



Conference of Representatives of Local Medical Committees Agenda

Tuesday 19 March at 2.00pm and Wednesday 20 March 2019 at 9.00am



Conference of Representatives of Local Medical Committees

Agenda

To be held on

Tuesday 19 March at 2.00pm and Wednesday 20 March 2019 at 9.00am

At the ICC Belfast, 2 Lanyon Place, Belfast BT1 3WH

Chair Mark Corcoran (Avon)

Deputy Chair Katie Bramall-Stainer (Hertfordshire)

Conference Agenda Committee

Mark Corcoran (Chair of Conference)

Katie Bramall-Stainer (Deputy Chair of Conference)

Richard Vautrey (Chair of GPC UK)

Uzma Ahmad (Walsall)

Haldane Maxwell (Ayrshire)

Rachel McMahon (Cleveland)

Shaba Nabi (Avon)

Anthony O'Brien (Devon)

Frances O'Hagan (Southern NI)

Elliott Singer (Waltham Forest)

NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 8 January 2019. Although 8 January 2019 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 conference staff lead – Catharina Ohman (cohman@bma.org.uk) – 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 GPC UK 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 GPC UK is prepared to accept without debate as a reference to the GPC shall be prefixed with the letters 'AR'.

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

Attached is a ballot form for chosen motions. The ballot closes at **noon on Thursday 14 March 2019**.

LMC CONFERENCE ELECTIONS

The following elections will be held on Tuesday 19 and Wednesday 20 March 2019.

Chair of conference

Chair of conference for the session 2019-2020 (see standing order 67) – nominations to be submitted no later than **10.00am Wednesday 20 March**.

Deputy chair of conference

Deputy chair of conference for the session 2019-2020 (see standing order 68) – nominations to be submitted no later than **1.00pm Wednesday 20 March**.

Seven members of the GPC

Seven members of the GPC for the session 2019-2020 (see standing order 69) – nominations to be submitted no later than **12.00pm Tuesday 12 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 2019-2020 – nominations to be submitted no later than **1.00pm Wednesday 20 March**.

Seven members of UK conference agenda committee

Seven members of the UK conference agenda committee for the session 2019-2020 (see standing order 70) – nominations to be submitted no later than **1.00pm on Wednesday 20 March**.

Schedule of business

Tuesday 19 March 2019

| Item | Time |
|---|-------|
| Opening business | 14.00 |
| Report by the Chair of GPC UK | 14.20 |
| Report by the Chair of Northern Ireland GPC | 14.40 |
| Workforce | 14.50 |
| Public Health | 15.10 |
| Information governance | 15.20 |
| General Data Protection Regulation (GDPR) | 15.30 |
| Soapbox | 15.50 |
| Report by the Chair of Sessional GPs subcommittee | 16.15 |
| GPs working in sessional roles | 16.25 |
| Report by the Co-chairs of GP Trainees subcommittee | 16.35 |
| Education and training | 16.45 |
| Performance | 17.05 |
| Close | 17.30 |

Wednesday 20 March 2019

| Item | Time |
|---|-------|
| Brexit report by Paul Laffin, BMA Public Affairs Manager (European Union) | 09.00 |
| Brexit | 09.10 |
| Prescribing | 09.30 |
| Dispensing | 09.40 |
| Contract negotiations | 09.50 |
| Partnerships | 10.10 |
| Report by the Chair of GPDF | 10.30 |
| GPC/GPDF | 10.40 |
| LMCs | 10.50 |
| GMC | 11.00 |
| Funding | 11.10 |
| Collective working plenary | 11.30 |
| Breakout sessions | 12.10 |
| Lunch | 13.00 |
| Charities Dain Fund Claire Wand Fund Cameron Fund Annual General Meeting | 14.00 |
| Continuity of care | 14.10 |
| Integrated care and working at scale | 14.20 |
| Primary/secondary care interface | 14.30 |
| Online GP services | 14.40 |
| Commissioning and service development | 14.50 |
| Report by the Chair of Scottish GPC | 15.00 |
| Report by the Chair of GPC Wales | 15.10 |
| Question the UK chairs | 15.20 |
| Pensions | 15.40 |
| Regulation | 15.50 |
| Chosen motions | 16.00 |
| And finally ... | 16.20 |
| Close | 16.30 |

OPENING BUSINESS**14.00****RETURN OF REPRESENTATIVES**

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

STANDING ORDERS

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

REPORT OF THE AGENDA COMMITTEE

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

ANNUAL REPORT**14.20**

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

REPORT BY THE CHAIR OF GPC NORTHERN IRELAND**14.40**

- 5 RECEIVE: Report by the Chair of GPC Northern Ireland, Dr Alan Stout.

WORKFORCE**14.50**

- * 6 AGENDA COMMITTEE TO BE PROPOSED BY SUFFOLK: That conference mindful of the appalling statistics and circumstances of doctor suicides, charges GPC with:
- (i) raising the issue of GP suicide with all major stakeholders to seek better understanding of any preventable triggers and adverse drivers that lie within stakeholders' influence, in order to seek their removal where possible
 - (ii) lobbying government to adequately resource proper psychological support systems for all GPs, including GPs who are on parental or sickness leave or who are out of work, in order to prevent occupation related mental distress developing, rather than waiting to treat it once established
 - (iii) pressing for proper NHS funded coaching and supervision services to be made available to all GPs as standard
 - (iv) sourcing or developing an appropriate short survey tool to measure and classify work related stress amongst GPs.
- 6a SUFFOLK: That conference mindful of the appalling statistics and circumstances of doctor suicides, charges GPC with:
- (i) raising the issue of GP suicide with all major stakeholders to seek better understanding of any preventable triggers and adverse drivers that lie within stakeholder's influence, in order to seek their removal where possible
 - (ii) lobbying government to adequately resource proper psychological support systems for all GPs, including GPs who are on parental or sickness leave, or who are out of work – in order to prevent occupation related mental distress developing, rather than waiting to treat it once established
 - (iii) pressing for proper NHS funded Coaching and Supervision services to be made available to all GPs as standard.

- 6b NOTTINGHAMSHIRE: That conference acknowledges the fantastic work being provided for our own health as GPs by many services across the country including by LMCs. Furthermore, it calls on the NHS to provide core funding for this to continue and spread throughout the UK in order to support the profession and prevent further burnout and loss of GPs.
- 6c NORTH YORKSHIRE: As stress levels amongst GPs remain at high levels conference calls upon the GPC to:
- (i) source or develop an appropriate short survey tool to measure and classify work related stress amongst GPs
 - (ii) encourage every GP on a UK performers list to anonymously complete the survey annually
 - (iii) collect and evaluate the findings and trends
 - (iv) publish and promote the results to the general public and the profession
 - (v) ensure that GPs who identify themselves to be at critical levels and/or high risk based on their personal survey score have access to effective, free and confidential professional support throughout the country.
- 6d GLASGOW: That conference demands that SGPC works with the SG to deliver a comprehensive confidential NHS service for all GPs and GP trainees in Scotland suffering from mental health conditions, including stress and depression, which is at least comparable with the NHS GP Health Service available to GPs in England.
- 6e GLASGOW: That conference that many GPs are working under unsustainable workloads which are causing stress and mental health problems and calls on GPC to work with LMCs to increase their ability to identify and offer support to such GPs.
- 6f SOUTH STAFFORDSHIRE: That conference is worried about the falling morale of GPs and increasing stress and burnout, and demands that:
- (i) the NHS introduces a universal coaching and mentoring scheme to improve resilience and help GPs achieve their best potential throughout their careers
 - (ii) ring fenced funding is provided to delegated CCGs, to maximise the benefits of the GP retention scheme.
- 6g LEWISHAM: That conference noting the results of the 2017 NHS England GP coaching pilot in improving morale and GP retention, demands the national roll out of this coaching scheme.

PUBLIC HEALTH

15.10

- * 7 AGENDA COMMITTEE TO BE PROPOSED BY NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that health screening:
- (i) should not take place within the UK's national health services without the approval of the UK National Screening Committee
 - (ii) if carried out privately, requires the screening provider to provide follow up appointments with patients to discuss abnormal results, and if GPs end up doing this work for them, they are empowered to directly invoice the company for their time.
- 7a NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that both screening and 'case finding':
- (i) expose patients to potential harms as well as benefits
 - (ii) should be assessed using the same criteria

- (iii) should not take place within the UK's national health services without the approval of the UK National Screening Committee
 - (iv) if carried out privately, produce a responsibility on the screening provider to inform the patient of the results and provide any required initial treatment or referral.
- (Supported by Hull and East Yorkshire)
- 7b DEVON: That conference asks that companies providing private health screening must take responsibility for follow up appointments with patients to discuss abnormal results and if GPs end up doing this work for them, they are empowered to directly invoice the company for their time.
- 7c CONFERENCE OF ENGLAND LMCs: That conference believes comprehensive NHS Occupational Health Services should be available to all staff working in GP practices.
- 7d WEST PENNINE: That conference believes opportunistic health screening and promotion should be exempt from health insurance reporting as are the results of genetic screening as the current arrangement deters patients from having a full and frank discussion so disadvantaging their health care.
- 7e AVON: That conference in light of reports that in some regions the diabetes prevention programme is struggling to manage demand, and the blossoming of other pre-disease conditions which GPs are increasingly expected to identify and manage independently, such as pre-dementia (mild cognitive impairment), pre-cirrhosis (non-alcoholic fatty liver) and pre-stroke (atrial fibrillation), conference mandates GPC negotiators to:
- (i) agree with public health agencies appropriate steps so that the management of pre-disease does not adversely impact GPs' capacity to manage people who have manifest illness
 - (ii) ensure that guideline development groups structure recommendations so that GPs are not medico-legally prejudiced if a person develops disease after a pre-disease state and for whatever reason a recommendation that might have reduced the risk of disease has not been followed
 - (iii) support LMCs in negotiating with local health commissioners to ensure that appropriate services are developed for people with pre-disease to be properly managed with the support of, but not exclusively by, their GP.

INFORMATION GOVERNANCE

15.20

- * 8 GATESHEAD AND SOUTH TYNESIDE: That conference believes that the role of data controller is no longer compatible with modern general practice because:
 - (i) the time and financial resources taken up by this activity impede the ability of practices to deliver clinical care
 - (ii) it causes an unacceptable risk to individual practices who may inadvertently breach regulations
 - (iii) the role would be better taken over by a dedicated team at NHS England or equivalent allowing practices to concentrate on clinical care.

(Supported by the Conference of England LMCs)

- 8a CONFERENCE OF ENGLAND LMCs: That conference feels that the problems around processing medical records for the many people who can and do request them creates impossible burdens for the dwindling numbers of GPs who are already overworked and calls for GPC England to put the case to the government to relieve GPs of the role of data controllers for medical records, or call for provision of centralised clinically trained staff to check records for third party references or clinically sensitive information.

GENERAL DATA PROTECTION REGULATION (GDPR) 15.30

- * 9 AGENDA COMMITTEE TO BE PROPOSED BY MORGANNWG: That conference feels the impact of GDPR on practice workload has been significant and calls on:
- (i) all UK governments to recognise the extra workforce required to comply with regulations and fund it fully
 - (ii) the UK government to ensure inappropriate requests for reports masquerading as Subject Access Requests are appropriately penalised
 - (iii) the UK government to adapt the regulations to reverse the impact on GP practices
 - (iv) the GPC to take appropriate action, including funding a test case if necessary, to establish case law to prevent the injustice of general practice being a photocopying and postal service for lawyers continuing in perpetuity
 - (v) GPC, NHS Bodies, the Information Commissioner's Office, Law Society and Association of British Insurers to develop a set of guidelines as to what is a reasonable and proportionate response and what is 'excessive'.
- 9a MORGANNWG: That conference feels the impact of GDPR on practice workload has been significant and calls on:
- (i) all UK governments to recognise the extra workforce required to comply with regulations and fund it fully
 - (ii) the UK government to ensure inappropriate requests for reports masquerading as Subject Access Requests are appropriately penalised
 - (iii) the UK government to adapt the regulations to reverse the impact on GP practices.
- 9b SOMERSET: That conference deplores the use of GDPR to make general practice a free photocopying and postal service for lawyers and it:
- (i) profoundly regrets the current BMA advice which reinforces this approach
 - (ii) urges the GPC to take appropriate action, including funding a test case if necessary, to establish case law to prevent this injustice in perpetuity.
- 9c DERBYSHIRE: That conference demands that GPC works urgently with NHS Bodies, the Information Commissioner's Office, the Law Society and the Association of British Insurers to remove, reduce or mitigate the significant additional unfunded work that has landed in general practice as a consequence of the introduction of the Data Protection Act 2018 which included GDPR legislation.
- 9d LANCASHIRE COASTAL: That conference believes that the stimulation of SARS requests as a result of the GDPR is destroying general practice and calls on GPC, NHS England and the Information Commissioner to develop a set of guidelines as to what is a reasonable and proportionate response and what is 'excessive'.

- 9e SCOTTISH CONFERENCE OF LMCs: That conference with regard to the new general data protection regulations:
- (i) recognises that this adds significant workload and the public needs to know that all (SARs) subject access requests reduce the NHS capacity for other work
 - (ii) supports patients being allowed access to their own records free of charge where there is no involvement of solicitors or insurance companies
 - (iii) calls on SGPC/GPC UK to clarify whether lawyers' requests for subject access requests properly fall under requests for medical reports
 - (iv) believes that solicitors should not be allowed to make subject access requests free of charge
 - (v) demands that the Scottish Government urgently reviews the current system for GDPR / SAR's in general practice and provides funding to support practices providing this service for patients.
- 9f CONFERENCE OF ENGLAND LMCs: That conference is concerned about the increase cost to practices in implementing GDPR and instructs the GPC to negotiate an increase in the global sum to negate this cost.
- 9g CONFERENCE OF ENGLAND LMCs: That conference believes that providing data following a Subject Access Request under General Data Protection Regulations should be cost neutral.
- 9h NORTHAMPTONSHIRE: That conference insists that practices are able to charge for the administrative costs of note checking and handling under GDPR access requests.
- 9i LEEDS: That conference believes the government has failed to appreciate the impact the introduction of GDPR would have on practices and calls for a much more robust approach to support practices and protect patients from the actions of those using subject access requests to obtain patient information inappropriately.
- 9j GATESHEAD AND SOUTH TYNESIDE: That conference directs the GPC to enter into negotiations with NHS England to remunerate practices for the additional unresourced work arising from GDPR, in particular the burden of subject access requests.
- 9k SUFFOLK: That conference calls upon the GPC to find new money for the significant additional staffing and financial costs to practices incurred since the introduction of GDPR which is also adversely affecting patient care.
- 9l MID MERSEY: That conference believes that the introduction of Subject Access Requests under the General Data Protection Regulations has led to a fundamentally unfair and unacceptable increase in unfunded administrative work which is has a significant impact on practices' ability to deliver contracted services and instructs the GPC to develop a set of reasonable charges so that SARs become cost neutral and to inform the government that all practices will be advised to introduce such charges irrespective of current legislation.
- 9m NORTHERN IRELAND CONFERENCE OF LMCs: That conference urges GPC UK to continue to lobby the UK government for legislative changes to the present GDPR legislation to reduce or mitigate the now unresourced administrative burden on GP practices.

- 9n LIVERPOOL: That conference believes that solicitors are using the GDPR regulations in a manner that was not intended and calls upon GPC and the BMA to provide clear guidance, clarifying with the Information Commissioner, that solicitor requests for copies of medical records in relation to any litigation and insurance claims does not fall within the definition of Subject Access Request.
- 9o HIGHLAND: That conference is awake to the changed landscape relating to Subject Access Requests as a consequence of GDPR and:
- (i) recognises the substantial workload involved with checking GP-held medical records
 - (ii) warns of the detrimental impact of this on the time available to staff for other duties
 - (iii) demands that GPC urgently discusses the possible mechanisms of support with the government.
- 9p NOTTINGHAMSHIRE: That conference deplores the imposition of the GDPR on the profession in the area of subject access requests without regard to the resources needed to comply with the legislation and:
- (i) urges GPC to negotiate a fair price/reimbursement for the extra workload involved
 - (ii) demands that the BMA to negotiates an exemption for the provision of medical records
 - (iii) that GPC highlights the harm this legislation is causing not only financially but also in worsening relationships between doctors and solicitors as requests for medical records now increase along with SARs being misused.
- 9q DEVON: That conference demands that general practice be exempt from the multiple requests for information legislated by GDPR as this is creating unnecessary work and unfunded work in general practice taking clinicians and staff away from time that could be better spent on patient care.
- 9r WIGAN: That conference notes with concern the increase in Subject Access Requests for patient information which has followed the GDPR change. Irrespective of whether a fee can be charged, already overstretched practices are struggling under the additional administrative work this is creating. It calls upon GPC to engage with NHS England, NHS Digital, Law Society and Insurers to devise and agree an arrangement for compliance which dramatically eases the administrative burden on practices.
- 9s LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls that general practices should not subsidise insurance applications and claims, legal actions and other similar activities, and demands that the Data Protection Act 2018 is amended such that:
- (i) Subject Access Requests are limited to the reason defined in recital 63 of the General Data Protection Regulations and that a reasonable charge can be made for all other accesses
 - (ii) a reasonable fee can be charged for all access to data under the Access to Health Records Act 1990 for records of deceased patients.
- 9t GLASGOW: That conference believes that the introduction of GDPR and the removal of a fee for Subject Access Reports has had a detrimental effect on GPs workload.

- 9u NORFOLK AND WAVENEY: That conference asks GPC to demand that the government reviews GDPR regulations to:
- (i) allow practices to recover costs incurred in copying records for patients and their legal representatives
 - (ii) acknowledge the damaging effect on non-clinical workload.

- 9v GLASGOW: That conference calls on GPC to clarify whether lawyers' requests for SARs properly fall under requests for Medical Reports.

- * 10 CONFERENCE OF ENGLAND LMCs: That conference instructs GPC to devise a national assurance process with NHS Bodies that ensures all Data Sharing Agreements are GDPR compliant, have a legal basis and are ethically sound before being circulated to practices.

- 10a HAMPSHIRE AND ISLE OF WIGHT: That conference demands a national process for data sharing that is clear and GDPR compliant.

- 10b HIGHLAND: That conference recognises that practices need well-written data-sharing agreements and asks GPC to intervene in those areas where appropriate templates have not been made available to practices.

SOAPBOX

15.50

REPORT BY THE CHAIR OF SESSIONAL GPs SUBCOMMITTEE

16.15

- 11 RECEIVE: Report by the Chair of the Sessional GPs Subcommittee (Dr Zoe Norris).

GPs WORKING IN SESSIONAL ROLES

16.25

- * 12 AGENDA COMMITTEE TO BE PROPOSED BY GP SESSIONALS: That conference asks the GPC to recognise the plurality of roles taken up by GPs throughout the UK, which may include working regularly for a clinical commissioning group, regional health board or an alternative provider of general medical services, and demands that:
- (i) their employment rights are negotiated in a similar way to the model salaried GP contract
 - (ii) GPs working in non-clinical roles should be represented by the GPC
 - (iii) GPC negotiates model terms and conditions for this disparate group of GPs.

