Conference of England LMC Representatives

Agenda

Friday 10 November 2017
Conference of England LMC Representatives

Agenda

To be held on

**Friday 10 November 2017** at **9.30am**
At the **Mermaid London, Puddle Dock, London EC4V 3DB**

**Chair** Guy Watkins (Cambridgeshire)
**Deputy Chair** Rachel McMahon (Cleveland)

**Conference Agenda Committee**
Guy Watkins (Chair of Conference)
Rachel McMahon (Deputy Chair of Conference)
Richard Vautrey (Chair of GPC)

Katie Bramall-Stainer (Hertfordshire)
Roberta King (Dorset)
Brian McGregor (North Yorkshire)
Shaba Nabi (Avon)
Elliott Singer (Waltham Forest)
NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 18 September 2017. Although 18 September 2017 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the secretary – Jacqueline Connolly – prior to the conference, or handed in, in writing, at as early a stage of the conference as possible.

The agenda committee has acted in accordance with standing orders to prepare the agenda. A number of motions are marked as those which the agenda committee believes should be debated within the time available. Other motions are marked as those covered by standing orders 24 and 25 (‘A’ and ‘AR’ motions – see below) and those for which the agenda committee believes there will be insufficient time for debate or are incompetent by virtue of structure or wording. Under standing order 20, if any local medical committee submitting a motion that has not been prioritised for debate objects in writing before the day of the conference, the prioritisation of the motion shall be decided by the conference during the debate on the report of the agenda committee.

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

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

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

Attached is a ballot form for chosen motions. The ballot closes at noon on Friday 3 November 2017.
CONFERENCE OF ENGLAND LMCS ELECTIONS

The following elections will be held on Friday 10 November 2017.

**Chair of conference**
Chair of conference for the session 2017-2018 (see standing order 63) nominations to be handed in no later than **10.00am Friday 10 November**.

**Deputy chair of conference**
Deputy chair of conference for the session 2017-2018 (see standing order 64) nominations to be handed in no later than **13.00 Friday 10 November**.

**Five members of LMC England conference agenda committee**
Five members of the England conference agenda committee for the session 2017-2018 (see standing order 65) nominations to be handed in no later than **13.00 Friday 10 November**.
## SCHEDULE OF BUSINESS

**Friday 10 November 2017**

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OPENING BUSINESS 9.30

RETURN OF REPRESENTATIVES

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

STANDING ORDERS

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

REPORT OF THE AGENDA COMMITTEE

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

ANNUAL REPORT 9.55

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

NEW MODELS OF CARE 10.25

5 AGENDA COMMITTEE TO BE PROPOSED BY HEREFORDSHIRE: That conference asks GPC England to negotiate funding and statutory changes to ensure general practice can provide a strategic role in the development of new models of care and
(i) ensure parity with other parts of the health and social care service
(ii) ensure that they can be GP led organisations
(iii) ensure equitable use of savings made,
(iv) to explore other options for general practice holding core contracts.

5a HEREFORDSHIRE: That conference asks the GPC to negotiate funding to ensure general practice can provide a strategic role in the development of new models of place based care ensuring parity with other parts of the health and social care service.

5b ENFIELD: That conference demands that CCG should pass on the savings in their own management costs to GP federations when they choose to issue primary care contracts at scale.

5c BRADFORD AND AIRDALE: With a growing pressure to deliver general practice at scale, for example through super-partnerships with an associated increased risk of liability to individuals, that conference explores other options for general practice holding core contracts for example through limited liability partnerships.

5d MANCHESTER: That conference believes appropriate statutory changes should be made to new models of care to ensure they can be GP led organisations.

5e MANCHESTER: That conference believes MCP and Transformation is new work and should be funded appropriately.

5f NEWCASTLE AND NORTH TYNESIDE: That conference believes that any new funding arrangement in new models of care must ensure that core general practice funding is ring-fenced so that essential services are protected for all patients and there is no post code lottery.
AGENDA COMMITTEE TO BE PROPOSED BY THE SESSIONAL GPS SUBCOMMITTEE: That conference understands the value of independent contractor status but also recognises that not all GPs desire to work in this way and calls upon GPC to:

(i) formulate a blueprint for the future of general practice that includes a plurality of contractual types and provides meaningful support to both sessional and contractor GPs
(ii) lobby NHS England to investigate and invest in locum chambers as a proven GP retention model
(iii) recognise the acute workforce shortages in general practice and support a move to provide a structured pathway for locum GPs to work on a rotational basis with practices on fixed term salaried contracts – a ‘locum plus’ model.
(iv) ensure that locum GPs are protected from large web based platforms and locum banks which attempt to impose unfair terms of work and rates of pay.

6a THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPS subcommittee:
That conference calls upon GPC to lobby NHS England to investigate and invest in locum chambers as a proven GP retention method.

6b THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPSs subcommittee:
That conference understands the value of Independent Contractor status, but also recognises that not all GPs desire to work in this way. We call upon the GPC to formulate a blueprint for the future of general practice that includes a plurality of contractual types and provides meaningful support to both sessional and contractor GPs.

6c NOTTINGHAMSHIRE: That conference recognises the acute workforce shortages in general practice and supports a move to provide a structured pathway for locum GPs to work on a rotational basis with practices on fixed term salaried contracts – a ‘locum plus’ model. This may be a way of containing costs for the practices and giving them greater stability whilst preventing professional isolation for locums and allowing them the flexibility that they crave.

6d GATESHEAD AND SOUTH TYNESIDE: That conference believes that if locum GPs are to continue to play a vital role in sustaining general practice then they must:
(i) have appropriate access to NHS.net email addresses
(ii) have unobstructed access to educational opportunities similar to practice based GPs
(iii) be protected from large web based platforms and locum banks which attempt to impose unfair terms of work and rates of pay.

ONLINE CONSULTING

7 TOWER HAMLETS: That conference is concerned about the pressure to introduce online consulting into general practice:
(i) when there is no evidence that it will save time
(ii) and believes it will decrease access to more vulnerable patients who may struggle to use the internet
(iii) as it will add to an already unmanageable GP workload
(iv) and calls on GPC England to make it clear to government and NHS England that GPs will not formally agree to begin on line consulting until there is clear evidence that it is beneficial to the health of patients.

7a BARNET: That conference believes that although offering online/ tele-consultation access may look attractive for the patients, it will be a waste of time and funding in the absence of trained indemnified workforce and funding should instead be diverted to shore up an overstrained general practice.

7b LAMBETH: That conference believes that:
(i) there is no good evidence that online consultations reduce workload
(ii) it is disadvantageous to those patients who do not have access to the internet.
**CAPITA**

8 AGENDA COMMITTEE TO BE PROPOSED BY WALTHAM FOREST: That conference calls upon GPC England to:
(i) make the return of the delivery of primary care support functions to the public domain a central demand in the next round of contract negotiations
(ii) urgently address Capita’s failure to correctly collect superannuation contributions in England and seek recompense for those practitioners affected
(iii) demand that NHS England prioritise PCSE service improvement with regard to financial statements so that practices can undertake informed business planning.

8a WALTHAM FOREST: That conference calls on GPC to make the return of the delivery of primary care support functions to the public domain a central demand in the next round of contract negotiations.

8b KENT: That conference believes that Capita has been woefully inefficient and demands that its failure to correctly collect superannuation contributions should lead to a fine which can be distributed to general practice.

8c DORSET: That conference asks that NHS England and Capita are held to account for the current fiasco surrounding locum pensions.

8d BRENT: That conference condemns PCSE for its failure to establish an effective process for practices to understand and query financial statements, and calls upon GPC to demand that NHS England prioritise PCSE service improvement in this area so that practices can undertake informed business planning.

8e KENT: That conference believes that CAPITA is incompetent in every aspect of their purpose and remit and should be replaced.

**GPFV**

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

9a BEDFORDSHIRE: That conference calls on GPC England to advise government that simple checks of practice resilience and robustness in practices in England show that many more are at risk of closure than even the most negative predictions published so far.

9b DERBYSHIRE: That conference previously passed a vote of no confidence in the GPFV and to date there has been no evidence of action from GPC. Conference therefore demands GPC ensures:
(i) that monies must come directly to general practice with no unnecessary red tape nor complicated bidding process
(ii) that NHS England/CCGs are made to realise that a one-size fits all model does not fit our varied patient population
(iii) if the above do not occur, GPC must declare that the GPFV has failed by the next LMC England conference at the latest.

9c DERBYSHIRE: That conference instructs GPC to find out and publicise the quantity of money for the GPFV that has actively made it to front line general practice.
9d HERTFORDSHIRE: That conference anticipates that, given the present dire situation, general practice might not exist long enough for a ‘forward view’ of it to be taken and demands that GPC/GPDF initiate a major campaign to highlight to the public the government’s imperilment of this most cherished service.

9e HERTFORDSHIRE: That conference has no confidence in the ineffective implementation of the GP Forward View and believes that the outstanding monies ring-fenced for this purpose should be put directly into the global sum from 1 April 2018 calls upon the GPC England Executive to campaign for this.

9f DERBYSHIRE: That conference believes that it is irrelevant what motions are passed at the conference if they are not in keeping with GPC’s ideas conference recognises that the money released for the GPFV has been packaged in such small aliquots with associated procedural red tape that it is pointless for the majority of practices to bid for it and hence GPFV will not deliver its goals.

9g HERTFORDSHIRE: That conference has no confidence in NHS England’s lethargic approach to General Practice Forward View; its inaction rather than enaction is a prime example of fiddling whilst Rome burns.

9h WIRRAL: That conference believes that despite the rhetoric regarding primary care being the cornerstone of the NHS attempts to bolster primary care and general practice such as GP Forward View have been woefully inadequate. Unless drastic action is taken primary care general practice will continue to struggle and remain an unpopular career choice for junior doctors.

9i NORTH YORKSHIRE: That conference declares GPFV is not providing the lifeline general practice requires, and GPC need to negotiate an alternative in order that our profession and hence the NHS receives the help it needs NOW rather than risk reaching the point of no return!

9j SUFFOLK: That conference accepts that practices are in dire need of the two Rs – Relief and Resource. The Five Year Forward view as currently implemented appears to be delivering neither and conference instructs GPC to concentrate on getting the elements of the Prescription for General Practice implemented as a priority.

9k KENT: That conference demands that the GPFV is replaced by an appropriate rescue package that:
(i) is not detrimental to individual practices
(ii) does not inhibit investment in general practice infrastructure
(iii) does not distract CCGs
(iv) seeks to support individual practices
(v) is not a hollow promise.

9l LINCOLNSHIRE: That conference is distressed that eighteen months since the publication of the General Practice Forward View GP practices are still having to return their contracts, and demands that GPC and NHS England must find a single solution which will provide all general practices with adequate funding to make it sustainable.

9m HULL AND EAST YORKSHIRE: That conference believes that the level of resilience funding made available to practices via GPFV was unacceptable. We therefore call on the government to make an additional sum of £10 per patient available to all GP practices in England to facilitate incorporating true resilience into GP services.

(Supported by North and North East Lincolnshire LMC)

9n NORTH YORKSHIRE: That conference instructs GPC to negotiate provision of the GPFV transformation £3 nationally rather than cash strapped CCGs being told to provide it, which results in massive regional variation in delivery (with some receiving nil, and some only receiving it with ‘strings attached’ linked to CCG money saving projects rather than GP transformation).
9o DERBYSHIRE: That conference instructs GPC to undertake a survey of CCGs to ensure the £3 transformations money promised in the GPFV have not been obtained by top slicing other areas of the GP budget.

9p NORTH YORKSHIRE: That conference agrees that the GPFV commitment of delivering £3 per head to develop primary care at scale must be delivered directly from NHS England and not from stretched or in deficit CCG baselines to enable any reasonable chance of materialising and delivering change.

9q NOTTINGHAMSHIRE: That conference welcomes any new investment into general practice but contends that there is a real risk that the delivery of the GPFV will be greatly hampered and proposes that:
   (i)  NHS England is requested to directly inform practices of all schemes via their own website and directly via email
   (ii)  NHS England provides transparency over the use of funding allocated with regular reports at regional level of spend against scheme
   (iii)  GPC lobbies NHS England to ensure that any underspend against the allocated funding is made available to practices to spend on a fair shares basis.

9r CLEVELAND: That conference demands increased flexibility in how practices can utilise resilience funding, and specifically requests the option for this to be used to support the workforce.

