

# LMC Conference 2014

## General Practice – Facing the Future

### Agenda

22 and 23 May at the York Barbican, York

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**GPDF**  
General Practitioners  
Defence Fund

**BMA** 

# Conference of Representatives of Local Medical Committees

## Agenda

### To be held on

**Thursday 22 May 2014** at 9.30am

**Friday 23 May 2014** at 9.00am

at York Barbican, Paragon Street,

York YO10 4NT

**Chairman** Mike Ingram (Hertfordshire)

**Deputy Chairman** Guy Watkins (Cambridgeshire)

### **Conference Agenda Committee**

Mike Ingram (Chairman of Conference)

Guy Watkins (Deputy Chairman of Conference)

Chaand Nagpaul (Chairman of GPC)

Stuart Blake (Edinburgh)

Peter Horvath-Howard (Dyfed Powys)

Bobbie King (Dorset)

Hal Maxwell (Ayrshire)

Helena McKeown (Wiltshire)

Stephen Meech (Kent)

Emmanuel Owoso (Swansea)



## NOTES

Under standing order 18, in this agenda are printed all notices of motions for the annual conference received up to noon on 24 March 2014. Although 24 March 2014 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the secretary prior to the conference, or handed in, in writing, at as early a stage of the conference as possible.

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

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

Attached is a ballot form for chosen motions. The ballot closes at **noon on Friday 16 May 2014**.

	<b>Motions</b>	<b>Time</b>
Opening business	1 - 6	9.30
Annual report	7	10.00
Workload and patient safety	8 - 9	10.20
Commissioning of care	10 - 12	10.50
Government	13 - 15	11.20
Regulation, monitoring and performance management	16 - 19	11.40
Access	20 - 22	12.20
Charities		12.50
Dain Fund	23	
Claire Wand Fund	24	
Cameron Fund Annual General Meeting	25	
Lunch		13.00
Funding for general practice	26 - 30	14.00
Pensions	31	15.00
Premises	32	15.10
GP pay	33 - 34	15.20
GP partnerships and federations	35 - 37	15.40
The Market / Privatisation	38	16.00
GPC Northern Ireland	39	16.10
GPC Wales	40	
GPC Scotland	41 - 42	
General Practitioners Defence Fund (GPDF)	43	16.40
Sessional GPs	44 - 45	16.50
Other motions 1	46 - 48	17.10
Contingency		17.20
Close		17.30

	Motions	Time
Guest speaker	-	9.00
Contingency		9.30
Primary care workforce	49	9.40
Contract negotiations	50 - 52	10.10
Soapbox		10.40
Chosen motions		11.00
The future of general practice and the NHS	53 - 54	11.10
Quality and outcomes framework (QOF) and quality indicators	55 - 57	11.30
LMC Conference	58	12.00
Lunch		12.30
Ask the Negotiators		13.30
General Practitioners Committee	59 - 60	14.00
Public relations	61	14.20
LMCs and the new commissioning structures	62	14.30
GP education and training	63 - 65	15.40
Information management and technology	66 - 68	15.10
Patient registration	69	15.40
Medical indemnity	70 - 71	15.50
Clinical and prescribing	72	16.10
Primary and secondary care interface	73 - 74	16.20
Occupational health	75	16.40
Contingency		16.50
and finally ....	76	16.55
Close		17.00

## **ELECTIONS**

The following elections will be held on Thursday 22 May and Friday 23 May 2014.

### **Chairman of conference**

Chairman of conference for the session 2014-2015 (see standing order 72 - nominations to be handed in no later than **12 noon Thursday 22 May**).

### **Deputy chairman of conference**

Deputy chairman of conference for the session 2014-2015 (see standing order 73 - nominations to be handed in no later than **9.30am Friday 23 May**).

### **Seven members of the GPC**

Seven members of the GPC for the session 2014-2015 (see standing order 74 - nominations to be handed in no later than **1.00pm on Thursday 22 May**).

### **Seven members of the conference agenda committee**

Seven members of the conference agenda committee for the session 2014-2015 (see standing order 75 - nominations to be handed in no later than **1.00pm on Thursday 22 May**).

### **Three trustees of the Claire Wand Fund**

Three trustees of the Claire Wand Fund for 2014-2016 (see standing order 77 - nominations to be handed in no later than **1.00pm on Thursday 22 May**).

## RETURN OF REPRESENTATIVES

9.30

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

## MINUTES

2 **Receive** Minutes (AC19 2012-2013) of the 2013 Annual Conference of Local Medical Committees as approved by the Chairman of conference in accordance with the provision of standing order 87.

## STANDING ORDERS

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

4 **AGENDA COMMITTEE That a new standing order be introduced under the heading 'Rules of debate', underneath current standing order 39:  
After the debate, prior to the reply by the mover of the motion, a member of GPC with responsibility for the policy addressed by the motion may respond to matters of fact as to whether any motion would have inherent dangers that would preclude delivery and which have not been addressed in the debate. A maximum of one minute will be allowed for such a response.**

4a DONCASTER That conference has recognised that the negotiators exert excessive influence on the outcome of a motion when summing up. Conference asks the GPC to impartially reflect the sentiments of a motion when summing up rather than giving opinion and direction so that conference can find its own voice.

5 **AGENDA COMMITTEE That standing order 54.8 be amended to read:  
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.**

## REPORT OF THE AGENDA COMMITTEE

6 THE CHAIRMAN (on behalf of the agenda committee) That the report of the agenda committee be approved.

## ANNUAL REPORT

10.00

7 THE CHAIRMAN Report by the Chairman of GPC, Dr Chaand Nagpaul.

## WORKLOAD AND PATIENT SAFETY

10.20

8 **AGENDA COMMITTEE to be proposed by MORGANNWG That conference warns of the unsustainable workload in general practice and:**

- (i) **the consequent danger of collapse of services**
- (ii) **the imminent risk to the safety of patients**
- (iii) **the threat to the health and welfare of GPs**
- (iv) **demands that this is urgently recognised and resolved by the governments**

8a MORGANNWG That conference has great concerns about the health and welfare of many GPs in practices where workload is reaching intolerable levels because of the pressures in other parts of the NHS and in social care.

8b DEVON That conference warns the Secretary of State of the increasing workload in general practice, which is unsustainable, and advises him to reverse the reduction in resources and manpower before the service collapses.

8c CAMBRIDGESHIRE That conference believes that for reasons of public safety GPs, like airline pilots and HGV drivers, need a break from time to time, and that a lack of resources in general practice is increasing workloads to the extent that patients are being put at risk.

8d BERKSHIRE That conference believes many GPs are putting patient safety at risk by working hours that would not be allowed for other professionals such as pilots or lorry drivers, and asks the GPC to look urgently at the number of patients and hours a GP should reasonably safely see in a day and then make recommendations.

8e SOUTHWARK That conference notes the number of excess hours which GPs work out of goodwill and calls upon the government

- (i) to acknowledge this goodwill
- (ii) to clarify what steps will be put in place should GPs cease this goodwill and work the number of hours for which they are paid to work.

- 8f SOMERSET That conference:
- (i) instructs the GPC to make the sustainability of general practice its overriding priority, and
  - (ii) believes that general practice can only survive if the inexorably rising workload demanded of GPs can be limited.
- 8g SALFORD AND TRAFFORD That conference believes the current rate of unresourced transfer of work from secondary to primary care is unsafe and unsustainable and formally requests GPC to communicate its concerns to the CQC and the Department of Health.
- 8h NORFOLK AND WAVENEY That conference asks GPC to recognise that the current and future workload of GPs is potentially dangerous and unsustainable and take this into consideration with future contract negotiations.
- 8i SHEFFIELD That conference recognises the increasing number of GPs who are sat at their desks from at least 8 am until beyond 8 pm and:
- (i) feels this is a complete contradiction to the European Working Time Directive (EWTD), which is now in place for hospital doctors
  - (ii) is bad for GPs' health and that of their patients
  - (iii) asks the GPC to make NHS England aware this working pattern is unsustainable and work toward a solution.
- 8j LEEDS That conference condemns governments' failure to recognise, quantify and resolve the workload pressures facing general practice and calls for urgent action to rectify this.
- 8k NORTH YORKSHIRE That conference believes that general practice is at the point of workload saturation. It is essential that resources follow the flow of work.
- 8l HERTFORDSHIRE That conference is deeply concerned that the demands on general practice have reached such a point that younger GPs are being put off from entering the profession because of the risk to patients that such workload generates.
- 8m OXFORD DIVISION That conference believes that GP's should be able to base the time spent on individual patients, in relation to their clinical needs, rather than on short periods of a few minutes which may be inadequate for this purpose.
- 9 **AGENDA COMMITTEE to be proposed by BRO TAF That conference**
- (i) calls for the UK governments to recognise that there is a limit to the safe workload capacity of each practice**
  - (ii) believes general practitioners should have the right to close their lists if they can no longer safely provide care**
  - (iii) calls on GPC to gather evidence to define a safe workload**
  - (iv) calls on GPC to define what areas need to be relinquished to maintain safety.**
- 9a BRO TAF That conference calls for the UK governments to recognise that there is a limit to the safe workload capacity of each practice and so must:
- (i) introduce a robust emergency mechanism for practices to close to new patients when the practice judges that safe capacity has been reached, which can run in parallel with a formal list closure application
  - (ii) accept that Health and Safety considerations apply to staff as well as patients
  - (iii) indemnify practices if local health boards, local area teams, NHS boards and health and social care trusts force them to accept patients beyond a safe capacity
  - (iv) allow practices to know what evidence is submitted to any closure assessment panel
  - (v) allow practices to be represented at an assessment panel hearing.
- 9b SURREY That conference believes general practitioners should have the right to close their lists to new applications if they can no longer safely provide care to already registered patients. (Supported by West Sussex)
- 9c NORTHAMPTONSHIRE That conference insists that a practice at full capacity with an above average list size and unable to expand its premises must be allowed to close the list to new patients.
- 9d MID MERSEY That conference believes that the clinical and administrative workload in general practice should be annually benchmarked to ensure that future resources are matched against actual workload.
- 9e CROYDON That conference calls on the GPC to improve data collection relating to general practice workload statistics.
- 9f WILTSHIRE That conference deplores the reduction of funding in general practice as a percentage of NHS funding and asks GPC to advise practices on what services they should safely withdraw.
- 9g HULL AND EAST YORKSHIRE That conference recognises that, in setting the precedent of withdrawal of MPIG and abolition of PMS, that there should:
- (i) now be a level playing field in terms of service provision at practice level
  - (ii) be clear guidance from GPC as to what services currently provided in practice are not funded under GMS (e.g. phlebotomy, nursing care such as wound dressings), ECGs etc
  - (iii) that the BMA offers support to practices who wish to serve notice on such activities.
- 9h SALFORD AND TRAFFORD That conference calls on GPC to work with HPERU to collect and calculate what list sizes are safe for GPs to deliver safe care, given the current increased workload.

9i

HIGHLAND That conference:

- (i) believes that current GP workload is unsustainable because of the lack of resource allocated to general practice
- (ii) calls upon GPC UK to ask all GPs working in the UK to determine their priorities before our elected GP leaders negotiate on significant contract changes in future
- (iii) calls upon GPC UK to provide a clearer definition about what GPs are required to do under GMS so that GPs working in the UK can finally put a stop to the unresourced shifting of work from secondary care
- (iv) calls upon GPC UK to carry out a comprehensive GP workload survey to inform future policy on the GP contract.

9j

AVON That conference believes that the workload expected of general practitioners has become unsustainable and calls on GPC to publically assist general practitioners in defining what they can legitimately stop doing, whilst still complying with their core contracts and produce a toolkit to enable this process.

- 10 **AGENDA COMMITTEE to be proposed by LEEDS** That conference believes that the re-organisation of the NHS in England has been, and remains a shambles and condemns the consequences of:
- (i) arrangements that are complex and fragmented
  - (ii) undermining patient care
  - (iii) delayed payments to practices
  - (iv) obscuring what is done locally and what is done nationally
  - (v) this disorganised mess and instructs GPC to work to protect GPs from the problems it has caused.
- 10a LEEDS That conference believes that the re-organisation of the NHS in England:
- (i) has been, and remains, a shambles
  - (ii) has led to arrangements that are complex and fragmented
  - (iii) is undermining patient care.
- 10b BRADFORD AND AIREDALE That conference considers that NHS England (NHSE) is not fit to commission and manage general practice.
- 10c LEEDS That conference believes the inconsistency of approach between area teams suggests a lack of leadership by NHS England.
- 10d HERTFORDSHIRE That conference takes no joy in seeing the disorganised mess of NHS England and its area teams and instructs GPC to work to protect GPs from the problems this has caused.
- 10e AVON That conference has lost confidence in NHS England because it:
- (i) has little or no consistency in its approach from one area team to another
  - (ii) has failed to deliver on its mantra to “empower and support clinical leaders at every level of the NHS”
  - (iii) has failed to honour pre-existing agreements with regard to practice premises made between practices and PCTs
  - (iv) is effectively supervising the destruction of general practice in its abject failure to ensure fair funding for primary care.
- 10f DEVON That conference expresses no confidence in the senior executive of NHS England who seems to be taking every opportunity to disinvest in English general practice whilst expecting it do more each year for less.
- 10g SEFTON That conference calls upon the GPC to address with NHS England the excessive volume of demands upon general practice by NHSE area teams for information, data and the completions of protocols, much of which seems pointless but require unaffordable time to complete which could be better spent on direct patient care activities.
- 10h NORTHUMBERLAND That conference demands NHS England review its use of the primary care web tool to ensure it is:
- (i) fit for purpose
  - (ii) contains only indicators relevant to primary care
  - (iii) ensures use of current data
  - (iv) transparent in involvement of the CCGs in performance management.
- 10i MERTON, SUTTON AND WANDSWORTH That conference believes that GPs should be able to performance manage NHSE with the ability for sanctions to be imposed in much the same way that NHSE performance manages GPs.
- 10j GREENWICH That conference deplores the dictatorial and inflexible approach taken by NHSE towards practices missing deadlines, whilst failing to apply the same rigorous standards to itself, in making timely payments for work done.
- 10k MANCHESTER That conference demands payments from area teams, CCGs and public health are made to general practice within 30 days of submission of claims regardless of systems and process checks.
- 10l WEST PENNINE That conference wishes NHS England and area teams to standardise on paying business rates and water rates directly rather than practices having to pay and claim back.
- 10m EAST SUSSEX That conference deplores the continuing difficulties experienced by GP practices in terms of receiving payments and believes:
- (i) payments to GP practices should be made promptly
  - (ii) payment invoices and bank transfers should be clearly reconciled with practice claims
  - (iii) the payment process should be far more rigorously monitored
  - (iv) there should be clear accountability in terms of responsibility for making payments to GP practices.
- (Supported by Surrey)
- 10n NORFOLK AND WAVENEY That conference asks GPC to insist NHS England holds local area teams to account for any contract breaches incurred through missed payments to GP practices.
- 10o LAMBETH That conference is appalled by the lack of responsiveness and accessibility by NHSE to any inquiries and calls upon NHSE to be subject to access targets in the same way as GPs.

- 10p NORTHUMBERLAND That conference believes cash flow is so tight for many practices that the combined effect of the changes in GP income streams and payment schedules:
- (i) creates potential for financial instability
  - (ii) renders financial planning in 2014/15 impossible
  - (iii) will put practices out of business.
- 10q DEVON That conference:
- (i) notes that in the outsourcing of NHS financial systems payments to general practice have become woefully mismanaged
  - (ii) is alarmed that such mismanagement causes regular cash flow problems for practices, often leading to interest and bank charges
  - (iii) demands that all such losses incurred by practices are fully reimbursed by the NHS.
- 10r DONCASTER That conference has spent the last year in dismay; witnessing fragmentation of commissioning in the NHS and calls upon the GPC to encourage the strengthening of ties and improvement in communication between commissioners and general practice.
- 10s MANCHESTER That conference seeks clarification from NHS England about the circumstances in which area teams can deviate from the single operating model and undertake local negotiations.
- 10t HERTFORDSHIRE That conference is dismayed at the continuing disinvestment in and fragmentation of general practice and calls on GPC to insist that commissioners give the highest priority to directing resources to GPs and their teams for the co-ordination as well as the delivery of medical care.

**11 AGENDA COMMITTEE to be proposed by NOTTINGHAMSHIRE That conference views with alarm proposals contained in NHS England's (NHSE) interim response to the 'call for action for general practice' to make CCGs co-commissioners of GP contracts and**

- (i) believes that this will fatally damage relations between CCGs and their constituents**
- (ii) warns that this will undermine CCGs' chances of success in other areas of commissioning**
- (iii) predicts this will undermine the credibility of CCGs**
- (iv) asserts that conflicts of interests would be unacceptable**
- (v) insists that GP core contracts should not be held by CCGs.**

- 11a NOTTINGHAMSHIRE That conference views with alarm proposals contained in NHS England's interim response to the 'Call for action for general practice' to make CCGs co-commissioners of GP contracts and believes that this will
- (i) fatally damage relations between CCGs and their constituent practices
  - (ii) undermine CCGs' chances of success in other areas of commissioning
  - (iii) undermine the credibility of CCGs in the eyes of the public and patients who may view this development as a 'conflict of interest too far'.
- 11b NORTHUMBERLAND That conference acknowledges increasing numbers of GP's will have the potential for conflict of interest across their varying roles and requests that the GPC:
- (i) facilitates ongoing national debate
  - (ii) recognises the risks and values of such conflicts
  - (iii) undertakes the development of a simplified national code of practice for GPs.
- 11c NORFOLK AND WAVENEY That conference believes Department of Health recommendations that CCGs are given a joint role with the area team in commissioning primary care contracts and quality management carries with it risk of conflict of interest and risks the relationship with primary care.
- 11d DEVON That conference believes CCGs cannot in their current form be allowed to control local primary care contracts as the conflict of interests are unacceptable.
- 11e LANCASHIRE COASTAL That conference believes that the requirement on GPs who are CCG executive committee or membership council members to declare the remotest conflict of interest possibilities renders any true involvement in giving primary care advice impossible.
- 11f LEWISHAM That conference believes that GP core contracts should not be held by the CCG.
- 11g HILLINGDON That conference rejects co-commissioning of primary medical services by NHSE and CCGs as this will effectively remove GP CCG Board members from commissioning decisions because of their conflict of interest; the future of General Practice would be decided by non-GPs and non-clinicians. (Supported by Brent, Ealing Hammersmith and Hounslow, Harrow, Hillingdon, Kensington Chelsea and Westminster, Greenwich, Southwark, Lambeth, Barnet, Camden, Enfield, Haringey, Redbridge, Waltham Forest, City and East London LMCs)
- 11h BUCKINGHAMSHIRE That conference insists that any proposal for co-commissioning or co-monitoring of the GMS/ PMS contract by area teams and CCGs is completely unacceptable:
- (i) as it would cause an insoluble conflict of interest
  - (ii) and would call into question whether GPs could continue to support CCGs
  - (iii) and therefore supports GPC investigating legal options should this proposal be implemented.

- 11i BRENT That conference notes the distinction between GPs roles as health service commissioners and providers and calls upon commissioning bodies, including CCGs and local authorities, to:
- (i) recognise that GP commissioners cannot and do not represent GP providers
  - (ii) understand that they are putting their procurement and commissioning decisions at risk if they do not take account of GPs dual role in their engagement strategies.

- 12 **MERTON, SUTTON AND WANDSWORTH That conference believes that CCGs should commission general practice.**  
(This motion will fall if 11(v) is carried)

## GOVERNMENT

11.20

- 13 **SCOTTISH CONFERENCE OF LMCs That conference believes that the UK government's welfare reforms are having a detrimental impact on the health of many of our most disadvantaged patients and in view of this danger to the health of the public, urgent reform is required to prevent further harm.**

- 13a LOTHIAN That conference believes that the UK government's welfare reforms are having a detrimental impact on the health of many of our most disadvantaged patients and in view of this danger to the health of the public, urgent reform is required to prevent further harm.

- 14 **DYFED POWYS That conference deplores the NHS being used as a political football between governments in the UK.**

- 14a MORGANNWG That conference calls on politicians of all parties to refrain from denigration of the health systems in various countries of the UK and the erosion of public confidence in NHS care for the purpose of political points scoring.

- 14b DEVON This conference believes that the Daily Mail is an inappropriate publication for the Secretary of State for Health to use to communicate to general practitioners.

- 15 **ROTHERHAM That conference notes with regret that, due to government led and imposed reforms, general practice often no longer provides the services its patients deserve.**

- 16 **AGENDA COMMITTEE to be proposed by SOUTH STAFFORDSHIRE That conference deplores CQC's plans for a simplistic rating system for practices and demands:**
- (i) that where problems are identified by the CQC the necessary help, including funding, to improve premises is delivered speedily and efficiently
  - (ii) that the CQC takes into account what is deliverable/attainable in making their report
  - (iii) that the CQC must standardise the quality and professionalism of their inspections
  - (iv) that in relation to appointing new partners the CQC ceases its obstructive behaviour
  - (v) that GPC opposes this vehemently.
- 16a SOUTH STAFFORDSHIRE That conference believes that CQC is not fit for purpose and demands:
- (i) that where problems are identified by the CQC the necessary help including funding to improve premises is delivered speedily and efficiently to allow the GPs and practice to reach required standards
  - (ii) that the CQC takes into account what is deliverable/attainable in making their report. They need to standardise the quality and professionalism of their inspections in order to avoid apparent discrepancies in style and attitude of inspectors.
  - (iii) that in relation to appointing new partners the CQC ceases its obstructive behaviour through delays caused by burdensome bureaucracy and interviews.
- 16b KENT That conference asserts the CQC:
- (i) is a waste of resource
  - (ii) should simplify the process for practices when changing partners
  - (iii) should have a consistent and evidence based approach to their recommendations
  - (iv) should include an opportunity for organisations to provide feedback about the quality and conduct of their inspection.
- 16c SURREY That conference is gravely concerned that the costs of CQC registration and inspection process is money that would be much better spent on direct patient care.
- 16d DERBYSHIRE That conference demands that CQC assessments of general practice must be undertaken by those with direct first hand current operational experience of general practice and requests GPC to act accordingly.  
(Supported by East Midlands Regional Council)
- 16e CORNWALL AND ISLES OF SCILLY That conference believes the CQC is not fit for purpose and the £179 million used to fund it would do more to improve quality general practice if it were ploughed back into general practice than fund a crude, not fit for purpose, ratings system.
- 16f CAMBRIDGESHIRE That conference, in recognition of the similarity between the arbitrary and unevidenced outcomes of many CQC inspections and NHS Choices practice ratings, ironically and non-arbitrarily awards the chief inspector of general practice two stars.
- 16g DERBYSHIRE That conference demands that CQC obtains a sense of perspective and proportion in its dealings with general practice and ceases its mindless officious box ticking approach, and requests GPC to act accordingly.
- 16h HERTFORDSHIRE That conference calls on GPC to ensure CQC uses a standardised and consistent approach to assessing practices' compliance against outcomes.
- 16i HULL AND EAST YORKSHIRE That conference believes that general practices should be allowed a right-of-reply section in CQC inspection reports.
- 16j NORFOLK AND WAVENEY That conference deplores CQC's move to practice ratings as an unhelpful marker of quality.
- 16k MID MERSEY That conference believes that differences in geography, demography, social and other health care providers renders an OFSTED style CQC rating system meaningless.
- 16l HERTFORDSHIRE That conference deplores CQC's plans for a simplistic rating system for practices and calls on GPC to oppose this vehemently.
- 17 **MID MERSEY That conference deplores the CQC for advertising adverse findings disproportionately and demands an apology from the Chief Inspector of general practice.**
- 17a CORNWALL AND ISLES OF SCILLY That conference deplores the way CQC handled the press coverage of general practice inspections, believes it brought the profession into disrepute and should publically apologise to the vast majority of GPs who provide excellent standards of care.
- 17b SOUTH STAFFORDSHIRE That conference deplores the scapegoating of GP colleagues by the press following CQC reports and demands:
- (i) that the CQC is more careful in what it releases to the press so that it cannot be misrepresented in the media
  - (ii) there should be a formal complaints procedure and sanctions should be taken against those who publish false/exaggerated articles which unreasonably damage GPs reputations.

