without loss of rigour in maintaining standards. It calls upon GPC to secure with the CQC the permanent adoption of a remote triage approach.

GENERAL PRACTICE IN A POST-COVID-19 WORLD - LESSONS LEARNT FROM PANDEMIC AND VACCINATIONS

122 BRO TAF: That conference deplores the four UK governments' handling of the Pfizer COVID-19 vaccination programme by changing the schedule without any published data beyond six weeks and ask GPC to strongly support the BMA stance in challenging the adoption of the JCVI guidance on vaccine spacing.

123 SOUTH STAFFORDSHIRE: That conference believes that the current lower uptake of the COVID-19 vaccination amongst certain population groups, like the BAME population for example, requires a pro-active approach with financial incentives, better communication and a national drive to improve.

124 EALING, HAMMERSMITH AND HOUNSLOW: That conference regrets that by prioritising patients by age, the COVID-19 vaccination programme may have exacerbated the inverse care law and calls upon government to ensure that renewed efforts are taken to address the wider determinants of health and health inequalities across society.
(Supported by Kensington, Chelsea and Westminster, Brent, Harrow and Hillingdon)

125 HULL AND EAST YORKSHIRE: That conference strongly supports NHS colleagues who refuse to offer face to face care to patients who are medically able to but refuse to wear face coverings.

126 NORTH STAFFORDSHIRE: That conference asks the GPC Executive to make the COVID-19 vaccination compulsory for all healthcare workers (when not contraindicated), for their own safety and that of other staff and for the safety of patients. There is a conflict between personal autonomy and wider safety that is unbalanced and unjustified. This should be a professional probity issue.

127 DORSET: That conference is saddened that the UK has lost its WHO 'measles-free' status and calls for immediate action to counteract the false news spread by anti-vaxxers and re-establish levels sufficient to provide herd immunity.

128 NOTTINGHAMSHIRE: That conference prepares itself for potential future vaccination campaigns either for new strains/booster campaigns and requests that all prison and secure environment workers get greater priority in future mass vaccination campaigns.

129 LAMBETH: That conference demands:
(i) COVID-19 vaccine should be available without needing an NHS number
(ii) public facing workers who have the highest rates of death from COVID-19 should be prioritised for vaccination
(iii) GPC Executive lobby government to ensure that COVID-19 vaccine is available to the global poor as well as to the global rich.

130 TOWER HAMLETS: That conference believes that to mount effective resistance to COVID-19 that access to COVID-19 vaccine must be equitable. Conference demands:
(i) COVID-19 vaccine should be available without needing an NHS number
(ii) public facing workers who have the highest rates of death from COVID-19 should be prioritised for vaccination
(iii) GPC Executive lobby government to ensure that COVID-19 vaccine is available to the global poor as well as to the global rich.

131 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that GPC has once again let us down by not negotiating the terms of delivery and funding for COVID-19 vaccination programme:
(i) GPC undervalued primary care time and again whether its flu programme or CVP
(ii) primary care is bullied into agreeing term of politicians
(iii) always end up being scape goat for any failures

132 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that GPC should negotiate or influence NHS England to move from Push to Pull model for COVID-19 vaccination programme.

133 LIVERPOOL: That conference believes that now is the time to review the process for ordering flu vaccine from individual practice ordering to a central procurement method and instructs GPC to evaluate the benefits of changing the process.

134 KENT: That conference notes the present Covid Vaccinations Enhanced Service and:
(i) demands an amendment that allows individual practices to receive only the AstraZeneca vaccine
(ii) condemns the discrimination between GP surgeries and other providers that prioritised them for the AstraZeneca vaccine and visibility on the National Booking System
(iii) condemns it for setting up GPs to fail.

135 KENT: That conference notes the supplement paid for vaccinating housebound patients under the COVID-19 vaccination programme and demands that the GPC negotiate the same level of funding to support vaccination of housebound flu patients within the seasonal influenza and pneumococcal DES.

136 SOMERSET: That conference believes the annual ritual of practices being pressurised to gamble on ordering influenza vaccine supplies, often before a decision has been taken on brand reimbursement:
(i) is inefficient and outdated
(ii) that a central supply system where the government purchases vaccines and reimburses practices for administration should be introduced and,
(iii) the item of service fee should be raised to account for the loss of practice income that this change would incur.

137 OXFORDSHIRE: That conference condemns the inequitable deal that general practice has been given regarding the COVID-19 vaccination programme and believes that mass vaccination centres, pharmacy vaccination centres and other vaccination providers should have the same contractual obligations and total funding envelope as GP vaccination sites when it comes to delivering COVID-19 vaccines.

138 NORTH STAFFORDSHIRE: That conference recommends that:
(i) the GPC Executive negotiates to ensure that COVID-19 vaccination work by other providers should not be cherry picked or manipulated and
(ii) that the 20% extra work involved in providing the Pfizer vaccine (largely delegated to PCNs and practices due to its complexity) compared to the AstraZeneca vaccine is recognised in fair payments.

139 NOTTINGHAMSHIRE: That conference recognises that the offer of the COVID-19 vaccination has polarised views in parts of society. Despite changing the V&I QOF we will still be penalised by vaccine refusers and we ask for these patients to be removed from the denominator for payment purposes, so we are not penalised for their refusal.

