset )*
- 8j LEEDS: That conference welcomes the report of the Primary Care Workforce Commission led by Prof Martin Roland and supports the RCGP's call for the Commission's workforce recommendations to be fully funded with an additional £1.7bn.

- 8k MANCHESTER: That conference believes the GP workforce crisis cannot be resolved by back-filling posts with pharmacists and physician associates.
- 8l BRO TAF: That conference requests GPC to counter the unhelpful rhetoric from the NHS and other bodies that promotes the myth that other health professionals will provide the answer to the recruitment and sustainability crisis in general practice.
- 8m LOTHIAN: That conference asserts that it has to now be accepted that general practice is struggling for survival and, to help in both the short and long term, each practice should receive a set number of sessions of paid clinical pharmacist time per week, to undertake routine practice work, based on the number of patients with four or more repeat prescriptions.
- 8n GWENT: That conference demands robust monitoring and impact measurements on the contribution of allied health care practitioners to lessen the workload on general practitioners.

9 **AGENDA COMMITTEE to be proposed by NOTTINGHAMSHIRE: That conference, in order to address the current recruitment crisis, demands;**

- (i) **the government writes off a proportion of new GPs' student loans for each year of service, at five yearly intervals**
- (ii) **a Foundation training year 3 which should be undertaken entirely in general practice**
- (iii) **more support for newly qualified GPs to take on partnership roles more gradually**
- (iv) **an immediate increase in the number of GP training posts in Northern Ireland to a level equivalent to the other three UK countries.**

- 9a NOTTINGHAMSHIRE: That conference believes that to boost recruitment into GP training schemes and encourage GP trainees to remain working in the UK, the government should offer to write off a proportion of those GPs' student loans for each year of service at five yearly intervals.
- 9b DONCASTER: That conference requires GPC to negotiate a Foundation 3 training year which should be undertaken entirely in general practice, allowing junior doctors to experience the virtues of general practice as a career option whilst helping our immediate workforce crisis.
- 9c NORTHERN IRELAND EASTERN: That conference demands an immediate increase in the number of GP training posts in Northern Ireland to a level equivalent to the other three UK countries.
- 9d HERTFORDSHIRE: That conference believes that there needs to be a way for newly qualified GPs to take on partnership roles more gradually rather than being thrown in at the deep end.
- 9e NORTH WALES: That conference calls on government, the GMC and GPC UK to enable doctors to spend 6-12 months in supervised stand-alone 'F3' posts in general practice.
- 9f DERBYSHIRE: That conference notes that rising tuition fees and mounting student debt is a huge disincentive and financial obstacle to young GPs investing in GP partnerships and demands that the Secretary of State for Health and the Treasury consider options to resolve this.
- 9g AYRSHIRE AND ARRAN: That conference is concerned by the decline in applications to GP training over recent years and believes that there is an impending workforce crisis. Conference calls on GPC to work with relevant bodies in order to:
- (i) increase the amount of time medical students spend in general practice during medical school
  - (ii) increase the number of foundation trainees with general practice placements
  - (iii) promote the benefits of a career in general practice to potential applicants
  - (iv) increase the attractiveness of general practice to potential applicants.
- 9h BEDFORDSHIRE: That conference notes the need to attract more trainees into general practice and calls on GPC to negotiate a system of financial support for students on the condition they commit to a minimum period in general practice on the completion of studies.
- 9i CLEVELAND: That conference believes that financial incentives should be introduced to incentivise doctors to join the GP workforce.

10 **AGENDA COMMITTEE to be proposed by GWENT: That conference demands action on a strategy for retaining experienced general practitioners within the GP workforce, which should specifically include;**

- (i) **re-instatement of seniority payments or equivalent funding**
- (ii) **amendments to the NHS Pension Scheme to incentivise GPs to remain in practice**
- (iii) **voluntary exit interviews for GPs who are retiring or moving out of the UK**
- (iv) **reduced bureaucracy for the GP returners scheme.**

- 10a GWENT: That conference demands progress and action on a strategy for retaining experienced general practitioners within the GP workforce.
- 10b BEDFORDSHIRE: That conference laments the loss of many older GPs through early retirement and calls on the GPC to negotiate the re-instatement of seniority payments or equivalent funding for those GPs within ten years of state pension age.

- 10c LANCASHIRE COASTAL: That conference believes government changes to the NHS Pension Scheme have led to a huge increase in GPs retiring early and their vast experience being lost to the NHS and calls upon politicians in all devolved countries to work with NHS employee representatives to amend the Pension Scheme to incentivise GPs to remain in general practice.  
*(Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 10d GWENT: That conference demands that the government looks at voluntary exit interviews for GPs at all levels who are retiring or moving out of the UK, to inform objective measurable reasons for the haemorrhage and loss of resource.
- 10e LEEDS: That conference is alarmed at the GP workforce crisis and insists that NHS England and Health Education England do far more to reduce the bureaucracy of the GP returners scheme to enable more GPs to return to UK general practice.
- 10f HERTFORDSHIRE: That conference calls upon the government to facilitate the return of UK qualified GPs from overseas with a comprehensive recruitment package including:
- (i) financial assistance with relocation fees
  - (ii) facilitation of the process of getting onto the Performer's List
  - (iii) acceptance of existing enhanced DBS or equivalent for initial six months
  - (iv) acceptance of existing local appraisal documentation for initial six months
  - (v) ability to join a partnership without prior approval from CQC.
- 10g NORFOLK AND WAVENEY: That conference calls upon GPC to negotiate a return of seniority pay in an effort to retain experienced GPs within active general practice and avoid a further reduction in the GP workforce.
- 10h COVENTRY: That conference believes that seniority should be reinstated to improve retention.
- 10i BRADFORD AND AIREDALE: That conference believes that the first step in improving the retention of senior GPs would be to reverse the withdrawal of seniority payments.
- 10j ROTHERHAM: That conference believes there is no substitute for the experience and knowledge of senior GPs. The threat of losing this cohort of GPs due to the loss of seniority payments is a threat to delivering a safe and sustainable general practice service and demands they be reinstated immediately.
- 10k SEFTON: That conference calls upon the Secretary of State to staunch the loss of experienced principals and sessional GPs in general practice to premature early retirement. It calls upon him to provide immediately substantial incentives and benefits to encourage GPs to remain in active practice.
- 10l DERBYSHIRE: That conference urges NHS England:
- (i) to undertake any research necessary to determine why so many GPs are leaving the profession in their 50s or early 60s
  - (ii) to liaise with all appropriate agencies, including government departments and the GMC, to develop schemes to stem the exodus of this highly skilled and experienced workforce.
- 10m HERTFORDSHIRE: That conference laments the loss of many older and more experienced GP partners which is depriving younger partners of the mentorship and support that the older generation of GPs benefitted from and calls on GPC to explore mechanisms of replacing this unofficial resilience training through funded mentorship programmes.
- 10n HERTFORDSHIRE: That conference notes that there are still some older GPs who enjoy the job and are not ready to retire, and calls on GPC to actively seek out and work with these valuable colleagues to harness their experience and skills as inspiration and support for other GP colleagues.
- 10o HERTFORDSHIRE: That conference cannot wait any longer for NHS England or Health Education England to take action and instructs GPC to use GPDF money to fund schemes to improve recruitment of new GPs and the retention of older GPs.
- 10p NORTHERN IRELAND WESTERN: That conference calls upon the four UK Departments of Health to introduce measures to encourage the retention of experienced general practitioners.
- 10q NORTH STAFFORDSHIRE: That conference believes the current workforce crisis and unfunded workload transfer from secondary to primary care requires consideration of:
- (i) suspension of CQC visits, appraisals and CCG locality work
  - (ii) majority activity based contract, to reflect and reward workload transfer
  - (iii) reinstatement of seniority payments for retention
  - (iv) pension review to allow realistic ongoing working peri-retirement
  - (v) permanent GP registrar supplement.
- 10r LANCASHIRE COASTAL: That conference believes that a solution to the workforce crisis in general practice is central to the future of the NHS and needs to be addressed as a priority by the government over all other issues by:
- (i) making general practice more attractive than all other branches of medicine
  - (ii) providing sufficient funds to recruit and develop a full primary health care team to support GPs provide safe services to patients
  - (iii) reviewing the pension arrangements that are driving many GPs to early retirement
  - (iv) showing respect to GPs rather than confrontation and challenge.
- (Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 10s CLEVELAND: That conference demands, to aid workforce retention, the lifetime allowance on pensions be scrapped for GPs.

- 10t AVON: That conference calls for immediate action to address the recruitment crisis facing primary care by:
- (i) reducing the onerous nature of revalidation on GPs who have retired
  - (ii) promoting the benefits of primary care as a specialty choice
  - (iii) giving tangible incentives for senior GPs to remain within the profession
  - (iv) making changes to the pension structure to encourage GPs to remain within the workforce.
- 10u NORTH WALES: That conference believes that the government should acknowledge the crisis in British general practice and undertake the following measures urgently:
- (i) make general practice a shortage speciality under Home Office regulations, thus allowing appropriately trained doctors from outside the EEC to seek work in the UK
  - (ii) establish what measures can be taken to arrest the haemorrhage of experienced practitioners from the profession and introduce them to general practice
  - (iii) enact the bureaucracy reducing measures that have been proposed for several years but have yet to be implemented
  - (iv) restore the necessary expenditure necessary to maintain high standards of doctor delivered general practice.
- 10v KENT: That conference demands the government introduce a system of merit awards that recognises quality and experience.

**LUNCH**

**1.00**

**Maureen Baker, Chair of RCGP has been invited to address conference**

**2.00**

- 11 **DERBYSHIRE: That conference demands that, in the light of the unprecedented pressures on a demoralised and depleted NHS, the government convenes a new commission to report on the future form, function and funding of the NHS in the 21st century.**
- 11a BRADFORD AND AIREDALE: That conference calls upon the UK government to debate and decide upon the type of NHS that they wish to provide, to inform the public of the outcome of their deliberations and to fund the NHS in accordance with this.
- 11b WORCESTERSHIRE: That conference demands that health rationing decisions in future must be taken at a national level and so be consistent across the NHS and that an NHS policy of demand management is introduced urgently.
- 11c LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference formally requests the BMA to actively campaign for a cross party commission or Royal Commission to review the crisis in UK general practice to identify the root causes of problems and to propose a short, medium and long term solutions with the aim of an interim report with proposals for short term rescue measures to be produced by September 2016.
- 11d HAMPSHIRE AND ISLE OF WIGHT: That conference believes that you can have any two of fast, cheap or quality under current NHS funding arrangements and that the public needs to choose which two it prioritises or else acknowledge that investment is needed to achieve all three.
- 11e DERBYSHIRE: That conference:
- (i) reasserts its commitment to a national health service that is universal, comprehensive, funded from general taxation, free at the point of contact and based on the needs of the individual
  - (ii) calls upon the electorate to make it clear to politicians whether it supports such an ideal.
- 11f LIVERPOOL: That conference believes that until there is an adequate workforce and sufficient core funding provided to NHS GP practices, to enable appropriate access to a GP during core hours Monday - Friday, GP practices must not be expected to provide routine access to services seven days per week.
- 11g NORTHERN IRELAND SOUTHERN: That conference rejects the concept of seven day scheduled care until current working is adequately resourced.
- 11h GLOUCESTERSHIRE: That conference urges that continuity of patient care would be better achieved by increasing resources for practices rather than by politically motivated impositions.
- 11i SHROPSHIRE: That conference considers that government obsession with introducing seven day routine GP services to be perverse given its failure to identify additional resources and the current crisis in the NHS, and should be rejected.
- 11j SUFFOLK: That conference believes that the current emphasis on seven day working is a political push for the unachievable particularly in the light of the continued under-resourcing of primary care and insists that the seven day mantra be abandoned and any additional resource available should be used to enhance the weekend emergency cover services.
- 11k CAMDEN: That conference instructs the GPC to publish full financial modelling for extended hours and weekend working that includes ancillary and clinical staff costs, as well as building costs to enable public debate on how this money would best be utilised to support the care of practice patients.  
*(Supported by Barnet, Bexley, Bromley, City and East London, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)*
- 11l MID MERSEY: That conference believes that the government's flagship election pledge of seven day access is neither affordable nor deliverable in a safe and sustainable manner, is based on little evidence and calls upon the GPC to ballot the profession on its future.
- 11m SUFFOLK: That conference suggests that a contract promising an 'all-you-can-eat' delivery model of primary care, free at the point of delivery and on fixed funding, is unsustainable in any framework and should not be the starting point for any negotiations.
- 11n BUCKINGHAMSHIRE: That conference believes that there is a public expectation of rights and privileges about NHS services that exceeds the ability of the NHS to deliver, and insists that:
- (i) no politician should make any health promises to the public until it has buy-in from the key stakeholders to those promises
  - (ii) any new health initiative must be properly costed and funded from new monies.
- 11o DEVON: That conference insists that government funds general practice based on true medical need rather than perceived wants or convenience, unless they:
- (i) increase NHS funding
  - (ii) openly discuss rationing of NHS care.
- 11p SUFFOLK: That conference views the continued under-resourcing of primary care combined with the lack of willingness of the government to listen to our professional bodies as a perfect storm threatening the very existence of the whole NHS. Without an immediate and meaningful change in government policy in these areas the profession is likely to be forced to concentrate on matters of immediate patient safety only at the expense of all other work. Conference instructs GPC to leave the government in no doubt on this matter.

- 11q DERBYSHIRE: That conference asserts that the emotional blackmail of general practitioners by politicians, the NHS, journalists and opinion formers, to obtain NHS services from GPs without proper reward or reimbursement of expenses incurred, using the arguments that "patients will suffer / what about your dedication and vocation?" are those of the morally and intellectually bankrupt in the context of a wealthy nation such as the United Kingdom.
- 11r SUFFOLK: That conference laments a recent expression by an NHS England representative suggesting that primary care may not 'need' an uplift for expenses in 2016 and suggests that this is so far from reality that it brings into question the fitness of NHS England to manage GP contracts.
- 11s GLOUCESTERSHIRE: That conference, in the interests of equality of treatment for patients and the preservation of the NHS, believes the time has come for NHS services to be rationed and calls on the government to:
- (i) decide what should be included and what excluded from core services under the GMS contract
  - (ii) permit clinicians to charge privately for whatever work falls outside the agreed NHS provision.
- 11t SEFTON: That conference calls for an unrelenting coordinated campaign by the GPC and every LMC of publicising to the Media, MPs, public and patients. The crisis of workload and demoralisation of GPs and their staff. Personal testimonies suitably anonymised but authenticated should be collected and issued unremittingly so that current crisis can be truly felt and recognised by those who have the most to lose the users of general practice and those they vote for.
- 11u AVON: That conference believes that new ways of working such as vanguards, multi-speciality community providers and Prime Minister challenge fund projects will not solve the fundamental problems caused by successive governments' policies which have critically underfunded the NHS.
- 11v SUFFOLK: That conference believes in the current financial climate it is even more critical that government allocate resources to public health initiatives that have a robust evidence base instead of ideology. Based on this criteria health checks should be scrapped and money should be re invested to front line community services where there is proven need and which is not being appropriately met.
- 11w NORTH YORKSHIRE: That conference believes that in order to reverse the unsustainable workload pressures in general practice, the link between austerity and both poorer health outcomes and increased health seeking behaviours must be acknowledged and tackled through a range of measures, especially increased funding for primary care services.
- 11x NORTH STAFFORDSHIRE: That conference believes that general practitioners should be allowed to provide both private and NHS medical services to their patients in line with other medical and allied professionals such as physiotherapists, dentists and pharmacists.
- 11y BUCKINGHAMSHIRE: That conference believes that the government is not prepared to increase the funding envelope allocated to the GPs contracts and GPs must seek to both divest themselves of non-obligated work and obtain other sources of income outside the NHS.
- 11z CITY AND EAST LONDON: That conference totally opposes charges for primary care including general practice.  
*(Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest LMCs)*
- 11aa AVON: That conference believes that without an immediate increase in resources for general practice the NHS will fail under this government's watch and to prevent this calls upon the Department of Health to:
- (i) stand by the words of this Prime Minister and either to provide 5,000 extra GPs and 5,000 ancillary personnel, from where we do not know, or to provide general practice with the resources to start employing them, themselves immediately
  - (ii) undertake to bring funding for general practice up to at least 11% of the NHS budget during the course of this parliament
  - (iii) convene an independent (Royal) Commission on the future of and funding of the NHS.
- 11bb NORFOLK AND WAVENEY: That conference believes that primary care can no longer be free at the point of delivery and GPC should produce an appraisal document looking at the risks and benefits of a co-payment system.
- 11cc KENT: That conference puts an end to the tyranny of the present GP contract and replaces it with a co-payment model.
- 11dd SHROPSHIRE: That conference believes, that without the immediate allocation of significant additional resources to the health service, the government must now consider introducing a nominal charge to users as a means of limiting demand.
- 11ee HERTFORDSHIRE: That conference believes the most suitable way to curb inappropriate demand on primary care is to place a nominal charge on the GP consultation which will be reimbursed upon later individual application.
- 11ff AVON: That conference calls on the government to introduce patient fees for access to primary care.
- 11gg CORNWALL AND ISLES OF SCILLY: That conference believes that legislation change to allow co-payments is an effective way to encourage new funding streams into the NHS to guarantee a health service that is free at the point of care for the poorer in society.
- 11hh HULL AND EAST YORKSHIRE: That conference believes that an integrated health and social care service is the best model to provide for the needs of the population, but that the constant tendering and retendering of services hampers this model and wastes time and money.  
*(Supported by North & North East Lincolnshire LMC)*
- 11ii NORFOLK AND WAVENEY: That conference believes that in many areas out of hours primary care is poorly commissioned and promotes inappropriate expectations of the NHS and calls for a radical redesign and integration of all current out of normal hours services.