- 17c COVENTRY That conference was shocked by #maggotgate and other CQC related scandals, and insists that all visits by CQC are suspended until acceptable processes have been agreed with the GPC.
- 17d HERTFORDSHIRE That conference deplors misleading press statements from CQC on the state of UK general practice and calls on GPC to remind CQC that it was set up to ensure standards are met rather than to seek cheap publicity.
- 17e NOTTINGHAMSHIRE That conference deplors the way in which the CQC sought to 'name and shame' individual practices deemed to be non-compliant with its standards and the fact that information disclosed to the media about such practices was in some cases distorted and inaccurate and:  
(i) trusts the CQC has turned its back on such behaviour  
(ii) instructs the GPC to work with the CQC to draw up guidelines on how and when its information is to be made public and to devise an inspection regime that is efficient, fair and proportionate.
- 17f AVON That conference believes the presence of maggots should be encouraged by CQC in the treatment room of every GP surgery in the land.
- 17g SALFORD AND TRAFFORD That conference believes that the CQC should be ashamed of its policy of 'naming and shaming' practices that fall short of CQC standards. Such action only increases the stress levels on the practitioners concerned, and this additional stress is counterproductive as practices strive to reach compliance.
- 18 **KENT That conference believes that GP waiting and consultation rooms should:**  
**(i) be conducive to a therapeutic environment**  
**(ii) not be subject to the same standards of infection control as treatment rooms**  
**(iii) be permitted to have carpets and soft furnishings**  
**(iv) be cosy and comfortable.**
- 19 **DEVON That conference believes it should be an essential requirement of any primary care performance committee considering GPs performance to always contain at least one member nominated by the local medical committee.**

- 20 **AGENDA COMMITTEE to be proposed by WIRRAL That conference:**
- (i) **rejects the concept of routine general practice care 8-8 seven days a week**
  - (ii) **believes that GPs will only provide routine planned care 8-8 seven days a week if resources are provided to the satisfaction of the profession**
  - (iii) **commends GPs for already providing unscheduled general practice care for 24 hours every day, seven days every week.**
- 20a WIRRAL That conference notes the current move and determination of government to impose 8-8, 7 day working on already stressed and stretched general practice, and calls for caution on the part of the government. If 8-8, seven day working must be done, the government must:
- (i) ensure and guarantee that general practice is adequately resourced to cope with the additional work load it will create
  - (ii) seriously and pragmatically address the recruitment and retention difficulties currently facing GPs
  - (iii) ensure that the core traditional values of GP are protected.
- 20b HULL AND EAST YORKSHIRE That conference rejects seven day planned care working until proper and full resources are provided with the support of NHS England to the satisfaction of the profession.
- 20c WIRRAL That conference rejects the imposition of 8-8, seven day working on already stressed and demoralised general practitioners, in view of the current workforce crisis in general practice and the ever increasing workloads in the face of dwindling resources.
- 20d WIRRAL That conference rejects the current plan by the government to impose 8-8, seven day working on GPs because it will damage the fundamental core values of continuity of care to the patient for which general practice is known, loved and well respected.
- 20e NORTH YORKSHIRE That conference demands that any attempt to impose 8-8 seven day working on an increasingly overburdened GP workforce, already threatened by retention and recruitment challenges, should be vigorously opposed.
- 20f GATESHEAD AND SOUTH TYNESIDE That conference believes that whilst seven day non-urgent services are desirable, is there evidence that they are needed, affordable, and that unless properly resourced including additional extra clinicians, there will be a worsening of overall service provision in primary care.
- 20g WAKEFIELD That conference opposes seven day working for primary care without adequate and recurrent resources both financial and within the workforce.
- 20h LOTHIAN That conference:
- (i) recognises that seven day practice opening hours are unaffordable and undeliverable
  - (ii) commends GPs for already providing unscheduled general practice care for 24 hours every day, seven days every week.
- 20i MID MERSEY That conference believes that providing routine GP services over seven days will only be possible if:
- (i) sufficient resources are made available to support extra staff
  - (ii) routine phlebotomy, X-rays and diagnostic services are also available over seven days
  - (iii) funding is available to support the infrastructure oncosts.
- 20j SOUTHWARK That conference is concerned that the funding which has been made available for the 8am to 8pm access pilot (Challenge Fund) is inadequate and unsustainable and is likely to result in current services being harmed.
- 20k WEST SUSSEX That conference believes seven day working in general practice should:
- (i) distinguish between an in hours and out of hours service delivery model
  - (ii) be appropriately resourced
  - (iii) be supported by community and diagnostic services.
- (Supported by Surrey)
- 20l BRADFORD AND AIREDALE That conference acknowledges the drive to increase access to general practitioners by way of opening more days and for longer hours but believes it is impossible to deliver this by just re-structuring the working week and expecting GPs to carry the financial and personal burden of delivering such a service; it requires planning and full resourcing to deliver this aspiration.
- 20m SOMERSET That conference insists that expansion of current in hours primary care to seven day availability is only possible if:
- (i) there is appropriate expansion of the GP workforce
  - (ii) there is increased funding to support the opening of GP practices throughout the week
  - (iii) the management of patients with long term conditions is not compromised.
- 20n LIVERPOOL That conference believes that 8-8 working, seven days a week is unrealistic and unsustainable and mitigates against care for the most vulnerable; it values convenience over need.

- 20o CAMDEN That conference deplores the ill-conceived policy for seven day opening of practices that would lead to a:
- (i) 50% increase on the current working hour week for GPs and staff
  - (ii) GP workforce crisis
  - (iii) even further denigration of under resourced general practice thereby having an impact on quality for patients.
- 20p BRADFORD AND AIREDALE That conference believes that more needs to be done to help practices deal with the problem of being able to provide urgent access for acute conditions while not compromising quality and continuity for chronic conditions.
- 20q NORTH YORKSHIRE That conference points out to government, that its policy of longer opening hours and easier immediate access for patients, rewards inappropriate acute demand at the expense of considered planned medical review.
- 20r BRADFORD AND AIREDALE That conference believes that it is not possible to increase access, improve quality and provide increased continuity of care simultaneously in general practice without any further extensive investment and resource.
- 20s SOMERSET That conference believes that continuity of care in general practice for patients with long term conditions should not be sacrificed in favour of convenient access to primary care for those with minor conditions.
- 20t SOUTHWARK That conference deplores the political emphasis being placed on access while no extra resources are available to counter the increasing demand being placed on primary care by patients with long term conditions and the shift of work from secondary to primary care.
- 20u NEWCASTLE AND NORTH TYNESIDE That conference supports GPs taking part in the pilots that aim to extend patient access but remains concerned:
- (i) that the current workforce is already stretched trying to provide quality care within current access arrangements
  - (ii) that if the pilots are deemed to be successful, future roll outs to the profession generally will be without any additional resources.
- 20v NORFOLK AND WAVENEY That conference deplores the political expediency where access to services seems more important than quality and length of consultations.

21 **OXFORDSHIRE That conference believes the approach of NHS England to Christmas Eve and New Years Eve services by practices was hypocritical, misguided, and clumsily handled, and asks the GPC to educate them on the both GP contract wording and the practical reality of delivering GP services in difficult circumstances.**

- 21a BERKSHIRE That conference deplores the recent letter from NHS England insisting practices remain open on the afternoon on Christmas Eve and New Year's Eve and:
- (i) notes that GPs were proven correct when they predicted that this was an inefficient and ineffective waste of NHS resources to service tiny volumes of patient activity during these time frames when alternative comprehensive provision had been in place and tried and tested over many years
  - (ii) deplores this meddling in practices flexibility to organise services efficiently and effectively to meet the requirements of their patients
  - (iii) demands NHS England does not repeat this letter in future years
  - (iv) demands NHS England apologise for sending such a "Scrooge" like letter just before Christmas
  - (v) demands that the Department of Health publishes its staff cover arrangements for the same time periods.
- 21b HULL AND EAST YORKSHIRE That conference accepts GP practices have a duty to increase services where possible during times of high demand, and therefore have the right to reduce them during times of low demand, providing the requirements of their contract are met.
- 21c CENTRAL LANCASHIRE That conference is appalled by the way the issue of Christmas and New Year opening hours was handled by NHS England in 2013 and
- (i) insists that our independent contractor status allows us to vary opening hours
  - (ii) no further interference from NHS England should be allowed
  - (iii) an early firm stance should be adopted by GPC to avoid this situation recurring.

22 **LAMBETH That conference believes that assessment of eligibility for NHS treatment should not fall to GPs or secondary care and calls upon the government to develop a process whereby eligibility for NHS treatment is established by the relevant government department at the time immigration or asylum seeker status is granted.**

- 22a DEVON That in relation to eligibility for treatment in NHS general practice, conference:
- (i) notes that the current rules and regulations are confusing, and in places self-contradictory
  - (ii) acknowledges the invidious position in which practices are placed as a result, often leading to aggression against NHS staff
  - (iii) suggests that such policy vagueness is a political expedient designed not to address the issue of whom is eligible for NHS care, but to transfer that burden to individual GPs and receptionists
  - (iv) demands that clear, comprehensive and easily implemented rules are produced and published publicly.

- 22b BERKSHIRE That conference believes that the role of GP practice is the provision of health care, not a quasi agent of the Border Agency, and requests the GPC strenuously presents to the public and politicians
- (i) the intolerable moral and ethical impact on general practice of denying health care to people in need
  - (ii) the madness of requiring general practice to police an immigration system
  - (iii) the benefits of an alternative system where immigration checks are done by the appropriate authorities and not GPs.

## CHARITIES

12.50

### Dain Fund

- 23 **Receive:** Report by the Chairman of the Dain Fund (Dr Mike Downes).

### Claire Wand Fund

- 24 **Receive:** Report by the Chairman of the Claire Wand Fund (Dr Jane Wand).

### Cameron Fund Annual General Meeting

- 25 **Receive:** Report by the Chairman of the Cameron Fund (Dr Roger Chapman).

## LUNCH

13.00

## FUNDING FOR GENERAL PRACTICE

14.00

- 26 **AGENDA COMMITTEE to be proposed by HERTFORDSHIRE That conference notes the substantial reduction in the proportion of the total NHS budget spent in general practice and:**
- (i) believes that we will no longer have a sustainable NHS unless the decline in funding to general practice is urgently addressed**
  - (ii) deplores the political rhetoric which denies that general practice is underfunded**
  - (iii) recognises that general practice is the most cost effective part of the NHS**
  - (iv) demands that a greater proportion of the NHS budget must go to general practice to protect services to patients**
  - (v) demands urgent and consistent investment in global sum and PMS baselines to enable all GP practices to meet the essential primary healthcare needs of their patients.**
- 26a HERTFORDSHIRE That conference believes that a substantial reduction of primary care funding as a proportion of the total NHS budget has already impacted on the ability of general practice to undertake around 90% of patient contacts in the NHS and calls on GPC to ensure that:
- (i) this trend in funding is reversed
  - (ii) the public realises that their access to general practice is increasingly threatened.
- 26b CAMBRIDGESHIRE That conference demands that the GPC publicly declares that a greater proportion of the NHS spend must go into general practice to protect services to patients, and should be free to make such demands without being constrained by wider BMA politics.
- 26c LEEDS That conference believes that general practice:
- (i) is unsustainable with only £69.98 per weighted patient being made available by NHS England to fund essential and additional services
  - (ii) requires urgent and consistent additional investment into global sum and PMS baselines to enable all practices to meet the essential primary healthcare needs of their patients.
- 26d YORKSHIRE REGIONAL COUNCIL That conference believes that general practice:-
- (i) is unsustainable with only £69.98 per weighted patient being made available by NHS England to fund essential and additional services
  - (ii) requires urgent and consistent additional investment in to GMS global sum and PMS baselines to enable all practices to meet the essential primary healthcare needs of their patients
  - (iii) requires an increase in the share of NHS funding spent on it in England rather than the current 7.47%.
- 26e DEVON Regarding the percentage of NHS funds spent in general practice, conference:
- (i) recognises decades of research showing the efficiencies of monies spent in primary care
  - (ii) asserts that increased proportionate funding for general practice is the only feasible route to meeting the Nicholson challenge
  - (iii) deplores the reduction from 10% in 2004/5 to 8% in 2012/2013 as completely counter-intuitive
  - (iv) advises the Secretary of State to reverse this pernicious decline, in order to improve the care of patients and keep the NHS solvent.

- 26f CORNWALL AND ISLES OF SCILLY That conference believes that unless the decline in funding into general practice is urgently addressed we will no longer have a sustainable NHS.
- 26g AVON That conference deplores the political rhetoric which denies that primary care is underfunded and directs the GPC with the BMA to:
- (i) make public the true figures showing the proportion of NHS spend in primary care
  - (ii) re-double their efforts to negotiate a real-term increase in GP funding.
- 26h MID MERSEY That conference asserts that general practice is the most cost effective part of the NHS and demands increased investment in this NHS cornerstone.
- 26i CORNWALL AND ISLES OF SCILLY That conference deplores the sustained decrease in funding into general practice and urges the government to urgently invest in quality general practice.
- 26j CORNWALL AND ISLES OF SCILLY That conference believes the NHS will not be sustainable unless the government back general practice and invest in a significant increase in resources into general practice.
- 26k LEEDS That conference
- (i) believes that there is an urgent need to increase the share of NHS funding spent on general practice in England from the current 7.47%
  - (ii) calls on the Department of Health to mandate NHS England to increase each year the share of NHS funding spent on general practice.
- 26l OXFORDSHIRE That conference believes that with dramatic recent increases in GP workload and diminishing resources, government needs to improve the funding flow into general practice so it can play its rightful part in delivering care closer to home.
- 26m BORDERS That conference calls on the government to increase funding of general practice from 7.8% of NHS funding to 11% as recommended by the RCGP, to allow us to cope with the ever increasing workload being passed onto primary care.
- 26n MANCHESTER That conference expresses grave concern about the state of practice finances.
- 26o NORTHAMPTONSHIRE That conference feels that the insurance premium/capitation fee of around £69.95 per patient no longer reflects the professional cost of the number of both face to face consultations and administrative case reviews that now take place in modern general medical practice.
- 26p EAST MIDLANDS REGIONAL COUNCIL That conference insists that the insurance premium/capitation fee of around £75 per patient no longer reflects the cost of the large number of face to face consultations and administrative case reviews which take place in modern general practice.
- 26q AVON That conference deplores any overcharging for secondary care services and calls on the GPC to:
- (i) expose such institutional dishonesty wherever it occurs
  - (ii) work with LMCs, CCGs and NHS England so that money follows the patient into the community in line with the government's agenda
  - (iii) to highlight the fact that the present spend on primary care is at an all-time low.
- 26r KINGSTON AND RICHMOND That conference calls on GPC to focus on improving the resources available to enable general practice to deliver existing and improved services. (Supported by Surrey)
- 26s GLASGOW That conference calls on government to adequately resource general practices to enable GPs to continue to provide high quality primary care.
- 26t DEVON That conference directs GPC to demand that the Secretary of State for Health mandates NHS England to invest continuously in general practice at an equivalent premium to the investment in acute hospital services.
- 26u AYRSHIRE AND ARRAN That conference believes that in the light of the looming workforce crisis in general practice the RCGP campaign for fairer funding for primary care must be fully supported.
- 26v DEVON That conference asks the GPC negotiators to continue to pursue the important political message that a small percentage increase in primary care funding would have little effect on the NHS budget but a potentially massive effect on health outcomes for the population.
- 26w SOUTHWARK That conference calls for NHSE to provide more support and financial provision to GPs to enable them to continue to deliver the standard of care that is required for the growing number of patients with long term conditions.
- 26x CITY AND EAST LONDON That conference deplores that only 8% of the total NHS budget is currently spent on primary care and requests that CCGs should put an equitable amount of funding to match the ever increasing provision of services.
- 26y SCOTTISH CONFERENCE OF LMCs That conference:
- (i) believes that primary care is not sufficiently resourced to meet increasing health needs
  - (ii) wholeheartedly supports the RCGP campaign to 'Put patients first: Back general practice'
  - (iii) supports the call to increase the percentage of NHS resource allocated to general practice to 11% by 2017.

- 26z HERTFORDSHIRE That conference believes that general practice has reached crisis point and commends the GPC publication 'Developing general practice today: Providing healthcare solutions for the future' for drawing attention to the inexorable rise in demand on GPs.
- 26aa LEEDS That conference welcomes the GPC document 'Developing general practice today: Providing healthcare solutions for the future' and demands that
- (i) commissioners ensure that comprehensive community healthcare teams are built around GP practices
  - (ii) commissioners invest sustained additional funding to make this vision a reality
  - (iii) urgent steps are taken by departments of health to increase recruitment of GPs
  - (iv) a 10 year rolling programme should be urgently developed to ensure all practices that require it have a purpose-built surgery, working with NHS bodies, Local Authorities and third-party developers where necessary.
- (Supported by Yorkshire Regional Council)
- 26bb LEEDS That conference welcomes and supports the RCGP campaign 'Put patients first: Back general practice', calling for fairer funding for general practice and calls on GPC to co-ordinate actions with the RCGP to ensure the campaign is a success.
- 26cc BERKSHIRE That conference notes the predicted increase in demands on the NHS that arise from an aging population and:
- (i) believes that the most cost effective way of dealing with this demand is by enhancing capacity in primary care
  - (ii) believes investment should be directed to provision of adequate premises and expanding the workforce
  - (iii) calls on government to reverse the recent decline in investment in primary care.
- 26dd DONCASTER That conference deplores the continued reduction in investment in general practice which poses a serious threat to the viability of the future of the NHS and demands:
- (i) immediate action by the government to provide financial help to general practice
  - (ii) a commitment to safeguard general practice from future budget cuts.
- 26ee NORTHERN IRELAND CONFERENCE OF LMCs That conference supports and endorses the RCGP efforts to get equitable funding and resources for general practice to match these that have increased in secondary care.
- 26ff MERTON, SUTTON AND WANDSWORTH That conference deplores the reduction in the level of spend on general practice as a percentage of the overall health budget.
- 26gg CAMDEN That conference deplores the lack of funding for general practice, and urges NHS England to make available funding data for cost comparison across the country.
- 26hh WEST PENNINE That conference urges the GPC to press the Department of Health to redress the diminishing percentage of the total healthcare budget being spent on primary care when more and more work of a secondary care nature is being performed.
- 26ii NORTH WEST REGIONAL COUNCIL That conference believes that general practice is in crisis. Real net practice incomes have dropped by more than 20% since the introduction of the GP contract in 2004 and funding for general practice in England has slumped to just 8.5% of the total NHS budget. We ask GPC to demand an increase in funding to at least 10% of the NHS budget immediately, otherwise recruitment and retention of GPs will affect patient care, ultimately putting the NHS at risk.

- 27 **AGENDA COMMITTEE to be proposed by WILTSHIRE That conference:**
- (i) believes that general practice is unsustainable in its current format**
  - (ii) believes that it is no longer viable for general practice to provide all patients with all NHS services free at the point of delivery**
  - (iii) urges the UK governments to define the services that can and cannot be accessed in the NHS**
  - (iv) calls on GPC to consider alternative funding mechanisms for general practice**
  - (v) calls on GPC to explore national charging for general practice services with the UK governments.**
- 27a WILTSHIRE That conference believes the time is right for a fee for service for general practice.
- 27b AVON That conference calls on GPC to explore with the Department of Health the alternatives to a completely free at the point of access system.
- 27c GLOUCESTERSHIRE That conference believes the time has come to impose a national charge for consultations as part of a strategy of demand management.
- 27d KINGSTON AND RICHMOND That conference believes that alternative funding mechanisms for general practice must be explored in order to preserve universal general practice.
- 27e GLOUCESTERSHIRE That conference requires the GPC to consider a fundamental change to the contract, such as an alternative system of funding, as for instance that used in Guernsey.
- 27f MID MERSEY That conference believes as with dentistry and ophthalmology services, it is no longer viable for general practice to provide all NHS services free at the point of delivery for all patients.

- 27g NORTHERN IRELAND CONFERENCE OF LMCs That conference believes that in the light of the ongoing financial constraint facing the health service, along with the increasing demand for services, that the subject of what the NHS can afford and be reasonably expenses should be revisited, along with the subject of co-payments.
- 27h DEVON That conference believes the only meaningful way to engage patients in the issue of spiralling drug costs, is to explore some form of co-payment for medications provided by the NHS.
- 27i CORNWALL AND ISLES OF SCILLY That conference believes patients should be charged for repeated appointment DNAs and the inappropriate use of GP and A&E services.
- 27j DERBYSHIRE That conference:
- (i) believes that the principle of an NHS that is universal, comprehensive, free at the point of access and funded from general taxation is no longer sustainable in the current political and economic environment
  - (ii) urges the UK governments to design and implement systems of co-payments for all NHS services as a matter of urgency
  - (iii) urges the UK governments to limit the demands upon the NHS by defining, nation by nation, those types of service that can and cannot be accessed on the NHS.
- 27k LANCASHIRE COASTAL That conference believes that, due to increasing demands and reductions in funding, general practice in its current format is unsustainable.

- 28 **AGENDA COMMITTEE to be proposed by AVON That conference believes the loss of Minimum Practice Income Guarantee (MPIG) and PMS growth money will have a devastating impact on many practices and:**
- (i) believes it seriously jeopardises the viability of many practices**
  - (ii) deplores the damage this will have on the delivery of services to patients**
  - (iii) criticises the inadequate support for many practices**
  - (iv) calls on GPC to seek to negotiate specific funding for practices caring for particularly vulnerable populations**
  - (v) calls on GPC to seek to negotiate specific funding for rural practices.**
- 28a AVON That conference believes the loss of MPIG and PMS growth money will have a devastating impact on many practices and calls on the GPC to ensure that practices continue to receive sufficient resources to maintain the current levels of service. This is a particular problem for specialist practices caring for particularly vulnerable populations and GPC should seek to negotiate a specific funding regime for these practices.
- 28b CAMDEN That conference abhors the removal of MPIG from GMS practices which seriously jeopardises the viability of many practices already under tremendous pressure to provide services, and in particular criticises the inadequate support for outliers.
- 28c CITY AND EAST LONDON That conference deplores the destabilising effect on GMS practices of the phased withdrawal of MPIG and the damage it will have on patient services.
- 28d ENFIELD That conference deplores the weakening of general practice through the withdrawal of MPIG and other funding that will limit delivery of patient services.
- 28e DERBYSHIRE That conference notes that the government(s) are acting incompetently over the question of both dispensing and MPIG reform and in combination this is seriously threatening the viability of a number of rural practices.
- 28f EAST MIDLANDS REGIONAL COUNCIL That conference notes that the English government is acting incompetently over both dispensing and MPIG reform, which together are seriously threatening the viability of rural practice.
- 28g HULL AND EAST YORKSHIRE That conference believes NHS England has failed to provide adequate support for practices facing large MPIG adjustment losses, and as a result has neglected their duties to those practices' GPs and their patients.
- 28h SHROPSHIRE That conference views the proposed withdrawal of MPIG as a potentially terminal threat to the financial viability of many smaller rural practices, does not believe the government can fully understand the impact this may have and asks the GPC to look at ways of alerting the public to these concerns.
- 28i LANCASHIRE COASTAL That conference believes that NHS England should develop a comprehensive contingency plan to deal with situations where practices are in danger of ceasing to operate due to financial difficulties caused by the current turmoil in general practice funding, as failure to do so will lead to a collapse of the infrastructure of general practice and a failure of NHS England's duty of care to patients.
- 28j AVON That conference believes the loss of MPIG will lead to the demise of specialist practices caring for particular populations, and insists that GPC negotiates for central funding to be made available to enable them to continue their expert care for vulnerable people, specifically for mental health.

- 29 **BERKSHIRE That conference believes that the imminent PMS reviews:**  
**(i) are unnecessary in the context of the overall contract changes happening over the next few years**  
**(ii) are coming at a time when the practice profits are falling and GPs income is being squeezed**  
**(iii) require the GPC support in ensuring ensure fairness**  
**(iv) need to ensure the monies are recycled into general practice to ensure they are not 'lost in the system'.**
- 29a NOTTINGHAMSHIRE That conference accepts that, in the interests of equity, capitation payments should be equalised across GMS, PMS and APMS contracts on the basis of the revised Carr-Hill formula but  
 (i) asserts that monies taken from PMS practices following their contract reviews should be made available to all practices equally through payments for essential services  
 (ii) believes that funds badly needed to support the development for general practice should be derived from new monies  
 (iii) deplores the proposal to force area teams to redeploy, as local development funds, monies clawed back locally from PMS practices.
- 29b WAKEFIELD That conference insists that changes in PMS funding following reviews by NHS England are phased in nationally over at least a seven year period in line with the policy applied to GMS practices around MPIG changes.
- 29c CAMBRIDGESHIRE That conference believes that PMS reviews, as outlined by NHSE, will destabilise practices and damage patients because of the loss of resources in essential services.
- 29d LEEDS That conference condemns the failure of NHS England to use its review of PMS contracts to invest more funding in PMS baselines and global sum.
- 29e DEVON That conference warns the Secretary of State of the forthcoming PMS budget reviews and possible further reduction in general practice funding which will destabilise practices and will lead to a poorer service for patients with longer waiting times for appointments.
- 29f GATESHEAD AND SOUTH TYNESIDE That conference believes that there needs to be time to allow PMS practices to adjust financially, and this should be over seven years as it is with the MPIG.
- 29g WAKEFIELD That conference asks that in order to prevent serious destabilisation of general practices following PMS review that the PMS premium is reinvested into baseline funding or ring-fenced for investment in general practice.
- 29h YORKSHIRE REGIONAL COUNCIL That conference condemns the failure of NHS England to use its review of PMS contracts to invest more funding in PMS baselines and GMS global sum.
- 30 **AGENDA COMMITTEE to be proposed by LEWISHAM That conference asks that government ensures any reviews to NHS funding formulae for GP practices reflect the particular needs and circumstances of local populations and contain allowances for:**  
**(i) rurality**  
**(ii) deprivation**  
**(iii) high levels of migrant populations**  
**(iv) patients whose first language is not English**  
**(v) high levels of patient turnover.**
- 30a LEWISHAM That conference ask that the government ensures any reviews to the funding formula for practices reflect the particular needs and circumstances of local populations and be adequate to deliver primary care services in those areas.
- 30b SOUTHWARK That conference calls for the funding formula for any national standard PMS contract to contain allowances for inner cities to include:  
 (i) patient turnover  
 (ii) patients whose first language is not English  
 (iii) deprivation  
 (iv) increased numbers of homeless patients and patients with alcohol and/or drug problems.
- 30c CITY AND EAST LONDON That conference notes that deprived areas have significantly higher standard mortality rates than affluent areas and that this leads to a greater general practice workload in younger populations. Conference demands that deprivation be properly accounted for in all NHS funding formulas.
- 30d GREENWICH That conference notes that the list-turnover in many urban and inner city areas has risen steeply and causes practices huge amounts of work administratively and clinically; the GPC should therefore request that any NHSE reviews to the formula for practice funding reflect this fact.
- 30e LINCOLNSHIRE That conference believes that deprivation should have more weighting in the global sum formula (Carr-Hill formula) in order to reduce the impact of the inverse care law, and to aid recruitment and retention of clinical staff into deprived areas. The Carr-Hill formula was last reviewed in 2007, conference urges that it should be reviewed again to include more weighting for deprivation.

- 30f LINCOLNSHIRE That conference believes that rurality should have more weighting in the global sum formula (Carr-Hill formula) in order to reduce the impact of the inverse care law, and to aid recruitment and retention of clinical staff into rural areas. The Carr-Hill formula was last reviewed in 2007, conference urges that it should be reviewed again to include more weighting for rurality.
- 30g LANCASHIRE COASTAL That conference believes that NHS England should recognise, through an enhancement to the contract, that there is extra work, beyond any reasonable interpretation of core work, in meeting the needs of patients who reside in short term, high turnover, rehabilitation and other similar specialist community facilities.
- 30h NORFOLK AND WAVENEY That conference asks GPC to review remuneration and support for practices with high levels of migrant population and the support available to them to provide appropriate care for these patients.