140 LAMBETH: That conference:
(i) deplores the attempts by NHSE and CCGs to micro manage the roll out of the coronavirus vaccinations
(ii) insists that GPC in future negotiate specifications which give GPs more freedom.

141 LEWISHAM: That conference notes that the pandemic and the vaccination programme has highlighted health inequality in the BAME population and calls upon all STPs to work with communities to develop deliverable strategies to eliminate health inequality.

142 LEWISHAM: That conference:
(i) agrees that the last year has demonstrated the ability of general practice to rapidly and safely develop to meet a new and challenging scenario at both practice level and across a population and the successful roll out of the vaccine programme demonstrates its ability to work effectively at scale
(ii) agrees that in order for an ICS to effectively deliver change all partner need to be appropriately represented, and

(iii) insists that ICSs do not determine that representation but ask general practice across the ICS footprint to determine how best it is represented.

143 EALING, HAMMERSMITH AND HOUNSLOW: That conference acknowledges that the successful roll out of the COVID-19 vaccination programme could not have been achieved without the hard work and personal sacrifices of GPs and their practice staff, and calls upon the GPC to ensure that the value of general practice is reflected in the outcomes of forthcoming NHS reform.
(Supported by Kensington, Chelsea & Westminster, Brent, Harrow, Hillingdon)

144 NORTHUMBERLAND: Involvement of community pharmacy in the COVID-19 vaccination programme has been significantly hindered by red tape and inflexible criteria imposed centrally. Conference calls for the promised 'easing of bureaucracy', and a pragmatic approach to allow PCNs and pharmacies to work together effectively.

GP APPRAISAL AND REVALIDATION

145 SANDWELL: That conference mandates that the GPC commission an independent review of the appraisal system for general practitioners to determine if it has brought any objective or measurable benefit to general practice in the last 15 years.

146 LIVERPOOL: That conference believes that with the recent need to vary arrangements for appraisal on account of the COVID-19 pandemic, GPC must:
(i) call for a suspension of appraisals
(ii) undertake a full evaluation of the appraisal system to determine whether it should be continued or replaced with a system that is more fit for purpose.

147 KERNOW: That conference is asked to support a change in emphasis for GP appraisal away from being summative and regulatory. Conference demands that the NHS starts to look after it's GP workforce and funds an obligatory annual physical and mental health review through a stand-alone service that is entirely supportive and confidential.

CREATING AND MAINTAINING A WORKFORCE FIT FOR THE FUTURE

GP partnerships

148 NORTH STAFFORDSHIRE: That conference instructs the GPC to explore the best future contractual options to safeguard partners from open ended current partnership obligations. These include open liabilities, last man standing and lease requirements. This may take some of the form of LLPs or LLCs.

149 NOTTINGHAMSHIRE: That conference continues to lead the conversations with the government on commissioning reforms in the integrated agenda recognising the partnership model as the bedrock of general practice. The pace of change needed to enable the COVID-19 vaccination programme is arguably greatly helped by an independent contractor workforce leading the efforts.

150 GRAMPIAN: That conference recognises the additional workload for GP practices from post Brexit sponsorship of non UK graduates for their skilled worker visa (previously tier 2 visa) and calls on relevant agencies to lobby the government to make sponsorship of these doctors a health board responsibility.

151 BEDFORDSHIRE: That conference calls on GPC to ask that the governments of the UK should finance more places in medical schools both to meet the increase in numbers achieving grades due to the 2020 grading fiasco and also as a means to try to address the GP shortage.

152 SOMERSET: That conference, holding that employing practices know best what training is needed by their Allied Health Professional employees, and that although guidelines, aspirational roadmaps etc from other

agencies are useful and well-intentioned, demands that they should never supersede locally agreed requirements.

153 DORSET: That conference is appalled at attempts to corral locum GPs into "flexible pools", thus imposing terms and conditions, pay and a loss of autonomy. We ask for GPC to ensure that this is a collaborative process, with sessional GPs recognised and protected as independent contractors.
(Supported by Sessional GPs Committee)

154 AYRSHIRE AND ARRAN: That conference:
(i) recognises the significant adaptation in the role of primary care over the last decade
(ii) recognises the risk of deskilling of the primary care medical workforce with the expansion of the primary care team
(iii) demands ongoing protected training time for established GPs to develop and maintain the skills needed for their new role.

155 HERTFORDSHIRE: That conference instructs GPC to negotiate any necessary increase in clinical time and supervision, during the pandemic, to safely train medical students to be able to conduct phone and video consultations safely and effectively.

156 BEDFORDSHIRE: That conference calls on GPC to work with the governments of the UK to see how general practice can be helped to increase education capacity in primary care in order to improve UK self-sufficiency.

157 GP TRAINEES COMMITTEE: That conference believes future CSA exams should be delivered not only in London, but in each regional educational body local training region within the UK and calls on the RCGP to develop local services to facilitate this.

158 WORCESTERSHIRE: That conference is concerned by the apparent lack of vacancies for newly qualified GPs whose roles seem to have been replaced by ARRS staff and retired GPs returning to work to support the pandemic effort and believes that initiatives to support their employment must be urgently put in place.

159 WORCESTERSHIRE: That conference believes that practices who have GPs taking part in the GP Fellowship scheme must have full backfilled funding to allow them to be released for training in order for the scheme to achieve its objectives.