- 11jj SHEFFIELD: That conference demands that government addresses the acknowledged historical widening imbalance between secondary care and primary care funding which is destabilising general practice to the point of extinction.
- 11kk LANCASHIRE COASTAL: That conference lays the blame for the current crisis in general practice fairly and squarely at the door of our politicians.  
*(Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 11ll DERBYSHIRE: That conference now warns the public that, in the absence of both a categorical denial and positive remedial action from the government, it appears that the government is hell bent on ending the NHS GP service by means of attrition through policies which have the effect of working GPs to the point of ill health, resignation from the service or bankruptcy caused by financially starving out GP practices.
- 11mm DERBYSHIRE: That conference does NOT believe that the NHS is safe in this government's hands and warns the general public that their GP service faces extinction within 5 years unless radical changes acceptable to the profession are made.
- 11nn LANCASHIRE COASTAL: That conference knows that UK general practice is woefully underfunded and has been for many years and calls upon the Departments of Health to recognise this and put in place urgent proposals to bring funding back to levels that the profession feels it needs to provide a safe and sustainable service for our patients.  
*(Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 11oo GLASGOW: That conference, in the light of the recent findings of research published in the British Journal of General Practice, calls upon GPC negotiators to ensure that the huge difference in premature multi-morbidity across the social spectrum is reflected in the allocation of funding and resources.
- 11pp BIRMINGHAM: That conference believes that primary care transformation must be delivered by building upon, not tearing up, a fit for purpose and properly funded core national GMS contract.
- 11qq KENT: That conference demands that a royal commission is set up to investigate the state of general practice with regard to:
- (i) NHS premises
  - (ii) GP workload
  - (iii) problems of recruitment in the NHS
  - (iv) GP retention.

- 12 **AGENDA COMMITTEE to be proposed by GATESHEAD AND SOUTH TYNESIDE: That conference insists that new models of care must be based on:**
- (i) personalised care being delivered to patients by general practices supported by extended primary health care teams**
  - (ii) a registered list of patients**
  - (iii) an adequately resourced, safe and sustainable national core GP contract**
  - (iv) cherishing and building on the independent contractor model**
- 12a GATESHEAD AND SOUTH TYNESIDE: That conference insists that any development of new models of care should be based on the following:
- (i) a fundamental principle of personalised care being delivered to patients by general practices supported by extended primary health care teams
  - (ii) maintenance of a registered list of patients
  - (iii) work that provides the best care for patients within a framework of disease specific guidelines whilst maintaining the independence plan for the individual patient and not the disease
  - (iv) primary care teams supported by excellent management, which should be based on current good practice and evidence using the economies of scale.
- 12b CAMBRIDGESHIRE: That conference believes that new models of care, must be built upon the foundation-stone on adequate resourced, safe and sustainable national list-based core GP contract.
- 12c NORTH WALES: That conference believes that whatever the future models of general practice, the good things about independent contractor status that make it efficient and effective should be cherished and built on.
- 12d SUFFOLK: That conference notes that traditional general practice was one of the preferred models in the five year forward plan and demands that this model remains equally attractive as any new model.
- 12e WIGAN: That conference does not believe that the transition to new models of care and contracts, ie MCP, primary care home etc, can produce the immediate relief needed to ensure the stability of general practice. General practices needs to be stabilised before such transitions can be truly successful.
- 12f HEREFORDSHIRE: That conference demands NHS England support primary care networks to immediately address the risk to practices of 'last partner standing' caused by the national shortage of GPs.
- 12g NORTHERN IRELAND EASTERN: That conference recognises that if MCP organisations are to achieve their potential to redesign services, they require substantial start-up funds from out with the GP community.
- 12h SUFFOLK: That conference demands that all contractual models are constructed in a way that means they are viable in the whole of England.



- 12i WOLVERHAMPTON: That conference believes the great strength of the GMS contract has been the fact that it is centrally negotiated. It is now time to rein in all the locally negotiated bolt on services for central negotiation to strengthen the GMS contract and general practice.
- 12j MID MERSEY: That conference believes that the introduction of the voluntary contract will result in a divided profession to the detriment of patient care and will threaten the existence of safe and sustainable general practice.
- 12k STOCKPORT: That conference believes that the renegotiation of GP contracts at local levels is unacceptable as it has the potential to impact adversely on and destabilise the provision of high quality, safe, personalised care for our patients.
- 12l NOTTINGHAMSHIRE: That conference instructs GPC to try to ensure that incentives for practices to work collaboratively under 'voluntary' contractual arrangements do not require those practices to relinquish their national core contracts and that where practices do so GPC endeavours to negotiate additional measures to protect those GPs beyond the guaranteed 'return ticket' to nationally negotiated contractual arrangements.
- 12m NEWCASTLE AND NORTH TYNESIDE: That conference is seriously concerned about any movements away from a national contract and strongly believes:
- (i) a national contract is necessary to ensure equitable and consistent delivery of care to patients across the United Kingdom
  - (ii) new models of care can be developed and delivered whilst retaining a core national contract
  - (iii) a 'return ticket' will be very difficult to deliver in any movement from a national GP contract in the delivery of new models of care.
- 12n NORFOLK AND WAVENEY: That conference believes that district nurses are an essential part of the core primary care team and should be directly employed by practices or networked/federated practices in order to achieve an efficient and sustainable primary and community service.
- 12o HULL AND EAST YORKSHIRE: That conference believes that the twin principles of continuity of care and longevity of relationship should underpin all future policy in relation to general practice.  
*(Supported by North and North East Lincolnshire)*
- 12p DYFED POWYS: That conference demands that GPC negotiates a contract that is not totally devolved to local determination.
- 12q LOTHIAN: That conference maintains that, in order to deliver a safe and sustainable service, general practitioners require much stronger community nursing teams to play a significantly greater role in managing long term conditions, and provide first line assessment of nursing and care home patients.
- 12r LEEDS: That conference believes that in order for practices to remain sustainable and patients to continue to receive an acceptable general practice service a core GMS contract with ring-fenced funding must be provided to practices when working with a multi-specialty community provider.
- 12s WESTERN ISLES: That conference insists UK governments re-invest in community nursing, re-invest in community mental health and re-invest in training and employing health visitors and school nurses to support general practice.

## REGULATION

- 13 **AGENDA COMMITTEE to be proposed by CITY AND EAST LONDON:** That conference believes that over regulation and monitoring of the profession has eroded morale and had an adverse effect on the sustainability of General Practice, and:
- (i) **opposes any increase in the fees demanded of practices by the Care Quality Commission and demands that all fees be fully reimbursed.**
  - (ii) **demands that GPC actively campaigns to abolish the regulation of General Practice by the CQC.**
  - (iii) **demands that GPC produces realistic proposals for an effective peer led quality assurance scheme for General Practice based on criteria that improve patient care and safety.**
  - (iv) **calls on GPC to explore all options by which GP practices could lawfully withdraw from engaging with the Care Quality Commission.**
- 13a CITY AND EAST LONDON: That conference:
- (i) deplores the enormous cost to general practice of the CQC both in terms of finance and time taken to prepare for inspections
  - (ii) deplores the detrimental effect on an already fragile morale in many cases
  - (iii) demands that the GPC actively campaigns for the abolition of un-evidenced inspection regimes and organisations.
- (Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest)*
- 13b CORNWALL AND ISLES OF SCILLY: That conference calls for the abolition of the CQC and the re investment of its budget into frontline GP services.
- 13c SOUTHWARK: That conference requires that the GPC agrees with NHSE that they will:
- (i) ensure any future performance criteria are based on positive outcomes that improve patient care and safety
  - (ii) abandon current negative processes, such as CQC assessments that focus on negative criteria such as theoretical infection risk
  - (iii) report the outcome of the agreement to the 2016 Annual Conference of LMCs.
- (Supported by Barnet, Bexley, Brent, Bromley, Camden, City and East London, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Redbridge, Waltham Forest)*
- 13d CITY AND EAST LONDON: That conference will instruct all GPs to cease to cooperate with CQC inspections until such a time that general practice resources, in terms of time, money and manpower, are restored to a level which is adequate to be able to support the inspections without adding to the existing strain on patient care.
- (Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest)*
- 13e WAKEFIELD: That conference feels significant time and financial resources could be freed in general practice for patient care by the abolition of CQC.
- 13f WILTSHIRE: That conference, regarding CQC fees for registration for Practices, believes:
- (i) fees should not rise
  - (ii) proposals for several fold increases are outrageous
  - (iii) any cost of CQC registration should be fully reimbursed.
- 13g WILTSHIRE: That conference deplores the rise of the CQC demands for payment from practices and demands that GPC co-ordinates a mass campaign of non-payment.
- 13h ROTHERHAM: That conference believes the increasing costs for CQC registration should actually be spent on improving GP services and not on incompetent processes. We call on the GPC to explore all options for GP practices to completely withdraw from engaging with CQC and pursue this via judicial review if needed.
- 13i AYRSHIRE AND ARRAN: That conference demands:
- (i) an end to the external measurement of quality, eg CQC, within practices
  - (ii) the development of a professional peer led framework to support practices in providing and maintaining quality of patient care.
- 13j SHROPSHIRE: That conference requests the GPC ballot general practitioners to gauge support for a unified refusal to participate in CQC procedures or pay CQC fees.
- 13k SOMERSET: That conference demands that GPC:
- (i) undertakes its own cost/benefit analysis of the effect of CQC inspections in primary care
  - (ii) surveys practices and practitioners about the effect on practice viability and GP retention of the current inspection regime and the proposed quintupling of CQC fees
  - (iii) produces realistic proposals for a simple, effective and cheap quality assurance scheme for primary care.
- 13l LEEDS: That conference notes that the Care Quality Commission's finding that 85% of GP practices are providing a good or outstanding service is in line with what patients have been reporting for years and therefore demands that government remove from practices the significant expense and bureaucratic burden of the unnecessary CQC registration and inspection.

- 13m DERBYSHIRE: That conference demands that:
- (i) routine inspections of general practice by the Care Quality Commission (CQC) should be abandoned, at least until the general practice workforce crisis has been resolved to the satisfaction of the profession
  - (ii) unannounced inspection of general practices by CQC should not be triggered by otherwise un-investigated complaints about the clinical practice of individual clinicians.
- 13n SUFFOLK: That conference believes that the current CQC primary care inspection regime is unwieldy and unfit for purpose. Conference requests that GPC negotiate a more proportionate monitoring scheme for GP practices and insists that this is funded centrally in full.
- 13o DERBYSHIRE: That conference:
- (i) demands that, if the Care Quality Commission (CQC) is to continue inspecting general practice, any increases to its fees to the sector should not exceed 1% per annum for as long as public sector pay restraint continues at this level
  - (ii) demands that the government produces an impact assessment of the transaction costs of cycling money from the Treasury through the department of Health, NHS commissioners and NHS providers to the CQC as compared to direct funding of the CQC by the Treasury.
- 13p HERTFORDSHIRE: That conference is concerned by the increasing number of practices closing or on the brink of financial collapse, and calls upon NHS England with the government to agree to the following measures as an emergency rescue package until at least the end of this parliament:
- (i) an urgent review of CQC processes and inspections to simplify and support practices
  - (ii) CQC inspections to take place every five years with self-declaration measures in the interim
  - (iii) a freeze on 2014 CQC fee schedule.
- 13q BRADFORD AND AIREDALE: That given the perfect storm of rising workload decreasing resources and a workforce recruitment and retention crisis, conference calls for:
- (i) the CQC inspection regimen to be radically overhauled to be much less onerous, less ticky-boxy in nature and more amicable to GP providers, and
  - (ii) that conference opposes in the strongest terms any increase in the fees paid to the CQC.
- 13r NORTH YORKSHIRE: That conference believes that CQC needs to be reviewed for its purpose, its competence and its cost-effectiveness on identifying practices, which may cause a potential risk to the public.
- 13s LIVERPOOL: That conference believes that the requirement for practices to be inspected in a heavy-handed manner by CQC is having an adverse effect on GPs and the safety and sustainability of General Practice, and now calls on such inspections to be conducted with a light touch.
- 13t MID MERSEY: That conference believes that the proposed 7 fold increase in CQC inspection fees is unjustified and not necessary for the delivery of safe and sustainable GP services and calls on the GPC to ballot all practices about refusing to pay en masse.
- 13u GLOUCESTERSHIRE: That conference believes that:
- (i) CQC inspections should be replaced by peer review, thus promoting mutual help and a sharing of ideas rather than bureaucratic focusing on 'hotel' aspects
  - (ii) or, in the alternative, that:
    - (a) CQC should target those practices which merit their attention
    - (b) the costs of such inspections should be borne by those who wish the inspections to take place, not by practices.
- 13v LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges the BMA to take advice from a range of independent legal experts in order to actively pursue a legal challenge (up to and including a judicial review) to the requirement of GP surgeries to be registered with a monopoly inspectorate (the CQC).
- 13w GATESHEAD AND SOUTH TYNESIDE: That conference believes there is no justification for the proposed increases in CQC inspection fees, and these should be resisted by whatever means is necessary by the profession, and that these fees and the CQC inspection regime needs an urgent review and made fit for purpose.
- 13x NORFOLK AND WAVENEY: That conference believes that CQC in its present format is damaging to a safe and sustainable general practice.
- 13y EAST SUSSEX: That conference believes the CQC inspection process creates a considerable and unnecessary workload for practices and does not contribute to making general practice either safe or sustainable.  
*(Supported by Croydon, Kingston & Richmond, Surrey, East Sussex and West Sussex)*
- 13z WALSALL: That conference believes that rising CQC fees and workload costs around the inspection preparation process are not reflected in the current contract, are diverting time and resources away from direct patient care and are burdensome to GP practices, especially in the current funding crisis. Therefore conference demands that:
- (i) CQC fees should be fully reimbursed to the practices by NHS England / Department of Health
  - (ii) GPC contract negotiations for 2016/17 should take into account the work load and costs related to the CQC inspection process and ensure that they are included in global sum as additional money
  - (iii) CQC must simplify their inspection process and make it less disruptive to the delivery of GP services.  
*(Supported by Dudley, Sandwell and Wolverhampton)*
- 13aa COVENTRY: That conference believes that non evidence based overly bureaucratic CQC inspections should be stopped and the money that is being spent on them be reinvested in general practice. We therefore call on the GPC to explore all options for GP practices to completely withdraw from CQC inspections and fees until a robust and evidence based system is put in place.

- 13bb CITY AND EAST LONDON: That conference believes that money and time spent on CQC inspections is better spent on patient facing activities.  
*(Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest)*
- 13cc LOTHIAN: That conference insists that quality is best assessed by locality based discussion and feedback - and not a national inspectorate - and urges the government and national negotiators to urgently explore new models for such fora.
- 13dd CUMBRIA: That conference believes that the increased CQC fees being requested of practices is one step too far and that all practices should refuse to pay these increased fees whilst still co-operating with the CQC inspection process.  
*(Supported by Lancashire Coastal, Lancashire Pennine and Central Lancashire)*
- 13ee DONCASTER: That conference has no confidence in the Care Quality Commission and demands an immediate ballot of the profession on industrial action calling upon all BMA members to withhold CQC Fees.
- 13ff DONCASTER: That conference demands an immediate ballot on industrial action calling upon general practitioners to cease engagement with the care quality commission.
- 13gg BIRMINGHAM: That conference directs GPC to negotiate the full and direct reimbursement of CQC registration fees for all GP practices.
- 13hh BIRMINGHAM: That conference directs GPC to negotiate the abolition of CQC regulation of general practice.
- 13ii NORTHAMPTONSHIRE: That conference demands an end to burdensome supervision and onerous regulation of general practitioners which is interfering with service delivery. This will entail the:
- (i) removal of Healthwatch inspection
  - (ii) scaling back of CQC to a five yearly inspection with agreed parameters and central funding of inspections
  - (iii) reduction of appraisals to a three yearly cycle where the process is satisfactory
  - (iv) integration of local and central GMC complaint handling with adequate support for GPs and timely resolution
  - (v) reintroduction of the concept of no double jeopardy.
- 13jj HERTFORDSHIRE: That conference is concerned about the increasing burden on GPs of multiple inspections, meeting attendances and data demands from their commissioners and regulators and calls on GPC to insist that these are curtailed with immediate effect.
- 13kk NORTH AND NORTH EAST LINCOLNSHIRE: That conference insists that there is a significant reduction in the high level of reporting and performance management on general practice to all NHS bodies thus adding further pressure to an already under strain front line.  
*(Supported by Hull and East Yorkshire)*
- 13ll CLEVELAND: That conference demands the abolition of all targets applied to general practice, unless there is good evidence of substantial clinical benefit.
- 13mm SANDWELL: That conference calls on the GPC to work to reduce the non-clinical burden on practices. The non-clinical workload in primary care has escalated due to regulatory activity and visits, due to appraisal, audits and CCG meetings. The extra workload has had an adverse effect on face to face patient clinical care.
- 13nn SHROPSHIRE: That conference:
- (i) believes the bureaucratic workload in UK general practice to be excessive, unnecessary and unsustainable, and
  - (ii) calls on the government to mandate a 'pause' in appraisal, revalidation, CQC inspections and other workload that does not contribute directly to patient care.
- 13oo WILTSHIRE: That conference agrees with the Secretary of State for Health that GPs are 'the jewel in the crown' of the NHS and:
- (i) asks him to demonstrate his accolade by reducing the regulatory burden and micro management of services provided by GPs to restore the high trust low bureaucracy principle GPs signed up for
  - (ii) demands an end to the triple jeopardy of three regulators for English GPs with the GMC, the CQC and Quality Improvement teams from NHS England.
- 13pp HAMPSHIRE AND ISLE OF WIGHT: That conference agrees with the Secretary of State for Health that GPs are 'the jewel in the crown' of the NHS and:
- (i) asks him to demonstrate his accolade by reducing the regulatory burden and micro management of services provided by GPs to restore the high trust low bureaucracy principle GPs signed up for
  - (ii) demands an end to the triple jeopardy of three regulators for English GPs with the GMC, the CQC and Quality Improvement teams from NHS England.
- 13qq DORSET: That conference agrees with the Secretary of State for Health that GPs are 'the jewel in the crown' of the NHS and:
- (i) asks him to demonstrate his accolade by reducing the regulatory burden and micro management of services provided by GPs to restore the high trust low bureaucracy principle GPs signed up for
  - (ii) demands an end to the triple jeopardy of three regulators for English GPs with the GMC, the CQC and Quality Improvement teams from NHS England.