- 31 **AGENDA COMMITTEE to be proposed by MID MERSEY That conference:**
- (i) is concerned that it is unacceptable to ask all GPs to work up to the age of 68
  - (ii) believes pension lifetime allowance caps and the taxation of pension growth are persuading GPs to cease payments to the pension scheme early and to retire early
  - (iii) believes that the recent large increase in GP pension contributions together with the reduction in the annual allowance and reduction in the lifetime allowance will make NHS pensions increasingly unattractive for younger GPs and will destabilise the GP pension scheme
  - (iv) asks that general practitioners should be allowed to opt out of paying superannuation contributions for work undertaken 'out of hours' in order to encourage GPs to continue to provide medical cover in this period
  - (v) demands that increased employer pension contributions announced on 13 March 2014 are fully funded by the NHS for GPs and their staff.
- 31a MID MERSEY That conference is concerned that it is unacceptable to ask all GPs to work up to the age of 68.
- 31b MID MERSEY That conference believes pension lifetime allowance caps and the taxation of pension growth are persuading GPs to cease payments to the Pension Scheme early and to retire early.
- 31c CUMBRIA That conference believes that the recent large increase in GP pension contributions together with the reduction in the annual allowance and reduction in the lifetime allowance will make NHS pensions increasingly unattractive for younger GPs and will destabilise the GP pension scheme.
- 31d SCOTTISH CONFERENCE OF LMCs That conference asks that general practitioners should be allowed to opt out of paying superannuation contributions for work undertaken 'out of hours' in order to encourage GPs to continue to provide medical cover in this period.
- 31e AYRSHIRE AND ARRAN That conference asks that general practitioners should be allowed to opt out of paying superannuation contributions for work undertaken out of hours in order to encourage GPs to continue to provide medical cover in this period.
- 31f CLEVELAND That conference demands that increased employer pension contributions announced on 13 March 2014 are fully funded by the NHS for GPs and their staff.
- 31g NOTTINGHAMSHIRE That conference insists that the 'Working Longer Review Group' reclassifies GPs to ensure that GPs enjoy parity with other NHS workers who are accorded special consideration, recognising that 'capable of work' is not the same as competence to work and that, for the safety of patients, GPs are available to retire at an appropriate age.
- 31h SCOTTISH CONFERENCE OF LMCs That conference deplores the ongoing fallout from the imposition of unfair pension and tax changes affecting doctors and insists that the UK government:
- (i) acknowledges and addresses the unintended consequences of the NHS Superannuation Scheme and working age changes
  - (ii) should delay the changes to the NHS Superannuation Scheme until the unintended consequences have been fully evaluated and addressed
  - (iii) should protect all members of the current NHS Superannuation Scheme from the changes being imposed in 2015
  - (iv) delay any changes to the NHS Superannuation Scheme until the NHS has been fully resourced to take account of the unintended consequences of the changes to be implemented in 2015.
- 31i BUCKINGHAMSHIRE That conference deplores the increased cost of the employers contribution to the pension scheme which for GPs will be unfunded.

- 32 **NOTTINGHAMSHIRE** That conference believes the absence of a scheme by which new GP premises, fit for the 21st century, can be cost effectively constructed where required, represents the biggest obstacle to improving the delivery of primary care in the UK.
- 32a SHEFFIELD That conference calls for a new contractual model to support GP premises development to underpin the development of primary care services.
- 32b NORTH YORKSHIRE That conference deplores the lack of investment in primary care premises and government expectation of transfer of work from secondary to primary care is unrealistic without adequate resources.
- 32c NORTH AND NORTH EAST LINCOLNSHIRE That conference regrets the inability of the Department of Health and its agencies to recognise the serious situation in the provision and updating of GP premises and asks the GPC to press hard for funding streams to enable NHS England area teams to allocate money to practices to improve premises and provide capacity for new services to be provided in the general practice locus.
- 32d WIGAN That conference calls upon the GPC negotiators to secure a substantial investment in general practice premises which is not tied to PFI type arrangements and which can aid the development of collaborative working by general practices.
- 32e NORFOLK AND WAVENEY That conference believes that the uncertainty regarding lease arrangements by NHS Property Services undermines the stability of traditional general practice and calls for a consistent approach to be adopted for all leases with NHS Property Services.
- 32f NORTHERN IRELAND CONFERENCE OF LMCs That conference insists that the time has come for definitive, accurate, written guarantees around the funding and running costs of premises developments.
- 32g LEEDS That conference:
- (i) condemns NHS England and the Department of Health in England for failing to invest in general practice premises
  - (ii) believes new and significant levels of funding is urgently needed to enable the development of general practice premises
  - (iii) calls on the GPC to produce comprehensive guidance to support GPs that want to develop their practice
  - (iv) calls on the GPC to publicise what can be achieved in general practice through the use of good practice premises and what service development is being prevented by the lack of investment.
- 32h CITY AND EAST LONDON That conference instructs the GPC to negotiate a more effective and sustainable premises strategy that will enhance innovation and development in general practice for years to come, and believes that GP practices may become destabilised through lack of investment.
- 32i HERTFORDSHIRE That conference instructs GPC to investigate which will cause the earlier extinction of general practice: the crumbling workforce or its crumbling premises.
- 32j AVON That conference, in the light of the government's drive to shift work from secondary to primary care, calls on the Department of Health to make a real and significant investment in the bricks, mortar and infrastructure of general practice.
- 32k MID MERSEY That conference believes there is an urgent need for the government to inject much needed funds to improve GP surgeries.
- 32l EALING, HAMMERSMITH AND HOUNSLOW That conference regrets the lack of premises support from NHS England and asks the GPC to seek urgent clarification about the funding and development of GP practices.
- 32m GLASGOW That conference continues to believe that the current inadequate funding and investment in premises by health boards is detrimental to GP services.
- 32n NOTTINGHAMSHIRE That conference believes the establishment of a new scheme by which GP premises can be rendered fit for the 21st century is vital to the career progression of younger GPs and to the succession planning of older GPs and calls on the:
- (i) GPC to draw up a blueprint for such a scheme involving creation of a 'land bank' to facilitate purchase of GP owned premises which are no longer fit for purpose
  - (ii) government to set aside treasury funding for such a scheme, ensuring it does not replicate the mistakes of disastrous PFI and public/private schemes like LIFT, and precludes any involvement whatsoever by NHS property services.
- 32o KENT That conference demands the government provides additional capital investment in primary care premises in order to:
- (i) allow transfer of services from secondary to primary care
  - (ii) comply with CQC requirements
  - (iii) provide modern facilities
  - (iv) allow co-location of community based services.
- 32p SOMERSET That conference notes the paucity of contractual requirement on NHS England area teams to develop GP premises, and asks the GPC to negotiate clear sources of capital funding and revenue support so this can take place.
- 32q CAMBRIDGESHIRE That conference regrets that current investment levels in GP premises appear to be based on a 200 year replacement cycle, and believes this to be wholly inadequate.

- 32r SOUTHWARK That conference demands a robust strategy for GP primary care premises, including small and medium sized improvements to existing premises, as without adequate infrastructure, GPs will not be able to deliver the NHS reforms.
- 32s CITY AND EAST LONDON That conference notes that the government wishes to review the current system of general practice premises reimbursement to identify opportunities for improving value for money and promoting more innovative use of estates. Conference expects that this will not be in a way that will further destabilise practices particularly smaller practices. Conference demands that any innovative use of estates takes into account the current premises that currently exists and not to further in debt the NHS with new building and associated costs.
- 32t MERTON, SUTTON AND WANDSWORTH That conference calls for NHSE to increase investment in GP practices and their premises.
- 32u GRAMPIAN That conference is dismayed that the rhetoric about transferring care closer to the patient has not been matched by any significant programme of premises expansion to cope with this work.
- 32v DERBYSHIRE That conference advises the government that in the absence of a fair and adequate practice premises policy, shift of care from secondary to primary care will fail.
- 32w DEVON That conference urges the Secretary of State and NHS England to provide resources for new premises and improvements to practices to improve care for patients in the community.
- 32x NORTHAMPTONSHIRE That conference insists that the government spends as much on supporting smaller economical practices which use all their facilities for the NHS as it does on supporting grand expensive 'super-practices' whose rent in terms of pounds per patient can be many multiples of their neighbouring practices for no obvious clinical or social benefit.

- 33 **BUCKINGHAMSHIRE That conference finds the Doctors' and Dentists' Review Board (DDRDB) report:**  
**(i) unacceptable as once again GPs are facing a reduction in income not just a pay freeze**  
**(ii) influenced too heavily by the government who claimed a 1% uplift is all that is affordable**  
**(iii) unbelievable as how can a 0.28% increase to expenses translate into a 1% increase to take home remuneration**  
**(iv) incompetent, and asks GPC to explore whether we should continue to participate in the DDRB arrangements.**
- 33a MORGANNWG That conference deplores the interference by UK governments with the DDRB Report 2014 which will lead to further de-funding of general practice.
- 33b LEEDS That conference believes the DDRB award for general medical practice in 2014/15 will lead to a further significant pay cut for GP principals and:  
 (i) fails to recognise the rising workload burden of practices  
 (ii) will further undermine the morale of GPs  
 (iii) will exacerbate the recruitment and retention crisis of GPs  
 (iv) calls on Departments of Health to seriously address the funding crisis facing general practice.
- 33c DERBYSHIRE That conference demands the full reinstatement and functioning of at least the GP expenses determination functions of the DDRB and requires both the GPC and the BMA to take action as a matter of urgency.
- 33d BUCKINGHAMSHIRE That conference has repeatedly seen government unilaterally ignoring the recommendations from a number of pay review bodies and believes that the:  
 (i) government undermines the trust in the fairness of established processes  
 (ii) government risks leading by bad example and creating a society where organisations and individuals can no longer trust official bodies and government  
 (iii) GPC should no longer cooperate with the DDRB, call for its abolition and negotiate pay reviews directly with NHS Employers.
- 33e BERKSHIRE That conference:  
 (i) deplores the failure of the government to honour its commitment to impose a pay freeze on NHS GPs and instead to allow GP income to fall for successive years  
 (ii) believes that falling income, combined with increasing workload, is harming recruitment and retention into general practice to the detriment of the public good.
- 33f DONCASTER That conference recognises that DDRB pay recommendations do not reflect NHS GPs' pay as they are based upon income drawn from HMRC tax returns which includes both NHS and private incomes, and as such, calls upon the GPC to negotiate with the government a new means of assessing GPs NHS income.
- 33g WIGAN That conference condemns the Secretary of State for Health and the Prime Minister for their refusal to grant the full DDRB award to general practice.
- 33h HAMPSHIRE AND ISLE OF WIGHT That conference is surprised that the DDRB awarded a 0.28% uplift yet practices are receiving less funding.
- 33i EDGWARE AND HENDON DIVISION That conference notes that there are flaws in the funding formula used by the DDRB in determining funding for general practice, and calls on the DDRB to work with the BMA to develop a new fit for purpose methodology that fairly recognises GP workload and expenses for future years.
- 34 **NOTTINGHAMSHIRE That conference deplores the government's proposed publication of GPs' take home pay which it believes:**  
**(i) is politically motivated and panders to the prejudices of ill-informed sections of the media which are avowedly hostile to GPs**  
**(ii) risks creating divisions between GPs and practices, between GPs and other doctors, and between GPs and their patients**  
**(iii) must not be presented in a simplistic way that makes GPs a target for further unfair media criticism**  
**(iv) should only be published once its accuracy has been verified by the GPC and only then in a manner that differentiates between NHS and private income and properly reflects the complexities of GPs' working arrangements.**
- 34a KINGSTON AND RICHMOND That conference believes the decision to publish GP earnings is a politically motivated attempt to divert attention from the true cost pressures within the NHS.
- 34b SCOTTISH CONFERENCE OF LMCs That conference demands that any publication of GP NHS earnings preserves GPs' right to privacy and that the data must reflect the differing workload and services that practices provide.
- 34c GLASGOW That conference demands that any publication of GP NHS earnings preserves GPs' right to privacy and that the data must reflect the differing workload and services that practices provide.

- 34d **BERKSHIRE** That conference requests that the government be truthful about GP income data when publishing this in future and requests the GPC to ensure:
- (i) it seeks full agreement with the Department of Health in ensuring the data is accurate and representative
  - (ii) it asks the government to eliminate the artificial inflation of income inherent in including employer and employee pension contributions (up to 28.5%)
  - (iii) the general erosion of GP income over the years is made transparent to all concerned
  - (iv) publicity for the negative effect inaccurate political and media commentary on general practice pay and conditions is having on general practice morale, recruitment and retention.

## **GP PARTNERSHIPS AND FEDERATIONS**

**15.40**

- 35 **NORTHERN IRELAND CONFERENCE OF LMCs** That conference calls on GPC to actively support the development of GP federations, and in particular to encourage the opportunity for every GP, whether partner, salaried or sessional, to be actively involved.
- 36 **MID MERSEY** That conference considers it neither necessary nor desirable for GPs to work in consortia.  
(This motion will fall if motion 35 is carried)
- 37 **CITY AND EAST LONDON** That conference demands that NHS England ensures that GPs understand the risks and challenges of staying single-handed and appropriately encourage them to take on partners, to assure general practice succession planning is in place.

## THE MARKET / PRIVATISATION

16.00

- 38 **NEWCASTLE AND NORTH TYNESIDE** That conference believes that the:
- (i) government has accelerated the process of privatisation as increasing numbers of English NHS contracts since April 2013 are now delivered by private providers
  - (ii) GPC should urgently publicise this privatisation to the public
  - (iii) GPC should campaign for the NHS in England to be provided by the public sector
  - (iv) devolved countries should be congratulated on their failure to reintroduce a market in health.
- 38a AVON That conference challenges the government to:
- (i) refute the perception that primary care is being shoe horned into the privatised health economy
  - (ii) reverse its policy of privatisation of primary care provision by stealth and by the starvation of resources.
- 38b BEXLEY That conference asks GPC to call for an immediate halt to all attempts to create and develop private markets within the NHS; and to request that the government:
- (i) terminates private provider contracts, in order to prevent the NHS being subject to the Transatlantic Trade and Investments Partnerships agreement; and
  - (ii) introduces legal measures to prevent multinational corporations from suing for losses of potential future income if they are not allowed access to health service contracts.
- 38c GATESHEAD AND SOUTH TYNESIDE That conference believes that the present accelerated privatisation of NHS services is leading to fragmented patient care with bureaucratic procurement processes, increasing costs and no discernable improvement in quality.

## GPC NORTHERN IRELAND

16.10

- 39 **Receive:** Oral report by the Chairman of the Northern Ireland GPC (Dr Tom Black).

## GPC WALES

- 40 **Receive:** Oral report by the Chairman of GPC Wales (Dr Charlotte Jones).

## GPC SCOTLAND

- 41 **Receive:** Oral report by the Chairman of Scottish GPC (Dr Alan McDevitt).
- 42 **GLASGOW** That conference believes that GP involvement in health and social care partnerships is vital and demands that GP time is adequately resourced to enable GPs to contribute.

## GENERAL PRACTITIONERS DEFENCE FUND (GPDF)

16.40

- 43 **Receive:** Report by the Treasurer of the General Practitioners Defence Fund (Dr John Canning).

- 44 **AGENDA COMMITTEE to be proposed by SESSIONAL GP SUBCOMMITTEE That conference believes that the change in locum superannuation employers contributions monies from area teams to practices has been bad for general practice, and:**
- (i) **has been seriously detrimental to small, remote/rural practices and practices under pressure from sickness and recruitment difficulties affecting patient services and access**
  - (ii) **has been seriously detrimental to the locum pool, disadvantaging non retired GP locums and encouraging them to either leave the NHS pension scheme, general practice or the UK**
  - (iii) **has contributed to the GP and out of hours (OOH) workforce crisis**
  - (iv) **calls on GPC to negotiate to protect locum GP pension contributions from the consequence of delayed practice payments**
  - (v) **demands this change is reversed.**
- 44a THE GPC That the GPC seeks the views of conference on the following motion from the sessional GPs subcommittee:  
That conference believes that the change in locum superannuation employers contributions monies from area teams to practices has been bad for general practice in England, and
- (i) has been seriously detrimental to small, remote/rural practices and practices under pressure from sickness and recruitment difficulties affecting patient services and access
  - (ii) has been seriously detrimental to the locum pool in England disadvantaging non retired GP locums and encouraging them to either leave the NHS pension scheme, general practice or the UK.
  - (iii) has contributed to the GP and OOH workforce crisis
  - (iv) demands NHS England reverse this change.
- 44b KENSINGTON, CHELSEA AND WESTMINSTER That conference condemns the government for having transferred the responsibility for paying employers superannuation contributions for locum GPs from PCOs to practices, and
- (i) demands that government reverses this change or seeks an alternative whereby the practice receives funding for superannuation costs dependant on use of locums
  - (ii) calls upon practices to continue to treat locums fairly and not encourage them to drop out of the pension scheme or use the superannuation as a tool to reduce the rates for those that choose to remain within the pension scheme.
- 44c CARDIFF AND VALE OF GLAMORGAN DIVISION That conference:
- (i) condemns the government for having transferred the responsibility for paying employers superannuation contributions for locum GPs from PCOs to practices;
  - (ii) demands that the government reverses this change to the pension regulations or seek an alternative whereby the practice receives funding for superannuation costs dependant on use of locums;
  - (iii) insists that practices treat locums fairly and do not encourage locums to drop out of the pension scheme;
  - (iv) insists that practices treat locums fairly and do not use the superannuation as a tool to reduce the rates for those that choose to remain within the pension scheme.
- 44d EAST SUSSEX That conference calls on GPC to negotiate to protect locum GP pension contributions from the consequences of delayed practice payments.
- 45 **THE GPC That the GPC seeks the views of conference on the following motion from the sessional GPs subcommittee: That conference is concerned about the rising use of 'zero hours' contracts that many employers now use for sessional GPs and:**
- (i) **believes these offer no security in the form of tenure nor entitlement to any kind of leave**
  - (ii) **are often used to exploit sessional GPs**
  - (iii) **condemns the indiscriminate use of such contracts.**

## OTHER MOTIONS 1

17.10

- 46 **SOMERSET** That conference has no confidence in the ability of shared business services to provide primary care support services (PCS) and insists that, unless rigorous and fully monitored and enforced key performance indicators are imposed, PCS should revert to local provision.
- 46a GATESHEAD AND SOUTH TYNESIDE That conference believes that the Shared Business Services is:
- (i) not fit for purpose and has caused financial anguish to many practices
  - (ii) beyond comprehension as an international IT company that cannot accept emails
  - (iii) incompetent and caused practices to incur extra financial costs, which should be reimbursed
  - (iv) now a more complicated, bureaucratic and less efficient service than we have had in the past
- 46b NORTH ESSEX That conference insists that primary care support services (PCS) should only be reconfigured when:
- (i) the specification for all services has been agreed
  - (ii) there is general agreement on what is within core services
  - (iii) alternative providers have been identified for any services which will no longer be provided within PCS.
- 47 **NORTHAMPTONSHIRE** That conference insists that patients leaving the armed forces have their primary care medical record automatically shared with their new registered GMS/PMS practice.
- 48 **CUMBRIA** That conference believes that the GPC should actively campaign for the re democratisation of the GMC, as:
- (i) medical members of the GMC are now appointed by the Secretary of State without reference to the fee paying members of the profession
  - (ii) the current arrangements make the GMC merely another rent seeking government regulator
  - (iii) historically the medical members were elected by popular ballot organised by the electoral reform society
  - (iv) a return to an electoral basis for appointment will restore the democratic credentials of the organisation.

## CONTINGENCY

17.20

## CLOSE

17.30

**GUEST SPEAKER****9.00****CONTINGENCY****9.30****PRIMARY CARE WORKFORCE****9.40**

*In order to accommodate the large number of motions put forward for debate in this section, it is proposed, in accordance with standing order 66, that the motion be formally proposed by Ayrshire and Arran (3 minutes) and that the subsequent debate shall be held at microphones from the floor with speeches lasting up to 1 minute each. The motion will then proceed to a vote in the normal manner.*

- 49 **AYRSHIRE AND ARRAN** That conference insists that the government prioritises the workforce crisis that is threatening primary care and the safety of our patients.
- 49a BUCKINGHAMSHIRE That conference:
- (i) believes current workload, low morale, political interference and resource starvation is driving a recruitment and retention crisis in general practice
  - (ii) believes traditional British general practice is an endangered species
  - (iii) believes the Secretary of State (England) and government will recognise the problem
  - (iv) supports GPC working with RCGP to improve recruitment and retention.
- 49b CORNWALL AND ISLES OF SCILLY That conference believes general practice is facing a perfect storm of a profession where older GPs are looking for the exit and young GPs do not wish to join and calls on the government to urgently support general practice to prevent a workforce crisis.
- 49c HEREFORDSHIRE That conference agrees that the current shortage of GPs in the face of over overwhelming demand is a real and immediate threat to the NHS.
- 49d HEREFORDSHIRE That conference asks NHS England to make immediate contingency plans to:
- (i) provide support to the sections of England's population who will shortly be without a family doctor due to the acute and very real recruitment crisis in primary care
  - (ii) give emergency support to those practices where they cannot recruit doctors to help avoid a mad dash to the exits by remaining partners as they try to avoid bankruptcy
  - (iii) avoid allocating large numbers of patients from failing practices to other local practices in turn causing them to fail
  - (iv) help support A and E departments who are coming under increasing pressure as the local population has less and less access to primary care.
- 49e DUMFRIES AND GALLOWAY That conference believes that the current combination of increased workload in primary care, increased income tax burden and lowering of pensions cap are combining to make full time working in general practice impractical for young GPs starting their career and contributes to the looming staffing crisis as the current generation of general practitioners moves towards retirement.
- 49f LIVERPOOL That conference believes that there are insufficient GPs with sufficient time to deal with societal expectations and therefore there needs to be a major drive in GP recruitment.
- 49g LEEDS That conference notes the alarming conclusions of the Department of Health in England commissioned seventh work-life survey of GPs reporting the lowest levels of job satisfaction since the 2004 contract, the highest levels of stress since the start of the survey series and a substantial increase in GPs intending retiring in the next five years and calls on the Department of Health to commission an eighth survey to continue to monitor this situation.  
(Supported by YORKSHIRE REGIONAL COUNCIL)
- 49h MORGANNWG That conference demands GPC highlights the difficulty of recruiting young doctors into general practice in several parts of the UK, identifies the causes of the problems and looks for ways to address the situation.
- 49i BRADFORD AND AIRESDALE That conference believes that the government should recognise and resume their role in medical manpower planning and the profession calls upon it to work honestly with the GPC to do all that is necessary to secure the future primary care workforce.
- 49j LIVERPOOL That conference believes that GP morale is low and that a decrease in GP recruitment, together with the unprecedented increase in loss of very experienced GPs, who are leaving the profession earlier than would have been expected owing to disillusionment, is creating a paucity of expertise.
- 49k LIVERPOOL That conference believes that the increasing number of GPs who are not staying for long in any particular general practice is destabilising the traditional role of the family doctor, in providing care to generations of their population.

- 49l CITY AND EAST LONDON That conference believes the viability of general practice is threatened by fast-declining resources, increased patient expectation and unsustainable workload and that is reflected by the number of GPs leaving practice early and putting the physical and mental well-being of GPs at risk.
- 49m THE GPC That the GPC seeks the views of conference on the following motion from the sessional GPs subcommittee:  
That conference believes that retaining and returning GPs is more cost effective than training new GPs, and:  
(i) many GPs are lost to the workforce because there is no proper funding for retainer and induction and returner schemes  
(ii) the loss of such GPs to the workforce contributes to the GP workforce crisis both in and out of hours  
(iii) demands the UK governments take action now to ensure retainer and induction and returner schemes are adequately supported and funded.
- 49n NORTHERN IRELAND CONFERENCE OF LMCs That conference asks GPC to develop a strategy to prevent depression and burnout among GPs and their staff.
- 49o MID MERSEY That conference regrets that given the current state of general practice, it cannot recommend a career in primary care to prospective new entrants.
- 49p HERTFORDSHIRE That conference is sad to witness the loss of large numbers of senior GPs from the workforce due to the changes in pension rules and calls on GPC to:  
(i) highlight the devastating waste of GPs retiring when they still have a number of productive years ahead of them  
(ii) ensure that governments realise that this is a direct result of their policies  
(iii) monitor the impact of these changes on the workforce.
- 49q NOTTINGHAMSHIRE That conference believes that insufficient attention is being paid to the consequences of GP recruitment being 'a leaky bucket' and calls on the:  
(i) GPC to work with NHS England and Health Education England to develop a range of positive incentives to encourage doctors to choose careers in general practice and to encourage GPs qualifying to stay and work in the UK  
(ii) Department of Health to consider whether it would be beneficial to re-establish the Medical Practices Committee in some form as other to facilitate the equitable distribution of GPs wherever they are needed across the UK.
- 49r NORTHERN IRELAND CONFERENCE OF LMCs That conference demands an increase in GP training scheme places given the developing GP workforce crisis.
- 49s CORNWALL AND ISLES OF SCILLY That conference believes performance list regulations are too restrictive for returners and urges the GPC to negotiate a more appropriate process to enable GPs to return more easily to general practice.
- 49t CORNWALL AND ISLES OF SCILLY That conference deplores the lack of national workforce planning and demands the government urgently address this in order to prevent a workforce crisis in general practice.
- 49u SOUTH STAFFORDSHIRE That conference demands that steps are taken by the GPC to stop the media portraying the negative views of general practice which are directly contributing to the crisis in retention and recruitment of established and new GPs.
- 49v NORTH YORKSHIRE That conference believes that workforce planning has failed to recognise the looming crisis in general practice where the pre-retirement cohort are carrying out the majority of the work and a future where an inadequate number of newly trained, potentially part time and portfolio career doctors will struggle to continue to offer a comprehensive primary care service.
- 49w BERKSHIRE That conference notes that only 12 years ago GPs were being offered a golden hello of £5000 to come into general practice and now sees GP morale, quality of life and income eroded again, and calls on this government to take action to prevent another such short term and short sighted quick fix being necessary.
- 49x DONCASTER That conference recognises and resolves to have the GPC publicise that the year on year erosion of general practice income has resulted in primary care job losses causing GP stress and burn out and risks serious long term staffing deficiencies within general practice.
- 49y DONCASTER That conference has grown tired of the relentless attack on general practice over the last year, scapegoating GPs for the worsening crisis in the NHS and calls upon the GPC to undertake a primary care workforce census to help inform the government, media and public of the current pressures in primary care staffing.
- 49z BORDERS That conference is very concerned about the problems in out of hours recruitment and retention, and is concerned how this may affect in hours workload.
- 49aa NORTHAMPTONSHIRE That conference insists that we welcome back UK trained GPs who wish to return to the UK having worked abroad or who have taken a prolonged break from work, and re licensing requirements are effected as quickly as possible.
- 49bb HERTFORDSHIRE That conference continues to be very concerned about the low state of GP morale and the impact this is having on general practice and calls on GPC to highlight this parlous state to:  
(i) government  
(ii) the nation  
(iii) the press.