9s NORFOLK AND WAVENEY: That conference recognises that the current Resilience Fund arrangements are woefully under-resourced leading to many deserving practices unable to access necessary funding in order to improve resilience and thus survive.

9t BRENT: That conference deplores commissioner’s reliance on management consultants to discharge its responsibilities under the GPFV, and calls upon NHS England to require that funding released under the Resilience Programme should be made directly available to general practice.

CAPPED EXPENDITURE PROCESS

10 AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference deplores the imposition of the capped expenditure process (CEP) and calls on GPC to negotiate with NHS England and NHS Improvement to abandon this process because:
   (i)  GP providers are already struggling to provide services within what is already a limited financial envelope
   (ii)  general practice and GP service provision will necessarily and disproportionately experience the impact of this cost cutting exercise
   (iii)  even with economies of scale this has the potential to destabilise general practice to the overall detriment of patient care
   (iv)  the CEP is likely to significantly increase workload in general practice without any additional funding, or any consideration being given to the impact or sustainability of this transfer of work.

10a TOWER HAMLETS: That conference deplores the imposition of the capped expenditure process and calls on GPC to negotiate with NHS England and NHS Improvement to reverse the areas affected because:
   (i)  GP providers are already struggling to provide services within what is already a limited financial envelope
   (ii)  general practice and GP service provision will necessarily and disproportionately experience the impact of this cost cutting exercise
   (iii)  even with economies of scale this has the potential to destabilise general practice to the overall detriment of patient care.

(Supported by Barnet, Bexley, Brent, Bromley, Camden, City and Hackney, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington, Chelsea
and Westminster, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Sutton, Waltham Forest and Wandsworth LMCs)

10b CAMBRIDGESHIRE: That conference instructs GPC, when negotiating with NHS England regarding the 14 health economies placed under the CEP, whilst thinking the unthinkable, should:
   (i) ensure that GPs are not held responsible for inevitable care rationing
   (ii) eliminate contractual ambiguities in any agreements made
   (iii) not allow any indirect increase of GP workload due to the requirements of the CEP.

10c TOWER HAMLETS: That conference:
   (i) is opposed to the introduction of the Capped Expenditure Process
   (ii) calls on GPC to lobby government to abandon it.

10d AVON: That conference deprecates the continuing inconsistencies throughout the country, which allows the use of certain treatments in some areas but not in others. It calls on the GPC to negotiate and campaign for a standard service applicable throughout England and available to all patients whatever their postcode.

10e NORTHAMPTONSHIRE: That conference calls on government to be professional and stop money from coming down in small pots with 100s of documents. It is inefficient and confusing. ONE CONTRACT with schedules for additional services with the funding clearly attached.

11 AGENDA COMMITTEE PROPOSED BY HERTFORDSHIRE: That conference demands that individual CCGs should not be able to impose restrictions on prescribing and calls upon:
   (i) NHS England to undertake a national review of prescribing regulations and entitlements
   (ii) delegated CCGs to remove pressure on GPs to reduce or limit their prescribing

11a HERTFORDSHIRE: That conference calls upon NHS England to undertake a national review of prescribing regulations and entitlements, and calls upon delegated CCGs to remove pressure on GPs to reduce or limit their prescribing.

11b LAMBETH: That conference demands that individual CCGs should not be able to impose restrictions on prescribing.

11c AVON: That conference calls on NHS England to increase the investment in self-care rather than paying lip service to this policy by targeting over-the-counter medicines and gluten-free products.

12 AGENDA COMMITTEE TO BE PROPOSED BY AVON: That conference deplores the over-regulation of general practice and it calls upon GPC England to lobby government to:
   (i) abolish the NHS Choices reporting system
   (ii) abolish the Friends and Family test reporting system
   (iii) review the current procedure for GP complaints so that trivial complaints can be taken out of the system, as the practice time and resources they consume are disproportionate

12a AVON: That conference deplores the over-regulation of general practice, which is demoralising, divisive and ineffective, and it calls on the GPC to lobby government to abolish the NHS Choices and Friends and Family tests reporting systems.

12b CAMBRIDGESHIRE: That conference believes that the NHS Choices GP surgery rating system is fundamentally flawed, unreliable and unfair, and asks GPC to ensure it is discarded at this time of historically low and worsening GP morale.

CLINICAL AND PRESCRIBING 11.30

REGULATION 11.40
12c  WAKEFIELD: That conference wants the current procedure for GP complaints to be re-visited so that trivial complaints can be taken out of the system as the practice time and resources they consume are disproportionate.

* 13  AGENDA COMMITTEE TO BE PROPOSED BY DERBYSHIRE: That conference demands that GPC works with NHS England to:
  (i) ensure the standards set for appraisal and revalidation are the same across the country and are not open to interpretation by individual Responsible Officers
  (ii) that appraisal remains a supportive, formative tool for professional development, in line with current RCGP guidance and not a performance management tool
  (iii) ensure that confidentiality is an integral part of the appraisal process and that performance management groups do not have the right to access an appraisal without a GP’s written consent.
  (iv) reject any attempt by NHS England or others to introduce minimum activity levels on the Medical Performers List

13a  DERBYSHIRE: That conference demands that standards set for appraisal and revalidation are the same across the county and are not open to interpretation by individual Returning Officers.

13b  SUFFOLK: That conference demands, particularly in the current recruitment and retention crisis, that GPC:
  (i) firmly rejects any proposal by any arm of NHS England, or indeed any other bodies, to alter the minimum annual GP workload requirement that is necessary for existing GPs to remain on the National Performers List
  (ii) insists that NHS England increases the support available to GPs, making it consistently available, visible and accessible to all GPs, whether they be well or unwell
  (iii) ensures that NHS England monitors the GP appraisal and revalidation systems - to ensure they are not being inappropriately used as a performance management tool, or pass/fail test, but remain a personally relevant, supportive and formative professional development process for the individual GP; in line with current GMC and RCGP guidance.

13c  CENTRAL LANCASHIRE: That conference believes that the need to keep appraisals confidential does not go far enough and performance groups should not have access to appraisals without the doctor’s explicit written consent.

13d  NORTH ESSEX: That conference rejects any attempt by NHS England or others to introduce minimum activity levels for GPs on the Medical Performers List (MPL).

LIST CLOSURES  12.00

* 14  AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference asks GPC England to enter into discussions with NHS England:
  (i) to develop a new category of list closure that would allow a practice to close its list in agreement with the commissioners, and in the interest of patient safety, so that it can, for a period, decline to accept new registrations from patients who have not changed address
  (ii) to improve financial support to practices taking on patients following a list dispersal with the creation of a centrally negotiated payment per patient
  (iii) to work towards funding to practices taking on patients after a list dispersal flowing in ‘real time’ and not in arrears at quarter-end,
  (iv) so that commissioners must agree the terms of any list dispersal with the LMC(s) involved to ensure neighbouring practices taking on extra workload are supported appropriately and not destabilised.

14a  CLEVELAND: That conference demands a change to the regulations to improve the financial support to practices taking on patients after a list dispersal, specifically:
  (i) the funding should flow in real time, not at the end of a quarter
  (ii) there should be a new centrally negotiated payment.
14b HAMPSHIRE AND ISLE OF WIGHT: That conference asks GPC to enter into discussions with NHS England to develop a new category of list closure that would allow a practice under pressure to agree with commissioners that it can for a period decline to accept new registrations from patients who have not changed address.

(Supported by Avon, Devon, Cornwall, Gloucestershire, Somerset, Wiltshire (BSW), Dorset LMCs)

14c HERTFORDSHIRE: That conference instructs the GPC to:
(i) support and guide practices in their quest to protect patient safety by closing lists
(ii) renegotiate the regulations to ensure that a swift and easy mechanism is introduced to allow practices to close their lists to protect patient safety.

14d SOUTHWARK: That conference demands that CCGs discuss the terms of any list dispersal with the LMC to ensure that neighbouring practices who are taking on the extra workload are supported appropriately.

PRIVATE GENERAL PRACTICE 12.20

* 15 BEDFORDSHIRE: Given that a number of GPs genuinely feel that they can no longer operate within the NHS, conference calls on GPC England to urgently look at how these GPs can be supported to operate within a private, alternative model.

WORKLOAD LIMITS 12.40

* 16 AGENDA COMMITTEE TO BE PROPOSED BY LEEDS: That conference:
(i) believes tired doctors are potentially unsafe doctors
(ii) believes no GP should work longer than 12 hours in a day
(iii) calls on GPC England to issue guidance to support GPs to limit their working day to ensure patient safety
(iv) calls on NHS England and the government, working with GPC England, to make patients aware of the importance of reducing GP workload to safe levels
(v) believes GPs should be supported to say “NO” without feeling guilt.

16a LEEDS: That conference:
(i) believes tired doctors are potentially unsafe doctors
(ii) believes no GP should work longer than 12 hours in a day
(iii) calls on GPC England to issue guidance to support GPs to limit their working day to ensure patient safety
(iv) calls on NHS England and the government, working with GPC England, to make patients aware of the importance of reducing GP workload to safe levels.

16b HEREFORDSHIRE: That conference:
(i) agrees that overwhelming patient demand is one of the reasons for the current collapse of the GP services in England
(ii) asks the GPC to work with NHS England and our elected politicians to find realistic solutions to curb unnecessary patient demand to allow a sustainable future for NHS general practice.

16c NORFOLK AND WAVENEY: That conference instructs GPC to take all reasonable steps to ensure that NHS England understands and supports a reasonable and safe clinical workload for a GP to undertake without being subject to unfair criticism and sanctions from GMC and CQC.

16d ENFIELD: That conference believes GPs are being forced into providing 8-8 seven days a week appointments for patients. Conference believes that this is an unnecessary and unwarranted use of GP time, which could best be used to provide consultations during the week, allowing for a longer length than the standard 10 minutes and thereby better supporting patients with increasing complexity of need.
16e NORTH ESSEX: That conference calls for GPC to produce practical tools for use by practices to control GP workload and to reduce it, where necessary, to safe levels.

16f CUMBRIA: That conference believes that general practice should refrain from extending the hours of access until the numbers of staff have increased in real terms to support the service in a safe way.

16g NORFOLK AND WAVENEY: That conference instructs GPC to resist all attempts to extend the contractual working week to 7 days until the promised extra 5000 GPs have been recruited and the current 5 day GMS contractual week has return to a position of stability and robustness.

16h SANDWELL: That conference mandates the GPC to forthwith declare, in the interests of patient safety and quality:
(i) a GMS session will consist of 13 consultations per session in 2018, falling to nine consultations, each of 15 minutes' duration by 2020
(ii) nine such sessions per week will be provided for every 1500 patients
(iii) experienced practitioners, who have the personal capacity to safely do so, should be commissioned to do additional consultations, in their own practice or in a hub
(iv) this will allow adequate remuneration for additional GPs for those principals who otherwise risk burn out.

16i HAMPSHIRE AND ISLE OF WIGHT: That conference believes GPs should be supported to say “NO” without feeling guilt.

16j DERBYSHIRE: That conference demands the GPC stand up to the department of health and say ‘NO’ to its increasing unreasonable demands of general practice.

LUNCH

13.00

QUESTION THE EXECUTIVE TEAM

14.00

We would like to invite Representatives to submit specific questions on the topics of;
– GP or practice workforce
– Progress on recent motions passed at UK Conferences relevant to GPC England

The Agenda Committee have grouped together a number of motions relating to Workforce that we felt could not be best dealt with through traditional debate. These motions can be found in Annex A, starting with a Q number. This session will be held under standing order 55.

Questions must be submitted in advance by email to Karen Day (kday@bma.org.uk), to reach Karen by noon on Monday 6th November. There is no limit to the number of questions an individual Representative can submit.

The Agenda Committee will review the questions submitted to avoid duplication, and Representatives will be able to vote to prioritise the order of questions from 8am to noon on Friday 10 November (the day of Conference). Voting will be carried out using single transferrable vote and members of the BMA election team will be available to assist with any technical difficulties.

Questions will be asked from the Chair during this session.
**INDEMNITY**

* 17  AGENDA COMMITTEE TO BE PROPOSED BY GATESHEAD AND SOUTH TYNESIDE: That conference believes that the rising cost of medical indemnity in England is making general practice unsustainable and adding to the workforce crisis in England, and calls upon GPC England to:
  (i) ensure that inflationary reimbursements made by NHS England are recurrent and made directly to the individual GP or practice that is paying the indemnity
  (ii) demand that the government must introduce a system of indemnity comparable with secondary care which covers all GPs on the performers list and all NHS GP practice staff.
  (iii) survey GPs to consider withdrawing their out-of-hours commitment if direct reimbursement for their out-of-hours indemnity is not provided

17a  GATESHEAD AND SOUTH TYNESIDE: That conference congratulates the GPC on negotiating some reimbursement of the GP indemnity costs for the next two years, but believes that this money should be reimbursed to the individual or practice who pays the fee, in order to improve financial equity.