- 13rr SOMERSET: That conference agrees with the Secretary of State for Health that GPs are 'the jewel in the crown' of the NHS and
- (i) asks him to demonstrate his accolade by reducing the regulatory burden and micro management of services provided by GPs to restore the high trust low bureaucracy principle GPs signed up for
  - (ii) demands an end to the triple jeopardy of three regulators for English GPs with the GMC, the CQC and Quality Improvement teams from NHS England.
- (Supported by Wessex)*
- 13ss LINCOLNSHIRE: That conference calls for an end to the excessive, unresourced bureaucracy requirements of CQC, GMC, NHSE and CCG's which is driving the profession and practices into the ground both financially and organisationally.
- 13tt LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges the BMA to lobby government to seek an independent review into the burden of bureaucracy, regulation and scrutiny on GPs and their teams to identify the overall impact and potential unintended consequences of this burden and to make proposals to streamline such activity to be consistent with other leading international health systems.
- 13uu BUCKINGHAMSHIRE: This conference believes that a culture of punitive over-regulation has drastically eroded morale and now creates more harm to the profession than it does good, specifically:
- (i) both the CQC and GMC should be asked to demonstrate what they have in place to prevent them from being trial-by-media, political tools, rather than independent bodies. They should investigate all allegations where their objectivity is being called into question
  - (ii) the regulatory bodies, such as the GMC/CQC should have a media role in informing patients about the limits of their rights and expectations
  - (iii) the GMC should have formal guidelines on how clinicians should decline offering investigations or treatments under the circumstances of (i) lack of clinical appropriateness, and (ii) lack of resources
  - (iv) the GMC and CQC should have a formal policy that supports the clinician or practice who is a victim of a vindictive complaint.
- 13vv CUMBRIA: That conference believes that the over regulation, monitoring and reporting arrangements for practices
- (i) presents multiple layers of jeopardy to GMC, CQC, Ombudsman, NHSE, CCG HealthWatch et al
  - (ii) is a bureaucratic and unnecessary overhead that is crippling practices
  - (iii) and that the GP profession should only be accountable to one organisation.
- (Supported by Lancashire Coastal, Lancashire Pennine and Central Lancashire)*
- 13ww SALFORD AND TRAFFORD: That conference believes that the number of regulatory bodies should be drastically reduced.
- 13xx GLOUCESTERSHIRE: That conference believes that the costs of CQC registration should be centrally funded to protect the limited resources available for patient care in general practice.
- 14 **AGENDA COMMITTEE to be proposed by KENT: That conference:**
- (i) recognises that appraisal and revalidation consume time that General Practitioners could use for direct patient care.**
  - (ii) calls for the appraisal and revalidation requirements to be reviewed and simplified.**
  - (iii) calls for appraisal to return to being a formative process.**
  - (iv) calls for the frequency of appraisals to be reduced**
  - (v) calls for revalidation to be suspended.**
- 14a KENT: That conference demands that in order to sustain general practice, regulatory activity needs to be significantly decreased by:
- (i) returning appraisal to a formative process
  - (ii) removing the need for a face to face appraisal
  - (iii) the suspension of revalidation
  - (iv) suspension of CQC inspections.
- 14b NORTH WALES: That conference believes that appraisal and revalidation are labour intensive and poorly evidence based. We call for both to be suspended pending review.
- 14c AYRSHIRE AND ARRAN: That conference demands the provision of additional resource to allow general practitioners time to complete the requirements of appraisal and revalidation
- 14d HERTFORDSHIRE: That conference is concerned by the increasing number of practices closing or on the brink of financial collapse, and calls upon NHS England with the government to agree to the following measures as an emergency rescue package until at least the end of this parliament:
- (i) a review of appraisal and revalidation requirements with a view to simplification and support of practitioners
  - (ii) appraisals to take place at intervals of twenty four months and revalidations to take place each decade
  - (iii) NHSE to pay for nationwide contract with online appraisal toolkit.
- 14e SOUTH ESSEX: That conference recommends that to better enable GPs to deliver a safe and sustainable service the frequency of appraisal is reduced to every 2-3 years instead of annually.
- 14f DONCASTER: That conference recognises that appraisal and revalidation consume time of GPs when they should be with patients and demands an immediate cease in the revalidation of GPs until such time that GPs have adequate time to safely care for their patients first.

- 14g DERBYSHIRE: That conference demands that in view of the current critical workforce crisis and extended working days the following measures be enacted immediately:
- (i) TWO yearly appraisal system with no more than three appraisals in a six year period plus an RO recommendation = revalidation
  - (ii) CQC be abolished
  - (iii) the current extended hours DES be abolished and the money returned to the global sum or the PMS baseline and that any replacement scheme be funded from entirely new money.
- 14h KIRKLEES: That conference believes that general practice has become excessively over regulated through the intrusive nature of CQC inspections and the emerging appraisal processes:
- (i) this further increases the workforce pressures by increasing the number of GPS taking their retirements earlier and reducing the numbers of recruits making general practice their career choice
  - (ii) that the appraisal process has become more threatening, requiring appraisers to submit and use as yet unvalidated methods of scrutiny and reporting, striving for excellence rather than competence
  - (iii) that the methods used by NHS England to assess the quality of medical record keeping is setting as yet unagreed, impractical and unvalidated standards which very few of us can actually attain.
- 14i HERTFORDSHIRE: That conference believes that the appraisal system is compounding the workforce crisis by setting too rigid conditions and asks GPC to ensure NHS England instructs responsible officers to allow:
- (i) appraisals by video link for GPs temporarily working abroad
  - (ii) GPs nearing retirement to have a fourth appraisal with the same GP where appropriate.
- 14j NORFOLK AND WAVENEY: That conference demands GPC negotiates an appropriate reduction in the burden of appraisal and revalidation for GPs who work part time to encourage GPs who may otherwise have retired completely to support and ensure a safe and sustainable NHS.
- 14k NOTTINGHAMSHIRE: That conference believes that to free up more time for patient care and ease GPs' administrative burdens the number of appraisals required for revalidation purposes should be reduced to three within the preceding five years, and instructs GPC to negotiate this change at the earliest opportunity.

## PREMISES

- 15 **AGENDA COMMITTEE to be proposed by GLASGOW: That conference:**
- (i) believes that the GP owned premises model is no longer sustainable.
  - (ii) believes that GP practices should have a right to insist that their practice premises be owned by the NHS and to this end demands that the NHS must take on the head lease role of any GP premises on the request of the GP principal involved.
  - (iii) calls for a "buyer of last resort" scheme to be established for privately owned or rented GP premises to safeguard practices where the financial risk associated with the premises threatens viability.
  - (iv) calls for an accelerated programme of update and redevelopment for practices whose premises are inadequate to deliver 21st-century primary care.
- 15a GLASGOW: That conference calls for the governments in all four nations to put in place a 'buyer of last resort' scheme for privately owned or rented GP premises to safeguard general practices where the financial risk associated with surgery premises is threatening practice viability.
- 15b WILTSHIRE: That conference recognises that the premises in which we have worked in the last 30 years are not necessarily right for the 21st century and demands that NHS England use the flexibilities in the Premises Cost Directions (England) to buy out buildings which are past their best-by date and take the head leases on future developments or re-financing.
- 15c WILTSHIRE: That conference demands that NHS England or its successor contract holder organisation must take on the head lease of a GP who requests this.
- 15d WILTSHIRE: That conference demands a limitation to the liability of GPs who are either lease holders or owner-occupiers to avoid the 'last man standing' scenario.
- 15e WILTSHIRE: That conference recognises the difficulties of the 'last man standing' in the provision of GP premises which causes difficulty in recruitment to general practice to the detriment of the efficient running of the service and insists that government should use the provisions already enshrined in the Premises Cost Directions (England) to take on the head lease of any GP premises on the request of the GP principal involved.
- 15f SHROPSHIRE: That conference believes the current recruitment and retention problems in general practice are exacerbated by the 'last man standing' issue and that the GPC should seek the introduction of measures by the government to mitigate this.
- 15g NORTHERN IRELAND EASTERN: That conference believes that the GP owned premises model is no longer sustainable.
- 15h DERBYSHIRE: That conference asserts that confidence in the current GP system can be improved by the Treasury agreeing to underwrite the 'last person standing' scenario in a practice subject to suitable safeguards.
- 15i KENT: That conference demands the regulations are amended to protect the 'last man standing' when practices fail by:
- (i) allowing partnerships to become Limited Liability Partnerships
  - (ii) protecting practices from staff redundancy costs
  - (iii) NHSE underwriting premises risks
  - (iv) ensuring list dispersal is the solution of last resort.
- 15j GLOUCESTERSHIRE: That conference believes that practices should have the right to insist that their practice premises be owned by the State.
- 15k AYRSHIRE AND ARRAN: That conference, given the current situation in general practice, calls on the UK governments to provide more substantive support for premises development to allow GPs to meet the demands of modern general practice.
- 15l SHROPSHIRE: That conference deplores as grossly inadequate current levels of funding for primary care premises and also deplores the convoluted regulations preventing access to money for building and improvements, even when it appears to be available.
- 15m NORTHAMPTONSHIRE: That conference demands that the government honour its stated commitment to substantial financial support for GP premises development and that this is available to grassroots GP partnerships that provide the backbone of service delivery.
- 15n MID MERSEY: That conference has no confidence in CHP's ability to manage property services, especially in LIFT buildings, putting practices at risk of financial ruin, particularly in deprived areas, and threatening their ability to deliver safe and sustainable services, and calls upon the GPC to intervene urgently to try to resolve this crisis.
- 15o KENT: That conference believes that NHS Property Services has:
- (i) failed in its duty of enabling provision of good patient care fit for the 21st century
  - (ii) not been made accountable for its lack of action and mismanagement
  - (iii) demanded service charges that are unrealistic, unaffordable, prohibitive and destabilising to practices.
- 15p DERBYSHIRE: That conference has no confidence in the ability or desire of NHS Property Services or Community Health Partnerships to ensure that every patient will eventually have access to appropriate, fit-for-purpose health care properties for all aspects of their healthcare that cannot be delivered at home.
- 15q NORFOLK AND WAVENEY: That conference calls for GPC to demand accelerated investment via the primary care infrastructure fund (now transformation fund) which has so far failed to deliver on its promises to provide premises fit to provide a safe and sustainable service.

- 15r KENT: That conference welcomes the FYFV but insists its implementation will require the:
- (i) replacement of current inadequate premises
  - (ii) compulsory purchase orders of land for premises
  - (iii) reimbursement for non-GMS/PMS space.



- 16 **LEEDS:** That conference notes that practices currently provide a year of care for an average of £141 per patient and believes that this is wholly inadequate to provide a safe, sustainable and responsive service that meets the growing needs of their patients and therefore calls on governments to ensure that all practices receive at least £200 per patient per year.
- 16a BIRMINGHAM: That conference directs GPC to negotiate a doubling in recurrent expenditure on core general practice to £22 per patient per month in order to ensure the provision of safe GP services, including an increase in average GP consultation times to twenty minutes.
- 16b LINCOLNSHIRE: That conference recognises that general practice is the most efficient and cost effective part of the NHS, which provides 90% of the patient contacts. However the ever decreasing proportion of the funding is making this scenario unsustainable. Conference thus calls on government to recognise the excellent work which general practice does, and to fund it appropriately.
- 16c CHESHIRE: That conference believes that general practice in England is no longer sustainable.
- 16d LEEDS: That conference believes that the underfunding of general practice is a fundamental cause of the current workload and workforce crisis which is undermining safety and sustainability of practices and impacting on the quality of care provided to patients and demands that:
- (i) the government set a target for commissioners that 11% or more of the NHS budget should be invested in general practice
  - (ii) NHS England and CCGs should ensure 11% or more of the £3.8bn provided to the NHS in the Spending Review should be invested in general practice in 2016/2017
  - (iii) NHS England and CCGs should make clear commitments to make above inflation annual real terms increase in investment for general practice and be held account to deliver this.
- 16e GLOUCESTERSHIRE: That conference calls for a sustained and significant increase in core funding for general practice.
- 16f SURREY: That conference believes that safe and sustainable general practice is unachievable at current funding levels.  
*(Supported by Croydon, Kingston & Richmond, Surrey, East Sussex and West Sussex)*
- 16g SOMERSET: That conference calls for a sustained and significant increase in core funding for general practice.  
*(Supported by Gloucestershire)*
- 16h BUCKINGHAMSHIRE: That conference insists that
- (i) the government policy of starving general practice of funding for years has resulted in practices that provide good patient care becoming financially non-viable
  - (ii) the 4.1% investment in general practice each year for 4 years will only maintain the current inadequate funding of general practice
  - (iii) for general practice to survive, maintain high standards of patient care, and transform patient services, the government(s) and NHSE must commit to spending 11% of the NHS budget on general practice services.
- 16i CAMBRIDGESHIRE: That conference believes that in order to deliver a safe service for patients that general practice needs more than 8% of the budget to continue to deal with more than 90% of all contacts with the NHS.
- 16j NEWCASTLE AND NORTH TYNESIDE: That conference demands that this government demonstrates a meaningful commitment to general practice by investing 11% of the NHS budget in general practice.
- 16k NORTHERN IRELAND NORTHERN: That conference calls for general practice funding to be restored to a minimum of 11% of NHS spending.
- 16l NORFOLK AND WAVENEY: That conference believes that an independent contractor model delivered under a national contract has a future and:
- (i) demands the government restores the percentage share of funding back to the levels of 10 years ago
  - (ii) demands that sufficient recurrent resources must be provided to deliver a safe service
  - (iii) calls for a scheme that provides 70% reimbursement for directly employed staff on a recurrent basis.
- 16m DERBYSHIRE: That conference reminds the Chancellor of the Exchequer that the planning of transformational change requires resources over and above those needed to run either the current system or the future system.
- 16n DERBYSHIRE: That conference demands that health and social care services in the community are given the resources needed to do the job that the public can reasonably expect.
- 16o LANCASHIRE COASTAL: That conference believes the requirement by the government for the NHS to 'save' over £20bn is having a disastrous effect on the NHS and UK general practice and calls upon the government to recognise this and free up these monies to allow UK general practice to receive the funding it needs to provide a safe and sustainable service.  
*(Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 16p HULL AND EAST YORKSHIRE: That conference believes that the percentage of GDP that is spent on the NHS rises until we reach the average of other OECD developed nations in the next few years.  
*(Supported by North and North East Lincolnshire)*

- 16q LEEDS: That conference demands that government and NHS England reverse the funding cuts in general practice since 2006 and invest further to enable practices to manage the rise in workload, complexity and patient expectation.
- 16r LIVERPOOL: That conference believes that GPC needs to secure adequate realistic core funding for GP practices to enable practices to be sufficiently resourced to provide essential GP services in a safe and sustainable manner.
- 16s SEFTON: That conference demands that general practices in the NHS receive an 'emergency crisis relief' payment of £20 per patient to enable them to relieve crippling workload pressures by employing additional professional staffs and other means.
- 16t NORFOLK AND WAVENEY: That conference believes that, in order to maintain a safe working environment, NHS England should provide appropriate support, including financial support to all practices irrespective of whether they have any adverse CQC ratings or not.
- 16u SHEFFIELD: That conference calls for a sufficient rise in the global sum to make general practice sustainable.
- 16v NORTHAMPTONSHIRE: This conference insists that core contract funding be stabilised to a level that will provide budget stability for practices and GP income.
- 16w CHESHIRE: That conference believes that the government has ignored the ever rising costs of providing general practice and has overseen a 21% decrease in GP partner income which is unsustainable. Without additional financial support UK general practice will continue to deteriorate and be lost forever. We call upon the government to ensure at least 10% of total health expenditure is dedicated to general practice to ensure sufficient, high quality services are delivered to patients.
- 17 **WALTHAM FOREST: That conference supports patients' requirements for safe and sustainable services which can only be delivered by stable general practices and therefore requires that:**  
 (i) the GPC rejects annual contract renegotiations  
 (ii) the GPC agrees a national contract which will last at least the length of a parliament  
 (iii) such a contract will be subject to genuinely independent financial review only.  
*(Supported by Barnet, Bexley, Bromley, Camden, City and East London, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark and Redbridge)*
- 17a LEEDS: That conference believes the use of the current GMS contract and annual contract negotiations to micro manage practices is undermining the morale of GPs and adding a significant burden to practices and therefore calls for a simplified national core contract that empowers GPs as professionals and provides greater long-term stability for practices.
- 17b BEDFORDSHIRE: That conference calls on GPC to negotiate with government a new deal for GPs based on the principles of the 'Red Book' payment system.
- 17c DEVON: That conference believes that there should be a simple capitation based funding model for general practice which:  
 (i) recognises quantity of work  
 (ii) recognises quality of work  
 (iii) rewards positive outcomes  
 (iv) fully funds continuing professional development  
 (v) fully funds registration and practice participation in CQC.
- 17d SOMERSET: That conference believes that there should be a simple capitation based funding model for general practice which:  
 (i) recognises quantity of work  
 (ii) recognises quality of work  
 (iii) rewards positive outcomes  
 (iv) fully funds continuing professional development  
 (v) fully funds registration and practice participation in CQC.  
*(Supported by Devon)*
- 17e BEDFORDSHIRE: That conference calls on GPC to negotiate with government a payment which underlines the importance of partners, similar to the Basic Practice Allowance.
- 17f AYRSHIRE AND ARRAN: That conference calls on the return to a basic practice allowance to allow core stability to practices for the provision of services.
- 17g BUCKINGHAMSHIRE: That conference believes the partnership model has been a highly cost effective method of providing general practice and:  
 (i) insists that government(s) states publically whether this is a model of service provision that they will support  
 (ii) demands that the government(s) invest in and support this model of care to make it attractive to recruit and retain partners  
 (iii) proposes that GPC negotiates the reintroduction of a Basic practice allowance type payment to reward practices for appointing new permanent partners and clinical staff to improve patient care.
- 17h DERBYSHIRE: That conference demands that any new contract for GP services to the public be comprehensive and simple so that practices do not have to spend time making multiple claims for payments from multiple funders.
- 17i BIRMINGHAM: That conference directs GPC to negotiate contractual changes to explicitly and adequately fund additional GP partners.