- 12a AVON: That conference asks the GPC to recognise the plurality of roles taken up by GPs throughout the UK, which may include working regularly for a clinical commissioning group, regional health board or an alternative provider of general medical services and demands that their employment rights are negotiated in a similar way to the model salaried GP contract.

- 12b THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference believes that GPs working in non-clinical roles should be represented by the GPC and calls upon GPC England to create model terms and conditions for this group of GPs.

- 12c DORSET: The conference ensures GPs working within the new STPs have terms no less favourable than the BMA Model Contract, regardless of provider.
- 12d AVON: That conference believes that GPs working regularly in non-clinical NHS roles, such as for clinical commissioning groups, regional health boards and the Department of Health, should be protected by employment law, and calls upon GPC to create model terms and conditions for this group of GPs.

REPORT BY THE CO-CHAIRS OF GP TRAINEES SUBCOMMITTEE

16.35

- 13 RECEIVE: Report by the Co-chairs of the Trainees Subcommittee (Dr Zoe Greaves and Dr Sandesh Gulhane).

EDUCATION AND TRAINING

16.45

- * 14 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference recognises GP training is outdated and needs radical overhaul. We call upon GPC to work with relevant stakeholders to:
- (i) push for GP trainees to be predominantly based in general practice with set time to attend secondary care for learning opportunities
 - (ii) overhaul the e-portfolio requirements to ensure it is equitable across the UK
 - (iii) learn skills vital to modern GPs such as leadership, business, and management through funded courses
 - (iv) ensure all FY2s have a community placement.
- 14a CONFERENCE OF ENGLAND LMCs: That conference proposes that GP trainees should be primarily based in general practices with shorter secondments to secondary care for specialist experience.
- 14b BRO TAF: That conference:
- (i) recognises the shortage of GPs working within the prison estate
 - (ii) believes recruitment into general practice in prison could be improved by increasing opportunities for exposure to prison GP 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.
- 14c THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference mandates that GPC UK England to work with relevant bodies to ensure that all Foundation Year doctors have a placement in the community as required recommended by the Collins report.
- 14d LOTHIAN: That conference condemns the Shape of Training Steering Groups rejection of RCGP/BMA proposal to increase the length of training in GP from 18months to 30 months and calls on them to reconsider the balance of postgraduate training that is needed.

- 14e THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference notes that GP trainees in hospital settings are frequently used to plug rota gaps in overstretched services, rather than focus on education and training of the individual. We deplore this situation and call for:
- (i) publication of dedicated GP trainee exception reports in England and equivalent reports in the devolved nations for both educational and service time for all hospital placements
 - (ii) detailed exit interviews to collate feedback on individual hospital posts and how to improve them specifically for GP trainee development
 - (iii) lead employers and the GMC to withdraw GP trainees from posts that provide little educational value.
- 14f NOTTINGHAMSHIRE: That conference recognises that recent changes to the study budget allocation for GP trainees has led to regional inconsistencies and mandates the GPC to work closely with the RCGP and other trainee committees and subcommittees to:
- (i) include leadership as part of core training so that costs relating to any leadership courses and conferences will be reimbursed
 - (ii) increase the funding for future generations of GPs such that they may attend courses or conferences relevant to their portfolio interests
 - (iii) agree on a national framework for study budget allocation to reduce inconsistencies across various regions.
- 14g AVON: That conference believes that the GP training programme is not adequately preparing trainees to take on the complexity, intensity and uncertainty within general practice and calls upon the GPC to negotiate with educational bodies within the UK to:
- (i) mandate compulsory GP training within foundation programmes
 - (ii) extend GP training to four years and ensure that the fourth year is spent acquiring business and management skills within a practice
 - (iii) reduce the onerous hoops within the training e-portfolio so that trainees can return to being an apprentice once again.
- * 15 NORTH YORKSHIRE: That conference recognises that good numbers of GPVTS trainers are critical to assisting with the GP recruitment/ retention crisis and instructs GPC to negotiate some national minimum standardisation regarding necessary qualifications for potential trainers so that:
- (i) prior experience is transferable when a trainer moves location
 - (ii) potential new trainers are not put off by additional onerous requirements in certain geographical areas.

PERFORMANCE

17.05

- * 16 AGENDA COMMITTEE TO BE PROPOSED BY NOTTINGHAMSHIRE: That conference calls upon GPC UK to work with the GMC and respective NHS Bodies to overhaul GP appraisal and revalidation by:
- (i) returning to a process that is formative rather than summative
 - (ii) taking opportunities to offer practical support and assistance to colleagues in distress
 - (iii) shifting emphasis from information gathering meetings to pastoral care and mentorship by appraisers
 - (iv) streamlining the process to a full appraisal every three years for those GPs who have had five consecutive 'successful' appraisals with annual probity statements continuing
 - (v) changing the revalidation cycle from five to six years.

- 16a NOTTINGHAMSHIRE: That conference, despite recognising that many GPs find appraisal a useful and cathartic annual 'debrief' with a supportive third party, believes the process is both too costly to the NHS and too onerous for GPs and thereby calls upon the GPC to facilitate:
- (i) a change in the period of appraisal evidence submission and discussion thereof from yearly to two-yearly
 - (ii) a shift in emphasis of the non-evidence submission appraisal meetings from information gathering to pastoral care and mentorship by the NHS England GP appraisers
 - (iii) a change in the period of the revalidation cycle from five to six years
 - (iv) consistency in the appraisal process among clinical specialties.
- 16b 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.
- 16c SCOTTISH CONFERENCE OF LMCs: That conference believes that there has to be a different way to appraise GPs and:
- (i) more should be taken of the opportunity presented by appraisal (which is after all compulsory) to screen our colleagues for evidence of distress and struggle so that practical support and assistance can be offered
 - (ii) the process should be streamlined with a full appraisal once every 3 years for those GPs who have had 5 consecutive 'successful' appraisals with annual probity statements continuing.
- 16d NORTH WALES: That conference calls for compulsory annual appraisal to be set aside and a more reasonable expectation of two appraisals in each revalidation cycle should be introduced.
- 16e NORTH WALES: That conference calls for anonymous 360 degree feedback to be scrapped in favour of a more transparent, constructive, feedback in view of the malign influences that malicious and unsubstantiated negative comments can have on a doctor and their relationship with colleagues.
- 16f LIVERPOOL: That conference believes that the current appraisal and revalidation system is failing to encourage experienced GPs to continue working in NHS health care hence contributing to an increasing number of doctors leaving the service and calls on the GMC to review the overall process.
- 16g NORTH WALES: That conference agrees that the most recent GMC guidance on Reflective Practice within Appraisal and Revalidation remains unworkable.
(Supported by Welsh Conference of LMCs)
- * 17 KENT: That conference demands that the performance regulatory processes dealing with patient complaints:
- (i) anonymise doctors' details to reduce any bias in the system
 - (ii) establish reducing risk to doctors as one of their main aims.

- 17a NORTH AND NORTH EAST LINCOLNSHIRE: That conference demands that the work of the Local Performance Advisory Groups (PAGs) is scrutinised by the GMC and produces local and national data highlighting:
- (i) the age, gender and ethnicity specific demographic breakdown of any formal or informal concerns raised about GPs and their clinical practice
 - (ii) any disproportionality in specific groups of GPs being targeted by the process
 - (iii) the trends on an annual basis
 - (iv) recording and elimination of institutional bias should be a performance target for all NHS organisations.
- (Supported by Hull and East Yorkshire)
- 17b NORTH AND NORTH EAST LINCOLNSHIRE: That conference is appalled at the level of institutionalised racism in the NHS and is concerned that the ethnicity of the GPs under scrutiny might play a significant role in the outcome of the Local Performance Advisory Groups (PAGs).
- (Supported by Hull and East Yorkshire)
- 17c NORTH AND NORTH EAST LINCOLNSHIRE: That conference calls on the Professional Standards Authority to urgently review the Local Performance Advisory Groups (PAGs) to establish the level of racism and ageism associated with these processes.
- (Supported by Hull and East Yorkshire)
- 17d CUMBRIA: That conference believes that decisions about the future career of doctors going through performance committees (PAG and PLDP) is too often made on an arbitrary basis and calls for a fundamental overhaul of the standards and consistency when deciding the level of sanction or remedial action to apply.

CLOSE**17.30**

BREXIT**09.00**

- 18 RECEIVE: Report by Paul Laffin, BMA Public Affairs Manager (European Union).
- * 19 NORTHERN IRELAND CONFERENCE OF LMCs: That conference recognises the unique and devastating effect that Brexit may have on the delivery of healthcare in Northern Ireland and calls on the UK government to take immediate steps to mitigate this.
- 19a NORFOLK AND WAVENEY: That conference believes that Brexit negotiations has damaged the health service by:
- (i) promoting the risk of shortages of medicines and vaccines
 - (ii) reducing the confidence of EU doctors and health professionals to live and work in the NHS
 - (iii) adverse financial market effects resulting in a more costly NHS
 - (iv) leaving Euratom which regulates the import and export of radioactive and nuclear materials including radio-isotopes used to treat cancer, materials which cannot be produced in the United Kingdom
 - (v) has diverted the attention of the civil service and politicians away from the severe difficulties that the NHS is facing.
- 19b HULL AND EAST YORKSHIRE: That conference calls on the government to guarantee that no UK resident will have their health adversely affected due to Brexit.
(Supported by North and North East Lincolnshire)
- 19c THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference stops being against Brexit in all its forms and concentrates only upon being against the health concerns raised by Brexit.
- 19d DERBYSHIRE: That conference abhors and laments the loss of two years of effective governance and leadership resulting from the entire Brexit process and the inevitable negative impact that this is and will continue to have for the foreseeable future for every patient in the United Kingdom.
- 19e NORTH YORKSHIRE: That conference is very worried about the impact Brexit will have on staffing issues in general practice and the wider NHS and instructs GPC to:
- (i) publicly object to the Home Office proposals to limit EU migration to those earning >£30
 - (ii) to highlight the very significant impact this will further have on general practice recruitment.

PRESCRIBING**09.30**

- * 20 GLASGOW: That conference is concerned of the impact of short supply of medication is to good patient care and GP workload, and demands that health departments across the UK address this ongoing and increasingly problematic issue.
(Supported by Scottish Conference of LMCs)

- 20a OXFORDSHIRE: That conference believes requests by pharmacies to GPs to make minor adjustments to prescriptions due to shortages of medicines, brands or preparations represents an increasing waste of GP time, and:
- (i) believes such minor adjustments should be possible without the input of the GP
 - (ii) calls on GPC to produce joint guidance for GPs and pharmacists on this issue
 - (iii) calls on GPC to work with other stakeholders to improve electronic prescribing systems to mitigate such requests.
- 20b GRAMPIAN: That this conference urges GPC UK to work with relevant bodies to resolve medication shortages as they are causing an increase in workload for GPs in trying to provide an alternative or altering patient care.
- 20c LEEDS: That conference believes that the longstanding problem with the unavailability of many commonly prescribed drugs is not just a problem related to Brexit but a daily problem impacting practices and patients and therefore calls on UK governments to take this issue more seriously and address the fundamental causes.
- 20d BERKSHIRE: That conference is increasingly concerned by the growing lack of availability of certain medications and calls on the GPC to work with NHS England and the government to put systems in place to mitigate this.
- 20e NORTH YORKSHIRE: That conference agrees that the GPC should be insisting that the Department of Health ensures a continuous supply of commonly used medications in order to prevent the frequent disruption and cost to patient pharmacists and in particularly GPs when a standard medication is no longer available for use within the NHS requiring a suitable alternative to be found.
- 20f NORTH YORKSHIRE: Medication supplies are already increasingly a problem, impacting significantly on patients and on general practice capacity. Conference is concerned about the further impact Brexit will have on medication supplies, and instructs GPC to:
- (i) have urgent negotiations with the government to prevent supply issues
 - (ii) ensure any supply issues and their impact on patients and general practice are measured
 - (iii) ensure any additional impact on general practice is resourced appropriately.
- 20g SANDWELL: That conference conveys to NHS England concerns general practitioners have about frequent shortages of prescription drugs in the UK and the burden placed on practices having to re-prescribe and find alternatives, which then frequently themselves become unavailable.

DISPENSING**09.40**

- * 21 AGENDA COMMITTEE TO BE PROPOSED BY GLOUCESTERSHIRE: That conference recognises the importance of dispensing to rural general practices and demands that GPC UK seek to support greater practice resilience by seeking:
- (i) a fair dispensing fee
 - (ii) reduction or elimination of clawback
 - (iii) full funding for EPS for dispensing doctors
 - (iv) a change to the regulation which prevents some rural patients in merged practices from receiving dispensing services from their GPs even after they have changed their home address.
 - (v) accountability for the appalling lack of planning by NHS bodies for the implementation of the Falsified Medicines Directive in general practice.
- 21a GLOUCESTERSHIRE: That conference recognises the importance of dispensing to rural general practices and urges that practice resilience be improved by:
- (i) maintaining a fair dispensing fee
 - (ii) reducing or eliminating clawback.
- 21b WORCESTERSHIRE: That conference believes that dispensing doctors should be entitled to the same reimbursement for IT for the Electronic Prescription Service (EPS) as pharmacists received and calls for the GPC to negotiate full funding for EPS for dispensing doctors by NHS England.
- 21c NORTHUMBERLAND: Dispensing practices continue to provide an excellent service in terms of quality and efficiency. In an era of choice, and conference demands that:
- (i) dispensing services are supported and maintained
 - (ii) allowed to compete on a level playing field with community pharmacies
 - (iii) special consideration is given to the provision of pharmacy services in rural areas.
- 21d GLOUCESTERSHIRE: That conference, in order to provide equity to patients, seek to change the regulation which prevents some rural patients in merged practices from receiving dispensing services from their GPs even after they have changed their home address.
- 21e SUFFOLK: That conference is appalled at the lack of planning by NHS England for the implementation of the Falsified Medicines Directive in general practice and calls upon the Secretary of State to explain that he has held Simon Stevens to account for this failing and demands a similar process takes in place in Scotland, Wales and Northern Ireland.

CONTRACT NEGOTIATIONS**09.50**

- * 22 TOWER HAMLETS: That conference notes that it is GPC policy that GPs should not do the work of the home office by checking immigration status of patients and:
- (i) 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

- (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 GMS1 Form
- (iii) instructs GPC to insist that the supplementary questions are removed during the next round of contract negotiations
- (iv) instructs GPC to insist that the obligation on practices to send information regarding patient's residency status to NHS Digital is removed during the next round of contract negotiations.

PARTNERSHIPS

10.10

- * 23 AGENDA COMMITTEE TO BE PROPOSED BY HERTFORDSHIRE: That conference reaffirms its support for the GP partnership model, which represents value for money unparalleled anywhere else in the NHS, and calls upon the GPC to:
 - (i) negotiate a real terms uplift to core funding which is not contingent on targets
 - (ii) reduce the financial risks associated with partnership by negotiating with UK governments to allow practices to become Limited Liability Partnerships without the risk of the contract being put out to tender
 - (iii) work with the RCGP so that partnership teaching becomes a fundamental part of the GP training curriculum
 - (iv) demand that steps are taken to reduce both the amount of regulation and the administrative burden that comes with being a GP principal
 - (v) ensure that memoranda of understanding (MOUs) or contractual measures are in place to support individual partnerships as organisations such as Primary Care Networks (PCNs) and Integrated Care Systems (ICSs) become functional.
- 23a HERTFORDSHIRE: That conference directs GPC UK to negotiate with government for a change in policy to allow practices to become limited liability partnerships without the risk of the contract being put out to tender, which may reduce the perceived risk associated with partnerships and encourage new GPs to become partners.
- 23b SANDWELL: That conference advises to the GPC that the Department of Health will never voluntarily end the sweet deal they are getting from general practice principals and the initiative for any change must come from the profession.
- 23c BROMLEY: That conference believes that greater resource and support should be given to protecting the current GP partnership model.
- 23d SURREY: That conference:
 - (i) reaffirms its support for the GP Partnership model of delivery of primary medical services
 - (ii) urges that any acceptable outcome of the current GP Partnership Review includes a direct financial uplift in GMS Global Sum and / or PMS Global Sum equivalent.
- 23e OXFORDSHIRE: That conference believes the independent contractor model represents value for money unparalleled anywhere else in the NHS, and:
 - (i) believes GP partners should be allowed to innovate without being micromanaged by commissioners or NHS managers
 - (ii) calls on GPC to negotiate a real terms uplift to core funding which is not contingent on targets.

- 23f LEEDS: That conference, noting the experience of managed practices in Wales, APMS contracts in England, and the potential impact of the integrated provider contract in England:
- (i) believes that the GMS contract remains the most effective way to deliver primary medical services
 - (ii) calls on UK governments to prioritise investment in and development of national GMS contracts.
- 23g AVON: That conference urges discussions with NHS England to allow practices to be given the option of choosing to become a Limited Liability Partnership, with guarantees that if they do they will be able to renew their existing GMS or PMS contract.
- 23h HERTFORDSHIRE: That conference directs GPC UK to negotiate with government for a change in policy to allow practices to become limited liability partnerships without the risk of the contract being put out to tender, which may reduce the perceived risk associated with partnerships and encourage new GPs to become partners.
- 23i WORCESTERSHIRE: That conference believes the level of clinical and financial risk held personally by GP partners is now unsustainable and demands that GPC seek to negotiate meaningful reductions as part of next year's GMS contract review.
- 23j HERTFORDSHIRE: That conference calls on GPC to:
- (i) negotiate the right for all partnerships to update their contracts as Limited Liability Partnerships (LLPs)
 - (ii) ensure that memoranda of understanding (MOUs) or contractual measures are in place to support individual partnerships as Primary Care Networks (PCNs) and Integrated Care Systems (ICSs) become functional
 - (iii) emphasise the value that the majority of GPs, regardless of contractual status, have assigned to the partnership model and their overwhelming enthusiasm for the partnership model to continue.
- 23k NORTH STAFFORDSHIRE: That conference now recognises that it is the government's explicit intent (despite the Watson review) to totally salarise the profession through all their recent proposed changes, which include the following:
- (i) annual allowance tax changes
 - (ii) employer contribution pension changes
 - (iii) indemnity cost envelope changes
 - (iv) future investment at mainly only network level.
- This will seriously diminish further the role, professionalism, quality of care ownership, capacity and residual goodwill of many general practitioner partners to the detriment of patient care. They will not know what they have lost until they destroy it.
- 23l NOTTINGHAMSHIRE: That conference believes GP-held medical service contracts and partnership are both the foundations and bedrock of general practice in the NHS and calls upon the GPC to ensure that:
- (i) GP contract-holders receive direct funding for being contract-holders
 - (ii) partnership is encouraged through individual partners receiving additional ring-fenced remuneration for being a partner
 - (iii) partnership teaching becomes a fundamental part of the GP training curriculum
 - (iv) steps are taken to reduce both the amount of regulation and the administrative burden that comes with being a GP principal.

