Conference of Representatives of Local Medical Committees
Agenda
Friday 9 March 2018
Conference of Representatives of Local Medical Committees

Agenda

To be held on

Friday 9 March 2018 at 9.00am
At the BT Convention Centre, King’s Dock, Liverpool Waterfront, Liverpool, L3 4FP

Chair Guy Watkins (Cambridgeshire)
Deputy Chair Mark Corcoran (Avon)

Conference Agenda Committee
Guy Watkins (Chair of Conference)
Mark Corcoran (Deputy Chair of Conference)
Richard Vautrey (Chair of GPC)

Uzma Ahmad (Walsall)
Roberta King (Dorset)
Haldane Maxwell (Ayrshire)
Rachel McMahon (Cleveland)
Shaba Nabi (Avon)
Elliott Singer (City and Hackney)
Kalindi Tumurugoti (Nottingham)
Notes

Under standing order 17, in this agenda are printed all notices of motions for the annual conference received up to noon on 21 December 2017. Although 21 December 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 25 and 26 (‘A’ and ‘AR’ motions — see below) and those for which the agenda committee believes there will be insufficient time for debate or are incompetent by virtue of structure or wording. Under standing order 20, if any local medical committee submitting a motion that has not been prioritised for debate objects in writing before the first day of the conference, the prioritisation of the motion shall be decided by the conference during the debate on the report of the agenda committee.

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

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

Under standing order 21, the agenda committee has grouped motions or amendments which cover substantially the same ground, and has selected and marked one motion or amendment in each group on which it is proposed that discussion should take place. Under standing order 28, the agenda committee has scheduled a series of major issue debates.

Attached is a ballot form for chosen motions. The ballot closes at noon on Friday 2 March 2018.
**LMC CONFERENCE ELECTIONS**

The following elections will be held on Friday 9 March 2018

**Chair of conference**
Chair of conference for the session 2018-2019 (see standing order 67 – nominations to be handed in no later than **10.00am Friday 9 March**.

**Deputy chair of conference**
Deputy chair of conference for the session 2018-2019 (see standing order 68 – nominations to be handed in no later than **1.00pm Friday 9 March**.

**Seven members of the GPC**
Seven members of the GPC for the session 2018-2019 (see standing order 69 – nominations close at **12.00pm on Friday 2 March**.

**Seven members of the conference agenda committee**
Seven members of the conference agenda committee for the session 2018-2019 (see standing order 70 – nominations to be handed in no later than **1.00pm on Friday 9 March**.

**Co-option to GPC of a doctor within five years of qualification**
Co-option to GPC of a doctor within five years of qualification for the session 2018-2019 nominations to be handed in no later than **1.00pm on Friday 9 March**.
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1 **RETURN OF REPRESENTATIVES 09.00**

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

2 **MINUTES**

   RECEIVE: Minutes (AC19 2016-1017) and GPC News (GPC News 6 – May 2017) of the 2017 Annual Conference of Local Medical Committees as approved by the Chair of conference in accordance with the provision of standing order 87.

3 **STANDING ORDERS**

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

   AGENDA COMMITTEE to amend the first sentence of standing order 70.1:

   The agenda committee shall consist of the chair and deputy chair of the conference, the chair of GPC UK and seven members of the conference, at least one of whom, subject to appropriate nominations being received, shall represent each of the four UK nations and not more than one of whom shall be a sitting member of GPC UK.

4 **REPORT OF THE AGENDA COMMITTEE**

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

5 **ANNUAL REPORT 09.30**

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

6 **WORKFORCE/RECRUITMENT AND RETENTION 09.50**

   AGENDA COMMITTEE TO BE PROPOSED BY HAMPSHIRE AND ISLE OF WIGHT: That conference believes the partnership model to be the most efficient and cost-effective way of delivering general practice and demands that government:

   (i) does everything possible to support and sustain this model

   (ii) invest in an incentive scheme to encourage GPs into permanent roles

   (iii) needs to explore all avenues to encourage older GPs to remain in practice

   (iv) encourage non-GP staff to become partners to further increase the sustainability of the partnership model.

   HAMPSHIRE AND ISLE OF WIGHT: That conference needs to encourage non-GP staff to become partners to modernise partnerships and bring further sustainability to the partnership model.

   Motion by CLEVELAND: That conference reaffirms its belief in continuity of care as the cornerstone of general practice, and requests the negotiation of an incentive scheme to encourage GPs to move into salaried or partnership roles.

   SOUTH Staffordshire: That conference believes in the future of the partnership model as the most efficient and cost-effective way to deliver general
practice and demands that government:
(i) does everything possible to support and sustain this model
(ii) provides reassurancs that, should practices be unable to recruit and survive, they will take over responsibility for commitments taken out on premises.

7d NORTHAMPTONSHIRE: That conference recognises that the partnership model is the most cost-effective and responsive method of providing GP care when properly funded and demands that the GPC do everything it can to make it the model of choice for any future service provision.

7e NORTHAMPTONSHIRE: This conference mandates the GPC to encourage the partnership model by negotiating a realistic supplement paid to partners to recognise the extra duties, risks and responsibility in proving the staff and infrastructure needed to run a successful practice.

7f SOUTHWARK: That conference is concerned that the trend for some practices to significantly restrict or even block the opportunity for any incoming GPs to be partners, particularly in the climate of 'at scale' practices and practice chains, conveys the risk of:
(i) creating a significant reduction in career choice for GPs in the future
(ii) changing the face of general practice from that of a service to a business
(iii) reducing the attraction of general practice as a career
(iv) undermining GPs who appreciate autonomy
(v) jeopardising workforce retention.

7g MORECAMBE BAY: That conference recognises the value of the partnership led independent contractor status of NHS GPs, deplores its steady erosion by misguided government policies and calls on GPC to negotiate significant incentives for this model of general practice.

7h 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 and come to a solution regarding last man standing being left with premises responsibility
(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.

7i BRO TAF: The GMS contract and independent contractor status are the foundation stone of the primary health care system. To maintain independent contractor status, conference requests the UK governments to ensure that they provide enhanced investment in independent contractor GMS practices in preference to managed practices and other forms of GP service models.

7j LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges the GPC to have a mentoring scheme available to all GPs with in their first five years of practice who decide to take up partnerships.

7k BRO TAF: That conference requests the GPC to begin negotiations to introduce a new payment for GP partners over the age of 55 to encourage them to remain in practice.

7l SOUTH STAFFORDSHIRE: That conference believes that all avenues need to be explored to keep older GPs in work; in particular by reintroducing seniority awards and by giving financial incentives to stay in work.

7m HERTFORDSHIRE: That conference believes that the loss of seniority has contributed to the lack of resilience of newly qualified GPs and calls on GPC to negotiate a suitable replacement.
7n DEVON: That conference instructs the GPC to work with HEE to promote, enhance and rationalise the GP retainer scheme to ensure that the UK does not continue to lose excellent GPs to retirement.

7o NORTHAMPTONSHIRE: That conference demands that a serious effort is made to recognise the reasons why GP leave the profession early and deal with these instead of tinkering around the edges with schemes of only limited appeal.

7p HERTFORDSHIRE: That conference is dismayed and profoundly worried by the drop in the GP UK workforce announced in Autumn 2017 rather than the increase promised by the Secretary of State and calls on GPC UK to negotiate to develop radical recruitment and retention packages for targeted groups within the profession at risk of drop-out namely:
(i) GPs aged 25-35
(ii) GPs aged 36-45
(iii) GPs aged 46-55
(iv) GPs aged over 55.

7q HERTFORDSHIRE: That conference believes that the loss of senior GPs in their mentoring role is contributing to the workforce crisis and calls for a new role of GP mentor.

8 AGENDA COMMITTEE TO BE PROPOSED BY NORFOLK AND WAVENEY. That conference acknowledges the increased role played by allied health care professionals within the practice team, as a result of the GP workforce crisis, and calls upon the GPC to demand:
(i) full, recurring and direct reimbursement for their employment costs
(ii) an extension to the sickness reimbursement scheme for key practice staff
(iii) that GP practices are funded to provide a formal support structure for them

8a 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.

8b WORCESTERSHIRE: That conference believes it is essential to increase the size of the general practice workforce if we are truly to sustain UK general practice and that GPC needs to explore with the government alternative ways of funding such extra staff including direct reimbursement.

8c 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 groups improve the quality and safety of the services within general practice but are not doctor substitutes and neither guarantee reduction in GP workload.

8d LEEDS: That conference welcomes the increasingly important role pharmacists play as members of practice teams and calls on all UK governments to build on current national developments and ensure every practice is supported by a recurrently funded pharmacotherapy service.

8e HAMPSHIRE AND ISLE OF WIGHT: That conference mandates the GPC to negotiate an extension to the sickness reimbursement scheme for other key practice staff.

8f DORSET: That conference believes GP surgeries should try to demonstrate a commitment to all surgery staff wellbeing (not just GPs) to help improve morale, assist with staff retention and improve sickness absence rates.

8g MERTON: That conference believes GPs, regardless of contractual status, should support our clinical colleagues within general practice to enable the development of skill mix within the practice.
8h GRAMPIAN: That conference believes that physician assistants/associates (PAs) may offer part of a solution to workload pressures in general practice, but believes that their potential is limited while they are not registered with a regulatory body and calls on GPC to work with governments to find a solution to this problem.

8i WORCESTERSHIRE: That conference believes it is essential to increase the size of the general practice workforce if we are truly to sustain UK general practice and that GPC needs to explore with the government alternative ways of funding such extra staff including direct reimbursement.

8j CLEVELAND: That conference deplores the prioritisation of funding to train physician associates at the expense of funding to support GP training, and demands the immediate restoration of, and ring-fencing of the GP training budget.

**PRACTICE CLOSURES**

9 AGENDA COMMITTEE TO BE PROPOSED BY AVON: That conference is concerned about the number of recent practice closures and
(i) believes that unmanaged dispersals lead to patient safety issues
(ii) believes that more needs to be done to make the public aware of the mounting threat to the system of general practice
(iii) demands details of the contractual arrangements to provide ongoing primary care after a practice closure, are made public
(iv) instructs GPC to take urgent action to ensure the protection of ‘last man standing’ GPs from any additional costs of resignation or retirement resulting from practice closure

9a AVON: That conference is concerned about the contractual arrangements that have been made to provide ongoing primary care when the contract has been handed back by provider GPs and calls on GPC to petition the government to release details of these contractual settlements.

9b LANCASHIRE COASTAL: That conference believes that GPC should challenge advice from NHSE that patients should be dispersed when a practice closes to preserve patient choice as this leads to patient safety issues with vulnerable patients left to their own devices and leads to unplanned pressures on surrounding practices; both of which could be addressed through adequate planning and managed dispersals.

9c MID MERSEY: That conference instructs GPC to take urgent action to ensure the protection of ‘last man standing’ GPs from any additional costs of resignation or retirement resulting from this status.

9d SHROPSHIRE: That conference regrets the woeful under-resourcing of primary care in the UK, the closure of so many practices that has resulted and the escalating pressure on those that remain, and believes that more needs to be done to make the public aware of the mounting threat to the system of general practice that most have grown up with.

9e HAMPSHIRE AND ISLE OF WIGHT: That conference mandates the GPC to negotiate national funding for the additional work involved for receiving patients from list dispersals.

9f MORECAMBE BAY: That conference sadly notes the common occurrence of GP surgeries closing down across England due to inadequate funding and recruitment/retention issues and calls on GPC to launch a campaign exposing these closures with the loss of vital services to patients and prematurely ending GPs careers.
REPORT BY THE CHAIR OF SCOTTISH GPC  

10 RECEIVE: Report from the Chair of Scottish GPC, Alan McDevitt.

11 CUMBRIA: That conference believes that there is much to be gained by examining the Scottish Contract Offer and how elements of it could be incorporated into the English contract negotiations.

11a CAMBRIDGESHIRE: That conference believes that continued unmanageable workload and unacceptable risk is destroying both general practice itself, and the careers of those working so hard within it, and calls upon the GPC to:
(i) accept that ’Saving General Practice’ is merely a wish list that, without any leverage behind it, is incapable of saving general practice
(ii) accept that, without contract negotiation, NHSE will continue to dictate where it invests, and risks the GPC becoming irrelevant in delivering any suitable, significant change for GPs
(iii) acknowledge that some areas of the UK are looking at contractual changes as an effective resolution
(iv) negotiate contractual changes in all areas of the UK that will offer general practice a safe and sustainable future.

11b LEEDS: That conference welcomes the proposals in Scotland to work towards funded protected learning time for all GPs and calls on other UK governments to do the same.

11c GLASGOW: That conference calls on GPC to ensure that GP training continues to produce GPs who can work in all four nations despite the divergence of GP contracts in these four nations.

PREMISES

12 NORTHAMPTONSHIRE: This conference demands that GP premises are fully resourced to meet the demands and needs of the population of the UK.

12a GATESHEAD AND SOUTH TYNESIDE: That conference believes that practices using NHS Property Services buildings:
(i) are being asked to pay exorbitant service charges which threaten viability
(ii) have no means to pass on this cost increase to their consumers as in the commercial world
(iii) should not be subject to the usual commercial world unless properly funded to do so
(iv) should be fully reimbursed on a permanent basis any increase in service charges as a matter of urgency.