- 17j OXFORDSHIRE: That conference believes that to ensure funding follows activity, temporary resident work should revert to being funded as item of services activity as it was under the Red Book.
- 17k NEWCASTLE AND NORTH TYNESIDE: That conference:  
 (i) totally opposes charges for consultations in NHS primary care and  
 (ii) demands that the government funds general practice by increasing its share of the NHS budget to 11%.
- 17l 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.
- 17m NORTHERN IRELAND SOUTHERN: That conference believes that essential GMS services should remain part of a national, sustainable, adequately funded and practice based contract.
- 17n LANCASHIRE COASTAL: That conference believes that the incompatibility between the way that different sectors of the health economy are paid:  
 (i) has worked against the stated NHS policy of care closer to home  
 (ii) has directly led to a diminution in the share of NHS funds directed to general practice for an increased workload by transferring block funding out of primary care to activity based secondary care  
 (iii) has had a detrimental affect on the viability of general practice  
 (iv) and calls on the government to remedy this basic flaw in health service funding.  
*(Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 17o HERTFORDSHIRE: That conference applauds NHS Scotland's decision to abandon QOF and pool resources into the global sum and, in the interests of efficiency and the protection of core GP services for the population of England, calls upon NHS England to agree to the same.
- 17p GWENT: That conference supports the reduction of QOF and that the trend of returning the money to global sum should be accelerated as the professionalism of general practice has been proven and does not need this repeated measurement.
- 17q DONCASTER: That conference can no longer bear the time consuming administrative burden of QOF which removes GPs and their staff from the care of patients and demands its immediate removal, instead reinvesting this resource into the global sum to provide practices with financial stability and time to care for the patients safely.
- 17r CORNWALL AND ISLES OF SCILLY: That conference believes that:  
 (i) general practice is no longer safe or sustainable in its current form and  
 (ii) QOF should be abolished and the funds transferred into global sum pending a review of national GP services.
- 17s MID MERSEY: That conference believes that QOF adds an unnecessary administrative burden to practices, it has served its purpose, is no longer needed or useful for the delivery of safe and sustainable general practice and calls on the GPC to negotiate an end to it.
- 17t DERBYSHIRE: That conference reiterates that medicine is not a free good and provision of medical services must be through just and equitable contracts that reward skill, effort, risk and responsibility.
- 17u BUCKINGHAMSHIRE: That conference believes that the current GP capitation funding is a block contract that works against practice viability by encouraging workload transfer from many NHS and non-NHS organisations.
- 17v GLOUCESTERSHIRE: That conference understands the benefits to patients of having certain services moved from secondary care to primary care, and strongly suggests that the government should ensure that such services are directly paid for by the hospital devolving those services.
- 17w DERBYSHIRE: That conference reminds the government that over the years GPs have, given the right tools and incentives, always been willing to innovate and change but that change and innovation requires resource, investment, time and, a clear long term strategy free of micro management.
- 17x MANCHESTER: That conference believes general practice requires longer term contracts to ensure financial stability, eg QOF, DESs.
- 17y BRADFORD AND AIREDALE: That conference believes general practice cannot rely on annual contract negotiations with NHSE delivering a 'safe and sustainable service' and the GPC needs to develop an alternative model allowing practices to contract directly with patients. For the last eight years the profession has had to make the best of what little was offered or imposed and we need an alternative option if future negotiations follow the same pattern.
- 17z WORCESTERSHIRE: That conference demands that in future all GP contract negotiations must be based on a minimum of three year agreements.
- 17aa DONCASTER: That conference demands stability for general practice and in doing so mandates GPC to withdraw from annual contractual negotiations with the Department of Health and instead hold national negotiations every five years.
- 17bb CLEVELAND: That conference:  
 (i) believes that the 2004 GMS contract is no longer fit for purpose  
 (ii) mandates GPC to open negotiations on a new GMS equivalent contract.
- 17cc COVENTRY: That conference believes that the GMS contract will not be renegotiated more frequently than every three year and there will be an uplift to GMS every year to fully cover increase in expenses.

- 18 **WORCESTERSHIRE:** That conference demands that the reimbursement of GP expenses must be properly and fully funded if practices are to continue to function and remain open.
- 18a DERBYSHIRE: That conference instructs the GPC to negotiate the reintroduction of an effective guaranteed system of global practice expenses reimbursement for the profession.
- 18b BUCKINGHAMSHIRE: That conference believes that the NHS should fully reimburse GP surgeries for any locum cover required for any absence due maternity, paternity, adoption leave, carer's leave, sick leave, suspension or any other similar absence of the workforce.
- 18c CITY AND EAST LONDON: That conference instructs GPC to negotiate with NHSE reimbursement of maternity and long term sickness payments to enable the full cost to be claimed by the practice.  
*(Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest LMCs)*
- 18d HILLINGDON: That conference requires that the GPC:  
(i) negotiates into GP contracts for 2016/7 that the true cost of all necessary expenses is fully reimbursed  
(ii) understands that lack of such an agreement will make any proposed contract unacceptable to GPs  
(iii) reports the outcome to the 2016 Annual Conference of LMCs.  
*(Supported by Barnet, Bexley, Bromley, Camden, City and East London, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)*
- 18e GWENT: That conference demands that government takes action and supports practices with rising expenses which impact on surgery viability against a backdrop of falling income.
- 18f GLOUCESTERSHIRE: That conference believes the costs imposed on general practice should be reviewed and wherever possible reduced.
- 18g LOTHIAN: That conference insists that, in order to maintain safety and ensure equity, a revised contract should:  
(i) adequately resource appointments requiring a translator  
(ii) ensure provision of sufficient and rapid access to translator services.
- 18h NORTH WALES: That conference seeks that the DDRB recommendations on GMP pay are non-negotiable after evidence is submitted.
- 18i DERBYSHIRE: That conference, noting the nature of the practice of medicine in the United Kingdom, where the government controls medical school output, controls post graduate education, controls commissioning of care and where de facto the NHS is ultimately the monopoly employer; demands there MUST be a just and equitable doctors' pay review mechanism the output of which is beyond criticism by either the profession or the government on behalf of the taxpayer.
- 18j SUFFOLK: That conference notes the year-on-year fall in publicly reported GP income over the last five years leading to instability in the delivery of primary care and calls upon the GPC to seek a dedicated meeting with the Secretary of State for Health and to report openly to the profession the outcome of that meeting to:  
(i) point out that mechanisms in place for maintaining stability of the profession and its income, particularly the DDRB, are clearly failing in their role  
(ii) discuss paths of remedy for this situation  
(iii) seek a guarantee that it is the intention of the Department that rises in expenses which are beyond the control of the profession are demonstrably fully remunerated in future pay rounds.
- 18k NORTHERN IRELAND NORTHERN: That conference calls for full reimbursement of GP medical defence costs.
- 18l BIRMINGHAM: That conference directs GPC to negotiate contractual changes to fully and directly reimburse all clinical indemnity costs for NHS general practice.
- 18m GATESHEAD AND SOUTH TYNESIDE: That conference believes that the present medical indemnity costs are rising at a rate, which is unsustainable, and the Department of Health needs to act and give assurance that the true cost of indemnity will be reflected in uplifts in the present contract, or an alternative system of reimbursement is sought as a matter of urgency.
- 18n WILTSHIRE: That conference recognises that indemnity fees are rising excessively and demands direct reimbursement from NHS England, to include:  
(i) those fees paid on behalf of salaried colleagues by their employers, and  
(ii) the fees paid on behalf of other practice clinicians.
- 18o BIRMINGHAM: That conference directs GPC to negotiate contractual changes to provide direct reimbursement, including all employer pension, employer national insurance and employee clinical indemnity costs, for employed practice staff including salaried GPs.
- 18p NORTH WALES: That conference seeks an immediate increase in financial resource to general practice to fairly reflect the rise in expenses that has occurred since 2004.

- 19 **HERTFORDSHIRE:** That conference calls upon the GPC to negotiate Crown Indemnity for all GP work, both in and out of hours, in all NHS working environments, with immediate effect.
- 19a NORTH WALES: That conference recognises that rising indemnity costs are a danger to the long term ability of GPs to provide care both in and out of hours. We ask GPC UK and UK government to find a solution to alleviate this situation with urgency.
- 19b DEVON: That conference notes the top-up of indemnity fees for out of hours additional shifts and calls upon GPC to negotiate an extension of this principle to cover all GP work, both in and out of hours.
- 19c NORTH STAFFORDSHIRE: That conference:
- (i) believes the increasing costs of medical indemnity are now unsustainable
  - (ii) researches and supports either a rapid move to the New Zealand indemnity model, minimising legal costs, levelling fair compensation and allowing sustainable medical costs or the role out of crown indemnity
  - (iii) supports the full recognition and mitigation of the additional GP risk involved in supervising extended non-doctor teams.
- 19d DERBYSHIRE: That conference warns the government and the public that the exponential rise in professional indemnity fees may, on its own, destroy general practice in the United Kingdom.
- 19e NORTHAMPTONSHIRE: That conference demands that the governments take on the indemnity costs of all NHS work undertaken in primary care.
- 19f DERBYSHIRE: That conference is alarmed by the exponential rise in medical defence organisations premiums, and insists that the government takes on the entire clinical (not professional) indemnity risks of provision of GP out of hours services and services to patients who are not on the treating GP's list where the GP has no access to the patient notes.
- 19g KENT: That conference calls for Government to provide a solution to the spiralling cost of medical indemnity insurance by:
- (i) adequately reflecting it in the global sum
  - (ii) covering primary care under crown indemnity.
- 19h MID MERSEY: That conference believes that the spiralling costs of medical indemnity cover is destructive to general practice and calls upon the GPC to negotiate an alternative safe and sustainable model.
- 19i BUCKINGHAMSHIRE: That conference recognizes that current indemnity fees are a crippling burden in general practice and:
- (i) impair both the retention of GPs and/or their willingness to take on more work
  - (ii) strongly urges government(s) to provide Crown cover as provided to secondary care colleagues
  - (iii) recommends government(s) consider a cap on damages payments and the accompanying lawyers' fees.
- 19j GLOUCESTERSHIRE: That conference urges the GPC to negotiate for the burden of professional indemnity premiums to be borne centrally rather than by individuals.
- 19k NEWCASTLE AND NORTH TYNESIDE: That conference demands that the Department of Health urgently covers the cost of Indemnity to GPs doing NHS work.
- 19l NOTTINGHAMSHIRE: That conference noting the recent decision to underwrite the indemnity costs of GPs working extended hours in response to 'winter pressures', believes that the NHS should extend this cover to all GP out of hours and special interest work and cover indemnity costs of non-medical professionals appointed to GP practice teams to cover unfilled GP vacancies.
- 19m CITY AND EAST LONDON: That conference demands that the Government, as a matter of urgency, extend Crown Indemnity to GPs. *(Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest LMCs)*
- 19n CITY AND EAST LONDON: That conference:
- (i) believes that the rising cost of indemnity syphons valuable NHS resources away from patient care and
  - (ii) demands that the GPC agrees a satisfactory national solution with the department of health
  - (iii) requires the GPC to report the outcomes of the above to the 2016 annual Conference of LMCs.
- (Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest)*
- 19o COVENTRY: That conference believes that the rise in indemnity fees are unsustainable and destabilising general practice especially the provision of out of hours care. We therefore call on the GPC to explore the extension of Crown Indemnity to cover general practice.
- 19p CENTRAL LANCASHIRE: That conference believes that Crown indemnity for GPs is the only way forward as the huge rise in indemnity costs is making it prohibitive for GPs to undertake additional work, particularly to increase GP access for patients, and will only increase the probability of GPs leaving the profession.  
*(Supported by Lancashire Coastal, Lancashire Pennine and Cumbria)*

- 19q THE GPC: That GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference instructs GPC to urgently address the rising costs of medical indemnity for general practitioners, and to take action to minimise the direct financial cost of indemnity to GPs and GP practices. This conference calls for the GPC to explore options including but not limited to:
- (i) GP indemnity to be funded centrally
  - (ii) GPs to be given crown indemnity
  - (iii) GP per session indemnity to be capped nationally.
- 19r THE GPC: That GPC seeks the views of conference on the following motion from the sessional GPs subcommittee:  
That conference demands that the Department of Health finally acknowledges the degree to which the spiralling indemnity costs facing the profession, particularly for those providing out of hours care, is acting as a significant impediment and disincentive to providing adequate care and service provision, and that they should:
- (i) engage in a sincere and meaningful way in discussions with the GPC so that a valid and proper solution can be reached
  - (ii) ensure that all GPs who work in England including locums should benefit
  - (iii) ensure that a properly funded system similar to crown indemnity should be funded to cover all aspects of NHS GP work.

- 20 **BUCKINGHAMSHIRE:** That conference instructs GPC that should negotiations with government for a rescue package for general practice not be concluded successfully within 6 months of the end of this conference:
- (i) actions that GPs can undertake without breaching their contracts must be identified to the profession
  - (ii) a ballot of GPs should be considered regarding what work/ services must cease to reduce the workload to ensure safe and sustainable care for patients
  - (iii) undated resignations from the current NHS contracts held by GPs should be requested.
- 20a **DERBYSHIRE:** That conference instructs the GPC to revise and review its scheme of sanctions ready to be enacted in the absence of negotiated contractual funding and policy revisions for general practice which are acceptable to the profession.
- 20b **NEWCASTLE AND NORTH TYNESIDE:** That conference requests that urgent legal advice be sought on what forms of industrial action can be taken by all types of general practitioners on the GMC register including those employed by different types of employers, and those holding contracts as self-employed.
- 20c **SHROPSHIRE:** That conference believes GPs should consider withdrawing from administrative duties, such as providing medical certificates, letters and reports until workload pressures in general practice improve.
- 20d **BUCKINGHAMSHIRE:** To ensure that they can provide safe and sustainable care for their patients, conference urges all GPs to review their workloads, and where excessive, should cease all non-contracted work.
- 20e **NORTHAMPTONSHIRE:** This conference demands that GPs follow the lead of junior doctors in standing up for themselves in the face of unrealistic and draconian government imposition of workload and finances to be able to provide a safe and accessible service delivery to our patients. General practice must be prepared to:
- (i) decline non-core work delivery
  - (ii) decline CQC fee payment
  - (iii) decline the appraisal process
  - (iv) decline to engage with CCGs and federation integration
  - (v) prepare unsigned letters of resignation.
- 20f **LEICESTER, LEICESTERSHIRE AND RUTLAND:** That conference urges the BMA to develop a clear charter of the top ten requirements of a safe and sustainable system of general practice and produces a plan of how to campaign for the implementation of this charter including a well-resourced professional communication and engagement campaign and staged options for various types of industrial action including the threat of resignation from GP contracts.
- 20g **SUFFOLK:** That conference notes the difficulties which self-employed contractors face in delivering any meaningful industrial action and that useful guidance for resolution of this problem was notably absent when the profession was last called to IA. Conference therefore calls on GPC to consider this matter and if necessary to set up a working group to produce appropriate guidance now in case this is needed in 2016.
- 20h **HERTFORDSHIRE:** That conference calls on GPC to follow the example of our junior colleagues and adopt a more proactive and bullish stance in negotiations with the Secretary of State.
- 20i **GATESHEAD AND SOUTH TYNESIDE:** That conference believes that in any call for industrial action by GPs it is essential that GPC reinforces the following principles:
- (i) a well trained, well supported and appropriately remunerated workforce is essential to delivery of good and affordable health care
  - (ii) that our unique system of generalist care provided by GPs provides preventative advice and care, long term condition management and terminal care to all regardless of their ability to pay
  - (iii) that well trained general practitioners hold risk and manage uncertainty saving millions in unnecessary investigations
  - (iv) that a system of marketisation and privatisation is unable to support UK general practice as we know it.
- 20j **NORFOLK AND WAVENEY:** That conference believes that the only way to achieve change is for GPC to produce a more militant action plan which considers:
- (i) the possibility of all GPs resigning their contracts
  - (ii) that all GPs cease CCG cooperation/engagement
  - (iii) that all GPs withdraw from the present appraisal and revalidation process
  - (iv) referring all patients to contact their MP when inappropriate secondary care requests are made of primary care.
- 20k **NORTHAMPTONSHIRE:** That conference asks the GPC to collect undated letters from practices saying they will stop providing unpaid services.
- 20l **SOUTH STAFFORDSHIRE:** That conference requests the GPC to be realistic and:
- (i) renegotiate our current payments structure insisting the changes are implemented in three years' time
  - (ii) understand that the current one way business relationship cannot survive with global demand on GPs affecting every aspect of their lives
  - (iii) develop an exit strategy for an independent profession, truly independent of the NHS, if the government cannot agree that the service is buckling under the present unreasonable and frankly childish arrangements.

