

2022 Annual Conference of England LMC representatives

Thursday 24 November 2022

Building Safe Practice



Conference of England LMC Representatives

Agenda

To be held on

Thursday 24 November at 10.30

[Friends House, 173-177 Euston Road, London NW1 2BJ](#)

Chair Shaba Nabi (Avon)

Deputy Chair Elliott Singer (Waltham Forest)

Conference Agenda Committee

Shaba Nabi (Chair of Conference)

Elliott Singer (Deputy Chair of Conference)

Paul Evans (Gateshead and South Tyneside)

Matthew Mayer (Buckinghamshire)

Simon Minkoff (Manchester)

Zoe Norris (Yorkshire)

Roger Scott (Liverpool)

Members of the England LMC Conference Agenda Committee 2022

Dr. Shaba Nabi



Chair of the Agenda Committee

Dr. Elliott Singer



Deputy Chair of the Agenda Committee

Dr. Paul Evans



Member of the Agenda Committee

Dr. Matt Mayer



Member of the Agenda Committee

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NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 8 September 2022. Although 8 September 2022 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 emailed to the secretariat via the LMC conference inbox which is info.lmcconference@bma.org.uk by 9am on Monday 21 November.

The agenda committee has acted in accordance with standing orders to prepare the agenda. A number of motions are marked as those which the agenda committee believes should be debated within the time available. Other motions are marked as those covered by standing orders 24 and 25 ('A' and 'AR' motions – see below) and those for which the agenda committee believes there will be insufficient time for debate or are incompetent by virtue of structure or wording. Under standing order 19, if any local medical committee submitting a motion that has not been prioritised for debate objects in writing before the first day of the conference, the prioritisation of the motion shall be decided by the conference during the debate on the report of the agenda committee.

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

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

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

While the Agenda Committee has done the best job it can of prioritising motions for debate in the normal way, avoiding where possible existing policy, we know that some of the motions not prioritised for debate are also important to you, and you can use the chosen motions ballot form to nominate motions from Part 2 of the Agenda which you would like to see debated at the appropriate time during the conference. The online system will also be used to allow representatives to vote for their three preferences in advance. Further details will be sent to representatives nearer to the conference. The ballot for chosen motions is open and will close at 9am Monday 21 November – [please click here](#).

CONFERENCE OF ENGLAND LMCs ELECTIONS

The following elections will be held on Thursday 24 and Friday 25 November 2022.

Chair of conference

Chair of conference for the session 2022-2023 (see standing order 63) - nominations will be open at noon on Thursday 17 November and closes at 2pm on Thursday 24 November 2022.

Deputy chair of conference

Deputy chair of conference for the session 2022-2023 (see standing order 64) - nominations will be open at noon on Thursday 17 November and closes at 2pm on Thursday 24 November 2022.

Five members of LMC England conference agenda committee

Five members of the England conference agenda committee for the session 2022-2023 (see standing order 65) - nominations will be open at noon on Thursday 17 November and closes at 2pm on Thursday 24 November 2022.

How to take part

When nominations open, eligible representatives may nominate themselves using the following link: <https://elections.bma.org.uk/>.

To take part in elections you must have a BMA website account. This can be created using the following link: <https://www.bma.org.uk/about-us/about-the-bma/bma-website/bma-website-help>. Registration for a temporary account is about half way down the page.

Voting opens for all positions: 3pm on Thursday 24 November 2022

Voting closes for all positions: 3pm Friday 25 November 2022

Results announced soon after voting closes.

The reason for closing the vote after the first day of conference is to ensure representatives are able to focus on engagement on what we anticipate will be an intense day for all those participating.