12b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers NHS England property issues. Where they are providing a limited service that has extortionate charges with no reliable lease or contract.

12c LANCASHIRE PENNINE: That conference believes that service charges to many practices in NHS PS or CHP buildings are rising exponentially in comparison to historic payment levels without any justification or itemised list of charges and the situation is worse for practices who have already signed a lease.

12d DERBYSHIRE: We ask 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.
12e DONCASTER: That conference requires GPC and NHS England to work together to appoint an organisation to act as the last man standing for NHS premises leases for contractors who inhabit non-NHS owned leasehold premises.

12f WIGAN: That conference condemns the lack of primary care capital funding to renew and develop owner occupied general practice premises. It calls upon the GPC to make a special initiative to secure the necessary increase in funding and to ensure this is equitably distributed.

REPORT BY THE CHAIR OF GPC WALES 11.10

13 RECEIVE: Report from the Chair of GPC Wales, Charlotte Jones.

REPORT BY THE CHAIR OF GPC NORTHERN IRELAND

14 RECEIVE: Report from the Chair of Northern Ireland GPC, Tom Black.

ONLINE GP SERVICES

* 15 AGENDA COMMITTEE MOTION TO BE PROPOSED BY HERTFORDSHIRE: That conference is concerned that new online GP services are targeting healthy, less complex patients, the funding for whom is partly used to subsidise care for more complex patients on the registered list and calls on GPC to:
   (i) demand a stop to the undermining of general practice by private companies who cherry pick the patients to whom they offer services
   (ii) demand that online consultation schemes do not become established unless they are prepared to provide a comprehensive package for all patients
   (iii) support general practice to explore innovative ways of providing health care
   (iv) demand the allocation of additional funds to NHS general practice to provide training, support and appropriate software and hardware in order to establish on-line consultation services.

15a HERTFORDSHIRE: That conference calls on GPC to:
   (i) demand a stop to the undermining of general practice by allowing private companies to cherry pick patients to whom they provide services
   (ii) support general practice to provide innovative ways of providing health care
   (iii) demand the re-allocation of additional funds to NHS general practice to provide training and support in order to establish on-line consultation services
   (iv) demand that present pilot schemes cannot become established services unless they are prepared to provide a comprehensive care package for all patients.

15b BRADFORD AND AIREDALE: That conference believes now online services are targeting least-complex patients and offering them a more convenient service, inadequate funding of more complex patient groups in primary care needs to be reviewed as for too long general practice has only survived by using the funding for the healthy patients on their list to subsidise care for the more complex patients.

15c NORFOLK AND WAVENEY: That conference believes that tighter regulation is required to prevent private providers capitalising on attempts to widen patient online access in the form of smart phone application models.
15d LEWISHAM: That conference is concerned that ‘GP at hand’ negatively impacts upon the doctor/patient relationship particularly in relation to patients with complex needs.

15e HULL AND EAST YORKSHIRE: That conference, whilst supporting innovation, is concerned about emerging online GP consultation models that are undermining the traditional model of general practice and the NHS. (Supported by North and North East Lincolnshire)

15f HERTFORDSHIRE: That conference notes with interest and concern that as of December 2017, the Hammersmith and Fulham CCG subcontracted service ‘GP@Hand’ administered by Babylon, had attracted 7000 registrations representing approximately £600,000 of practice funding for patients by utilising a loophole in The Out Of Area Registration Regulations. Conference regrets the potential iniquity in this commissioning arrangement as it currently stands and calls upon:
(i) GPC UK to investigate the original commissioning process around GP@Hand to see if a referral to the ombudsman for maladministration is warranted
(ii) GPC UK and the JCITGP to work with NHSE and CCGs in enabling potentially every practice to choose to offer the technology through their GPSoC with a dedicated funding stream for remote electronically enabled patients
(iii) GPC UK to seek to close the loophole in the GMS regulations around out of area registrations to ensure that ‘donating’ practices arrange with ‘receiving’ practices a safe handover so that the patient is never left ‘without’ a GP.

15g LEEDS: That conference believes that all practices should be able to offer video consultations for their patients through the free provision of appropriate hardware and software that is fully compatible with current GP IT systems and calls on UK governments to enable this implementation.

INFORMATION MANAGEMENT AND TECHNOLOGY

* 16 AGENDA COMMITTEE TO BE PROPOSED BY BEDFORDSHIRE: That conference with respect to the GDPR (General Data Protection Regulation):
(i) believes that GPs feel highly exposed to the GDPR
(ii) believes that it is no longer sustainable for the GP to be the sole data provider
(iii) calls on GPC to urgently explore the possibility of commissioning health organisations having one data protection officer for all GP practices in their area
(iv) calls on GPC to negotiate with governments a review of the application of GDPR to general practice
(v) demands an appropriate uplift in the core contract to reflect the resulting impact of the new regulation.

16a BEDFORDSHIRE: That conference:
(i) believes that GPs feel highly exposed to GDPR and
(ii) calls on GPC to seek reassurances from the Department of Health that GPs and general practices will be protected from its draconian penalties.

16b WORCESTERSHIRE: That conference believes the requirements of the new GDPR regulations are so onerous that the responsibility and liability for data protection must be taken off the shoulders of GP partners.
16c BEDFORDSHIRE: That conference:
(i) believes that the short timescales, onerous conditions, technical impossibility and vastly inappropriate complexity of GDPR, mean that most practices will choose not to share patient information at all rather than risk a fine of up to €20 million
(ii) calls upon the government either to make changes to the regulations or else refuse to implement this EU legislation altogether.

16d CLEVELAND: That conference recognises the impact of the General Data Protection Regulation (GDPR) on practice and demands:
(i) an appropriate uplift in the core contract to reflect the removal of reimbursement and potential increase in patient record requests as a direct consequence of the new Regulation
(ii) the national negotiation of a fee for record requests with a shorter requested response time than that specified within the GDPR.

16e BEDFORDSHIRE: That conference:
(i) believes that it is inappropriate for GDPR to be applied in a healthcare setting such as general practice and
(ii) calls on GPC to negotiate with government a review of the application of GDPR to general practice.

16f CONFERENCE OF NORTHERN IRELAND LMCs: That conference asks that GPC works with the Department of Health to produce guidance to enable practices to be compliant with the new GDPR coming into effect in May 2018.

16g BEDFORDSHIRE: That conference:
(i) believes that the concept that, under GDPR, a practice could be fined up to €20 million must be rejected and
(ii) calls on GPC to negotiate with government that GDPR be suspended until the lunacy of its disproportionate financial penalties is addressed and until its technical demands are better aligned with UK healthcare informatics practice.

16h GRAMPIAN: That conference believes that as we move towards greater use of multi-disciplinary teams and other healthcare professionals both using and inputting into the clinical record, that it is no longer sustainable for the GP to be the sole data controller and requests GPC to engage with government and regulators to find a workable solution.

16i GLASGOW: That conference in light of the new GDPR and Joint Data Controller issues, calls on GPC to urgently explore the possibility of having the health authorities (HBs. HSCPs) have one data protection officer for all GP practices in their area.
THEMED DEBATE – WORKLOAD 12.00

The Workload Themed Debate will be conducted under standing order 51. The motions submitted by LMCs that the Agenda Committee considers best covered by this themed debate are included in the agenda here, and are numbered TD1 to TD 25.

The Themed Debate will be introduced by a representative of the GPCUK Chair (SO 53.3), who will report on recent GPC activity arising from recent Conference policy on workload management. The themed debate will be held in response to this statement, and the motions in this section. All members of conference may take part in this debate by speaking from the microphones in the hall, rather than from the podium, when called by the Chair, with a speaker time limit of one minute per speaker (SO 53.5).

At the conclusion of the debate a further representative of the GPCUK Chair may conclude the debate.

The response of LMC representatives to the GPC work, and the themed debate, will be measured in a way to be outlined in the Supplementary Agenda.

TD1 CONFERENCE OF ENGLAND LMCs: That conference:
(i) believes tired doctors are potentially unsafe doctors
(ii) calls on GPC England to issue guidance to support GPs to limit their working day to ensure patient safety
(iii) calls on NHS England and the government, working with GPC England, to make patients aware of the importance of reducing GP workload to safe levels
(iv) believes GPs should be supported to say “NO” without feeling guilt.

TD2 CONFERENCE OF NORTHERN IRELAND LMCs: That conference calls on the four GPCs to define working limits for GPs wrt consultations, prescriptions, blood results and hospital communications.

TD3 SHROPSHIRE: That conference believes that twenty-five face to face GP-patient consultations is a reasonable level for practice workload and that exceeding this may not be sensible for doctors or safe for patients.

TD4 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges GPC to invest time in defining ‘safe working levels’ for GPs.

TD5 SANDWELL: That conference in the interests of patient safety and quality, conference calls on the GPC to unilaterally declare that a reasonable GMS session will consist of 13 consultations per session in 2018, falling to 9 consultations, each of 15 minutes duration by 2020. Nine such sessions per week should be provided for every 1500 patients. Experienced practitioners, who have the personal capacity to safely deliver additional consultations, can be commissioned to do additional consultations, in their own practice or in a hub.

TD6 CORNWALL AND ISLES OF SCILLY: That conference believes that the biggest threat to UK general practice is workload and calls on GPC to define a safe working day.

TD7 WIRRAL: That general practitioners spend significantly less time in face to face consults with patients but more time for clinical admin, planning and leading their teams.
TD8 LANCASHIRE PENNINE: That conference believes that the ever-increasing pressures on health care require a primary care escalating alert system to ease workload and reduce the number of patients in line with the secondary care alert system.

TD9 DEVON: That conference asks the GPC to develop a method by which GP practices can flag dangerous workload pressures equivalent to the hospital operating escalation systems.

TD10 CORNWALL AND ISLES OF SCILLY: That conference believes with increasing numbers of contracts being handed back, partners are taking, we are told, to drink or drugs and a routine 12-hour day — primary care can no longer be considered to be a safe service either for patients or doctors.

TD11 CORNWALL AND ISLES OF SCILLY: That conference believes that the thin veneer of patient safety that covers primary care can no longer be sustained and that urgent moves are needed if a safe service is to be delivered.

TD12 DERBYSHIRE: That conference reasserts that any work not covered by essential services or explicitly covered by an enhanced service is NOT the responsibility of the practice to undertake and that responsibility lies firmly with commissioners and instruct the GPC to negotiate and, if need be, litigate accordingly.

TD13 SHROPSHIRE: That conference believes present GP workload is unsustainable, that this can only be partially mitigated by the use of allied professionals in general practice, and for GPs and practices to function effectively the forced allocation of patients to practice lists must now stop.

TD14 CORNWALL AND ISLES OF SCILLY: That conference asks GPC to develop workload analysis tools so that we can effectively demonstrate that UK general practice is full.

TD15 MID MERSEY: That conference is concerned that rising workload in general practice has not been recognised or accounted for in annual pay awards, and asks GPC to undertake research to annually benchmark the volume and intensity of clinical and administrative work done by practices, with (as far as is reasonably possible) historic comparisons over recent years, in order to ensure that the DDRB takes account of and fully funds past and future workload increases.

TD16 HARINGEY: That conference deplores the government’s drive to improve access in general practice at the expense of quality without providing a clear definition of what ‘improved access’ means.

TD17 MORGANNWG: That conference calls on government to urgently scrap the requirement for GPs to confirm allegations or findings of domestic violence cases in order to qualify for legal aid, which is driving up demand on GP appointments and creating unnecessary GP workload.

TD18 NORTH YORKSHIRE: That conference believes that the NHS 5 year forward view has not and will not deliver the investment general practice requires to survive the current workload demands and a radical new GP contract is required.
TD19 LIVERPOOL: That conference believes that an appropriate impact assessment should be undertaken into the implementation of the GP Forward View, as whilst the GP Forward View ‘10 High Impact Actions’ have shifted some tasks and workload to other members of the primary care multi-disciplinary team, GP consultations with patients have become increasingly more complex and time consuming.

TD20 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 an increase in the general practice workforce funded by government.

TD21 CORNWALL AND ISLES OF SCILLY: That conference calls on GPC to demand the end to the political tokenism of 88.

TD22 BRADFORD AND AIREDALE: That conference believes at a time of system stress when workload is becoming unmanageable, in addition to temporarily closing lists, practices should have the option of suspending home visiting.

TD23 NORTH YORKSHIRE: That conference agrees that primary care is being asked to radically reform whilst at the same time coping with a dwindling workforce, increase in demand and a reduction in funding.

TD24 NORTH YORKSHIRE: That conference believes that the issue of recruitment and retention in general practice can only be solved with a clear long-term strategy for primary care backed by major contract changes.

TD25 NORTH WALES: Solutions to the workforce crisis need to be wider than a purely Wales based solution. Conference calls on GPCW and Welsh Government to recognise that solutions for North Wales need to recognise the natural links with the North West of England and build on those in addition to the work being done in Cardiff and Swansea.

**CHARITIES**

**Dain Fund**

17 RECEIVE: Report by the Chair of the Dain Fund (Dr Bill Strange).

**Claire Wand Fund**

18 RECEIVE: Report by a Trustee of the Claire Wand Fund (Dr Russell Walshaw)

**Cameron Fund Annual General Meeting**

19 RECEIVE: Report by the Chair of the Cameron Fund (Dr Gary Calver).

**LUNCH**

13.00
REPORT BY THE CHAIR OF GPDF  14.00

20 RECEIVE: Report from the Chair of the GPDF (Dr Douglas Moederle-Lumb)

QUESTION THE UK EXECUTIVE TEAM

21 Members of conference may ask questions from the indicated microphones of the four UK chairs and the England Executive team.