- 20m NORTH STAFFORDSHIRE: That conference instructs the GPC to negotiate a plan C of general practice service delivery that:
- (i) is beyond the NHS England plan B of destabilising short term APMS tendering with associated locum bidding wars and/or forced allocations
  - (ii) avoids/mitigates a black hole of no patient service cover at all (as is already occurring out of hours)
  - (iii) realistically preserves patient safety with very low GP to patient ratios
  - (iv) indemnifies GPs and their staff for working in these high risk conditions
  - (v) rewards and incentivises GPs for rising to this challenge.
- 20n DERBYSHIRE: That conference instructs GPC to produce a series of brief educational leaflets aimed at:
- (i) NHS managers
  - (ii) social services
  - (iii) hospital doctors
  - (iv) MPs
  - (v) others to inform them of the limits and obligations of general practitioners working in the NHS.
- 20o BIRMINGHAM: That conference directs GPC to canvass the willingness of GPs to submit their undated resignations should negotiations with the government fail to deliver a fit for purpose and adequately funded national GP contract.
- 20p WILTSHIRE: That conference directs GPC to collect undated resignations from GPs to strengthen their hand in re-negotiation of our contract and that GPs are encouraged to have the courage to provide such letters of resignation as the only way in which to bring the government seriously to the table.
- 20q DERBYSHIRE: That conference:
- (i) asserts that the 2004 GP contract is no longer fit for purpose
  - (ii) instructs GPC to initiate negotiations with NHS England regarding a new contract based on principles acceptable to the profession
  - (iii) instructs GPC to collect from practices undated notices of termination of contract, to be used in the event of a failure to negotiate an acceptable contract.
- 20r ROTHERHAM: That conference calls on the BMA/GPC to organise mass undated resignations from all the NHS GP Contractors in England immediately to force the government to come up with a viable plan to save general practice.
- 20s NORTH STAFFORDSHIRE: That conference:
- (i) believes the NHS in general, and general practice in particular, is in crisis
  - (ii) views as shameful the failure of successive governments to recognise and address the issues that have led to this position
  - (iii) demands the government urgently implements measures to relieve the intolerable pressures on general practice
  - (iv) requests the GPC to canvass the willingness of GPs to submit their undated resignations if a speedy and appropriate response is not forthcoming
  - (v) believes the use of sanctions should now be considered and requests that the GPC explores the realistic options for industrial action.
- (Supported by Shropshire and South Staffordshire)*
- 20t NORTHERN IRELAND WESTERN: That conference recognises the imminent collapse of general practice services due to a workload, workforce and funding crisis and calls on GPC to ballot the profession on taking industrial action.
- 20u HERTFORDSHIRE: That conference mandates the GPC to ballot the profession with a number of options for undertaking legal industrial action.
- 20v HAMPSHIRE AND ISLE OF WIGHT: That conference calls upon the BMA to ballot its GP members for industrial action if a fair, sustainable and modern GP contract cannot be achieved through negotiation.
- 20w NEWCASTLE AND NORTH TYNESIDE: That conference demands that the GPC seeks the BMA to ballot all GPs on industrial action to ensure a safe and sustainable future general practice for patients.
- 20x CITY AND EAST LONDON: That conference in response to repeated and sustained attacks on general practice resources, morale and workload, demands that the GPC ballots all GPs on whether they are prepared to consider industrial action to ensure a safe and sustainable general practice for patients.
- (Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest)*
- 20y CAMBRIDGESHIRE: That conference notes things have worsened since last year's workload survey and calls upon the GPC to survey the professions' willingness to take different actions to protect their patients should a speedy and appropriate government response to the crisis not be forthcoming before our Annual Conference.
- 20z BIRMINGHAM: That conference directs GPC to ballot the profession on taking industrial action, through mechanisms which would be neither detrimental to patient care nor put GP partners at risk of contractual action, should negotiations with the government fail to deliver a fit for purpose and adequately funded national GP contract.
- 20aa THE GPC: That GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference believes that increasing workload and lack of resource represents a significant threat not only to the health and wellbeing of practitioners but to the ability of general practice to deliver high quality care. It demands the GPC consider all actions available, including industrial action, in order to ensure a sustainable future for general practice services for patients.



- 20bb LEEDS: That conference is concerned at the increasing numbers of practices struggling to provide a safe and sustainable service and insists that in order to protect patients practices are enabled to self-declare a safety alert when they have reached capacity on any specific day and can then direct patients to alternative service providers such as a walk-in-centre or A&E.
- 20cc BUCKINGHAMSHIRE: To ensure that they can provide safe and sustainable care for their patients, conference urges all GPs to review their workloads, and where excessive, should cease all non-contracted work.
- 20dd NORFOLK AND WAVENEY: That conference calls on GPC to negotiate contractual changes that allow practices to limit activity when they reach a threshold that the practice determines is operationally unsafe, except for treatment of real emergencies and that commissioners have a responsibility to ensure suitable additional support and services are available.
- 20ee CAMDEN: That conference demands that the GPC:
- (i) urgently agrees with NHSE a rescue package for general practice that addresses the conditions that lead to GPs and practices struggling to provide high quality, safe and sustainable services to patients and
  - (ii) reports the outcome to the 2016 Conference of LMCs.
- (Supported by Barnet, Bexley, Bromley, City and East London, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)*
- 20ff BUCKINGHAMSHIRE: That conference believes that for general practice to survive, the government must agree and implement an emergency rescue package for the service, based on proposals agreed at this conference.
- 20gg HAMPSHIRE AND ISLE OF WIGHT: That conference demands a Charter for safe and sustainable practice that:
- (i) reflects the outcomes of the Conference, and
  - (ii) the government should be challenged to sign it

**CLOSE**

**5.30**

# Special Conference of Representatives of Local Medical Committees

Agenda: Part II  
(Motions not prioritised for debate)



# Agenda: Part II

## (Motions not prioritised for debate)

### A and AR Motions

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

25. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chairman of the GPC as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.
26. 'AR' motions: Motions which the chairman of the GPC is prepared to accept without debate as a reference to the GPC shall be prefixed with the letters 'AR'.

### WORKLOAD

- A 21 KENT: That conference demands that the relentless march towards meeting patients wants rather than needs is damaging, and that:
- (i) a comprehensive and continuous patient education programme about the appropriate use of the NHS is established
  - (ii) provision is made to ensure that all other professionals and agencies understand the scope of primary care.
- A 22 LOTHIAN: That conference insists that, in the interests of maintaining patient safety at a time of extreme workload, national governments need to stop promoting general practice as 'all things for all people' and, instead, investigate resources, measures and public education campaigns to address the:
- (i) inappropriate use of services by patients
  - (ii) unrealistic demands of patients, particularly in terms of the speed of response expected
  - (iii) underuse of third parties, when appropriate.
- A 23 CORNWALL AND ISLES OF SCILLY: That conference demands that the NHS focus on patients' needs, not wants and ignore the vanity projects of politicians.
- A 24 MANCHESTER: That conference calls for a major national campaign to promote self-care and patients' responsibilities.
- A 25 SOMERSET: That conference requires the GPC to work with other interested parties to produce publicity materials for practices to share with patients to explain what services NHS primary care provides, and what it does not.
- A 26 AYRSHIRE AND ARRAN: That conference urges the government to be honest with the public about current pressures facing primary care.
- A 27 SOMERSET: That conference requires GPC to make it clear at every opportunity that in the absence of any demand side controls in healthcare, any changes of configuration, or short term additional funding for the NHS, simply delay the inevitable melt down.
- A 28 SOMERSET: That conference requires the launch of a major, sustained, government backed, evidence-based public relations initiative to reduce demand on general practice.  
*(Supported Gloucestershire)*
- A 29 CAMDEN: That conference instructs the GPC to negotiate an immediate pause to the plan for extended hours and weekend working until such a time when there is sufficient funding to support the delivery of safe in-hours general practice for patients.  
*(Supported by Barnet, Bexley, Bromley, City and East London, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)*
- A 30 CAMBRIDGESHIRE: That conference believes there is a lack of demand for seven day routine GP care, and pilots already compromise patient safety by over stretching limited GP numbers, and calls on GPC to reject any contractual requirement to extend routine care beyond what is safe.
- A 31 NORFOLK AND WAVENEY: That conference believes that the government's ideological obsession with seven day working will produce a less safe and sustainable NHS until the issues of workload and workforce are addressed.
- A 32 BIRMINGHAM: That conference, recognising that seven day services meeting both the expectations of the overwhelming majority of patients and their clinical needs are already provided in general practice, and that simply extending routine core GP services to seven days is inappropriate, undeliverable and will lead to unsafe care, directs GPC to negotiate appropriate investment and contractual changes to improve existing services across both core hours and out of hours.

- A 33 WAKEFIELD: That conference opposes routine Sunday appointments for patients in primary care because there:
- (i) is no patient demand ( as demonstrated by pilots)
  - (ii) are not financial resources to support it if rolled out across all of England
  - (iii) are inadequate numbers of GPs nationally to provide a safe service over seven days.
- A 34 NORTH YORKSHIRE: That conference believes, that further work on a non-evidence based seven day a week general practice model needs to be stopped before the end of 2016, before it continues to disengage clinicians, confuse the public and waste resources.
- A 35 LANCASHIRE PENNINE: That conference believes that the unfounded drive to seven day GP access is counterproductive in that it:
- (i) thins out an already depleted workforce that is struggling to cope with five day working
  - (ii) adds yet further stress to over worked GPs
  - (iii) demotivates GPs and further compromises any semblance of family life that a GP may have.
- (Supported by Lancashire Coastal, Central Lancashire and Cumbria)*
- A 36 NORTH AND NORTH EAST LINCOLNSHIRE: That conference insists that all further requests to extend opening hours be blocked, until GPs can cope with core hour working, to stop spreading general practice too thinly and increasing risks to patients and clinicians.
- (Supported by Hull and East Yorkshire)*
- A 37 SOMERSET: That conference asserts that the government's preoccupation with seven day access to routine GP services is:
- (i) not a reflection of the needs of patients
  - (ii) not wanted by the majority of the population
  - (iii) not a priority for the limited financial resources of the NHS, and
  - (iv) unachievable given the current GP workforce crisis.
- (Supported by Somerset)*
- A 38 AYRSHIRE AND ARRAN: That conference calls for an immediate end to the unresourced work that comes to general practice from secondary care.
- A 39 LOTHIAN: That conference believes that there needs to be nationally agreed and nationally enforced systems to ensure that GPs are no longer 'delegated' routine secondary care work.
- AR 40 NORTHAMPTONSHIRE: That conference will remind practices of their duty to refer patients for further investigations and opinions whenever indicated.
- A 41 NORTHERN IRELAND SOUTHERN: That conference calls for a high trust, low bureaucracy GMS contract to allow GPs to spend their time seeing patients.
- A 42 AVON: That conference calls upon the GPC to raise, once again, the worsening, inappropriate and unresourced work shift-from secondary to primary care which has meant that:
- (i) primary care share of NHS resource now stands at an all time low
  - (ii) primary care is severely compromised by carrying out work that secondary care is being resourced to provide
  - (iii) there is an unmanageable and exhausting workload for primary care doctors.
- A 43 SOMERSET: That conference calls upon the GPC to raise, once again, the worsening, inappropriate and un-resourced work shift-from secondary to primary care which has meant that:
- (i) primary care share of NHS resource now stands at an all- time low
  - (ii) primary care is severely compromised by carrying out work that secondary care is being resourced to provide
  - (iii) there is an unmanageable and exhausting workload for primary care doctors
- (Supported by Avon)*
- A 44 WEST SUSSEX: That conference believes general practitioners should refuse to undertake work that is properly the clinical and professional responsibility of hospital colleagues.
- (Supported by Croydon, Kingston & Richmond, Surrey, East Sussex and West Sussex)*
- A 45 CHESHIRE: That conference believes that the off-loading of all work on general practice from all services has to stop.
- A 46 CAMBRIDGESHIRE: That conference demands a halt to workload pushed onto GPs from secondary care and community services that keeps us from doing our job, and calls on the GPC to unite the profession in saying enough is enough.
- A 47 LEEDS: That conference believes that in order to reduce the bureaucratic burden on practices and to improve services to patients NHS England must insist that all hospital services:
- (i) have in place easily accessible systems to enable patients to manage their appointments and to contact the specialist responsible for their care without the need to involve their GP
  - (ii) stop advising patients to ask their GP for a letter to expedite their appointment.
- A 48 WAKEFIELD: That conference feels that public health campaigns should not be initiated without first identifying the impact on primary care of the added workload and resourcing primary care adequately to deal with it.

- AR 49 KENT: That conference asks that as we are 'one profession that stands together' and the secondary care workforce has increased over primary care, they must:
- (i) order their own tests
  - (ii) issue medical certificates routinely
  - (iii) follow up patients
  - (iv) support general practice
  - (v) stop treating GPs as their housemen.
- A 50 GLOUCESTERSHIRE: That Conference, while eagerly seeking a reduction in pressure on practices and a general reform of the system, wants all concerned to recognise that, because individual practice circumstances vary, varied solutions will be needed for each.
- A 51 BUCKINGHAMSHIRE: The RCGP (and GPC) should do more to inform our clinical colleagues in secondary care about the working hours currently experience by a trainee and qualified GPs.
- A 52 GLOUCESTERSHIRE: That conference requires the launch of a major, sustained, government backed, evidence-based public relations initiative to reduce demand on general practice.

## WORKFORCE

- A 53 LOTHIAN: That conference calls on the government to:
- (i) stop driving general practice to the inevitable outcome of a universal (and potentially more expensive) salaried service by ongoing erosion of our infrastructure, resource and morale
  - (ii) maintain - with reasonable additional support - the viable option of GP partnerships with their 60-year history of evidence-based development, effectiveness, continuity, comprehensiveness and efficiency.
- A 54 AYRSHIRE AND ARRAN: That conference in the light of the current workforce difficulties calls for a UK wide Performers List for GPs to allow greater workforce mobility.
- A 55 COVENTRY: That conference believes that funding should be provided to remunerate GPs who wish to return from a break or working abroad whilst retraining.
- A 56 SHROPSHIRE: That conference believes it should be made easier for UK trained GPs working overseas to return to work in this country.
- A 57 HERTFORDSHIRE: That conference believes that there should be an easier, quicker and less costly way for GPs to return to practice than the present system and asks GPC to negotiate this as a matter of urgency.
- A 58 NORTH YORKSHIRE: That conference suggests that the government should urgently conduct an objective assessment of the true current levels of burn-out or near burn-out amongst general practitioners.
- A 59 LINCOLNSHIRE: That conference believes that a short term solution to the workforce shortfall in general practice is recruitment from overseas, and that the current Induction and returner scheme places too many barriers in the way of overseas doctors coming to the UK. Conference therefore calls for a more streamlined process which allows doctors to work in practices whilst they gain their equivalency qualifications.
- A 60 FORTH VALLEY: That conference calls on both the RCGP and GMC to review postgraduate training for general practice to enable new GPs to cope with the increasing complexity of general practice
- A 61 WAKEFIELD: That conference believes that safe and sustainable primary care requires an extended practice based team including health visitors and district nurses.
- A 62 WILTSHIRE: That conference believes the BMA has guidelines and a standard contract for non-principal GPs but these are little known and in reality not followed by many Practices. This Conference believes that the difficulties in recruitment and retention of Salaried GPs would be reduced if all Practices were to publicise and implement the BMA standard contract.
- A 63 DEVON: That conference notes the new occupational health service arrangements for GPs and believes that:
- (i) it is not fit for purpose
  - (ii) needs to be fully funded and comprehensive for all of general practice
- A 64 AYRSHIRE AND ARRAN: That conference calls for wider recognition and understanding of the crisis facing general practice amongst the public, our NHS colleagues and politicians.
- A 65 SOMERSET: That conference instructs GPC to use all its endeavours to ensure that the public understands that the constant corrosive criticism of GP services from parts of the daily press is directly responsible for the rapidly deteriorating GP workforce position in much of the country.
- A 66 GWENT: That conference demands government action to reverse the trend of GP morale being at an all-time low.

- AR 67 LEEDS: That conference believes that in order for practices to deliver a safe and sustainable service there is an urgent need for a significant expansion of the general practice workforce which should include:
- (i) fully funding a pharmacist for every practice that wants one
  - (ii) fully funding an expansion of the number of practice nurses through measures equivalent to the 'Ten Point Plan' for 5000 additional GPs
  - (iii) fully funding an expansion of the number of healthcare assistants
  - (iv) fully funding an expansion of GP support staff capable of reducing the administrative burden carried by GPs such as dealing with hospital correspondence and prescription requests
  - (v) greater support and training for practice managers.
- AR 68 HERTFORDSHIRE: That conference believes that practice nurses have a pivotal role in delivering patient care but there is no defined career pathway for them and calls on GPC to work with the RCN to develop vocational training schemes to encourage and enthuse newly qualified nurses into general practice.
- AR 69 HERTFORDSHIRE: That conference calls on GPC to insist that NHS England recognises recruitment problems when considering list closure applications by placing higher emphasis on numbers of patients per whole time equivalent GP rather than on patients per square meter.
- A 70 KENT: That conference believes that the unacceptably high cost of the MRCGP exams hinders entrance to the profession and demands that this be reduced and brought in line with other royal colleges.
- A 71 SHROPSHIRE: That conference believes recognition of UK general practitioners as specialists in family medicine (as is the case in Europe) would improve GP status and morale which, in turn, would have a positive effect on recruitment and retention.
- A 72 CITY AND EAST LONDON: That conference:
- (i) deplores the unprecedented workforce crisis in general practice and its impact on the health and safety of practice teams and their patients
  - (ii) supports the tireless work of the GPC and its executive to engage government in finding effective solutions
  - (iii) demands that NHSE listens to its general practice workforce
  - (iv) requires the GPC to agree an immediate, package with the NHSE sufficient to reverse GP burnout, and
  - (v) requires the GPC to agree with NHSE measures to make general practice an attractive career for prospective doctors and GPs.
- (Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest)*
- AR 73 CUMBRIA: That conference believes that the future viability of general practice relies on the recruitment of an adequate number of trainees and it is therefore incumbent on the government and everyone within the profession to secure and promote the benefits and rewards of general practice to potential trainees.
- (Supported by Lancashire Coastal, Lancashire Pennine and Central Lancashire)*
- A 74 THE GPC: That GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference believes that burnout is a serious issue for GPs, and GP trainees, which is impacting on recruitment and retention. We call on the GPC and LMCs to work with training practices, training schemes, and post-graduate health education organisations to:
- (i) ensure the framework GP trainee contract is implemented for every GP trainee to better address work-life balance and ensure safe care for patients
  - (ii) ensure training practices are adequately funded to be able to provide good supervision and training
  - (iii) ensure GP trainees receive the two structured educational and one independent study sessions per week as stated in the framework contract
  - (iv) introduce a system of mandatory monitoring of GP trainee working hours and educational sessions to ensure GP trainees are not routinely working beyond the 40 hours a week stated in the framework contract
- AR 75 THE GPC: That GPC seeks the views of conference on the following motion from the sessional GPs subcommittee:  
That conference acknowledges that since its inception, the BMA Salaried Model Contract has acted as a benchmark for and protected the terms and conditions of employed GPs, and, given that salaried GPs may soon comprise the majority of the GP workforce
- (i) it recognises that this model contract may end up defending the majority of the GP workforce against unfair terms and conditions
  - (ii) it asks GPC to ensure the protection of the future GP workforce by preserving and promoting the terms and conditions within the model contract.
- AR 76 WESTERN ISLES: That conference asks the UK governments to place a duty on NHS human resources departments to support practice recruitment.
- A 77 WESTERN ISLES: That conference proposes all medical schools should be obliged to provide significant general practice experience and a remote and rural GP attachment as part of the curriculum.
- AR 78 FORTH VALLEY: That conference calls on the UK governments to use their leverage to ensure medical schools promote general practice as a rewarding, meaningful and intellectually stimulating career option.