49cc	AYRSHIRE AND ARRAN That conference asks government to introduce a block in general practice in all Foundation Year Programmes to help promote the GP career option, improve primary secondary care interface and to bring new capacity to practices.
49dd	EAST SUSSEX That conference urges the government to review the current annual allowance which is affecting the retention of experienced general practitioners.
49ee	MORGANNWG That conference deplores the constant denigration of GPs in the UK press which is so damaging to morale, recruitment and retention and the doctor-patient relationship.
49ff	NORFOLK AND WAVENEY That conference believes that despite the rhetoric of Health Education England the workforce crisis is worsening rather than improving.
49gg	NORTH STAFFORDSHIRE That conference recognises that the difficulty in practices recruiting and retaining GPs, particularly when compared with the increase in numbers of hospital consultants, is putting patient safety and GP health at risk and wants urgent action not just now but an ongoing commitment.
49hh	NORTH STAFFORDSHIRE That conference believes that the continued negative portrayal of general practice in the media: <ul style="list-style-type: none"> <li>(i) undermines the morale in general practice</li> <li>(ii) adversely affects recruitment, retention and sustainability of general practice</li> <li>(iii) needs to be counterbalanced by positive information to the public as patients are a regular captive audience in surgeries, waiting rooms should be used to broadcast these positive messages</li> <li>(iv) the GPC media unit should support practices in providing suitable material for this.</li> </ul>
49ii	NORTH STAFFORDSHIRE That conference believes that the GP recruitment/retention versus training timeline will now cause an imminent unavoidable severe lack of GPs in the UK to the level that parts of the UK will no longer have GP cover. This should be dealt with by an apolitical emergency committee to minimise and mitigate the harmful impact on patients and their remaining GPs.
49jj	GLASGOW That conference is concerned that some OOHs services have been unable to recruit adequate numbers of doctors to fill shifts and to maintain services.
49kk	DORSET That conference demands a simplification regarding return to general practice to avoid wastage of talent.
49ll	NORTH ESSEX That conference rejects the proposal from NHS England to refer all GPs who are returning to work after an absence of two years for assessment by an induction and refresher programme, and demands: <ul style="list-style-type: none"> <li>(i) a more flexible and realistic policy towards GPs who have career breaks</li> <li>(ii) provision of career support and advice to all GPs, funded by Health Education England</li> <li>(iii) a full investigation by NHS England as to why so many GPs are leaving the profession earlier than expected.</li> </ul>
49mm	DEVON That conference warns the Secretary of State of the continuing crisis in recruitment and retention of general practitioners and practice nurses. Urgent training investment is needed and conference advises him to direct more resources and incentives to Health Education England to rectify matters.
49nn	REDBRIDGE That conference asks the government to acknowledge the growing crisis recruiting GPs into primary care and requires them to look at the diminishing resources and how this could be addressed.
49oo	REDBRIDGE That conference deplores that lack of manpower in primary care in relation to the amount of work flowing into primary care and demands that NHS England proactively considers succession planning for GPs and how it would encourage GPs to stay in the profession rather than retire early.
49pp	SOUTHWARK That conference calls upon the GPC and NHSE to focus on developing incentives to improve work satisfaction for GPs and to ensure that a good quality workforce is retained.
49qq	GREENWICH That conference notes that the cost of living in large cities is considerably higher than the rest of the UK and calls upon the GPC to enter into negotiations with government to support a realistic weighting for practices to help address the unique problems for recruiting and retaining staff in those cities.
49rr	WIGAN That conference calls upon the GPC to pursue with NHS England the introduction of measures, investments and incentives to arrest the impending GP workforce retention crisis caused by substantial numbers of experienced general practitioners fleeing into early retirement.
49ss	GRAMPIAN That conference, recognising the skills and benefits of experienced GPs both to the profession and to patients, is therefore concerned by reported problems in retention of this group in the workforce, and so calls on the government to formally study the effects of its changes to pensions and to change policy if it is found to be harming retention.
49tt	GRAMPIAN That conference is concerned that in many areas GPs are being replaced inappropriately by allied health professionals in the out of hours services, and insists that quality out of hours should not be diminished in attempting to find a quick solution to GP recruitment issues.

49uu	EALING, HAMMERSMITH AND HOUNSLOW That conference believes the majority of young doctors do not deem general practice in this country an attractive option and requests that the GPC informs junior doctors and medical students about life in general practice, to allow them to better understand and cope with the ever increasing complexity of infrastructure, logistics and management structures.
49vv	CAMBRIDGESHIRE That conference believes that the recruitment crisis in general practice is made worse by inconsistent and unattractive returners schemes and calls on the GPC to reduce the hurdles facing returners to the profession.
49ww	NORTHERN IRELAND CONFERENCE OF LMCs That conference believes we are heading into a significant recruitment and retention crisis in general practice due to significant increases in workload, unfunded work and patient demand and calls for a review of workforce planning and work conditions.
49xx	<p>AYRSHIRE AND ARRAN That conference:</p> <ul style="list-style-type: none"> <li>(i) believes that the location where a GP trains is a significant predictor of where they will work once their training is completed</li> <li>(ii) recognises that there are inequalities in distribution of GP training resources throughout the UK, and</li> <li>(iii) calls for the UK government and postgraduate deaneries to ensure that the current bias towards cities in allocating GP training posts is minimised.</li> </ul>

## CONTRACT NEGOTIATIONS

10.10

- 50 **KENT** That conference believes the capitation funding formula for GP services is unfit for purpose and calls upon the GPC to negotiate a Payment by Results based contract because the current system:
- (i) fails to resource actual workload
  - (ii) fails to recognise the ever increasing demand for access, and complex care
  - (iii) fails to incentivise practices to invest
  - (iv) exacerbates the current inequity in NHS resources between secondary and primary care
  - (v) is the biggest single reason for the current recruitment crises.
- 50a SHEFFIELD That conference believes the GP contract is still unfit for purpose. It does not reward activity and does not enable patient services to develop in the changing NHS landscape. GPC should therefore open negotiations for a new GP contract.
- 50b MERTON, SUTTON AND WANDSWORTH That conference believes that GPs should be paid by activity.
- 51 **RM MORGANNWG** That conference recognises the inevitable and allows the GP committees of the devolved nations to negotiate a contract in the best interests of their constituent GPs rather than one based on the whim of the UK government.
- 51a GRAMPIAN That conference, while recognising that the medical needs of patients across the UK are similar, pragmatically recognises that differing health policy, structures and governmental approaches to negotiation mean that, where it is in the best interests of their patients and GPs, contracts should be negotiated at a national rather than UK level.
- 52 **CAMDEN** That conference demands more clarity on future funding planning and strategy to enable practices to budget effectively.
- 52a CLEVELAND That conference believes that annual, or other short term, contracting arrangements, especially at a local level:
- (i) do not enable practices to provide care as safely as should be expected
  - (ii) discourage uptake of local initiatives and services
  - (iii) are neither efficient, nor effective, nor economic for patients, practices or the NHS
  - (iv) should be a priority area for action by the GPC achieve their removal.
- 52b DERBYSHIRE That conference castigates the government and its agencies for their tardiness in producing the relevant contractual information, relating to changes introduced on 1 April 2014, to enable practices to plan their finances during this period of financial stringency.
- 52c EAST MIDLANDS REGIONAL COUNCIL That conference castigates the government and its agencies for their tardiness in producing the relevant contractual information to allow practices to plan their finances during this period of financial stringency.
- 52d HARROW That conference believes that changes to the GP contract occur too frequently and asks the GPC to impress upon the government the importance of stability in forward planning.
- 52e DUMFRIES AND GALLOWAY That conference believes that the ongoing dripfeed of temporary multi-source funding into primary care makes financial and workforce planning more difficult in general practices. It creates uncertainty, increases workload and transaction costs to the NHS as a whole.

## SOAPBOX

10.40

Standing order 57:

- 57.1 A period shall be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
- 57.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
- 57.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
- 57.4 GPC (UK) members shall not be permitted to speak in the soapbox session

## CHOSEN MOTIONS

11.00

- 53 **AGENDA COMMITTEE to be proposed by BUCKINGHAMSHIRE That conference firmly believes that general practice is the solution to many of the current problems facing the NHS but general practice cannot achieve its full potential while being seriously damaged by:**
- (i) the continuing disinvestment in general practice**
  - (ii) the phasing out of Minimum Practice Income Guarantee (MPIG) financial support**
  - (iii) the lack of premises investment**
  - (iv) the rapid reduction in the number of GPs due to government policies.**
- 53a BUCKINGHAMSHIRE That conference firmly believes that general practice is the solution to many of the current problems facing the NHS but general practice cannot achieve its full potential while being seriously damaged by:
- (i) the continuing disinvestment in general practice resulting in only 7.6% of the total NHS budget being allocated for provision of all GP services (while GPs provide 90% of NHS care)
  - (ii) the phasing out of MPIG financial support which will make many GP practices financially unviable especially in rural and hard to reach communities
  - (iii) the lack of premises investment for many years preventing the expansion of multi-disciplinary clinical teams and provision of additional services close to patients
  - (iv) the rapid reduction in the number of GPs due to government policies.
- 53b AVON That conference deplores the incompetence of a government that has produced a perfect storm of:
- (i) wholly inadequate primary care funding
  - (ii) morale at an all-time low
  - (iii) workload at an all-time high
  - (iv) hugely disadvantageous changes to NHS pensions
  - (v) a recruitment and retention crisis that will take years to address.
- 53c SALFORD AND TRAFFORD That conference believes that all the chickens have come home to roost, and general practice will soon be a lame duck!
- 53d SALFORD AND TRAFFORD That conference sends out a signal loud and clear that general practice is in crisis – a crisis intensified by wholesale reorganisation, the resulting omni-shambles, lack of joined up thinking from the panoply of new organisations, a recruitment crisis, exhausted GPs and lack of adequate funding.
- 53e AVON That conference demands that the Department of Health and NHS England work towards longer term contracts lasting a minimum of three years allowing a predictable income stream to aid and even better delivery of services.
- 53f AVON That conference calls on the BMA to launch a full scale campaign to promote the virtues of general practice in the light of the catastrophic failure of NHS re-organisation and reverse the crumbling spirit of general practitioners.
- 53g DUMFRIES AND GALLOWAY That conference believes pressure of work is making traditional full time general practice unsustainable.
- 53h LOTHIAN That conference believes that general practice is entering a palliative phase and urgently requires an anticipatory care plan.
- 53i KINGSTON AND RICHMOND That conference believes efficiency savings in general practice are now only achievable if services are reduced. (Supported by Surrey)
- 53j DERBYSHIRE That conference reminds the government that the continued overt and covert assault on general practice and neglect of its finances is a serious threat to the survival of the NHS particularly in the light of demographic change within the profession and society as a whole.
- 53k SOUTHWARK That conference believes that the ethos of general practice has been lost as a result of the pace of change and direction of travel being imposed on it by NHSE and calls upon NHSE to enter into more of a direct dialogue with practices about the pace of change and direction.
- 53l SOUTHWARK That conference believes that the National Health 'Service' is at risk of transforming to a National Health 'Business' where quality of care is put at risk in the attempt to quantitate clinical outcomes, 'conveyor belt' patients, and make a profit.
- 53m WALTHAM FOREST That conference is concerned that the loss of MPIG and forthcoming PMS review will produce unviable practices. This will result in further unacceptable consequences including:
- (i) worsening access for patients to primary care
  - (ii) practice staff redundancies
  - (iii) closure of practices
- and that conference calls on the GPC to negotiate with the Department of Health over funding for primary care in order to stabilise current practices and divert funding to primary care that recognises that the vast majority of patient contacts takes place in primary care.

- 53n DUMFRIES AND GALLOWAY That conference re-inforces its support for dispensing practices who are under renewed and sustained threat from commercial pharmacies, where the loss of a dispensing practice would lead to markedly poorer general practice provision.
- 53o BRADFORD AND AIREDALE That conference calls on the GPC to negotiate a reduction of the average practitioner list size from 1800 patients to 1200 patients with no reduction in funding, to allow the profession to safely cater for the demands associated with looking after an ageing population with more chronic disease and co-morbidity.
- 54 **AGENDA COMMITTEE to be proposed by CORNWALL AND ISLES OF SCILLY That conference:**
- (i) **believes that patient expectations on primary care services have rocketed and that the NHS cannot afford for patients to have what they want when they want it**
  - (ii) **urges the government to stop stoking unrealistic patient expectations**
  - (iii) **demands that the government forges a new compact with the public and tells them the truth about rationing**
  - (iv) **demands a national self-care strategy to ensure NHS resources are used appropriately and that the NHS remains affordable.**
- 54a CORNWALL AND ISLES OF SCILLY That conference believes the NHS cannot afford for patients to have what they want when they want it and urges the government to stop stoking unrealistic patient expectations or increase funding to pay for want not need.
- 54b WIRRAL That conference recognise that patient expectations on primary care services have rocketed and that this must be addressed.
- 54c LEEDS That conference believes that the A&E four hour waiting target, investment in walk-in-centres, and a policy for routine seven day services are fuelling unsustainable demand and disempowering patients from appropriate self-care.
- 54d CORNWALL AND ISLES OF SCILLY That conference demands a national self-care strategy to ensure NHS resources are used appropriately and that the NHS remains affordable.
- 54e BEDFORDSHIRE That conference believes that public expectation of the NHS needs to be managed and calls on the GPC to push for a public information campaign on patients' responsibilities when using the NHS.
- 54f NORTHUMBERLAND That conference supports a renewed and honest debate on the tension between quality, demand and resources in primary care and how GPs are supported to create a silk purse out of a sow's ear.
- 54g AVON That conference demands that the government forges a new compact with the public and tells them the truth about rationing.
- 54h LEEDS That conference believes commissioning of NHS services should be honest and open with patients about the limitations on service provision caused by the current financial situation and should not raise expectations that cannot reasonably be delivered.
- 54i BRADFORD AND AIREDALE That conference calls on the GPC to demand that the government make the NHS free at the point of need not free at the point of delivery, before NHS general practice collapses due to increasing patient demand and expectation.
- 54j GLASGOW That conference believes that government needs to stop blaming GPs for the financial and workload issues in our NHS and start tackling patient demand.
- 54k BEDFORDSHIRE That conference believes that the current political emphasis on patient satisfaction is jeopardising the care of the least vocal and more vulnerable members of society and believes that the further exploitation of inadequate GP resources by those with the loudest voices and sharpest elbows should be resisted and calls on the GPC:
- (i) to challenge the concept of 'patient-pleasing' as always being a marker of excellent GP performance
  - (ii) to seek to stop further use of the 'friends and family' test for GP services.
- 54l CORNWALL AND ISLES OF SCILLY That conference believes the crisis in the NHS is caused by politicians' unrealistic promises rather than by underfunding.
- 54m NORTHUMBERLAND That conference believes acute same day demand for minor illness is not controllable until there is alignment of funding mechanisms across primary care and secondary emergency department services.
- 54n MORGANNWG That conference demands the government and devolved administrations come clean with their electorates about what the NHS can deliver with the current levels of funding.
- 54o SOMERSET That conference asserts that it is not possible to provide unlimited demand-led general practice services within a financially constrained primary care budget and insists that it is the role of government to make explicit rationing decisions for the health service.

## QUALITY AND OUTCOMES FRAMEWORK (QOF) AND QUALITY INDICATORS

11.30

- 55 **RM** **CORNWALL AND ISLES OF SCILLY** That conference believe QOF has become a box ticking monster and demand GPC negotiate the transfer of the rest of the core clinical QOF points into core general practice funding.
- 55a SHEFFIELD That conference believes unachievable QOF targets:
- (i) drive practices to chase targets at the expense of clinical judgement and patients' best interests
  - (ii) will only have the effect of increasing exception reporting when sound clinical judgement is used and could therefore threaten practice income
  - (iii) are a cynical attempt to claw back practice investment, should be withdrawn and paid to practices in full.
- 55b LEEDS That conference believes the changes to QOF as part of the 2014/15 contract agreement were a step in the right direction and encourages negotiators to make further reductions to the size of QOF with funding again being transferred to global sum and PMS baselines.
- 55c YORKSHIRE REGIONAL COUNCIL That conference believes the changes to QOF as part of the 2014/15 contract agreement were a step in the right direction and calls for further reductions to the size of QOF to be made with funding again being transferred to global sum and PMS baselines.
- 56 **NEWCASTLE AND NORTH TYNESIDE** That conference does not support any local QOF scheme or local contract that goes beyond what has been agreed as part of the nationally negotiated contract agreement and believes:
- (i) such local arrangements could undermine national contract negotiations
  - (ii) local contracts could potentially lead to worse financial outcomes for practices.
- 57 **CAMBRIDGESHIRE** That conference commends the flexibility demonstrated by some area teams in agreeing with LMCs early implementation of national QOF changes, designed to improve services to patients, in a way that does not undermine national negotiations.

## LMC CONFERENCE

12.00

*A paper on the future of LMC conference will be published with the Agenda. This debate shall be held under the standing orders of a major issue debate. There will be an introductory speech followed by an open microphone debate at which speakers may address conference for up to one minute. There shall be the opportunity of a response by the Chairman of GPC. There will be the opportunity of a response by the introductory speaker. At the end of the debate conference shall vote on motion 58 below.*

- 58 **AGENDA COMMITTEE** That conference, in the light of recent feedback, requests the agenda committee to set aside a period of about two hours during the 2015 Annual Conference of Representatives of LMCs, for the purpose of trialling an alternative model of working, supported by appropriate temporary standing orders.
- 58a CLEVELAND That conference recognises that the medico political scene changes frequently and therefore believes its current format is no longer fit for purpose. From 2015, conference should:
- (i) continue to be the principal means whereby LMCs, on behalf of all GPs, hold GPC to account for its actions
  - (ii) continue to meet annually for two days
  - (iii) not debate individual policy motions for more than half the time available
  - (iv) concentrate on establishing broad objectives rather than individual policies
  - (v) be enabled to meet in parallel sessions.
- 58b AVON That conference needs to reflect and decide whether:
- (i) it is fit for purpose
  - (ii) it achieves its outcomes
  - (iii) it can justify the time for delegates and the expense for GPDP
  - (iv) there could be an alternative forum for setting GPC policy more effectively.
- 58c LEEDS That conference believes that the short period of time between the LMC Conference and the BMA ARM leads to repetition of debate and reduces our impact in the media and therefore calls on the Agenda Committee and GPC to work with the BMA organisation committee to ensure there is at least a three month gap between the Annual Conference of LMCs and the BMA ARM.
- 58d MID MERSEY That conference supports an annual conference of English LMCs.

58e	<p>DEVON That conference:</p> <ul style="list-style-type: none"> <li>(i) notes the delightful surroundings and warm welcome afforded by both Liverpool and York for LMC conferences</li> <li>(ii) recognises the immense travel and logistical problems presented to other more remote parts of the country in arriving at these venues, given that the UK has a wheel-spoke transport system with London at its hub</li> <li>(iii) acknowledges the considerable extra costs incurred by more remote LMCs making long journeys with multiple changes</li> <li>(iv) instructs the organising committee to book Logan Hall for the next five years so we can reduce our costs and improve efficiency.</li> </ul>
58f	MID MERSEY That conference congratulates the organisers for continuing to host the conference in different locations outside of London.
58g	<p>DEVON We propose that before any speaker addresses the conference he should declare whether he has any other roles within healthcare provision or purchasing. We would like</p> <ul style="list-style-type: none"> <li>(i) declaration to be written on speaker slip</li> <li>(ii) speech open with statements of fact regarding other roles and own perceived potential conflicts of interest if they exist</li> <li>(iii) other roles to be written on screen behind speaker and remain in view throughout their time addressing conference.</li> </ul>
58h	<p>DEVON We propose an alteration to the rules of conference regarding emergency speaker slips. We accept that these can be abused and frown on this behaviour. However they do empower representatives to hold the platform to account and this is important. We propose (as in modern day tennis and cricket player challenges):</p> <ul style="list-style-type: none"> <li>(i) if the seated chair judges that the emergency speaker slip has been used entirely appropriately then it is not removed from the representative and so can be used again later in the conference</li> <li>(ii) if seated chair deems the emergency speaker slip to have been used inappropriately it is withdrawn from the delegate as under the current rules.</li> </ul>

## LUNCH

**12.30**

## ASK THE NEGOTIATORS

**13.30**

## GENERAL PRACTITIONERS COMMITTEE

14.00

- 59 **AVON** That conference would like to congratulate the negotiators on their achievement in this year's contract negotiations that has brought about the reversal of some of the most damaging and morale-busting elements of last year's imposition.
- 59a BERKSHIRE That conference congratulates the GPC on its negotiations with the government resulting in
- (i) a reduction of QOF tick boxing and a return to holistic general practice
  - (ii) monies deducted from QOF being added to baseline contract funding
  - (iii) more time for practices affected by MPIG withdrawal to prepare for reduced funding
  - (iv) ongoing efforts to achieve continual constructive negotiations and agreement with the Department of Health.
- 59b LIVERPOOL That conference welcomes the shifting of resources from QOF to global sum which will restore professionalism to the care of patients as well as hopefully reduce the micro-management of GPs.
- 59c HERTFORDSHIRE That conference congratulates GPC in negotiating a contract which diverts money from imposed QOF futility to the core funding that is so essential to the viability of general practice.
- 59d GLOUCESTERSHIRE That conference congratulates the GPC Negotiators on the agreements they have made for 2014-15, and urges them to seek the necessary funding to expand the number of GPs in the future, and to seek appropriate premises funding.
- 59e MID MERSEY That conference congratulates the GPC and the Department of Health on the successful completion of this year's negotiations on the GP contract.
- 59f SOUTH ESSEX DIVISION That conference continues to support Dr Chaand Nagpaul, the Chair/GPC, for his efficient negotiations with the government to help GPs towards successful commissioning for the benefit of the public.
- 59g SOUTH ESSEX DIVISION That conference appreciates the efforts taken by the GPC, especially with the efficient negotiations by the Chair Dr Chaand Nagpaul to ensure that the Health of the Nation is in safe hands, in spite of several attempts to take the NHS away from Public Hands.
- 60 **THE GPC** That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: **The conference appreciates that experience is required for the effective running of GPC and values the contributions of its more experienced members. This conference is however concerned by the lack of recently qualified GPC members. Conference therefore calls on GPC to:**
- (i) explore options for increasing the number of newly qualified GP members on GPC
  - (ii) implement a mechanism to increase the number of newly qualified GP members on GPC
  - (iii) put mechanisms in place to train and nurture the future leaders of general practice.
- 60a HERTFORDSHIRE That conference recalls motion 63 from the 2013 Conference of LMCs which called for an investigation into making GPC fully representative of the profession as a whole, and requests publication of the results of this investigation.

## PUBLIC RELATIONS

14.20

- 61 **DEVON** That conference believes that the BMA public relations department is not currently fit for purpose in representing the plight of GPs and mandates the GPC to urgently review its function and consider a reprocurement to ensure an effective service.
- 61a MERTON, SUTTON AND WANDSWORTH That conference asks the BMA to improve their public relations on behalf of practices, to prevent unfair portrayals in the media.

- 62 **AGENDA COMMITTEE to be proposed by HULL AND EAST YORKSHIRE That conference:**  
**(i) congratulates LMCs for shouldering additional vital work during the chaotic NHS changes of 2013/14**  
**(ii) believes LMCs will be strengthened by the establishment of a national LMC body.**
- 62a HULL AND EAST YORKSHIRE That conference supports the establishment of a national LMC body which would help in:  
(i) training and retaining LMC officers  
(ii) sharing of information  
(iii) sharing of good practice  
and lead to increased participation in LMC work and greater job satisfaction and therefore asks that such a body be established.
- 62b HERTFORDSHIRE That conference congratulates LMCs for shouldering additional vital work during the chaotic NHS changes of 2013/14 which includes taking on the unsung roles of custodians of organisational memory; navigators through the labyrinthine quagmire of NHS England; counsellors for ex-PCT staff; and conduits for communication between different commissioners of GP services.
- 62c HAMPSHIRE AND ISLE OF WIGHT That conference believes that the LMC/GPC axis is the true representative body for general practice. It is not the RCGP and comments about provision should be from the GPC rather than the RCGP. Bearing that in mind, conference believes the GPC needs to present a constructive and instructive view on the future of general practice / primary care to NHS England.
- 62d NORFOLK AND WAVENEY That conference call on GPC to recognise the increased workload of LMC offices since the demise of primary care support in the latest NHS reorganisation.