REPORT BY THE CHAIR OF THE SESSIONAL GPs SUBCOMMITTEE  14.30

22 RECEIVE: Report from the Chair of the Sessional GPs Subcommittee (Dr Zoe Norris)

REPORT BY THE CHAIR OF THE GP TRAINEES SUBCOMMITTEE

23 RECEIVE: Report from the Chair of the GP trainees subcommittee (Dr Tom Micklewright)

EDUCATION AND TRAINING  14.50

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

That conference is concerned by the 3+1 proposal from the Shape of Training report for GP Trainees and calls on GPC and the BMA to:
(i) oppose mandatory post-CCT jobs
(ii) work with relevant bodies to improve current training and make hospital jobs for training and not for service
(iii) pressurise programme directors to withdraw GP trainees from units that do not offer trainees regular clinics (if applicable eg A&E), reasonable study leave opportunities and formal teaching.

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

That conference finds out of hours training for GP trainees requires stringent guidelines and restructuring so it calls upon GPC to work with relevant bodies to ensure:
(i) a minimum of 6 weeks’ notice is provided for shifts
(ii) the supernumerary status of trainees is recognised
(iii) direct supervision of trainees is performed by a GP, whilst working in GP out of hours
(iv) the trainee can choose the shifts they work
(v) trainees can access opportunities to work with other out of hours’ services in a shadowing capacity, to achieve their curriculum competencies.

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

That conference calls upon GPC to work with RCGP e-portfoio and revalidation portfolios to ensure GP trainees and GPs are made aware their reflections can be used against them in court.
REGULATION 15.30

27 AVON: That conference is concerned about the number of gross negligence manslaughter trials which involve members of the medical profession and calls on GPC to work with the BMA and other relevant organisations to petition the government for less adversarial approach to adverse events that recognises the importance of system failures and seeks to learn rather than blame.

28 MID MERSEY: That conference is concerned that assessment of GPs' and practices' performance may be based on unreasonably high standards, insists that any such assessments must be based on the typical achievement of peers and must take into account both workload and funding constraints, and asks that GPC takes appropriate steps to help establish 'real world' benchmarks that reflect current normal standards of practice.

28a DORSET: That conference is concerned that NICE guidance is being used to criticise GPs when complaints are investigated by the Parliamentary Ombudsman or the GMC. Conference mandates the GPC to:
   (i) negotiate a return to the use of the Bolam principle in assessing complaints made against GPs
   (ii) inform our colleagues who make retrospective judgements on our performance that the small print of NICE guidance does not always represent best practice in primary care
   (iii) recognise that the use of NICE guidance in judging GP performance is harming the recruitment and retention of GPs.

28b AVON: That conference deplores the proposal by the secretary of state to consider merging healthcare regulators into a single organisation. It calls on the GPC and the BMA to:
   (i) resist this proposal and to uphold the established principle of peer review as opposed to a single regulator attempting to distinguish between the widely differing roles of many professions
   (ii) work with the GMC and the Medical Practitioners Tribunal Service, to ensure that they are fit for purpose and that they fulfill a cost-effective and supportive role that protects both doctors and patients alike.

29 MID MERSEY: That conference is concerned at the very significant impact on practitioners and practices subject to NHS Performance Investigation and at the lack of independent oversight or accountability of NHS Medical Directorates, and asks GPC to undertake or commission research to determine the total number of practitioners and practices investigated per year, the range of reasons for such investigations, the typical timescales for completion of investigations and the range of outcomes, and also to obtain and collate the views of practitioners and practices that have experienced such investigation.

29a MID MERSEY: That conference is concerned at the cost and workload implications for practices involved in NHS Performance Investigations, particularly the time involved for practices in gathering evidence, preparing reports and attending meetings, and asks GPC to negotiate to ensure that practices can claim reasonable professional expenses for time and costs incurred in complying with the process.
30 Soap box is held under Standing Order 56:

57.1 A period shall be reserved for a ‘soapbox’ session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.

57.2 Other representatives shall be able to the issues raised during the soapbox session or afterwards via means to be determined by the agenda committee.

57.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.

57.4 GPC (UK) members shall not be permitted to speak in the soapbox session.

**DISPENSING 16.40**

31 AYRSHIRE AND ARRAN: That this conference:

(i) views with alarm moves to further restrict GPs’ prescribing of medicines that are available ‘over the counter’ (OTC) rather than by efficacy

(ii) is appalled that no account has been taken of patients in remote and rural areas where there is no counter available over which to buy such OTC medicines

(iii) calls on the relevant health bodies throughout the UK to ensure that patients are not disadvantaged by restrictions to provision of medicines either through poverty or simply because of where they live

(iv) demands that the GP contracts are amended to permit doctors who dispense to be permitted to provide OTC medicines to their patients’ other than by prescription.

31a SUFFOLK: That conference views with alarm moves to restrict GP’s prescribing on the grounds of a medicine’s availability over the counter rather than its efficacy, and is appalled that no account has been taken of patient’s in remote and rural areas where there is no counter available over which to buy them. Conference calls on the relevant health bodies to ensure that:

(i) patients are not disadvantaged by such restrictions either through poverty or simply because of where they live

(ii) the GP contract is amended to permit doctors who dispense to provide such OTC medicines to their patients otherwise than by prescription.

31b SHROPSHIRE: That conference views with alarm moves to restrict GP prescribing on the grounds of a medicines availability over the counter rather than its efficacy, the impact this may have on poorer patients and those living in remote and rural areas where there is no counter available over which to buy them, and asks that the GP contract be amended to allow doctors who dispense to provide such OTC medicines to their patients other than by prescription.

31c NORTH AND NORTH EAST LINCOLNSHIRE: That conference is concerned that the ongoing lack of support for dispensing practices from government and NHS England is threatening the service to patients in remote and rural areas. We call up on them to address this as a matter of priority. (Supported by Hull and East Yorkshire)
**PRIMARY AND SECONDARY INTERFACE**

32 AGENDA COMMITTEE TO BE PROPOSED BY CONFERENCE OF NORTHERN IRELAND LMCs: That conference welcomes the recent hospital contract changes in England and further insists;

(i) on the implementation throughout all of the four nations
(ii) that hospital discharge summaries and clinic letters conform to a national standard and name the responsible hospital clinician, thus improving communication and therefore patient safety
(iii) that the commissioners must ensure that the responsible hospital clinician acts upon the results of patient investigations whilst in hospital, outpatients or at accident and emergency departments
(iv) that GPC 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
(v) on the imposition of sanctions on trusts that are not compliant with the Hospital Standard Contract

32a CONFERENCE OF NORTHERN IRELAND LMCs: That conference insists that the hospital contract agreed in England is implemented throughout all of the four nations.

32b DEVON: That conference demands that the GPC works with the appropriate bodies to ensure that hospital discharge summaries and clinic letters conform to a national standard, improving communication and therefore patient safety.

32c SOMERSET: That conference is deeply concerned about the progressive blurring of the line of clinical responsibility for patients seen by non-medical practitioners in secondary care and believes that the responsible hospital doctor should always be named in correspondence to the GP practice. (Supported by Gloucestershire)

32d 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, in compliance with the Hospital Standard Contract.

32e CONFERENCE OF ENGLAND LMCs: 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.

32f WEST SUSSEX: That conference calls on NHS England to impose sanctions on trusts that are not compliant with the Hospital Standard Contract.

32g SUFFOLK: That conference is dismayed by the lack of commitment to the standardised hospital contract currently shown by hospitals and calls upon GPC to employ all possible means to enforce compliance with the contract’s fundamental terms, if necessary through contractual means.
32h MERTON: That conference calls upon NHSE to ensure that all hospital initiated investigations are:
   (i) relayed in writing to the patient in clear and simple terms
   (ii) followed up by the hospital and, if necessary, an appointment booked with the patient to explain the results and any further required actions.

32i LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference to consider recommending that secondary care moving work to primary care should be discussed with GPs and appropriately resourced.

32j AYRSHIRE AND ARRAN: That conference (whilst recognising that the NHSE Standard Hospital Contract addresses some of these issues) believes there needs to be formal agreement across all parts of the UK that:
   (i) delineates the responsibility of secondary care services with regard to organising investigations, following up the results and conveying those results to the patient
   (ii) when primary care is asked to be involved, it is the responsibility of secondary care to ensure that the patient has been informed of the need to attend their primary care service.

32k GWENT: That Conference calls for patients to be able to directly request that their Secondary Care appointment be expedited without the need to involve their GP.

32l MANCHESTER: That conference believes GPC should negotiate an appropriate tariff for work transferred from secondary to primary care, to act as a catalyst for changed behaviour.

32m LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges the GPC to negotiate a ‘fee for service’ for all unfunded work. This would include services that are being moved from acute sector into the community. The first such fee would be for payments for producing and attending child safeguarding reports.

32n LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges the GPC to make sure that funding follows the patients and hence practices are appropriately resourced for any work that is moved from acute sector into the community.

* 33 HERTFORDSHIRE: That conference believes that the survival of the profession should take precedence over the survival of the NHS.

33a HAMPSHIRE AND ISLE OF WIGHT: That conference believes that general practitioners impose on themselves too much responsibility for the welfare of the NHS at huge personal cost and:
   (i) should concentrate on their duties to patients, and
   (ii) should support those with true responsibility for the NHS only to the extent that this does not harm the care of our patients, and
   (iii) should engage our patients fully in holding to account those responsible for the current state of the NHS.
CHOSEN MOTIONS  

34 Motions chosen for debate (chosen from the agenda in advance of conference under SO27) may be chosen from motions in part 2 of the Agenda.

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

CLOSING BUSINESS

CLOSE  

17.30
Conference of Representatives of Local Medical Committees

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

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

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

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

WORKFORCE/RECRUITMENT AND RETENTION

A 35 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference recognises that locums are an invaluable part of the NHS workforce who have knowledge and expertise which can be of benefit to the NHS and local health system and mandates GPC to ensure that no locums are excluded from CCG (or their successor organisation) elections and that locums are eligible to stand in governing body elections.

AR 36 SHROPSHIRE: That conference views with concern the increased staffing costs practices will incur in meeting planned increases in the national minimum wage (including employers NI and pension contributions) and calls on the GPC to negotiate an increase in global sum to reflect this.

PRACTICE CLOSURES

A 37 NORTH YORKSHIRE: That conference believes that to encourage the newer generation of GPs towards the partnership model, practices should be allowed to operate as a limited liability company and still hold a GMS or PMS contract.

A 38 BEDFORDSHIRE: That conference calls on GPC to support GPs who provide good standards of care and who do not wish to be part of big PCOs but to remain as independent GMS contractors in their current GP partnerships.

A 39 BEDFORDSHIRE: That conference calls on GPC to inform all GPs of the legal implications, risks and potential benefits of all new working at scale structures.

A 40 BRADFORD AND AIREDALE: 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.
A 41  BEDFORDSHIRE: That conference calls on GPC, in any negotiations about future ways of working, to protect the three jewels of general practice, namely the:
(i) registered list
(ii) GMS contract in perpetuity
(iii) ability of a GP to make individual decisions about a patient without external incentives.

A 42  MID MERSEY: That conference believes that DDRB must take account of the failure of previous pay awards to deliver intended funding uplifts to general practice, and that future pay awards must incorporate additional specific uplifts to target and correct any historic shortfalls.

A 43  NORTH YORKSHIRE: That conference believes there needs to be secured investment in primary care through list based global sum or equivalent payments, rather than complex add on schemes prone to cherry picking through competitive tenders.

A 44  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.

**CLINICAL AND PRESCRIBING**

AR 45  CONFERENCE OF NORTHERN IRELAND LMCs: That conference asks for GPC to negotiate the ability for GPs to administer and get paid for flu vaccinations they provide to their own patients, who are NHS staff, if the patient feels that this is more convenient for them.

A 46  HERTFORDSHIRE: That conference deplores the manipulation of the market that creates shortage of medicines in community pharmacies and escalating costs for the NHS and instructs GPC to press for changes to the regulations to ensure a safe continuity of supply of medications at appropriate cost.

A 47  NORFOLK AND WAVENEY: That conference asks GPC to seek guidance to enable experienced GPs to continue to take cervical smears without having to provide evidence of cervical smear competence and updates which is linked more with bureaucratic and financially motivated educational schemes than with improvements in patient safety.

A 48  CONFERENCE OF ENGLAND LMCs: 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 49  MORGANNWG: That Conference believes the HPV vaccination should be offered to all school age children of both sexes and should be administered at Primary school to be more effective

**INFORMATION MANAGEMENT AND TECHNOLOGY**

A 50  DEVON: That conference welcomes the Department of Health call for increased digitalisation of medical records and asks that IT providers be mandated to deliver the intra-operability that has been promised for years as the delay potentially puts patients at risk.
AR 51 DEVON: That conference welcomes the Department of Health call for increased digitalisation of medical records and asks that the GPC IT subcommittee negotiates:
(i) 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) retrospective payments to practices who have self-funded digital advances that are now becoming mainstream.