17b  LEEDS: That conference believes that the high and rising cost of medical indemnity for GPs is now unsustainable and:
  (i) is a key element causing the recruitment and retention crisis in general practice
  (ii) will lead to the collapse of GP out-of-hours services if not urgently resolved
  (iii) demands that the government must introduce a system of indemnity comparable with secondary care which covers all GPs on the performers list and all NHS GP practice staff.

17c  HARROW: That conference recognises the significant threat increased indemnity costs pose to the sustainability of general practice, and calls upon the GPC to:
  (i) demand government immediately set out how it will address this threat
  (ii) ensure that sessional and salaried GPs have access to any measures designed to mitigate the impact of increased costs, including NHS England indemnity reimbursements.

17d  LANCASHIRE PENNINE: That conference believes that if timely progress is not made on direct reimbursement of direct indemnity costs then GPs should be urged to stop doing out-of-hours.

17e  THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
  That conference calls on GPC to negotiate a permanent solution to the indemnity crisis and:
  (i) demands that all medical indemnity for NHS and public sector work should be included in the solution
  (ii) expects that this should either be wholly paid for, or reimbursed directly to, individual doctors and not via practices.

17f  KENT: That conference demands full reimbursement for indemnity costs for all GPs delivering NHS Services.

17g  KENT: That conference requires GPs to be covered by Crown Indemnity.

17h  DORSET: That conference insists NHS England resolves the current indemnity crisis facing GPs by providing trust indemnity through the NHS Litigation Authority for all.

17i  SOUTH STAFFORDSHIRE: That conference believes that the soaring cost of medical indemnity is a major contributing factor to the crisis in general practice and:
  (i) deplores the Medical Defence Organisation’s intention to increase indemnity fees even for important enabling incentives outlined in the GP Forward View, such as telehealth, online consultations and primary care access hubs
  (ii) instructs GPC to negotiate with NHS England for full reimbursement of indemnity fees, similar to colleagues in secondary care.
17j  WIRRAL: That conference believes that the current medical indemnity situation is totally unacceptable with ever escalating premiums for GPs and associated staff. We call on NHS England and the government to set up a separate national indemnity service that is not funded by GP practices.

17k  LIVERPOOL: That conference believes that the recent increases in GP indemnity fees are adversely affecting both the recruitment of, and retention of, GPs within the workforce and that now is the time to introduce Crown indemnity for both in-hours and out-of-hours GPs.

17l  COVENTRY: That conference believes that the Department of Health must urgently address the impending significant increase in professional indemnity fees to ensure that GPs, like other doctors, have Crown Indemnity.

17m  MANCHESTER: That conference believes with the rocketing cost of medical indemnity for salaried/locum GPs an increase in the GP contract should be negotiated and passed on to offset these increases.

17n  NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that the indemnity crisis will end general practice as we know it and demands that the government provides comprehensive state funded clinical indemnity to all NHS general practitioners.

(Supported by Hull and East Yorkshire LMC)

17o  NORFOLK AND WAVENEY: That conference believes that unless the crisis in affordability of medical indemnity is solved then the demise of NHS general practice will be guaranteed.

17p  GREENWICH: That conference believes that the current indemnity arrangements are not fit for purpose and potentially ruinous for the sustainability of general practice.

17q  SURREY: That conference demands a solution is found to address the ever-increasing personal cost of NHS indemnity insurance for general practitioners.

17r  MID MERSEY: That conference believes that the spiraling cost of indemnity cover for GPs is unsustainable and poses a real risk to the viability of general practice.

**PRIMARY/SECONDARY CARE INTERFACE**

18  AGENDA COMMITTEE TO BE PROPOSED BY NORTHAMPTONSHIRE: That conference recognises the right and responsibility of general practitioners to refer patients for specialist opinion and regarding referral management systems:

(i) requires legal confirmation that the clinical responsibility will rest with the individual making the decision that a referral may or may not proceed

(ii) believes they are an unacceptable barrier to patients accessing appropriate secondary care

(iii) believes the time involved is a poor use of the GP workforce

(iv) demands that the government takes measures to ensure that the postcode lottery these create ceases immediately

(v) calls upon the GPC England to oppose this false economy and allow GPs as highly skilled generalists to continue to act with professional autonomy.

18a  NORTHAMPTONSHIRE: That conference demands that the right and responsibility of general practitioners to refer patients for specialist opinion is not overridden by referral review systems.

18b  SURREY: That conference assents that any general practitioner can refer a patient for a further opinion without the requirement for peer-review.

18c  NORTHAMPTONSHIRE: That conference demands that where referral review systems are imposed that the clinical responsibility will rest with the individual making the decision that a referral may or may not proceed.
18d HERTFORDSHIRE: That conference notes that GPs are contractually obliged to refer patients when necessary, and expresses concern that ever increasing referral criteria and management increases patient harm and increases medico-legal risks to the GP, and calls upon the GPC England Executive to push back against this false economy and allow GPs as highly skilled generalists to continue to act with professional autonomy.

18e HERTFORDSHIRE: That conference condemns the denigrating plans for a national peer review of referrals and:

(i) demands that NHS England takes full responsibility for any associated delay
(ii) calls on all colleagues to consider the ethical issues of acting as referees
(iii) calls for GPs to lower their threshold for referrals to ensure patient safety
(iv) calls on GPC to oppose this scheme.

18f HERTFORDSHIRE: That conference deplores attempts by NHS England or CCGs to erect barriers to referrals, including the bureaucracy of numerous templates for different referrals, and directs GPC to ensure that this threat to patient safety and GP responsibility is removed.

18g CLEVELAND: That conference, in respect of referral management schemes currently being implemented across England:

(i) believes they are an unacceptable barrier to patients accessing appropriate secondary care
(ii) demands they are abandoned immediately, unless there is good evidence of clinical effectiveness.

18h LAMBETH: That conference demands that restrictions in relation to referrals to secondary care should be national rather than local to avoid a postcode lottery in terms of access to care.

18i SOUTHWARK: That conference believes that given the current workforce crisis, the introduction of formal peer review of referrals should be halted.

18j GATESHEAD AND SOUTH TYNE SIDE: That conference rejects moves towards clinical peer review of all routine referrals and believes that:

(i) it would not save the money anticipated
(ii) that it would be time consuming and detract from direct patient care
(iii) would be seen by the public as another attempt to prevent referrals to secondary care.

18k HULL AND EAST YORKSHIRE: That conference is appalled that the government is now forcing the CCGs to ration care to patients by underfunding them and leaving them no options but to use referral management systems and prescribing restrictions. The conference is concerned that NHS England is not doing anything to stop this variation of health service provision and demands that the government takes measures to make sure that this postcode lottery ceases immediately.

(Supported by North and North East Lincolnshire LMC)

18l NOTTINGHAMSHIRE: That conference rejects the notion of prior approval referrals and requests that the GPC ensures that the CCGs accept all medico-legal risk that goes with such commissioning decisions; the GP has discharged their duty of determining the need and acting on it appropriately.

18m NOTTINGHAMSHIRE: That conference is unhappy with the introduction of the new NHS England initiatives that were launched seemingly without due consultation with the profession e.g. Clinical Peer Review. Clear guidance is needed for practices and for LMCs advising them around whether the GPC supports such initiatives and on the obligation or otherwise for practices to work towards such schemes.
* 19 LEWISHAM: That conference is concerned that with the increase in use of ‘advice and guidance’ by trusts on Electronic Referral System (ERS) that:

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

(Supported by Barnet, Bexley, Brent, Bromley, Camden, City and Hackney, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington, Chelsea and Westminster, Lambeth, Merton, Newham, Redbridge, Southwark, Sutton, Tower Hamlets, Waltham Forest and Wandsworth LMCs)

19a GLOUCESTERSHIRE: That conference opposes the 100% e-referral utilisation in the hospital contract, especially as it may result in referrals being passed back to GPs as well as delays when the system is down or manipulated by overburdened hospital trusts.

* 20 AGENDA COMMITTEE TO BE PROPOSED BY KENT: That conference welcomes the recent hospital contract changes which empower GPs to reject inappropriate work from secondary care but feels it does not go far enough and demands that:

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

20a KENT: That conference agree that the new NHS contract doesn’t go far enough and demands:

(i) an identified e-mail address for every hospital to receive and act upon breaches
(ii) that new clinicians joining trusts should be educated on their obligations
(iii) onward referral be allowed on the basis of clinical judgement
(iv) that providers are financially penalised for breaches.

20b HARROW: That conference recognises the current GP workload crisis and calls upon the GPC to demand that NHS England and CCGs hold secondary care providers to account for compliance with the requirements of the NHS Standard Hospital Contract

20c BRENT: That conference condemns commissioners for allowing secondary care work to be transferred into primary care by stealth, and calls upon them to undertake robust contract management of secondary care providers to ensure that trusts are held to account for inappropriate workload transfers.

20d WEST SUSSEX: That conference asks NHS England to ensure the responsible clinician acts upon the results of patient investigations whilst in hospital, outpatients or at accident and emergency departments.

20e MID MERSEY: That conference fully supports the recent hospital contract changes which empower GPs to appropriately send back work appropriately thrust upon them from secondary care and asks that the GPC encourages NHS England to insist that hospitals publicise their arrangements for fulfilling their contractual obligations to patients.
20f HERTFORDSHIRE: That conference directs GPC to negotiate a tariff system which can be used to assign value and, consequently, payment to work carried out by practices, which should be done by secondary care providers so that GPs can be financially compensated for diverting their limited resources to complete such tasks.

20g HARROW: That conference condemns any unresourced transfer of secondary care work to general practice, and calls upon the GPC to make clear to government and commissioners, that GPs will not deliver services which have not been appropriately commissioned in primary care.

**URGENT CARE**

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

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

21a DERBYSHIRE: That conference believes that the NHS England document on Integrated Urgent Care is not fit for purpose as it will increase demand on an already overstretched and under resourced workforce.

**GP TRAINEES**

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

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

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

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

(Supported by Barnet, Bexley, Brent, Bromley, Camden, City and Hackney, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington, Chelsea and Westminster, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth LMCs)
PREMISES 15.50

* 24 AGENDA COMMITTEE TO BE PROPOSED BY BEDFORDSHIRE That conference instructs GPC England to negotiate with government:
   (i) an extension to the deadline for the reimbursement package including contributions to Stamp Duty Land Tax, VAT, legal costs and service charge management fees
   (ii) a guarantee that the ‘last man standing’ in a partnership will have the building either bought back or the remaining lease taken over by the government
   (iii) that the lease liability for non-NHS Property Services (NHS PS) should be accepted by NHS England in the same way as for NHS PS premises
   (iv) to ensure equivalent investment in partner owned premises as in purpose built and NHS Property service buildings
   (v) that NHS Property Services be dissolved and the properties to be devolved to CCGs.

24a BEDFORDSHIRE: That conference calls on GPC England to negotiate with the government:
   (i) a process to appeal against unjustifiable management and service charges
   (ii) options for shorter leases for GP premises, as long leases are a significant disincentive to doctors becoming partners.

24b BEDFORDSHIRE: That conference calls on GPC to negotiate that the lease liability for non-NHS Property Services (NHS PS) should be accepted by NHS England in the same way as for NHS PS premises, so that all GPs have the same protection for lease liability.

24c BEDFORDSHIRE: That conference calls for NHS Property Services to be replaced and NHS PS properties to be devolved to CCGs.

24d NORFOLK AND WAVENEY: That conference demands GPC to negotiate an extension to the deadline for the reimbursement package including contributions to Stamp Duty Land Tax, VAT, legal costs and service charge management fees to allow satisfactory negotiations to conclude with NHS Property Services because of the slow response from NHS Property Services to justified queries.

24e DERBYSHIRE: That conference instructs GPC to negotiate with the Department of Health to ensure that the ‘last man standing’ in a partnership will have the guarantee of the building being bought back by the government.

24f LINCOLNSHIRE: That conference demands that NHS England issues a notice which assures GP practices in lease-hold premises that in the event of a practice closure the responsibility for the lease will be transferred to NHS England or CCGs.