- A 79 HIGHLAND: That conference asserts that the personal health and wellbeing of doctors should not suffer from unrealistic professional obligations, and therefore asks GPC to
- (i) identify ways to improve the support available around absence from the workplace;
  - (ii) push for the governments to ensure that efforts are directed towards maintaining workforce health in areas that are experiencing excessive pressures;
  - (iii) continue to push for GPs and their staff to have access to a centrally-funded, high-quality occupational health service.
- A 80 HIGHLAND: That conference believes in working environments where people feel dignified and demands that GPC explore how contractual arrangements might:
- (i) better protect staff in general practice in dealing with patients who request testing or treatments that are not supported by guidelines, are not medically indicated, or which may even be potentially harmful;
  - (ii) avoid unnecessary exposure of staff to the harmful effects that occur when patients repeatedly exhibit behaviour that is aggressive, abusive or intimidating.

## REGULATION

- A 81 NORTH WALES: That conference believes that QOF is no longer serving a useful purpose and that the process of coding and monitoring is in fact a negative influence on patient care.
- A 82 WESTERN ISLES: That conference calls on the Scottish government to have a single performers' list for the whole of Scotland with an on-line digital register.
- A 83 NORTHAMPTONSHIRE: That conference informs governments that GPs will no longer use forms devised by other parties when making referrals, but will diligently and appropriately make written referrals to named colleagues.
- A 84 KENSINGTON, CHELSEA AND WESTMINSTER: Conference commends the GPC motion passed at its meeting on 17 December 2015 and agrees that it has no confidence in the CQC's current chief inspector of general practice' and 'demands his resignation forthwith'. (Supported by Barnet, Bexley, Bromley, Camden, City and East London, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)
- A 85 OXFORDSHIRE: That conference believes that the repeated and deliberate denigration of GPs by Professor Steve Field has led to an irrecoverable breakdown in the relationship between him and the entire profession; believes that it is impossible for him to continue in his current role; and calls for him to resign from involvement with CQC without delay.
- A 86 HERTFORDSHIRE: That conference is dismayed by the betrayal to the profession shown by Professor Steve Field and believes that his relationship with GPs has irretrievably broken down and calls on him to resign from his CQC role.
- A 87 CORNWALL AND ISLES OF SCILLY: That conference believes Professor Field should be ashamed of his comments regarding systemic failure in general practice and calls on him to resign from the CQC.
- A 88 MID MERSEY: That conference believes that Professor Steve Fields' recent comments undermine attempts to deliver safe and sustainable general practice services, that he should publically apologise for his unwarranted public statement denigrating general practice and calls for his immediate resignation.
- A 89 NEWCASTLE AND NORTH TYNESIDE: That conference has no confidence in Professor Steve Field and calls for his removal as Chief Inspector of CQC with immediate effect.
- A 90 NOTTINGHAMSHIRE: That conference:
- (i) wholeheartedly endorses the GPC's call for Professor Steve Field to resign from his position at the CQC
  - (ii) believes his comments offer further proof that the CQC as an institution is not fit for purpose and should immediately cease all further operations pending a root and branch review of its purpose, structure and modus operandi.
- AR 91 GATESHEAD AND SOUTH TYNESIDE: That conference believes the GPC should work with NHS England and GMC to deliver an evidence based costed plan which allows retention of sessional GPs and supports them in keeping up to date clinically in order to comply with revalidation requirements.

## FUNDING

- A 92 NORTHAMPTONSHIRE: That conference demands an end to new clinical and administrative work being passed to general practice without clear consultation, contract negotiation and appropriate funding.
- A 93 CORNWALL AND ISLES OF SCILLY: That conference believes that GPs should be able to charge patients for the provision of those services the NHS chooses not to commission.
- A 94 AVON: That conference calls on the government to address the constant form filling and bean-counting required for payment of activities such as enhanced services and other contracts, which diverts attention away from patient care.
- A 95 CORNWALL AND ISLES OF SCILLY: That conference believes that the current practice of micro-management and 'bean counting' is an inefficient waste of precious primary care resources.



- A 96 OXFORDSHIRE: That conference believes that given the inadequate NHS funding of general practice, patients will only get the full range of services they wish from GPs when the current constraints on charging registered patients are removed and practices are allowed to charge for services that are not provided on the NHS. It calls on the GPC to renegotiate the wording of Regulation 24 and schedule 5 so that this can happen.
- A 97 NOTTINGHAMSHIRE: That conference believes that to boost practice income at no cost to the taxpayer and increase patient choice, regulations governing private fees should be amended to permit practices to charge patients for treatment which is not available on the NHS locally and which they are content to purchase from their GP practices.
- A 98 CLEVELAND: That conference, in respect of non-negotiable fees for non-NHS work:  
 (i) believes that work should always attract an appropriate fee  
 (ii) calls for urgent action to address the persistent underfunding of this work  
 (iii) believes that practices should be instructed to stop this work if an appropriate fee structure cannot be agreed by March 2017.
- A 99 WILTSHIRE: That conference reminds the government that MPIG was promised to the profession 'in perpetuity' and not just for the duration of a political cycle and that it must be fully reinstated to allow survival of those practices that rely on it to provide adequate resources to care for their patients.
- A 100 NORTH WALES: That conference believes that the process of MPIG redistribution is affecting rural and multi-site practices disproportionately and conference calls for the process to be halted pending a review of fair funding.
- A 101 HERTFORDSHIRE: That conference welcomes the promise of £10 million to support vulnerable GP practices but notes that this will not support practices that are losing income due to MPIG changes and calls on GPC to negotiate transitional relief for practices adversely affected by these changes
- A 102 DEVON: That conference calls upon GPC to negotiate that PMS premium monies are fully re-invested directly into global sum.
- A 103 AVON: That conference calls on the government to revert the draconian funding cuts being imposed on Public Health England, which will have a devastating effect, both on the health of the public and on primary care workload.
- A 104 SOMERSET: That conference calls upon GPC to negotiate that PMS premium monies are fully re-invested directly into global sum.  
*(Supported by Devon)*
- A 105 CORNWALL AND ISLES OF SCILLY: That conference insists that changes to GMS must be evidence based and show benefit to the service.
- A 106 GLOUCESTERSHIRE: That conference believes greater funding of information technology, in particular for sharing data with secondary and tertiary care colleagues, would ease pressures on general practice.
- A 107 KIRKLEES: That conference is concerned that the provision of general practice IT systems is made to a consistent standard across the four nations and should at a minimum provide the following and that the CCGs should be resourced so that they can deliver them a:  
 (i) consistent standard of hardware and software linked to a rolling upgrade programme to keep abreast of IT developments  
 (ii) minimum infrastructure of support and training to enable all practices to optimise their system usage. Suggest around 10 working days per year for an average practice and a named engineer  
 (iii) system of maintenance to ensure that essential kit is repaired or replaced in the shortest time on the same day wherever possible.
- A 108 SHROPSHIRE: That conference deplores the damage to health care provision that will occur as a consequence of inadequate public health and social care funding.
- A 109 LIVERPOOL: That conference believes that the GP profession must resist reforms that facilitate the cherry picking of profitable services for privatisation that favour the few, to the detriment of the majority and particularly the most vulnerable with the greatest health needs and complexity.
- AR 110 HULL AND EAST YORKSHIRE: That conference believes that the current framework for enhanced services is too complex, puts an unreasonable bureaucratic burden on practices and requires simplification.  
*(Supported by North & North East Lincolnshire LMC)*
- A 111 WAKEFIELD: That conference opposes the shift of non-resourced work from secondary to primary care until primary care has the financial and human resources to absorb it safely.

## Agenda: Part II

### (Motions not prioritised for debate)

- 112 WAKEFIELD: That conference feels that the occult national policy of making small practices unsustainable should end.
- 113 WAKEFIELD: That conference believes that GP trainees should be protected against the disproportionately adverse effects of the governments planned junior doctor reforms; as general practice is not safe or sustainable if there are no new GPs.
- 114 DORSET: That conference believes every patient who receives a service from the NHS should be informed of the cost of that service.
- 115 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that a new GP contract is urgently required which:
- (i) rewards innovation and new ways of working
  - (ii) allows contracts to be held by limited liability organisations, such as LLPs or Ltd companies
  - (iii) removes the liability from GPs from funding regulation by CQC and similar
  - (iv) abolishes the monopsony model of funding for General Practice and permits a multi-customer model.
- 116 WILTSHIRE: That conference recognises the need for more carers to provide care in the community and:
- (i) welcomes a commitment to care workers receiving a living wage and supports measures aimed at increasing the number of paid care workers
  - (ii) recommends care workers receive NHS terms and conditions of service
  - (iii) calls for care workers to be considered key workers and given advantageous deals on housing.
- 117 WILTSHIRE: That conference advises that patients should be given their paper notes for safekeeping.
- 118 WILTSHIRE: That conference believes that it would be professionally advantageous for GPs to be renamed "Consultants in Primary Care.
- 119 WILTSHIRE: That conference believes that in order to reduce obesity and the increasing incidence of related diseases, the Government should quickly implement a tax on sugar and curbs on discounts of unhealthy foods as recommended by the Health Select Committee. This would also reduce a large part of the increasing workload on GPs.
- 120 HULL AND EAST YORKSHIRE: That conference believes that to help address the workforce crisis, the government should fund GP training in return for a specified term of service as a fully qualified GP within UK primary care.  
*(Supported by North and North East Lincolnshire)*
- 121 HULL AND EAST YORKSHIRE: That conference believes that the transfer of public health to local authorities has been unsuccessful and calls for properly resourced reintegration into the NHS in order to deliver safe and consistent patient care.  
*(Supported by North and North East Lincolnshire)*
- 122 HULL AND EAST YORKSHIRE: That conference believes that public health should be returned to the NHS where a fully joined up service can be provided. The move to local authority control has led to a fragmented service, especially for women, will lead to a deskilled GP workforce with regards to sexual health, and inadequate prescribing systems which will have detrimental long term effects.  
*(Supported by North and North East Lincolnshire)*
- 123 HULL AND EAST YORKSHIRE: That conference believes that general practice is still one of the best jobs in the world and we need government and GPC to make a public commitment to support GPs to deliver a high quality cradle to grave service.  
*(Supported by North and North East Lincolnshire)*
- 124 SANDWELL: That conference calls upon the GPC to change the advice given in the document 'Managing workload to deliver safe patient care' 2015. Instead of writing to offenders, GPs should be advised to send them a bill for services at rate of their choosing. GPs can be advised that no attempt to collect should be made for 12 months but thereafter all sums may be pursued vigorously. The reason for this is that unless a financial imperative is applied to abusers no worthwhile change will ever occur.
- 125 SANDWELL: That conference recognises that consultants, trainees and general practitioners are in this together and the GPC and BMA should co-ordinate our actions in the interests of patients.
- 126 NORTH WALES: That conference seeks the re-establishment of the Medical Practice Committee, or similar, to ensure that primary care provision is spread across the UK in a way proportionate to population need.
- 127 NORTH WALES: That conference calls for the recognition that training of non-doctor health care professionals who will be used as part of the primary care workforce must include adequate learning about the skills necessary for provision of high quality primary care.
- 128 NORTH WALES: That conference calls for QOF to be abandoned, and for the funding to be transferred into global sum. (To be transferred)

- 129 DEVON: That conference recognises the need for a stable, supported locum workforce and proposes:
- (i) the establishment of a national GP locum recruitment service
  - (ii) explores the setting up of locum networks of GP locums in stable employment by GP practice networks.
- 130 DEVON: That conference proposes that work streams with no strong evidence of clinical benefit to patients are stopped and their funding immediately transferred to global sum and this applies but is not limited to:
- (i) NHS health checks
  - (ii) admission avoidance DES
  - (iii) some elements of QOF.
- 131 DEVON: That conference calls for immediate recognition and resourcing for patients in intermediate care beds.
- 132 DEVON: That conference demands that the GPC:
- (i) investigates and compiles a database of enhanced services across the country
  - (ii) negotiates annually with the government a list of new enhanced services that should be added.
- 133 DEVON: That conference recognises that there are significant public relations dangers in seeking to define the 'core contract' as:
- (i) GPs might be perceived by the public to be pedantic and penny pinching
  - (ii) this strategy may diminish GPs professionalism from the public perspective
  - (iii) GPs may be portrayed as missing the point about future funding of the NHS.
- 134 DEVON: That conference would like to thank the GPC for organising an excellent day of debate and hope:
- (i) morale of GPs will be lifted
  - (ii) it will lead to significant actions being taken
  - (iii) that if there needs to be another emergency conference it is held in Sydney Australia as it will be warmer and an easier commute for an increasing number of UK GPs.
- 135 ROTHERHAM: That conference believes that the current exorbitant fees charged by GP locums are a disgrace to the profession, and are partly responsible for the demise of general practice in some areas. We call for a unanimous stance against gold-digging locums and agencies to limit their costs, thereby encouraging more doctors to take up substantive posts and partnerships.
- 136 AYRSHIRE AND ARRAN: That conference is concerned by the current workload in general practice and believes that this is both unsustainable and is acting as a disincentive to those who might otherwise consider a career in general practice. Conference calls on GPC to work with relevant bodies to reduce the workload managed in general practice by:
- (i) creating a mechanism for patients to self-refer to professions allied to medicine including but not limited to physiotherapy, podiatry and counselling
  - (ii) increasing the number of pharmacists working in general practice who can deal with medication reviews and repeat prescriptions
  - (iii) stopping the need for re-referrals to secondary care where patients have been discharged following failure to attend appointments
  - (iv) exploring mechanisms for triaging patients prior to them being appointed to see a GP.
- 137 AYRSHIRE AND ARRAN: That conference is concerned by the current workload and workforce issues facing primary care and believes it will soon become unfeasible for general practitioners to continue to be the first point of contact for all patients seeking medical care.
- 138 AYRSHIRE AND ARRAN: That conference believes the development and implementation of a single electronic patient record is long overdue and represents a significant patient safety issue which must urgently be addressed.
- 139 AYRSHIRE AND ARRAN: That conference is concerned by the lack of funded time available to general practitioners for both continuing professional development and service development and calls on GPC to work with four governments and primary care organisations for increased funding and protected time for:
- (i) continuing professional development for general practitioners
  - (ii) general practitioners to work on local service developments.
- 140 AYRSHIRE AND ARRAN: That conference believes that the total abolition of prescription charges in Scotland is a drain on already stretched NHS resources and adds to GP workloads. Conference calls on SGPC to work with relevant bodies towards the reintroduction of a means tested prescription charge.
- 141 SHROPSHIRE: That conference insists the government should urgently set up an independent public review of the reasons for the recruitment and retention crisis in UK general practice before it is too late.
- 142 SOMERSET: That conference requires the GMC to ask government, that as the structure of UK general practice can no longer be stopped from falling, just what it plans to do when the rubble hits the ground.
- 143 SOMERSET: That conference requires GPC to act upon the wealth of information it now has about the need for structural reform so that it can better represent the profession, and to set a firm timetable for its transition to a smaller, more effective and properly representative organisation.
- 144 SOMERSET: That conference asks GPC to ensure that the disproportionate damaging effects of current NHS changes on rural populations are properly recognised, noting that the loss of a small country practice when the nearest alternative is many miles away may be very serious indeed for vulnerable people.
- 145 AVON: That conference calls upon the GPC to explore the removal of locums from the primary care workforce and have them centrally contracted to provide a flexible and cost-effective resource to provide continuity of service.

- 146 SOUTH STAFFORDSHIRE: That conference believes that politicisation of the NHS has led to the imminent failure of the present 50 year compact between patients, GPs and the government of the day. We believe that an alternative and independent body is better placed to manage finite resources in a sustainable way at an arm's length from the short term political climate. Conference therefore requests the GPC to enter into discussions with the government that will lead to creation of such a body.
- 147 AVON: That conference calls upon the Prime Minister to demonstrate his personal integrity and sack any and every Minister of the Crown who abuses his office by deliberately misleading or lying to Parliament and the people of England.
- 148 SOMERSET: That conference instructs the GPC to work with the RCGP and other relevant organisations to produce clear evidence for the government that
- (i) the workload of a typical GP has become unmanageable and must be reduced if general practice is to survive,
  - (ii) the partnership model of general practice is a key reason why UK primary care is amongst the most cost-effective in the world,
  - (iii) the reduction of the investment in primary care from 10.5 % to 7.5% of NHS spending has directly resulted in GPs shunning partnership in favour of more lucrative sessional work or salaried roles, and
  - (iv) the impending demise of GP Partnership will result in increasing NHS costs without an equivalent improvement in the quality of patient care.
- (Supported by Somerset)*
- 149 NORTHAMPTONSHIRE: That conference demands that the crisis in recruitment and retention be addressed by reducing workload, realistic practice budgets and premises development support at practice level.
- 150 DERBYSHIRE: That conference requests our profession to come together to agree a fair and reasonable cap on GP locum fees.
- 151 DERBYSHIRE: That conference calls upon the government to extend the legislation requiring employers to release pregnant employees for ante-natal care appointments to employees who require routine appointments for the monitoring of other conditions
- 152 DERBYSHIRE: That conference reminds the government of the mathematical certainty that an extension of the breadth and depth of general practice services at weekends will mean a diminution on weekdays unless the number of appropriate primary care clinicians is increased by 40%.
- 153 DERBYSHIRE: That conference calls for the urgent incorporation of contingency planning for large numbers of patients being left without general practice services at very short notice into all NHS emergency preparedness and resilience planning.
- 154 DERBYSHIRE: That conference notes with alarm the unprecedented crisis in general practice workforce and workload and:
- (i) urges the government to make it clear to the English electorate what services can be provided by general practice under these circumstances, and in what timescales
  - (ii) urges the government to make it clear to the English electorate the difference between what general practice could deliver in an ideal world and what it can deliver in the real world
  - (iii) warns the government that the current burden of over-regulation and reporting requirements takes up so much of the limited time available to general practitioners and their staff that patients may not be receiving the clinical care they deserve.
- 155 NORTHAMPTONSHIRE: That conference demands that governments stop playing the game of Buckaroo with general practice by immediately removing onerous, pointless and wasteful burdens placed on the backs of the profession.
- 156 DERBYSHIRE: That conference recognises that other safety critical industries budget for their qualified workforce to spend around 25% of their paid time in training but the NHS does not and demands that this situation be remedied.
- 157 SUFFOLK: That conference expresses outrage that GPC appears to be on the periphery rather than at the centre of processes which may lead to the development of a new primary care contract and instructs GPC to demand full participation in all discussions from their commencement.
- 158 NORTHERN IRELAND SOUTHERN: That conference demands that funding for the Northern Ireland out of hours GP service is at least doubled to allow it to provide a safe and sustainable service.
- 159 DERBYSHIRE: That conference notes the direction of travel in 'Vanguard Sites' and calls for the abandonment of the purchaser/provider split in state funded healthcare in England.
- 160 DERBYSHIRE: That conference reminds both the government and NHS managers that the NHS is NOT the profession of general practice and the profession of general practice is NOT the National Health Service but that both parties come together on the basis of equality and parity to provide quality clinical services to patients from a basis of mutual benefit and not by way of exploitation of one party by the other.
- 161 HERTFORDSHIRE: That conference is concerned by the increasing number of practices closing or on the brink of financial collapse, and calls upon NHS England with the government to agree to the following measures as an emergency rescue package until at least the end of this parliament:
- (i) a moratorium on QOF for the remainder of 2015/16 and for 2016/17, with payments to practices based upon 2014/15 returns or 2015/16 projections (whichever is the higher)
  - (ii) a moratorium on DESs for the remainder of 2015/16 and for 2016/17, with payments to practices based upon 2014/15 returns or 2015/16 projections (whichever is the higher)
  - (iii) crown indemnity to be afforded to general practitioners from 1.4.16
  - (iv) area team bursaries to contribute to employed GP staff costs where GP vacancies threaten practice viability
  - (v) emergency 'amnesty' fund whereby practices who wish to hand back GMS contract to the PCO may do so without incurring prohibitive costs or risk of bankruptcy.