EDUCATION AND TRAINING

A 52 CONFERENCE OF ENGLAND LMCs: That conference recognises the inconsistent out-of-hours arrangements in GP training across the country and requires GPC, through the GP trainees subcommittee, to engage with the RCGP curriculum review and HEE review of OOH to ensure that:
(i) OOH work for GP trainees is for training and not service provision
(ii) hours requirements for OOH work is consistent across the country
(iii) trainees are supernumerary and supervised when managing patients in the OOH setting by a GP, and should not be expected to work as independent practitioners during their training

A 53 NORTHAMPTONSHIRE: This conference demands that GPs have professional autonomy in determining their educational development needs.

A 54 CONFERENCE OF ENGLAND LMCs: 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.

A 55 CONFERENCE OF ENGLAND LMCs: That conference is concerned that swingeing cuts to Health Education England budgets demonstrates that education and training is becoming a lower priority for investment by the government.

A 56 NOTTINGHAMSHIRE: That conference is concerned that swingeing cuts to Health Education England budgets demonstrates that education and training is becoming a lower priority for investment by the government.

GPC/GPDF

AR 57 DYFED POWYS: That conference demands increased transparency and accountability from GPC UK and requires all GPC conflict of interest statements be published on a public, regularly updated register that constituents may access.

A 58 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.

REGULATION

A 59 CROYDON: That conference remains very concerned at the continuing bureaucratic and unnecessary demands associated with CQC Inspections. (Supported by Kingston and Richmond LMC)

A 60 KENT: That conference believes a doctor under investigation should be kept informed except in exceptional circumstances such as a criminal investigation.
A61 LINCOLNSHIRE: That conference insists that there should be a single National Performers List so that GPs from all four nations can work anywhere in the UK without bureaucratic barriers.

A62 CLEVELAND: That conference demands frictionless borders for GPs moving between the four UK national performers lists.

A63 BEDFORDSHIRE: That conference calls on GPC to call on the Department of Health to allow practices to charge their own patients for non-NHS services as they already can for items such as insurance medicals.

A64 GWENT: That conference calls on the UK government to hold a single performers list enabling GPs to work without restriction throughout the UK.

**PRIMARY AND SECONDARY CARE INTERFACE**

A65 CONFERENCE OF ENGLAND LMCs: 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.

A66 NORTHAMPTONSHIRE: This conference demands that general practice be given parity of involvement, influence and esteem in STP care redesign.

A67 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.

AR68 DEVON: That conference asks the GPC to call attention to the contractual difficulties developing as a result of the drive to move clinical care out of hospitals into the community which means care for patients previously looked after by hospitals is now the responsibility of GPs with no extra funding to enable this to happen safely.

A69 DEVON: That conference calls on the GPC to publicise and promote innovative projects which are good examples of properly funded intermediate care developing in some areas where patients discharged early from hospital have specific funding identified to enable clinical teams to deal with their complex needs in this interim period.

A70 SURREY: That conference asserts that any general practitioner can refer a patient for a further opinion without restriction.

A71 CONFERENCE OF ENGLAND LMCs: 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.
A 72 CONFERENCE OF ENGLAND LMCs: 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.

A 73 CONFERENCE OF ENGLAND LMCs: 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 74 TOWER HAMLETS: That conference:
(i) is alarmed at reports that some hospital trusts are asking GPs to discuss eligibility for NHS treatment with patients when considering referral
(ii) insists that GPs will continue to refer on the basis of clinical need and that it is not the job of the GP to check immigration status.

INDEMNITY

AR 75 AVON: That conference welcomes the announcement from the Secretary of State to introduce a state funded indemnity scheme for NHS general practitioners, however, it
(i) is concerned by the recent move by Medical Defence Union to change its arrangements from 1 November 2017 to a claims made, from an occurrence based system, that will not cover run off costs if members leave the scheme.
(ii) calls on the GPC to seek guarantees that no GP is left vulnerable, compromised or discriminated against by any of the three main defence organisations throughout the transition process, regardless of how long it takes to introduce the new scheme.

A 76 CONFERENCE OF NORTHERN IRELAND LMCs: That conference believes that all GPs should be fully reimbursed for their individual indemnity costs.

A 77 GRAMPIAN: That conference recognises the increasing cost of indemnity in some parts of the country and calls on all governments to ensure that GPs are not left to carry the financial burden of these increases.

A 78 BRO TAF: That conference instructs the GPC to continue negotiations with the government with the aim of introducing full, personal reimbursement of indemnity costs to all GPs, regardless of their contracts or working arrangements.
A 79 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference welcomes the secretary of state’s announcement of a state backed indemnity scheme in general practice and calls on GPC to ensure that this is available to all GPs – locum, salaried, partner – working in the NHS and that there is no financial disadvantage to individuals or inequity because of the scheme.

A 80 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference welcomes the secretary of state’s announcement of a state backed indemnity scheme in general practice and calls on GPC to ensure that this is available to all GPs – locum, salaried, partner – working in the NHS and that there is no financial disadvantage to individuals or inequity because of the scheme.

NATION SPECIFIC

A 81 CONFERENCE OF ENGLAND LMCs: 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.

A 82 CONFERENCE OF NORTHERN IRELAND LMCs: That conference demands that the Department of Health pays GPs for looking after every patient in Northern Ireland and increases the budget accordingly.

A 83 GLASGOW: That conference welcomes the new 2018 GMS Contract in Scotland and congratulates SGPC negotiators in their work in securing an agreement with the Scottish Government.

REVALIDATION

A 84 CONFERENCE OF ENGLAND LMCs: 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.
A 85 KENT: That conference believes that with regards to appraisal:
(i) the systems are too onerous
(ii) funding for the time involved has failed to match the increased requirements and bureaucracy
(iii) national standards should be applied to eliminate the variation in approach between individual appraisers and between responsible officers
(iv) there should be a return to a process that is formative rather than summative.

SESSIONAL GPs

A 86 HERTFORDSHIRE: That conference believes that non-standard contracts and terms of engagement around non-clinical GP is increasingly affecting significant numbers of GPs and calls on GPC to:
(i) gather information from GPs with regards to a paucity of employment rights
(ii) take this matter forward and produce guidance for employing organisations and employed GPs in these roles, and direct negotiation with statutory bodies (eg HEE, GIG Cymru, CCGs, NHSE) who may provide such contracts.

AR 87 MID MERSEY: That conference instructs GPC to warn GPs that any form of collaboration by practices or groups of practices to seek to cap GP locum fees is illegal under UK competition law and could expose them to the risk of fines (up to 10% of turnover) and legal action by any locums affected.

WORKLOAD

A 88 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges the GPC to produce a list of services that are currently unfunded.

A 89 NORFOLK AND WAVENEY: That conference asks GPC to negotiate changes to regulations covering travel vaccinations believing that:
(i) all travel vaccines should be taken out of GMS provision and become chargeable
(ii) that imposition of a ‘travel tax’ be levied on holiday costs to fund such a service
(iii) this is a Public Health England commissioning function
(iv) that currently it uses too much scarce practice nurse and administrative time and resource
(v) that centralised clinics for travel advice and vaccinations should be established.

AR 90 NORTHAMPTONSHIRE: That conference affirms that the GP is the best person to provide holistic care to the general population and should be the professional of choice for patients, supported by other health care professionals when the GP considers it appropriate and not as a substitute for their immense skill.

AR 91 WIRRAL: That general practitioners are more enabled to lead primary care teams.
FORMS AND FEES

A 92 GRAMPIAN: That conference reiterates the right of GP practices to charge for letters and certificates issued out with the GMS contract, and encourages practices to do so, both to reflect the work involved, but also to contain the potential growth in workload if charges weren’t applied.

A 93 CONFERENCE OF ENGLAND LMCs: 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.

A 94 CONFERENCE OF ENGLAND LMCs: 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.

A 95 GLASGOW: That conference is concerned that Department of Work and Pensions staff are still verbally advising claimants to seek letters of support from their doctors for claims.

A 96 GLASGOW: That conference is concerned that GPs are still getting requests from patients for GP statements of support in their pursuit of appeals against refusal of benefit.

A 97 GRAMPIAN: That conference deplores the practice of some Department for Work and Pensions offices to ask patients for extra letters, unfunded and duplicating information which may have already been provided.

A 98 GRAMPIAN: That conference believes that as we increasingly move towards multi-disciplinary working that it remains anachronistic that only doctors can issue medical certificates (Med3 certificates) and that GPC UK should engage with the Department of Work and Pensions and any other appropriate agencies to encourage them to develop a system where other healthcare professionals can issue these when appropriate.

AR 99 SUFFOLK: That conference believes completion of the medical certificate cause of death (MCCD) in paper format, is an antiquated inefficient use of GP time and calls on GPC to take the appropriate steps to digitising the MCCD for completion in line with other forms such as Med3.

A 100 NORFOLK AND WAVENEY: That conference believes that the current ‘Fit Note’ process is time-consuming and a potential conflict of interest and should be outsourced to an appropriately funded and commissioned occupational health service.

CONTRACTS

AR 101 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 102 AVON: That conference is dismayed by the annual fiasco of winter pressure funding and calls on the health departments of all four nations and commissioning bodies to:

(i) announce winter pressure monies no later than July to allow appropriate deployment of this investment

(ii) ensure consistency and transparency in how funds are distributed

(iii) recognise that such short-term resources are mere sticking plasters for a primary care service that is dying from financial exsanguination.

CONFERENCE OF LMCs

A 103 MANCHESTER: That conference believes the GPC should have a formal process to report to LMCs on the progress of motions carried at conference.

A 104 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.

PUBLIC HEALTH

A 105 CONFERENCE OF ENGLAND LMCs: That conference believes that cuts to funding for public health and associated local authority services pose a serious health risk for generations to come.

A 106 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.

GOVERNMENT

A 107 NORTH YORKshiRE: That conference believes it is unacceptable for the government, via CCGs (or equivalent), to expect GPs to ration services on their behalf, and instruct GPC to work with the government to start a cross party national debate around what the NHS can or should provide.

A 108 LAMBETH: That conference demands that there is an open and transparent conversation at UK level about what the NHS can and cannot fund.

A 109 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.

AR 110 MORECAMBE BAY: That conference believes the statement by the Secretary of State for Health wanting the NHS to be ‘the safest healthcare system in the world’ is incompatible with funding levels to general practice which leads to GPs feeling they are working in an unsafe environment day to day and calls on the Secretary of State to recognise the real situation and increase NHS funding to well above the EU average.
PENSIONS

A 111 CONFERENCE OF ENGLAND LMCs: That conference asks NHS England to ensure that all sessional GPs doing NHS work are entitled to NHS pensions, regardless of contractor.

A 112 COVENTRY: That conference believes that GPs should be allowed to superannuate a defined fraction of their certified income (rather than the whole) to:
(i) encourage retention of older GPs in the workplace
(ii) to maintain continued contributions to the NHS Superannuation Scheme for the cash flow benefit of all members
(iii) to encourage younger members to join the scheme.

EU NATIONS AND BREXIT

AR 113 GLASGOW: That conference calls upon GPC, in light of the current workforce crisis, to work with the GMC to ensure that the effect of Brexit does not result in unnecessary barriers acting to delay or prevent entry to UK general practice.

AR 114 AVON: That conference recognises the adverse impact that Brexit could have on individuals and on the health service and calls on the government to release an impact assessment of how it anticipates staffing in primary care will be affected.
Conference of Representatives of Local Medical Committees

Agenda: Part II
(Motions not prioritised for debate)
WORKFORCE/RECRUITMENT AND RETENTION

115 LEEDS: That conference recognises the important role played by practice managers in UK general practices and calls on GPC UK to establish a practice manager network to facilitate electronic dialogue, shared learning and mutual support.

116 HAMPSHIRE AND ISLE OF WIGHT: That conference recognises that not all partners are GPs and extend the voting rights for these staff in CCG elections.

117 CONFERENCE OF ENGLAND LMCs: 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) 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.

118 LEEDS: That conference is seriously concerned at the level of GP burnout, stress and workload burden and believes:
   (i) a fully funded programme of sabbaticals for all GPs should be introduced
   (ii) GPs should have the opportunity for a sabbatical every 10 years
   (iii) GP sabbaticals could be for up to three months
   (iv) GPs should normally use a sabbatical to engage in an activity of professional development, in the UK or elsewhere in the world, alongside a period of rest and rejuvenation
   (v) GPs would be encouraged to produce a report to share with peers on return to work summarising the outcomes of the professional development gained during their sabbatical.

119 CONFERENCE OF NORTHERN IRELAND LMCs: That conference instructs the four GPCs to negotiate enhanced incentive schemes for under doctored areas.

120 DEVON: That conference instructs the GPC to work with HEE to introduce a new scheme to enable young GPs who have left the NHS an easier path to negotiate to return to practice.

121 BRO TAF: That conference:
   (i) recognises the shortage of GPs working within the prison estate
   (ii) believes recruitment into prison GP could be improved by increasing opportunities for exposure to prison general practice during training
   (iii) calls for GPC UK to work with RCGP to formalise arrangements for training within prison general practice during GP training and post-CCT.

122 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference discusses the resilience of GPs, especially the ones returning to practice.

123 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that international recruitment is not the answer to the primary care workforce crisis but simply a ‘sticky plaster’ on an open wound which needs complex dressing.