24g AVON: That conference is affronted by the explicit policy of NHS England and CCGs to only invest in purpose-built primary care facilities and to ignore the desperate need of partner owned premises.

24h BEDFORDSHIRE: That conference has no confidence in NHS Property Services (NHS PS) and feels that it has never been, and never will be, fit for purpose; that there has never been any consistent leadership; that it demands extortionate management fees and service charges, which they seem unable to justify when challenged, and which can amount to double the rent and are not reimbursable, and which are a major bar to joining a partnership.

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

25a NORTH YORKSHIRE: That conference instructs GPC England to negotiate a national solution regarding who funds increased revenue costs following ETTF premises developments to avoid essential projects stalling at the first hurdle due to neither CCGs or NHS England accepting this responsibility.
INFORMATION MANAGEMENT AND TECHNOLOGY  16.10

* 26 AGENDA COMMITTEE TO BE PROPOSED BY HARINGEY: That conference requires GPC England to:
  (i) negotiate with relevant bodies on the development of a standardised overarching data sharing template and data sharing agreement format
  (ii) ensure that NHS England/CCGs recognise the importance of information governance provider development arrangements
  (iii) work to ensure that properly resourced regional information governance and data sharing support arrangements are put in place to provide expert support and advice to GP provider organisations
  (iv) appoint regional data sharing experts to provide advice and support to all LMCs on all data sharing agreements
  (v) ensure that NHS England is recognised as the data controller for primary care.

26a HARINGEY: That conference requires GPC to:
  (i) negotiate with relevant bodies on the development of a standardised overarching data sharing template and data sharing agreement format
  (ii) ensure that NHS England/CCGs/HCBs recognise the importance of provider development information governance arrangements
  (iii) work to ensure that properly resourced regional Information Governance and data sharing support arrangements are put in place to provide expert support and advice to GP provider organisations
  (iv) appoints regional data sharing experts to provide advice and support to LMCs on all data sharing agreements.

(Supported by Barnet, Bexley, Brent, Bromley, Camden, City and Hackney, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Harrow, Hillingdon, Islington, Kensington, Chelsea and Westminster, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth LMCs)

26b NORTHAMPTONSHIRE: That conference demands that, given the nationally driven wider data sharing arrangements and implications of the new models of care, GPs are no longer legal data controllers and deemed accountable for such data sharing of practice based patient sensitive information.

26c CLEVELAND: That conference believes that the data controller for general practice should be NHS England.

* 27 WALTHAM FOREST: That conference supports the piloting of artificial intelligence health systems but insists that, prior to further rollout:
  (i) all systems need to be piloted and assessed against set national criteria
  (ii) the systems need to demonstrate a sustainable reduction in GP workload
  (iii) any system needs to fully integrate with GP clinical systems.

(Supported by Barnet, Bexley, Brent, Bromley, Camden, City and Hackney, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Haringey, Harrow, Hillingdon, Islington, Kensington, Chelsea and Westminster, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth LMCs)

CQC  16.30

28 GLOUCESTERSHIRE: That conference demands that the procedure be far easier for GPs to become a CQC ‘registered manager’, and that possession of GMC registration and placement on the Performers List alone should be sufficient requirements for this post.
GPDF 16.40

* 29 HAMPSHIRE AND ISLE OF WIGHT: That conference resolves to ask GPC England members of GPDF to abstain from voting at meetings so that the LMC members can ensure the Meldrum Review reforms are properly implemented.

(Supported by Avon, Devon, Cornwall, Gloucestershire, Somerset, Wiltshire, Dorset LMCs)

* 30 CORNWALL AND ISLES OF SCILLY: That conference recommends to LMCs that they should stop forwarding the voluntary levy to GPDF and instead use the money to set up a national and regional support and resource network for LMCs.

(Supported by Gloucestershire and Somerset)

ENGLAND CONFERENCE STANDING ORDERS 17.00

* 31 DEVON: That conference asks for an additional standing order to be introduced that directs the Agenda Committee to treat motions submitted by a regional LMC organisation in the same way as those from individual LMCs.

CHosen Motions 17.10

Close 17.30
Conference of England LMC Representatives

Agenda: Part II
(Motions not prioritised for debate)
A and AR Motions

LMCs every year send very any topical and relevant motions to conference which for reasons of space cannot be included. While every LMC can submit its unreached motions to the GPC for consideration, few do so. The Agenda Committee in consultation with the GPC Chair proposes acceptance of a large number of ‘A’ and ‘AR’ motions to enable them to be transferred to the GPC. A and ARM motions and the procedure for dealing with them are defined in standing orders.

NEW MODELS OF CARE

A 32 CAMBRIDGESHIRE: That conference notes the many ambitious plans to move towards Accountable Care Systems or organisations and believes that it is vital that GPC England and LMCs work to ensure that:
   (i) the general practice registered list is a fundamental building block of all such systems
   (ii) new arrangements do not threaten the continuity of contracts to provide general practice care
   (iii) GPs are not constrained in their ability to speak with independence and integrity.

A 33 EALING, HAMMERSMITH AND HOUNSLOW: That conference is appalled by some local authorities refusing to pay GP practices for work performed under the collaborative funding arrangements and demands that the GPC inform these organisations of their financial obligations for non-contractual work performed by general practitioners.

AR 34 KENT: That conference condemns the illogical contribution rate penalty for GP locums if they have a three-month gap between sessions.

A 35 SOUTHWARK: That conference believes that the disparity of earnings between salaried GPs and contractors is too wide, and calls on the GPC to:
   (i) ensure that contractors do not become rich at the expense of their salaried employees
   (ii) find a way to create more opportunities for salaried doctors to become partners, particularly in prospering practices
   (iii) ensure that supermarket-style contractors are held to account if the respect of salaried colleagues is not deemed to be adequate

(Supported by Tower Hamlets LMC)

A 36 DORSET: That conference asks NHS England to ensure that all sessional GPs doing NHS work are entitled to NHS pensions, regardless of contractor.

A 37 GATESHEAD AND SOUTH TYNESIDE: That conference believes that in relation to salaried GPs routinely working in excess of their contracted hours:
   (i) the GPC should support and empower them to raise the issue of unpaid work with their employer
   (ii) that it is inconsistent for the GPC not to support salaried GPs in deflecting unremunerated work back to their employers
   (iii) that such support could highlight improved systems of delegating administrative work away
   (iv) that supporting salaried GPs to claim for extra contractual hours is consistent with the GPC’s policy of encouraging practices to negotiate enhanced services for non-contractual activity.
A 38 THE GPC: That the GPC seeks the views of conference on the following motion from the
Sessional GPs subcommittee:
That conference agrees with the principle that GPs should be paid for the work that they do and
calls upon GPC to support Sessional GPs to claim payment or time in lieu for extra contractual
hours they are asked to undertake by their employers.

ONLINE CONSULTING

AR 39 NORTH ESSEX: That conference calls on GPC to ensure that the definition of what constitutes
core GP IT equipment is updated to reflect new working arrangements and thereby ensuring
that CCGs retain responsibility for meeting the full cost of system purchases, upgrades, support
and cyber security.

A 40 MANCHESTER: That conference believes the new General Data Protection Regulation will have
an adverse impact on practice workload and resources, and an exception should be made to
copies of patient records being free of charge.

AR 41 COVENTRY: That conference believes that support must be made available from NHS England
to ensure that GP2GP transfer of patient records must be available for the records of those
patients that do not register elsewhere until after their original practice has closed.

CAPITA

A 42 HERTFORDSHIRE: That conference calls on GPC England to procure an urgent renegotiation of
the GP contract to empower GPs to provide more choice to patients by allowing them to offer
their patients treatment privately when it is not available on the NHS.

A 43 CAMBRIDGESHIRE: That conference agrees with NHS England in its guidance note: ‘GP
practices serving Atypical populations’, that using the GMS funding formula would not ensure
the delivery of an adequate general practice service for this cohort of patients and demands
that GPC ensures that NHS England directs CCGs to implement its recommendations.

AR 44 NORTH ESSEX: That conference requests GPC to ensure that the maximum amount payable
to GP performers covering maternity leave is increased to a realistic level that properly takes
account of current locum costs and prevents the discrimination against GPs working full time
that currently exists.

AR 45 LAMBETH: That conference believes that negotiations in relation QOF should be done at a
national level and not at a local CCG level.

A 46 NORTHAMPTONSHIRE: That conference demands that where GPs are asked to provide a
written, detailed, professional report for safeguarding conferences that this is remunerated by
the requesting body to reflect the professional and administrative time, expertise and sensitive
nature of the work involved.

AR 47 WAKEFIELD: That conference wants the payments GPs currently receive from NHS England
when ill to be able to be used more flexibly than just for like for like replacement.

A 48 BUCKINGHAMSHIRE: That conference believes that the government and NHS England are
negligent in not addressing the inadequacies of the average per capita payment for a year of
GMS care because:
(i) £142.62 (NHS Digital figures for 2015/16) per patient per year does not match the
demands made on practices under GMS
(ii) £142.62 per patient per annum does not permit the employment of a workforce of
adequate size
(iii) the resourcing to workload mismatch has produced stresses that have made general
practice increasingly unpopular and difficult to recruit to.
A 49  CLEVELAND: That conference demands that the government recognises that the costs of running a practice continues to rise at a rate above the annual increase in the global sum and insists that these costs should be fully reimbursed so that GPs receive a deserved pay rise rather than a pay cut.

A 50  BRENT: That conference opposes the inclusion of any unfunded new requirements in the national contract, and calls upon the GPC to explain to government that general practice has no spare capacity within its current budgets.

A 51  DEVON: That conference calls for GPC to ensure all practices in England continue to have the automatic right to return from local PMS to a national GMS contract at any point of their choosing and will not be prevented from making this choice by any local attempts by NHS England or CCGs to alter their PMS contract.

A 52  CAMBRIDGESHIRE: That conference calls on GPC to insist that NHS England should not continue to put GPs, practice staff and patients at risk from violent patients by re-allocating patients who have been violent back to the original practice where the violence occurred, because of minor procedural errors.

A 53  NOTTINGHAMSHIRE: That conference is appalled at the gross incompetence of Capita in managing the transition of PCSE services and seeks to mitigate the damage by:
(i) lobbying NHS England to make payments to practices for monies still due to them
(ii) requesting that NHS England (not Capita) sends regular updates to practices about its progress on all areas of activity handed over to Capita and accepts responsibly for clear failings in the service delivery.

AR 54  NORTH ESSEX: That conference requests GPC to ensure that the maximum amount payable to GP performers covering maternity leave is increased to a realistic level that properly takes account of current locum costs and prevents the discrimination against GPs working full time that currently exists.

AR 55  LAMBETH: That conference believes that negotiations in relation QOF should be done at a national level and not at a local CCG level.

GPFV

A 56  AVON: That conference believes that the GP forward view has been a failure in that it has promised much and delivered little. It calls on GPC to negotiate and campaign for an effective programme, which is properly and appropriately resourced and funded, directly to practices, in order to stabilise and rebuild general practice.

CAPPED EXPENDITURE PROCESS

A 57  KENT: That conference demands a national enhanced service for care homes.

A 58  SUFFOLK: That conference affirms that the 2016 Special Conference resolved that sustainable medical care for patients in nursing homes required ‘different contractual arrangements’ from those currently pertaining. Conference instructs GPC England to accelerate the negotiations necessary to achieve these different arrangements by the end of the financial year.

AR 59  TOWER HAMLETS: That conference believes that the routine antenatal appointment is the best time for pregnant women to receive pertussis and influenza immunisation and calls on GPC to lobby NHS England to commission this service from midwives.

AR 60  WALTHAM FOREST: That conference believes that the NHS should not continue contracting with private sector support companies which have failed to deliver NOR should they pay them off.
A 61 GATESHEAD AND SOUTH TYNESIDE: That conference believes that the £6/head directed to extended access across England is misdirected and is based upon a political wish list and not patient need. It is believed that this £6/head should be allocated to the global sum in order to try to address the under investment in general practice at its core.

AR 62 COVENTRY: That conference believes that NHS England should ensure that any funding streams announced for general practice are administered with clear criteria, clarity as to where the funding sits and with a minimum time frame of three weeks for practices or organisations to apply for the funds. When funds are available they should be released promptly.

REVALIDATION AND REGULATION

A 63 TOWER HAMLETS: That conference:
(i) is opposed to private GP services advertising themselves as NHS doctors
(ii) calls on GPC to complain to the Advertising Standards Authority about any misleading adverts of this nature.