160 DERBYSHIRE: General practice is facing an existential crisis and an exodus of staff following the COVID-19 pandemic. Conference calls upon GPC to address this by negotiating and agreeing the following with NHSE:
(i) a five year commitment to invest in GP resilience and retention
(ii) ensure no reintroduction of the red tape that we have been freed from
(iii) keep appraisal high trust low evidence
(iv) enable flex in the GP contract to allow ARRS money to be used to fund GPs
(v) cull extended hours and recycle the funding into the core contract.

161 DORSET: That conference acknowledges the economic and professional impact COVID-19 has had on locum GPs and calls for GPC to work with NHSE to:
(i) prioritise locums for work
(ii) enable locums to work safely
(iii) ensure locums are equipped and trained for new ways of working
(iv) ensure locums are included in future discussions over primary care's response to and recovery from the crisis.

162 SANDWELL: Conference requests that the GPC negotiate with NHSE to establish a recruitment and training program for general practice nurses with sufficient resources and places to address the chronic shortage of GPNs.

163 HIGHLAND: That conference welcomes the NHS Highland Healing Process and:
(i) offers its sincere thanks to the Cabinet Secretary for Health and Sport for the personal interest she took in supporting the victims of bullying

(ii) is pleased that affected GPs and other NHS workers now have a route to a personalised apology, psychological therapy and an independent review panel
(iii) is deeply concerned that NHS Highland's 2020 survey of staff in Argyll & Bute, recommended by John Sturrock QC, has identified further bullying
(iv) seeks ongoing assistance from government to support vital cultural change.

164 LAMBETH: That conference recognises that ARRS budgets to London PCNs have effectively been cut by 20% and additional funding should be made available to fund the high cost of living supplement in order to make the funding equitable.

165 CITY AND HACKNEY: That conference welcomes the change in ARRS funding to enable payment of high cost of living supplement but requires further negotiation to provide additional funding to enable this in the long term without reducing the workforce available to high cost areas compared to other parts of England.

166 NEWHAM: That conference, with regard to additional roles reimbursement scheme:
(i) believes they have so far done little to reduce primary care workload
(ii) recognise the recruitment, necessary training and supervision has actually increased workload
(iii) asks for a nationally recognised, standardised, minimum training pathway for all clinical roles.

167 WIGAN: That conference is aware from authoritative sources that numbers of general practice staff are increasing save for GPs the successful increase in GP numbers must involve staunching the rate of outflow of GPs to premature retirement. It calls on the GPC to explore with the NHSE&I and treasury a substantial financial 'commitment ' award scheme which is exempt from the annual and lifetime allowance calculation and the counterproductive taxation arrangements which apply to both.

DIGITAL TECHNOLOGY AND DATA

168 NORFOLK AND WAVENEY: That conference believes that increased use of technology should be employed to reduce the current workload rather than creating more demand.

169 DERBYSHIRE: That conference seeks to establish new mechanisms for LMCs to both communicate clearly with GPC and receive timely responses rather than relying on a list server which is not fit for purpose.

170 KERNOW: That conference believes that leaving negative social media reviews might help to focus the minds of businesses who can significantly change the way that they provide a service in the private sector but that leaving negative reviews regarding patient care is counter-productive for patients. One star reviews with negative narrative can reduce staff morale and negatively impact on recruitment and retention of clinical and administrative which is a struggle at the best of times. Public facing messages should be published centrally urging patients that there best redress for concerns is a direct approach via a complaints procedure rather than the moral sapping negative Facebook or google review

171 MID MERSEY: That conference notes that some online services offer a review facility allowing the public to provide star ratings and reviews of GP practices, recognises that some reviews may be defamatory and cause significant reputational damage, and calls on GPC to take appropriate steps to hold such services to account for defamatory posts posted on their sites.

GDPR AND DIGITAL SERVICES

172 BUCKINGHAMSHIRE: That conference asks GPC to investigate whether insurance companies and other private organisations are subverting the GDPR rules by instructing patients to raise Subject Access Requests as a means of obtaining patient information without charge and share any such evidence with the ICO.

173 DERBYSHIRE: That conference is incensed that in respect of NHS GP computer systems for spurious reasons attributed to 'IT Security':
(i) minor IT glitches can no longer be addressed by GP staff resulting in serious detriment to patient services when they occur

(ii) reasonable and normal routine internet access has been withdrawn hampering ordinary legitimate practice operation both administratively and clinically
(iii) GPs and their staff are being treated as untrustworthy by censorious IT managers acting in isolation and without an agreed mandate

and that GPCs must negotiate to reverse these changes to provide a better working environment for staff and service to patients.

174 DERBYSHIRE: That the recently withdrawn administrator IT privileges afforded to practice staff be restored without delay in order to prevent serious dislocation of patient services occasioned by minor IT glitches and that the GPCs negotiate accordingly.

175 WORCESTERSHIRE: That conference believes that as access to patient records and data sharing spreads over an increasingly wide footprint general practice faces unprecedented risk and liability which is unsustainable for independent contractors.

176 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that following Brexit there must be no reduction in the protection of data as defined in the European General Data Protection Regulations and the Data Protection Act 2018.