124 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference debates why spending £100 million on international recruitment and little or none for home grown doctors/ medical workforce.
125 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges GPC to reconfigure the GP returners scheme as it needs to be better funded and supported. Currently the scheme is very ambiguous with no defined structure with the entire onus on the GP to source practice and support. Conference asks the GPC to make sure that the scheme is clear and funding made available up-front for GP returners.

126 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges GPC to ask NHSE to stop investing into the IR scheme with immediate effect, until there is evidence that the scheme has long-term benefits.

127 COUNTY DURHAM AND DARLINGTON: That conference abhors the lack of coordinated planning in its drive to recruit overseas GPs and ask the NHS England to:
   (i) be transparent about differential career progression of overseas doctors in the UK at the time of recruitment
   (ii) include fully resourced support and ongoing mentorship for those recruited, including support for settlement into communities
   (iii) ask the department of health to work with the home office to urgently review the immigration policies in the context of NHS recruitment.

128 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.

129 WIRRAL: That general practice/primary care sees an increase in the number of whole time equivalent GPs’ nationally to match the increased numbers of hospital consultant’s posts that have been created over the past 10 years.

130 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
   That conference believes that all GPs, regardless of contractual status, should be recognised and supported as essential parts of the workforce and calls on NHSE to commission research looking at the relative retention and morale benefits of different models of working including freelance, through chambers, platforms, agencies and salaried GP work.

131 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:
   That conference believes that whilst golden hellos represent a welcome investment in GP recruitment, they are an oversimplified solution that risks destabilising the regional workforce and with little evidence of their long-term impact. We therefore call on GPC to:
   (i) demand a full evaluation of their impact on workforce across the UK and their cost-benefit before further money is spent
   (ii) lobby relevant bodies to invest money instead on improving trainees’ experience of general practice
   (iii) work with educational bodies to explore the creation of regional Centres of Excellence for GP training which offer additional training opportunities, including in leadership and global healthcare, to attract trainees to under-recruited areas.

132 MID MERSEY: That conference believes that general practice is not all that it is cracked up to be.
133 GWENT: Conference demands that GP Out of Hours providers treating GPs as “employed for taxation purposes” should now allow GPs to accrue annual and sick leave and offer a contract of employment which would compensate them for their loss of self-employed benefits.

PREMISES

134 MANCHESTER: That conference believes GPC should provide more assistance to LMCs to provide leadership, support and advice to practices in CHP and NHS Property Services premises.

135 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.

136 MANCHESTER: That conference believes that due to the BMA's involvement in the delay of the new Premises Directions, they should ensure that the Estates and Technology Transformation Fund is rolled over into 2018/19.

CLINICAL AND PRESCRIBING

137 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands GPC renegotiates the flu vaccine enhanced service to address the 'competition' between GPs and pharmacists.

138 COUNTY DURHAM AND DARLINGTON: That conference:
   (i) recognises that there is no evidence to show that the Community Pharmacy Seasonal Influenza Vaccination Advanced Service has significantly increased immunisation rates
   (ii) recognises the Community Pharmacy Seasonal Influenza Vaccination Advanced Service risks destabilising the immunisation campaign as a whole
   (iii) calls for the Community Pharmacy Seasonal Influenza Vaccination Advanced Service not to be commissioned in the future.

139 CONFERENCE OF ENGLAND LMCs: 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.

140 SUFFOLK: The intermittent interruption in supply of a variety of medications is inconvenient to GPs and both inconvenient and at times dangerous to patients. GPC to ask NHSE to urgently understand, resolve and then disseminate their plans to all parties affected to deal with the significant safety concerns for some and the considerable inconvenience to the whole health care system.

141 SUFFOLK: 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 explore the topic and accelerate the negotiations necessary to achieve these different arrangements.
142 NORFOLK AND WAVENEY: That conference believes that current GP funding via GMS for care home residents is wholly inadequate and calls for:
(i) separate national funding stream to support care for care home residents
(ii) mandatory assessment of primary care provision before granting of new care home applications.

143 KENT: That conference asserts with respect to the taking of cervical smears that:
(i) the technique is the same in Kent as it is in Surrey
(ii) GPs should not need to be registered to perform the task
(iii) any register of primary care smear takers should be national.

144 KENT: That conference proposes that national clinical guidance should not:
(i) require GPs to purchase expensive equipment of limited utility
(ii) waste valuable GP and staff time gaining qualifications of limited value
(iii) waste large amounts of money in their development that could be better spent on frontline healthcare.

145 SHROPSHIRE: That conference demands a review of drug pricing in order to restore a system that ensures that generic prescribing is cheapest and removes the current, shambolic, situation in which practices are placed under pressure to constantly review changes in individual drug prices and prescribe branded medication if currently less expensive.

146 LIVERPOOL: That conference believes that as increasingly more time is being wasted by prescribers altering prescriptions to take account of problems in the supply chain for medicines, pharmacists should:
(i) automatically be expected to dispense the cheapest brand available if prescribed generically
(ii) be able to substitute one brand for another without involving the prescriber.

147 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges GPC to have GMS plus contract specification for services that serve any atypical population. One of them would be ‘nursing home DES’.

148 DEVON: That conference calls for the government to remove the following from the approved list of prescription items and find another way of funding these if they wish to continue to provide them to patients with a NHS subsidy:
(i) gluten free foods
(ii) stoma care related products
(iii) specialist toothpastes
(iv) specialist suncreams.

149 TAYSIDE: That conference urges GPC to press government for stricter regulation of private health ‘screening’ services, to allow patients to make fully informed choices and prevent unnecessary and escalating demand on general practice.

150 LEEDS: That conference believes that in the event of an influenza pandemic, or similar major public health emergency, a representative of the LMC should be a core member of the local command and control team and calls on Public Health England and equivalent bodies in the UK to make this explicit in national guidance.

151 LEWISHAM: That conference calls for a national group to be established to tackle the significant risk caused by ‘out of stock’ medication.

152 SHROPSHIRE: That conference requests, again, a review of the eligibility criteria for free prescriptions as the present system is flawed and unfair and appears to penalise many sufferers of chronic conditions.
153 SHROPSHIRE: That conference calls for:
(i) a rational prescription of drug charge exemption for preventative drugs
(ii) charging for acute items
(iii) NHS payment of the cheapest generic price with patients required to pay the difference if they request a specific brand (unless recognised best practice to prescribe by brand, eg anticonvulsants).

154 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference confirms the situation with weighing scales in practices - what is the national guidelines?

155 COUNTY DURHAM AND DARLINGTON: That conference deplores the use of penalties for general practices that do not achieve targets for reducing admissions and referrals.

156 LINCOLNSHIRE: That conference calls for there to be one guidance body for the UK.

157 WIGAN: That conference believes that the transfer of care from the secondary to the primary sector cannot be safely and sustainably undertaken without robust and comprehensive shared care protocols being agreed and implemented. It is not acceptable that GPs are expected to take on complex care and prescribing regimes without clearly defined and documented protocols identifying the respective responsibilities of specialist and generalist practitioner. Conference calls upon the GPC to secure from the Medical Directors of NHS England, Scotland, Wales and NI a policy requirement upon all hospital units that explicit shared care protocols must be in place in respect of all transfers of care to general practice.

INFORMATION MANAGEMENT AND TECHNOLOGY

158 NORTHAMPTONSHIRE: This conference demands that IT infrastructure is fully resourced to meet the demands and needs of the population of the UK.

159 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 workload in general practice.

160 DERBYSHIRE: That conference believes that for modern effective, quality general practice to thrive, it must have IT that is capable of keeping step with the job we are required to do. We therefore instruct GPC to ensure that GPFV ETTF monies go direct to practices with no strings attached, so that all practices are able to improve their IT systems so they can transform in line with GPFV.

161 COUNTY DURHAM AND DARLINGTON: That conference:
(i) is frustrated by the lack of progress in implementation of a solution to allow general practices to access to patient records stored on an alternate clinical system (eg viewing a EMIS record from SystmOne)
(ii) is concerned that lack of a solution threatens safe patient care and causes untold wasted administrative hours in the NHS
(iii) demands that GPC ensures NHS Digital are held to account for the lack of progress and makes implementation of a solution the highest priority.

162 LANCASHIRE COASTAL: That conference believes that adequate safety nets should be put in place by NHSE to ensure there are no major system breakdowns when national IT systems and processes are changed, especially bearing in mind the problems that general practice has encountered with regard to major disruptions caused by Capita and the future introduction of the replacement to the Exeter system.
163  AYRSHIRE AND ARRAN: That conference in recognising the increased team approach to the care of patients calls for a single unified electronic health care record used across all disciplines.

164  WORCESTERSHIRE: That conference has no confidence in the current plans to impose e-referral on general practice in England.

**EDUCATION AND TRAINING**

165  THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:
That conference acknowledges the results of the GMC trainers survey, particular with reference to GP trainers working beyond their rostered hours more often than any other specialty, and calls on GPC to work with relevant stakeholders to urgently address this to prevent GP trainer burnout to the detriment of GP training and GP workforce.

166  DORSET: That conference believes each CCG should consider having a formal leadership development programme in order to upskill newer GPs to be up to the job of working for the CCG.

**REGULATION**

167  NORFOLK AND WAVENEY: That conference asks GPC to negotiate changes so that non-GPs can safely undertake safeguarding leadership posts for children and vulnerable adults in general practice.

168  NORTH WALES: Conference calls for compulsory annual appraisal to be set aside and a more reasonable expectation of two appraisals in each revalidation cycle to be introduced.

**DISPENSING**

169  BEDFORDSHIRE: That conference:
(i) believes that dispensing practices should not lose dispensing rights simply because a pharmacy opens in the area, and
(ii) calls on GPC to negotiate that practices should be given the opportunity to continue to dispense and to compete with pharmacists on a level playing field.

170  GLASGOW: That conference calls on GPC to end the unfairness that allows HBs to easily remove the dispensing contract from GP practices.

171  SOMERSET: That conference believes that the pharmaceutical needs assessment process is not fit for purpose and that the ‘unforeseen benefit’ clause allows applications to be granted offering minimal service improvement that have been made for purely commercial purposes. [Supported by GLOUCESTERSHIRE]

172  SHROPSHIRE: That conference calls for an urgent review of the reimbursement system for dispensing doctors in England, particularly clawback which assumes a significantly discounted purchase price whereas the vast majority of drugs are no longer discounted or are priced above tariff, and which creates perverse incentives when prescribing.
173 WIRRAL: That general practice training becomes less focussed on consultation skills/communication skills and more focussed on solid clinical skills and knowledge.

174 COUNTY DURHAM AND DARLINGTON: That conference calls upon the RCGP to:
(i) scrap the existing format of the MRCGP
(ii) replace it with a more flexible format tailored to the learning needs of individual registrars that encourages GP recruitment and relies more on work place based assessments.

175 WIRRAL: That GP training is valued and assessed in the same way as hospital specialist training.

176 WIRRAL: That GP training now lasts four years following the FY2 year and includes mandatory rotations in A&E, paediatrics, obs and gynaec and psychiatry.

177 NORFOLK AND WAVENEY: That conference is concerned regarding the future NHS medical workforce and:
(i) believe that an urgent review of admission criteria to medical school is needed with the evidence of soaring dropout rates both before and after graduation
(ii) ensure there are sufficiently funded foundation year places within general practice
(iii) that GP education is given the highest priority in resources and support.

178 NOTTINGHAMSHIRE: That conference understands that the amount of SIFT tariff paid to general practice when supervising a student is 50% less in general practice compared to same work in hospitals. If this is proven to be the case, we urge GPC to put pressure on for this sum to be uplifted.

179 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:
That conference calls upon GPC to ensure GP training will mirror any changes made to GPs working structure by new contracts and guarantee that its implementation must involve GP trainee’s subcommittee representation to:
(i) ensure hospital jobs offer training and not just service provision
(ii) mould training within GP practice to reflect changes to GP priorities
(iii) ensure physicians assistants do not take away training opportunities
(iv) limit the role of physicians assistants so that they do not provide doctor-level care on the cheap, leaving trainees to refer on their behalf and to bear responsibility for their practice.

180 THE GPC: That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:
That conference notes the significant gap between the proportion of GPs who are academics or who undertake academic activity and the proportion of the consultant workforce who are academics. Conference believes that:
(i) the UK government’s objective of recruiting more GPs will require more teaching and training in primary care settings
(ii) improving patient care in primary care will require more medical research activity to be undertaken in primary care, and
(iii) that both these objectives require more academic general practitioners and more academic activity by GPs.
That conference therefore calls for:
(i) increased opportunities for GPs to become involved in academia during their training and post-CCT, including expansion in the number of NIHR in practice fellowships and doctoral research fellowships awarded to GPs
(ii) improved pay arrangements for academic GPs; to ensure remuneration of GP academics post CCT recognises their completion of training status and is no less favourable than for their full time equivalent clinical colleagues

(iii) access to the academic pay premia for GP trainees, who unlike hospital trainees, extend their training by one year when undertaking academic clinical fellowships and are disadvantaged by the current terms

(iv) greater transparency on the awarding of ‘senior academic GP’ status and through that access to clinical excellence awards, including for GP educators

(v) GPC to support MASC in its work addressing these issues.