WORKLOAD

A 64 MID MERSEY: That conference believes that the independent contractor model of general practice provides the best continuity of care for patients and the best value for money for the NHS.

A 65 WILTSHIRE: That conference demands government urgently lists general practice as a job in the medical practitioners ‘shortage occupation’ code.

A 66 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference believes that in order to sustain and retain the GP workforce in new ways of working, leadership and engagement opportunities must be made available to all GPs and calls on GPC, working with LMCs, to lobby for equal access to these roles within CCGs and at scale providers.

INDEMNITY

A 67 NOTTINGHAMSHIRE: That conference is becoming increasingly concerned with a trend of GPs being refused the renewal of their indemnity cover by the medical defence organisations leading to a worsening of the GP workforce crisis. We implore the GPC to:
(i) negotiate with the MDOs to change the rules that they do not have to give reasons for refusals to the GP
(ii) request that an appeals process is put in place to allow a right of reply for the individual GPs involved
(iii) call upon the government to make alternative arrangements possible when the usual firms will not or cannot supply indemnity or provide an overreaching indemnity cover in the form of a ‘national indemnity scheme’.

PRIMARY/SECONDARY CARE INTERFACE

A 68 CLEVELAND: That conference believes that general practice should be under no obligation to provide GMS services to hospital in-patients, and calls on GPC England to work with the relevant bodies to enact this.

A 69 GREENWICH: That conference believes that it remains the responsibility of secondary care to determine patients’ eligibility for secondary care treatment.
AR 70 CAMBRIDGESHIRE: That conference calls upon GPC to ensure that specialist services in the community should be recommissioned with the facility to prescribe rather than all prescribing requests defaulting to general practice.

A 71 CLEVELAND: That conference believes NHS England should no longer hide behind CCGs to implement the changes NHS England want in the system and calls on GPC England to demand greater transparency and clarity.

A 72 LEWISHAM: That conference believes that cuts to funding for public health and associated local authority services pose a serious health risk for generations to come.

**CQC**

A 73 NOTTINGHAMSHIRE: That conference notes the inconsistencies of the CQC inspection approach and urges the GPC to take a more active role in supporting practices, through their LMCs, who feel that they are victims of this.

A 74 GATESHEAD AND SOUTH TYNESIDE: That conference congratulates the GPC on negotiating reimbursements of CQC fees for 2017/18 but calls upon GPC to ensure that this is paid indefinitely.

**EDUCATION & TRAINING**

AR 75 GLOUCESTERSHIRE: That conference, with respect to ‘mandatory training creep’, insists that the BMA and RCGP together need to issue the strongest possible joint guidance that a trained GP who is on the performers list and is required to participate in the NHS annual appraisal process to ensure they are revalidated by the GMC is, by the nature of their qualification and registration, not required to undergo further specific training for these purposes, and commissioners as well as GMC and CQC must cease to require them to do so.

A 76 NOTTINGHAMSHIRE: That conference is concerned that swinging cuts to Health Education England budgets demonstrates that education and training is becoming a lower priority for investment by the government.

AR 77 DEVON: That conference requests that consideration be given to supporting back to work UK trained GPs who previously left due to family commitments by utilising some of the monies recently allocated to recruitment & training of international doctors to augment the GP workforce.

**GPC/GPDF**

A 78 SUFFOLK: That conference requests that an annual summary of action taken on the previous year’s resolutions be made available to all LMCs, following the practice of the BMA Annual Representative Meeting.

A 79 NORFOLK AND WAVENEY: That conference asks GPC to develop proposals and guidance on how GPs in future Accountable Care Organisations and MCPs are represented by LMCs.

AR 80 WILTSHIRE: That conference requires GPC to arrange that the GPC England and LMC list servers are amalgamated within the next three months.

(Supported by Avon, Devon, Cornwall, Gloucestershire, Somerset, Hampshire & IOW and Dorset LMCs)
STP

A 81 KENT: That conference with respect to Sustainability Transformation Partnerships (STPs) condemns:
(i) them as a thinly disguised vehicle for the privatisation of the NHS and the introduction of savage cuts to health and social care
(ii) the fees paid to private consultants that support the process.

AR 82 DERBYSHIRE: That conference is frustrated to hear how many millions of pounds have been spent on management consultants for STPs and demands that GPC negotiate that all STP moneys are spent locally and not on such consultants.

AR 83 LEWISHAM: That conference believes that STPs across England continue to exclude appropriate representation from general practice and this exclusion threatens the sustainability of NHS services.

(Supported by Bexley LMC)

LMCS

A 84 LEEDS: That conference:
(i) reaffirms the essential role that LMCs play in supporting all GPs and in the development of general practice
(ii) recognises the benefit of LMCs learning from one another to improve their effectiveness
(iii) calls on GPC England to coordinate an annual LMC audit to provide benchmarking information for all LMCs to use.

A 85 CAMBRIDGESHIRE: That conference believes in this time of crisis in the NHS that local medical committees and their executive remain pivotal to the survival of general practice by continuing to:
(i) represent the ever changing needs in general practice
(ii) support all doctors in general practices regardless of contractual status
(iii) work closely with GPC to secure a fair and positive future for the profession
(iv) remain a reliable and stable presence in times of change.

A 86 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference calls for LMCs to have robust systems in place to ensure that are able to ballot all Sessional GPs within their region for regional GPC elections.
MOTIONS NOT PRIORITISED FOR DEBATE

NEW MODELS OF CARE

87 AVON: That conference deplores the falling numbers of GP practices caused by practice closures and mergers and calls on the Department of Health and NHS England to:
(i) adequately fund primary care
(ii) stop the drive towards ‘bigger is better’ as this policy lacks an evidence base but is ripping the heart out of local primary care and adversely affecting continuity.

88 GATESHEAD AND SOUTH TYNESIDE: That conferences believes that the present STP structure is now forging ahead with Accountable Care Systems and will override potential MCP structures, and it is clear that many GPs are unaware of this and there needs to be a concerted effort nationally so that GPs retain their enhanced services alongside their national GMS contract.

89 NORTHAMPTONSHIRE: That conference demands that no organisation may write protocols or other care specifications that designate responsibility to general practice without application to the GPC nationally or LMCs locally by completing a detailed application process for which an application fee will be charged.

90 HARINGEY: That conference is concerned regarding the setting up of the Primary Care Dynamic Purchasing System and the potential and destabilising risks to GPs and GP organisations and instructs GPC to negotiate with NHS England further as to the necessity of such an arrangement and ensure a level playing field for GPs and GP provider organisations.

(Supported by Barnet, Bexley, Brent, Bromley, Camden, City and Hackney, Ealing, Hammersmith and Hounslow, Enfield, Greenwich, Harrow, Hillingdon, Islington, Kensington, Chelsea and Westminster, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth LMCs)

91 BARNET: That conference notes that Care Closer to Home Networks (CHINs) are the preferred NCL STP and Individual CCGs’ model for the movement of out of hospital services into general practice, and quality improvement support teams (QIST) is the means of ensuring any variation in service provision and outcomes is equalised across practices or GP provider organisations. Conference demands that CHINs/QISTs model be abandoned as they are a means of shifting unfunded work into general practice, there is no workforce to support or provide this change in provision and is a performance management tool.

ONLINE CONSULTING

92 AVON: That conference calls on NHS England to fund a Primary Care IT Innovation Hub, which would have responsibility to create IT solutions across all primary care interfaces and software to improve efficiency, patient care and reduce work load in general practice.

93 AVON: That conference calls for investment in a single coordinated health care record for all patients across clinical systems and care providers with the anticipation of improvement in:
(i) coordination and continuity of care
(ii) patients in taking responsibility for their own health
(iii) communication regarding patients
(iv) health outcomes
(v) greater protection for vulnerable patient groups.

94 LAMBETH: That conference deplores the sharing of patient information with the Home Office in order that it can locate undocumented migrants which undermines the essence of patient confidentiality.
95 WEST PENNINE: That conference believes patient consent for information sharing can only be valid when patients have access to their clinical record and so are aware of the content, they are then giving permission to share.

96 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference believes that GPs are currently bombarded with emails from different sources, and this risks important information being missed. We call upon GPC to lobby NHS England / Department of Health to create a single source of email for essential information that requires national dissemination.

97 DEVON: That conference welcomes the Department of Health call for increased digitalisation of medical records and asks that the GPC IT policy group:
(i) negotiates an agreement for practices to be given funding to digitalise and then completely destroy historic medical records in order to make additional clinical space within their buildings
(ii) negotiates retrospective payments to practices who have self-funded digital advances that are now becoming mainstream
(iii) consider resigning en masse if they continue to make snail like progress on this issue before the National Conference in March.

98 AVON: That conference calls on NHS England to fund a Primary Care IT Innovation Hub, which would have responsibility to create IT solutions across all primary care interfaces and software to improve efficiency, patient care and reduce work load in general practice.

99 AVON: That conference calls for investment in a single coordinated health care record for all patients across clinical systems and care providers with the anticipation of improvement in:
(i) coordination and continuity of care
(ii) patients in taking responsibility for their own health
(iii) communication regarding patients
(iv) health outcomes
(v) greater protection for vulnerable patient groups.

CAPITA

100 BEDFORDSHIRE: That conference believes practices should have the right to demand a deposit, refundable on attendance, for patients with a history of frequent unexplained DNAs.

101 DEVON: That conference calls for the introduction of a co-payment system for some medications in England as the best way to encourage shared decision making with patients about the cost-effectiveness of certain treatments.

102 LEEDS: That conference believes travel vaccinations should not be funded by the NHS and calls for all practices to be able to offer travel vaccinations as a private service to their patients.

103 HERTFORDSHIRE: As patients can now get a same-day consultation on their smartphone with a private GP, conference calls on GPC to get regulations changed so that NHS GPs can start to offer the same sort of services.

104 WIRRAL: Primary care general practice has changed beyond recognition over the last generation. It is an unpopular career choice with the current doctors in service suffering low morale. Conference believes primary care general practice needs rebranding and relaunching with a new contract.

105 BUCKINGHAMSHIRE: This conference believes that with multiple recent changes in NHS structures the system for claiming and paying for services provided under collaborative arrangements is now so mired in mystery that GPs are being deprived of payment for increasing volumes of demands from local authorities and calls on the GPC to rectify this situation.
106 COVENTRY: That conference mandates GPC England to negotiate a changes to our core contract to:
(i) recognise and directly remunerate activity and workload
(ii) set a maximum threshold for an average number of patient contacts offered per head of population per week
(iii) introduce charges for work over and above the defined safe threshold within the GMS contract.

107 NOTTINGHAMSHIRE: That conference believes the relevance of QOF has greatly deteriorated as a tool to drive up quality and calls for its abolition and the transfer of funding into the global sum.

108 TOWER HAMLETS: That conference believes that the PMS review has further destabilised practices and calls on the GPC to:
(i) formally encourage all practices to revert to GMS
(ii) lobby government to enable transition money to be used to support practices who revert from PMS to GMS
(iii) negotiate with the government to re-invest the PMS premium funding into the core GMS budget.

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109 CHESHIRE: That conference believes that GPC should negotiate to secure additional funding in the nGMS contract to support GP partners’ management activity and associated costs.

110 DEVON: That conference requests that CCGs and NHS England be mandated to ensure that much needed funds promised by Health Ministers are made available for general practice and not considered to be negotiable depending on CCG budgeting.

111 NORTHAMPTONSHIRE: That conference believes data collection for the sake of data collection is costing both the NHS and government a humungous amount of money. We call on the conference to insist that the results of the data collected must be reported back within 28 days to the originator or in the same time scale as the request made.

112 DERBYSHIRE: That conference deplores the fact that GPs cannot get real time data on our pensions, and demands that GPs should pay no higher percentage contribution than any other NHS employees.

113 GLOUCESTERSHIRE: That conference believes the current NHS Pension arrangements for locum GPs are inefficient and waste a significant amount of NHS administrative resource and therefore calls for the:
(i) GPC to negotiate the necessary changes to allow the replacement of the current (Locum A, B and Solo) forms with a single annual online form per employer/locum
(ii) establishment of a simple electronic payment system allowing monthly or annual direct debits.