177 LIVERPOOL: That conference believes that the rationalisation of GP computer systems to a limited number of accredited systems has resulted in GPs receiving a poor service from suppliers and insists that either current suppliers improve their services or GPC takes action to allow more accredited systems of choice.

178 HIGHLAND: That conference supports the use of open platforms for our digital health systems, including electronic health records, especially where this prevents the lock-in of data.

179 BEDFORDSHIRE: That conference:
(i) believes that once a patient has died then the GP should no longer be the data controller for those notes and
(ii) calls on GPC to negotiate that any request for access to the notes of a dead patient should be passed to another appropriate person, eg the relevant Secretary of State or the provider of primary care support services.

180 WEST PENNINE: That conference believes that there are significant risks in sharing patient data under the COPI notice, as it is unlikely that the data will be returned or deleted when the COPI Notice expires. We do not know what errors there are and it is important for patients and / or their carers to also be able to responsibly see and understand their data as we live with and beyond COVID-19.

181 BEDFORDSHIRE: That conference calls on GPC to negotiate an item of service fee for the provision of online access for patients to their complete medical record rather than this being part of Global Sum.

THE ROLE OF GPC AND LMCs

The GPC

182 WELSH CONFERENCE OF LMCs: That conference does not see the purpose of a separately elected GPC UK in a country with four devolved health services and that pan-UK issues should be discussed and managed by representatives of the four national GPCs coming together not a separate and expensive body.

183 SURREY: That conference believes the interests of the profession would be better served by engaging a professional negotiating team, working with a remit set by GPC, than the current arrangements.

The role of LMCs

184 SCOTTISH CONFERENCE OF LMCs: That conference believes that, in relation to LMC and GP subcommittee office bearers, the title 'medical secretary' is no longer fit for purpose and calls on SGPC, working with GPC UK as required, to agree an alternative title for this role.

185 WORCESTERSHIRE: That conference demands that NHSE include LMCs in its distribution lists and ensures that formal communication with general practice is not by means of WhatsApp messaging.

186 WORCESTERSHIRE: That conference insists that LMCs are recognised in formal documentation relating to Integrated Care Systems and demands that it be mandatory for LMCs to be represented on ICS boards in all areas.

187 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires the GPC to negotiate to ensure that LMCs are formally represented on ICS boards.

188 KENT: That conference notes the development of Integrated Care Systems and demands that:
(i) LMCs must have a seat at board level
(ii) LMCs must be acknowledged as the only representatives of grass roots general practice.

189 LAMBETH: That conference requires GPC to:
(i) negotiate mandatory representation of LMC to ICS and to place-based boards
(ii) reinforce the autonomy of the partnership, registered list model of GP through a ring-fence budget
(iii) place a statutory duty on ICS to manage conflicts of interest
(iv) establish a funding structure which enables the transfer of funding out of hospital to community care
(v) ensure that there are clear lines of governance and accountability in ICS including transparency in how contracts are awarded and monitored.

The Annual Conference of LMCs

190 NORTHUMBERLAND: The pace of change is now so great that today's concerns are frequently resolved and replaced by others within a few days. Submitting motions nearly 3 months in advance of the conference, albeit with limited flexibility through emergency motions, restricts conferences' ability to consider important current issues. This mode of debate is no longer fit for purpose and an urgent review standing orders is necessary.

191 MERTON: That conference, in recognition that UK LMCs have represented the voice of general practice in a statutory capacity for over a century, calls upon the government to recognise British general practice's fundamental role within the National Health Service by requiring the Secretary of State for Health to attend the annual UK Conference of LMCs, to make a presentation to the delegates and respond to questions.

GP CONTRACT NEGOTIATIONS

192 WORCESTERSHIRE: That conference ensures that no future contracts are negotiated and agreed to by GPC that can be unilaterally varied.

193 KENT: That conference notes that individual practices are the fundamental building blocks of primary care and that this is prioritised in all contract negotiations.

194 SUTTON: That conference is concerned that senior NHS management and ministers are communicating via the media to GPs about changes to general practice services. The conference asks GPC to not condone this and formally inform senior NHS management that:
(i) it is not acceptable to use the media to inform the profession about changes to service delivery in this manner
(ii) changes to service delivery should be communicated to GPs via the appropriate channels
(iii) social media should not be used to share such information
(iv) direct criticisms made about general practice via the media are wholly inappropriate and destroy any trust that GPs have with the NHS and DHSC leadership.

195 NEWCASTLE AND NORTH TYNESIDE: That conference believes that all governments included those of the devolved nations should show their commitment to the NHS by prioritising an increase in NHS funding (including a boost for primary care) and the workforce crisis.

196 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes primary care should be proportionally represented based on patient contacts in decision making bodies at neighbourhood, place and system levels.

197 NORFOLK AND WAVENEY: That conference asks GPC to negotiate the statutory meaningful representation of general practice on care systems in order to protect general practice and protect the independent contractor model.

198 KENT: That conference demands that the awarding of lead provider status affecting the provision of community and primary care services should:
(i) not occur without LMC agreement
(ii) prioritise general practice before other providers.

199 BUCKINGHAMSHIRE: That conference notes a pattern of increasingly underhand techniques used by NHS bodies when negotiating with GPC. Conference demands an end to such practices and calls on GPC to stop rewarding such bad behaviour, and calls on GPC to:
(i) (re)negotiate a code of behaviour with all NHS bodies to inform future major contractual negotiations
(ii) refuse on principle to agree to any contract that gives NHS bodies the right to make wholesale changes without GPC agreement
(iii) refuse to accept inferior contractual terms when there is recent evidence of better terms for similar projects being offered to private contractors.