- 23m THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference wants to keep the partnership model and notes there is a decrease in newly qualified GPs wanting to take up partnerships. To promote partnerships, we mandate GPC to work with relevant bodies to help salaried doctors experience partner responsibility whilst being adequately remunerated.
- 23n SHEFFIELD: That conference recognises the advantages of maintaining continuity of care despite the falling number of clinical practitioners in primary care, and calls on NHS England to:
- (i) prioritise primary care investment in 'in-hours' care 8 am-6.30 pm Monday to Friday
 - (ii) invest more money directly into GMS/PMS core contracts to allow practices to provide greater continuity of care
 - (iii) reduce and rationalise the confusing myriad out of hours and urgent care options.

REPORT BY THE CHAIR OF GPDF

10.30

- 24 RECEIVE: Report by the Chair of GPDF, Dr Douglas Moederle-Lumb.

GPC/GPDF

10.40

- * 25 AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference is concerned about the transfer of funding for GPC work to the BMA from the GPDF and:
- (i) is concerned that this has led to a lack of clarity of payment of honoraria for work done
 - (ii) believes that this is likely to deter representation on committees by grass roots GPs
 - (iii) demands any future scheme is equitable to all NHS GPs undertaking work for the GPC and its committees regardless of contractual status
 - (iv) demands any future scheme pays for all approved meetings attended on behalf of the GPC
 - (v) demands any future scheme pays for approved electronic work undertaken on behalf of the GPC.
- 25a CLEVELAND: That conference insists that the arrangement for GPC honoraria:
- (i) entitles claimants to payment for all agreed work undertaken
 - (ii) is equitable to all NHS GPs, undertaking work for the GPC and its committees regardless of contractual status
 - (iii) pays for all approved meetings attended on behalf of the GPC
 - (iv) pays for approved electronic work undertaken on behalf of the GPC.
- 25b SCOTTISH CONFERENCE OF LMCs: That conference is concerned about the transfer of funding for GPC UK/SGPC work to the BMA from the GPDF and:
- (i) is concerned that this has led to a lack of clarity of payment of honoraria for work done
 - (ii) believes that this is likely to deter representation on committees by grass roots GPs
 - (iii) calls on the GPC UK / SGPC to lobby for clarity of funding for time spent on committee work.

- 25c THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference recognises the barriers to sessional GPs representation at LMC conferences and mandates GPDF to pay honoraria to members of the sessional GP subcommittee to attend LMC conferences.
- 25d HERTFORDSHIRE: That conference has no confidence that the BMA is adequately financially supporting the work of GPC at this time of crisis in general practice and calls upon the BMA to correct this.
- 25e GLASGOW: That conference is concerned that changes to funding arrangements for LMC conferences will have an adverse effect on debate and policy formation as it threatens attendance by GPC representatives and calls upon GPC UK to work with the GPDF to ensure that conferences remain effective and representative.
- 25f BIRMINGHAM: That conference believes that GPC UK should take steps to become more representative of its constituents.
- 25g NORTH WALES: That conference agrees, following the GPDF reforms, that each LMC should now reimburse their own LMC conference delegate expenses and deduct such expenses from their normal GPDF levy contributions.

LMCs**10.50**

- * 26 AVON: That conference believes that the very survival of LMCs is under threat by new models of care and requests that the GPC ensure:
- (i) new contractual arrangements include a provision for payment and collection of levy payments
 - (ii) GPs do not lose their only independent, statutory representation
 - (iii) an improved system for identifying and supporting locum GPs
 - (iv) private providers are under the same obligation to fund LMC levies as current NHS providers.
- 26a NOTTINGHAMSHIRE: That conference recognises that statutory and voluntary levies are calculated on a capitated list size with no weighting unfairly affecting some practices whose income is on a weighted basis; We therefore demand that GPC conducts a review of how levies are calculated with a view to considering the merits or otherwise of moving to receiving levies on a weighted list basis
- 26b CONFERENCE OF ENGLAND LMCs: That conference recognises the need to ensure that all locally agreed levies are collected and forwarded to LMCs whatever the future primary medical services contractual relationships may be.

GMC**11.00**

- * 27 SHROPSHIRE: That conference acknowledges the legal hurdles to creating a single professional register but demands that the GMC now makes a public statement recognising that GPs are Specialists in Family Medicine and starts the process necessary to change the current regulations.

- 27a CAMBRIDGESHIRE: That conference believes the skills of general practitioners remain disgracefully unrecognised and underestimated, with consequent effects on GP status, morale and recruitment, and calls for GMC registration to reflect the equal status of a GP and secondary care consultant by creating a single specialist register with GPs as primary care consultants.
- 27b NORTH WALES: That conference agrees that a registered general practitioner is a consultant in primary care and that this should be legally affirmed and recorded on the GMC register.
- 27c WELSH CONFERENCE OF LMCs: That conference agrees that a general practitioner is a consultant in primary care and this should be legally affirmed and recorded on the GMC register.
- 27d GLOUCESTERSHIRE: That conference that GPs are specialists in primary care and calls on the GMC to recognise this equivalence in status.
- 27e EALING, HAMMERSMITH AND HOUNSLOW: That conference instructs GPC to seek formal recognition both within the profession and government of the importance of the role of the GP as the expert generalist and not as just a specialist in chronic disease management.
- 27f WIRRAL: That conference requests all stakeholders to acknowledge general practice as a speciality in its own right.
- 27g COVENTRY: That conference insists that GPs are regarded as specialists and general medical experts. Furthermore, there is appreciation that we are best placed to make clinical decisions tailored to our individual patients and that there is a recognition that strict adherence to an increasing plethora of guidelines is not always in the best interests of patients.
- 27h KENT: That conference believes the title of GP be replaced with the title of Consultant in Community Medicine.
- 27i WIRRAL: That conference considers the title general practitioner to be obsolete and that GPs as specialists are re-titled primary care physicians.

FUNDING

11.10

- * 28 AGENDA COMMITTEE TO BE PROPOSED BY MID MERSEY: That conference demands that payments in any GP contract should:
- (i) reflect numbers of patient contacts undertaken as well as list size
 - (ii) ensure that practices receive payment for registered patients who die before the end of a quarter.
- 28a MID MERSEY: That conference directs GPC to ensure that practices receive payment for registered patients who die before the end of a quarter.
- 28b WIRRAL: That conference requests that the payments in a new GP contract should reflect numbers of patient contacts undertaken as well as list size.

COLLECTIVE WORKING – PLENARY SESSION**11.30**

Mindful of the general direction of travel in all four nations, the Agenda Committee has decided to set some conference time aside to allow members an opportunity to consider the subject of collective working and what this may mean for different nations. We have invited four guest speakers, one from each nation, to outline the landscape similar to them, to talk briefly about the models they currently are practising within, and to discuss the challenges and opportunities that their particular working model presents.

These speakers will be:

- Tracey Vell (England)
- Iain Kennedy (Scotland)
- Peter Horvath-Howard (Wales)
- David Ross (Northern Ireland)

Following this presentation, conference members will have the opportunity to join one of three groups, to take part in a more focused, facilitated discussion led by members of the Agenda Committee. Each group will concentrate on one particular area, more related to the specifics of at-scale working across the UK. These groups will also include relevant members of the GPC executive teams, and policy leads, who will be acting as a supportive resource for specific technical details.

The options for group sessions will be:

Representation

- How to bring the profession with you
- How to manage external influences

Nuts and Bolts

- Legal and financial considerations
- IT systems
- Data sharing arrangements
- Staff contracts

Continuity vs Access

- How to balance getting the best of what we understand to be traditional general practice whilst creating efficiencies through working at scale
- How to accommodate the rural and isolated, where networks/ clusters of populations and geographies might not fit the political/ contractual deal

BREAKOUT SESSIONS**12.10****LUNCH****13.00**

CHARITIES**14.00****Dain Fund**

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

Claire Wand Fund

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

Cameron Fund Annual General Meeting

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

CONTINUITY OF CARE**14.10**

- * 32 CONFERENCE OF ENGLAND LMCs: That conference instructs that policy makers should prioritise improving GP continuity of care over extended access as there is mounting evidence in the past year that this is a more cost-effective way of achieving positive health outcomes including improved mortality, patient satisfaction and reduced A&E admission.
- 32a CONFERENCE OF ENGLAND LMCs: That conference values continuity of care and the registered list above passing trends for provision at scale: which lacks long term evidence of both improvements in patient care and practitioner morale alike.
- 32b CAMBRIDGESHIRE: That conference is frustrated at the continued focus on increasing access to primary care, with an apparent complete lack of concern about the consequent destabilisation of general practice, and implores GPC to insist that the relevant decision-makers stop:
- (i) neglecting the evidence which proves that continuity of care benefits patients, clinicians and the NHS budget
 - (ii) ignoring GPs who know from experience that continuity of care is vitally important in the care of many patients, especially the most vulnerable
 - (iii) fundamentally destabilising the system which forms the bedrock of the NHS, by forcing change that is unsustainable within the workforce and budget constraints that exist.
- 32c DEVON: That conference recognises that the best way to reduce spending in the NHS is to invest in schemes that promote continuity of care between patient and their GP as there is significant evidence that shows rewarding this approach would lead to less hospital admissions, healthier patients and less stressed, happier GPs.
- 32d BEDFORDSHIRE: That conference notes that “the doctor who knows all about me” has become “the doctor who knew all about me” and the loss of this knowledge results in increased risk of missed diagnoses and in reduced quality of care.
- 32e BEDFORDSHIRE: That conference instructs GPC to seek reassurances from the Secretary of State for the many GPs between 55 and 60 that, when they need continuing medical care in their later years (maybe 15 to 20 years from now), there will be compassionate and empathic GP-led care teams there to fulfil the role, since not all the functions of a GP can be replaced by an app.

- 32f WALTHAM FOREST: That conference, with regard to access:
- (i) does not believe that the availability of in-hours GP appointments has a significant impact on AE attendances
 - (ii) deplores the focus on acute access at the expense of planned long-term care
 - (iii) believes practices, working with their patients, are best suited to determine the best access systems to meet their patients' needs
 - (iv) instructs GPC to not agree any contractual changes that would result in contractual access targets.

INTEGRATED CARE AND WORKING AT SCALE

14.20

- * 33 AGENDA COMMITTEE TO BE PROPOSED BY LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the development of primary care networks:
- (i) will not improve general practice
 - (ii) will undermine the autonomy of general practitioners.
- 33a LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that development of primary care networks will not improve general practice but will undermine the autonomy of general practitioners.
- 33b COVENTRY: That conference believes that the relentless drive in pursuit of at scale working is designed to destroy the partnership model of general practice and so generate:
- (i) a fully salaried service through which we will be at the mercy of our employers
 - (ii) resulting in a shift pattern of working as in hospitals to achieve the government's 8 to 8 service seven days a week
 - (iii) a mobile GP pool that will have to work at whatever practice they are sent to work at on any given day
 - (iv) and with NO consideration of the detrimental consequences such as loss of continuity of care.
- 33c LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls that the NHS 10 Year Plan will fail unless it is accepted that:
- (i) digital access to services will increase demand and activity increasing need for capacity
 - (ii) the workforce cannot be expanded and motivated unless job satisfaction is improved
 - (iii) new funding for new services will not be beneficial unless chronic underfunding of current activity is addressed first
 - (iv) patients should not have an absolute right to online consultations as this should be primarily determined by clinical appropriateness
 - (v) primary care networks will increase rather than reduce pressures in primary care by diverting limited staff from general practice.
- 33d NORTHUMBERLAND: That conference recognises the contribution that practices of all shapes and sizes make to our primary care services. This diversity of provision must not be compromised in our rush to construct primary care networks.
- 33e AVON: That conference calls on the GPC to:
- (i) stop colluding with government in attempting to find inappropriate solutions for the crisis within general practice such as federations and mergers

- (ii) stop colluding with government in attempting to find inappropriate solutions for the crisis within general practice such as substituting the dwindling GP workforce with alternative health care professionals including nurses, pharmacists and PAs
 - (iii) focus on providing appropriate funding and recruitment to general practice so that the service can be appropriately staffed by doctors.
- 33f NORTHUMBERLAND: The NHS ten year plan refers to contractual requirements to join primary care networks, conference demands that:
- (i) it is recognised that 30,000 - 50,000 population may cover a very large geographical area
 - (ii) there must be sufficient flexibility to allow for different populations especially rural communities
 - (iii) allowance for primary care networks not to be geographically based
 - (iv) not to jeopardise existing practice groupings.
- 33g HERTFORDSHIRE: The NHS long term plan marks the extinction of the local GP. GPC must be clear about this in all negotiations and argue against the following consequences of this:
- (i) loss of continuity of care
 - (ii) loss of the cost-effective GP partnership model with potential loss of local primary care premises as a consequence
 - (iii) loss of small effective health care teams that communicate constructively for the benefit of patients
 - (iv) health inequality based on patient digital competence and ability to travel to appointments.

PRIMARY/SECONDARY CARE INTERFACE

14.30

- * 34 AGENDA COMMITTEE TO BE PROPOSED BY OXFORDSHIRE: That conference:
- (i) is deeply concerned by the lack of consent of the GP by means of a shared care agreement for work transfer
 - (ii) believes that due to gaps in commissioning GPs are being encouraged to work beyond their competencies in a number of clinical areas
 - (iii) ensure that no GP is pressurised by commissioners into prescribing medication outwith their competence due to failures of specialist commissioning
 - (iv) urges GPC UK to influence commissioning organisations by promoting guidance which encourage GPs and secondary care colleagues to work together on transfer of work issues, ensuring that if any work is transferred it is done with appropriate discussion and with appropriate funding.
- 34a OXFORDSHIRE: That conference is deeply concerned by the increasing number of requests by secondary care for GPs to monitor patients with complex specialist problems, without seeking the consent of the GP by a shared care agreement, and:
- (i) condemns the practice of unceremoniously dumping work onto GPs without their consent
 - (ii) insists that such requests must be accompanied by a shared care agreement, which the GP is free to accept or refuse depending on resources, workload or clinical experience
 - (iii) calls on GPC to ensure that, where the GP has agreed to such a shared care agreement, funding for such tests and follow up moves out of secondary care into primary care.

- 34b CONFERENCE OF ENGLAND LMCs: That conference believes that due to gaps in commissioning GPs are being encouraged to work beyond their competencies in a number of clinical areas and calls on GPC England to:
- (i) ensure that no GP is pressurised by NHS England into prescribing medication outwith their competence due to failures of NHS England specialist commissioning
 - (ii) call on the GMC to amend their guidance on Trans Healthcare as their current guidance is in neither patients nor doctors best interests
 - (iii) negotiate for safe and effective secondary care high risk medical monitoring for patients with eating disorders to be available in all parts of England
 - (iv) ensure appropriate services are commissioned for the management of substance misuse.
- 34c GRAMPIAN: That conference urges GPC UK to influence health authorities by promoting guidance which encourage GPs and secondary care colleagues to work together on transfer of work issues, ensuring that if any work is transferred it is done with appropriate discussion and with appropriate funding following the work rather than informal ad-hoc requests.
- 34d BUCKINGHAMSHIRE: That conference expresses frustration that despite template letters in line with guidance from GPC, secondary care providers continue to ignore their contractual obligations and send unfunded inappropriate work to primary care, and:
- (i) mandates GPC to escalate this issue directly with NHS national bodies
 - (ii) calls on GPC to nationally audit these occurrences so that the worst affected areas are highlighted.
- 34e LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls on the GPC to agree robust arrangements underpinned by regulation with the department of health to stop the inappropriate transfer of work from secondary to primary care.
- 34f AVON: That conference deplores the constant and increasing shift of unresourced work from secondary to primary care, which is causing extreme hardship for general practitioners. It calls on the GPC to mount a national campaign to ensure that:
- (i) this behaviour by secondary care is exposed and stopped
 - (ii) work already transferred is appropriately costed and primary care compensated accordingly
 - (iii) CCG and health boards work with general practice to stop this behaviour.
- 34g AVON: That conference deplores the continuing wholesale disregard for the NHS standard contract by secondary care organisations, who continue to seek to pass excessive quantities of work to general practice; work for which secondary care is funded within tariff and for which general practice is not. It calls upon the Department of Health to:
- (i) ensure that secondary care clinicians and managers are properly educated in terms of their responsibilities under the NHS standard contract
 - (ii) introduce sanctions for trusts who are in breach of the NHS standard contract
 - (iii) ensure that general practice is allowed to invoice trusts whenever such breaches occur and that payment of such invoices is properly enforced.

- 34h HILLINGDON: That conference recognises the significant extra workload associated with transfer of services from the hospital to the community and instructs the GPC to:
- (i) negotiate that any such transfer is preceded by an impact and needs assessment
 - (ii) ensure that it is appropriately resourced
 - (iii) ensure that adequate training is given to GPs at no cost to their practices in advance of a service being rolled out. (Supported by Wandsworth)
- 34i DERBYSHIRE: Conference asserts that with an ever increasing number of commissioning gaps in patient care it is inappropriate to expect GPs to subsidise healthcare in the UK and calls on GPC to:
- (i) negotiate a contract fit for purpose that includes mechanisms for funding local commissioning gaps
 - (ii) demand urgent action from CCGs to adequately fund commissioning gaps within 3 months of a gap being identified
 - (iii) condemn the emotional coercion that originates from CCGs for practices to fill these gaps and support them in saying no if no funding is forthcoming.
- 34j HULL AND EAST YORKSHIRE: That conference is appalled that the government has failed to commission appropriate services for Trans and non-binary people undergoing gender transition services and demands that this is addressed immediately. (Supported by North and North East Lincolnshire)
- 34k SUFFOLK: That conference calls upon GPC to ensure that GPs are not responsible for the various NHS screening programs' failure to address the needs of transgender patients and that NHS England and PHE are tasked with adequately commissioning services to include transgender patients.
- 34l BERKSHIRE: That conference believes the increasing complexity of trying to make certain referrals such as for joint replacement - performing tests, initiating referrals to other agencies and recording outcomes represents another example of unacceptable and inappropriate shift of workload onto general practice, and calls on GPC either block this work or ensure it is adequately funded.
- 34m BRO TAF: That conference asks GPC to negotiate a formal Clinical Communications document, based on the Clinical Communication Protocol adopted by Wales, to finally address inappropriate transfer of work.

ONLINE GP SERVICES

14.40

- * 35 AGENDA COMMITTEE TO BE PROPOSED BY HULL AND EAST YORKSHIRE: That conference is concerned about the emergence of various IT solutions that are non-evidence based, untested and poorly regulated and:
- (i) believes that this is having a negative effect on patient care
 - (ii) believes that IT solutions should be tested and approved at least in line with other medical and surgical interventions
 - (iii) believes that the IT developers should be held responsible legally and financially if these result in adverse outcomes for patients.
 - (iv) demands that GPC support general practices in refusing to implement IT-based medical algorithms; unless and until acceptable regulation and liability agreements are in place.