- 63 **NORFOLK AND WAVENEY** That conference ask the GPC to work, as a matter of urgency, with those responsible for medical education to:
- (i) bring about a higher degree of accuracy in the numbers of places in medical schools to properly reflect the needs across all medical specialties in the future
  - (ii) implement a national standard training programme for GP trainers that is appropriate and easily accessible and flexible to support practices to become training practices and ensure succession planning is in place to support the loss of GP trainers that may be seen with the likely early retirement of GPs
  - (iii) encourage a career in general practice from year one of medical training
  - (iv) ensure the proposed extension of GP training to four years is used to increase practical experience for trainees, rather than as a political tool to fill gaps in service provision, and practices receive appropriate resourcing to support this.
- 63a **NORTH YORKSHIRE** That conference believes there is an urgent need for younger GPs to become trainers to address the looming GP workforce crisis and that the current requirement for an educational qualification is an unnecessary deterrent to those wishing to apply to become trainers.
- 63b **CLEVELAND** That conference urges the GPC to seek a reduction in the costs to GPs of becoming a trainer.
- 63c **NORTHERN IRELAND CONFERENCE OF LMCs** That conference demands clarity regarding the fourth year of GP training.
- 63d **SOUTH STAFFORDSHIRE** That conference demands that conditions for GP trainers are improved by reducing intolerable bureaucracy and even more importantly increasing remuneration in order to address the crisis in recruiting more trainers and thus training more GPs.
- 63e **BRADFORD AND AIREDALE** That conference calls for recognition that more GPs are required for the future (especially if GPs are to provide a seven day service) and as such there is the need to increase the number of GP training places and make general practice a more attractive career choice for trainee doctors.
- 63f **DERBYSHIRE** That conference recognises the inadequacy and variability of financial, legal, medico-legal and business organisational training in the GP training curriculum and calls upon GPC to pressurise the relevant educational authorities to ensure that by the time of a grant of a CCT a newly qualified GP is adequately prepared to keep themselves out of trouble in these matters.
- 63g **DERBYSHIRE** That conference is appalled at the variation in financial, legal, medico-legal and business organisational education in GP training and calls upon GPC to pressurise the relevant educational authorities to ensure that by the time of grant of a CCT a GP trainee can at least keep themselves out of trouble in these matters.
- 63h **GRAMPIAN** That conference is increasingly worried by the difficulty practices are experiencing in recruiting and retaining GPs, and calls for urgent action from governments to improve the numbers of trainees entering GP training.
- 63i **CORNWALL AND ISLES OF SCILLY** That conference believes any reduction in the GP trainers grant or a move to practices being charged a tariff for a GP trainee as a result of extended GP training (EGPT):
- (i) must not be used to subsidise extending GP training
  - (ii) would be the death knoll of quality GP training
  - (iii) would lead to an underclass of sub CCT salaried GPs
  - (iv) must not be used to dumb down the quality of training.
- 63j **CLEVELAND** That conference is dismayed that there is no funding for the proposed additional year of training proposed for GPs and demands action by government and Health Education England (HEE) to achieve an early resolution of this unacceptable situation.
- 63k **THE GPC** That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: That conference is concerned by the decline in applications to GP training and believes that there is an impending workforce crisis. Conference therefore calls on the RCGP to work with GPC to:
- (i) promote the benefits of a career in general practice to potential applicants
  - (ii) increase the attractiveness of general practice to potential applicants
  - (iii) increase the number of GP training positions.
- 63l **DORSET** That conference supports a fourth year for GP training as long as it is in general practice and not in secondary care, and fully funded for the training practice.
- 63m **SCOTTISH CONFERENCE OF LMCs** That conference believes all doctors in training should now spend a minimum period of time working in general practice to help promote the GP career option and improve the understanding between primary care and secondary care doctors.
- 63n **THE GPC** That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: The conference is concerned that the current GP training programme is heavily populated by box ticking exercises and calls on the RCGP to address this immediately by focusing more on the practical and management skills of general practice.

64 **THE GPC That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: The conference is concerned that the future of GP workforce is at risk due to perpetual lack of funding and calls on Health Education England (HEE) and relevant bodies in the devolved nations to fully fund:**  
**(i) the costs involved with increasing the number of GP training posts**  
**(ii) enhanced GP training.**

64a BUCKINGHAMSHIRE This conference believes that:  
(i) high quality GP training deserves appropriate and transparent funding that takes into consideration the specialist knowledge necessary to fulfil this role as well as the increasing workload and time that GP trainers have to dedicate to their role as educational supervisors  
(ii) the GPC needs to urgently review the way educational supervision for ST2 and ST3 is funded across England  
(iii) the GPC needs to negotiate with HEE (Health Education England) rather than LETBs an acceptable way of remunerating GP trainers  
(iv) the GPC needs to ensure that funding moves away from locally agreed tariffs to a transparent approach that ensures GP trainers throughout England are paid in the same way.

64b THE GPC That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: The conference is concerned that the quality of GP training is being compromised due to financial and capacity issues in primary care, and calls on COGPED to publicly name the deaneries (or equivalent bodies) that are failing to adhere to their guidance on GP training by August 2014.

65 **KENT That conference demands that tax relief is automatically granted to GP trainees for the cost of mandatory exit examinations.**

65a BIRMINGHAM That conference:  
(i) believes that the process for GP trainees to claim tax relief on their mandatory exit examinations, through having to argue their case with HMRC individually and provide appropriate evidence is unduly onerous; and  
(ii) instructs GPC to do all it can to ensure that tax relief is automatically granted for GP trainees' mandatory exit examinations.

65b LINCOLN DIVISION That conference believes that the process by which GP trainees have individually to provide appropriate evidence and argue their case with HMRC in order to claim tax relief on their mandatory exit examinations is unduly onerous, and instructs GPC to do all it can to ensure that such tax relief is granted automatically.

- 66 **AGENDA COMMITTEE to be proposed by BEDFORDSHIRE** That conference believes the introduction of care.data has been nothing short of a disaster and:
- (i) **approves the decision of NHS England to put its roll out on hold until the autumn**
  - (ii) **believes that GPs have been placed in a difficult position in respect of the demands of the Health and Social Care Act and the Data Protection Act**
  - (iii) **asserts that data should be pseudonymised or anonymised before it leaves the practice**
  - (iv) **asserts that extraction should only take place with the explicit and informed consent of patients opting-in**
  - (v) **insists that it should only be used for its stated purpose of improving health care delivery, and not sold for profit.**
- 66a BEDFORDSHIRE That conference notes with approval the decision of NHS England to put the rollout of care.data on hold until the autumn, and calls on GPC to ensure that, before the rollout is attempted:
- (i) the data is pseudonymised or anonymised before it leaves the practice
  - (ii) the consent model is 'opt-in'
  - (iii) everyone receives a full and honest explanation of the use of the information collected by HSCIC.
- 66b GATESHEAD AND SOUTH TYNESIDE That conference believes that within the care.data programme:
- (i) patients need to give explicit, informed consent with respect to their private, confidential health data;
  - (ii) the process should be one of opting in and not opting out;
  - (iii) GPs have been placed in a difficult position in respect of the demands of the Health and Social Care Act and the Data Protection Act;
  - (iv) urgent clarification and a legal opinion is obtained on the position of GPs who opt out the whole practice population as a default.
- 66c DEVON That conference demands that with respect to care.data:
- (i) consent to upload confidential patient data is opt in rather than opt out
  - (ii) data should be fully anonymised
  - (iii) GP practices should be fully indemnified by the crown against financial penalties resulting in them complying with the legislation in the HSCA.
- 66d LANCASHIRE COASTAL That conference believes that any usage of personal health data:
- (i) should stay within the NHS for health care and research
  - (ii) any sharing of this data for these functions should be subject to consent.
  - (iii) any extract of information for research or planning should be anonymised within the practice before being extracted.
- 66e MID MERSEY That conference believes that the introduction of care.data is nothing short of a disaster and is a contradiction in terms.
- 66f NORTH AND NORTH EAST LINCOLNSHIRE That conference supports the concept that:
- (i) caredata.com extraction must only take place with the explicit and informed consent of patients and that opting-in should be the norm
  - (ii) extracted data must be anonymised at source.
- 66g SHROPSHIRE That conference believes the extraction of patient data from GP records, without the express consent of the patient, risks loss of patient confidence and a reluctance to share sensitive information which may jeopardise effective consultation and, as a result, threaten optimum delivery of care.
- 66h COVENTRY That conference believes that the implementation of care.data has been shambolic, has placed general practices in an invidious position, and has brought all data extractions into disrepute, and demands that any further extractions must not occur until general practices are indemnified against any allegation of breach of the Data Protection Act 1998 and the public have been properly informed.
- 66i COVENTRY That conference believes that using pseudonymisation at source for care.data or in other healthcare data extraction settings derogates neither from the need to ensure patients are fully informed nor from allowing patients to individually opt out.
- 66j HERTFORDSHIRE That conference deplores the wholesale extraction of identifiable patient data from general practice and calls on the GPC to insist on pseudonymisation at source.
- 66k WAKEFIELD That conference wants clear guidance for grass-roots GPs on what data sharing is and what it involves and where the risks and responsibilities for individual practitioners lie.
- 66l WAKEFIELD That conference regards current data sharing models and the confusion surrounding them by both doctors and patients as demonstrating they are not fit for purpose.

- 66m AVON That conference believes that the government's credibility in health IT projects has been fatally wounded by the care.data fiasco and insists that the GPC should decline to be involved in any data collection projects unless they are:
- (i) clinician led
  - (ii) transparently organised
  - (iii) adequately promoted to the public
  - (iv) not for profit.
- 66n NOTTINGHAMSHIRE That conference, in view of recent revelations about the selling of anonymised patient data to the insurance data, has no confidence in the assurances given to the public about the use of information obtained from Care.data and therefore insists
- (i) that it should only be used for its stated purpose of improving health care delivery
  - (ii) that anyone authorising its use for other than currently stated purposes should be liable to prosecution.
- 66o WEST SUSSEX That conference is gravely concerned that the avoidable care.data fiasco has damaged public confidence in NHS data security. (Supported by Surrey)
- 66p LIVERPOOL That conference believes that for patients and clinicians to have confidence in care.data, personalised data extracted from GP computer systems should be anonymised at the point of extraction.
- 66q SUFFOLK That conference understands that the data section of the Health and Social Care Act requires GPs to permit the upload of patient data to a central location unless a patient has made an individual request to opt out. This is at variance with the current responsibility of the GP as data controller for those records and therefore puts GPs at legal risk. Conference requests GPC to consider carefully in light of the government's assault on the confidentiality of patient records whether it is any longer appropriate for the GP to be the controller of primary care data and if it decides that it is not, to take appropriate steps to raise the matter to government attention for discussion with the intention of achieving change.
- 66r BEDFORDSHIRE That conference believes that the current double-bind on GPs as data controllers but obliged to allow information to be released under the Health and Social Act is unacceptable and calls on GPC to resolve this impossible mess.
- 66s DEVON That conference believes unless government concedes on both full anonymisation and opt in consent, it should be open and honest about the threat to patient confidentiality and simply post everyone's entire health records onto the internet. Only then will the public appreciate just how cavalier this government is being with their confidential data.
- 66t DEVON That conference believes that our patients deserve better than to receive their care.data information wedged between a Domino's menu and a TalkTalk envelope.
- 66u NORTH ESSEX That conference insists that the care.data patient information is collected and held in an anonymised form.
- 66v NORTHUMBERLAND That conference deplores the continuing, conflicting statutory duties placed on GPs in relation to care.data and calls for:
- (i) development of a national code of practice to support the process of continuing consent implicit in this project
  - (ii) the GPC to lobby for a resolution of the legal conundrum to ensure GPs will not be liable to prosecution.
- 66w SHROPSHIRE That conference believes that patients give personal information to their doctors voluntarily, in the belief it will be used confidentially to help with their healthcare; believes that the sale of this information to commercial organisations represents a betrayal of that trust, and insists the government should cease extraction of data from patients' records unless informed individual consent is obtained.
- 66x NEWCASTLE AND NORTH TYNESIDE That conference believes that:
- (i) an individual patient should be able to choose to share their health records
  - (ii) the extraction of data without patients' active consent will lead to some patients not disclosing information to their GP and with negative consequences to their personal health and health care
  - (iii) once patient data has been extracted, 'pseudonymised' and sold on as part of care.data, it cannot be retracted, and so consent for data extraction should only be permitted with the active consent of the patient.
- 66y NEWCASTLE AND NORTH TYNESIDE That conference:
- (i) supports the situation in Scotland where GPs can opt out of providing all or part of patient data to SPIRE (Scottish Primary Care Information Resource)
  - (ii) regrets that the law states that English GPs cannot opt out of providing patient data to the Health and Social Care Information Centre.
- 66z JUNIOR DOCTORS CONFERENCE That this conference strongly believes in the principles of patient autonomy and patient confidentiality as the foundation of all clinical work and therefore
- (i) supports each patient's choice to object to the storage of their data in a central database, through an opt-out system
  - (ii) demands the right of each patient to view all of their stored data, to be informed with whom their data is shared, and to have any objections to its accuracy recorded
  - (iii) calls for access to pseudonymised data to be limited to situations in which there is a public interest (for example, a specific research hypothesis)
  - (iv) requires data cannot be traced back to the individual patients if data is shared outside the NHS, without the consent of its use for this purpose by patients;
  - (v) opposes the use of patient data by NHS and government to generate profit.

- 67 **BRADFORD AND AIREDALE That conference calls on the GPC to negotiate an end to GPs being custodians of a patient's medical record now that GPs no longer have control over who accesses or uses it.**
- 67a BRADFORD AND AIREDALE That conference believes GPs should relinquish ownership and administration of the patient record due to it no longer being a resource purely for GP use.
- 68 **AGENDA COMMITTEE to be proposed by SOMERSET That conference in respect of GP IT:**
- (i) **believes that patient care would be improved if significant current illnesses and previous medical problems were available to clinicians in the summary care record (SCR)**
  - (ii) **believes that a shared medication record is the only safe method for recording all patients' medications across primary care, hospital, community and mental health services**
  - (iii) **laments the inverse care law inherent in the current GP to GP electronic transfer of medical records and instructs the GPC to ensure that it is possible to transfer the full records of the most complex patients**
  - (iv) **calls for funding to digitise patient notes to improve general practice IT and patient care**
  - (v) **call upon the GPC to secure compensatory recognition for the difficulties caused by the ill functioning QOF year end submission and attendant information uploading systems.**
- 68a SOMERSET That conference believes that patient care would be improved if significant current illnesses and previous medical problems were available to clinicians in the summary care record (SCR), and instructs the GPC to negotiate the inclusion of this information in the SCR.
- 68b GLASGOW That conference believes that a shared medication record is the only safe method for recording all patients' medications across primary care, hospital, community and mental health services.
- 68c SOMERSET That conference asserts that in addition to medication prescribed in primary care being accessible on a patient's summary care record (SCR), medication initiated in an acute or community hospital setting should also be uploaded to, and accessible on, the SCR.
- 68d SOMERSET That conference laments the inverse care law inherent in the current GP to GP electronic transfer of medical records and instructs the GPC to ensure that it is possible to transfer the full records of the most complex patients.
- 68e KENT That conference calls for funding to digitise patient notes to improve general practice IT and patient care.
- 68f WIGAN That conference is appalled at the mayhem and uncertainty which has been caused around QOF year end submission of data and information by the ill functioning CQRS and attendant information uploading sub systems. It calls upon the GPC to secure compensatory recognition for the difficulties and extra work this has caused to general practice.

## PATIENT REGISTRATION

15.40

- 69 **AVON That conference deplores the fact that the principle of zero tolerance towards abusive and threatening patients has been totally emasculated by management fudge and a hostile ombudsman.**
- 69a DERBYSHIRE That conference demands that the violent patient scheme regulations be updated to ensure that patients who are assessed as being at high risk of acting violently in a health care setting can be cared for in secure primary care environments without having to wait until they have actually been violent in a primary care setting.

## MEDICAL INDEMNITY

15.50

- 70 **DEVON** That conference recognises the crippling cost of medical indemnity for doctors working significant periods of time in an out of hours setting, and instructs GPC to open negotiations with all administrations to ameliorate this worrying trend through some form of crown indemnity risk sharing.
- 70a LEEDS That conference is alarmed at the rising indemnity costs for GPs working out of hours and believes urgent steps need to be taken by governments to address this.
- 70b THE GPC That the GPC seeks the views of conference on the following motion from the sessional GPs subcommittee:  
That conference believes that the rapid increase in and high costs of indemnity for GPs who undertake out of hours sessions has contributed to the OOH workforce crisis and calls on NHS England to introduce an NHS crown indemnity scheme for OOH GPs.
- 70c YORKSHIRE REGIONAL COUNCIL That conference is alarmed at the rising indemnity costs for GPs working out of hours and:-  
i) believes this risks OOH organisations being unable to recruit enough GPs to provide a safe and sustainable service in the future;  
ii) calls on health departments in the UK to take urgent steps to address this.
- 71 **KENSINGTON, CHELSEA AND WESTMINSTER** That conference deplores the increasing risk stratification and consequent higher costs of medical indemnity and calls upon commissioners to:  
**(i) consider GPs indemnity costs fully in the pricing of enhanced services and out of hospital contracts and**  
**(ii) recognise that prohibitive indemnity costs will negatively impact on service provision to vulnerable and higher risk patients.**
- 71a BEDFORDSHIRE That conference calls on GPC to work with MDOs for them to be transparent regarding their policies and thresholds for loading GPs' insurance premiums.

## CLINICAL AND PRESCRIBING

16.10

- 72 **DEVON** That conference:  
**(i) notes that the childhood vaccination programmes in England, Wales, Scotland and Northern Ireland currently only offer the HPV vaccine (Gardasil) to girls**  
**(ii) acknowledges that the prevalence of anal cancer in gay men is equivalent to the unacceptable level of cervical cancer in unscreened women**  
**(iii) calls upon the Departments of Health to change their policies and offer the HPV vaccination (Gardasil) to boys as well.**

- 73 **DERBYSHIRE** That conference requests that all drugs started in secondary care should initially be prescribed in secondary care and that in this regard:
- (i) the responsibility for considering advising on contraindications, side effects and interacting residues with the initiating clinician
  - (ii) the responsibility for patient counselling residues with the initiating clinician
  - (iii) the responsibility for baseline investigations residues with the initiating clinician
  - (iv) the responsibility to provide management plans when starting new medication residues with the initiating clinician
  - (v) the responsibility for on-going monitoring, eg, blood test or ECGs, residues with the initiating clinician until agreed and accepted by the patient's primary care clinician.
- 74 **LIVERPOOL** That conference believes that the lack of GP open access to a certain hospital based investigations is hampering identification of serious illness in patients at an early stage.

- 75 **AGENDA COMMITTEE to be proposed by LEEDS That conference:**
- (i) **deplores the government decision to no longer fund an occupational health service for GP practices (unless there is a performance issue)**
  - (ii) **deplores the government decision that requires trainee general practitioners to now fund their own occupational health assessment before they can start work**
  - (iii) **calls on GPC to strive for continued funding to maintain a high quality, long term service to GPs and their staff**
  - (iv) **demands that the NHS ensure a comprehensive occupational health service is made available to all members of staff in GP practices**
  - (v) **demands that the NHS ensure a comprehensive occupational health service is made available to all locum GPs on the performers lists.**
- 75a LEEDS That conference:
- (i) condemns the cuts by NHS England to occupational health services
  - (ii) demands that NHS England ensure a comprehensive occupational health service is made available to all members of staff in GP practices in England
  - (iii) demands that NHS England ensure a comprehensive occupational health service is made available to all locum GPs on the performers list in England.
- 75b SHROPSHIRE That conference deplores the government decision to no longer fund an occupational health service for GP practices (unless there is a performance issue) and, particularly, the need for trainee general practitioners to now fund their own occupational health assessment before they can start work.
- 75c MID MERSEY That conference notes with grave concern that NHS England proposes to discontinue dedicated occupational health services for general practice.
- 75d HULL AND EAST YORKSHIRE That conference deplores the renegeing by NHS England on the 2004 Occupational Health agreement and calls upon GPC to strive for continued funding to maintain a high quality, long term service to GPs and their staff.
- 75e GLOUCESTERSHIRE That conference demands that GP practices, as subcontractors of the NHS, be provided with a fully funded occupational health service.
- 75f LEEDS That conference believes that GPs entering onto the performers list should not be required to:
- (i) have an occupational health assessment
  - (ii) pay for an occupational health assessment.
- 75g MANCHESTER That conference demands a solution to occupational health services for all practice staff.
- 75h CLEVELAND That conference is dismayed that area teams have disregarded the instruction by NHS England to preserve funding of occupational health services for GPs at least in 2013/14 and urges GPC to negotiate the provision of a proper and effective service for GP occupational health which will support the workforce and prevent performance issues arising.
- 75i SALFORD AND TRAFFORD That conference calls on GPC to robustly seek the reintroduction of occupational health services for all GPs (whether or not their performance has already started to give cause for concern) as well as for practice staff. This provision would be a minimum sign of good will to support general practice as it struggles to survive.
- 75j NOTTINGHAMSHIRE That conference condemns the unilateral decision by NHS England to withdraw funding for free access to occupational health services by GPs and their staff, which it believes:
- (i) unfairly discriminates against GPs as small NHS providers experiencing extreme pressures in delivering NHS services
  - (ii) undermines NHS commitments to provide a safe and supportive working environment for all its staff and contractors.
- 75k DEVON That conference:
- (i) recognises that wise systems invest in their staff especially when, like GPs, they cost £400,000 to train
  - (ii) acknowledges that with such high training costs, GPs are 'expensive pieces of kit'
  - (iii) demands that NHS England adequately funds occupational health services for GPs, including comprehensive psychological support
  - (iv) advises NHS England that this would be a very wise and cost-effective investment against capital write-off.
- 75l SOMERSET That conference regrets the withdrawal of a formal commissioned occupational health service (OHS) for general practice and believes that the patient safety benefits of a GP OHS far outweigh the costs by:
- (i) retaining trained GPs in the workforce through support after illness
  - (ii) protecting GPs, practice staff, and patients through the provision of immunisations
  - (iii) improving practice team effectiveness through provision of employment OH advice.

- 75m NEWCASTLE AND NORTH TYNESIDE That conference is greatly concerned that NHS England are discontinuing dedicated occupational health services for GPs and believes:
- (i) the current proposals that GPs with problems contact their appraiser or the area team medical director is totally inadequate
  - (ii) GPs will be deterred from seeking health advice.
- 75n BARNET That conference demands that NHS England fund occupational health services for GPs and primary care teams so that the government's 'Healthy staff, better care for patients' agenda can be achieved.

**CONTINGENCY**

**16.50**

**AND FINALLY...**

**16.55**

- 76 NORTH ESSEX That conference requests that common sense be re-introduced to the NHS.

**CLOSE**

**17.00**

# **Conference of Representatives of Local Medical Committees**

## **Agenda: Part II** **(Motions not prioritised for debate)**



## Agenda: Part II (Motions not prioritised for debate)

### A and AR Motions

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

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

#### WORKLOAD AND PATIENT SAFETY

- A 77. BARNET That conference demands further funding or the halting of work being transferred from secondary care and/or social care onto general practice.

#### COMMISSIONING OF CARE

- A 78. MANCHESTER That conference demands CCGs, public health and area teams have robust evaluation processes in place prior to the commissioning of services and pilots.
- A 79. SURREY That conference does not believe that tendering NHS contracts for low value primary medical services is an efficient use of NHS financial or managerial resources.
- A 80. CAMDEN That conference believes that GPs are fully occupied providing quality care to patients and are unable to concentrate on NHS strategic planning without appropriate resourcing for this additional work.
- A 81. BRENT That conference recognises the important role that GPs have in commissioning secondary care services and calls upon the GPC to insist that GPs undertaking clinical commissioning work for CCGs are properly compensated.
- AR 82. NEWCASTLE AND NORTH TYNESIDE That conference believes that the King's Fund paper on commissioning is furthering the developing mantra that the existing GP contract is an impediment to innovation and believes:
- (i) larger primary care provider contracts are a panacea for increasing vertical integration
  - (ii) there is a concerted effort to break up the national contract and national conditions and terms of service.
- A 83. DEVON That conference believes that the applicability of the current NHS standard contract to general practice is about as appropriate as the use of shipping regulations to run a bird sanctuary, and demands that it is completely rewritten with GPC input for the purpose of the job in hand.
- A 84. LEEDS That conference believes that practices either singly or collectively should be enabled by CCGs to employ or directly manage community nurses to create comprehensive teams built around practices to provide a seamless and more flexible nursing service for patients in the community.
- A 85. NORFOLK AND WAVENEY That conference asks GPC to ensure NHS England provides appropriate and robust guidance to CCGs to ensure they:
- (i) hold acute trusts to contract
  - (ii) commission all aspects of appropriate patient care within secondary care contracts to ensure inappropriate work does not default onto general practice
  - (iii) ensure all hand-over between secondary care and general practice follows good medical practice guidelines.
- AR 86. DEVON That conference believes that with respect to the NHS standard contract:
- (i) the document is not fit for purpose
  - (ii) that GPC should urgently seek to amend the document to make it more suitable for use in primary care.
- A 87. CLEVELAND That conference is dismayed that area teams have disregarded the instruction by NHS England to preserve funding of collaborative arrangements and urges the BMA to seek an effective and efficient scheme for funding by the NHS under Section 80 of the NHS Act 2006 as amended.

- A 88. CLEVELAND That conference reminds the GPC, BMA and government that collaborative arrangements are funded by the NHS not the local authority and will resist any changes to that arrangement without:
- (i) a proper consultation
  - (ii) necessary changes to primary legislation
  - (iii) proper funding of work done by GPs
  - (iv) ring-fenced funding
  - (v) superannuation rights guaranteed.

## GOVERNMENT

- A 89. KINGSTON AND RICHMOND That conference urges any future government not to subject the NHS to further destabilising reorganisation. (Supported by West Sussex and Surrey)

## REGULATION, MONITORING AND PERFORMANCE MANAGEMENT

- A 90. SHEFFIELD That conference believes regulation of GPs and practices:
- (i) is an increasing burden
  - (ii) will not produce improvement in patient services
  - (iii) is introduced by politicians as a knee-jerk response, contrary to any evidence of its effectiveness
  - (iv) must be reduced to an absolute minimum
  - (v) should be paid for by society, not GPs or their practices.
- A 91. GLOUCESTERSHIRE That conference deplors any action by the ombudsman that may be disproportionate or unfair to GP practices.
- A 92. MID MERSEY That conference believes that general practice is overly regulated leading to a demoralised profession.