200 SANDWELL: That conference wishes to inform the GPC that the profession does not feel that the crisis in general practice has been abated to any significant degree. Virtually none of the elements of "urgent prescription for general practice" have been implemented. Consequently, motion 20, passed at the special conference of Jan 2016, still mandates the GPC to act.

201 AVON: That conference mandates the GPC to express its opposition to these changes and to seek to amend them to give GPs a greater say in the new system. The system will move from one where:
(i) GPs have a leading role, to one where GPs will be just one voice among many with the consequence of a significantly reduced role and influence
(ii) the funding for primary care will no longer be separate from the single pot which the leadership of the integrated care system will disburse as it sees fit.

202 CHESHIRE: That conference requests that the GPC negotiate to ensure that any growth of PCN manpower and resource is not at the expense of a practice based funding.

203 KENT: That conference notes the that the wording used in the January PCN ballot was not reflective of the motion passed and was a breach of conference good will, and demands:
(i) the GPC acknowledges this
(ii) the GPC desists from its apparent bias towards the PCN model
(iii) a future ballot of the PCN DES will only allow GPs to vote.

204 KENT: That conference acknowledges the failure of the present GMS contract to sustain the profession and:
(i) demands the negotiation of a co-payment model
(ii) believes the PCN DES has had a negative effect on workload.

205 KENT: That conference believes that the PCN DES should be abolished and demands that:
(i) practices should be able to exit the PCN DES at any point and not suffer any financial penalties
(ii) GPC negotiates an exemption for VAT costs incurred under the PCN DES
(iii) PCN funding is diverted into the core contract.

206 NORTH STAFFORDSHIRE: That conference seeks the GPC executive to make NHSE/I agree for it to be mandatory to have LMC representation on the emerging ICS boards.

207 NORTH STAFFORDSHIRE: That conference asks the GPC Executive to negotiate the protection of all delegated and non-delegated budgets for general practice going forwards into ICSs and ICPs post 1.4.22.

208 AVON: That conference instructs the GPC to work with NHSE to ensure that the GP independent contractor model of care continues.

209 AVON: That conference calls for NHSE to work with the GPC to produce a clear specification on the expectations of how general practice should be consulted and involved in decision making within ICPs, ICSs and STPs.

210 WANDSWORTH: That conference:
(i) commends the way general practice has played a crucial role as part of the system response to the pandemic
(ii) is concerned that despite its vital role in the response to the pandemic general practice has no formal representative role in the proposed new Integrated Care Systems.

211 AVON: That conference instructs the GPC to seek the necessary reassurance that as the new NHS reforms develop, the position of PCNs in the ICP structure is maintained and strengthened. PCNs are the cornerstone of general practice, which the DES supports.

212 CITY AND HACKNEY: That conference is concerned that the PCN DES results in a considerable amount of extra work and additional cost to practices without a significant reduction in clinicians workload and requires GPC to ensure that practices and their PCN are not held responsible for the delivery of service specification for which they have insufficient resourcing.

213 CITY AND HACKNEY: That conference, with regard to the implementation of new PCN DES service specification seeks assurance from NHSE that they will be introduced at a realistic and achievable pace.

214 TOWER HAMLETS: That conference notes that APMS contracts are being used as a vehicle to sell general practice to global multinationals and:
(i) believes that this sounds the death knell of holistic, community based family medicine and continuity of care
(ii) demands that GPC Exec make clear to government that GPs will not tolerate this attack
(iii) demands that the GPC run a high-profile publicity campaign explaining to the public what is happening
(iv) demands that the profession is balloted for action up to and including industrial action to defend the traditional model of general practice

215 WALTHAM FOREST: That conference, in light of 38 CCGs merging into 9 as of 1 April 2021 and the DHSC White paper (February 2021), is concerned regarding the future of the GMS / PMS contract and needs urgent clarification from SoS HSC that:
(i) there will be a continuation of the current local community based, partnership model of general practice based on the GMS contract
(ii) the GMS contract will be commissioned by NHSE primary care teams and not delegated to ICS boards
(iii) the development of general practice services with appropriate resourcing will be a key requirement of all ICS.

216 MID MERSEY: That conference notes that the Additional Roles Reimbursement Scheme for primary care networks specifically excludes advanced nurse practitioners, while supporting the recruitment of dieticians, occupational therapists, paramedics, physician associates, nurse associates, mental health practitioners, clinical pharmacists, care coordinators and social prescribing link workers – and calls on GPC to ensure that future regulations support the recruitment of advanced nurse practitioners working in network roles.

217 MID MERSEY: That conference believes that limiting each primary care network to recruitment of a single mental health practitioner for 2021-2022, and just two such practitioners for 2022-2023, is grossly insufficient to improve the provision of mental health care for patients in primary care, and calls on GPC to urgently ensure that the regulations enable networks to use their available ARRS funding to recruit mental health practitioners according to need.

218 BEDFORDSHIRE: That conference calls on GPC to negotiate an item of service fee for each registration of a temporary resident, rather than this being part of Global Sum.