- 35a HULL AND EAST YORKSHIRE: That conference is concerned about the emergence of various IT solutions that are non-evidence based, untested and poorly regulated. The conference believes that:
- (i) this is having a negative effect on patient care
 - (ii) IT solutions should be tested and approved at least in line with other medical and surgical interventions
 - (iii) the IT developers should be held responsible legally and financially if these result in adverse outcomes for patients.
- (Supported by North and North East Lincolnshire)
- 35b LAMBETH: That conference:
- (i) believes that algorithms should be regulated
 - (ii) demands that online consultation tools should be subject to an appropriate regulatory framework
 - (iii) demands that there should be agreed governance structures and clarity of liability for adverse incidents arising from use of online consultation tools
 - (iv) demands that online consultation systems be subject to independent evaluation of effectiveness before NHS bodies procure them for practices
 - (v) demands that GPC support general practices in refusing to implement such algorithms unless and until acceptable regulation and liability agreements are in place.
- 35c AVON: That conference calls on the government to legislate for proper regulation of healthcare apps. Medicines require extensive assessment before being declared safe for patient use and the same stringent requirements should be required for apps that are intervening in patients' health.
- 35d AVON: That conference urges GPC to work with NHS England to develop a regulatory approval and monitoring regime, as exists for drug interventions, for mobile and web based applications that are designed for use by patients and which may be interpreted as giving specific medical advice to the individual without consultation with a clinician.
- 35e LEWISHAM: That conference, whilst supporting the use of digital technology, requires practices to be protected from clinical risk and negative outcomes related to the use of third-party diagnostic and signposting apps.
- 35f BEDFORDSHIRE: That conference believes that many GPs might be happy to be replaced by an app but would want to be shown who provides the indemnity for such an app.
- 35g KENT: That conference believes it is not the role of the Secretary of State for Health to promote private telephone based, artificial intelligence dependent GP services.
- 35h LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls on the new secretary of state for health and social care, with his interest in IT, to review Babylon's 'GP at Hand' as the solution to relieve pressures on GP services! making sure that it does not start to destabilise general practices which might be left to deal with complex patient with limited funding.
- 35i LIVERPOOL: That conference has no confidence in a Health Secretary who thinks it is acceptable to actively publicise a private provider that is undermining NHS general practice through unethical means.

- 35j SCOTTISH CONFERENCE OF LMCs: That conference believes that the availability of commercial internet-based GP services should not be allowed to disadvantage existing GP practices.
- 35k AVON: That conference believes that IT development alone will not address the workload and workforce crisis and it calls on the Department of Health to renew its efforts to explore all avenues to save general practice.
- 35l LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls that the development of digital GP services but demands that:
- (i) the NHS does not recognise any provider who only provides digital access for any patient
 - (ii) rate of funding for digital services should be less than for face to face services
 - (iii) it is recognised that digital services will not increase capacity but will increase demand for services so must be funded by new funding
 - (iv) all practices are provided with appropriate software to provide digital services embedded into clinical systems at no cost.

COMMISSIONING AND SERVICE DEVELOPMENT

14.50

- * 36 AGENDA COMMITTEE TO BE PROPOSED BY BEDFORDSHIRE: That conference, with regard to the commissioning of urgent care services:
- (i) calls for urgent action by governments to address the problems of ambulance delays which are detrimental to patient care
 - (ii) believes that GP out of hours services should remain defined as primary medical services and not be separated into a collection of sub-specialist services under the title of 'urgent care'
 - (iii) calls for a full evaluation of NHS 111 and equivalent services that continues to mis-direct patients and overload already stretched NHS services.
- 36a BEDFORDSHIRE: That conference is horrified to learn that, despite protestations to the opposite, urgent ambulance calls from practices are triaged to being less urgent than a call from the general public because a doctor is present and calls for:
- (i) realisation that a GP, though not a paramedic, has assessed the situation as urgent and that the patient is in need of the skills of the paramedic team precisely because the GP is NOT paramedic-trained
 - (ii) a better resourced ambulance service which shouldn't have to make such decisions
 - (iii) powers for ambulance services to be able to decline calls from those who persistently abuse the service if this is detracting from genuine need.
- 36b CONFERENCE OF ENGLAND LMCs: That conference states, general practice is NOT an emergency service and calls upon GPC England to:
- (i) condemn those ambulance services who downgrade calls from GP practices for emergency ambulance, thereby putting seriously unwell patients at risk due to delay in response times
 - (ii) address the mission creep in out of hours general practice in providing stop-gap, unsafe emergency care to plug deficiencies in our under-funded ambulance service
 - (iii) demand an evaluation of 111 in England to ensure value for money and appropriate signposting to other services
 - (iv) declare that the diversion of GPs or practice staff to immediately attend local emergencies in place of ambulance staff is a misuse of primary care resources.

- 36c GLASGOW: That conference calls for urgent action by governments to address the problems of ambulance delays which are detrimental to patient care.
- 36d GLOUCESTERSHIRE: That conference considers any downscaling of the urgency for ambulance transport just because it is from a GP surgery as dangerous and calls on GPC to negotiate a halt to this process.
- 36e BIRMINGHAM: That conference believes that GP out of hours services should:
- (i) remain defined as primary medical services
 - (ii) not be separated into a collection of sub-specialist services under the title of 'urgent care'
 - (iii) principally be aimed at supporting GP practices in providing appropriate patient access to primary medical services at all times.
- 36f LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls for a full evaluation of NHS 111 as it continues to mis-direct patients and overload already stretched NHS services.
- 36g BRO TAF: That conference demands that GPC UK and the UK Government urgently take up the issue of hospitals becoming ambulance car parks for ambulance services.

REPORT BY THE CHAIR OF GPC SCOTLAND

15.00

- 37 RECEIVE: Report by the Chair of GPC Scotland, Dr Andrew Buist.

REPORT BY THE CHAIR OF GPC WALES

15.10

- 38 RECEIVE: Report by the Chair of GPC Wales, Dr Charlotte Jones.

QUESTION THE UK CHAIRS

15.20

PENSIONS

15.40

- * 39 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference notes the inflexibility of the NHS Pension Scheme and the problems the recent HMRC changes in annual allowance are causing and asks the GPC to:
- (i) negotiate for GPs to be able to adjust their percentage contribution to the NHS Pension Scheme on an annual basis
 - (ii) seek specific changes that will obviate the financial incentive for GPs to stop and start their contributions
 - (iii) actively seek changes to the Pension Scheme that will help PCSE manage it better
 - (iv) actively seek changes to the Pension Scheme to help retain older GPs
 - (v) ensure that sessional doctors should enjoy the same NHS Pension rights as the rest of the workforce and in particular death in service benefits.
- 39a DEVON: That conference notes the inflexibility of the NHS Pension scheme and the problems the recent HMRC changes in annual allowance are causing and asks the GPC to:

- (i) negotiate for GPs to be able to adjust their percentage contribution to the NHS Pension scheme on an annual basis
 - (ii) seek specific changes that will stop the financial incentive for GPs to stop and start their contributions
 - (iii) actively seek changes to the Pension scheme that will help PCSE manage it better
 - (iv) actively seek changes to the Pension scheme to help retain older GPs.
- 39b CONFERENCE OF ENGLAND LMCs: That conference believes that sessional doctors should enjoy the same NHS Pension rights as the rest of the workforce and in particular death in service benefits.
- 39c NORTH STAFFORDSHIRE: That conference believes that the substantial tax increases triggered by the annual allowance changes are making the NHS pension scheme non viable, both for individual general practitioners and the scheme as a whole, and are acting as a workforce retention disincentive.
- 39d BEDFORDSHIRE: That conference calls on GPC UK to look at the pension / tax situation which is creating the perverse incentive for GPs to reduce their clinical session to avoid being hit by pension/tax rules if they work for the NHS.
- 39e SCOTTISH CONFERENCE OF LMCs: That conference believes that the UK government must address the tapered annual allowance for GP pensions to halt the mass exodus of GPs from the pension scheme and the profession.
- 39f NORTHAMPTONSHIRE: That conference demands that NHS pensions contribution changes pension rules to encourage not penalising GPs by being limited and acting as a disincentive to GP retention.
- 39g SOUTH STAFFORDSHIRE: That conference is concerned about the impact of lowering of annual and lifetime pension allowance and proposals to raise employer contributions and demands that:
- (i) annual allowance thresholds are increased from £40,000 to at least £60,000 if not £80,000
 - (ii) lifetime allowance is increased from £1.03 to £2.03 m
 - (iii) maximum employer pension contributions are frozen at 14.38%.
- 39h DORSET: That conference calls for HMRC to admit that the changes to the NHS pension scheme with respect to annualisation of employee contributions are discriminatory and unfair. As such they should be scrapped immediately and the additional monies paid refunded to those affected.
- 39i LEEDS: That conference believes the NHS pension annual allowance arrangement is having a major impact on GP retention and therefore patient services and calls on the BMA to contact every MP, MSP, Welsh AM and NI MLAs to highlight this serious problem and to seek a solution.
- 39j NORTHERN IRELAND CONFERENCE OF LMCs: That conference recognises the impact that the annual and lifetime allowance charges are currently having to the GP workforce and directs GPC UK to explore ways to allow GP principals to have flexibility with their contributions to help mitigate the excess charges.
- 39k BEDFORDSHIRE: Because GPs in their early 50s are being advised that, due to the annual allowance and lifetime allowance, their best option is to reduce the number of sessions they work in order to avoid effectively being taxed twice on their pension pots – creating a situation the opposite

of what is needed if we are to stop the haemorrhage of experienced GPs - conference calls on GPC England to ask government to look urgently at the pensions situation.

- 39l WIGAN: That conference notes with dismay the failure to increase recruitment of GPs in any appreciable number from overseas sources to provide relief in the short and medium for the GP manpower crisis. It calls upon GPC to engage with NHS England, Secretary of State, and Treasury to seek a special dispensation from the pension funding disincentives which apply to older GPs who desire to remain in active non locum practice.
- 39m BEDFORDSHIRE: That conference instructs GPC to advise DHSC that the government:
- (i) has disincentivised GP clinical work by its pension/tax rules
 - (ii) whilst claiming it wants more GPs, is actually contributing to the reduction in sessions and to early retirements as a result of its pension/tax policies
 - (iii) needs to work urgently on reviewing the situation to encourage GPs to reconsider if they are considering early retirement or reduction of sessions due to increased taxation/fall in income.
- 39n WIRRAL: That conference observes that the current changes to pension annual allowance and Lifetime allowance are negatively impacting on GPs and as such:
- (i) have the potential of further compounding the already existing recruitment and retention problem of general practice
 - (ii) call upon the GPC to urgently seek redress from NHS England and the government.

REGULATION

15.50

- * 40 HIGHLAND: That conference deplores bullying as an abuse of power that does not belong in our healthcare cultures and:
- (i) expresses its heartfelt condemnation of any bullying of doctors and other workers in the NHS
 - (ii) wishes to expose and nullify the malign tactics used by some people to target, intimidate, marginalise, and scapegoat others
 - (iii) bemoans the lack of effective whistle-blowing procedures across the NHS
 - (iv) salutes those individuals who have the courage to whistle-blow, when other processes have failed
 - (v) demands coordinated actions from our professional associations and governments that will move UK healthcare towards a culture of learning and support.
- 40a DEVON: That conference is very concerned by the behaviour of NHS England in some areas to interpret the GP contract in contradictory ways in an attempt to bully GP practices into changing their provision of services.
- 40b DERBYSHIRE: Following the Francis Report recommendations in 2016 there remains a huge inequity in support for and protection of Whistleblowers in general practice when compared with other areas of the NHS. Conference calls for a properly funded and robust support structure for whistleblowers in primary care.

- 40c BEDFORDSHIRE: That conference believes that there should be a 'GMC for healthcare managers' with powers to impose sanctions on NHS managers up to, and including, depriving them of the right to work in the NHS, so that NHS managers are liable for the impact of the systems they have set up or for bullying behaviour or repeated incompetence.

CHOSEN MOTIONS**16.00****AND FINALLY...****16.20**

- 41 DEVON: That conference would like to ask the new Secretary of State for Health for more precise details for his IT solutions to the GP recruitment crisis and asks him to distribute these via hashtag the missing 5000.

CLOSE**16.30**

Conference of Representatives of Local Medical Committees

Agenda: Part II

(Motions not prioritised for debate)

Agenda: Part II

(Motions not prioritised for debate)

A and AR Motions

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

PUBLIC HEALTH

- | | | |
|-----------|----|--|
| A | 42 | WEST PENNINE: That conference believes that treatment for HIV and other illnesses requiring medications with high risk of serious and fatal interactions must be routinely conveyed to the patients GP. |
| A | 43 | DEVON: That conference with respect to Prescription Medication Administration Record forms (PMARs), demands that: <ul style="list-style-type: none"> (i) GPs are not obliged to complete these forms for a third-party provider (ii) the responsibility for completion lies with the employer of the health care professional administering the medication (iii) any arrangement in place should not involve transcription of medication by hand. |
| AR | 43 | SURREY: That conference believes all Public Health England initiatives should be 'sense-checked' before release by the GPC. |
| A | 45 | LIVERPOOL: That conference believes that if GPs are expected to vaccinate patients against seasonal influenza: <ul style="list-style-type: none"> (i) clearer and earlier guidance needs to be given to GPs on the preferred vaccines to be ordered for each age group (ii) the supply of vaccine to GPs needs to be prioritised over non-medical providers to ensure that patients in at risk groups can be appropriately protected. |
| A | 46 | BRO TAF: That conference recognises the deleterious effects of homelessness on physical and mental health and calls for the BMA to lobby the relevant UK governments to introduce legislation to ensure that no person completing a prison sentence is released to conditions of homelessness. |
| A | 47 | LEEDS: That conference is seriously concerned by the increased number of homeless people living and sleeping outdoors across the UK and calls on all governments to commit additional resources and commission dedicated teams to support the primary medical care of these vulnerable people. |

INFORMATION TECHNOLOGY AND MANAGEMENT

- A** 48 CONFERENCE OF ENGLAND LMCs: That conference insists that IT infrastructure must:
- (i) provide proper function for clinical use by practices before introducing political wants such as WiFi for patients
 - (ii) meet basic standards agreed with the GPC for connectivity and speed
 - (iii) provide appropriate recompense to practices for failure
 - (iv) include the full reimbursement of practice costs incurred by system and provider changes including the purchase of systems and services for any proposed future working at scale environment
 - (v) include a penalty clause in all future NHS IT contracts securing funding for any unforeseen workload required of general practice following a system failure.
- A** 49 BEXLEY: That conference believes that it is essential for the current out-dated operating systems and IT infrastructure of general practice to be reviewed and improved to lay the groundwork for greater technological advances and that this occurs before any further investment is made in the alternative digital healthcare model.
- A** 50 WEST SUSSEX: That conference:
- (i) notes the increased workload required of GP practices following identified NHS IT failures
 - (ii) demands that this workload must be appropriately recompensed by NHS England
 - (iii) demands that future NHS IT contracts should include a penalty clause securing funding for such future workload, if required.
- A** 51 NORTHAMPTONSHIRE: That conference demands that GP IT systems are fully maintained and replaced as required by NHS.
- A** 52 HIGHLAND: That conference looks forward to more modern GP IT systems becoming available and asks GPC to pursue adequate resource in support of training staff to use these systems well.
- A** 53 AVON: That conference is gravely concerned by recurrent IT failures by third parties such as Docman that result in risk and extra workload for GPs and their staff and it calls on GPCUK to negotiate a national compensation package when these failures occur.

GPs WORKING IN SESSIONAL ROLES

- A** 54 KENT: That conference calls for an amendment to the BMA standard salaried GP contract to ensure that GP educators:
- (i) are given appropriate remuneration
 - (ii) are given the protected time needed to fulfil the role.

EDUCATION AND TRAINING

- A** 55 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference recognises that ways of working in GP have changed, and that full-time equivalent hours are often worked in less than 5 days. This conference calls on GPC to recognise that:

- (i) such arrangements can be used in training
- (ii) work schedules can be more reflective of post CCT working through consolidation of clinical sessions to reduce the number of days worked whilst maintaining contractual hours.

A 56 KENT: That conference calls on the GPC to renegotiate remuneration for GP educators.

PRESCRIBING

A 57 CLEVELAND: That conference deplores the chronic underfunding of Child and Adolescent Mental Health Services (CAMHS), which is transferring to non-specialists, and leaving children and families vulnerable.

A 58 TAYSIDE: That conference asks that on discharge from hospital /prison there is a set national standard issue of a minimum of at least 14 days' supply of medication, to allow time for general practice and community pharmacy to safely reconcile medication.

A 59 BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference believes that:

- (i) secondary care including community doctors should be commissioned to electronically prescribe initial prescriptions
- (ii) secondary care including community physicians must be commissioned to prescribe specialist medicines, unless the patient's GP accepts prescribing being handed over for the specialist medication
- (iii) community nurses including palliative care nurse and prescribing clinicians should be commissioned to electronically prescribe medicines that are within their scopes of practice.

A 60 GLASGOW: That conference is aware of the requirement in England that hospitals must supply medication to patients following attendance at an out-patient clinic and calls on SGPC to work with Scottish government and boards to make this a requirement in Scotland.

A 61 COVENTRY: That conference believes the preparations for the flu immunisation campaign for 2018-9 have been chaotic, tardy and give advantage to pharmacies over general practice by providing earlier, guaranteed supply of vaccine. That this has potential to lead to the later vaccination of vulnerable groups of patients and a higher level of risk within the community if there is an outbreak of influenza this season.

A 62 NORTHERN IRELAND CONFERENCE OF LMCs: That conference commends GPs for delivering the flu vaccine campaign this year despite the supply problems and all the complications around this year's campaign. The conference calls on the Department of Health and Public Health Association to ensure the same problems do not happen next year.

A 63 CONFERENCE OF ENGLAND LMCs: That conference remains concerned by the introduction of barriers which block GPs from making clinically appropriate referral to secondary care colleagues, so conference instructs GPC to:

- (i) give guidance on the actions they should take when referrals pathways are created requiring GPs to undertake work or actions outwith of their agreed contracts before being able to refer

- (ii) tackle the surfeit of referral templates and protocols which are resulting in a subtle transfer of workload from secondary to primary care
 - (iii) publicise that CCG referral management schemes and procedures of low clinical value are only about cost cutting and rationing
 - (iv) negotiate with NHS England and government the need to agree an England wide list rather than have postcode lottery decisions.
- A** 64 DEVON: That conference calls for NHS England to stop asking GPs to facilitate short issue prescription changes from one branded generic medication to another and then another ad infinitum for no clinical gain and all at the expense of GP workload.
- A** 65 GRAMPIAN: That conference urges GPC UK to produce guidance on referral pathways that insists on GP involvement in development of these pathways and other guidelines to enable effective referral processes for both primary and secondary care.
- A** 66 GRAMPIAN: That conference calls on GPC UK to find a solution to improve referral rate acceptance and reduce rejection of referrals which affects both patients and GPs.
- A** 67 AVON: That conference deplores the lack of government funds to provide support for the increasing numbers of vulnerable people who are struggling to cope with mental health issues and it calls upon the GPC to make representations to the responsible government minister to provide increased resources for the care of patients with mental health issues.

CONTRACT NEGOTIATIONS

- A** 68 SCOTTISH CONFERENCE OF LMCs: That conference calls upon the government to mandate all health boards to reimburse the cost of maternity leave for retainer GPs.
- A** 69 DERBYSHIRE: With general practice transforming to create new models of care, the make-up of our practice workforce is changing. We ask GPC to negotiate with NHS England to ensure that the SFE for sickness cover and maternity leave extends to all allied health professionals as a matter of urgency.
- A** 70 WANDSWORTH: That conference believes in the concept of independent contracted general practice and in recognition of this, demands legislative change to:
- (i) ensure commissioners directly fund any NHS services outside of core contract
 - (ii) enable practices to directly charge registered patients in order to provide them with services that are not being commissioned by the NHS.
- A** 71 MANCHESTER: That conference agrees that GPC should be working to ensure that working as a GP in this country remains attractive through working conditions, pay, support and development.