114 MANCHESTER: That conference believes that as the GP role becomes more challenging more should be done to protect and improve retirement rights.
115 TOWER HAMLETS: That conference notes that 90% of NHS prescriptions are currently dispensed free of charge to the 60% of the population eligible for free prescriptions, many of whom are in the greatest need of medication for acute and long term conditions and:
(i) condemns the government for further attempting to undermine the comprehensive NHS by proposing to disallow NHS prescriptions for effective items also available over the counter
(ii) recognises that such a move would further increase inequalities, in relation to medical conditions, age and socio-economic status
(iii) believes that this will increase risks to patients, as prescribers deal with increased demand for prescription only, more toxic medicine such as opioids and NSAIDS for pain, or that inappropriate medication may be purchased
(iv) calls on the government and NHS England to withdraw their current plans.

116 HULL AND EAST YORKSHIRE: That conference believes that clinical peer review is a positive notion, but is dismayed at the ’Clinical Peer Review of Referrals’ proposals from NHS England which are short-sighted, unfunded, unrealistic and unworkable.

(Supported by North and North East Lincolnshire LMC)

117 NORTH AND NORTH EAST LINCOLNSHIRE: That conference acknowledges that some GP practices are now beginning to work collaboratively in larger organisations. We therefore call on the GPC to work with the Dispensing Doctors Association to secure the dispensing rights of GP practices in this new world for general practice.

(Supported by Hull and East Yorkshire LMC)

118 AVON: That conference deplores gaps in the availability of medicines, such as the current global shortage in the hepatitis B vaccine, which is a risk to patient health.

119 AVON: That conference is dismayed by recent NICE guidance to offer statins to larger numbers of patients and calls on the government to better fund other elements of primary prevention such as smoking cessation, weight management, diabetes prevention and management rather than relying on a formula so heavily based on age that it is merely medicalising old age and ignoring the opportunities in earlier life.

120 GLOUCESTERSHIRE: That conference continues to be concerned at the ongoing manufacturer supply issues for commonly used medications and proposes that:
(i) there should be a fee for general practitioners for the extra time involved
(ii) the pharmaceutical industry should financially contribute to the NHS for the disruptions in the community.

121 NORTH YORKSHIRE: That conference believes that we, as a profession, should be more honest regarding the likely benefits or not of hospital admission and intensive treatment to elderly frail patients at end of life.

122 COVENTRY: That conference believes that the government must ensure that addiction services are adequately funded with their funding protected. This should include adequate provision for those who are dependent on benzodiazepines, gabapentin/ pregabalin and prescription opiates as well as novel psychoactive substances and alcohol. It must be ensured that all services have full access to mental health services providing psychological support to deal with underlying mental health problems.

GPFV

123 WORCESTERSHIRE: That conference previously welcomed the GP Forward View as a frank recognition of the parlous state of general practice but it is dismayed at the lack of any real changes that will prevent the imminent collapse of general practice in England, and encourages GPC to press for real and fully funded action by NHS England.
CAPPED EXPENDITURE PROCESS

124 NOTTINGHAMSHIRE: That conference believes some CCGs put prescribing cost savings ahead of appropriate clinical behaviour and so, to avoid a postcode lottery, suggests that the:
(i) prescribing budgets for all CCGs nationally are taken over by NHS England and costs are met centrally
(ii) government fully fund the cost of clinical pharmacists for all GP practices.

125 GLOUCESTERSHIRE: That conference holds that NHS England have a responsibility to protect GPs and their staff from potential as well as actual physical and verbal aggression and therefore
(i) suggests that the ‘violent patient scheme’ should be renamed the ‘potentially violent or abusive patient scheme’
(ii) insists that the importance and swift mechanism of the service be pointed out to providers and that the service be as swift as possible, including withdrawing the need for a police incident number.

126 CAMBRIDGESHIRE: That conference calls on GPC to ensure that government recognises that the general practice OOH service is at imminent risk of collapse in some areas, and;
(i) should abandon the Extended Hours Scheme as it risks further depleting GP resource from essential urgent care services to convenience–led services
(ii) should lengthen the NHS England funded Winter Indemnity Scheme from seven to twelve months
(iii) acknowledge that the increasing workload for GPs in–hours is preventing GPs from safely working in the OOH setting.

127 DEVON: That conference calls for the government to bravely bring forward legislation that will undo the purchaser/provider constraints of the Health & Social Care Act 2012 that are currently significantly impeding the valiant attempts of NHS England leaders to make sensible changes to the healthcare system.

128 ENFIELD: That conference requires competitive tendering processes to be abandoned post-Brexit when the UK is no longer subjected to European Law.

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129 KENT: That conference demands negotiation of an alternative to GP home visits.

130 SOUTHWARK: That conference demands that when awarding practice contracts to large organisations consideration should be taken of:
(i) records of past performance
(ii) any records of staff satisfaction including any reasons for significant changeover of staff, and
(iii) in–built opportunities to take on equity partners.

131 LIVERPOOL: That conference believes that GPC should vigorously oppose any change to funding arrangements for general practice that would result in care to patients not being available free at the point of use.

132 AVON: That conference deplores the scandalous increase in government spending on purchasing healthcare from non-NHS bodies, which rose by 4.8% in 2016/17 compared with the previous year.

133 BRADFORD AND AIREDALE: That conference calls on the GPC to negotiate a relaxation of the QOF timescales, back to the original 15 months rather than the current 12 months as this will reduce unnecessary workload.
134 BRADFORD AND AIREDALE: That conference believes that the current funding for general practice provision for care home residents (nursing and residential) via GMS / PMS budgets is inadequate. Conference would support a separate national funding stream for this group of complex and vulnerable patients that would both improve patient care and, unlike the recent DES, reduce unplanned admissions.

135 MID MERSEY: That conference believes that practices should be able to remove from their lists patients who repeatedly do not attend appointments and that it is NHS England’s responsibility to explain to them why and ask them to modify their behaviour.

136 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the NHS was rated first out of ten but ninth out of ten for healthcare outcomes and urges the GPC to obtain adequate funding to maintain the best system in the world.

137 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that GP involvement in CCGs is counterproductive, and the failure to apply sanctions in support of Five Years Forward View and GP Forward view is a damaging example which must be corrected.

**REVALIDATION AND REGULATION**

138 GLOUCESTERSHIRE: That conference holds that patients who fail to attend a scheduled appointment should be considered to have done so knowingly and thus have taken on responsibility from the clinician for the consequences of that missed appointment.

139 AVON: That conference requires the GPC to persuade the GMC to acknowledge and accept that GPs are specialists in their own right and not to expect GPs to take on other specialist tasks on demand.

140 DERBYSHIRE: Conference demands that, in this increasingly litigious society, GPC challenge the assumption by MDOs/CQC/GMC that responsibility for following up missed outpatient appointments and investigations always defaults to GPs, ignoring the responsibilities that patients should accept themselves.

141 NORFOLK AND WAVENEY: That conference believes that the current Fit Note process is not fit for purpose, is time-consuming and should be outsourced to an appropriately commissioned occupational health service.

142 COVENTRY: That conference believes that the process for death certification in England should be changed in line with Scotland (the Death Certification of Scotland Act 2011) along with the removal for the 14-day rule.

143 NORTHAMPTONSHIRE: That conference demands that the GMC restricts activity to role in fitness to practice supervision and ceases to pontificate on contractual issues such as primary care prescribing of specialist treatments.

144 GATESHEAD AND SOUTH TYNE SIDE: That conference believes that GPs on the Performers List should be offered more flexibility to spend time working abroad as GPs, providing they maintain their skills and undergo annual appraisal.
WORKLOAD

145 CAMBRIDGESHIRE: That conference notes that GPs currently shoulder unprecedented burdens of clinical risk and manage the uncertainty of evolving and often unpredictable illness at a time of increased demand in a relatively isolated way, without immediate recourse to the comfort of investigation or numerous opinions and believes that:

(i) GPs provide this care for patients in an environment which is otherwise often risk averse, unrealistic in expectation, intolerant of ambiguity, oriented to blame with the benefit of hindsight and aggressively regulated

(ii) the survival of the NHS depends on the work of GPs and this should be acknowledged and celebrated by government, the media and public

(iii) there should be far greater acknowledgement by government and regulators of the challenges faced by modern day general practice

(iv) GPC must work to understand the effect of managing increasing clinical risk on morale, recruitment and retention in order to devise a strategy to support GP resilience.

146 NORTHAMPTONSHIRE: That conference demands that the constant barrage of external priorities, which exhaust and demoralise practices as well as consume precious energy and time and financial resource for negligible benefit, must cease in order to allow safe, efficient and effective core service provision as well, encouraging GPs to remain in their vital role.

147 LEEDS: That conference believes the current national scheme that provides reducing funding for pharmacists working in general practice is wholly inadequate and calls on NHS England to ensure recurrent funding is made available to enable a sustainable expansion of the workforce.

148 NORFOLK AND WAVENEY: That conference asks GPC to negotiate a full reimbursement of pharmacists within general practice recognising the professional value they bring to the primary care team.

149 NORFOLK AND WAVENEY: That conference asks GPC to negotiate full genuine reimbursement for schemes that employ allied clinical professionals such as physiotherapists, pharmacists and paramedics within general practice. These professional groups improve the quality and safety of the services within general practice but are not doctor substitutes or always significantly reduce GP workload.

150 SANDWELL: That conference mandates the GPC to advise NHS England that two new patient registrations per WTE GP per week is the reasonable number a practice can be expected to accommodate. Any registrations in excess of this can be commissioned from practices at the fair market rate. This will allow practices to resource the extra burden i.e. advertising, recruiting and inducting staff all the way up to premises extension.

151 WAKEFIELD: That conference acknowledges there is very little practical help nationally for a practice in difficulties and wants there to be an upper limit to GP list size; at which the practice feels that it is not clinically safe to maintain the required workload they are supported to reduce their workload in a way which is minimally bureaucratic and does not carry financial penalties.

152 BEDFORDSHIRE: That conference calls on GPC England to negotiate with government a rights and responsibilities contract which patients will be required to sign when they register with a practice.
INDEMNITY

153 EAST SUSSEX: That conference:
(i) notes the increasing burden of work placed upon out-of-hours GP services due to overload of in-hours GP services
(ii) acknowledges the consequent increased blurring of boundaries between in-hours and out-of-hours GP services
(iii) calls for out-of-hours GP services to be properly funded so as to maintain adequate rota-fill
(iv) calls for out-of-hours indemnity payments to be reduced
(v) calls for the provision of commonality of computer systems between in-hours and out-of-hours GP services.

154 CLEVELAND: That conference believes, in recognition of the decision to reimburse indemnity fees to general practice, NHS England have a duty to ensure annual rises in indemnity fees are explained and justified in order to ensure cost-effectiveness for the tax payer.

PRIMARY/SECONDARY CARE INTERFACE

155 DORSET: That conference calls for urgent evaluation of the GP streaming scheme to ensure it is safe, effective, efficient and not taking valuable resources away from primary care and current OOH services.

156 WEST PENNINE: That conference believes discussion should be initiated with the Department of Health around the possibility of transforming A&E to a referral only service.

157 TOWER HAMLETS: That conference:
(i) notes that it is conference policy that GPs should not do the work of the Home Office by checking immigration status of patients
(ii) opposes the new obligation in the GP contract to check EHIC cards
(iii) instructs GPC to remove this clause during the next round of contract negotiations.

158 TOWER HAMLETS: That conference:
(i) in tandem with existing conference policy, opposes involving general practice in checking immigration status
(ii) calls on GPC to advise practices to strike out the box asking for immigration status on registration forms.

159 NORTHAMPTONSHIRE: That conference believes that it is wrong for private insurers to use NHS GPs to vet or screen referrals for private treatment for their private clients.

160 TOWER HAMLETS: That conference:
(i) supports the facilities staff at Bart’s Health in their fight to retain their previous terms and conditions
(ii) regrets that the situation has been allowed to deteriorate by SERCO and Bart’s Health so that 98% of those balloted feels forced to take strike action as a last resort.

161 BRADFORD AND AIREDALE: That conference calls on the government to reverse its inequitable and vindictive stance and allow GPs to charge overseas patients in the same way that secondary care providers can.

162 DEVON: That conference asks the GPC to continue to pursue efforts to seek a clear definition of intermediate care:
(i) as being the new area of work evolving between old boundaries of secondary and primary care
(ii) in order to give clear direction to GPs as to how to identify, monitor and agree who has clinical responsibility for patients in this new category.
163 CAMBRIDGESHIRE: That conference believes that government’s obsession with weekend routine access to care, including the general practice extended hours’ scheme, is based on flawed, absent or cherry picked evidence, and calls upon the Secretary of State to have the humility to listen to, rather than argue with, the conclusions of one of the most esteemed and respected scientists of our generation.