219 SURREY: That conference expresses its concern that the latest White Paper on NHSE reorganisation paves the way for the abolition of CCGs, and the consequent loss of any meaningful GP representation as part of local NHS bodies.

220 WEST SUSSEX: That conference believes the requirement for general practitioners to publish income information on their website should be waived unless all primary care contractor groups have the same contractual requirement, or, if that is not the case, withdrawn entirely as it inappropriately targets general practitioners in the eyes of both NHSE and the public.

REGULATION AND UK PROFESSIONAL ISSUES

221 KENT: That conference demands that an independent judicial review be conducted into deaths of GPs occurring while they undergo performance processes.

222 NOTTINGHAMSHIRE: That conference recognises that primary care teams need to have a wide skill mix but given the workload issues cannot run on GPs alone, particularly with falling WTE numbers. Present regulations mean that a GP must be named on a GMS contract, and although that has been the tractional model, we ask that this could be changed to enable practice evolution.

223 GRAMPIAN: That conference instructs the BMA to expedite the publication of the professional fee engine which has been developed by the Professional Fees Committee.

224 NOTTINGHAMSHIRE: That conference recognises that there is a mismatch between coronial regulations and crematoria regulations throughout the UK leading to body viewing still being necessary at times even if the coroner is satisfied that events can proceed. We ask for urgent clarification, and hopefully unity throughout the UK to enable bereaved families to proceed with their affairs without the complication and delay that can occur when referees need urgent GP clarification.

225 KENT: That conference demands that the specification for the Child Health Surveillance additional service in the GMS contract should state that:
(i) the responsibility for weighing and measuring babies remains with the health visiting service
(ii) GPs should perform physical checks to screen for congenital anomalies
(iii) commissioners should encourage the establishment of joint clinics where GP and health visitors work together.

226 MORGANNWG: That conference calls for all four home nations to recognise UK-wide Medical Performers Lists, geographical boundaries should no longer be a barrier and a mechanism is required to aid both the short and long term movement of virtual and F2F service delivery.

227 DERBYSHIRE: General practice is not an emergency service which should be commissioned elsewhere.

228 KENT: That conference believes that the professional regulatory processes discriminate against BAME doctors and demands a major review of the system.

229 KENT: That conference requires that all complaints submitted to GP practices:
(i) are dealt with at local level only
(ii) cannot be escalated to multiple regulatory bodies following resolution at local level
(iii) be subjected to one complaints process in total
(iv) treated fairly in an unbiased proceeding which is neither doctor nor patient centric.

230 WAKEFIELD: That conference welcomes the settlement the negotiators have reached for the first part of 2021 but want the income protection we have had around QOF to be extended at least until June, in line with the COVID-19 uncertainty that is still ongoing and the continuation of the mass vaccination programme.

231 NORFOLK AND WAVENEY: That conference calls on GPC to negotiate better standardised financial and specialist support for practices rated Inadequate or Requires Improvement by a Regulatory Authority to make the required improvements.

232 NORFOLK AND WAVENEY: That conference recognises and requests GPC to insist that LMCs represent practice networks through their GPs and constituent practices and not self-imposed organisations such as NHS Confederation.

233 NORFOLK AND WAVENEY: That conference calls on GPC to negotiate better financial protection and terms to GP partners securing a bank loan if they have been rated Inadequate or Requires Improvements by a Regulatory Authority.

234 DERBYSHIRE: That conference asks GPC, in their negotiations with NHSE, to ensure that LMCs, as the independent representatives of general practice, are compulsorily included alongside PCNs in the proposed ICS structure as published in the recent white paper.

235 LIVERPOOL: That conference believes that the level of GP representation on Integrated Care Systems where GPs will cease to exist is egregiously and despicably low and calls on GPC to actively support increased GP representation on ICS Boards.

236 KENT: That conference notes NHSEI's commitment to reduce bureaucracy in general practice in the General Practice Forward View and demands:
(i) no additional data collection or proforma may be sanctioned without the agreement of the LMC
(ii) all providers and organisations requiring non-contractual proforma should be required to pay a fee for each completed
(iii) NHSEI and CCGs should conduct an annual audit on the burden of bureaucracy on general practice, discussing their findings with their LMC and demonstrate year on year improvements.

237 KENT: The conference demands that:
(i) CQC collects data on ethnicity and diversity of its inspectors and teams, as well as the people/practice teams it inspects
(ii) CQC is held accountable for ensuring that it treats practices and GPs fairly and without any discrimination.

238 SOUTH STAFFORDSHIRE: That conference believes that the move towards the ICS model threatens the distinct and hard-earned discipline of general practice and calls for regulation to ensure a depth and breadth of GP opinion is incorporated into such schemes over and above token primary care representation.

239 DEVON: That conference notes that CQC mandates practices to provide evidence of equality, diversity, and inclusion training in practice staff but does not provide publicly available evidence that its teams have undergone the same training nor that it is seeking to improve its representation of the profession it inspects. As anecdotal evidence of disproportionate adverse outcomes from CQC inspections arise from practices with BAME CQC leads is increasing, conference requests that GPC negotiate for:
(i) publication of diversity data including protected characteristics of CQC inspectors
(ii) publication of CQC inspection outcomes stratified by the protected characteristics of practice CQC leads including ethnicity and gender
(iii) CQC's plan to improve its representation of the population should its data demonstrate a diversity gap.