## ACCESS

- A 93. GLASGOW That conference supports GP led out of hours (OOHs) services and calls for health boards to fund OOHs services adequately.
- A 94. GLOUCESTERSHIRE That conference believes triage is a task for the clinically qualified, not for an NHS111 'customer service operator'.
- A 95. SHROPSHIRE That conference believes that triage by experienced clinicians is the best and safest way to deliver out of hours care and that the algorithm reliant approach of NHS 111 is inferior and misguided.

## FUNDING FOR GENERAL PRACTICE

- A 96. DERBYSHIRE That conference demands that all legitimate professional expenses incurred by general practitioners in NHS service delivery be reimbursed in their totality.
- A 97. BEDFORDSHIRE That conference calls on GPC to ensure that there are resources available for general practice to cope with the additional workload created by NHS public health campaigns.
- A 98. SOMERSET That conference believes that those services provided in general practice that are most valued by patients are not always amenable to performance monitoring and insists that national funding for primary care should reflect this.

## PENSIONS

- A 99. EAST SUSSEX That conference calls on the government to remove all historical gender inequalities in relation to pension arrangements.

## GP PARTNERSHIPS AND FEDERATIONS

- A 100. NORTH YORKSHIRE That conference believes that the independent contractor model of general practice should remain available to all and continues to be the driver for responsive, high quality, holistic primary care.
- A 101. CORNWALL AND ISLES OF SCILLY That conference demands the GPC fights for the independent contractor model of providing general practice on behalf of patients and GPs, as it remains the bedrock of the NHS.
- A 102. BRO TAF That whilst conference applauds the diversity of career options offered in primary care, it recognises the independent contractor model must remain as the essential cornerstone on which the GP contract is based.
- A 103. LIVERPOOL That conference believes that the BMA should be actively promoting the partnership model, as the best way of providing GP services, and should be encouraging newer members of the profession to consider entering into partnership, in general practice.

- A 104. CORNWALL AND ISLES OF SCILLY That conference believes the partnership model of general practice remains the best way to provide general practice services.
- A 105. SURREY That conference believes there should be a return to the basic practice allowance (or equivalent) to encourage the partnership model of general practice delivery.
- A 106. SHROPSHIRE That conference asks the GPC to urgently renegotiate financial support for GP partners taking maternity leave as the current (GMS) arrangements leave either the GP or the practice concerned severely penalised.

## THE MARKET / PRIVATISATION

- A 107. BEXLEY That conference believes that private finance initiative liabilities have had a destabilising impact on the delivery of NHS services; and calls upon GPC to request that government renegotiate or terminate such contracts.

## SESSIONAL GPs

- A 108. SOUTHWARK That conference believes that with the increasing privatisation of the NHS and primary care the salaried GP workforce will play an even more important role in the provision of services in the future and calls upon the GPC to ensure that:
  - (i) every opportunity should be taken to encourage and support salaried GPs to become an integral part of emerging GP networks
  - (ii) salaried GPs are adequately remunerated for their work
  - (iii) salaried GPs' remuneration should reflect their experience
  - (iv) salaried GPs' workload should be commensurate with the number of sessions for which they are paid.
- A 109. BRO TAF That conference recognises that many GPs welcome a salaried option, but calls upon all employers to ensure that they adhere strictly to the BMA contract and do not, as unfortunately appears to happen sometimes, expect their employed doctors to work hours which are outside the contract.
- A 110. THE GPC That the GPC seeks the views of conference on the following motion from the sessional GPs subcommittee: That conference believes that sessional GPs now comprise an important and significant proportion of the GP workforce, and:
  - (i) that their representation is fundamental to the workings of the BMA, GPC and LMCs
  - (ii) they are still poorly represented on many LMCs
  - (iii) asks GPC to urge LMCs again to ensure they have representation from salaried, locum and OOH GPs on their LMCs.
- A 111. CUMBRIA That conference believes that NHS England failing to take a lead on developing direct, inclusive channels of communication with sessional GPs will result in the disengagement and alienation of a vast swathe of the profession, with consequent detrimental impact on the development of general practice for the future, and a serious risk of destabilisation that will affect all.
- A 112. EAST SUSSEX That conference recognises the contribution made by salaried and locum colleagues and asks GPC to:
  - (i) provide improved advice and support to locums affected by late or disputed practice payments
  - (ii) encourage LMCs to engage with salaried and locum GP colleagues.

## OTHER MOTIONS 1

- A 113. SURREY That conference calls for transparency over contract pricing when APMS contracts are procured. (Supported by West Sussex)
- AR 114. DERBYSHIRE That conference requires GPC to promulgate the concept that other organisations' operational, organisational, financial or budgetary problems in delivery of patient services do not, as the default position, become the problems of general practitioners.
- AR 115. BEDFORDSHIRE That conference instructs GPC to continue to ensure that GPs are not incentivised in any way to withhold treatment from patients.
- A 116. LIVERPOOL That conference believes that the procurement process which was designed for large businesses is inappropriate for small organisations.

## PRIMARY CARE WORKFORCE

- A 117. THE GPC That the GPC seeks the views of conference on the following motion from the sessional GPs subcommittee: That conference believes that despite the formation of a national performers list in England that:
  - (i) area teams still do not adequately maintain the distribution lists to keep them up to date
  - (ii) area teams still fail to adequately cascade important clinical information to sessional GPs
  - (iii) NHS England should take action now to ensure area teams properly maintain the distribution lists and cascade information to all GPs including sessionals.

- A 118. BIRMINGHAM DIVISION That conference demands, in respect of locum and freelance sessional GPs:
- (i) they should automatically be included in all NHS circulation and information lists
  - (ii) that GPC should insist that NHS England take responsibility for including them in NHS information cascades
  - (iii) that they should be included in NHS information cascades from the date of inclusion on the medical performers list.
- A 119. WELSH CONFERENCE OF LMCs That conference calls for the UK government, GPC UK and the RCGP to acknowledge that doctors who have been out of UK general practice for more than two years should have an individualised assessment of their competence to return to practice rather than being subjected to the same retraining requirements even if they have been in clinical practice in other countries.
- A 120. MID MERSEY That conference recognises the immense contribution and dedication to the profession by small and single handed general practitioners.

## THE FUTURE OF GENERAL PRACTICE AND THE NHS

- A 121. SOMERSET That conference believes that a genuinely patient centred health service must ensure that each different element of care is provided in the most appropriate setting, and insists that funding streams must be sufficiently flexible to facilitate this.
- A 122. SOUTHWARK That conference believes that vertical integration is not the appropriate way forward and calls upon primary care to be the driving force of integration.
- A 123. WILTSHIRE That conference believes that the NHS cannot function efficiently or safely without the adequate social care necessary to address the problems of our increasingly elderly population.
- AR 124. ISLINGTON That conference embraces collaborative working and calls on the GPC to provide:
- (i) a clear vision and purpose on collaborative working
  - (ii) the tools and guidance to LMCs on facilitating federations and other partnership arrangements.
- AR 125. NORFOLK AND WAVENEY That conference asks GPC to produce national guidance to support LMCs to facilitate their practices setting up an appropriate provider organisation.
- AR 126. MERTON, SUTTON AND WANDSWORTH That conference would like to see support and resources made available to enable groups of GPs to become more proficient in bidding for services.
- A 127. WORCESTERSHIRE That conference believes general practice is in crisis and that serious urgent action is needed by government to rescue the situation and demands that the government:
- (i) needs to formally recognise that we have a serious recruitment and retention problem and will take serious steps to address this crisis
  - (ii) has also to accept that we have major workload issues and to take significant steps to address this
  - (iii) should agree that annual contractual changes are not in the best interest of general practice and move to agreeing a longer term deal that will allow some stability and that this deal will attempt to fix the crisis in general practice.
- A 128. BRADFORD AND AIREDALE That conference expresses regret concerning erosion of the status and respect of general practice as a professional entity, and calls for an immediate debate about the restoration of GP professional standing.

## QUALITY AND OUTCOMES FRAMEWORK (QOF) AND QUALITY INDICATORS

- AR 129. CAMBRIDGESHIRE That conference calls for a return to the 15 month interval for QOF reviews in England.
- AR 130. LEEDS That conference notes that the chronic kidney disease indicators have been removed from QOF in Wales and believes they should also be removed from QOF in England.

## GENERAL PRACTITIONERS COMMITTEE

- A 131. MANCHESTER That conference requests GPC set up a separate website to the BMA and all relevant BMA information is available via this website.
- AR 132. MORGANNWG That conference demands the author of GPC News identifies all articles that are only relevant to practice in England and marks them accordingly.

## LMCs AND THE NEW COMMISSIONING STRUCTURES

- A 133. DONCASTER That conference is deeply concerned by a number of CCGs who have failed to engage LMCs in matters concerning GPs and demands that CCGs recognise and engage LMCs as the statutory representative body of local GPs.

## GP EDUCATION AND TRAINING

- AR 134. KENT That conference believes that work experience in general practices is a valuable way to inspire young people to become GPs.

- A 135. BRADFORD AND AIREDALE That conference calls on the GPC to negotiate with Health Education England to make a placement in general practice mandatory for all hospital specialties in order to increase understanding and respect of the workload in general practice, and that this is accompanied by an appropriate transfer of funding.
- A 136. DEVON That conference believes that UK qualified (MRCGP attained) GPs returning from working abroad in an equivalent appraisal monitored healthcare system (e.g. Australia, New Zealand) should not be penalised by having imposed retraining on their return.
- A 137. THE GPC That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee: The conference believes that good quality GP training programmes make good GPs, not simply the length of training, and calls on COGPED to ensure that before any extension to training is introduced the educational content of all training posts be made explicit to trainees prior to commencement of training (e.g. by the use of Form Bs).

## INFORMATION MANAGEMENT AND TECHNOLOGY

- A 138. KENT That conference views with alarm the inadequate funding of practice IT and the effect that this has on the efficient provision of GP services.
- AR 139. AVON That conference calls on GPC to instruct the Department of Health and NHS England to only remove pre-existing IT systems when new systems are fit for purpose.
- A 140. LIVERPOOL That conference believes that opening up medical computerised records to online access for individual patients has significant pitfalls particularly to the vulnerable and is open to exploitation.
- A 141. BRENT That conference believes that software interoperability is of critical importance to effective integrated care, and calls upon NHSE to:
- (i) affirm the GP System of Choice framework
  - (ii) ensure that practices are able to properly exercise their right to choose.

## MEDICAL INDEMNITY

- A 142. MANCHESTER That conference looks into the problems encountered by GPs obtaining defence cover and explores solutions with defence unions.

## CLINICAL AND PRESCRIBING

- A 143. SCOTTISH CONFERENCE OF LMCs That conference believes that there should be a simple fast-track system for obtaining oxygen for palliative care patients who would benefit from it.
- A 144. WILTSHIRE That conference accepts that GPs are not grocers and have no role in prescribing foodstuffs and that this requirement should be lifted.
- A 145. KENT That conference believes that a named doctor for over 75s without a supporting primary care team is like the emperor and his new clothes.
- A 146. HAMPSHIRE AND ISLE OF WIGHT That conference believes that the work involved in respect of acute prescribing and monitoring repeat prescriptions (and the resulting responsibility for this) is not reflected in current funding.
- A 147. WILTSHIRE That conference asserts the rights of all patients to NHS prescriptions, whether being treated on the NHS or privately.
- A 148. LIVERPOOL That conference believes that the continued stream of ever changing targets in disease management detracts from excellent holistic patient care.
- A 149. NORTH ESSEX That conference deplores the repeated and potentially dangerous shortages of a variety of commonly used medicines, and urges GPC to insist that appropriate action be taken by the Department of Health to control or regulate such behaviour by the pharmaceutical industry.
- A 150. DEVON That conference is aware that in Scotland, Wales and Northern Ireland there is funding that makes the drugs and therapeutic bulletin accessible by all GPs. This is not the case in England. We ask the GPC to discuss with NHS England how this inequality can be rectified so this well regarded publication can be available free of charge to all UK GPs.
- A 151. MID MERSEY That conference believes that there is no justification for patients receiving thyroid replacement therapy to continue to receive other prescriptions free of charge.
- A 152. MID MERSEY That conference believes that there is need for a radical overhaul of prescription charges in the United Kingdom.
- A 153. DEVON That conference believes that the current prescription charge in England is:
- (i) inequitable compared with the other home nations
  - (ii) often higher than the cost of the drug concerned, representing an illness tax on decent hard-working people
  - (iii) is costly to administer and demands that it is scrapped.

## PRIMARY AND SECONDARY CARE INTERFACE

- A 154. MORGANNWG That conference demands that it should be the professional responsibility of hospital practitioners who request investigations to interpret and act on the tests even if it means communicating directly with the patients, rather than dumping the task onto the patient's GP.
- A 155. GLASGOW That conference supports closer working between GP and secondary care colleagues when designing clinical services and calls on governments to direct health boards to facilitate this.
- A 156. MID MERSEY That conference deplors the off-loading of secondary care into primary care with no accompanying resources.
- A 157. CORNWALL AND ISLES OF SCILLY That conference believes there should be no further shift of work from secondary to primary care unless there is a commensurate shift of resources to fund it.
- A 158. SUFFOLK That conference believes that resources should accompany workload, so a transfer of work from secondary care to primary care requires a transfer of resource. The conference demands that NHS England does not allow any more transfer of work to general practice until they can implement a robust way to transfer funds.
- A 159. BROMLEY That conference is concerned about the transfer of responsibilities from secondary to primary care without adequate resources being put in place to support the undertaking of additional work by GPs and practice staff.
- A 160. BIRMINGHAM That conference instructs GPC to negotiate changes to regulations to make it explicit that:
- (i) there is no requirement for practices to register any patient who is an in-patient in any hospital
  - (ii) there is no requirement for practices to provide any NHS primary medical services to their registered patients whilst they are in-patients in any hospital
  - (iii) appropriate services outside of NHS primary medical services arrangements must be in place to meet the primary medical care needs of all hospital in-patients.

## OCCUPATIONAL HEALTH

- A 161. LEEDS That conference is alarmed at the rising rates of GPs suffering stress and burnout and calls on departments of health working with relevant national bodies to:
- (i) recognise the seriousness of the problem
  - (ii) commission research to quantify and understand the problem
  - (iii) put in place locally available services to support GPs suffering stress and burnout.
- A 162. BORDERS That conference calls on the government to accept the ever increasing stress and workload in primary care and take urgent action to rectify the problem.

## RURAL PRACTICE SUSTAINABILITY

- A 163. CORNWALL AND ISLES OF SCILLY That conference demands GPC negotiate changes to the dispensing regulations to enable all GPs to be able to dispense to all their patients.
- A 164. LINCOLNSHIRE That conference believes that the current dispensing regulations, which prevent dispensing practices from dispensing to patients who live within 1.6km of a pharmacy, are both anti-competitive and also anti-choice. Conference thus urges the GPC to negotiate a level playing field for dispensing and non-dispensing practices, to be able to provide dispensing services to all patients who desire to use them.
- A 165. SUFFOLK That conference demands that NHS England implements a fair system of reimbursement for dispensing doctors as soon as possible.
- A 166. WELSH CONFERENCE OF LMCs That conference appreciates that with the advent of extensive generic prescribing, the dispensing clawback deal is outdated and urges GPC UK to negotiate a dispensing contract that reflects this.
- A 167. SUFFOLK That conference demands that NHS England implements EPS Release 2 for dispensing practices as soon as practically possible.
- A 168. KENT That conference demands NHS England implements EPS Release 2 for dispensing practices as soon as possible.
- A 169. LANCASHIRE COASTAL That conference believes that it is inherently unfair and prejudicial to the success of dispensing practices and the needs of their patients that there is no software available to such practices to implement the electronic prescribing service.
- A 170. NORFOLK AND WAVENEY That conference asks the GPC to negotiate a fair reimbursement system that takes account of changes to category M pricing.

## PUBLIC HEALTH

- A 171. SEFTON That conference calls for greater and effective engagement by local authority public health teams with general practice in the creation and conduct of local public health campaigns.
- A 172. NOTTINGHAMSHIRE That in view of the increasing mortality associated with liver disease in the UK the Government should compel supermarkets and the drinks industry to promote and support the costs of primary prevention of liver disease.
- A 173. DEVON That conference deplores the abandoning of minimum pricing on alcohol and calls on the GPC to:
- (i) put more pressure on the government to reconsider their decision and keep to an election promise
  - (ii) expose the government meetings with the alcohol industry
  - (iii) produce and publish the evidence for minimum pricing to the nation with a media campaign.
- A 174. LIVERPOOL That conference believes that it would be in the interests of patients' general health if there was the introduction of minimum unit pricing for alcohol.
- A 175. SEFTON That conference calls for greater transparency of local public health budgeted expenditure.

## INFLUENZA

- A 176. GLOUCESTERSHIRE That conference is concerned that in many parts of the country midwives are unable to administer flu vaccinations to pregnant women, largely for bureaucratic reasons, and urges the GPC to negotiate for a more seamless flu immunisation campaign for 2014.
- A 177. BRADFORD AND AIREDALE That conference believes that to effectively deliver the expanding influenza vaccine campaign the provision of the vaccine earlier in the year would allow practices to better plan and manage this important public health matter.
- A 178. BEDFORDSHIRE That conference calls on GPC to ensure that agreements between public health departments and pharmacists for the delivery of flu vaccinations do not jeopardise existing GP flu vaccination services and thereby put vulnerable patients at risk.

## COMMUNITY SERVICES

- A 179. WAKEFIELD That conference would support increased resourcing of district nursing teams whose role is essential in the current drive to maintain patients care closer to home. These should also be managed in the community rather than by acute hospital trusts as this leads to a dilution of the service.
- A 180. GLASGOW That conference believes that housebound patients needing care best provided by a nurse should be seen by community nurses and not practice nurses or GPs.
- A 181. LIVERPOOL That conference believes that the speed of progressing the shift from hospital based to community based services is detrimental to patient well being and is putting an unsustainable strain on general practice and community services.
- A 182. SOUTH ESSEX That conference supports constructive engagement with community pharmacists in order to:
- (i) improve patient experience in primary care
  - (ii) help reduce preventable prescription related disease (PPRD)
  - (iii) share the burden of the rising work load in general practice.

## SAFEGUARDING

- A 183. ENFIELD That conference demands that additional funding be given to deal with safeguarding issues to ensure a safe and proper immediate response.
- A 184. LEWISHAM That conference calls upon GPC to demand that the government provide greater support and resources for GPs to help them undertake vital work relating to child protection issues.

## REVALIDATION

- A 185. BEDFORDSHIRE That conference calls on GPC to ensure that, for the benefit of both doctors and patients, appraisal is
- (i) less time-consuming
  - (ii) less stressful
  - (iii) consistent, and
  - (iv) neither bureaucratic nor 'tick-box'.
- A 186. CORNWALL AND ISLES OF SCILLY That conference demands responsible officers (ROs) stop imposing local conditions and training requirements for appraisal above those required for revalidation unless specifically negotiated by GPC.
- A 187. NORTH YORKSHIRE That conference has grave concerns regarding the inconsistency of standards being applied in respect information requirements for medical appraisal.

- A 188. NORTH AND NORTH EAST LINCOLNSHIRE That conference believes that GP appraisal has become a box-ticking exercise and ignores the original concept that it should be about personal development and asks the GPC to clarify the function of appraisal with NHS England.
- A 189. OXFORDSHIRE That conference believes that the current appraisal system is a tick-box exercise that fulfils no useful purpose and wastes resources that could be better spent on GP education, and calls for it to be radically modified or scrapped.
- A 190. LIVERPOOL That conference believes that the process of appraisal which was initially viewed as being developmental has become a tick sheet exercise with a barbed wire whip.
- A 191. GLOUCESTERSHIRE That conference protests the national appraisal policy, which denies retired GPs and locums acting as appraisers the extra funding received for superannuation by other appraisers, as discriminatory, illogical and irrational, and demands that it be challenged.
- A 192. WEST SUSSEX That conference believes NHS England proposed GP appraisers contract was ill-thought through and undermined the GP appraisal process.
- A 193. SALFORD AND TRAFFORD That conference believes that current revalidation processes are:
- (i) not fit for purpose
  - (ii) do not provide adequate assurance to the public
  - (iii) and as they are a waste of overstretched time resources, add to the GP workforce crisis.
- AR 194. BERKSHIRE That conference recognises the value of a robust system of appraisal and revalidation with good quality appraisers and appraisal leads and calls on the GPC to:
- (i) draw attention to the fact that the workload involved in being an appraisal lead has not been adequately recognised or remunerated
  - (ii) press NHS England to seek independent assessment of the workload involved in the appraisal lead role and to remunerate it appropriately.

## CARE PATHWAYS

- AR 195. OXFORDSHIRE That conference recognises the contradiction GPs face in on the one hand being pressurised to reduce referrals and on the other hand being criticised for not referring patients quickly enough (eg for possible cancer) and asks the GPC to articulate how difficult it is to reconcile such polarised objectives and encourage politicians and commentators to take a more considered approach in its dealings with primary care.
- AR 196. MID MERSEY That conference believes that often life is over medicalised and the general public should be able to access lifestyle services without the need of a medical referral.
- A 197. NORTHAMPTONSHIRE That conference insists that, unless the referring GP requests otherwise, the report from the hospital should be personally addressed to the GP who made the referral.
- A 198. HERTFORDSHIRE That conference notes the ever increasing incidence of patients with outstanding investigations being discharged back into the community and calls on GPC to work with other branches of practice to highlight the dangers of this behaviour.
- A 199. DUMFRIES AND GALLOWAY That conference believes that patient safety is paramount when a GP is considering referral to a consultant and particularly when referring an ill patient for assessment. Patient safety takes precedence over any referral management initiatives.

## MEDICAL CERTIFICATES AND REPORTS

- AR 200. COVENTRY That conference believes that the fees paid for copy of records (£17.00) and medical reports (£33.50) for First Tier Tribunals of the HM Courts and Tribunal Service are insulting and result in GPs subsidising this service, and demand that the GPC negotiate appropriate level of fees.
- A 201. GLASGOW That conference in regard to firearms and shotgun certificates, believes that GPs should not be asked for a medical opinion on the fitness of an individual to hold a firearms or shotgun license.
- A 202. DERBYSHIRE That conference warns the government that the ever increasing problem of access to general practice is being exacerbated by the ever increasing misuse of the Data Protection Act by commercial organisations, such as insurance companies and solicitors, to acquire at minimal cost information that they need to progress their business objectives.

## PATIENT REGISTRATION

- A 203. CITY AND EAST LONDON That conference believes that geographically defined practice areas are essential to the delivery of high quality, multi-disciplinary primary care. Conference opposes all attempts to remove practice boundaries.
- A 204. MID MERSEY That conference believes that lifting restrictions on practice boundaries is a political gimmick which will:
- (i) put patients at risk
  - (ii) prove very difficult and expensive to manage.

- A 205. MID MERSEY That conference believes sadly dual registration is a bridge too far.
- A 206. MERTON, SUTTON AND WANDSWORTH That conference believes that the current list cleansing process is not fit for purpose and calls upon NHSE to develop a process suitable for a 21st century lifestyle.

# Agenda: Part II

## (Motions not prioritised for debate)

### WORKLOAD AND PATIENT SAFETY

207. DERBYSHIRE That conference in the context of austerity rejects the intellectually idle assertions of the ilk that “we are all in this together” or “we have to work smarter” or “it is in the patients best interests” as forms of emotional blackmail to induce GPs to undertake unresourced work, bearing the expenses of such work from their take home pay, and requires GPC to take actions to educate accordingly.
208. SALFORD AND TRAFFORD That conference deplores the push for general practice in the Greater Manchester area to deliver additional work, as part of the Primary Care Strategy of Healthier Together – without the necessary resources being in place of workforce, funding and adequate premises.
209. DERBYSHIRE That conference insists that the GPC initiates a campaign against unresourced, uncontracted workload dumping on GPs and to this end develops an educational package for GPs to identify such activity and provides a toolkit to counter such activity.
210. LIVERPOOL That conference believes that GP practices are having to produce numerous policies, that have little to do with improving patient care, to satisfy both NHS England and CQC.

### COMMISSIONING OF CARE

211. EALING, HAMMERSMITH AND HOUNSLOW: That conference deplores the policy of NHS England to undertake all new primary care contracting through APMS and calls upon the GPC to:
- (i) highlight the detrimental impact this will have on continuity of care and other aspects of patient care
  - (ii) resist any interference with the freedom of practice of potential new entrants to general practice
  - (iii) affirm doctors’ rights to practice as independent contractors.
212. SHEFFIELD That conference believes the quality premium for CCGs:
- (i) is unfit for purpose as it encompasses elements completely beyond the control of CCGs
  - (ii) should have the elements linked to secondary care withdrawn.
213. BEDFORDSHIRE That conference supports greater clinical leadership within the NHS but believes that the perverse incentive of the national tariff can only lead to a failure of CCGs
214. REDBRIDGE That conference demands that NHS England stop pressurising the CCGs not to properly scrutinise acute trust invoices and that CCGs are given complete autonomy to manage these contracts as they see fit.
215. CITY AND EAST LONDON That conference is dismayed by the inconsistency of remuneration for CCG clinical leads and the way in which they are paid, and requests that NHS England:
- (i) agrees that remuneration should recompense properly for the specialist time working at a CCG
  - (ii) agrees that clinical commissioning leads and clinical leads should have a job description, contract, regular appraisals and funded training (commensurate with the clinical lead role)
  - (iii) that GPs should not be salaried through a CCG but as a contractor along with any other contractor providing a services to the CCG.
216. NORTH YORKSHIRE That conference believes that if the current CCG model of commissioning is to survive a structured programme of support and succession planning needs to develop to encourage new GP involvement.
217. DEVON That conference is concerned that CCGs are using too broad an interpretation of business confidentiality laws to limit public access to parts of their board meetings.
218. LEWISHAM That conference asks that NHS England provide evidence on whether the £3.8bn Better Care Fund will achieve one of its stated aims of reducing demand on A&E services.
219. DEVON That conference demands an answer to the question: Clinical senates - Why? We request that any useful suggestions are e-mailed to: [wedonotreallyknowwhatwaredoing@nhs.england](mailto:wedonotreallyknowwhatwaredoing@nhs.england).
220. MERTON, SUTTON AND WANDSWORTH That conference calls upon NHSE to improve its dialogue with GPs through a facilitative approach.
221. GATESHEAD AND SOUTH TYNESIDE That conference believes that the future CCG allocation formula should be based upon health outcomes and not on the simple process of the numbers of patients and use of hospital services. If not, then money will be taken from areas of poor health and given to areas of better health thus promoting health inequalities.