PARTNERSHIPS

- A** 72 NOTTINGHAMSHIRE: That conference agrees that the NHS 'zero tolerance' policy is not taken seriously by the NHS and the CCGs, therefore insists that these organisations change their position such that not only do they enforce the zero tolerance policy in future, but that they also actively support the victims.

LMC CONFERENCE

- A** 73 CONFERENCE OF ENGLAND LMCs: That conference agrees GPC should provide formal feedback on actions taken as a result of carried motions from the previous conference.

GMC

- A** 74 BEDFORDSHIRE: In relation to hearings by GMC, coroners and the courts which relate to alleged negligent behaviour by healthcare workers, conference believes that it should be mandatory that evidence of stress levels, overload and systemic problems related to the delivery of care to the patient(s) in question are presented to the hearing, and that evidence on these matters cannot be ruled as inadmissible.
- A** 75 CONFERENCE OF ENGLAND LMCs: That conference believes in the light of the successful appeal by Dr Bawa Garba, has no confidence in the GMC as a professional regulator.
- AR** 76 KENT: That conference proposes that the GMC be more transparent and:
- (i) inform doctors whenever a complaint is made against them
 - (ii) cease the practice of indefinitely retaining records of complaints that do not meet the threshold for investigation.
- A** 77 KENT: That conference believes the GMC executive should be elected by doctors.
- A** 78 SURREY: That conference in the light of the successful appeal by Dr Bawa Garba, has no confidence in the GMC as a professional regulator.

FUNDING

- A** 79 CONFERENCE OF ENGLAND LMCs: That conference:
- (i) welcomes the DDRB prioritising general practice in its 2018 report
 - (ii) condemns the government for failing to implement the 4% award in full
 - (iii) condemns the government for failing to provide practices with sufficient funding to pay their staff the equivalent of the Agenda for Change award made to other NHS staff
 - (iv) believes the failure of the government to properly invest in general practice will make recruitment and retention of GPs harder
 - (v) calls on the government to establish a truly independent pay review body for doctors, which binds them to award the recommendations made, in the same way that applies for MPs' pay.
- A** 80 SURREY: That conference deplores the failure of the government to implement in full the DDRB's 2018/19 recommendations for general practitioners

- A** 81 WORCESTERSHIRE: That conference believes that it is unacceptable for the government to ignore the recommendations of the Doctors' and Dentists' Review Body and acknowledges the detrimental effect on GP morale, recruitment and retention.
- A** 82 GLASGOW: That conference calls on GPC to work with government health departments to match the commitment of the Welsh Government this year and achieve implementation of the full the DDRB Pay Review in future years.
- A** 83 NORTHAMPTONSHIRE: That conference demands that the government fulfils its promise to increase core funding for general practice.
- A** 84 AVON: That conference demands that, notwithstanding recent modest funding increases, the government explains why it has significantly decreased funding to GPs over the past decade and that it remedies immediately the serious funding deficiencies in general practice.
- A** 85 NORTHERN IRELAND CONFERENCE OF LMCs: That conference instructs GPC UK to negotiate additional funding to address the increasing salary needs, including pension contributions, of our support staff.
- A** 86 LEWISHAM: That conference, whilst supporting practice development through quality improvement work, requires practice time to be appropriately resourced to deliver this.
- A** 87 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon the GPC to negotiate with the department of health to allow GPs to charge patients for services not available through the NHS.
- A** 88 EALING, HAMMERSMITH AND HOUNSLOW: This conference deplores the fact that many practices continue to be asked by local authorities to provide medical reports for safeguarding purposes without any funding and asks the GPC to:
- (i) make it plain to local authorities that this work is non-contractual and attracts a fee
 - (ii) work with the NHS England to ensure that there is a funding mechanism for non-contractual work.
- A** 89 HIGHLAND: That conference believes in the importance of good anticipatory care planning and asks GPC to negotiate adequate recurrent funding for these activities.
- A** 90 NOTTINGHAMSHIRE: That conference believes that in these troubled times general practice can be the salvation of the NHS, and calls for:
- (i) adequate funding to treat all our sick to the best of our ability patients regardless of postcode
 - (ii) adequate funding to train and continuously educate our NHS workforce
 - (iii) increased funding to maintain the health of the nation through a proper public health strategy.

INTEGRATED CARE AND WORKING AT SCALE

- A** 91 CONFERENCE OF ENGLAND LMCs: That conference calls for an end to the continued squeeze on health and social care budgets and that government realises that innovation, primary care at scale and joint working across health and social care cannot in itself be successful in delivering the government's health and social care agenda without adequate resources, financial, educational, clinical and managerial.
- A** 92 NORTHAMPTONSHIRE: That conference demands that there be an increase in funding to allow working at scale in a meaningful way.
- A** 93 NORTHAMPTONSHIRE: That conference demands that increased funding for working at scale is available at practice level.
- A** 94 CONFERENCE OF ENGLAND LMCs: That conference calls for an end to the continued squeeze on health and social care budgets and that government realises that innovation, primary care at scale and joint working across health and social care cannot in itself be successful in delivering the government's health and social care agenda without adequate resources, financial, educational, clinical and managerial.
- A** 95 CONFERENCE OF ENGLAND LMCs: That conference calls upon the GPC to make the process easier and simpler for GPs returning back to the UK, as currently they are finding the paperwork and retraining involved a challenge.
- A** 96 CONFERENCE OF ENGLAND LMCs: That conference believes comprehensive NHS Occupational Health Services should be available to all staff working in GP practices.
- A** 97 KINGSTON AND RICHMOND: That conference believes comprehensive NHS occupational health services should be available to all staff working in GP practices.

PRIMARY/SECONDARY CARE INTERFACE

- A** 98 LANCASHIRE PENNINE: That conference believes that understanding and mutual respect between consultants and GPs is hindered by workload pressures and calls on the BMA to promote national and local programmes to facilitate networking and understanding between the two branches of medicine.
[Supported by Conference of England LMCs]
- A** 99 NORTHERN IRELAND CONFERENCE OF LMCs: That conference commends GPs for delivering the flu vaccine campaign this year despite the supply problems and all the complications around this year's campaign. The conference calls on the Department of Health and Public Health Association to ensure the same problems do not happen next year.
- A** 100 NORTHAMPTONSHIRE: That conference demands that NHS 111 ceases to act merely to pass the public on to other areas of the NHS and to relieve pressure on GPs and A+E by offering good advice.

COMMISSIONING AND SERVICE DEVELOPMENT

- A** 101 CONFERENCE OF ENGLAND LMCs: That conference calls for an integrated and connected health service with a commitment to delivering care in the community with adequate and supported care organised by a primary health care team.
- A** 102 CONFERENCE OF ENGLAND LMCs: That conference believes that the funding for care in the community is inadequate and that:
- (i) patients are suffering
 - (ii) general practice cannot be the safety net for deficiency in provision of services.
- A** 103 KENT: That conference demands that no work that sits outside the GMS contract can be sent to GPs until it has been properly commissioned and funded.
- A** 104 WANDSWORTH: That conference demands that the funding of all enhanced services/locally commissioned schemes, whether commissioned by NHS England, CCGs or local authorities be reviewed regularly in order that the funding adequately reflects the rate of inflation on a yearly basis.
- A** 105 KENT: That conference demands that any clinical pathways, protocols or service changes that have an impact on general practice are agreed by GPC or LMCs before implementation and that this principle is formally recognised in any future service redesigns.
- A** 106 CONFERENCE OF ENGLAND LMCs: That conference demands that any clinical pathways, protocols or service changes which have an impact on general practice are agreed by GPC or LMCs before implementation.

PENSIONS

- A** 107 DEVON: That conference demands that prior to announcing increases in NHS pension contributions, satisfactory financial commitments are made to enable this money to be in practices base line funding.

INDEMNITY

- A** 108 CONFERENCE OF ENGLAND LMCs: That conference demands the issue of indemnity is sorted once and for all.
- A** 109 NORTHAMPTONSHIRE: That conference demands that state backed GP indemnity is from new funding.
- A** 110 DERBYSHIRE: With an increasingly mobile workforce and salaried GP indemnity often being paid by practices, conference is concerned about the impact of the requirement for run-off cover for claims-based indemnity which could leave both practices and GPs with inadequate medical indemnity. Whilst a state-backed indemnity scheme is pending, we urge GPC to create some robust guidance on this issue for practices.
- A** 111 NORTH STAFFORDSHIRE: That conference believes that the placing of the inflationary medico-legal indemnity cost burden within the general practice funding envelope will be unsustainable and will threaten the viability of the partner role and partnership model.

- A** 112 NOTTINGHAMSHIRE: That conference calls upon the GPC to explicitly adopt the policy that 'crown' indemnity must be provided to all primary care practitioners within general practice without any loss of either income or direct funding to practices.
- A** 113 WALTHAM FOREST: That conference, is appalled by the announcement that the forthcoming state backed indemnity scheme will be covered from within the existing GP allocation and:
- (i) believes that this will be another nail in the coffin of the partnership model as the funding will come directly from GP contracts
 - (ii) believes that this misrepresents what was originally proposed to the profession
 - (iii) urges GPC to negotiate a scheme in which the funding for indemnity is centralised and kept separate from practice funding.
- A** 114 AVON: That conference mandates negotiators to ensure that any package for a state backed indemnity does not result in lower funding through the global sum or other core funding.

PREMISES

- A** 115 HERTFORDSHIRE: That GPC negotiate an increased premises uplift for practices.
- A** 116 NORTHERN IRELAND CONFERENCE OF LMCs: That conference recognises that premises issues are rapidly becoming one of the most significant threats to the viability of practices going forward. The conference calls on GPC UK to negotiate a premises scheme that includes all of the devolved nations to address this significant threat
- A** 117 SCOTTISH CONFERENCE OF LMCs: That conference believes that practices should have access to financial support to allow them to adapt or add to existing premises in order to allow them to accommodate new allied health professionals.

WORKLOAD

- A** 118 AVON: That conference believes that sickness certification creates an unnecessary administrative burden upon GPs and calls upon GPC to negotiate the following changes:
- (i) an extension of self-certification from 7 to 14 days
 - (ii) allow allied health care professionals such as physiotherapists, midwives and nurses to complete fit notes
 - (iii) remove the responsibility for any sickness certification lasting longer than three months from GPs to specialised occupational health physicians.
- A** 119 DEVON: That conference agrees that a change in policy to allow Fit Notes to be signed by competent clinicians as well as GPs would help reduce GP workload and we urge the GPC to petition for such a policy change.
- A** 120 KENT: That conference demands the GPC negotiates a maximum level of safe working that:
- (i) sets a ceiling on the maximum number of patient contacts per day
 - (ii) allows for a declaration of a black alert
 - (iii) triggers a diversion to a CCG commissioned overflow service.

Agenda: Part II

(Motions not prioritised for debate)

WORKFORCE

- 121 SCOTTISH CONFERENCE OF LMCs: That conference believes that GPs nearing retirement need to be offered strong incentives to encourage them to continue to work and help ease the workforce crisis.
- 122 NOTTINGHAMSHIRE: That conference believes that the active retention of GPs who may be approaching retirement is essential to maintain GP services whilst workforce is being reconfigured and calls for:
- (i) incentives to encourage GPs to maintain defer retirement
 - (ii) incentives for practices to employ retired GPs
 - (iii) active help for “the last man standing” to prevent practices having to close as the only avenue left to enable retirement.
- 123 AVON: That conference given the large numbers of highly skilled and experienced GPs who have left clinical practice in the last ten years, and given the present GP shortage, conference calls upon the government to make it easier and worthwhile for retired GPs to return to clinical practice by offering appropriate inducements.
- 124 HERTFORDSHIRE: That GPC negotiate a review of the ending of seniority payments and ensure that there are ongoing and incremental financial incentives for GPs to be rewarded for time in post, to incentivise them to remain within the profession.
- 125 BRADFORD AND AIREDALE: That conference demands the immediate postponement of international GP recruitment and to use the funds from this programme to:
- (i) improve pay and fully implement the DDRB recommendations)
 - (ii) improve current working conditions especially of sessionals
 - (iii) support the retention of UK GPs.
- 126 CONFERENCE OF ENGLAND LMCs: That conference is dismayed at the large sums of money spent on trying to recruit overseas doctors yet failing to prioritise recruitment and retention of GPs who have been trained and are often well-established in the UK.
- 127 DEVON: That conference is disappointed that the IGPR scheme has not been the success that was heralded and implores GPC to negotiate with NHS England for a new, more attractive scheme.
- 128 SOUTH STAFFORDSHIRE: That conference expresses concerns about the shortage of GPs and demands that:
- (i) general practice is urgently declared a shortage occupation
 - (ii) EU doctors and nurses working in the NHS are urgently granted permanent residency in the UK
 - (iii) suitably qualified overseas GPs from countries in South Asia are urgently supported to accredit their qualifications and helped with visa applications to help with GP recruitment.
- 129 BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference supports the reintroduction of bursaries for student nurses, as this will increase workforce availability for primary care.

- 130 BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference supports NHS England offering some sort of student bursary for medical students who pledge to become GPs.
- 131 DORSET: That conference believes that improvements in access to general practice should be during practice opening hours and demands:
- (i) a fully funded expansion in practice workforce to deliver more capacity
 - (ii) funded training of the new workforce
 - (iii) new remuneration for general practitioners overseeing and taking responsibility for the actions of the new workforce
 - (iv) the money kept by practices who deliver extended hours following the agreement of the 2004 GMS contract continues to go to practices and does not support out of hours contracts.
- 132 HERTFORDSHIRE: That conference:
- (i) notes the failure to recruit the 5000 extra GPs promised in GPFV
 - (ii) is dismayed that the government is pressing ahead with plans for extended access when the workforce to deliver in-hours care is already so stretched
 - (iii) calls on GPC to get the government to suspend extended access at least until the GP workforce had been increased by the 5000 extra GPs promised in GPFV.
- 133 DEVON: That conference is disappointed that the GPC did not put more effort into disputing with the government the value of a 7 day 8am – 8pm GP service as there is no evidence of clinical gain but it is highly likely to have a detrimental effect on GP recruitment and retention.
- 134 HERTFORDSHIRE: That conference notes how ineffectual the GPFV has been in securing improvements to GP retention and recruitment.
- 135 SCOTTISH CONFERENCE OF LMCs: That conference recognises that a resilient out of hours GP service is vital to 24/7 patient care and calls on the government to include a focus on out of hours staffing in recruitment and retention strategies by means of improving remuneration and raising the profile of the out of hours GP role.
- 136 BEDFORDSHIRE: That conference:
- (i) notes that rather than Jeremy Hunt putting the NHS on track to recruit 5000 new GPs by 2020 the number of GPs is actually falling; and
 - (ii) welcomes the new Health Secretary and fervently hopes he succeeds in revitalising general practice where Jeremy Hunt so patently failed.
- 137 BEDFORDSHIRE: That conference believes that the NHS has no hope of getting an additional 5000/6000 GPs by 2020 unless the problem with GP premises is addressed satisfactorily.
- 138 BEDFORDSHIRE: That conference believes that the NHS has no hope of getting an additional 5000/6000 GPs by 2020 unless the problem with GDPR is addressed satisfactorily.

PUBLIC HEALTH

- 139 DERBYSHIRE: Conference asserts that the management of substance abuse, including prescription and over the counter medication is a specialist service and not part of the GMS contract and instructs GPC to advise NHS England and RCGP accordingly.
- 140 WELSH CONFERENCE OF LMCs: That conference demands that 'social prescribing' be re-named urgently in order to de-medicalise the concept.
- 141 GLOUCESTERSHIRE: That conference is dismayed that the life expectancy of UK citizens is less than that for comparable nations and calls on the BMA to urgently find out why.
- 142 NOTTINGHAMSHIRE: That conference deplores the decision to allow public health budgets to be controlled by local authorities resulting in the continuing underfunding particularly of sexual health, drug and alcohol services, and
- (i) calls on the government to urgently bring public health budgets under NHS control
 - (ii) increase funding to these essential community services
 - (iii) increase training provision in these areas enabling these GPs with a special interest in this area to more adequately treat these vulnerable members of our society.
- 143 LEEDS: That conference believes that the separation of public health from the NHS has led to increased bureaucracy both nationally and locally, unacceptable funding cuts that have been damaging for patients' health and undermined practices' ability to offer comprehensive services to their patients, and therefore calls for this policy to be reversed.
- 144 NORTHUMBERLAND: The NHS 10 year plan is based on prevention; however, this occurs at a time when public health budgets are yet again reducing. Conference demands that we utilise efficiently and adequately resource our public health colleagues.
- 145 SOMERSET: That conference deplores the cuts forced upon local government to sexual and other public health services and:
- (i) acknowledges that this is putting more pressure on already overstretched practice teams
 - (ii) instructs BMA to call out this unacceptable but entirely predictable result of the fragmentation of health services, and
 - (iii) instructs BMA to reiterate demands for properly funded public health services as being essential to a civilised, modern society.
- 146 LAMBETH: That conference:
- (i) deplores previous and planned cuts to the public health budget
 - (ii) asks the BMA to lobby the government to bring smoking cessation services, sexual health services, and substance misuse services in England back into the control of NHS England and/or CCGS.
- 147 LIVERPOOL: That conference believes that illness is neither an indulgence for which people should have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community, with NHS services being free at the point of contact and not adding to other social inequalities.

- 148 AVON: That conference is deeply concerned about the government's incompetent and inadequate response (through public health) to the measles outbreak last year. It considers that public health is not adequately resourced to deal with future infectious disease outbreaks and that the government needs to address urgently the issue of funding, instead of taking the lazy default response that general practice would take responsibility for dealing with infectious diseases outbreaks.
- 149 BRADFORD AND AIREDALE: That conference demands that patients who attend A&E due to alcohol intoxication should be invoiced with a means tested charge to be used to fund public health campaigns regarding the dangers of drinking to excess.
- 150 BRADFORD AND AIREDALE: That conference demands that government bans advertising unhealthy food to children, improves nutritional education in schools and medical schools and makes healthy food more affordable.

GDPR

- 151 NORTH YORKSHIRE: Whilst conference welcomes new technology that may improve both a patient's and clinician's experience, it is concerned by the Secretary of State for Health and Social Care's plan to drive forwards or endorse various non evidence based IT projects and instructs GPC to negotiate that:
- (i) before embarking on new technology, it is ensured that our current technology functions adequately
 - (ii) current technology (such as fax machines) are not decommissioned prior to there being reliable electronic alternatives in place for all the NHS and partners to use
 - (iii) that any new technology suggested for use in primary care is evidence based before it is introduced.
- 152 TAYSIDE: That conference, whilst welcoming plans to phase out fax machines use within the NHS as an outdated modality, demand that governments and health boards/authorities ensure that any replacement method of communication to/from general practice links directly with GP clinical systems and does not use personal NHS email addresses or involve printing/scanning/copying documents into practice systems
- 153 SURREY: That conference believes that:
- (i) IT innovation offers opportunities to facilitate patient consultations
 - (ii) the GP core contract capitation payment arrangements must support the wider use of IT within general practice.
- 154 HIGHLAND: That conference accepts that security of information and the NHS network is of vital importance to all patient care and instructs GPC to seek better centrally funded measures of support for general practice.
- 155 HIGHLAND: That conference believes that GPs and other clinicians providing services in the out of hours must have the appropriate information technology to perform their roles and looks to GPC to investigate the extent to which this is currently being achieved.
- 156 MID MERSEY: That, in the current climate, conference believes that Practice Data Protection Officers should be able to receive free training to ensure a high standard throughout the UK.