181 DONCASTER: That conference requires GPC to lobby the Department for Education to develop in partnership with the BMA a self-care curriculum to be taught in state schools enabling the discovery of principles of care for oneself and others during periods of illness.

PRIMARY AND SECONDARY INTERFACE

182 WEST PENNINE: That conference believes the current situation in some A&E departments where paramedics are delayed having to queue to hand over patients, is unacceptable and compromises patient safety in the community, potentially putting lives at risk due to delays in paramedic response time.

183 MERTON: That conference:
(i) is appalled by NHSE’s shortfall in its commissioning of adequate physical health management for all psychiatric patients under almost exclusive specialist care
(ii) calls upon NHSE to commission adequate physical health management services for such patients including dyslipidaemia, impaired glucose tolerance and smoking cessation.

184 DEVON: That conference asks the GPC to negotiate a direct enhanced service contract for intermediate care.

185 CENTRAL LANCASHIRE: That conference believes the procurement of individual service elements from different service providers leads to a fragmented health service, puts extra pressure on GPs in coordinating care between providers and is against the spirit of integration and partnership being promoted by NHSE.

186 HERTFORDSHIRE: That conference recognises the substantial transfer of work from secondary care to GPwSI and insists that:
(i) funding for this follows the work from secondary into primary care
(ii) GPwSI are provided with a career pathway that includes support and continuing medical education.

187 DORSET: That conference believes it should be a professional obligation for hospital doctors to introduce themselves by full name and job title when answering bleeps to assist communication with GPs.

188 NORFOLK AND WAVENEY: That conference asks GPC to use all powers available to mitigate the detrimental effect on in-hours general practice that the imminent collapse of ambulance services and A&E services within acute trusts may cause.

189 CONFERENCE OF NORTHERN IRELAND LMCs: That conference insists that a mechanism must be established to enable services to be directly commissioned from GP Federations.
190 COVENTRY: That conference demands that the national GP contract is altered to facilitate the sharing of individual GP expertise between practices for the clinical benefit of patients without using GPwSI mechanisms which are overly onerous and insulting to the professionalism of such individuals.

191 LIVERPOOL: That conference deplores the STP efficiency plans, the development of accountable care systems and placed based care initiatives as they are a stalking horse for the take over of large elements of NHS provision through privatisation.

192 LANCASHIRE PENNINE: That conference believes that true collaboration between hospitals and primary care can only happen if doctors are familiar with each other’s work and calls on GPC to open discussions with stakeholders with a view to hospital doctors being required to spend a session in a GP surgery as part of their revalidation cycle.

193 DERBYSHIRE: In this increasingly litigious society we demand that 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.

194 MORGANNWG: That Conference believes GPs are better placed to assess the acuity of USC referrals and that Secondary care colleagues who have not yet assessed our patients should be prevented from downgrading USC referrals.

SECRETARY OF STATE/GOVERNMENT POLICY

195 NOTTINGHAMSHIRE: That conference believes some CCGs may be putting prescribing cost savings ahead of appropriate clinical behaviour and so, to avoid a post code lottery, suggests that the:
   (i) prescribing budgets for all CCGs nationally are taken over by NHSE and costs are met centrally
   (ii) government fully fund the cost of clinical pharmacists for all GP practices.

196 CORNWALL AND ISLES OF SCILLY: That conference believes that the political token gestures of the last few years have failed to halt the collapse of primary care and demands talks on urgent remedial measures.

197 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.

198 AVON: That conference deplores 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.

199 NORTH YORKSHIRE: That conference believes it is unethical for the government to fuel demand for GP appointments with rhetoric around 8-8 working, whilst ensuring other much needed services are rationed through deliberate underfunding of CCGs (or equivalent), and insists the government:
   (i) end this insistence of 8-8 working regardless of need
   (ii) start a national public debate about what the NHS can afford rather than rationing by stealth.
200 SUFFOLK: The NHS poster campaign concerning availability of GP appointments over the Christmas 2017 period belied the reality of what was actually available, and caused confusion by inappropriately inflating patient expectations. Conference believes that, in a system beyond breaking point, a reality check is needed and requests GPC to undertake that reality check with NHSE.

201 NORTH YORKSHIRE: That conference believes that although local decision making has its place, government policy of devolving ever increasing responsibility to CCGs (or equivalent) has removed the 'National' from the NHS, and that any further devolution will only exacerbate this unacceptable postcode lottery, and instructs the GPC / BMA to pursue 'National' guidance regarding access to common treatments.

202 NORTH AND NORTH EAST LINCOLNSHIRE: That conference demands that no structures of 'accountable care organisations' are introduced in the UK without appropriate public consultation. (Supported by Hull and East Yorkshire)

203 DEVON: That conference calls for the government to immediately relax all rules regarding annual NHS financial targets that currently constrain NHSE and CCGs so enabling proper long term NHS planning and realistic investment that will reap clinical rewards over a longer time scale.

204 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.

205 NORTH YORKSHIRE: That conference believe that much of the ethos and direction of travel for the NHS in all sectors comes from the Secretary of State for Health, Jeremy Hunt, and expresses a vote of no confidence in his leadership and support for patients or staff working in and reliant on the NHS.

206 LAMBETH: That conference:
   (i) deprecates the consumerisation of the NHS
   (ii) asks the BMA to collect and collate instances of consumerisation and publicise where this is happening

207 DEVON: That conference calls for the GPC to bravely start the debate about a possible 'opt in' to resuscitation status for patients after a certain age to reduce the confusion, bureaucracy and additional workload associated with the current 'opt out' system.

208 DEVON: That conference calls for the government to bravely bring forward legislation that will immediately undo the purchaser / provider constraints of the Health and Social Care Act 2012 where these currently impede development of sensible changes to the healthcare system.

209 DEVON: Concerning the development of large retirement communities conference asks the GPC to use their influence with the government to adapt planning legislation to ensure GP practices are consulted early in the planning stages.
210  DEVON: That conference calls for the government to mandate CCGs to implement a capitated budget for a locality abolishing the current tariff based system.

211  AYRSHIRE AND ARRAN: That conference believes that reckless alcohol and recreational drug use to the point of incapacitation, is placing an unacceptable burden on a cash strapped NHS. Legislation is now required to render such behaviour liable to prosecution.

212  SEFTON: That conference in the light of the failure of the Chancellor of the Exchequer to provide adequate funding to meet the urgent needs of the NHS, calls upon the GPC to secure an alliance with representatives of Hospital doctors to campaign for the immediate halt to the implementation of the costly Health and Social Care Act Reforms etc and for the funding and resources bound up with these to be re-directed to frontline primary and secondary care.

213  BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference believes that there should be further debate involving general practitioners about the eventual possibility of assisted dying (in this country) in specific cases where patients have a terminal prognosis of less than 6 months and a predetermined wish to die with dignity.

214  DEVON: That conference calls for the government to cease relaxations made to RTT targets as this has led to increased patient wait with an increase in GP consultations whilst waiting.

GPC/GPDF

215  GLOUCESTERSHIRE: That conference declares the primary goal of the GPC and BMA is to protect the status of the NHS as an entirely publicly delivered and free at the point of use service and, further to this, that:
   (i) any form of co-payment or payments for services by patients, even those not provided by the NHS, raises the spectre of a two tier system and must be prohibited
   (ii) all motions debated at conference should be assessed with reference to how they may be perceived or reported by journalists
   (iii) the status of the NHS must be protected and promoted, even where this is prejudicial to the financial interests of general practices and the terms and conditions under which GPs work as independent contractors.

216  AVON: That conference:
   (i) congratulates the new chair of GPDF for his constructive and facilitative approach towards much needed reform of the organisation
   (ii) requests that GPDF funding is used to resource the development of regional support networks for LMCs by LMCs across the UK, as a matter of urgency.

217  NORTH YORKSHIRE: With the current uncertainty over future conference dinner arrangements and the potential for loss of a significant income stream from donations to the Cameron Fund, conference respectfully requests GPDF in future years to make an appropriate donation annually to the Cameron Fund on its behalf.

218  DONCASTER: That conference requires GPC to negotiate a clause in the PMS standard contract mandating contractors to be members of an LMC by virtue of payment of a LMC levy.
219 WIRRAL: That general practice is rebranded and redefined with a clear role.

220 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands GPC reviews its own structure and membership to produce a leaner and cost effective organisation.

221 DERBYSHIRE: That conference is deeply disappointed by the wilful 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.

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

**INDEMNITY**

223 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers that GP members need urgent clarification on indemnity changes, as per Mr Hunt’s offer. What are GP members to do and when? A request for a timeline and organisation specific information eg MOU.

224 SURREY: That conference demands that costs associated with indemnity provision prior to the introduction of the State supported GP Indemnity Scheme are met by the Scheme itself.

**LMC**

225 AVON: That conference instructs the GPC to respond to the challenges and threats to the future of LMCs by setting up a working group to review the future statutory role of LMCs and to report back to conference with recommendations to ensure the survival of LMCs.

226 DORSET: That conference believes each LMC should consider having a plan for recruiting and upskilling more inexperienced members in order to succession plan for the future.

227 DERBYSHIRE: That conference notes that whilst millions are being spent on management consultants for STPS, LMC 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 STPS.

**CONTRACTS**

228 DONCASTER: That conference requires GPC to negotiate a clause in the national ACO Standard Contract mandating contractors to be members of an LMC by virtue of payment of a LMC levy.

229 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges GPC to negotiate with NHSE a commitment to support practices during winter with ring fenced funding for a ‘winter resilience scheme’. This will enable practices to cope with the increasing demand on services over the winter period and will have a beneficial outcome for acute sector.
230 DEVOH: That conference asks the GPC to negotiate a direct enhanced service contract for an enhanced level of care provision for patients in nursing and residential care.

231 DERBYSHIRE: That conference instructs GPC to meet with NHSE to ensure that there are no unfunded contractual gaps occurring as a result of STPs moving services from secondary care to primary care.

232 BEDFORDSHIRE: That conference believes that change and collaborative working should take place when it is the right local solution to local problems and that it should not be driven top-down by a political change.

233 MORECAMBE BAY: That conference believes that, in the event of a salaried model of general practice ever being discussed as a large-scale solution within the NHS, GPC should take a non-negotiable stance on terms and conditions being under standard NHS contracts with total length of service, including as an independent contractor, being recognised.

234 WIRRAL: That the long term view is that general practitioners become salaried (rather than largely self employed) and on the same pay scale and pension rights as NHS hospital consultants.

235 GREENWICH: That conference:
   (i) believes that funding for the current directed enhanced services is vital for the ongoing stability of practices
   (ii) calls upon GPC to obtain an assurance from NHSE that the DES funding will continue for the next three years without additional onerous requirement.

236 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, 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.

237 WORCESTERSHIRE: That conference demands that the national GP contract is altered to facilitate the sharing of individual GP expertise between practices for the clinical benefit of patients without using GPwSI mechanisms which are overly onerous and insulting to the professionalism of such individuals.

238 MID MERSEY: That conference is concerned that published GP earnings are not adjusted to take into account actual hours of work, which for full time GPs are typically greatly in excess of 40 hours per week, and asks GPC to publish adjusted figures for baseline income to exclude hours worked 'overtime' (ie those in excess of 40 hours per week for full time GPs).

239 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference makes funding available directly to practices on a per capita basis, so that individual practices can decide who and how to deploy their workforce.

240 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 taken 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. Therefore, conference demands that GPC negotiate a reinstatement of the DDRB recommendations.
241 CONFERENCE OF NORTHERN IRELAND LMCs: That conference believes that the GMS contract is no longer fit for purpose.

242 SOUTH STAFFORDSHIRE: That conference demands the government ends its policy of ‘privatisation by stealth’ and looks again at the tendering process to make it open, transparent and fit for purpose, in view of the track record of private companies tendering for NHS work, offering the earth on a shoestring budget then failing to deliver, which can end in distress for patients or worse, in court.

243 WIRRAL: That the title general practitioner or GP is obsolete and that GPs should be renamed consultants in primary care.

244 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.

245 SHROPSHIRE: That conference deplores the persistent denigration of the expertise, experience and skill of UK GPs by government and media and asks for the amendment of the medical Act to affirm their status as specialists in general practice.

246 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urges the GPC to support practices by negotiating within the contract regulations, by which, practices can charge patients a defined nominal fee for DNA appointments. That can be funded back to patients when they attend.

247 SOUTHWARK: That conference deplores the fact that organisations which are well versed in tendering, and often own many practices, are usually more advantaged than local GPs in winning tenders.

248 LAMBETH: That conference calls upon the GPC to work to ensure that collaborative arrangements are more stringently enforced so that outside bodies pay GPs for reports and other non-NHS/extra-contractual work.

249 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.

NATION SPECIFIC

250 CONFERENCE OF NORTHERN IRELAND LMCs: That conference welcomes the reintroduction of the retainee scheme in Northern Ireland but insists on some protection for practices against the impact of sickness and maternity leave.

251 HULL AND EAST YORKSHIRE: That conference is concerned that NHS England is yet again trying to introduce an initiative such as 111 being allowed to book directly in to GP appointments without appropriate due diligence. We demand that no such initiative is introduced nationally before publishing the analysis from the pilot sites. (Supported by North and North East Lincolnshire)

252 SUFFOLK: The GP Forward View as currently implemented continues to fail practices. Although it claims to aspire to return general practice to 11% of healthcare expenditure the actual figure remains stubbornly close to 7% while practice workload continues to spiral. GPC is instructed to change its negotiating tactic to reverse this trend and ultimately to dissociate itself from the Forward View if this cannot be achieved.
253  BIRMINGHAM: That conference believes the outcome of the 2018 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.