222. DEVON That conference recognises that meeting the Nicholson challenge can be achieved only by increased investment in general practice and community services. Conference therefore calls for the Secretary of State to direct every CCG to increase the percentage of its total budget spent on local contracts by 1% per annum for the next five years.
223. MERTON, SUTTON AND WANDSWORTH That conference believes that PCTs should be brought back to replace NHSE and CCGs and calls upon the government to instigate this change.
224. WILTSHIRE That conference supports moves to greater integration and instructs the GPC to ensure four nation provision: including ensuring CCGs, commission community nursing and health visiting, services that are fit for purpose.

## GOVERNMENT

225. BEXLEY That Conference believes that the Secretary of State for Health's duty to provide universal comprehensive publicly funded care through the NHS must continue.
226. HULL AND EAST YORKSHIRE That conference notes that politicians believe that 'in perpetuity' is synonymous with 'temporarily', and demands that GPDF provide them with a copy of The Shorter Oxford English Dictionary. In future, if extra-dictionary definitions of words are to be used in agreements or negotiations this is to be indicated:
- (i) in writing, by the use of Comic Sans font
  - (ii) verbally, by unilateral blepharospasm
  - (iii) verbally, by bilateral flexion of the elbows, pronation of the forearms, and repeated flexion and extension of the interphalangeal joints of the index and middle fingers.
227. DEVON That conference recognises that commissioning as outlined in the HSCA has little evidence base and has led to an expensive, unnecessary upheaval in the NHS. These changes were driven by political ideology. The main political parties were dishonest with the electorate by not publishing their plans in their manifestoes. In effect the medical profession was politically out-manoeuvred. To prevent this reoccurring in the future and recognising there will be a general election in 2015 we request that:
- (i) any future white paper proposals should be voted on at an early stage by all GPs
  - (ii) there is opportunity for clear messages from grass roots to leadership of GPC to occur regularly throughout any major negotiating process.
228. DEVON That conference was distressed to see the Environment Agency blamed for the recent floods and demands the politicians and media blame GPs as they normally do for the countries problems.
229. DEVON That conference notes the alarming fragmentation and division of previously well-oiled functions within the NHS, and calls on the Secretary of State to champion a culture of common sense between agencies in an attempt to rectify this problem.
230. SOMERSET That conference deplores the fact that mental health trusts in England are being directed to make savings of 20% more than acute trusts from already underfunded budgets, and instructs the GPC to expose the hypocrisy this implies for the government's stated policy of equating the importance of physical and mental health.
231. NORFOLK AND WAVENEY That conference believes the clinicians in the North Staffordshire tragedy have taken far too much of the, which in truth should lie at the door of government policy of target setting and cost control.

## REGULATION, MONITORING AND PERFORMANCE MANAGEMENT

232. NORTH YORKSHIRE That conference believes that the NHS reorganisation has failed to liberate local clinicians as the micromanagement of CCGs is no less than the old PCTs and additional controls from Monitor, CQC, ombudsman are imposing more regulatory burden and cost on practices.
233. COVENTRY That conference deplores the haste with which PCOs use every performance issue as an excuse to embark on a trawling exercise.
234. DERBYSHIRE That conference insists that, in respect of out of hours providers and their CQC inspections, if a sessional GP has been appraised and revalidated within their daytime practice environment then it is unnecessary to repeat the process for the out of hours service.
235. EAST MIDLANDS REGIONAL COUNCIL That conference insists that if a sessional GP has been appraised and revalidated within their daytime practice environment then it is unnecessary to repeat the process for the out of hours service, and calls upon the GMC to support this position.
236. SALFORD AND TRAFFORD That conference regards the subsidising of the CQC by general practice as wholly iniquitous and demands that GPC pursue a much more aggressive stance in opposing it and ensuring all necessary funding for its functions are met from general taxation.
237. AVON That conference believes that CQC:
- (i) remains not fit for purpose
  - (ii) is a huge waste of money
  - (iii) seeks to promote itself as an organisation rather than promoting good quality and safe medical practice
  - (iv) should be abolished.
238. DERBYSHIRE That conference demands the abolition of the CQC as a wasteful duplication of the regulation of general practice.

## ACCESS

239. WEST PENNINE That conference deplores the further thinning of an over stretched workforce to create the illusion of comprehensive 8-8 \*7 care.
240. NORFOLK AND WAVENEY That conference asks GPC to work on a standard 111 template that is clear, concise and clinically safe.
241. MANCHESTER That conference demands NHS 111 and out of hours services reduce the length of their feedback report and include a summary sheet of the consultation and outline the actions for the GP.
242. NORFOLK AND WAVENEY That conference asks the GPC to negotiate that the current 111 system is fined when transferring inadequately triaged work onto an already overworked primary care, ambulance service and A&E departments in its current risk averse model.
243. BRADFORD AND AIREDALE That conference demands that the government stops scapegoating GPs for the problems in A&E departments and:
- (i) simplifies the accessing of urgent care to GP, 111 and 999
  - (ii) supports clinicians to divert patients who do not need to be seen in A&E to more clinically appropriate settings.
244. COVENTRY That conference is perturbed by some communications from Dr David Geddes of NHS England and insists that the GPC provide him with a copy of all relevant regulations and provide him with free training.
245. NORTHUMBERLAND That conference believe government insistence on raising expectation in a resource limited service is ethically indefensible and creates clinical risk.
246. HAMPSHIRE AND ISLE OF WIGHT That conference recognises urgent care GPs as valued colleagues, requiring a different skill set to in hours GPs and thus additional support and training.
247. MID MERSEY That conference believes that the multi publicised rise in Accident and Emergency (A&E) attendances were a direct result of NHS 111.
248. GATESHEAD AND SOUTH TYNESIDE That conference believes that, whilst accepting that the principle of NHS 111 is reasonable, the way that it has been introduced has led to a service with clinical concerns regarding patient safety that has:
- (i) increased face-to-face consultations;
  - (ii) increased the number of inappropriate cases going to A&E, out-of-hours organisations and walk-in centres;
  - (iii) clinical concerns regarding patient safety especially in those complex patients who present with more than one main symptom.
249. LEEDS That conference reminds government and the media that whilst some patients raise concern about the difficult of making an appointment to see a GP, over 300 million people successfully achieve this every year.

## FUNDING

250. LANCASHIRE PENNINE That conference believes that the existing arrangements for the provision of the core general medical services contract with NHS England are:
- (i) already under severe pressure through rising workload with reducing funding and manpower
  - (ii) developing a false illusion that doing extra work for the CCGs will somehow make the core contract workload easier
  - (iii) placing a severe strain on an already overstretched manpower resource
  - (iv) subjecting practices to a plethora of performance and monitoring scrutiny.
251. LANCASHIRE COASTAL That conference believes that the role of CCGs in commissioning health care and improving the quality of primary care is being compromised by the shifting of work from NHS England area teams to CCGs without any commensurate shifting of resources.
252. CENTRAL LANCASHIRE That conference believes that at a time of increasing genuine demand on GP's time, a wholly unnecessary extra burden is being imposed by the fragmentation of services being commissioned along dis-integrated patient pathways, leading to increased risk of elements of services being missed and forcing GPs to make less efficient use of their time, acting as the referral link or gap-filling when they could be seeing patients in need of medical care.
253. BRENT That conference believes that current funding for general practice cannot match increasing demand and recognises that there is little evidence that walk in units provide continuity of care, clinical efficacy and value for money, and requests that CCGs reallocate funds from these units in order to support general practice on which the primary care transformation agenda depends.
254. NORTHUMBERLAND That conference supports a redistribution of CCG funding that is currently heavily based on age population and therefore perversely results in a drain from north to south funding.
255. BARKING AND HAVERING That conference believes that NHS England increasingly promoting pharmacists to do more clinical work (health check, immunisation, COPD and asthma etc) will affect practices financially.
256. GLOUCESTERSHIRE That conference requires, given the ever more demanding requirements for staff to be trained in ever more complex procedures, that the GPC seeks an uplift in the global sum to assist with these costs.

257. AYRSHIRE AND ARRAN That conference insists that health boards increase funding into primary care to resource service development and training for primary care staff.
258. SHROPSHIRE That conference regrets the apparent reluctance of NHS England to provide the discretionary help to practices hitherto forthcoming from most PCTs and, on the basis that reimbursement levels were set at a time such help was available, asks the GPC to negotiate an appropriate increase in payments to practices.
259. WILTSHIRE That conference believes that funding for health and social care needs to come from one pot.
260. DERBYSHIRE That conference demands that resources be made available up front when the Department of Health, NHS England or other agencies sends to practices electronically information that needs to be produced as hard copy for patients.
261. BEDFORDSHIRE That conference deplores the continuous and disproportionate reductions in funding that University GP surgeries (or GP surgeries that provide services directly to UK universities) receive, as a result of the way that GMS and PMS budgets are implemented. It calls for an immediate investigation to ascertain :  
 (i) how much funding has been lost to this section of general practice  
 (ii) the reductions in services to students being provided if any  
 (iii) why it has been possible for these vulnerable providers to have been destabilised as a result of contract negotiations that did not protect this minority group  
 and calls for the creation of a working party within GPC to look at the plight of such surgeries.
262. BEDFORDSHIRE That conference recognises that age, prevalence and deprivation on their own are not universally appropriate tools to calculate health need or GP funding arrangements, and calls for :  
 (i) public recognition by the Departments of Health and the GPC that university students have their own unique set of health needs when compared to other population demographics that are not resourced or supported  
 (ii) the recognition that GP funding arrangements as negotiated actively discriminate against, and destabilise GP services that are provided in and to universities and their students  
 (iii) urgent strategies to be implemented to prevent further damage to university GP services, and repair the damage already done.
263. NEWCASTLE AND NORTH TYNESIDE That conference believes that:  
 (i) the new English NHS funding allocation for CCGs will mean that the more affluent and healthier south-east will benefit at the expense of the poorer and less healthy north  
 (ii) his shift in funding will lead to a widening of health inequalities within England.
264. SEFTON That conference condemns the behaviour of NHS England in engaging in a strategy of piecemeal cuts to reimbursements to general practice and funding of supporting services - trade waste charges reimbursement and occupational health services being just two examples.
265. DONCASTER That conference is appalled that NHS England have chosen to withdraw discretionary payments for the disposal of trade waste and calls upon the GPC to safeguard future remuneration to practices for the disposal of waste associated with the business of carrying out NHS general practice.
266. DARTFORD GRAVESEND AND MEDWAY DIVISION That conference questions the nationwide and locality wise disparity in the allocation of global sum payments when there is a standard GMS contract.
267. LINCOLN DIVISION That conference:  
 (i) believes investment in primary care will reduce demand on secondary care and lead to better patient outcomes  
 (ii) is concerned that funding to General Practice as a share of the total NHS budget has fallen every year since 2006 whilst practice expenses and workload have greatly increased so that General Practice now has grossly insufficient resources and capacity to meet safely the current and future needs of patients  
 (iii) welcomes the RCGP's "Put Patients First: Back General Practice" campaign and instructs the BMA to lobby the Health Departments to increase funding to General Practice in real terms.

## PENSIONS

268. BUCKINGHAMSHIRE This conference believes that:  
 (i) the 'day of action' in 2012 was a disaster that harmed the BMA's negotiation position, partly because it stopped short of full strike action  
 (ii) a full strike can be a legitimate way forward in disputes with government  
 (iii) a full strike including a complete refusal to work is not unethical for doctors  
 (iv) when necessary the membership has to be balloted on all options including full strike action.
269. WIRRAL That conference calls on government to demand that there is an absolute guarantee on the NHS pension entitlement in view of the fact of increases in employee contribution rates towards pensions.
270. HERTFORDSHIRE That conference believes that if pension changes were the nail in the coffin of workforce retention, then the removal of seniority is the six feet of earth on top and calls on GPC to uphold the principle of rewarding experience.
271. SEFTON That conference opposes the increased superannuation contributions which are to be borne by the profession and other health service workers; this is little more than a poll tax on doctors and health service staff to pay for a deficit caused by the financial sector.

## PREMISES

272. DERBYSHIRE That conference demands an urgent revision to the 2013 Premises Costs Directions to address, inter alia, the issues of trade waste, stamp duty land tax, rent review processes and premises valuations and requests GPC to act accordingly. (Supported by EAST MIDLANDS REGIONAL COUNCIL)

## GP PAY

273. HULL AND EAST YORKSHIRE That conference accepts the publication of GP incomes, but insists that this must be in a form that enables true comparisons with other public sector workers, and so must be adjusted with respect to confounding factors including:
- (i) premises
  - (ii) superannuation
  - (iii) dispensing
  - (iv) training
  - (v) medical indemnity and locum insurance
  - (vi) private income
  - (vii) hours in excess of 37.5 per week.
274. CUMBRIA That conference deplores the redistribution of seniority payments as it is contrary to the normal rules of rewarding long service and experience, which is standard practice not just in the NHS but in most employment.
275. CAMDEN That conference deplores the reduction of seniority payments as this is unjust and unfair and calls upon the GPC to negotiate their restitution with NHS England.

## GP PARTNERSHIPS AND FEDERATIONS

276. CHESHIRE That conference believes that government and NHS England policies are designed to kill off the partnership model of provision of general medical services.
277. GRAMPIAN That conference recognises the benefits of the GP partner model of practice above large private healthcare companies with salaried GPs, but is concerned that some very large practices with few partners and high numbers of salaried GPs make this distinction blurred and more difficult to argue against greater involvement of the private sector.

## THE MARKET / PRIVATISATION

278. DEVON That conference is aware that there is still no evidence that a competitive market in healthcare will make the NHS fairer, better, or cheaper.

## GPC SCOTLAND

279. BORDERS That conference believes that health boards should fund cover for protected learning time for primary health care teams to:
- (i) encourage learning
  - (ii) allow networking opportunities
  - (iii) reduce isolation and help with stress management.

## SESSIONAL GPs

280. CITY AND EAST LONDON That conference notes that the plethora of different contracts, whether salaried or 'self-employed', now available to GPs including those undertaking a portfolio career can be confusing and can lead to an unintentional loss of previously available employment benefits. Conference calls on all NHS employers or employers contracting to the NHS to provide clear written information about whether the post is eligible for the NHS pension scheme, whether pay is pensionable, whether sickness and maternity benefits are payable and who is liable for employer and employee contributions. Conference calls on GPC to negotiate the reinstatement of eligibility of those providing NHS general practice services to the NHS pension scheme and ensure eligibility for sickness and maternity benefit.
281. MID MERSEY That conference deplores the cessation of funding to sessional GPs for their time spent in preparation of their appraisals.
282. BIRMINGHAM DIVISION That conference insists that locum and freelance GPs should be paid by the NHS for preparing for and undertaking NHS appraisals.

## OTHER MOTIONS 1

283. WILTSHIRE That conference advocates that a sustained effort should be made to share simple systems / templates and ways of running GP surgeries that can be rolled out across practices in similar areas / with similar IT systems in place and instructs the GPC develop or work with NHS England and equivalent bodies to provide appropriate resourcing.
284. DERBYSHIRE That conference calls for ambulance services to be required to report on missed target times in terms of total times by which targets have been missed as well as by percentage of calls where targets have been missed.

285. SCOTTISH CONFERENCE OF LMCs That conference is concerned that some food banks are demanding that people have to be referred to them by GPs before they are given support.
286. GLASGOW That conference is concerned that some foodbanks are demanding that people are referred to them by GPs before they are given support.
287. DONCASTER That conference recognises that England, Scotland and Northern Ireland are not 'Londonland' and calls upon the GPC to remind national policy makers that policies modelled upon behaviours of the London populace are unlikely to be useful across the rest of the UK and as such, require local influence.
288. MANCHESTER That conference revisits the Health and Social Care Act (HSCA) to ensure there are no further errors or changes that have not already been identified.
289. AVON That conference demands that GPC highlights, exposes and deplores bullying wherever it occurs and believes that:
- (i) bullying in the NHS will continue until politicians and senior NHS managers acknowledge their own role in creating a bullying culture
  - (ii) such behaviour by ministers and senior managers is as unacceptable in them, as it is in all others
  - (iii) those in a position of leadership should undertake to lead by example and to model respect, kindness and empathy
  - (iv) the Department of Health should promote the well-being of all staff in the NHS and
  - (v) the making of such an undertaking should be a prerequisite for anyone accepting political or senior office within the NHS.
290. NORFOLK AND WAVENEY That conference insists that if Scotland votes for independence that Norfolk is allowed to align themselves with Holland from where many of its constituents originally emanate from.
291. SOUTH ESSEX That conference kindly requests that professional courtesy is restored to communication with GPs.
292. SOUTHWARK That conference believes that many of the targets which have been imposed are unattainable and are prejudicial against high prevalence and low social class and calls upon such targets to be removed or adjusted to take prevalence and factors such as social class into account.
293. WIGAN That conference recognises with admiration, and salutes with applause, the unstinting dedication and ability of practice managers, and their teams, who have coped astoundingly in sustaining an extremely high level of operational effectiveness in general practice during a year of unrelenting demands and changes- CQC standards and inspections; new and uncertain QOF data gathering systems; the introduction of remote and demanding NHSE area teams; CCG expectations for locality meetings expectations. and on and on.....
294. HARINGEY That conference demands and requires that LMCs not only be consulted on proposals for RCGP guidelines but that any proposal must be approved by LMCs on the basis that only LMCs are the only truly elected and representative body of all GPs.
295. CAMDEN That conference believes that a system based on targets undermines the quality of care for patients.
296. CAMBRIDGESHIRE That conference calls on the GPC to make GPs aware that they will still be held to account, by CQC and others, for all services provided for patients, regardless of whether or not what they are doing is commissioned, contracted or funded.
297. MANCHESTER That conference investigates the legality of local procurement processes and produces advice.
298. WILTSHIRE That conference asks the GPC to support and publicise the ability of nurses with relevant experience and training to be able to complete DNAR forms where appropriate.

## PRIMARY CARE WORKFORCE

299. HERTFORDSHIRE That conference believes that general practice has reached crisis point and calls on GPC to:
- (i) insist that governments allow GPs to see and treat patients without political interference
  - (ii) resist any attempt by governments to control or dictate consultation length.
300. NOTTINGHAMSHIRE That conference, while welcoming recent guidance on handling GP performance concerns by NHS England area teams, calls on NHS England to realise that adequate funds are needed to:
- (i) pay for the time of GPs who sit on performers' list decision groups and performance screening groups and to train them in their roles
  - (ii) support a network of practices equipped to host remedial training for performers needing assessment, supervision and retraining.
301. KENT That conference instructs GPC to negotiate reciprocal recognition of national performers lists to enable the free movement of GPs to work across the UK.
302. LINCOLN DIVISION That conference believes there is a need for reciprocal recognition of national performers' lists to enable the free movement of GPs to work across all four nations within the UK and instructs the BMA to lobby for legislation to be amended to allow this.
303. NORFOLK AND WAVENEY That conference asks GPC to negotiate a change in formal title from general practitioner to consultant in primary care so that we are perceived both by politicians and the public on a par with our secondary care colleagues.

304. GLASGOW That conference believes it is time to rebrand general practitioners as 'consultants in primary care'.
305. SOUTHWARK That conference is concerned that good clinicians are being lost to management positions and calls upon the GPC and NHSE to review and compare the salaries being paid to managers and those of clinicians.
306. WIRRAL That conference notes that the NHS needs to focus more attention into making other specialties more flexible for men and women who have family commitments instead of criticising female doctors for choosing part time general practice; this may mean employing larger numbers of doctors but on a more part time basis.
307. CORNWALL AND ISLES OF SCILLY That conference believes there are too many women in general practice, and the lack of testosterone is having a negative effect on our profession.
308. THE GPC That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
The conference is appalled by constant references to 'women' and 'pregnancy' being the source of all workforce problems in general practice and states that men are equally responsible for the pregnancy.
309. BIRMINGHAM That conference believes that there is a need for reciprocal recognition of national performers lists to facilitate the free movement of GPs to work across all UK administrations and instructs GPC to negotiate legislation changes to allow this.
310. COVENTRY That conference insists that any review of Working Time regulations do not reverse the health and safety protections provided by the current arrangements for salaried GPs and GP trainees.
311. NORTHAMPTONSHIRE That conference regrets the trend towards over emphasis of academic qualifications in the training schedules for nurses and health care assistants to the detriment of practical caring capabilities. (Part 2)
312. SALFORD AND TRAFFORD That conference expresses concern that GPs may all soon be employees of foundation trusts.
313. AVON That conference recognises that there has been a recruitment and retention crisis within general practice, in part due to the inequality of access to and provision of maternity and paternity benefits most notably between GP registrar training and sessional GPs and calls on GPC to:
- (i) investigate inequalities of working benefits between GPs including but not limited to maternity rights, paternity rights
  - (ii) develop recommendations that can be implemented for GPs in salaried or partnership posts .
314. BRISTOL DIVISION That conference recognises that there has been a recruitment and retention crisis within General Practice and believes this is in part due to inequality of access and provision of maternity and paternity benefits for working most notably between GP registrar training and sessional GPs and calls on the BMA to:
- (i) investigate inequalities of working benefits between different groups of GPs including but not limited to maternity rights and paternity rights
  - (ii) develop recommendations based upon this information that can be implemented for GPs in salaried or partnership posts
  - (iii) produce recommendations for employers based on their findings.
315. NORTH STAFFORDSHIRE That conference believes that the general practice nurse recruitment and retention crisis is:
- (i) a reality, and in some areas of the country already acute
  - (ii) leading existing staff to seek better pay and conditions by applying for jobs in other local practices
  - (iii) driving up costs to practices due to pay and conditions competition amongst practices
  - (iv) driving up costs to practices as nursing staff often have to be recruited from outside general practice - resulting in training costs.
316. WEST PENNINE That conference is concerned with the wide-spread myth of federations giving the UK GP workforce any more manpower.
317. DERBYSHIRE That conference reminds all concerned that general practitioners are family physicians and not universal practitioners!
318. DERBYSHIRE That conference:
- (i) insists that the constitution of and operating procedures of performers list decision panels and professional advisory groups to be set up by NHS England must conform with the principles of natural justice and
  - (ii) urges the directors of General Practitioners Defence Fund to consider, whenever appropriate, mounting of a judicial review if the principles in part (i) are breached at any time.
319. REDBRIDGE That conference advocates that GPs are the forefront of primary care and that allied health professionals provide services that support primary care.
320. NORTH STAFFORDSHIRE That conference believes that the current state of general practice endangers the health of general practitioners.

## CONTRACT NEGOTIATIONS

321. MID MERSEY That conference believes that there should be only one GP contract for general practice across the UK.
322. HULL AND EAST YORKSHIRE That conference has serious concerns about the risks to GPs' long-term interests should areas enter into local permanent variations of national GMS contracts.

323. DERBYSHIRE That conference requests GPC to negotiate an enhancement to global sum payments to cover the cost to practices of contacting patients who:
- (i) attain the age of 16 to explain to them their rights in respect of data sharing schemes such as the Summary Care Record, the Spine and care.data
  - (ii) attain the age of 75 to inform them of their named doctor.
324. SHEFFIELD That conference calls for a reimbursement of monies lost from the ill thought out imposition of the 2013 / 14 QOF changes in the 2014 / 15 contract adjustment.
325. HULL AND EAST YORKSHIRE That conference requests that the government acknowledges:
- (i) that primary care is working above and beyond the capacity for which it is historically funded, and
  - (ii) that it recognises the principle established in the 2004 contract of no new work without new money.
326. GLASGOW That conference calls on GPC to negotiate a list of national enhanced services with sensible pricing and bureaucracy for the enhanced services which are common throughout the UK.
327. WALTHAM FOREST That conference is astounded by the short-sightedness of NHSE in developing the specifications for DES. That conference demands that NHSE review the evidence referenced in all DES specifications and ensure that they are relevant and appropriate to primary care and not just utilising inappropriate secondary care guidance.
328. LAMBETH That conference deplores the fact that practices do not receive additional payments in relation to temporary patient activity and calls upon the GPC to negotiate an agreement whereby services provided to temporary patients are claimable by way of a quarterly return of activity as an item of service payment.
329. LIVERPOOL That conference believes that the concept of a named GP for 75 year olds and over should be extended to the whole population, for continuity of care and development of faith and trust in the profession.
330. CORNWALL AND ISLES OF SCILLY That conference believes GPs should be able to sell goodwill and asks the GPC to negotiate the ability to do so.
331. SUFFOLK That conference request the GPC to seek ministerial assurances that sale of goodwill within NHS primary care is regulated and equitable regardless of the vendor.