GPs WORKING IN SESSIONAL ROLES

- 157 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference condemns locum transfer fee clauses which require practices to pay a proportion of newly appointed salaried GPs salary to the agency they previously worked through. This disadvantages individual GPs recruitment prospects, places a financial burden on practices and fuels the general practice workforce crisis. We call on GPC to:
- (i) work with NHS England to ban the use of these clauses in general practice
 - (ii) make individual GPs and GP practices aware that such clauses exist and provide advice on how to avoid and challenge them.
- 158 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee:
That conference is concerned by the Chancellor's announcement that IR35 will be extended to the private sector and the impact that this will have on freelance GPs. We call on GPC to:
- (i) engage with relevant consultations on the introduction of the regulation and lobby to minimise the impact on GPs
 - (ii) ensure that there is timely guidance and support available to GPs affected by the legislation.

EDUCATION AND TRAINING

- 159 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference recognises that trainees' terms and conditions exist to maximise educational opportunities and protect trainees to ensure the best trained GPs for the future. We call on GPC to lobby relevant stakeholders to introduce training for trainers on relevant aspects of their trainees' terms and conditions and employment law to ensure that all trainees are treated fairly and consistently.
- 160 BIRMINGHAM: That conference requires GPC UK to resist any post - Brexit attempt to remove or weaken the GP Vocational Training Regulations.
- 161 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference:
- (i) regrets that trainees who return to work from a prolonged period of leave (e.g. maternity, shared parental or sick) are frequently unilaterally reallocated into rotations differing to those previously competitively allocated at selection
 - (ii) believes that the practice of reallocating posts following prolonged periods of leave is unjust and disproportionately affects women
 - (iii) calls upon the BMA to lobby relevant stakeholders to create joint guidance to end this practice and promote a model that seeks to honour original rotation allocations.
- 162 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference notes that retention of GP trainees is essential for recruitment to post-CCT GP posts. With this in mind we believe that facilitating LTFT working with a flexible approach is essential, which may require simple solutions such as term-time working and 'step-up, step-down' working patterns.

- 163 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference is concerned that junior doctors are burning out and struggling with their workload. With the King's Fund announcement that qualified GPs work on average 3.5 days we call upon GPC to work with relevant bodies to allow trainees to work at:
- (i) less than full time for any reason
 - (ii) any percentage with appropriate notice.
- 164 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference welcomes the increase in medical student numbers and the creation of new medical schools. We call on GPC to work with relevant bodies to ensure:
- (i) parity of payment with secondary care for undergraduate placements
 - (ii) ensure we increase capacity and not use current GP training places
 - (iii) increase the capacity to train GPs and practices to trainer status.
- 165 DERBYSHIRE: With the drive towards an increased skill mix within general practice, conference calls for the creation of a national competency framework for all general practice based allied health professionals.
- 166 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference recognises that academic GP is an important and relevant career for trainees and call on GPC to work with relevant bodies to ensure there is pay parity with secondary care academic doctors.
- 167 LIVERPOOL: That conference believes that the current pressures on general practice is failing to take account of the fact that increasing numbers of students at undergraduate and postgraduate stages, are requiring placements in general practice to meet the needs of the changing workforce; unless planning and investment priorities recognise these core activities and ensure that time and resources are available to adequately train the future workforce, there will be long term damage to teaching, training and research in primary care and community settings.
- 168 GREENWICH: That conference believes that general practice is at a breaking point in trying to maintain standards and deliver quality patient care and demands that NHS England provides:
- (i) the resource necessary to urgently implement the recommendations suggested in the GMC 2018 Annual report
 - (ii) support and mentoring for all practice staff; and
 - (iii) promotion and protection of continuing professional development (CPD) and other non-clinical activity.
- 169 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference believes that all training practices need to demonstrate a thorough knowledge of the GP trainee contract in order to be permitted to continue as training practices.
- 170 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference recognises the importance of GP trainees' representation within the BMA and guarantees trainee representation at all meetings relevant to GP training in all nations.

REVALIDATION

- 171 SUFFOLK: That conference insists GPC highlight the unintended consequences of revalidation, which can impact severely on individual GPs; and that GPC seeks commitment from both NHS England and the GMC to ensure that:
- (i) extra unnecessary steps and/or inappropriate delays are not inserted by individual NHS England responsible officers, without proper lawful basis and justification
 - (ii) that responsible officers do not seek to replicate, or duplicate, an individual GPs appraisal
 - (iii) that the confidential nature of 1:1 appraisal discussions is respected
 - (iv) that all GPs are routinely advised who to contact if they feel their revalidation journey is not being handled fairly
 - (v) all responsible officers involved in making revalidation recommendations about GPs have sufficient knowledge and understanding of the highly varied nature of modern GP working patterns, in order for them to be competent in fairly assessing any individual GPs suitability for revalidation.
- 172 GLASGOW: That conference believes that responsible officers should not be able to decide, based solely on the number of sessions of general practice work undertaken, to refuse to make revalidation recommendations. This threatens the sustainability of general practice and conference insists instead that a supportive approach to facilitate appraisal, revalidation and safe practices is adopted.
- 173 SUFFOLK: That conference asks GPC to seek a further review of the wording in the 'Low Volume GP Clinical Work Guidance' introduced by NHS England in July 2018; (likely to soon be adopted in the four nations) to ensure that (mindful of the NHS Public Sector Equality Duties as per Section 149 of the Equality Act 2010) vulnerable subgroups of GPs are not at risk of inappropriate challenge or unlawful discrimination by NHS England, purely because of a low volume of clinical work when there are no performance concerns arising from :
- (i) disability related sickness absence
 - (ii) maternity or paternity related absence
 - (iii) absences from work related to any other protected characteristic as set out in the Equality Act 2010.
- 174 HULL AND EAST YORKSHIRE: That conference is still concerned about the implications of the Bawa Garba case and what it means for appraisal and revalidation for GPs. We call on the BMA to provide clear and concise information about the actions that GPs can take to ensure that they do not fall foul of the necessary regulations. (Supported by North and North East Lincolnshire)
- 175 SUFFOLK: That conference demands that GPC ensures that doctors' personal reflections during appraisal and revalidation should be protected by law and not used by GMC as evidence in fitness to practice cases.
- 176 NORTH ESSEX: That conference believes that:
- (i) GPs are increasingly compromised in meeting all the duties of a doctor, as set out in 'Good Medical Practice', through the decisions made by external bodies
 - (ii) all external bodies with power to impact on, or influence, the duties of a GP must have responsibility to ensure that their decisions do not adversely impact a GP's ability to meet all duties of doctors, as stated in 'Good Medical Practice'

- (iii) GPC should insist that all such bodies, including commissioners, must carry out an impact assessment on the ability of GPs to meet the duties of a doctor, as stated in 'Good Medical Practice, as part of their decision making process for any proposals that may have an impact on general practice.

PERFORMANCE

- 177 WORCESTERSHIRE: That conference is alarmed that NHS Performance Advisory Groups do not require the attendance of an LMC representative in order to be quorate and demands that:
- (i) LMC representatives are present when GP Performer cases are discussed
 - (ii) protection is given to GPs who run Special Allocation Schemes as they are more likely to receive vexatious complaints
 - (iii) whistle blowers are kept informed and updated about outcomes of their cases
 - (iv) when a complaint is not upheld, any record of the complaint be removed from the retained record of that doctor.
- 178 NORTH ESSEX: That conference believes that:
- (i) GPs are increasingly compromised in meeting all the duties of a doctor, as set out in 'Good Medical Practice', through the decisions made by external bodies
 - (ii) all external bodies with power to impact on, or influence, the duties of a GP must have responsibility to ensure that their decisions do not adversely impact a GP's ability to meet all duties of doctors, as stated in 'Good Medical Practice'
 - (iii) GPC should insist that all such bodies, including commissioners, must carry out an impact assessment on the ability of GPs to meet the duties of a doctor, as stated in 'Good Medical Practice, as part of their decision making process for any proposals that may have an impact on general practice.

BREXIT

- 179 LEWISHAM: That conference believes that given the risks posed to patient care by Brexit and EU departure, a mandate for a second UK referendum is now required.
- 180 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference lobbies the treasury for the £250 million weekly post Brexit to be spent in primary care on improving mental health resources.

PRESCRIBING

- 181 NOTTINGHAMSHIRE: That conference realises the possible value of prescribing incentives schemes to NHS finance and in promoting good prescribing practices but tasks the GPC to negotiate a guaranteed level of re-investment back into general practice to recompense practices for the hard work it is saving the commissioners.

- 182 COVENTRY: That conference demands that GPs retain the right to prescribe so called 'low priority' prescriptions and that whilst recognising the importance that GPs look at more cost effective alternatives, GPs should be
- (i) trusted to make the best decisions for their patients, and
 - (ii) able to prescribe these so called low priority prescriptions where the GP believes they are the best treatment option for that patient.
- 183 HAMPSHIRE AND ISLE OF WIGHT: That conference notes the increasing demands on GPs to complete funding forms for NHS continuing healthcare funding for patients approaching end of life and believes that:
- (i) GPs are not best placed to complete these forms
 - (ii) is not the purpose of CHC funding
 - (iii) diverts funding away from patients who should qualify for CHC funding under the national framework
 - (iv) reflects underfunding of end of life care needs.
- 184 CONFERENCE OF ENGLAND LMCs: That conference believes that communications to primary care should be paperless.
- 185 CONFERENCE OF ENGLAND LMCs: That conference is aware that in some areas two week wait does not mean what it says and demands NHS England step in to enforce this when required.
- 186 WELSH CONFERENCE OF LMCs: That conference demands that 'social prescribing' be re-named urgently in order to de-medicalise the concept.
- 187 GLOUCESTERSHIRE: That conference is dismayed that the life expectancy of UK citizens is less than that for comparable nations and calls on the BMA to urgently find out why.
- 188 LAMBETH: That conference deplores Britvic's sponsorship of Diabetes UK which compromises the charity's aims and calls for any local diabetes initiatives backed by Diabetes UK to be boycotted.
- 189 CLEVELAND: That conference supports hospital letters being written directly to patients, but insists that:
- (i) minimum professional standards must also be adhered to, in order that these letters can form a clinically safe part of the GP medical record
 - (ii) that electronic communications between secondary care and general practice are further developed to ensure that GPs receive letters before patients
 - (iii) if letters are to be sent to patients these must be structured properly to be of use to GPs without wasting their time.
- 190 CLEVELAND: That conference demands a review of prescription charges in England, to specifically include:
- (i) the extension of the conditions eligible for medical exemption
 - (ii) a cap on the maximum charge to each individual patient in one year.
- 191 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.

- 192 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.
- 193 EAST SUSSEX: That conference requests GPC to negotiate a nationally agreed DNAR template for use across England and agreed national protocols for its implementation.
- 194 SANDWELL: That conference conveys to NHS England and the Department of Health it's concern about the failure of trusts to adhere to the six amendments to the NHS standard contract, particularly the provisions for DNA and blood test follow up policies.
- 195 CORNWALL AND ISLES OF SCILLY: That conference believes any attempt to prevent a GP requesting help from a secondary care department contravenes GMC guidance on the need to recognise and work within the limits of competence.
- 196 CORNWALL AND ISLES OF SCILLY: That conference defends the right of GPs to tailor guidelines to an individual patient's needs and will oppose attempts to make GPs follow 'one size fits all' protocols.
- 197 HAMPSHIRE AND ISLE OF WIGHT: That conference believes it should be a professional obligation for hospital doctors to introduce themselves by full name and job title when answering beeps to assist communication with GPs.
- 198 DORSET: That conference calls for a full evaluation of IAGPS and GP streaming initiatives to assess whether the money would be better invested in core general practice.
- 199 BERKSHIRE: That conference believes requests for GPs to assess mental capacity for reasons of Power of Attorney, Deprivation of Liberty Safeguards (DOLS) and other legal reasons lies outside both the contractual obligations and the usual competences of GPs and calls on GPC to produce further guidance in order to support GPs in refusing this work.
- 200 BARNET: That conference recognises when requiring two week wait bookings to be made via eRS this adds to an increase in workload, not just for GPs but also practice administrative staff, and significantly in the areas of monitoring work-lists and chasing referrals. Further, this raises important questions about clinical liability in the process if, for reasons outside a GPs control, the referral results in a deferred or cancelled appointment, and instructs GPC to work with NHS digital to further support GPs and their staff in resolving these problems.
- 201 LOTHIAN: That conference opposes misleading and unscientific claims made in specialist infant milk advertisements in medical journals and calls on the government to tighten regulation of such advertising claims, building on the plans made in the 'Feeding Products for Babies and Children (Advertising and Promotion) bill 2016-2017, to reduce industry driven over diagnosis in infant feeding.
- 202 HERTFORDSHIRE: That conference believe that all GMC registered doctors (whether Private or NHS) should have the right to issue any medication on a FP10 (subject to local or national guidelines) to any UK citizen or person qualifying for NHS treatment.

- 203 HERTFORDSHIRE: In light of the use of disclaimer statements relating to private GP prescriptions from online GPs, conference calls upon GPC to:
- (i) ensure that full responsibility rests with the prescribing private GP
 - (ii) challenge the validity of disclaimer statements
 - (iii) negotiate that private GP prescribing is in accordance with local CCG prescribing guidance for the area where the patient lives when it is expected or likely that the NHS GP is to continue a prescription.
- 204 DEVON: That conference recognises that continuity of care in general practice increases quality of care, increases patient satisfaction and calls on NHS England to incentivise it.
- 205 AVON: That conference deplores the mechanism by which NHS England is imposing restrictions on over the counter medicines, which places GPs in direct conflict with patients, and demands that these medications are placed on a national blacklist if their use is to be curtailed.
- 206 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls that general practitioners have been put at risk by NHS England's 'Guidance on conditions for which over the counter items should not routinely be prescribed in primary care' and demands that no further extension to this project are made without appropriate alteration to regulations.
- 207 WEST PENNINE: That conference believes NHS England requires proof of NHS eligibility, and a minimum dataset of; particular vaccine used, batch no and date of expiration, site of injection whenever a vaccine is administered and, when that is not undertaken by the patients practice, that full dataset is shared with the practice.
- 208 GLASGOW: That conference urgently calls on our negotiators to work with the four nations governments' to ensure access to mental health services in the community and particularly to CAMHS is significantly improved.

CONTRACT NEGOTIATIONS

- 209 CONFERENCE OF ENGLAND LMCs: That conference believes that the rise of out of area alternate primary care providers:
- (i) has the potential to destabilise the local health economy, threatening the viability of the current model of general practice
 - (ii) urges the government to halt the roll out of these models before it has considered the impact on primary care
 - (iii) requires the government to reassess the benefits of online consulting to the patients
 - (iv) instructs the GPC to insist that all providers must offer and deliver a full range of services, equitably, to all patient groups without any exceptions based on age, sex and morbidity or technological competence
 - (v) calls for the abolition of the out of area registration clause in the GMS contract.
- 210 SEFTON: That conference supports the NHS Long Term Plan in calling for the repeal of the compulsory procurement of health care provision (Section 75 of the Health and Social Care Act 2012) and to free the NHS from inclusion in the Public Contract Regulations.

- 211 SUFFOLK: That conference insists that GPC clarifies the definition of 'attended' in the case of GPs certifying death in the context that other health care professionals are often the last to have direct or significant contact with terminally ill patients.
- 212 HAMPSHIRE AND ISLE OF WIGHT: That conference notes many GPs are unable to offer a comprehensive range of medical services to all patients and demands a contractual change be negotiated enabling GPs to provide non-NHS services privately to their own registered patients, bringing the alternative of holistic and continuing care to the existing private options.
- 213 NORTH YORKSHIRE: That conference is anxious that GPC is actively involved in the preparations for the proposed introduction of medical examiners for death certification from April 2019 to avoid a collapse of the management and logistics of death certification.
- 214 BRADFORD AND AIREDALE: That conference calls on GPC to demand that NHS England stop advising CCGs to encourage GPs to break their terms of service via national 'guidance' and instead negotiate the appropriate amendments to the regulations and SFE.
- 215 NORFOLK AND WAVENEY: That conference asks GPC to negotiate reimbursement for the employment of social prescribers within general practice believing that they enhance integrated health and social care at a time of huge budget cuts in social services affecting the most vulnerable in society.
- 216 BRENT: That conference regrets that NHS Choices does not provide an adequate mechanism for constructive feedback to practices on the patient experience and calls upon GPC to demand changes to the NHS Choices website which:
- (i) encourage patients to contact their practice in the first instance
 - (ii) strengthen moderation of anonymously posted negative comments and make changes to enable practices to respond positively to patients concerns.
- 217 REDBRIDGE: That conference disagrees with David Geddes interpretation of the GMS contract and what is required to meet the reasonable needs of our patients and instructs GPC to:
- (i) robustly support and represent any practice found in breach of their contract for not complying with the David Geddes definition of reasonable needs
 - (ii) provide information for the public explaining why some practices need to close for half a day per week
 - (iii) legally challenge any CCG or NHS England Area Team that breaches a practice on the basis of David Geddes' interpretation.
- 218 MORGANNWG: That conference is concerned at an apparent change in DVLA process which has seen increasing numbers of patients directed to GPs before applying for licence renewals and calls on DVLA to stop wasting valuable GP appointments in order to compensate for their own lack of medical advisory personnel and to ensure they remunerate GPs promptly for reports provided.
- 219 HERTFORDSHIRE: That conference:
- (i) has reached the conclusion that the GPFV is a smokescreen and that general practice is undergoing a significant intentional disruptive change, and

- (ii) calls on the GPC to find a way to work with HMG, as this process continues, to prevent the process being as disorderly as it is at the present.
- 220 DEVON: That conference demands that the arrangements for home visits for out of area registered patients are reviewed such that:
- (i) all such patients have a defined provider of home visits
 - (ii) that the arrangements meet the same standards as a fully registered patient
 - (iii) all such patients and the registering practice are informed as to those arrangements.
- 221 BRADFORD AND AIREDALE: That conference notes the dramatic success of the '5p plastic bag tax' and request that the GPC negotiate for GPs to be permitted to levy a maximum 20p charge for all surgery appointments and home visits.
- 222 WIRRAL: That conference believes that current GP contract is no longer fit for purpose and should be completely re-negotiated.
- 223 AVON: That conference agrees that whilst home visits are an essential part of British general practice, they are unsustainable with the current funding structure and the crisis affecting general practice. Conference therefore calls on GPCUK to negotiate with Health Departments to ensure that there is:
- (i) appropriate bespoke funding to ensure that every practice is able to field a dedicated visiting doctor for at least part of every working day
 - (ii) recognition and acceptance by health departments that it is not a patient's right to have a home visit but should be a clinical decision made by a doctor
 - (iii) agreement that GPs can genuinely refuse to visit patients who are not genuinely house bound, without fear of complaint or action for breach of contract.
- 224 AVON: That conference believes that QoF is now outdated and is a distraction from providing targeted care to those who most need it and the funding for chronic disease management should be moved into the global sum.
- 225 AVON: That conference following the success of GPC Scotland in their contract negotiations, conference calls upon GPC England to follow their lead and to negotiate a new national GP contract in England.
- 226 AVON: That conference calls for the GPC to negotiate on a robust itemised fee-for-service contract for primary care, rather the current unsustainable block contract.
- 227 DERBYSHIRE: That conference demands GPC lobby for legislation to reinstate the Health Secretary's duty to "secure or provide" free of charge "a comprehensive health service for the prevention, diagnoses and treatment of illness" which was removed by the 2012 Health and Social Care Act, section 75.
- 228 DERBYSHIRE: That conference calls for the NHS to be de-politicised and for GPC UK to push for a cross-party approach to the NHS to be legislated for across the United Kingdom.