254  CONFERENCE OF NORTHERN IRELAND LMCs: That conference calls for regional out of hours GP rates to be uplifted as the rate has been unchanged in NI since 2004.

255  CONFERENCE OF NORTHERN IRELAND LMCs: That conference instructs GPC to negotiate with the Department of Health to review the current policy of travel/transport expenses for medical students on GP placement in Northern Ireland to bring them in line with the rest of the UK.

256  MANCHESTER: That conference believes GPC should ensure that GP providers in Greater Manchester have a defined role in Accountable Care System strategy and development.

257  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.

258  MORECAMBE BAY: That conference believes that GPC should strongly advise NHSE and STPs that CCGs are not the providers of general practice.

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

260  COVENTRY: That conference demands that NHS England monitor CCGs to ensure that redistributed PMS monies are spent within primary care after consultation with the appropriate LMC and that they are spent within a timely manner, rather than being allowed to accumulate over several years.

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

**REGULATION**

262  MID MERSEY: That conference expects that NHS Performance Investigations in general practice should be conducted according to the published NCAS guidance ‘How to conduct a local performance investigation’.

263  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.

264  MID MERSEY: That conference believes that the CQC’s efforts in ‘trying to improve its consistency and judgement as regards practice ratings’ is not fit for purpose and demands an end to this rating system which leads to low morale, jeopardising the very future of general practice.

265  NORTHAMPTONSHIRE: This conference insists that where formal CQC inspection may be reduced in frequency for good and outstanding practices this should not be replaced by onerous constant supervision.
266 CORNWALL AND ISLES OF SCILLY: That conference believes that the structure of the General Medical Council should reflect the proportion of UK doctors in general practice and should always include at least one non-academic practicing GP.

267 GLASGOW: That conference is concerned that the GMC, which is funded by doctors subscriptions, has said that it is best placed to take on the role of regulator for physician associates and calls on GPC to insist that the GMC focusses all its efforts upon providing a more effective and efficient regulatory process for the medical profession.

268 GLASGOW: That conference is concerned that the change to legal chairs MPTS hearing panels will result in reduced medical expertise within the panel and may degrade the decision making process.

269 CLEVELAND: That conference mandates the GPC to work with the relevant bodies to produce UK – wide guidance on the minimum number of sessions of clinical GP work require for:
   (i) appraisal
   (ii) revalidation
   (iii) performers list registration.

270 LINCOLNSHIRE: That conference requests that GPC UK negotiates a single GP contract for the whole UK, which makes all four nations equal and sustainable.

271 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference to debate that CCG board members should not be exclude GP members from the voting process if there practice are members of a federation.

272 AVON: That conference welcomes the reduction in GMC registration fees and is a welcome rain drop in the baron desert of primary care finances.

273 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference supports GPs and protects them from the ever increasing regulators and meddling bodies which now include: NHSE, CCG, CQC, Trading Standards, Councils. Will it be Ofsted next?

274 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.

275 North Wales: Conference calls for compulsory annual appraisal to be set aside and a more reasonable expectation of two appraisals in each revalidation cycle to be introduced.

276 AYRSHIRE AND ARRAN: That conference notes the barrier that appraisal is presenting to retention of older and sessional doctors and calls for a simplification of the process with the focus on a combination of a CPD log and reflective case studies replacing the formal audit and SEA process.

277 DERBYSHIRE: That conference believes that, contrary to NHSE policy, an individual GP should be able to have the same appraiser for more than three years and asks GPC to address this with NHSE accordingly.
SESSIONAL GPs

278 BRO TAF: That conference asks GPC to negotiate a revised and more realistic contract for salaried GPs, given the increasing disparity between principals and salaried GPs since the rosy days of the 2004 contract.

279 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference has a national and local locum bank made available to practices directly.

WORKLOAD

280 NOTTINGHAMSHIRE: That conference sees a fundamental flaw in some CCGs ‘levelling up’ on enhanced services payments to redress historical discrepancies in core payments. This has seen some practices providing enhanced services for next to no payment due to being PMS and on historically higher payments per patient. We would like to see GPC address this with NHSE and CCGs with a view to establishing the clear principle that non-core work is adequately funded separately.

281 SANDWELL: The GPC has been mandated to produce a comprehensive list of what is, and what is not, included in the GP core contract. Conference holds:
(i) that they have not so done and
(ii) calls on the GPC to compile a comprehensive, itemised list within six months from this date.

282 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands GPC to finally negotiate a definition of the core responsibilities of a GP.

283 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) recognises that the variation in quality of out-of-hours GP service provision across the country amounts to a ‘postcode lottery’
(iv) calls for out-of-hours GP services to be properly funded so as to maintain adequate rota-fill
(v) calls for the provision of commonality of computer system between in-hours and out-of-hours GP services country-wide.

284 HAMPSHIRE AND ISLE OF WIGHT: That conference deplores the increased general practice workload and delayed patient care caused by the unprecedented rise in individual funding request requirements and calls upon CCGs to:
(i) limit and reduce the number of situations where individual funding must be applied
(ii) streamline the process to reduce delay for patients and the administrative burden on staff involved
(iii) stop using the process to unfairly ration care for certain patient groups to their detriment, eg the obese awaiting orthopaedic procedures for arthritis who struggle to lose weight as a result of their limited mobility.
(Supported by Bath and North East Somerset, Swindon and Wiltshire)
SANDWELL: It is now 5 years since an RCGP survey found the profession was in crisis, 3 years since the “five year forward view”, 2 years since the “GP forward view” and 2 years since the special conference of LMCs gave the GPC the task of balloting GPs on the protest measure of submitting undated resignations. Conference wants to inform the GPC that:
(i) there has been no improvement at all in general practice
(ii) there appears to be no prospect of any improvement
(iii) there is in fact further deterioration in the safety and sustainability of general practice
(iv) general practice needs emergency surgery, not an urgent prescription.

WIRRAL: That general practitioners, although mostly choosing to use services other than themselves to cover patient care at night and weekends (eg an OOH service), take back the overall responsibility for 24 hour patient care.

MID MERSEY: That conference believes that given the very substantial workload associated with the current policy that requires practices to issue almost all repeat prescriptions on a monthly basis, that GPC should commission research to estimate the cost to general practices of administering this policy and to estimate the projected savings of alternative potential timescales such as 2-monthly, 3-monthly or even 6-monthly issues of repeat scripts for appropriate medications (such as low cost generic drugs) and subsequently if found to be beneficial to explore the implementation of extended repeat prescribing timescales by practices.

NORFOLK AND WAVENEY: That conference asks GPC to negotiate changes to regulations covering travel vaccinations believing that:
(i) all travel vaccines should be taken out of GMS provision and become chargeable
(ii) that imposition of a ‘travel tax’ be levied on holiday costs to fund such a service
(iii) this is a Public Health England commissioning function
(iv) that currently it uses too much scarce practice nurse and administrative time and resource
(v) that centralised clinics for travel advice and vaccinations should be established.

CORNWALL AND ISLES OF SCILLY: That conference believes primary care can no longer be considered a safe environment for patients or for doctors.

Morgannwg: that conference is frustrated by the increasing demands from the DVLA for medical reports, medical assessments and their increasing transfer of responsibility to GPs regarding the decision of a patient’s fitness to drive whilst calling on them to remunerate GPs promptly and commensurately for the work involved.

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.
PUBLIC HEALTH

292 MORECAMBE BAY: That conference believes that, at a time of extreme pressure on general practice, GPC should take an immediate firm line with transference of work from Public Health England as their actions are causing safeguarding concerns for all patients by overburdening existing GPs.

293 AVON: That conference deplores the cuts to the public health budget in England and the consequent reduction in service provision and instructs the GPC to make representations to the government to reverse the cuts and to reinstate the services.

294 GREENWICH: That conference calls upon the GPC to work with Public Health England to stop the erosion of public health funding.

295 MORECAMBE BAY: That conference deplores the reductions in public health funds available to local authorities which results in severe cost cutting to child health services and the awarding of contracts to private healthcare providers, leading to fragmentation of patient care and diverting millions of pounds away from the frontline and into shareholders pockets.

296 AVON: That conference welcomes the English government’s announcement of a consultation on organ donation opt-out system and supports strategies to increase organ donation across the UK.

297 MID MERSEY: That conference calls for an immediate end to sanitary poverty which is unfair and unacceptable in this day and age.

FORMS AND FEES

298 CAMDEN: That conference recognises the problems regarding the increasing frequency with which law firms are requesting notes, many of which are being made incorrectly as SARS, and the administrative burden for practices attached to this, not compensated for by the small cost that practices are allowed to charge for this and:

(i) instructs the PFC to negotiate a realistic fee for this service and
(ii) with the impending implementation of GDPR, the BMA looks to revise its current advice on Access to Medical Records that will enable practices to such refuse requests made as a SARS, ensuring that the correct process (iii) is followed.

(This motion is jointly supported by Camden and Enfield LMCs)

299 HULL AND EAST YORKSHIRE: That conference calls on GPC to liaise with other relevant legal, professional and regulatory bodies and draft a nationally agreed policy on the verification of death. This should:

(i) make clear the difference between the ‘verification’ and ‘certification’ of death
(ii) replace the notions of ‘expected/unexpected death’ with ‘death where there is concern’ and ‘death where there is no concern’.

(Supported by North and North East Lincolnshire)

300 NORFOLK AND WAVENEY: That conference asks GPC to undertake negotiations with the coroner’s service to widen the range of clinicians who are legally able to sign a death certificate or cremation form.
301 COVENTRY: That conference believes that the 14 day rule for death certification should be extended to six weeks where the certifying doctor has been involved in the management of the patient’s final illness and feels able to certify the stated cause of death as true to the best of their knowledge. This would streamline the process of registration of death to ease pressure on coroners’ offices, GPs, funeral directors and bereaved families.

302 LAMBETH: That conference deplores the funding constraints associated with excess mortality and calls for more funding for health and social care.

303 LAMBETH: That conference calls for more resources for community care to enable district nurses to work effectively with practices.

304 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 obligation on practices to send a copy of the GMS1 form to NHS Digital of patients who self declare that they hold either a non UK issued EHIC card, PRC or S1 form and opposes the obligation to manually record this information in the patient’s medical record
   (iii) instructs GPC to remove this obligation during the next round of contract negotiations.

305 TOWER HAMLETS: That conference:
   (i) in tandem with existing conference policy, opposes involving general practice in checking immigration status
   (ii) calls on GPC to support practices who wish to cross out the supplementary questions (Patient Declaration for all patients who are not ordinarily resident in the UK) on the new GMS1 Form
   (iii) calls on GPC to insist on the removal of these questions from the GMS 1 Form.

306 CONFERENCE OF NORTHERN IRELAND LMCs: That conference believes that signing sick / fit notes isn’t a priority for hard pressed GPs and that this work should no longer be done by GPs.

### CONFERENCE OF LMCs

307 DERBYSHIRE: That conference acknowledges the reasons for the change to LMC conference and recognises the sterling work of the Agenda Committees, but believes the resulting system of two conferences in quick succession is costly and not fit for purpose. We call for a return to a single two day conference where day one has separate conference for the devolved nations and day two is LMC UK.

308 KENSINGTON, CHELSEA AND WESTMINSTER: That conference:
   (i) combines the devolved nation LMC Conferences and the UK Conference of LMCs into a single two day conference with the individual devolved nation conferences on day one and UK conference on day two
   (ii) reinstates the conference dinner on the evening of the first day of a two day conference.

309 DEVON: That conference calls for the combined and individual nation conferences of LMCs to take place at the same time over two consecutive days on an annual basis and are held in each of the devolved nations on a four year rotation.
310 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that a one day UK conference is too short to allow adequate debate and networking and requests that:
(i) the two day UK conference is re-instated
(ii) the one day single country conferences continue as before
(iii) any increased expenditure created by this change is met from the GPDF reserves without any increase in the voluntary levy
(iv) that the previous time of May is a more appropriate time for the conference avoiding end of year pressures for representatives and being approximately six months from the England conference.

311 SOMERSET: That conference believes that the last date for the submission of motions to this conference is unacceptably early and requires the Agenda Committee in future to set this no earlier than one month before the conference date.

312 LIVERPOOL: That conference believes that the membership of the UK conference of LMCs should:
(i) more closely represent gender spread of GPs working in each LMC area
(ii) request that LMCs consciously take these factors into account when selecting representatives to the UK Conference of LMCs.

313 DERBYSHIRE: That conference believes that a deadline for motion before Christmas for a conference in March is too early and requires the Agenda committee to review this in time for next year’s deadline for the 2019 LMC Conference.

314 GLOUCESTERSHIRE: That conference believes that the last date for the submission of motions to this conference is unacceptably early and requires the Agenda Committee in future to set this no earlier than one month before the conference date. (In support of Somerset LMC)

315 SHROPSHIRE: That conference states that general practice is the robust base of any cost-effective health service and demands that it should receive funding commensurate with its workload and that moreover approaches the EU average.