## THE FUTURE OF GENERAL PRACTICE AND THE NHS

332. DEVON That conference believes that GPC should collate information regarding the national picture of GP provider organisations and become a useful resource for areas in which no such organisation exists.
333. SOUTHWARK That conference believes that the requirement for practices to set up structures in order to bid for services detracts from their ability to continue to provide good medical care.
334. WALTHAM FOREST That conference believes that NHSE should realise that the loss of DES in primary care will result in the de-skilling of GPs, worsening of patient care and an increase in secondary care costs.
335. BRO TAF That conference calls for the UK governments to:
- (i) introduce a fair mechanism to resource care for growing populations
  - (ii) recognise that normalisation compounds the problems caused by growing populations by unfairly reducing resources
  - (iii) better recognise the pressure of high list turnover, especially if combined with list growth by, for example, implementing an enhanced service over and above the Carr Hill formula weighting.
336. HULL AND EAST YORKSHIRE That conference insists that government is honest with the public about the funding shortfall in the NHS, including falling allocations formulae, QIPP, and CIPs. Meaningful change in the NHS is hampered by government sending one message to the public (demand more) and a different one to the NHS (spend less). It is time the government came clean with the public and should initiate meaningful, open and honest dialogue with the public about what should and what should not be provided on the NHS.
337. DORSET That conference believes patients should be given a notional bill, on one given day, outlining the cost of drugs prescribed, the cost of out patients appointments etc.
338. WILTSHIRE That conference proposes a new patient information service which includes a notional bill for things that might include the cost of non-attendances or certain interventions or medicines.

339. BIRMINGHAM That conference:
- (i) believes that general practice has grossly insufficient resources and capacity to meet safely the current and future needs of patients, let alone the ever-increasing bureaucratic workload and politically induced demands on the service
  - (ii) believes that the campaign of constant negative media attention contributes to very low GP morale, which is enormously damaging to the profession and the NHS as a whole
  - (iii) notes that funding to general practice since 2006 has been virtually frozen and fallen in real terms and that general practice's share of the total NHS budget has fallen year on year throughout this period whilst practice expenses and workload have risen enormously
  - (iv) believes that plans to shift further work from hospitals to general practice are simply undeliverable without significant new investment in core general practice first and that such investment will both pay for itself through reduced demand on secondary care and lead to better patient outcomes
  - (v) commends the RCGP's 'Put patients first: Back general practice' campaign and instructs the GPC to do everything in its power to ensure the required increase in funding to general practice is delivered.
340. CLEVELAND That conference fully recognises that changes in medical care and practice are often appropriate and:
- (i) insists that change should be evidence based
  - (ii) insists that pilots are properly analysed to seek evidence of benefit
  - (iv) demands that proper consideration is given to assessing unintended consequences.
341. AVON That conference calls upon GPC to inform government that their chances are running out and that once general practice disintegrates, the whole NHS will irredeemable.
342. SEFTON That conference welcomes the growing general recognition that collaboration and co-operation not market completion is the best way of organising and delivering health care services. It calls upon NHS England to cease referring to patients as 'customers' and plans and policies as 'customer solutions'.

## QUALITY AND OUTCOMES FRAMEWORK (QOF) AND QUALITY INDICATORS

343. DERBYSHIRE That conference recognises the importance of the huge public health gains from the fall in teenage pregnancies in the last few years and that:
- (i) one of the principal drivers has been the increased use of LARCs
  - (ii) the QOF has probably had an important role in fostering this change in practice
  - (iii) that con003 should continue in the QOF, and, if necessary, at the loss of con002.

## 344. GENERAL PRACTITIONERS COMMITTEE

345. DEVON That conference believes that due to the advent of local contract deals:
- (i) the role of regional GPC representatives is even more important and attendance at regional LMC meetings should be funded by GPDF as part of their role
  - (ii) GPC should act in an advisory capacity to those areas considering local contract deals.
346. GLOUCESTERSHIRE That conference believes the GPC's voice should be heard at regional LMC meetings, and therefore proposes that at each regional LMC meeting at least two GPC regional members should attend, such attendance being paid for by the GPC if they are not already attending in their capacity as LMC members.
347. KENT That conference requires the GPC to implement existing policy to develop a distinctive, easy to find GPC website and:
- (i) widely publicise its existence and content
  - (ii) for it to contain a discussion forum
  - (iii) publish statistics of its use in the Annual Report.
348. MANCHESTER That conference requests that BMA updates the current listservers to ensure historical items can easily be found and researched.
349. DEVON That conference would like to congratulate the GPC negotiators on the way they listened to conference 2013 and altered their modus operandi.
350. BERKSHIRE This conference congratulates the GPC on electing a new Chairman and further recognising the diversity of British general practice.
351. HERTFORDSHIRE That conference is sorely disappointed at the failure of GPC to ensure adequate funding for safeguarding in general practice is made available despite the passing of motion 69 at last year's conference.

## PUBLIC RELATIONS

352. NORTH STAFFORDSHIRE That conference believes that the GPC should form a social media unit to deal with public relations, championing and defending general practice.

353. DEVON That conference is aware that a lot of NHS work is created by sloppy journalism leading to misreporting of medical facts. Conference directs GPC to:
- (i) produce a draft journalistic code requiring that NNT and ARR are included in any media report based on a RRR
  - (ii) work with the RCGP to establish a course for journalists to help them understand medical statistics to the extent that they could interpret and understand the importance of results
  - (iii) work with RCGP to establish a Royal College accredited qualification in medical statistics reporting with the aim of it becoming an industry standard.

## LMCs AND THE NEW COMMISSIONING STRUCTURES

354. DEVON That CCGs are mandated to look after population healthcare. LMCs exist to represent, inform, support and lead individual GPs and their practices. It is not possible to have a senior role in both organisations as this will inevitably lead to a conflict of interest. We ask conference to:
- (i) recognise, support and enforce this
  - (ii) advise LMCs to appropriately redirect GPs seeking support due to issues relating to their CCG role (as we do for GPs employed in community hospitals).

## GP EDUCATION AND TRAINING

355. NORTH YORKSHIRE That conference believes that the present training recommendations for general practitioners to undergo CPR training are excessive, do not represent value for money and the professional time involved could be better employed.
356. DERBYSHIRE That conference demands an end to the practice within the appraisal system that requires a GP to undertake on an annual basis a series of courses in particular subjects. Such a policy is incompatible with lifelong self directed learning.
357. NORFOLK AND WAVENEY That conference asks that more educational support needs to be provided for final year trainees and newly qualified GPs to enable them to contribute to OOH care.
358. BRADFORD AND AIREDALE That conference notes that GP training and examinations should better prepare trainees for consultations dealing with multiple presenting complaints and QOF work. The current CSA exam of a surgery of patients each presenting with one problem is no longer fit for purpose.
359. NORTH STAFFORDSHIRE That conference believes that the regional deanery mechanism for accessing specialist training excessively preserves the centre of regions to the detriment of their peripheries. This is producing local hot spots of recruitment crisis and is not equitable or safe.
360. THE GPC That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
The conference demands that every GP trainee be given:
- (i) a personal study budget per year with a clearly specified sum that cannot be used for mandatory training
  - (ii) a specified number of personal study days which the trainee can use to better their training experience, that should not be part of mandatory training
  - (iii) private study days to prepare for the mandatory examinations of the training program.
361. THE GPC That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
That conference is concerned about deficiencies in the information available to guide informed choices amongst prospective GP trainees, and therefore calls on education providers to guide them on which GP training programmes to apply for. In order to allow GP trainees to make an adequate comparison between GP training programmes this conference calls on education providers to:
- (i) make public the quantity of teaching sessions available to GP trainees in each hospital speciality placement
  - (ii) publicise the proportion of available teaching sessions GP trainees actually attend
  - (iii) publicise the anonymous feedback gathered during these teaching sessions.
362. WALTHAM FOREST That conference is concerned that since the re-organisation of the NHS, key educational functions that were previously being funded by the PCT are no longer being funded. Conference demands clarification on who is responsible for providing this essential training and that these organisations re-instate this training as a matter of urgency.
363. THE GPC That the GPC seeks the views of conference on the following motion from the GP trainees subcommittee:  
The conference recognises that a number of GP trainees have demonstrated potential but fail to progress in their training programme. We call upon Health Education England (and equivalent bodies in the devolved nations) and COGPEd to:
- (i) increase the extension period of GP training in line with other speciality training programmes to 12 months
  - (ii) ensure that trainees are not pressured to take the exams before they are adequately prepared
  - (iii) clarify their position on extensions to GP training and instruct LETBs to not to limit extension of training to part time or shorter periods due to financial constraints
  - (iv) provide support for doctors who experience difficulties at ARCP with structured support tools
  - (v) proactively engage at an early stage, with doctors who at risk of being released from GP specialty training programmes, including guidance and support in securing further employment well in advance of the termination of their training contracts.
364. SOMERSET That conference notes the need to ensure that training for general practice is cost effective and believes that all relevant foundation year experience should be credited for GP training purposes.

365. DEVON That conference believes that detailed feedback should be provided to any candidate not achieving a pass mark in the MRCGP CSA examination.
366. NORTHAMPTONSHIRE That conference insists that GPs remain in the NHS for 10 years after completion of training, and are required to repay a proportion of their training expenses if they emigrate to work as a GP in another country during this time.
367. WALTHAM FOREST That conference congratulates the LETBs on beginning to develop formalised training for practice nurses and primary care HCAs. Conference welcomes investment to improve training of all allied health professionals in primary care and believes that this will improve recruitment.
368. MERTON, SUTTON AND WANDSWORTH That conference believes that there is a lack of good practice nurses and calls for joined up training for practice nurses to make it a valued training pathway
369. DERBYSHIRE That conference believes that the annual training demands concerning safeguarding, information governance and other matters are disproportionate and are detracting from patient service delivery and mandates GPC to negotiate a more sensible position on such matters.

## INFORMATION MANAGEMENT AND TECHNOLOGY

370. COVENTRY That conference believes that the current requirement for multiple separate passwords for software used in general practice is inappropriate and conversely leads to reduced security, and insists that all:
- (i) GP clinical systems and supportive national or local software can be logged into using the NHS Smartcard or by user alterable password
  - (ii) GPSoC software is mandated to include the ability to log on using the NHS Smartcard, or by user alterable password
  - (iii) passwords must be subjected to the same requirement for frequency of renewal.
371. COVENTRY That conference believes that NHSmail must continue to provide general practices with a centrally funded SMS service to enhance patient services and reduce inequality of access when communicating with patients whose hearing is impaired or for who English is not their first language.
372. HERTFORDSHIRE That conference is concerned about the possibility of mandating the use of video-technology in the consulting room and calls on the GPC to ensure that:
- (i) the feasibility of this is fully investigated before it is rolled out
  - (ii) it is fully resourced before being progressed any further.
373. NORTH AND NORTH EAST LINCOLNSHIRE That conference believes that portfolio doctors, including sessional and locum doctors, are disadvantaged as NHS mail has not lived up to the initial concepts and expectations of providing an email address for life and asks the GPC to negotiate an improvement so that doctors who take a break from the NHS can remain connected.
374. DEVON That conference respectfully requests that the RCGP alters their new eportfolio so that it fits within a standard computer screen.
375. SHEFFIELD That conference calls for a national solution to the current problem of patient consent for health professionals involved in their care to view their records.
376. SCOTTISH CONFERENCE OF LMCs That conference welcomes the proposed pilot of GP2GP in 2014 as this is long overdue.
377. COVENTRY That conference is concerned that Data Subject Access requests under the Data Protection Act remain an excessive cost pressure to general practices and that their scope for use has expanded beyond what was initially intended and insists that the GPC liaise with the ICO and:
- (i) clarify and produce guidance regarding scope of requests
  - (ii) negotiate flexibility to give option that where the cost of producing the report would otherwise be greater than the maximum charge, of either charging more than the current limit, or offering the data subject or their representative to examining the record in the surgery.
378. CHESHIRE That conference believes that the withdrawal by certain IT providers of the capacity to measure consulting volumes in general practice will have an adverse affect on workforce planning and access in the future.
379. LIVERPOOL That conference believes that once computerised medical records are available to view online, it will not be long before a programme is developed enabling alteration of clinical records.
380. DEVON That conference recognises that there are many potential IT solutions that could make the NHS more efficient, transparent and accessible. However we ask that any negotiated IT innovations specifically exclude e-mail consultations.
381. DEVON That conference has considerable concerns about the decreasing number of GP computer system providers and the need to guard against the creation of a monopoly in this area.
382. GRAMPIAN That conference is dismayed that some areas are still unable to provide reliable clinical IT systems for general practice, and calls for the establishment of more robust national standards to allow safe, reliable and timeous access to these essential systems.

383. HARINGEY That conference requests that the financial penalties for delays in all GP software providers contracts be changed to 30 minutes rather than 16 hours (which is equivalent to two working days).

## MEDICAL INDEMNITY

384. BIRMINGHAM That conference believes that arrangements for medical indemnity cover cause unacceptable difficulty for some GPs and that GPC should do all it can to ensure that reasonably priced, affordable medical indemnity cover is available to all GPs, including those who are unable to obtain it through the usual medical defence organisations.
385. TOWER HAMLETS DIVISION That conference notes that hospital doctors are protected from litigation for NHS work by Crown Immunity, obviating their need to buy expensive medical defence insurance. This Meeting calls for General Practitioners to be similarly protected.

## CLINICAL AND PRESCRIBING

386. GLASGOW That conference believes the changes in the supply of oxygen to patients have adversely affected the availability of oxygen in emergencies in GP practices and:
- (i) is concerned that practices are only able to obtain the emergency drug oxygen by purchasing themselves
  - (ii) believes that oxygen for use in emergencies should be available to all GP practices free of charge.
387. SCOTTISH CONFERENCE OF LMCs That conference believes the recent changes in the supply of oxygen to patients have adversely affected the availability of oxygen in emergencies in GP practices. This conference believes that oxygen for use in emergencies should be available to all GP practices free of charge.
388. SOMERSET That conference is concerned that the trend to provide or encourage the purchase by patients of self-monitoring medical equipment increases patient anxiety and demand, and may be counter-productive.
389. BEDFORDSHIRE That conference believes that the role of the community pharmacist in repeat prescribing requires better control and regulation to prevent wasteful over-ordering and dispensing by pharmacists and calls on the GPC to produce a standard operating procedure to safeguard against this.
390. SOUTH ESSEX That conference agrees that all GP practices should be in possession of a working automated external defibrillator (AED).
391. BRADFORD AND AIREDALE That conference calls on government to introduce a scheme where a patient's nominated pharmacist can provide small quantities of paracetamol to them at appropriate intervals if they are entitled to free prescriptions, subject to agreement from, and an appropriate level of reimbursement for, the pharmacy profession.
392. MORGANNWG That conference calls upon GPC to negotiate a change to the regulations that would allow a practice to supply services such as long acting reversible contraception to patients of another practice where the service is not available and to prescribe items relevant to the supply of the service for those patients.
393. LOTHIAN That conference believes that GPs should be able to prescribe a pedometer on a GP10 to effectively promote exercise.
394. DERBYSHIRE That conference demands that resources be made available up-front to enable practices to upgrade their refrigeration capacity when appropriate each time a new national immunisation program is implemented.
395. BUCKINGHAMSHIRE Because it poses a risk to safe clinical care, conference rejects the centrally imposed target in England that everyone referred to a specialist with breast symptoms should be seen within two weeks of referral by a GP, and requests that this target be removed without further delay to bring England into line with other nations within the UK.
396. SOMERSET That conference believes that the Government request to NICE to consider 'wider societal benefit' in its decisions on the approval threshold for the treatment of individual patients is dangerous and divisive, and calls upon the GPC to resist any such proposals.

## PRIMARY AND SECONDARY CARE INTERFACE

397. COVENTRY That conference demands the GPC negotiate a nationally enforceable tariff that practices can recharge secondary and tertiary care providers for undertaking their work, including arranging follow up investigations, chasing results and providing fitnotes.
398. BRO TAF That conference insists that it is made clear to patients that appointments for secondary care cannot be expedited without significant alteration of the clinical picture and secondary care clerical staff should inform patients who query the waiting times accordingly.
399. OXFORDSHIRE That conference believes practices and LMCs should make a stand on the tendency of hospital employees to dump work on practices without knowledge of the GP contract or ensuring resources are in place to take on extra-contractual work.

400. SOUTHWARK That conference calls upon the GPC to collaborate with its relevant counterpart craft committee(s) which represent secondary care clinicians to work towards developing better ways of working including virtual clinics between different specialists and primary care in relation to complex patients which would:
- (i) assist GPs to obtain a consultant generalist opinion
  - (ii) reduce the number of attendance at out patient departments.
401. EAST MIDLANDS REGIONAL COUNCIL That conference rejects the assumption that General Practitioners are peripatetic community house officers, there to do the bidding of any other NHS or government organisation, and reminds all concerned that, except in an immediate clinical emergency, GPs are obligated only to perform tasks which they are:
- (i) contracted to undertake;
  - (ii) resourced to provide;
  - (iii) rewarded for performing
- and demands that the BMA takes action accordingly to promulgate and enforce these messages at all times.

## PUBLIC HEALTH

402. WEST SUSSEX That conference believes that its GP delegates should practise the healthy lifestyles that they promote to their patients.
403. MID MERSEY That conference would like to encourage all GPs to refrain from alcohol for the month of January 2015 to send a serious message to the public on the health implications of drinking.
404. NORTHAMPTONSHIRE That conference feels that non-medical genital mutilation of babies and children conflicts with a child's right to autonomy and physical integrity. [European Human Rights].

## INFLUENZA

405. MID MERSEY That conference deplores public health England's meddling in the flu vaccination delivery by primary care.

## COMMUNITY SERVICES

406. DEVON That conference recognises that disputes over whether patients come to the GP surgery or are treated at home by district nurses is a problem encountered throughout the UK. We ask the GPC negotiators to put an end to these local arguments by prioritising this issue and so ensuring a workable definition of what exactly constitutes a 'housebound' patient is available for conference 2015.
407. LOTHIAN That conference believes that there should be NHS audiology services on the high street - analogous to optometry ones - to provide a wider, better and more local service, particularly in view of our ageing population.
408. BEDFORDSHIRE That conference believes that the success of the unplanned admissions DES is dependent on the resources and responsiveness of social services and others beyond the control of GPs and calls on GPC to ensure that no GP practice is penalised due to the shortcomings of their local authority.

## SAFEGUARDING

409. GLOUCESTERSHIRE That conference requires an authoritative rebuttal of the rumour that a level 3 safeguarding qualification is a prerequisite for passing CQC inspections and personal appraisals.
410. DEVON That regarding safeguarding training, conference:
- (i) recommends to GPs that keeping up to date in this area is good medical practice
  - (ii) would like to promote the pro-active approach currently in operation in Devon
  - (iii) acknowledges that it is not a requirement for revalidation.
411. DEVON That conference recognises that safeguarding issues are important and applauds the work of all CCGs and GPs in improving how these cases are dealt with. However in some areas safeguarding has become inappropriately synonymous with 'not my problem over to you'. We ask the GPC to produce clear guidance for auxiliary medical service providers to ensure:
- (i) ambulance crews do not inappropriately label cases as 'safeguarding issues'
  - (ii) the correct patients are identified by the correct bodies
  - (iii) safeguarding teams are not swamped by difficult to solve social problems.

## REVALIDATION

412. NORFOLK AND WAVENEY That conference calls upon GPC to recognise the burden of revalidation on older GPs nearing retirement and negotiate alternative arrangements so these GPs are not lost to the workforce purely because of demands of bureaucracy.
413. NORFOLK AND WAVENEY That conference calls upon GPC to renegotiate annual appraisal and revalidation requirements which have become increasingly arduous and time consuming.
414. LEEDS That conference insists that GPs should be able to choose their appraiser from an approved local list of GP appraisers.

415. GLASGOW That conference is concerned that NHS boards are withdrawing existing access to GP appraisal by introducing arbitrary minimum session requirements and calls for:
- (i) a nationally agreed minimum requirement of work undertaken in general practice settings by which an individual GP would be entitled to be appraised under the Scottish GP appraisal scheme
  - (ii) this agreed minimum requirement to have an evidence base either in maintenance of skills or availability of clinical governance information, or in the absence of this, to be agreed by all major stakeholders
  - (iii) any minimum requirement to be implemented only with reasonable notice to allow GPs to make any necessary adjustment to their working pattern
  - (iv) the impact of the imposition of this minimum requirement on the GP workforce to be monitored
  - (v) this minimum requirement to be applied equally to GP contractors and sessional GPs
  - (vi) the impact of this unilateral and potentially demoralising action to be offset by evidence of commitment from boards to assist sessional GPs in their efforts to maintain skills and learn from clinical governance information.
416. BEDFORDSHIRE That conference believes that the RCGP tail is wagging the GP appraisal dog and instructs GPC to get this creature back on a proper lead.

## CARE PATHWAYS

417. NORTHAMPTONSHIRE That conference insists that when GPs are obliged to request special funding approval for certain referrals, the decision of the named arbiters is copied to the patient in clear laymen's terms.
418. BRO TAF That conference insists it must be a hospital/NHS trust requirement for receivers of referrals not to alter the priority without discussion with the referrer.
419. DEVON That conference recognises the lack of any evidence that the additional work, bureaucracy and costs that referral management centres impose on GPs is of any benefit to the efficient functioning of the NHS. We ask the GPC to:
- (i) request formally that the Department of Health properly evaluates whether these centres really do represent value for money for the tax payer
  - (ii) recognise that CCGs who currently commission them cannot be asked to properly evaluate them as there are many who now sit in CCGs who were, or still have, commercial and/or professional interests in these bodies
  - (iii) communicate clearly to politicians and CCG board members that no real money is saved if a referral does not take place until such reduced rates lead to hospital budgets falling.

## MEDICAL CERTIFICATES AND REPORTS

420. SURREY That conference believes the training of disability employment advisers should be improved.
421. ENFIELD That conference demands that those public bodies requesting data from primary care should be supplied with a standardised simple format claim form.
422. ENFIELD That conference demands that GPs responding to public body requests for information, such as OFSTED, should respond through a standardised letter.
423. MID MERSEY That conference believes a GP's role in support of Personal Independence Payment (PIP) claims should be limited to a factual account of existing medical conditions.
424. MID MERSEY That conference deplores the actions of some travel assistance companies:
- (i) who despite taking premiums, refuse to provide health assistance without a GP medical report which they then refuse to pay for
  - (ii) and asks the GPC to negotiate an approved fee with the insurance industry.
425. DEVON That conference is aware that in the future there will be a different process by which documentation and legal requirements prior to cremation are collated. We welcome the reduced bureaucratic burden for GPs. However we would like to request that the new regulations:
- (i) properly pay GPs for any work they have to do for the medical examiner
  - (ii) ensure any work required from GPs by the medical examiner is collected in a professional and truly auditable manner
  - (iii) recognise that 'heart failure' can be a cause of death and not solely a 'mode of death' as the current cremation forms state.
426. MID MERSEY That conference believes that third parties requesting computer printout encounter reports:
- (i) should not do so without proper clinical justification
  - (ii) often do so without patient consent, inviting a breach of confidentiality
  - (iii) should not need to do so where the National Summary Care Record has been rolled out
  - (iv) calls on the GPC to develop guidance for practitioners on how to deal with such requests.

# CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

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# CONFERENCE OF REPRESENTATIVES OF LOCAL MEDICAL COMMITTEES

## STANDING ORDERS

### Conferences

#### Annual conference

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

#### Special conference

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

### Membership

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

### Representatives

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

### Observers

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

### Interpretations

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

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

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

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

### **Suspension of standing orders**

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

### **Agenda**

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

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

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

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

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

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

## Procedures

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

## Rules of debate

36. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.
37. Every member of the conference shall be seated except the one addressing the conference. When the chairman rises, no one shall continue to stand, nor shall anyone rise, until the chair is resumed.
38. A member of conference shall address the chairman and shall, unless prevented by physical infirmity, stand when speaking.
39. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.
40. Members of the GPC, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.
41. The chairman shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.
42. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.
43. The chairman shall take any necessary steps to prevent tedious repetition.
44. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.
45. Amendments shall be debated and voted upon before returning to the original motion.
46. Riders shall be debated and voted upon after the original motion has been carried.
47. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 44, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.

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

## **Allocation of conference time**

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

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

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

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

### **Quorum**

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

### **Time limit of speeches**

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

### **Voting**

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

## Majorities

68. Except as provided for in standing order 48 and 49 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:
- 68.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC structure, or
  - 68.2 a decision which could materially affect the GPDF Ltd funds.
69. Voting shall be, at the discretion of the chairman, by a show of voting cards or electronically. If the chairman requires a count this will be by electronic voting.

## Recorded votes

70. If a recorded vote is demanded by 20 representatives at the conference, signified by their rising in their places, the names and votes of the representatives present shall be taken and recorded.
71. A demand for a recorded vote shall be made before the chairman calls for a vote on any motion, amendment or rider.

## Elections

72. Chairman
- 72.1 At each conference, a chairman shall be elected by the members of the conference to hold office from the termination of the BMA's annual representative meeting (ARM) until the end of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
  - 72.2 Nominations must be handed in on the prescribed form before 12 noon on the first day of the conference with any election to be completed by 4.00pm. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
73. Deputy chairman
- 73.1 At each conference, a deputy chairman shall be elected by the members of the conference to hold office from the termination of the ARM until the termination of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
  - 73.2 Nominations must be handed in on the prescribed form before 9.30am on the second day of the conference with any election to be completed by 12 noon. Nominees may enter on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
74. Seven members of the General Practitioners Committee
- 74.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. For six of the seats any registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, whether a member of the conference or not, is eligible for nomination providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. All GPs on the retainer scheme, and medically qualified LMC secretaries, are eligible for nomination regardless of their level of commitment to providing or performing NHS primary medical services. For the seventh seat, only an LMC representative at conference may be nominated, and that LMC representative must never have previously sat on the GPC. This LMC representative must also be a registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. The members elected will serve on the GPC from the conclusion of the following ARM until the conclusion of the ARM one year thereafter. Only representatives shall be entitled to vote.
  - 74.2 Nominations must be handed in on the prescribed form, by 1.00pm on the first day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word. Elections, if any, will take place on the second day of conference and be completed by 10.00am.
  - 74.3 The GPC shall be empowered to fill casual vacancies occurring among the elected members.
75. Seven members of the conference agenda committee

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

## **Returning officer**

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

## **Claire Wand award**

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

### **Motions not debated**

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

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

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

### **Mobile phones**

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

### **The press**

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

### **No smoking**

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

### **Chairman's discretion**

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

### **Minutes**

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

General Practitioners Committee

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