PARTNERSHIPS

- 229 NORTH YORKSHIRE: That conference believes the recommendations of the GP Partnership Review should be incorporated in full into the NHS 10-year plan if we are to sustain the GP partnership model and reverse the GP recruitment and retention crisis.

GPC/GPDF

- 230 HERTFORDSHIRE: That conference acknowledges the various consultations and reviews coming to fruition in 2019 and calls upon the GPDF to work with GPC England and, inter alia, the BMA in providing targeted financial support towards a public facing campaign to raise awareness of the perfect storm facing general practice and to galvanise patient, public and pan-professional support in advance of national contract negotiations.
- 231 KENT: That conference demands the GPC develops a media strategy to:
- (i) promote safe and effective use of general practice
 - (ii) show general practice in a positive light.
- 232 DEVON: That conference demands that this year contract negotiations have clear objectives that if not achieved can result in swift action being able to be taken by the profession rather than waiting until the next conference.
- 233 NORTH WALES: That conference believes that following the GPDF reforms, the Conference of Representatives of LMCs is now the forum to discuss the working and business relationships between LMCs and GPDF.
- 234 DYFED POWYS That conference demands the end to the disagreements and hostilities between GPDF and BMA immediately for the sake of national GP representation UK wide.
- 235 MID MERSEY: That given the increasing role of nurse practitioners and other non-medical clinicians in primary care, conference considers that GPC and LMCs should now take steps to ensure representation for all clinicians working in general practice.
- 236 KENT: That conference urges the GPC to establish a committee to represent the needs of small rural and semi-rural practices in these days of urbanisation and federation.
- 237 MANCHESTER: That conference agrees that following the mysterious decision to include GPC as part of the BMA, that clarity is sought as to what the GP Defence Fund levy is used for and suggests that until this information is forthcoming and all the necessary due diligence checks are undertaken, that LMCs withhold the GP Defence Fund levy.
- 238 HAMPSHIRE AND ISLE OF WIGHT: That conference, despite repeated calls, notes that the package of reforms promised to conference as a package (the Meldrum reforms) have yet to be implemented in full and demands that GPC deliver the reforms that conference were promised.
- 239 SOMERSET: That conference believes that the BMA should take affirmative action to become more representational of the wider workforce.

- 240 CAMBRIDGESHIRE: That conference reminds the GPC that GPs have repeatedly shown strong support for the provision of an NHS that is free at the point of contact for all, and calls on GPC to strongly publicise this fact, and in addition to:
- (i) commit to being visible and vociferous in educating the general public about the true state of general practice in today's NHS
 - (ii) make the general public aware that we risk losing the entire NHS if general practice fails
 - (iii) harness the huge amount of affection and support that the general public has for the NHS into a greater understanding of how patients can help better understand and support general practice and the wider NHS, through a national, powerful, patient-facing campaign to save general practice.

LMCs/LMC CONFERENCE

- 241 TAYSIDE: That conference believes that, in relation to local medical committee and GP subcommittee office bearers, the title 'medical secretary' is no longer fit for purpose and calls on GPC to agree an alternative title for this role.
- 242 BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference requires the Agenda Committee to include controversial and fun motions in the first part of the agenda.
- 243 NOTTINGHAMSHIRE: That conference believes the GMC suffers from a top-down institutional lack of insight and demands that the GPC works to ensure that:
- (i) the GMC is reorganised with independent senior medical leaders overseeing its reorganisation
 - (ii) the GMC becomes simply a licensing body and all disciplinary matters become the remit of the MPTS
 - (iii) a final decision made by the MPTS is just that and cannot be appealed by the GMC
 - (iv) the GMC will be directly funded from taxation with no loss of income to any doctor.
- 244 CAMBRIDGESHIRE: That conference believes, in the seven months since Dr Bawa-Garba was reinstated to the medical register, that the GMC has failed to do enough to address the concerns of the profession regarding this case, or to restore faith in their regulation of the profession and calls on the GMC to openly communicate how they intend to earn and restore professional trust in the organisation.
- 245 CUMBRIA: That conference believes that the GMC needs to improve its sensitivity, timeliness and general handling of trivial cases being referred to GMC as the end result is often a demoralised and demotivated GP who has yet another reason to leave the profession.
- 246 NORTH WALES: That conference calls for the General Medical Council to account for increasing this year's annual registration fee whilst still offering their staff expensive perks such as private health insurance.

- 247 NOTTINGHAMSHIRE: That conference believes a pervasive 'guilty until proven innocent' attitude exists among the overbearing regulatory bodies, which is creating a culture of intimidation and harassment of GPs by the NHS, GMC, CCGs and CQC. It therefore calls upon GPC to:
- (i) demand that the regulators adopt the fairer stance to the contrary ie 'innocent until proven guilty'
 - (ii) put a mechanism in place to stop GPs leaving the profession due to anxiety, stress and burnout following punitive regulatory measures.
- 248 KENT: That conference instructs that the statutory standard of proof required by GMC and any other local authorities to find a charge against a doctor should be 'beyond reasonable doubt' rather than the present 'balance of probabilities'.
- 249 KENT: That conference notes with concern the increasing distance between the GMC and the medical profession and calls for the GMC to be publicly funded.
- 250 SUFFOLK: That conference calls upon GPC to challenge that CQC routinely include inappropriate NHS resource utilisation (to include both primary and secondary care) as an inverse measure of quality when inspecting care facilities.
- 251 EAST SUSSEX: That conference requests GPC to negotiate a nationally agreed set of mandatory GP training requirements that will meet both:
- (i) CQC Inspection, and
 - (ii) NHS appraisal requirements
- 252 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference welcomes the high-court judgement allowing Bawa-Garba to work as a doctor again but feel the original charge was wrong. We call upon the BMA to continue to work with the relevant bodies to push for a change in the law for gross negligence manslaughter to reflect the Scottish law.

FUNDING

- 253 SHROPSHIRE: That conference demands the GPC urgently research current inequalities in funding for non core GMS work in different parts of the country, to help provide more accurate help, advice and support to LMCs having to negotiate for this with individual CCGs.
- 254 DEVON: That conference demands that with contract uplifts, the advice of the Doctors and Dentists Pay Review Body be adhered to with the same diligence as the MPs Pay Review Body.
- 255 DEVON: That conference requests that the GPC clarify why the advice of the Doctors and Dentists Pay Review Body was ignored by the government and push during next negotiations for a package to 'save general practice' and not a half-hearted attempt to pacify it!

- 256 AVON: That conference although acknowledging a recent small uplift in general practice funding, conference believes that funding in real terms continues to decline given the spiraling workload in general practice and it demands that:
- (i) the GPC negotiates a clear mechanism to allow a demonstrable link between services delivered and funding provided in all four nations
 - (ii) the UK government acknowledges the serious funding deficit in general practice and is publicly held to account for this by GPC UK
 - (iii) serious ongoing funding deficiencies in general practice are reversed.
- 257 NORTH YORKSHIRE: That conference believes the £4.5 billion committed to primary medical and community services in the next five years should deliver nationally agreed progressive annual increases in core general practice funding.
- 258 DERBYSHIRE: That conference calls for practice nurse training costs currently met by individual GP partnerships to be met by Health Education England in order that:
- (i) practice nurse training, particularly in areas such as chronic disease management, becomes more standardised
 - (ii) when practice nurses move on to new roles, possibly in locations of greater need, their current employer is not penalised having invested in their training only for their skills to be beneficial elsewhere.
- 259 MANCHESTER: That conference:
- (i) supports the availability of public access AEDs by members of the public on the advice of the local ambulance service, but is concerned that owners of the devices may restrict/deny use of their AEDs because of the risk of loss, theft, or damage; and
 - (ii) calls on the NHS (in each nation of the UK) to indemnify GP surgeries for public use of their private property when providing immediately necessary care to the public and provide reimbursement for the cost of consumables, eg disposable pads.
- 260 BRADFORD AND AIREDALE: Conference demands that GPs can charge:
- (i) their own patients a private fee for services that are not funded by the NHS
 - (ii) their own patients for services that are delivered outside their contracted hours
 - (iii) for all services delivered to overseas visitors.
- 261 NORTH YORKSHIRE: That conference believes that GP appointments are premium commodities for many patients, so must remain free at the point of access but conference calls on the GPC to advise on a practical procedure to enable the option for practices to rightfully charge a penalty to individual patients, who abuse the system and miss their appointment for no good reason other than apparent carelessness.
- 262 BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference supports that the patient care should be quality over equality and can be achieved by the patient being able to top up the cost of basic NHS care and asks that GPC England demands action from NHS England.
- 263 BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference supports that the patient should have the right to top up basic NHS care with their own funds where this care is deemed to be in the interest of the patient and asks that GPC England demands action from NHS England.

- 264 AVON: That conference calls on the government to introduce a system of patient fees for access to primary care.
- 265 CORNWALL AND ISLES OF SCILLY: That conference supports that in the NHS no one should be prevented from receiving excellent healthcare by poverty and that this is more important than the dogma that all healthcare should be free at the point of delivery.
- 266 LEEDS: That conference notes the increased investment being made by governments across the UK to expand the workforce working alongside practices and believes that this should be accounted for separately from core G/PMS funding in the annual investment report produced by NHS Digital.
- 267 DORSET: That conference believes that elderly patients need an increasing share of general practice's resources and demands:
- (i) increased funding to practices who have a higher than average elderly population
 - (ii) that funding is new money not a reworking of the Carr-Hill formula
 - (iii) that training and support in care of the elderly is fully funded to the extended primary healthcare team.
- 268 BRADFORD AND AIREDALE: That conference demands that funding is increased to support the development and implementation of technology to help patients self-manage their own chronic illness.
- 269 BUCKINGHAMSHIRE: That conference believes access to GPFV funding for staff training purposes is difficult and via an opaque and onerous process and calls on GPC to take steps to ensure GPFV monies are available swiftly and up front prior to any overhead costs on the part of the practice.
- 270 DEVON: That conference demands that NHS England demonstrate where the monies promised in GPFV to save general practice have been invested to dispel the myth that large amounts have been spent in administration or have simply been recycled or rebadged.
- 271 AVON: That conference calls on NHS England to make it mandatory that CCGs publish transparently and accurately how GP Forward View monies are being spent or wasted.
- 272 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon the GPC to finally negotiate a definition of role of the GP to allow extra funding to come into primary care.

CONTINUITY OF CARE

- 273 NORTHAMPTONSHIRE: That conference insists that there is no more expansion of GP services until the workforce is available to support them.
- 274 NOTTINGHAMSHIRE: That conference applauds the efforts to engage and nurture GPs at the beginning and end of their working lives, it is increasingly alarmed that mid-career GPs (the 'inbetweeners') are being deprived of the same opportunities and tasks the GPC to lobby for:
- (i) new fellowship programmes to be created which are open to GPs of all career stages; and
 - (ii) the opening up of access to existing Fellowship schemes to all GPs.

- 275 SOUTH STAFFORDSHIRE: That conference deplores the discontinuation of occupational health services for general practice staff other than GPs, and demands that NHS England urgently reinstates a universal occupational health service, fully funded by the NHS and to cover all practice staff, to include health professionals such as nurses, ANPs, pharmacists, management and all administrative staff.
- 276 LANCASHIRE COASTAL: That conference believes that:
- (i) too many of the young and talented GPs in the profession hate their jobs
 - (ii) this is not conducive to the delivery of safe, effective and efficient primary care
 - (iii) urgent measures should be taken to look at the reasons why so many hate their jobs and identify the ramifications for recruitment and retention.

INTEGRATED CARE

- 277 DORSET: That conference calls for Integrated urgent care services to be no longer seen as a 'Cinderella specialty' but to be adequately resourced, valued and recognised as a vital part of primary care and the NHS as a whole.
- 278 LEWISHAM: That conference believes that general practice needs to be perceived as an equal partner in integrated healthcare systems, rather than a conduit for work and risk that other parties are reluctant to take on. (Supported by Conference of England LMCs)
- 279 CROYDON: That conference has no confidence in the GP Forward View as the vehicle to provide the required investment needed to safeguard the future of NHS general practice.
- 280 COVENTRY: That conference deplores the amount of NHS Funding that is not going into front line patient facing services but is being spent on yet another structural reorganisation of the NHS with yet more tiers of management/ staffing with the development of federations, clusters, primary care networks STPs etc.
- 281 COVENTRY: That conference believes that NHS England in compelling practices to work collaboratively at scale is forging an overall plan to achieve by stealth the development of a salaried GP service with loss of the GMS contract and the demise of the partnership model of general practice, and calls upon GPC to:
- (i) ensure all funding is made available to all practices and not dependent on being part of a collaborative group of practices
 - (ii) proactively support practices of all sizes
 - (iii) ensure CCGs are not allowed to issue only new contracts as APMS but still allow GMS
 - (iv) ensure that working at scale plans are developed by practices rather than mandated by CCGs.
- 282 AVON: That conference is gravely concerned about the way STPs are being used as a smokescreen to justify swingeing cuts to NHS funding in all parts of England. It instructs the GPC to warn the Department of Health that STPs must, without exception, ensure that:
- (i) GPs and particularly LMCs are an integral part of any STP negotiation
 - (ii) real investment is made in general practice and primary care, which will inevitably lead to cost savings if there is less reliance on secondary care rather than within localities.

- 283 BUCKINGHAMSHIRE: That conference mandates GPC to ensure that the formation of, and participation in primary care networks (PCNs) is entirely funded from new money and that current GP funding streams will in no way be diverted to these initiatives.
- 284 CORNWALL AND ISLES OF SCILLY: That conference instructs the GPC to work with 111 and OOH providers to ensure communications to primary care IT systems are easily readable and do not contain unnecessary information.
- 285 CONFERENCE OF ENGLAND LMCs: That conference believes general practice will be the foundation on which other NHS services are developed within NHS England's long-term plan and therefore insists that general practice is prioritised for funding from the £20bn committed by government.
- 286 SEFTON: That conference welcomes the vision of improved patient care and the management of it which is contained in the long term NHS plan. It is dismayed that neither the manpower resources nor funding necessary to deliver it have been secured. It calls on all political parties to commit to a matching long term plan of achieving a level of health care funding equal to 8% of GDP.
- 287 HERTFORDSHIRE: The NHS long term digital revolution plan is aspirational. Whilst the use of technology must be welcomed it needs to be used wisely. GPC must negotiate collectively across the four nations for:
- (i) general practice evidence-based use
 - (ii) GDPR compliance and training for doctors and allied health care professionals
 - (iii) fully funded hard and software installation
 - (iv) robust assessment of effectiveness in terms of patient care and staff satisfaction
 - (v) no increase to indemnity costs for doctors.
- 288 AVON: That conference is disappointed that the government's remedy to the lack of GPs is to engage other clinicians rather than:
- (i) reviewing GPs' workload
 - (ii) improving GPs' remuneration
 - (iii) re-engage retired doctors
 - (iv) review the appraisal process.
- 289 NEWCASTLE AND NORTH TYNESIDE: That conference believes that in respect of the NHS long-term plan:
- (i) the funding uplift is below the 70 year average for the NHS and does not represent growth the NHS needs
 - (ii) primary care would be better served if billions of taxpayers' money were not spent on constant tendering of contracts and expanding the role of private providers.
- 290 HERTFORDSHIRE: GPC must be robust in its assessment of the long term NHS plan given its ambitious aspirations and historical underfunding of general practice and ensure the long term allocations of funds take into account:
- (i) chronic underfunding
 - (ii) shortage of staff
 - (iii) IT hard and software updates
 - (iv) training costs of the technology proposals
 - (v) managerial costs for setting up primary care networks.

PRIMARY AND SECONDARY CARE INTERFACE

- 291 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference supports a motion for the Department of Health to provide funding for robust alternative forms of communication for urgent matters between primary and secondary care with their wish to make fax machines redundant.
- 292 CLEVELAND: That conference is concerned that access to the trivalent influenza vaccine has been through one supplier only and believes this should be formally investigated by the Competition and Markets Authority.
- 293 CONFERENCE OF ENGLAND LMCs: That conference, with regard to procedures of limited clinical value:
- (i) calls for proper, evidence-based evaluation of all treatments given this title, taking into account the cost consequences of not providing treatment
 - (ii) calls for an end to acute trusts and CCGs insisting on prior approval being sought before referral for procedures of 'limited clinical value'
 - (iii) welcomes the NHS England consultation on procedures of limited value but demands that the evidence base for its implementation is approved by all stakeholders, including consultants, GPs and the public
 - (iv) believes that many CCGs are inappropriately using the concept of "procedures of limited clinical value" to simply save money.
- 294 AVON: That conference welcomes the NHS England consultation on procedures of limited value to reduce the postcode lottery existing between different CCGs but demands that the evidence base for its implementation is approved by all stakeholders, including consultants, GPs and the public.
- 295 NOTTINGHAMSHIRE: That conference deplores the provision of mental health services to citizens of the UK and calls upon the GPC to negotiate:
- (i) an end to out of area in-patient care unless absolutely necessary for clinical reasons
 - (ii) the provision of Mental Health practitioners within GP
 - (iii) improved access to CMHT teams
 - (iv) improved Mental Health crisis services
 - (v) a real increase in investment in Mental Health services which is protected from CCG interference.
- 296 NOTTINGHAMSHIRE: That conference deplores the failing of commissioners to adequately invest in mental health care thus causing a failure of service provision in many parts of the country and implores the health secretary to:
- (i) recognise that poor mental health has a major impact on all strata of society to the detriment of the nation
 - (ii) massively increase spending in mental health training and provision through the NHS
 - (iii) increase spending in social care proportionately; recognising that many of the mental health problems we encounter are a direct result of inadequate social care provision.
- 297 THE GPC: That the GPC seeks the view of conference on the following motion from the GP trainees subcommittee:
That conference notes the challenges in accessing healthcare and the considerably worse health outcomes for children and adults with autism. We note that there are some simple approaches which can help with access and improving healthcare for this group and their families. We mandate GPC to work with relevant stakeholders to explore and develop simple standards and policies which can be adopted by practices to ensure good practice.