240 SEFTON: That conference debates candidly the future organisation and purpose of general practice as a distinct and autonomous unit of health care delivery within the developing context of PCNs, their incorporation and the direction of primary care funding streams to PCNs and ICSs.

241 AVON: That conference notes that the NHS reform paper indicates that there is a fundamental change to the way primary care is organised and in the way that the funding will be allotted. The system will move from one where:

(i) GPs have a leading role, to one where GPs will be just one voice among many with the consequence of a significantly reduced role and influence
(ii) the funding for primary care will no longer be separate from the single pot which the leadership of the integrated care system will disburse as it sees fit.

242 AVON: That conference calls for the end of the postcode lottery of LES contracts and requests a centrally negotiated menu of appropriately funded additional services. This will give clear permission for practices to stop any unfunded work that was considered a LES elsewhere but is viewed as core business by their own CCG.

243 AVON: That conference demands that GPC, in negotiations with NHSE, insists that funding is not removed from primary care budgets as a result of the new NHS reforms.

244 CENTRAL LANCASHIRE: That conference believes that the fragmentation of primary care commissioning in the 2012 reorganisation should not be repeated in the 21 / 22 reorganisation.

245 MORECAMBE BAY: That conference believes that the impact of a remote and less accountable ICS to member practices will have a detrimental impact on general practice.

246 MID MERSEY: That conference calls on GPC to work with NHSE/I to provide conference with an annual report on NHSE/I's performance management processes and procedures in primary care, focusing not only on outcomes but also on the proportion of cases where early resolution has been reached, any steps taken to achieve a fair and consistent approach across different regions, and any data relating to the treatment of GPs with protected characteristics.

247 NORTHAMPTONSHIRE: That conference believes that there should be an incentive in the GMS contract for small practices to merge their contract to form five or more GP practices to manage the increase of bureaucracy, GDPR, CQC and data collection.

CLINICAL, PRESCRIBING AND DISPENSING

248 REDBRIDGE: That conference welcomes the community pharmacy services but is concerned that it needs to be developed further to enable integration with the wider primary care offer including:
(i) enabling direct booking by general practice into the service
(ii) referral by the pharmacist for any patient they believe needs to be reviewed by a GP
(iii) the ability for patients to self-refer to the service
(iv) a requirement for a record of the consultation including all the relevant medical information to be sent to the patient's GP.

249 NOTTINGHAMSHIRE: That conference notes that anticoagulation services are funded through a variety of mechanisms throughout the UK, warfarin being recognised as drug needing careful monitoring. More patients are now treated with Noval Oral Anticoagulants (NOACS) but these are not monitoring free drugs, and we ask for an enhanced service to be introduced in recognition of this.

250 SHROPSHIRE: That conference:
(i) recognises that appropriate use of dosette boxing of medication can be beneficial to patients and carers
(ii) notes that dispensing practices and pharmacies are not reimbursed for providing this service despite the additional costs involved
(iii) understands there is a move away from monitored dose systems but believes their use will continue for the foreseeable future
(iv) requests introduction of an enhanced dispensing fee, for dispensing practices and pharmacies, to reflect the additional costs incurred when dosette boxing is used, and
(v) believes payment of this fee should be contingent on monthly prescribing.

PUBLIC HEALTH

251 HIGHLAND: That conference believes that the coronavirus pandemic has demonstrated the importance of baseline population health on the resilience and wellbeing of citizens and asks GPC to explore with government how to improve the funding of the activities in public health and primary care that lead to improved population health outcomes.

252 NOTTINGHAMSHIRE: That conference recognises public health interventions achievable at scale and so lobbies for fluoridisation of water to all households in the UK.

PREMISES

253 NOTTINGHAMSHIRE: That conference recognises that practice change needs space and the ability to react to changing circumstances. We ask the GPC to negotiate with the DHSC so that primary care can enjoy the bounty of capital funding that secondary care has had over the past few years.

254 KERNOW: That conference is asked to support the following:
(i) a commitment from NHSE/I to provide MIG funding that is timely in its publication and purpose and available in perpetuity, to avoid the prevailing scramble required of practices, for investment in eligible projects
(ii) a commitment from NHSE/I to properly fund clinical space in premises for those valued community services such as midwifery, podiatry and community public health clinics which are being squeezed from GP premises due to lack of space through inadequate funding.

MEDICO-LEGAL AND INDEMNITY

255 KENT: That conference notes the concerns expressed by indemnity providers that the goodwill shown to clinicians in the pandemic will be lost under a deluge of litigations and demands the GPC seeks:
(i) full immunity for all doctors from clinical negligence claims during the COVID-19 pandemic
(ii) a Repeal of S2(4) of the Law Reform (Personal Injuries) Act 1948
(iii) the establishment of an independent body to define the NHS health and social care package which can give an appropriate standard of care for all patients irrespective of the cause of the patient's care requirements
(iv) seeks to limit compensation claims to the costs of additional care required
(v) that we move to a New Zealand no fault compensation scheme.

256 BEDFORDSHIRE: That conference calls on GPC to work with the governments of the UK to make any necessary changes to the law to protect doctors from retrospective manslaughter charges relating to decisions made during the pandemic.