164 NORTH YORKSHIRE: That conference believes that the NHS cannot afford for every person who would benefit from treatment can receive it.

165 DEVON: That conference calls for the government to relax all rules regarding the annual attempts to keep healthcare spending in England within budget as by freeing themselves from this delusional thinking there is the possibility that some sanity of thought regarding long term NHS planning and investment might actually become apparent.

166 LAMBETH: That conference demands that there is an open and transparent conversation at national level about what the NHS can and cannot fund.

167 DERBYSHIRE: That conference calls on GPC to seek an honest discussion with the public with regards to their expectations of the NHS vs the current reality, especially in the current climate of austerity driven politics.

168 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that general practice is held in thrall by the belief we have a duty to rescue the populace from folly and neglect.

169 DERBYSHIRE: That conference believes that the will of the Department of Health is to completely destroy general practice (despite claims to the contrary) in order to reduce cost to the tax payer, by privatising the NHS.

170 LEEDS: That conference condemns the government’s 1% public sector pay cap policy, believes it has seriously impacted recruitment and retention of NHS staff and undermined NHS services, and calls for it to be ended.

171 DERBYSHIRE: The government’s own survey has shown that since 2011 medical practitioners have taken a 5% pay cut. In the same time period air traffic controllers have had a 54% pay rise taking them well above doctors’ earnings. Whilst we recognise that the air traffic controllers work in a highly skilled and high intensity environment, this is no less so for general practice. Conference therefore demands that GPC negotiate a reinstatement of the DDRB recommendations.

172 SANDWELL: That conference mandates the GPC to explore the option of taking a class action suit against NHS England and Department of Health to recover all the redundancy payments that will fall on principals due to the systematic dismantling of general practice.

PREMISES

173 HERTFORDSHIRE: Given the atrocious state of GP premises and government’s failing commitment to remedy this through public sector investment, conference demands that GPC open discussions with private equity companies as the only realistic alternative.

174 MID MERSEY: That conference believes that rocketing PFI profits are unacceptably draining resources which would be better used for patient care and urges the GPC to take urgent steps to put it right.
CQC

175 NORTH YORKSHIRE: That conference believes that CQC are increasingly contributing to the GP crisis with their threatening behaviour and additional demands and calls on GPC to step up talks and negotiate a much needed reduction in the requirements and frequency of inspections.

176 HARROW: That conference condemns the CQC for inspecting practices that have been rated good in the last five years and calls on government to hold CQC to account for needlessly exacerbating the GP workload crisis.

177 HERTFORDSHIRE: That conference calls on GPC to insist that CQC withdraws any proposals for practices to have to make annual CQC progress reports.

178 HERTFORDSHIRE: That conference expresses concern that the national GP patient survey is regularly cited by the CQC in its critique of practices, yet is statistically dubious, misleading and unreliable and calls upon the GPC England Executive to negotiate its demise and the transfer of the significant resources invested in its annual production, to be reinvested into frontline general practice patient services.

EDUCATION & TRAINING

179 CUMBRIA: That conference believes GPs should remain generalists and that increasing sub-specialisation is not necessarily in the best interests of GPs or patients.

180 NORTH YORKSHIRE: That conference agrees that GP education is tailored to GP resilience and to encourage all GPs to train as GPwSIs.

181 GLOUCESTERSHIRE: That conference is concerned that the new contract for junior doctors is not easy to apply in general practice and calls for a change in allowable work patterns for junior doctors in GP placements to enable a better training experience.

182 NORFOLK AND WAVENEY: That conference believes that admission criteria to medical schools needs urgent attention in view of evidence of increasing drop-out rates during the university and foundation year periods.

183 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee: That conference calls on GPC to work with CCGs and HEE to ensure training opportunities and bursaries are available to all GPs irrelevant of their current contractual status.

GPC/GPDF

184 DERBYSHIRE: That conference is deeply disappointed by the willful manipulation of conference motions demonstrated by the obfuscation of the phrasing of the list closure ballot. The result was that most practices felt they would be in breach of contract by saying yes to the ballot. We demand the ballot to be re-held with more clarity and better engagement.

185 BIRMINGHAM: That conference believes that the outcome of the recent GPC England ballot of practices provides a very strong mandate for robust negotiations with the government and NHS England to finally achieve the required level of increased funding and other changes needed to ensure patient safety and to save NHS general practice in England.
186 TOWER HAMLETS: That conference notes the recent GPC survey which showed that 54% of practices which responded would be willing to consider temporary list closure due to unmanageable workload to protect the safety of their registered patients. Conference instructs the GPC to:
(i) make no formal decision as to whether or not we will proceed to a formal ballot
(ii) proactively seek out geographically similar groups of practices, such as in Folkestone, which are seriously considering closing their lists and bring this to the attention of the public in a highly visible campaign
(iii) report the data collected as at (ii) above, by LMC area, to each GPC England meeting.

187 BEDFORDSHIRE: Given that few in the UK understand that GP practices are third-party private providers, and therefore regard any attempt by GPs to request private payment for unfunded work as underhand profiteering, this conference instructs GPC to carry out a PR campaign to remind the nation that GP practices:
(i) are third-party, private providers, not state employees
(ii) have limited time
(iii) have to meet their own expenses, and therefore
(iv) can no longer accept any unfunded increase in workload.

188 EALING, HAMMERSMITH AND HOUNSLOW: That conference believes that NHS general practice is not viable in the long term and:
(i) that this is because subsequent governments have made the role of GPs and general practices untenable
(ii) the BMA needs to mount a substantive public campaign raising public awareness on what will happen when there are no more GPs or GP practices
(iii) that GPC produces and publishes an alternative plan to sustain general practice as demanded by previous conferences within three months of this conference.

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189 OXFORDSHIRE: That conference believes that at £563K in 2016 the money spent on conferences of LMCs could be put to better use for the benefit of general practice.

190 OXFORDSHIRE: That conference believes that use of the voluntary GPDF levy centrally needs closer scrutiny to ensure it is wisely spent for the benefit of those from whom it is levied, and calls on the new GPDF board to undertake a value for money exercise encompassing all lines of expenditure including conference itself.

191 BUCKINGHAMSHIRE: That conference believes that at a total cost of £563K in 2016, the benefit of Conferences of LMCs should be reviewed for value for money, and consideration given to other ways of collecting GP opinion and developing policy such as a listserver for motions (with voting) that could operate all year round.

192 HERTFORDSHIRE: That conference wishes to point out to GPC that the state of general practice in England is far more parlous than they think, and calls on GPC to negotiate:
(i) a special incentive scheme for England to retain older GPs in the profession
(ii) rescue funding to go directly into the global sum
(iii) an end to pointless inspections by CQC
(iv) benevolent and facilitative premises policies and agencies
(v) favourable pensions for general practice.

193 BEDFORDSHIRE: That conference calls on GPC England to:
(i) face up to its responsibility to show genuine leadership by recognising that the current model of general practice is letting down patients and the profession, and
(ii) undertake a full evaluation of all national and international models of primary care and devise a strategy to develop a primary care service that is fit for the 21st century.
194 KENT: That conference believes that one of the greatest threats to NHS general practice is corruption and demands that GPC England:
(i) hire forensic accountants to work out where the money has gone
(ii) determine who is profiting from the willful destruction of the NHS
(iii) petition for prosecution of those responsible for fraudulent procurement
(iv) hold those making ill-gotten gains to account.

195 DERBYSHIRE: That conference believes that GPs will never be able to stand against the willful destruction of general practice by NHS England whilst GPC continues to hide behind BMA legal advice.

196 MID MERSEY: That conference believes that the Meldrum reforms have not delivered the desired result and there remains a clear disconnect between GPs and the GPC.

197 DEVON: That conference:
(i) resolves to ask GPC England members of GPDF to abstain from voting at meetings so that the LMC members can ensure the Meldrum Review reforms are properly implemented
(ii) requires GPC to arrange that the GPC England and LMC listservers are amalgamated within the next three months
(iii) recommends to LMCs that they should stop forwarding the voluntary levy to GPDF and instead use the money to set up a national and regional support and resource network for LMCs.

STP

198 DERBYSHIRE: That conference notes that whilst millions are being spent on management consultants for STPs, LMCs, who have a statutory role to represent GPs, are present only because of the funding of their levy paying practices. We call on GPC to negotiate remuneration of LMCs’ time for involvement in the STPs.

199 NORTHAMPTONSHIRE: That conference demands that general practitioners have flexibility in determining the best approach to future sustainability and necessary transformation at practice level in serving the healthcare of their local population.

200 GLOUCESTERSHIRE: That conference asserts that Sustainability and Transformation Plans (STPs) are leading to the private sector taking too great an involvement in the administration and delivery of healthcare in the NHS, ‘cherry picking’ the most profitable parts, thus further increasing pressure on a workforce and NHS services that are already under-resourced; conference accordingly tasks the GPC to fight to limit private sector involvement.

201 NORTHAMPTONSHIRE: That conference halts STPs which are taking up hours of clinical time and effort.

202 NORTHAMPTONSHIRE: That conference demands that the NHS spends more money on consultancy fees in order to save money.

203 NOTTINGHAMSHIRE: That conference recognises the importance of the STP process in managing health and social care over the next few years. We implore system leaders to demonstrate close working with primary care at the heart of any location based plans, this is a necessity to enable a genuine integrated community system.
## STANDING ORDERS

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STANDING ORDERS

CONFERENCES

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

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

Membership
3. The members of conference shall be:
   3.1 the chair and deputy chair of the conference
   3.2 300 representatives of local medical committees
   3.3 the members of the GPC England
   3.4 the elected members of the conference agenda committee (agenda committee)
   3.5 those regionally elected representatives of the GP trainees subcommittee who were elected from regions in England, together with its chair
   3.6 those elected members of the sessional GPs subcommittee of the GPC who were elected from regions in England.

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

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

Interpretations
10. A local medical committee is a committee recognised by a PCO or PCOs as representative of medical practitioners under the NHS Act 2006.
11. ‘Members of the conference’ means those persons described in standing order 3.
12. ‘Representative’ or ‘representatives’ means those persons appointed under standing orders 4 to 8, and shall include the deputy of any person who is absent.

13. ‘The conference’, unless otherwise specified, means either an annual or a special conference.

14. ‘As a reference’ means that any motion so accepted does not constitute conference policy, but is referred to the GPC England to consider how best to procure its sentiments.

Motions to amend standing orders
15. No motion to amend these standing orders shall be considered at any subsequent conference unless due notice is given by the GPC England, the agenda committee, a local medical committee.

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

Agenda
17. The agenda shall include:
   17.1 motions, amendments and riders submitted by the GPC England, and any local medical committee. These shall fall within the remit of the GPC England, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and any Acts or Orders amending or consolidating the same
   17.2 motions submitted by the agenda committee in respect of organisational issues only.

18. When a special conference has been convened, the GPC England shall determine the time limit for submitting motions.

The agenda shall be prepared by the agenda committee as follows:
19. In two parts; the first part ‘Part I’ being those motions which the agenda committee believe should be debated within the time available; the second part ‘Part II’ being those motions covered by 24 and 25 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording.

20. ‘Grouped motions’: Motions or amendments which cover substantially the same ground shall be grouped and the motion for debate shall be asterisked. If any local medical committee submitting a motion so grouped objects in writing before the day of conference, the removal of the motion from the group shall be decided by the conference.

21. ‘Composite motions’: If the agenda committee considers that no motion or amendment adequately covers a subject, it shall draft a composite motion or an amendment, which shall be the motion for debate. The agenda committee shall be allowed to alter the wording in the original motion for such composite motions.

22. ‘Motions with subsections’:
   22.1 motions with subsections shall deal with only one point of principle, the agenda committee being permitted to divide motions covering more than one point of principle
   22.2 subsections shall not be mutually contradictory
   22.3 such motions shall not have more than five subsections except in subject debates.

23. ‘Rescinding motions’: Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters ‘RM’.

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

26. ‘C’ motions: Prior to the conference, a ballot of representatives shall be conducted to enable them to choose motions, (‘C’ motions), amendments or riders for debate. Using only the prescribed form, which must be signed and received by the GPC England secretariat by the time notified for the receipt of items for the supplementary agenda, each representative may choose up to three motions, amendments or riders to be given priority in debate. Chosen motions must receive the vote of at least ten representatives. The first three motions, amendments or riders chosen, plus any others receiving the vote of at least twenty representatives, shall be given priority.

27. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 42, 43, 44, and 45 shall not apply and the debate shall be held in accordance with standing order 50.