- 298 NORFOLK AND WAVENEY: That conference with regard to the health of the nation:
- (i) welcomes the proposal to ban the selling of energy drinks to those under 16 years of age
 - (ii) calls upon the government to extend taxation on unhealthy food and drink

ONLINE GP SERVICES

- 299 LIVERPOOL: That conference believes that the BMA should encourage the NHS to develop a national repository of patient information leaflets, available in all commonly used languages and that this is available to patients and health care services via the NHS website and a dedicated NHS app, thus allowing GPs to offer the same service and information to all patients, irrespective of their primary language.
- 300 BUCKINGHAMSHIRE: That conference is increasingly concerned by the Secretary of State's apparent obsession that IT is a panacea for the current crisis in general practice, and:
- (i) believes there is no evidence online consultations reduce GP workload
 - (ii) calls on GPC to ensure such schemes, where GPs choose to use them, receive commensurate new funding.
- 301 WIGAN: That conference condemns the lack of:
- (i) clarity and diligence which allows digital online providers of GP services to lead subscribers to unknowingly deregister from their extant GP practice
 - (ii) regulatory control which allows provider of this kind to register themselves off shore and to escape CQC and other regulations, and
 - (iii) conference calls upon GPC to pursue and secure a tighter regulatory framework applying to these specific providers.

COMMISSIONING AND SERVICE DEVELOPMENT

- 302 WELSH CONFERENCE OF LMCs: That conference:
- (i) believes that prison healthcare should not be practiced in silos of individual establishments and that general practice in prison would be well-served by the formation (and funding) of a specific prison primary care cluster
 - (ii) believes that sentenced prisoners in Welsh prisons should be subject to the same proposed GMS registration processes as those serving prison sentences in England, ensuring GP2GP transfer of records on reception into prison from the community and improved patient safety
 - (iii) is concerned about potential patient safety risks when patients in prison remain registered with their community GPs in addition to receiving care from GPs based in prison and calls for GPC UK to produce guidance on the community GP's role and responsibility in providing care to their registered patients who are serving prison sentences.

- 303 NOTTINGHAMSHIRE: That conference recognises the need to commission services, to agree specification and prices for service delivery but:
- (i) deplores commissioning decisions that affect general practice without input from GP commissioners
 - (ii) deplores commissioning decisions without input from the LMC
 - (iii) calls upon the GPC to negotiate the right for LMCs to be involved with such decision making.
- 304 WORCESTERSHIRE: That conference believes that many CCGs are inappropriately using the concept of 'procedures of limited clinical value' to simply save money and demands that GPC lobby NHS England to implement a genuine validated national scheme not open to local abuse.
- 305 WORCESTERSHIRE: That conference deplores the use of protocols and proformas by CCGs that actually seek to restrict patient care for financial reasons and requests that GPC should press for the misuse to cease.
- 306 MID MERSEY: That conference believes that to try and avoid fragmenting primary care when commissioning new general practice services existing local practices should be prioritised over alternative providers wherever possible.
- 307 CENTRAL LANCASHIRE: That conference believes that an undue burden of unnecessary work is placed on GPs by the commissioning of stand-alone services from different providers which results in GPs having to cross refer between these providers in the absence of direct referral pathways.
- 308 BERKSHIRE: That conference believes it should be illegal for a CCG to arbitrarily offer enhanced services to one practice in an area and not to another.
- 309 SOMERSET: That conference demands that clinical members of Individual Funding Request Panels (IFRPs) should not only to take into account written submissions and photographs from GPs or specialists when considering requests but also that the patients concerned
- (i) should have the right to be seen, questioned and examined by clinical members of the IFRP and
 - (ii) should have consequent decisions directly explained to them by the IFRP.
- 310 AVON: That conference believes that the NHS England procurement process is not fit for purpose, as highlighted by the awarding of contracts to providers such as Capita, and should be scrapped or reformed urgently. This is to ensure NHS providers and patients do not suffer any further by the awarding of contracts to the cheapest rather than the safest and most competent provider.
- 311 TAYSIDE: That conference believes that the current interface between prisons and general practice is inadequate with disparity between different areas and needs urgent improvement for quality and safety. (Supported by Scottish Conference of LMCs)

PENSIONS

- 312 CLEVELAND: That conference:
- (i) demands the reinstatement of an annual statement of contributions, to be sent to all doctors who are members of public sector pension scheme
 - (ii) requires clarity as to effective processes to resolve any discrepancies in contributions to the NHS Pension schemes
 - (iii) requires clear guidance as to the role of the Pensions Ombudsman in the NHS Pension Schemes
 - (iv) demands the modernisation of NHS Pensions Forms A and B system for GP locums into a fully electronic system.
- 313 GLOUCESTERSHIRE: That conference believes the current NHS pension arrangements for locum GPs are inefficient and waste a significant amount of NHS administrative resource and therefore calls for the:
- (i) GPC to negotiate the necessary changes to allow the replacement of the current (Locum A, B and Solo) forms with a single annual online form per employer / locum
 - (ii) establishment of a simple electronic payment system allowing monthly or annual direct debits.
- 314 LIVERPOOL: That conference believes that salaried GP pension contributions would be better paid direct by the employing practice to the pensions agency, as the practice does for all other salaried staff, rather than have the monies collected via the Exeter System, as the process for paying via Primary Care Support England is cumbersome, inefficient, and invariably inaccurate.
- 315 LEWISHAM: That conference:
- (i) notes the government consultation on changes to the NHS pension scheme regulations 2019
 - (ii) requests that the proposed new contribution rate of 20.6% for employers, effective from 1 April 2019, be strongly opposed, unless fully funded
 - (iii) believes that the impact of such pension scheme changes, without financial mitigation, would be disastrous, particularly for GP partners; and
 - (iv) requests that any financial reimbursement also take account of the potential extra tax that will be owed for those GPs reaching their annual pension cap, unless this cap is revised as part of any mitigation.
- 316 CORNWALL AND ISLES OF SCILLY: That conference believes that the proposed 6.3% increase in employer contribution rate will sound the death knell for the partnership model of general practice and calls on GPC to:
- (i) oppose this increase
 - (ii) ensure that any changes to employer contributions will be met by a fully funded ongoing agreement with the government.
- 317 LAMBETH: That conference deplores the proposals set out in the government consultation NHS Pension Scheme to increase the employer contribution rate from 14.38% to 20.6% from April 2019 which flies in the face of the commitments and aims of the GP Forward View.

- 318 KINGSTON AND RICHMOND: That conference believes the recent advice to general practitioners regarding possible discrepancies in their PCSE pension contributions:
- (i) undermines morale within the profession
 - (ii) further damages the professions confidence in PCSE
 - (iii) must not result in any financial disadvantage to general practitioners accrued pension entitlement, and
 - (iv) that the BMA's response should be supported by a legal opinion of the adequacy of PCSEs/NHS England's response.
- 319 CAMBRIDGESHIRE: That conference is concerned about the potential proposed increase in pension contributions to 20.6 % and:
- (i) believes that without adequate reimbursement this will lead to further destabilisation of the partnership model
 - (ii) demands that any such increase is not taken from existing GP funding
 - (iii) instructs GPC to negotiate sufficient reimbursement for GP partners to cover this proposed increase for both partners and staff.
- 320 SHROPSHIRE: That conference fears for the financial viability of practices following the recently announced increase in employers pension contributions from 14% to over 20% and instructs the GPC to seek confirmation that the additional costs incurred will be fully reimbursed and that this reimbursement will be ongoing.
- 321 BUCKINGHAMSHIRE: That conference believes the constant changes to employer contributions in the NHS pension scheme represent an unacceptable cost to GPs both directly and due to annual and lifetime allowance limits, and:
- (i) declares that the most recent proposed increase in employer contributions are wholly unacceptable
 - (ii) believes that GP partners disproportionately supporting the system in this way represents possible discrimination on the part of the government
 - (iii) expresses concern that these changes may cause GP partners to leave the scheme, destabilising the scheme for all NHS workers
 - (iv) mandates GPC to urgently address these issues with the government
 - (v) mandates GPC to, if such negotiations fail, initiate legal proceedings to protect the GPs it represents.
- 322 NORTH STAFFORDSHIRE: That conference believes that the limited one year guarantee to fund the substantially increased employer NHS pension contribution is an existential threat to the partner role and the partnership model.
- 323 GRAMPIAN: That conference is deeply concerned that the proposed changes to employers' superannuation contributions for the NHS pension schemes will greatly harm recruitment into the profession as well as retention of senior colleagues and calls on GPC UK to use every endeavour to try to mitigate these changes.
- 324 HERTFORDSHIRE: That GPC reject the proposal to raise employer's superannuation from 14.3% to 20.4%, unless this is fully funded as a separate payment.
- 325 DEVON: That conference demands that NHS England be held to account for the failures that have been uncovered with regards to management practitioner pension funds and guarantee that this is addressed within six months.

- 326 AVON: That conference in the light of recent reports indicating that more people are leaving the NHS pension scheme earlier than any other public sector scheme, conference calls on GPC to urgently resolve a litany of problems relating to the NHS pension scheme, specifically:
- (i) the inability of GPs to know how much they are deemed to have contributed in a year due to inadequate information from Capita
 - (ii) the proposed rise of employers' contributions to over 20%
 - (iii) the requirement to pension all NHS earnings rather than restrict contributions where this might be beneficial.

REGULATION

- 327 NOTTINGHAMSHIRE: That conference believes the GMC suffers from a top-down institutional lack of insight and demands that the GPC works to ensure that:
- (i) the GMC is reorganised with independent senior medical leaders overseeing its reorganisation
 - (ii) the GMC becomes simply a licensing body and all disciplinary matters become the remit of the MPTS
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- 330 NORTH WALES: That conference calls for the General Medical Council to account for increasing this year's annual registration fee whilst still offering their staff expensive perks such as private health insurance.
- 331 NOTTINGHAMSHIRE: That conference believes a pervasive 'guilty until proven innocent' attitude exists among the overbearing regulatory bodies, which is creating a culture of intimidation and harassment of GPs by the NHS, GMC, CCGs and CQC. It therefore calls upon GPC to:
- (i) demand that the regulators adopt the fairer stance to the contrary ie 'innocent until proven guilty'
 - (ii) put a mechanism in place to stop GPs leaving the profession due to anxiety, stress and burnout following punitive regulatory measures.
- 332 KENT: That conference notes with concern the increasing distance between the GMC and the medical profession and calls for the GMC to be publicly funded.

PRACTICE SUSTAINABILITY AND CLOSURES

- 333 NORTHAMPTONSHIRE: That conference insists that practices that can't sustain their workload are enabled to close their list.
- 334 SURREY: That conference believes commissioner approval should not be required for a GP contractor to close their list [as is the case under the current regulations] for a cumulative maximum period of twelve months in any two years.
- 335 DEVON: That conference agrees that the identification of 'at risk' practices is a good thing but that using data as a performance management tool is not to be supported and we urge the GPC to ensure this does not happen.
- 336 NORFOLK AND WAVENEY: That conference asks GPC to seek a solution and acknowledge the potential financial destabilisation to general practice of the potential removal of local commissioned services because:
- (i) of the limitations of current procurement rules to commissioners
 - (ii) they can represent 20% of practice income
 - (iii) future commissioning will be based on area populations than practice populations.
- 337 CONFERENCE OF ENGLAND LMCs: That conference asks GPC to celebrate general practice in all its shapes and sizes, as it is precisely this individuality which enables practices to continue to provide world class primary care tailored to their unique populations. GPC cannot allow NHS England to undermine this very essence of primary care.
- 338 BRO TAF: That conference urges the government to seriously consider the sustainability of primary care when practices terminate their contracts and insists that:
- (i) patient lists should not be dissolved without discussion and agreement with surrounding practices thus causing sustainability issues to existing practices
 - (ii) CCGs or Local Health Boards should take the interim responsibility of managing these practices in consultations with neighbouring practices and LMCs.

PREMISES

- 339 BUCKINGHAMSHIRE: That conference is concerned by the discrepancies between NHS property valuations and landlord imposed rent changes and calls on GPC to ensure this is addressed in ongoing premises costs negotiations.
- 340 MORECAMBE BAY: That conference believes that commissioners see the primary care estate as a free good and have ignored the need to develop the estate as part of the strategic Integrated Care Partnership intentions to transfer services out of hospital.
- 341 MORECAMBE BAY: That conference believes that the Estates and Technology Transformation Fund within the GPFV has done very little to improve the general practice estate and calls on NHS England to recognise the importance of investing in individual practice premises and to develop an investment programme accordingly.

- 342 MORECAMBE BAY: That conference believes that the Estates and Technology Transformation Fund within the GPFV has done very little to improve the general practice estate and calls on NHS England to recognise the importance of investing in individual practice premises and to develop an investment programme accordingly.
- 343 EALING, HAMMERSMITH AND HOUNSLOW: That conference, in regard to notional/cost rent reviews, deplores the lack of engagement from NHS England/CCGs and instructs GPC to negotiate a transparent process with clearly defined timelines.
- 344 BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE That conference, in recognition of the difficulties that some practices have had with toxic loans, complex or unfair leasehold arrangements and other financial issues asks GPC England to:
- (i) request a national assessment of the impact of financial arrangements within practices for loans, leases and other financial commitments, with particular focus on the impact that these have on GP staff morale, premises maintenance and/or renewal and succession planning
 - (ii) supports the provision of a central fund that can be accessed by practices in urgent needs of expert financial advice on the recommendation of their LMC, CCG or NHS England
 - (iii) practices with toxic loan arrangements or other punitive contract arrangements to have priority in accessing any available funding.
- 345 NORTH STAFFORDSHIRE: That conference believes that the national lack of progress on NHSPS and CHP leases and subsidy arrangements is threatening the succession viability of many partnerships, by diminishing the inter-generational general practitioner faith in the continuation of the partnership model and its property.
- 346 SOUTH STAFFORDSHIRE: That conference expresses concerns about the delay in publication of the premises directions and demands that:
- (i) practices are reimbursed at 100% of improvement grants that they may have been successful at bidding for, and approved since 1st April 2018
 - (ii) NHS Property Services are instructed to hold the head lease for all NHS owned premises and recover service charges directly from NHS England.
- 347 AVON: That conference as it has come to light that NHS property services are not able to robustly evidence sufficient or any basis for the service charges that are being passed to practices, and that the calculation and procurement of these costs and services is opaque, conference calls on the GPC to investigate how a more transparent process can be developed with NHSPS so that tenant GPs are not disadvantaged, compared to owner occupiers who are able to procure their own services.
- 348 AVON: That conference in light of ongoing delays at national level in agreeing a lease for GPs in properties owned by NHSPS, conference directs GPC to ensure that any practice that is obliged to sign a lease with NHSPS receives funding for legal costs and stamp duty to do so.

WORKLOAD

- 349 BEXLEY: That conference with regards to sick certification:
- (i) notes that a large proportion of time is spent in general practice preparing sick notes for the benefit of DWP
 - (ii) notes that most patients with ongoing chronic issues need occupational health to assess their fitness to work
 - (iii) recognises that GPs are not trained in occupational health
 - (iv) requires sick notes for chronic conditions be removed from the GP remit, and
 - (v) requires hospital teams to fulfil their contractual obligation and generate sick notes for patients under their care.
- 350 MID MERSEY: That conference considers that because GPs' are professionally required to act in their patients' best interests (and not those of employers, insurers or government agencies) sickness certification involves an unacceptable conflict of interest and calls on GPC to work towards the development of a system of certification that is fair to both patients and employers and that does not compromise practitioners.
- 351 WEST SUSSEX: That conference
- (i) believes GP workload is unsustainable
 - (ii) demands a cap on the number of patient consultations that can be undertaken by each GP per working day
 - (iii) that commissioners are responsible for providing NHS services to patients requiring same day care once the cap is reached.
- 352 SHROPSHIRE: That conference, given the change in general practice workload and patient demographics, instructs GPC to pursue increased future funding for general practice based on a whole time equivalent GP having a list size limit of 1500 patients.
- 353 SOUTH STAFFORDSHIRE: That conference expresses concerns about the impact of unfunded, unresourced work shift to the left on patient safety and GP morale, and demands that the GPC:
- (i) urgently designs and implements an OPEL style escalation protocol for general practice so that patients can be looked after safely during GMS contracted hours
 - (ii) negotiates a payment by results tariff, to pay for any and all work generated at the request of a third party external to the practice.
- 354 DERBYSHIRE: That conference believes that with patient health demands being infinite in need but with only a finite number of GPs GPC must ensure safe working limits are achieved in the next contract.
- 355 NOTTINGHAMSHIRE: That conference believes a GP who works three 12.5-hour days works full-time and should be treated the same as any other healthcare employee who chooses to work their 37.5 hour week over a three day period. We therefore demand that GPC:
- (i) conducts a review of how GP work is tallied up
 - (ii) recognises that what we currently think of as full-time GP working hours are, in fact, approximately 33% higher than what are considered full-time hours for a non-GP worker
 - (iii) works to change this erroneous perception of GPs' working hours and seeks to redefine it such that both the profession itself and the public better value a GP's time.

- 356 DEVON: That conference suggests that 'full time GP' is not a proper reflection of current working practices where almost all GPs spend a large proportion of their working week in unrecognised overtime.
- 357 SCOTTISH CONFERENCE OF LMCs: That conference believes that pressures on local GP practices should be formally considered as part of the planning application process for new housing developments.
- 358 CENTRAL LANCASHIRE: That conference believes that there are far too many serious system failures occurring on a national basis where practices are expected to pick up the pieces and calls on NHS England to develop a national contingency plan to support practices when such incidents occur.
- 359 NOTTINGHAMSHIRE: That conference deplores the winter planning which is heavily focused on secondary care with primary care expected to just match them with no extra resources and calls upon GPC to:
- (i) ensure adequate assessment of the winter pressures felt across general practice and not just in hospitals
 - (ii) stop hospitals from sending OPEL warnings to general practice and demand that system-wide warnings go out to the public instead
 - (iii) insist that all local A and E boards have GP provider representation to discuss alleviating winter pressures, not just in secondary care but also in primary care, and ensure that there is adequate funding allocated to primary care for the same
 - (iv) stop the NHS from sending patronising letters to general practice reminding them about their opening hours during the Christmas and New Year periods.
- 360 DEVON: That conference calls on NHS England to intervene to make sure that due consideration is given to the local general practice provision before any new housing development aimed at the frail elderly is given planning approval.
- 361 DEVON: That conference recognises that the work involved for GPs completing Department of Work and Pensions forms is of little value and suggests the system could be made more efficient if replaced by an electronic or telephone inquiry with specific questions for specific patients if required.

GPC SCOTLAND

- 362 GLASGOW: That conference believes that the new GP contract has the potential to make being a GP in Scotland a desirable career option.

INDEMNITY

- 363 DERBYSHIRE: That conference demands that in this increasingly litigious society, GPC challenge the assumption by MDO/CQC/GMC that responsibility for following up missed out patient appointments and investigations always defaults to GPs, ignoring the responsibility that patients should accept themselves.

STANDING ORDERS

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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, at least one of whom, subject to appropriate nominations being received, shall represent each of the four UK nations and not more one of whom shall 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-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected, and shall continue in office until the end of the following annual conference.
 - 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.
73. 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.

Committee Services, Policy Directorate

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