257 KENT: That conference applauds the duty of confidentiality which exists as an obligation under both common law and data protection legislation and demands that the GPC ensures that NHS resolution protects the confidentiality of GPs who seek advice and representation in negligence cases.

258 KENT: That conference demands that:
(i) GPs are not coerced into signing away their privilege and legal protections when seeking support from NHS resolution to answer any civil litigation requests
(ii) NHS resolution accords GPs full confidentiality when dealing with negligence claims
(iii) NHS resolution is forbidden from reporting GPs that have acted in good faith to NHS England and any other regulatory bodies when they are seeking assistance in negligence claims.

GENERAL PRACTICE PAY AND CONDITIONS

259 NORTHAMPTONSHIRE: That conference insists that GPs should be reimbursed for taking time out of practice to support the ICS and should not be penalised financially.

260 CONFERENCE OF ENGLAND LMCs: That conference strongly believes that the current GP funding formula is both seriously flawed and outdated and demands that GPC:

(i) urgently calls for a review of the GP funding formula
(ii) ensures that any future formula provides fair and full remuneration which recognises GP workload
(iii) ensures that a revised funding formula appropriately and proportionately accounts for differences in patient demographics, deprivation and health-seeking behaviour at individual practice level
(iv) ensures that any revision does not result in practices losing out.

261 BUCKINGHAMSHIRE: That conference believes that GP workload has increased in both volume and complexity to unmanageable levels, and:
(i) older patients, complex patients and patients with long-term conditions require more interactions with their GP service than their younger or healthier counterparts
(ii) online consultations increase the number of interactions between patients and GP services
(iii) NHS general practice needs to move from an annual block payment model for healthcare provision to an interaction based funding model and conference therefore mandates GPC to negotiate contract changes to that effect.

262 WANDSWORTH: That conference agrees that the current system of paying practices on weighted list sizes is outdated and payments should be based on raw list sizes to truly reflect the workload.

263 KERNOW: That conference accepts that final pay controls are appropriate in some cases to prevent artificial pay rises in a final year to enhance the future pension of an individual staff member. It is wrong however that in giving appropriate increases to staff groups or individuals to recruit / retain a workforce in the market place practices would need to breach discrimination law and not apply such rises to staff who might be approaching or at an age when they choose to draw their pension at some unforeseen time in the following three years. Flexibility should be allowed in the pay controls calculations rather than using a blanket approach.

MANAGING FUTURE DEMAND

264 MANCHESTER: That conference agrees NHS England must commission a specialist service inclusive of prescribing to ensure adult transgender patients receive an equitable service to that of other patients who require specialist services and which does not transfer this workload to general practice.

265 NORTH STAFFORDSHIRE: That conference calls upon the GPC to challenge NHSE/I about the service gaps in the care of people with gender dysphoria and to negotiate funding gender identity clinics to continue prescribing and monitoring their patient hormonal preparations.

266 WELSH CONFERENCE OF LMCs: That conference believes that End of Life care forms (including DNAR and treatment escalation plans) should be completed and signed off by the clinician most involved with the patient, in partnership with the patient as appropriate. Requiring a senior doctor to countersign such forms is a nonsense in an era of multidisciplinary working and needs to stop.

267 DERBYSHIRE: The increasing availability of private investigations that can be accessed without any referral, results of which then arrive unheralded in primary care, create additional work as well as the assumption of responsibility. Conference asks GPC to seek a judicial review on where the responsibility of dealing with the incidentalomas that are found should sit.

268 DERBYSHIRE: That the increasing tendency of clinical organisations to use email as the primary communication method especially for matters of a clinically urgent nature be outlawed as such practice:
(i) is dangerous
(ii) results in a patient's care becoming disconnected
(iii) promotes uncontracted work dumping onto general practitioners
(iv) results in unscheduled unwarranted extensions to the GP working day and the general practitioner committees must develop and negotiate appropriate policies and contractual terms as a matter of urgency.

269 DORSET: That conference calls for GPC to negotiate with secondary care to completely overhaul the process for GPs to admit patients to hospital. We call for:

(i) an end to the belief that anyone other than the GP can make the clinical decision as to whether further input into their patient's care is required
(ii) a fast, electronic process to input details
(iii) the passing over of responsibility to the secondary care clinician for the patient
(iv) GPs to specifically document the reason for admission.

PENSIONS

270 SCOTTISH CONFERENCE OF LMCs: That conference demands that GPs should have the option to receive all of the 20.9% employer superannuation contribution if they leave the NHS pension scheme as taxable income so they can most efficiently determine their future planning.

271 BRADFORD AND AIREDALE: That conference believes that the handling of the NHS pension scheme by PCSE is incompetent due to irregular and inaccurate withholdings that lead to financial instability in general practice due to delays in challenging and reimbursing incorrect assessments.

PRIVATE GENERAL PRACTICE

272 KENT: That conference demands that the GPC negotiates a reduction in restrictions on private practice in general practice.

273 WEST SUSSEX: That conference believes the current restrictions on NHS general practitioners to see and treat private patients should be removed.

LMC GOVERNANCE

The Annual Conference of LMCs

272 NORTHERN IRELAND SOUTHERN: We call on conference to change standing orders so that elections will ensure that the Chair and Deputy Chair of conference are not from the same nation.

STANDING ORDERS

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.