PENSIONS

316 DONCASTER: That conference requires GPC to work with the NHS Business Services Authority to arrange for pension contribution and total reward scheme statements to be sent to GP members of the NHS Pension Scheme annually.

317 DEVON: That conference calls on the GPC to negotiate with the government for a specific relaxation of tax relief rules for GPs over 50 who will incur large additional, often unexpected, tax charges due to changes in the current allowances and the unpredictability of the CPI and RPI rates.

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

319 BRO TAF: That conference feels locum GPs should not have access to the NHS pension scheme, to preserve advantage in the independent contractor status.

320 GLASGOW: That conference is dismayed that despite previous policy, GPs’ concerns about the effect of current pension regulations, have not been addressed and are seriously damaging the retention of GPs in the service.
EU NATIONS AND BREXIT

321 LEWISHAM: That conference:
(i) is concerned about the implications of Brexit on NHS staff recruitment and
retention and research activities
(ii) demands that the government honour the referendum campaign pledge
to provide extra resources for the NHS should the UK leave the EU.

322 CLEVELAND: That conference is concerned that the ongoing lack of clarity for
non-UK EU national doctors post-Brexit is contributing to the workforce crisis in
the NHS, and demands immediate action to rectify this from the UK government.

323 CONFERENCE OF NORTHERN IRELAND LMCs: That conference insists that the
GPC negotiate a special deal for NI in relation to how healthcare will be effected
by Brexit.

URGENT CARE

324 CONFERENCE OF NORTHERN IRELAND LMCs: That conference believes that NHS
111 is a major risk factor for the demise of general practice it is infectious and will
spread until it is isolated, treated and cured.

325 MORECAMBE BAY: That conference deplores the fact that GPs are having to
wait longer and longer for emergency ambulances when dealing with seriously
unwell patients in the community and calls on the GPC to highlight this issue with
ambulance authorities to lessen GPs exposure to this risk and minimise risks to
patients.

326 AYRSHIRE AND ARRAN: That conference is increasingly concerned about the
degradation of ambulance services resulting in significant delays to response
times and calls on the UK and devolved governments to address this potential
patient safety matter urgently.

327 GLOUCESTERSHIRE: That conference believes that the current arrangements for
urgent and emergency care out of hours are disjointed and ineffective and urges
GPC to press the UK and devolved governments to develop an integrated and
sustainable long-term solution. (In support of Somerset LMC)

MEDICO-LEGAL AND COMPLAINTS

328 NORFOLK AND WAVENEY: That conference seeks GPC action to mitigate the
effect on GPs caused by the culture of certain parts of the legal profession in
encouraging spurious claims against GPs which are both costly in time and
resources defending but equally damaging to morale and the doctor-patient
relationship.

329 NORFOLK AND WAVENEY: That conference believes that before direct
complaints are made to the GMC that evidence of attempts at local resolution are
documented and should become a requirement of the process.

330 MID MERSEY: That conference believes that a patient’s sexual orientation is
their private matter and asking practices to routinely record patients’ sexual
orientation is both unnecessary and intrusive.
**Conference of representatives of local medical committees**

**Standing orders**

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Conference of representatives of local medical committees

Standing orders

Conferences

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

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

Membership
3. The members of conference shall be:
   3.1 the chair and deputy chair of the conference
   3.2 365 representatives of local medical committees
   3.3 the members of the GPC UK
   3.4 9 members appointed by the Scottish GPC
   3.5 3 members appointed by the Welsh GPC
   3.6 2 members appointed by the GPC (Northern Ireland)
   3.7 2 members appointed by GPC England
   3.8 the seven elected members of the conference agenda committee (agenda committee)
   3.9 the regionally elected representatives of the GP trainees subcommittee, together with its immediate past chair
   3.10 the elected members of the sessional GPs subcommittee of the GPC.

Representatives
4. All local medical committees are entitled to appoint a representative to the conference.

5. The agenda committee shall each year allocate any remaining seats for representatives amongst LMCs. Allocation of additional seats shall be done in such a manner that ensures fair representation of LMCs according to the number of GPs they represent. Each year the agenda committee shall publish a list showing the number of representatives each LMC is entitled to appoint and the method of allocating the additional seats.

6. Local medical committees may appoint a deputy for each representative, who may attend, and act at the conference if the representative is absent.

7. Representatives shall be registered medical practitioners appointed at the absolute discretion of the appropriate local medical committee.

8. The representatives appointed to act at the annual conference shall continue to hold office from 15 January for 12 months, unless the GPC is notified by the relevant local medical committee of any change.
Observers
9. Local medical committees may nominate personnel from their organisations to attend conference as observers, subject to 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 as amended or by equivalent provisions in Scotland, Wales, and Northern Ireland.
11. ‘Members of the conference’ means those persons described in standing order 3.
12. ‘Representative’ or ‘representatives’ means those persons appointed under standing orders 4 to 8, and shall include the deputy of any person who is absent.
13. ‘The conference’, unless otherwise specified, means either an annual or a special conference.
14. ‘As a reference’ means that any motion so accepted does not constitute conference policy, but is referred to the GPC UK to consider how best to procure its sentiments.

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

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

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

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

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

20. In two parts; the first part ‘Part I’ being those motions which the agenda committee believe should be debated within the time available; the second part ‘Part II’ being those motions covered by 25 and 26 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording. If any local medical committee submitting a motion included in Part II of the agenda objects in writing before the deadline for items to be considered for the supplementary agenda, the transfer of the motion to Part I of the agenda shall be decided by the conference during the debate on the report of the agenda committee.

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

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

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

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

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

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

27. ‘C’ motions: Prior to the conference, a ballot of representatives shall be conducted to enable them to choose motions, ‘C’ motions, amendments or riders for debate. Using only the prescribed form, which must be signed and received by the GPC secretariat by the time notified for the receipt of items for the supplementary agenda, each representative may choose up to three motions, amendments or riders to be given priority in debate. Chosen motions must receive the vote of at least ten representatives. The first three motions, amendments or riders chosen, plus any others receiving the vote of at least twenty representatives, shall be given priority.
28. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 44, 45, 46, 47 and 52 shall not apply and the debate shall be held in accordance with standing order 54.

29. Identifying, by enclosing within a ‘black box’, motions received from those local medical committees which have failed to meet their quotas to the General Practitioners Defence Fund Ltd. Before effecting this, one year’s grace must be given to such local medical committees, who must have received warning that, unless the deficit is made up by 1 May after the following year, they would become subject to the ‘black box’ procedure.

Other duties of the agenda committee include:
30. Recommending to the conference the order of the agenda; allocating motions to blocks; allocating time to blocks; setting aside reserved periods, as provided for in standing orders 59 and 61, and overseeing the conduct of the conference.

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

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

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

34. No seconder shall be required for any motion, amendment or rider submitted to the conference by the GPC UK, a local medical committee, or the joint agenda committee, or for any composite motion or amendment produced by the agenda committee under standing order 22. All other motions, amendments or riders, after being proposed, must be seconded.

35. No amendments or riders will be permitted to motions debated under standing order 28.

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

37. A member of conference shall address the chair and shall, unless prevented by physical infirmity, stand when speaking.

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

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

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

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

43. 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.

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

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

46. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 44, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.

47. 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 UK and the mover of the original motion shall have the right to reply to the debate before the question is put.

48. 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.

49. Proposers of motions shall be given prior notice if the GPC intends to present an expert opinion by a person who is not a member of the conference.

50. 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.

51. Any motion, amendment or rider referred to the conference by the joint agenda committee shall be introduced by a representative or member of the body proposing it. That representative or member may not otherwise be entitled to attend and speak at the conference, neither shall he/she take any further part in the proceedings at the conclusion of the debate upon the said item, nor shall he/she be permitted to vote. In the absence of the authorised mover, any other member of the conference deputed by the authorised mover may act on their behalf, and if there is no deputy the item shall be moved formally by the chair.
52. 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.

53. In a major issue debate the following procedures shall apply:
   53.1 the agenda committee shall indicate in the agenda the topic for a major debate
   53.2 the debate shall be conducted in the manner clearly set out in the published agenda
   53.3 the debate may be introduced by one or more speakers appointed by the agenda committee who may not necessarily be members of conference
   53.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
   53.5 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.
   53.6 the Chair of GPC UK or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
   53.7 at the conclusion of the debate the introductory speakers may speak for no longer two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
   53.8 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

54. 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.

55. Motions will not be taken earlier than the times indicated in the schedule of business included in the agenda committee’s report.

56. ‘Soapbox session’:
   56.1 A period shall be reserved for a ‘soapbox’ session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
   56.2 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.
   56.3 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.
   56.4 GPC (UK) members shall not be permitted to speak in the soapbox session.

57. 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.

58. Motions prefixed with a letter ‘A’, (defined in standing orders 25 and 26) 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.

59. One period, not exceeding one hour, may be reserved for representatives of LMCs to ask questions of the GPC executive teams.
Motions not published in the agenda
60. Motions not included in the agenda shall not be considered by the conference except those:
   60.1 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
   60.2 relating to votes of thanks, messages of congratulations or of condolence
   60.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association
   60.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned
   60.5 prepared by the agenda committee to correct drafting errors or ambiguities.
   60.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions
   60.7 that may arise from a major issue debate; such motions must be received by the agenda committee by the time laid down in the major issue debate timetable published under standing order 54.

Quorum
61. 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
62. A member of the conference, including the chair of the GPC, 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.

63. 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
64. Except as provided for in standing orders 72 (election of chair of conference), 73 (election of deputy chair of conference), 75 (election of seven members of the agenda committee) and 76 (election of ARM representatives), only representatives of local medical committees may vote.

   Majorities
65. Except as provided for in standing order 48 and 49 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:
   65.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC structure, or
   65.2 a decision which could materially affect the GPDF Ltd funds.

66. 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

67. Chair

67.1 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. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.

67.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda of the conference with any election to be completed by the time indicated in the Agenda. 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.

68. Deputy chair

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

68.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda with any election to be completed by the time indicated in the Agenda. 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.

69. Seven members of the General Practitioners Committee UK

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

69.2 Only representatives shall be entitled to vote.

69.3 Nominations, election statements and photographs must be received by the GPC office seven working days before the start of the conference.

69.4 Nominees may submit an election statement of no more than 50 words, excluding numbers and dates in numerical format, in a manner and format which will be specified by the Agenda Committee (that format being specified one calendar month before the start of conference). Recognised abbreviations count as one word.

69.5 Nominees may also submit a photograph in a format specified by the Agenda Committee (that format being specified one calendar month before the start of conference).
69.6  All nominees shall have the opportunity to take part in any hustings arranged by the agenda committee.

69.7  All lists of candidates, in whatever format, shall be in random order.

69.8  Elections, if any, will take place at conference and be completed by the time indicated in the Agenda.

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

70. Seven members of the conference agenda committee

70.1  The agenda committee shall consist of the chair and deputy chair of the conference, the chair of the GPC UK and seven members of the conference, not more than one of whom may be a sitting member of the GPC UK. In the event of there being an insufficient number of candidates to fill the seven seats on the agenda committee, the chair shall be empowered to fill the vacancy, or vacancies, by co-optation 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.

70.2  The chair of conference, or if necessary the deputy chair, shall be chair of the agenda committee.

70.3  Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by the time indicated in the Agenda. Elections, if any, will take place at conference and be completed by the time indicated in the Agenda. 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.

70.4  The result of the election to the agenda committee shall be published after the result of the ARM election of GPC UK members is known.

70.5  The two members of the agenda committee to be appointed to the joint agenda committee in accordance with article 53 of the BMA’s Articles of Association shall be the chair of the conference and the chair of the GPC UK.

71. The representatives allocated to represent general practice at the BMA Annual Representative Meeting shall be members of the BMA both at the time of their annual appointment/election and throughout their term of office and shall comprise:

71.1  the chair and deputy chair of conference, if eligible

71.2  the chair of the GPC UK, if eligible

71.3  sufficient members of conference to fill the allocation of seats, elected on a regional basis in advance of conference by those members of the conference who are members of the BMA

71.4  should there be vacancies after the regional elections these shall be filled by the GPC UK from the unsuccessful candidates standing in those elections.

72. Three trustees of the Claire Wand fund

72.1  Nominations may be made only by representatives, and a representative may make not more than one nomination. Any registered medical practitioner who is, or has been, actively engaged in practice as a general medical practitioner under the National Health Service Acts, whether a member of the conference or not, is eligible for nomination.

72.2  Nominations must be handed in on the prescribed form before the time indicated in the Agenda. Elections, if any, will take place at conference and be completed by the time indicated in the Agenda. Only representatives in attendance at the conference may vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers.

72.3  Trustees will be elected on a triennial basis for a period of three years, to run from the termination of the next ARM.
Dinner committee
73.1 At each conference there shall be appointed a conference dinner committee, formed of the chair and deputy chair of the conference and the chair of the GPC, to take all necessary steps to arrange for a dinner to be held at the time of the following annual conference, to which the members of the GPC, amongst others, shall be invited as guests of the conference.

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

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

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

Distribution of papers and announcements
77. 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.

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

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

No smoking
80. Smoking or vaping is not permitted within the building during the conference.

Chair’s discretion
81. 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
82. Minutes shall be taken of the conference proceedings and the chair shall be empowered to approve and confirm them.