- 162 DERBYSHIRE: That conference asserts that becoming a registered medical practitioner did not involve the doctor taking either vows of poverty or consent to being chronically overworked.
- 163 DERBYSHIRE: That conference instructs GPC to
- (i) demand that the medical defence organisations offer indemnity policies to GPs which EXCLUDE any out of hours clinical indemnity cover
  - (ii) inform the government that from a date in the future, to be determined, that GPs will NOT carry clinical indemnity cover for OOH and that such cover must be provided by the NHS.
- 164 HERTFORDSHIRE: That conference calls for a recognition that the experience and skills needed to be a GP locum are such that this should be a specialist role within general practice and not open to GPs until they have completed a minimum number of years as a salaried GP or partner.
- 165 BERKSHIRE: That conference believes that (European Law permitting) the regulations on temporary resident registration should be altered to ensure foreign visitors with non-emergency problems are only eligible for private GP care.
- 166 OXFORDSHIRE: That conference believes that the public is largely unaware of the crisis in general practice and calls on the GPC to improve its communication of this message by a wider and more modern range of methods than it currently uses.
- 167 HERTFORDSHIRE: That conference recognises that list closure is a last resort for most practices and asks GPC to ensure NHS England supports list closure applications as a positive way for practices to manage their lists.
- 168 HERTFORDSHIRE: That conference calls on GPC to insist that NHS England proactively supports practices in areas that are struggling to recruit clinical staff by working with CCGs to allow list closures across entire towns or areas where this is necessary for patient safety and to prevent the domino effect.
- 169 DERBYSHIRE: That conference warns the English electorate that the actions of the government show that it does not understand:
- (i) the effect that current health policy is having on GPs
  - (ii) that investment in general practice is the most effective use of NHS money
  - (iii) that 7/7 8-8 is not the best use of NHS resource and will cause general practice to become unsustainable
  - (iv) that transformation takes time
  - (v) that pilots need evaluation before national roll out of a scheme.
- 170 NORTH YORKSHIRE: That conference believes, that forcing the formation of large sized practices through increasing political and financial pressure could be counter-productive to achieving or maintaining safe and sustainable general practice as needed by the public.
- 171 HERTFORDSHIRE: That conference notes that some LMCs are finding it increasingly difficult to justify sending thousands of pounds of GPs' money to the GPDF each year and calls on GPC to take immediate action to:
- (i) allow LMCs to bid to use some of its existing reserves for the direct and immediate support of struggling practices
  - (ii) give examples of how the fund has been used for the betterment of general practice
  - (iii) provide regular updates to LMCs about the size of the GPDF and how it is being used.
- 172 LINCOLNSHIRE: That conference recognises that there is a crisis in general practice workforce, and calls on GPC to lobby the government, GMC and HEE to:
- (i) increase places at medical schools to train a larger cohort of future doctors
  - (ii) create new medical schools which can provide a modern medical curriculum which encourages doctors to become GPs
  - (iii) modernise medical training so that undergraduates spend more time in general practice.
- 173 LINCOLNSHIRE: That conference recognises the government's hidden agenda, that the NHS becomes privatised. With this in mind, conference urges the GPC to approach a private provider who can buy practice premises and employ GP partners, to negotiate a good deal for GPs when this inevitably happens.
- 174 KENT: That conference demands that the plans for 8am to 8pm, seven day working are postponed until:
- (i) the lessons from pilots are realised
  - (ii) the safety risks in staffing levels and IT infrastructure are adequately addressed
  - (iii) OOH services are adequately funded
  - (iv) the differences between rural and urban populations are respected
  - (v) there is flexibility to accommodate local variations
  - (vi) continuity of care is given priority over access.
- 175 KENT: That conference demands that GP trainees who have failed their final exams and been assessed as trainable should be:
- (i) enabled to work as a staff grade GP for a defined time
  - (ii) supported educationally
  - (iii) paid more than a physician associate
  - (iv) protected by the BMA model contract.
- 176 KENT: That conference insists the GPC act on its mandate to seek a new national core contract which directly links payment to activity and:
- (i) demands that the government increase the funding for core work to a level of 12% of the total NHS spend in recognition of the increases in demand for access and complexity of care
  - (ii) secures an immediate suspension of MPIG erosion and PMS reviews pending negotiation
  - (iii) calls for a vote on industrial actions should this not be forthcoming.

- 177 CORNWALL AND ISLES OF SCILLY: That conference has no confidence in the current Secretary of State for health.
- 178 SUFFOLK: That conference believes GP IT provision is a critical pillar in the safe efficient provision of primary care and when this fails health practitioners and patients are put at significant risk. This is not acceptable and should be treated as a 'never' event.
- 179 NORTHERN IRELAND GPC: That conference is appalled at the way GP trainees have been treated in the ongoing junior doctor contract negotiations. This conference:
- (i) believes that a new 'unified' junior doctor contract, that does not acknowledge the nuances of training in GP will be detrimental to GP training and future GP recruitment
  - (ii) calls on the GPC to include GP trainees (whilst training in GP) in a new core general practice contract
  - (iii) calls on the Secretary of State for Health to end the rhetoric and back the future of general practice with actions.
- 180 MID MERSEY: That conference believes that the GPC's role in representing general practice is vital to the development of a safe and sustainable service into the future but it must adapt urgently to changing times and provide increased support to LMCs on a regional basis.
- 181 MID MERSEY: That conference believes that the government is responsible for a shambolic confrontational adversarial 2015 influenza vaccination campaign which has put vulnerable patients' care at risk, damaged professional relationships and calls upon the GPC to urgently negotiate a better system for 2016 which will allow practices to deliver a safe and sustainable service and place vaccination orders with confidence, minimising financial risk.
- 182 ROTHERHAM: That conference acknowledges the workforce crisis is threatening safe and sustainable general practice service and calls on the government to implement a scheme for reimbursement of 70% of total staff costs to GP practices immediately to save general practice.
- 183 GRAMPIAN: That conference believes that one action which could ensure a safe and sustainable service is to refocus the role of the GP as an expert medical generalist, leading (without necessarily employing) an expanded primary care team, all working at the top of their licence, allowing GPs the time for those patients who need us most, with practices working in clusters to ensure peer driven professionally led quality, but without being the contractual backstop for all of primary care.
- 184 HIGHLAND: That conference recognises the need for effective participation of patients in healthcare, and demands that GPC explore contractual models that can reflect the significant investment of time needed from GPs and other professionals to achieve the coproduction of services.
- 185 FORTH VALLEY: That conference commends the Scottish government in continuing to negotiate with SGPC a new GMS contract that aims to:
- (i) reposition the role of the general practitioner
  - (ii) be sustainable into the future
  - (iii) improve recruitment and retention
  - (iv) avoids privatisation.
- 186 GLOUCESTERSHIRE: That conference seeks recognition by the government of the present crisis in general practice and that this recognition must lead quickly to a 'back to basics' approach within general practice with the aim of:
- (i) putting priority on continuity of care
  - (ii) extending nominal appointment times to 15 minutes
  - (iii) reducing considerably the level of micromanagement currently imposed
  - (iv) providing extra funding beyond the capitation fee if patients exceed six appointments a year
  - (v) reducing practice boundaries to safe limits.
- 187 GLOUCESTERSHIRE: That conference believes general practice's ability to focus on people who are unwell and on those with chronic conditions would be enhanced by removing some tasks (eg contraception, antenatal care, vaccinations, dementia screening, unplanned admissions case management, travel advice and routine patient requested health checks) or by moving them to a separate service or services.
- 188 GLOUCESTERSHIRE: That conference believes the root cause of the current crisis is a loss of morale in primary care and urges that steps be taken to improve it.
- 189 GLOUCESTERSHIRE: That conference considers the government must recognise that understaffed practices are at risk of collapsing due to increasing work load performed by ever fewer clinicians, and in particular that:
- (i) general practice is struggling to retain and recruit doctors
  - (ii) the majority of patients do not want seven day access and therefore to ease pressure on general practice continued roll-out of the scheme should cease
  - (iii) the time taken to train a GP and the reluctance of graduates to become GPs means that promises of 5,000 extra GPs by 2020 are unachievable
  - (iv) money would be better spent on supporting GPs than on schemes that may sound good in theory but which in practice complicate further the delivery of services and do not necessarily reduce the pressure on general practice
  - (v) until adequate numbers of clinicians have been recruited and trained there is no point in introducing services that are supposed to improve health care but really take staff from an already shrinking pool
  - (vi) enthusiasm to join the profession is inversely affected by media denunciations and the converse may also prove true.
- 190 GLOUCESTERSHIRE: That conference wishes to see an increase in the number of medical school places.
- 191 GLOUCESTERSHIRE: That conference believes that being able to sell 'goodwill' would encourage GPs to take up partnerships.

- 192 BUCKINGHAMSHIRE: That conference recommends to government(s) that regulations be amended so that no NHS prescriptions are issued for medications that can be bought over the counter. (To be transferred)
- 193 BUCKINGHAMSHIRE: That conference calls upon the GPC to work urgently with the RCGP and Health Education England to review GP selection and training procedures which:
- (i) are currently a major obstacle to recruitment
  - (ii) are excessively time consuming both for trainee and trainer in completing the e-portfolio
  - (iii) impose excessive examination fees, unaffordable to a significant number of trainees
  - (iv) have failed to ensure newly qualified GPs can manage the business of general practice.
- 194 GATESHEAD AND SOUTH TYNESIDE: That conference believes that the GPC should set up a working group with the RCN and HEE to develop an evidence based and funded career development pathway with nationally agreed standards of qualification, educational support and development for practice nursing, which can be implemented by practices working together at scale.
- 195 NORFOLK AND WAVENEY: That conference calls on GPC to negotiate a NHS covenant similar to the military covenant afforded to the armed forces where NHSE's responsibility to its employees and independent contractors is enshrined in law to deliver a safe and sustainable general practice.
- 196 GATESHEAD AND SOUTH TYNESIDE: That conference calls on the GPC to negotiate for new models of care for general practice that focus on how we deliver a service to groups of patients, e.g. the frail and elderly, those requiring urgent care, those with substance misuse, offending behaviours, homelessness, mental health problems and learning disabilities as well as developing new structural models of care or disease specific pathways.
- 197 NORFOLK AND WAVENEY: That conference believes if you want to attract young doctors into the profession then the profession needs to be attractive with modern state of the art buildings and facilities, appropriate workload, pay and support networks.
- 198 DERBYSHIRE: That conference demands that paragraph 8 of the standard GMS contract be amended to make it explicit that essential services EXCLUDE any workload transferred by other agencies by whatever route.
- 199 DERBYSHIRE: That conference demands that the NHS standard national contract be amended to make it clear that, in line with government policy on reducing bureaucratic burdens on businesses, any new requirements for data must be on the basis of one in one out, ie some other bureaucratic requirement must be dropped.
- 200 DERBYSHIRE: That conference requests that GPC seek regulatory instruments be laid such that if ANY practice data held or gained by the NHS and its agencies is divulged without the specific written consent of the practice by the NHS or its agencies to external commercial organisations this shall be a criminal offence.
- 201 WIGAN: That conference cannot accept that any part of the £3.8bn 2016/17 NHS funding allocation be used to close the deficits of hospital trusts. These should be closed by a severe 'haircut' of PFI charges payments re existing hospital builds. The £1.8 bn which is reported to be earmarked for hospital deficit closure, should be ploughed into general practice where the increasing crisis justifies it.
- 202 WEST SUSSEX: That conference demands that:
- (i) all CCG commissioning decisions should require a mandatory impact assessment on General Practice before they are agreed, and
  - (ii) this should be published.
- (Supported by Croydon, Kingston & Richmond, Surrey, East Sussex and West Sussex)*
- 203 MANCHESTER: That conference believes sufficient support should be made available to ensure the sustainability of practices when partners retire.
- 204 NOTTINGHAMSHIRE: That conference believes to ensure general practice is financially sustainable, medical services delivered in primary care outside the core contract should be provided by general practice and fully funded and should be offered to general practice by default before being offered to any other provider.
- 205 WIGAN: That conference call for bold action to be taken by the Secretary of State and NHS England Wales, N Ireland and Scotland to:
- (i) encourage medical students and doctors in training to embrace a career in general practice
  - (ii) encourage GPs to take on principal ship
  - (iii) to make it worthwhile for both to do so by curtailing student loans, providing substantial inducements
  - (iv) to open access to the NHS for all overseas doctors with appropriate qualifications to work and train in UK general practice.
- 206 NORTH STAFFORDSHIRE: That conference given the acute and worsening workforce crisis in general practice and the fact that 20-30% of adult consultations in general practice relate to musculo-skeletal conditions, believes that the GPC should insist that without delay:
- (i) the government supports the roll out of a direct access physiotherapy system across the country, which allows self-referral by patients without prior consultation with the GP
  - (ii) the government develops a strategy which supports the employment of physiotherapists in general practice working as first line consulters for patients presenting with musculo-skeletal conditions
  - (iii) that in doing so the government makes funds available to practices to employ and indemnify these physiotherapists.

- 207 BARNET: That conference requires that the GPC:
- (i) negotiates an agreement with the Department of Health that up to 90% of available Health Education England funding should be directed to general practice education and staff development to reflect the level of general practice patient contacts within the NHS and the priority the government says it places on general practice, and
  - (ii) will be required to provide a report on the outcome of negotiation at the 2016 Conference of LMCs.
- (Supported by, Bexley, Bromley, Camden, City and East London, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)*
- 208 CAMBRIDGESHIRE: That conference believes that workforce planning at scale by the NHS has demonstrably failed, and at practice level is dependent upon adequate contract length and value.
- 209 BRENT: That conference instructs the GPC to agree with NHSE that:
- (i) practice closures are a poor performance indicator for area teams and CCGs
  - (ii) every practice closure generates the equivalent of a serious untoward event report to be completed by the area team and CCG
  - (iii) poorly performing area teams and CCGs are held to account by NHSE and have to demonstrate that they have improved their support for practices in difficulty.
- (Supported by Barnet, Bexley, Bromley, Camden, City and East London, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)*
- 210 LEWISHAM: That conference requires that the:
- (i) GPC agrees with NHSE to implement an effective independent mechanism whereby bullying of GPs and their staff by NHS bodies, their staff including clinicians, or contractors, may be reported, investigated and resolved and
  - (ii) details of the agreement will be presented to the 2016 annual conference of LMCs.
- (Supported by Barnet, Bexley, Brent, Bromley, Camden, City and East London, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Merton, Sutton and Wandsworth, Southwark, Redbridge, Waltham Forest)*
- 211 FORTH VALLEY: That conference commends the Scottish Government for continuing to negotiate with SGPC to try and negotiate a sustainable contract for 2017 and demands that NHS England engage with GPC in the same manner.
- 212 BRO TAF: That conference demands government to recognise that general practice is in dire crisis due to insufficient general practitioners and to take urgent actions to:
- (i) increase GP recruitment and retention
  - (ii) stop all secondary care work being dumped on GPs without additional human resources
- 213 CITY AND EAST LONDON: That conference instructs the GPC to negotiate cross border cover arrangements with public health, borough teams and CCG teams so that the services available to patients in a practice are available to all the practice patients, regardless if their registered address is in a neighbouring borough.
- (Supported by Barnet, Bexley, Bromley, Camden, Brent, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington Chelsea and Westminster, Lambeth, Lewisham, Merton, Sutton and Wandsworth, Southwark, Redbridge and Waltham Forest LMCs)*
- 214 BRO TAF: That conference calls on the UK Government to include the recruitment of GPs from non EU countries in its immigration policy as a priority for a safe and sustainable service.
- 215 LoTHIAN: That conference asserts that, if we are to move to different models of access and new electronic approaches, GPs should get paid for every email initiated by a patient to which they respond.
- 216 LoTHIAN: That conference insists that GPs should be paid for every letter they write for a benefit claim, whatever its source, to enhance social justice and push the government into reducing inappropriate demand and developing more appropriate systems.
- 217 LANCASHIRE COASTAL: That conference welcomes the investment in the general practice estate proposed over a four year period through the Primary Care Transformation Fund but insists that it is available to all GPs in proportion to their estate requirements in meeting the needs of their patients rather than to some unproven political incentive such as seven day GP access.
- (Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 218 LANCASHIRE COASTAL: That conference recognises the power of the agreement reached between the government and the junior doctors and believes that a similar high level concordat needs to be agreed between the government and the GPC setting out the strategic direction for general practice and giving commitments from both sides as to how they will work together in a climate of respect to achieve a safe and secure service to patients.
- (Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 219 LoTHIAN: That conference maintains that there should be a central, accessible, 'plain English' website for patients / organisations / employers outlining which documents, certificates and letters they are / are not entitled to on the NHS.
- 220 LoTHIAN: That conference recognises that terminal care is an increasing and valuable use of our time and should be generously and separately resourced both:
- (i) financially
  - (ii) in terms of expanded community nursing teams with palliative care expertise.