Other duties of the agenda committee include:

28. Recommending to the conference the order of the agenda; allocating motions to blocks; allocating time to blocks; setting aside reserved periods, as provided for in standing order 55, and overseeing the conduct of the conference.

Procedures

29. An amendment shall – leave out words; leave out words and insert or add others (provided that a substantial part of the motion remains and the original intention of the motion is not enlarged or substantially altered); insert words; or be in such form as the chair approves.

30. A rider shall – add words as an extra to a seemingly complete statement, provided that the rider is relevant and appropriate to the motion on which it is moved.

31. No amendment or rider which has not been included in the printed agenda shall be considered unless a written copy of it has been handed to the agenda committee. The names of the proposer and seconder of the amendment or rider, and their constituencies, shall be included on the written notice. Notice must be given before the end of the session preceding that in which the motion is due to be moved, except at the chair’s discretion. For the first session, amendments or riders must be handed in before the session begins.

32. No seconder shall be required for any motion, amendment or rider submitted to the conference by the GPC England, a local medical committee, or the joint agenda committee, or for any composite motion or amendment produced by the agenda committee under standing order 21. All other motions, amendments or riders, after being proposed, must be seconded.

33. No amendments or riders will be permitted to motions debated under standing order 27.

Rules of debate

34. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.

35. Every member of the conference should be seated except the one addressing the conference.

36. A member of conference shall address conference through the chair.
37. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.

38. Members of the GPC England, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.

39. The chair shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.

40. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.

41. The chair shall take any necessary steps to prevent tedious repetition.

42. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.

43. Amendments shall be debated and voted upon before returning to the original motion.

44. Riders shall be debated and voted upon after the original motion has been carried.

45. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 42, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.

46. If it is proposed and seconded or proposed by the chair that the conference adjourns, or that the debate be adjourned, or ‘that the question be put now’, such motion shall be put to the vote immediately, and without discussion, except as to the time of adjournment. The chair can decline to put the motion, ‘that the question be put now’. If a motion, ‘that the question be put now’, is carried by a two thirds majority, the chair of the GPC England and the mover of the original motion shall have the right to reply to the debate before the question is put.

47. If there be a call by acclamation to move to next business it shall be the chair’s discretion whether the call is heard. If it is heard then the proposer of the original motion can choose to:
   (i) accept the call to move to next business for the whole motion
   (ii) accept the call to move to next business for one or more subsections of the motion
   (iii) have one minute to oppose the call to move to next business.

   Conference will then vote on the motion to move to next business and a 2/3 majority is required for it to succeed.

48. All motions expressed in several parts and designated by the numbers (i), (ii), (iii), etc shall automatically be voted on separately. But, in order to expedite business, the chair may ask conference (by a simple majority) to waive this requirement.

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

Allocation of conference time
51. The agenda committee shall, as far as possible, divide the agenda into blocks according to the general subject of the motions, and allocate a specific period of time to each block.

52. ‘Soapbox session’:
52.1 A period may be reserved for a ‘soapbox’ session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
52.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
52.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
52.4 GPC England members shall not be permitted to speak in the soapbox session.

53. Motions which cannot be debated in the time allocated to that block shall, if possible, be debated in any unused time allocated to another block. The chair shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.

54. Motions prefixed with a letter ‘A’, (defined in standing orders 24 and 25) shall be formally moved by the chair of conference as a block to be accepted without debate during the debate on the report of the agenda committee in the first session of the conference.

55. Other periods of time may be allocated by the Agenda Committee for other purposes as indicated in the Agenda.

Motions not published in the agenda
56. Motions not included in the agenda shall not be considered by the conference except those:
56.1 covered by standing orders relating to time limit of speeches, motions for adjournment or “that the question be put now” motions that conference “move to the next business” or the suspension of standing orders
56.2 relating to votes of thanks, messages of congratulations or of condolence
56.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association
56.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned
56.5 prepared by the agenda committee to correct drafting errors or ambiguities.
56.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions
56.7 that may arise from a major issue debate; such motions must be received by the agenda committee by the time laid down in the major issue debate timetable published under standing order 50.
Quorum
57. No business shall be transacted at any conference unless at least one-third of the number of representatives appointed to attend are present.

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

59. The conference may, at any period, reduce the time to be allowed to speakers, whether in moving resolutions or otherwise, and that such a reduction shall be effective if it is agreed by the chair.

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

Majorities
61. Except as provided for in standing order 46 and 47 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:

61.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC England structure, or
61.2 a decision which could materially affect the GPDF Ltd funds.

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

Elections
63. Chair
63.1 At each conference, a chair shall be elected by the members of the conference to hold office from the termination of the BMA’s annual representative meeting (ARM) until the end of the next ARM. All members of the conference shall be eligible for nomination.

63.2 Nominations must be handed in on the prescribed form before 10am on the day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

64. Deputy chair
64.1 At each annual conference, a deputy chair shall be elected by the members of the conference to hold office from the termination of the conference. All members of the conference shall be eligible for nomination.

64.2 Nominations must be handed in on the prescribed form before 1pm on the day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

65. Five members of the conference agenda committee
65.1 The agenda committee shall consist of the chair and deputy chair of the conference, the chair of GPC England and five members of the conference, not more than one of whom may be a sitting member of GPC England at the time of their election. In the event of there being an insufficient number of candidates to fill the five seats on the agenda committee, the chair shall be empowered to fill any vacancy by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected, and shall continue in office until the end of the following annual conference.
65.2 The chair of conference, or if necessary the deputy chair, shall be chair of the agenda committee.

65.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by 1.00pm on the day of the conference. Any member of the conference may be nominated for the agenda committee. All members of the conference are entitled to vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

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

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

Distribution of papers and announcements
68. In the conference hall, or in the precincts thereof, no papers or literature shall be distributed, or announcements made, or notices displayed, unless approved by the chair.

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

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

Chair’s discretion
71. Any question arising in relation to the conduct of the conference, which is not dealt with in these standing orders, shall be determined at the chair’s absolute discretion.

Minutes
72. Minutes shall be taken of the conference proceedings and the chair shall be empowered to approve and confirm them.
ANNEX A – WORKFORCE THEMED DEBATE

Q1 HERTFORDSHIRE: That conference calls on GPC to:
   (i) once again stress to the government that 7-day access to routine general practice cannot be achieved in the current climate of record level staff shortages, and
   (ii) negotiate with the government that extended access to routine general practice can only be delivered after the increase in the workforce promised in the GPFV multi-disciplinary recruitment drive.

Q2 NOTTINGHAMSHIRE: That conference recognises that partnership as a career model is becoming less attractive and calls for this to be addressed in the following ways:
   (i) lobby the government to massively increase investment into premises development
   (ii) call upon the GPC to look at new models of career development to enable general practice to be the enticing exciting career we all know it can be
   (iii) GPC leads with a positive publicity campaign to help counterbalance the negative media attention that general practice has faced over the last 12 months and more.

Q3 NORTHAMPTONSHIRE: That conference calls on government to urgently make the partnership model more attractive and re-reinstate seniority payments to develop leaders and retain experience GPs.

Q4 SOUTHWARK: That conference believes that the current two-tiered system of sessional versus partners hinders the independent contractor status and calls upon the development of a system whereby:
   (i) practices are encouraged to open up more partnerships
   (ii) sessionals are encouraged to apply for partnerships
   (iii) courses or other opportunities should be provided to help sessional GPs understand the practical running of a practice.

Q5 MID MERSEY: That conference believes that the ever diminishing number of independent contractor GPs has contributed significantly to the workforce crisis and demands that the GPC urgently address this issue before general practice is completely decimated.

Q6 TOWER HAMLETS: That conference notes that 400 GPs are being reported as leaving NHS general practice a month and as many are retiring aged 55-59 as over 60. We call on NHS England to review what support and incentives are in place to stop this, including:
   (i) greater flexible working for older doctors
   (ii) reduced burden from appraisal and revalidation process for older GPs
   (iii) coaching and mentoring support
   (iv) greater support with indemnity funding.

Q7 HEREFORDSHIRE: That conference agrees that health services’ current inability to retain general practitioners is the greatest threat to the NHS since its inception.

Q8 DERBYSHIRE: That conference believes that the current mass exodus of GPs, the increased pressure in general practice and the sustained poor funding whilst there is an increase in workload will lead to the demise of general practice.

Q9 NEWCASTLE AND NORTH TYNESIDE: That conference urges the government to prioritise retention through improving the working lives of experienced GPs so that key skills are recognised and rewarded.

Q10 NORFOLK AND WAVENEY: That conference urges GPC to consider the merits of negotiating a return to GP seniority payments as a way to stem the rise of early retirements as the plug hole is leaking at a greater rate than the NHS tap can fill the workforce bath.
Q11  GREENWICH: That conference:
(i)  deplores the amount of money that has been spent on international GP recruitment, and
(ii)  believes that future funding should be directed towards recruitment and retention of UK resident GPs, with initiatives such as ‘golden hellos’ for salaried GPs nationwide.

Q12  SHROPSHIRE: That conference believes that spending significant sums of money attempting to recruit GPs from abroad is:
(i)  wasteful
(ii)  fails to address the issues underpinning poor recruitment and retention and,
(iii)  would be better spent reducing the prohibitive cost of indemnity insurance for existing UK GPs.

Q13  MANCHESTER: That conference believes incentives should be provided to recruit more ‘home grown’ GPs to replace the diminishing GP workforce.

Q14  MID MERSEY: That conference believes the governments initiative of spending £100 million to recruit 2000 GPs from abroad has been wasteful and asks the GPC to encourage the government to invest the money in general practice to encourage salaried and sessional doctors to join the ranks of independent contractors.

Q15  CAMBRIDGESHIRE: That conference welcomes the overseas GP recruitment initiative but recognises that:
(i)  it is not the answer to the GP workforce recruitment and retention crisis and
(ii)  that language competency is not the only prerequisite for safe and high quality care.

Q16  GATESHEAD AND SOUTH TYNESIDE: That conference believes that the present Home Office processes for granting working visas for GPs from abroad is not fit for purpose and is detrimental to overseas recruitment, and presses the Home Office to change the process as soon as possible.

Q17  NORTHAMPTONSHIRE: That conference challenges the government to stop the constant barrage of external ‘priorities’ which exhaust and demoralise the workforce and cost practices time, energy and money with little, if any positive benefit. Do this now and before it is too late to prevent further exodus of experienced GPs.

Q18  BEDFORDSHIRE: That conference:
(i)  believes that The Five Year Forward View has really failed to address lack of success in recruitment or retention, and
(ii)  calls on GPC to negotiate with NHS England a better pension policy for joiners and incentives such as ‘golden handcuffs’ for those aged 55+.

Q19  HULL AND EAST YORKSHIRE: That conference believes that the GP workforce crisis is created by politicians by not dealing with the increasing workload and not investing in general practice. The conference:
(i)  is appalled, but not in the slightest bit surprised, that the Secretary of State for Health’s pledge of 5000 extra doctors is already failing
(ii)  demands that the government comes up with long term sustainable solutions to addressing workforce problems rather than the short term fixes of importing them from countries with fewer doctors per capita than ourselves
(iii)  mandates GPC to urgently create a GP retention initiative to address the immediate workforce shortages
(iv)  asks the GMC to revisit the undergraduate medical curriculum to make sure that it has general practice at the core of it.

(Supported by North and North East Lincolnshire LMC)

Q20  AVON: That conference urges the GPC to deal with the GP recruitment crisis by discouraging the ineffective and inefficient use of AN Other clinicians to do a GP’s job and instead work with the Government to make general practice a career option of choice.
Q21  NEWCASTLE AND NORTH TYNESIDE: That conference views with increasing concern the current recruitment and retention crisis in general practice which now threatening the viability of traditional service delivery based on continuity of care.

Q22  SHROPSHIRE: That conference believes that general practitioners should be added to the current 'Shortage Occupations List' in an attempt to alleviate the problems of recruiting and retaining GPs.

Q23  SOUTH STAFFORDSHIRE: That conference demands the government realises and publicly acknowledges that the crisis in general practice recruitment will not be solved simply by money and bringing doctors from elsewhere, welcome as that would be, but by ceasing its apparent policy of making primary care unsustainable and unworkable.

Q24  CUMBRIA: That conference believes general practice offers excellent career opportunities and rewards such that we should all be promoting its strengths and benefits rather than only the negatives.

Q25  KENT: That conference demands that GP appraisal and re-validation be abolished in order to improve the retention of experienced GPs.