- 221 LOTHIAN: That conference recognises that current IT is not fit for purpose and demands a national primary care IT specification, with defined minimum standards of infrastructure, in order to provide safe, multi-disciplinary patient care.
- 222 LOTHIAN: That conference maintains that, in order to tackle the inverse care law, practice income should be weighted on the basis of recognised frailty scores, thereby delivering resource to the practices with greatest demand, including those which serve the complex frail elderly and patients with premature multi-morbidity.
- 223 LOTHIAN: That conference supports the concept of open access primary mental health services for patients presenting with any mental health issue.
- 224 LOTHIAN: That conference believes that access to medical services has become a political football, and that national governments must admit that the expectation that patients can demand to see the doctor of their choice, at a time and place of their choosing, is not compatible with a sustainable NHS.
- 225 BEDFORDSHIRE: That conference believes that today's GP has to deal with minor ailments for which earlier generations would never have visited their GP and conditions which were previously dealt with in secondary care and calls for:
- (i) funding and manpower to follow the patients from secondary care into general practice
  - (ii) resources to ensure that practices are able to safely separate urgent cases from routine care
  - (iii) education in self-care for minor illnesses to be widely taught at every opportunity in schools, A&E and GP practices
  - (iv) pharmacists to receive training in red-flag symptoms in minor illness so they can be more confident in their advisory role with patients.
- 226 CUMBRIA: That conference believes that the increasing profitability of locum work is counterproductive to the success of general practice and GPC, in collaboration with NHSE, should devise measures to regulate this perverse incentive which discourages doctors from taking permanent GP posts.  
*(Supported by Lancashire Coastal, Lancashire Pennine and Central Lancashire)*
- 227 BEDFORDSHIRE: That conference calls on GPC to negotiate with the government a system of financial supports or other inducements to make partnership in general practice a more attractive option for newer/younger GPs, OR conference calls on GPC to use GPDF surpluses to create a system of financial supports to make partnership in general practice a more attractive option for newer/younger GPs.
- 228 BEDFORDSHIRE: That conference is concerned that it seems to have become accepted that GPs' working conditions are so crushing and deforming that GPs need to be taught to be resilient and demands that GPC tells NHS England that resources should be put in to changing working lives for the better rather than changing people to be more hard-hearted
- 229 LANCASHIRE COASTAL: That conference believes that GMS and PMS practices with recognised and agreed atypical populations, such as university practices and unavoidably small practices, will be forced to close before any review of the Carr Hill Formula is enacted in 2017 and calls on NHSE to cease any withdrawal of funds, remedy any funding already withdrawn and maintain their viability until their funding can be secured through a full and proper answer to the dilemma of practices with atypical populations.  
*(Supported by Lancashire Pennine, Central Lancashire and Cumbria)*
- 230 CENTRAL LANCASHIRE: That conference believes that the increased fragmentation of NHS Services, through the uni-professional pursuit of economies of scale and the procurement of stand-alone services, compromises communications, safety and efficiency, places an undue burden on GPs and calls on the government to reverse this trend by integrating services around GP practices.  
*(Supported by Lancashire Coastal, Lancashire Pennine and Cumbria)*
- 231 DONCASTER: That conference demands that GPC immediately meets with the Department of Health to discuss nationalising the medical defence organisations, allowing a single state owned National Defence Union which would work with the National Health Service to indemnify and protect medical practitioners working for the British public.
- 232 SALFORD AND TRAFFORD: That conference believes that as the panoply of regulatory bodies monitoring general practice inform each other of any knowledge of a complaint, they should also share with each other when they decide not to progress a complaint.
- 233 BIRMINGHAM: That conference directs GPC to negotiate contractual changes to fund and incentivise general practice working at scale.
- 234 THE GPC: That GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference is horrified by the so called 'Hunt effect', by which patients are put off accessing care on a weekend due to the perception that the NHS does not function then. We call on GPC to:
- (i) instigate a public campaign to highlight that the NHS already provides 24/7 care, including primary care
  - (ii) condemn the Health Secretary for harming patients through dangerous rhetoric.
- 235 THE GPC: That conference believes that the junior doctors' contract negotiation issue has shown that the profession is strongest when it works together. We call on GPC to work with LMCs to encourage more GP trainees to become involved in the work of LMCs and the BMA.

## SPECIAL CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

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## SPECIAL CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

### STANDING ORDERS

#### Conferences

##### Annual conference

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

##### Special conference

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

#### Membership

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

#### Representatives

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

#### Observers

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

#### Interpretations

10. A local medical committee is a committee recognised by a PCO or PCOs as representative of medical practitioners under the NHS Act 2006 as amended or by equivalent provisions in Scotland, Wales, and Northern Ireland.
11. 'Members of the conference' means those persons described in standing order 3.

12. 'Representative' or 'representatives' means those persons appointed under standing orders 4 to 8, and shall include the deputy of any person who is absent..
13. 'The conference', unless otherwise specified, means either an annual or a special conference.
14. 'As a reference' means that any motion so accepted does not constitute conference policy, but is referred to the GPC to consider how best to procure its sentiments.

### **Motions to amend standing orders**

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

### **Suspension of standing orders**

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

### **Agenda**

17. The agenda shall include:
  - 17.1 motions, amendments and riders submitted by the GPC, and any local medical committee. These shall fall within the remit of the GPC, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and/or the National Health Service (Scotland) Act 1978 and/or the Health and Personal Social Services (Northern Ireland) Order 1972 and any Acts or Orders amending or consolidating the same and as from time to time extended to all or any part of the United Kingdom
  - 17.2 motions, amendments and riders connected with NHS general practice from constituencies of the British Medical Association's representative body, or one of the other craft conferences convened by a standing committee of the BMA, referred by the BMA's joint agenda committee
  - 17.3 motions passed at national LMC conferences and submitted by their chairmen
  - 17.4 motions relating to the Cameron fund, Claire Wand fund and the Dain fund
  - 17.5 motions submitted by the agenda committee in respect of organisational issues only.
18. Any motion which has not been received by the GPC within the time limit set by the BMA's joint agenda committee shall not be included in the agenda. This time limit does not apply to motions transferred to the conference by the BMA's joint agenda committee. The right of any local medical committee, or member of the conference, to propose an amendment or rider to any motion in the agenda, is not affected by this standing order.
19. When a special conference has been convened, the GPC shall determine the time limit for submitting motions.

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

20. In two parts; the first part 'Part I' being those motions which the agenda committee believe should be debated within the time available; the second part 'Part II' being those motions covered by 25 and 26 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording. If any local medical committee submitting a motion included in Part II of the agenda objects in writing before the first day of conference, the transfer of the motion to Part I of the agenda shall be decided by the conference during the debate on the report of the agenda committee.
21. 'Grouped motions': Motions or amendments which cover substantially the same ground shall be grouped and the motion for debate shall be asterisked. If any local medical committee submitting a motion so grouped objects in writing before the first day of the conference, the removal of the motion from the group shall be decided by the conference.

22. 'Composite motions': If the agenda committee considers that no motion or amendment adequately covers a subject, it shall draft a composite motion or an amendment, which shall be the motion for debate. The agenda committee shall be allowed to alter the wording in the original motion for such composite motions.
23. 'Motions with subsections':
  - 23.1 motions with subsections shall deal with only one point of principle, the agenda committee being permitted to divide motions covering more than one point of principle
  - 23.2 subsections shall not be mutually contradictory
  - 23.3 such motions shall not have more than five subsections except in subject debates.
24. 'Rescinding motions': Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters 'RM'.
25. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chairman of the GPC as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.
26. 'AR' motions: Motions which the chairman of the GPC is prepared to accept without debate as a reference to the GPC shall be prefixed with the letters 'AR'.
27. 'C' motions: Prior to the conference, a ballot of representatives shall be conducted to enable them to choose motions, ('C' motions), amendments or riders for debate. Using only the prescribed form, which must be signed and received by the GPC secretariat by the time notified for the receipt of items for the supplementary agenda, each representative may choose up to three motions, amendments or riders to be given priority in debate. Chosen motions must receive the vote of at least ten representatives. The first three motions, amendments or riders chosen, plus any others receiving the vote of at least twenty representatives, shall be given priority.
28. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 44, 45, 46, 47 and 52 shall not apply and the debate shall be held in accordance with standing order 54.

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

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

## Procedures

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

## Rules of debate

36. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.
37. Every member of the conference shall be seated except the one addressing the conference. When the chairman rises, no one shall continue to stand, nor shall anyone rise, until the chair is resumed.
38. A member of conference shall address the chairman and shall, unless prevented by physical infirmity, stand when speaking.
39. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.
40. Members of the GPC, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.
41. The chairman shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.
42. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.
43. The chairman shall take any necessary steps to prevent tedious repetition.
44. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.
45. Amendments shall be debated and voted upon before returning to the original motion.
46. Riders shall be debated and voted upon after the original motion has been carried.
47. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 44, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.
48. If it is proposed and seconded or proposed by the chairman that the conference adjourns, or that the debate be adjourned, or 'that the question be put now', such motion shall be put to the vote immediately, and without discussion, except as to the time of

adjournment. The chairman can decline to put the motion, 'that the question be put now'. If a motion, 'that the question be put now', is carried by a two thirds majority, the chairman of the GPC and the mover of the original motion shall have the right to reply to the debate before the question is put.

49. If there be a call by acclamation to move to next business it shall be the chairman's discretion whether the call is heard. If it is heard then the proposer of the original motion can choose to:
  - (i) accept the call to move to next business for the whole motion
  - (ii) accept the call to move to next business for one or more subsections of the motion
  - (iii) have one minute to oppose the call to move to next business.Conference will then vote on the motion to move to next business and a 2/3 majority is required for it to succeed.
50. Proposers of motions shall be given prior notice if the GPC intends to present an expert opinion by a person who is not a member of the conference.
51. All motions expressed in several parts and designated by the numbers (i), (ii), (iii), etc shall automatically be voted on separately. But, in order to expedite business, the chairman may ask conference (by a simple majority) to waive this requirement.
52. Any motion, amendment or rider referred to the conference by the joint agenda committee shall be introduced by a representative or member of the body proposing it. That representative or member may not otherwise be entitled to attend and speak at the conference, neither shall he/she take any further part in the proceedings at the conclusion of the debate upon the said item, nor shall he/she be permitted to vote. In the absence of the authorised mover, any other member of the conference deputed by the authorised mover may act on their behalf, and if there is no deputy the item shall be moved formally by the chairman.
53. If by the time for a motion to be presented to conference no proposer has been notified to the agenda committee, the chairman shall have the discretion to rule, without putting it to the vote, that conference move to the next item of business.
54. In a major issue debate the following procedures shall apply:
  - 54.1 the agenda committee shall indicate in the agenda the topic for a major debate
  - 54.2 the debate shall be conducted in the manner clearly set out in the published agenda
  - 54.3 the debate may be introduced by one or more speakers appointed by the agenda committee who may not necessarily be members of conference
  - 54.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
  - 54.5 subsequent speakers will be selected by the chairman from those who have indicated a wish to speak. Subsequent speeches shall last no longer than one minute.
  - 54.6 the Chairman of GPC or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
  - 54.7 at the conclusion of the debate the introductory speakers may speak for no longer two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
  - 54.8 the response of members of conference to any major debate shall be measured in a manner determined by the agenda committee and published in the agenda.

## Allocation of conference time

55. The agenda committee shall, as far as possible, divide the agenda into blocks according to the general subject of the motions, and allocate a specific period of time to each block.
56. Motions will not be taken earlier than the times indicated in the schedule of business included in the agenda committee's report.
57. 'Soapbox session':
  - 57.1 A period shall be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
  - 57.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
  - 57.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
  - 57.4 GPC (UK) members shall not be permitted to speak in the soapbox session.

58. Motions which cannot be debated in the time allocated to that block shall, if possible, be debated in any unused time allocated to another block. The chairman shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.
59. Not less than two periods shall be reserved for the discussion of other motions, and any amendments or riders to them, which cannot conveniently be allocated to any block of motions.
60. Motions prefixed with a letter 'A', (defined in standing orders 25 and 26) shall be formally moved by the chairman of conference as a block to be accepted without debate during the debate on the report of the agenda committee in the first session of the conference.
61. One period, not exceeding one hour, to be reserved for representatives of LMCs to ask questions of the GPC negotiating team.
62. The allocation of conference time should include a period of 'contingency time' on each day of the conference and a period for debate of chosen motion.

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

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

### **Quorum**

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

### **Time limit of speeches**

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

### **Voting**

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

### **Majorities**

68. Except as provided for in standing order 48 and 49 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:
  - 68.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC structure, or



68.2 a decision which could materially affect the GPDF Ltd funds.

69. Voting shall be, at the discretion of the chairman, by a show of voting cards or electronically. If the chairman requires a count this will be by electronic voting.

#### **Recorded votes**

70. If a recorded vote is demanded by 20 representatives at the conference, signified by their rising in their places, the names and votes of the representatives present shall be taken and recorded.

71. A demand for a recorded vote shall be made before the chairman calls for a vote on any motion, amendment or rider.

#### **Elections**

72. Chairman

72.1 At each conference, a chairman shall be elected by the members of the conference to hold office from the termination of the BMA's annual representative meeting (ARM) until the end of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.

72.2 Nominations must be handed in on the prescribed form before 12 noon on the first day of the conference with any election to be completed by 4.00pm. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

73. Deputy chairman

73.1 At each conference, a deputy chairman shall be elected by the members of the conference to hold office from the termination of the ARM until the termination of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.

73.2 Nominations must be handed in on the prescribed form before 9.30am on the second day of the conference with any election to be completed by 12 noon. Nominees may enter on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

74. Seven members of the General Practitioners Committee

74.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. For six of the seats any registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, whether a member of the conference or not, is eligible for nomination providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. All GPs on the retainer scheme, and medically qualified LMC secretaries, are eligible for nomination regardless of their level of commitment to providing or performing NHS primary medical services. For the seventh seat, only an LMC representative at conference may be nominated, and that LMC representative must never have previously sat on the GPC. This LMC representative must also be a registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. The members elected will serve on the GPC from the conclusion of the following ARM until the conclusion of the ARM one year thereafter. Only representatives shall be entitled to vote.

74.2 Nominations must be handed in on the prescribed form, by 1.00pm on the first day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word. Elections, if any, will take place on the second day of conference and be completed by 10.00am.

74.3 The GPC shall be empowered to fill casual vacancies occurring among the elected members.

75. Seven members of the conference agenda committee

75.1 The agenda committee shall consist of the chairman and deputy chairman of the conference, the chairman of the GPC and seven members of the conference, not more than one of whom may be a sitting member of the GPC. In the event of there being an insufficient number of candidates to fill the seven seats on the agenda committee, the chairman shall be empowered to fill the vacancy, or vacancies, by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected, and shall continue in office until the end of the following annual conference.

75.2 The chairman of conference, or if necessary the deputy chairman, shall be chairman of the agenda committee.

- 75.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by 1.00pm on the first day of the conference. Elections, if any, will take place on the second day of conference and be completed by 10.00am. With the exception of those appointed under standing order 3.7, any member of the conference may be nominated for the agenda committee. All members of the conference are entitled to vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
- 75.4 The result of the election to the agenda committee shall be published after the result of the ARM election of GPC members is known.
- 75.5 The two members of the agenda committee to be appointed to the joint agenda committee in accordance with article 53 of the BMA's Articles of Association shall be the chairman of the conference and the chairman of the GPC.
76. The representatives allocated to represent general practice at the BMA Annual Representative Meeting shall be members of the BMA both at the time of their annual appointment/election and throughout their term of office and shall comprise:
- 76.1 the chairman and deputy chairman of conference, if eligible
- 76.2 the chairman of the GPC, if eligible
- 76.3 sufficient members of conference to fill the allocation of seats, elected on a regional basis in advance of conference by those members of the conference who are members of the BMA
- 76.4 should there be vacancies after the regional elections these shall be filled by the GPC from the unsuccessful candidates standing in those elections.
77. Three trustees of the Claire Wand fund
- 77.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. Any registered medical practitioner who is, or has been, actively engaged in practice as a general medical practitioner under the National Health Service Acts, whether a member of the conference or not, is eligible for nomination.
- 77.2 Nominations must be handed in on the prescribed form before 1.00pm on the first day of the conference. Elections, if any, will take place on the second day of conference and be completed by 10.00am. Only representatives in attendance at the conference may vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers.
- 77.3 Trustees will be elected on a triennial basis for a period of three years, to run from the termination of the next ARM.
78. Dinner committee
- 78.1 At each conference there shall be appointed a conference dinner committee, formed of the chairman and deputy chairman of the conference and the chairman of the GPC, to take all necessary steps to arrange for a dinner to be held at the time of the following annual conference, to which the members of the GPC, amongst others, shall be invited as guests of the conference.

### **Returning officer**

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

### **Claire Wand award**

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

### **Motions not debated**

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

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

82. In the conference hall, or in the precincts thereof, no papers or literature shall be distributed, or announcements made, or notices displayed, unless approved by the chairman.

### **Mobile phones**

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

### **The press**

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

### **No smoking**

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

### **Chairman's discretion**

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

### **Minutes**

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

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