It is strongly recommended that representatives obtain a BMA website account in advance of conference to ensure there are no complications

Update on motions from Conference of England LMCs 2021

	Motion	Update
	Interface	
(5)	<p>That conference recognises the negative impact that inappropriate transfer of workload from secondary care to primary care is having on GP morale and recruitment and calls on GPC England to negotiate with NHSEI for a nationally funded hospital discharge review system that will:</p> <ul style="list-style-type: none"> (i) prevent contractually inappropriate requests (ii) help develop new discharge pathways appropriate to care in the community (iii) include an educational element for all clinicians (iv) create more clinical dialogue between primary and secondary care. <p>Proposed by Alistair Bradley, Sheffield</p> <p>Carried</p>	<p>The BMA has been involved as an advisory stakeholder in the production of soon-to-be-released guidance from NHS England on issues of medico-legal responsibility and clinical responsibility, which will address many of the issues GPs have faced around referrals using electronic referrals, where one of the primary issues reported by GPs has been inappropriate transfer of workload from secondary care to primary care.</p> <p>The BMA has particularly focused on the importance for systems to support more clinical dialogue between primary and secondary care, and has pushed NHS England to address elements of systems which do not support clinicians speaking with each other to help resolve issues more efficiently.</p> <p>The BMA also updated our Controlling workload in General Practice strategy, which provides practical advice on the control of workload, addressing the common factors usually involved.</p> <p>GPCE have developed flow charts for various pathways to prevent workload transfer and are planning to get these agreed by Consultants Committee and Academy of Medical Royal Colleges.</p>
	Advice and guidance	
(6)	<p>That conference is concerned about a lack of cohesion between general practice and secondary care and calls on GPC England to ensure that:</p> <ul style="list-style-type: none"> (i) GPs cannot be mandated to use advice and guidance by commissioners or providers (ii) GPs should be free to refer to a secondary care colleague when thought to be clinically necessary, without pre-referral interference (iii) if advice and guidance is used, then it is to be the role of secondary care, not general practice, to dispense the advice to patients and prescribe where appropriate. <p>Proposed by Jen Moss Langfield, Nottinghamshire</p> <p>Part (i) carried unanimously Parts (ii) and (iii) carried</p>	<p>The BMA has been involved as an advisory stakeholder in the production of soon-to-be-released guidance from NHS England on issues of medico-legal responsibility and clinical responsibility, which will address many of the issues GPs have faced around referrals using Advice and Guidance.</p> <p>The BMA has continued to be clear that the usage of Advice and Guidance should be voluntary and should not be mandated by local systems or by NHS England.</p> <p>GPCE has responded to NHSEI's proposed expansion of A&G during Operational Meetings with GPCE preventing this unresourced expansion</p>

	Motion	Update
	Consultants in general practice	
(7)	<p>That conference sees Integrated Care Systems as having the potential to support the general practice workload crisis so calls on GPC England to explore with NHSEI changes to the performers' list regulations to allow consultant staff to deliver care within general practice.</p> <p>Proposed by Katie Bramall-Stainer, Cambridgeshire</p> <p>Carried as a reference</p>	<p>The GMC announcement for Primary Care doctors is a step in this direction and conversations with NHSE and GMC will take place to discuss the principle of doctors working general practice not the GP register (including consultants). An update is due to be received at the GPC UK meeting in December and GPCE representatives are attending the RCGP council meeting in November to be involved in their discussion about this.</p>
	Integrated Care Systems (ICS)	
(8)	<p>That conference recognises that GP representation in the new Integrated Care Systems is unclear and variable and demands that GPC England negotiate with NHSEI that:</p> <ul style="list-style-type: none"> (i) all Integrated Care Systems should outline how they will enable LMCs to carry out their statutory role (ii) there should be no mandated limit on the number of general practice representatives on both NHS and Place Boards and general practice alone should decide who represents them within an ICS (iii) national funding for GPs roles in system and place leadership be made available (iv) funding must be ring fenced for enhanced services that are currently commissioned from general practice through locally commissioned services (v) where collaboration and streamlining of pathways involves work transferring to general practice from secondary care, funding and resource follows from funding previously aligned to secondary care budgets. <p>Proposed by David Herold, Worcestershire</p> <p>Carried</p>	<p>GPCE and the BMA have been explicit that GP representation on ICSs – specifically on ICBs (Integrated Care Boards) – must be enhanced. This has included a direct call to ensure LMCs have formal roles/recognition within the 42 different ICB structures.</p> <p>We lobbied for this representation to be included in statute via the Health and Care Act. The Act does secure a single guaranteed primary care clinical representative on every ICB – which is typically expected to be a GP – and allows for ICBs to directly recognise LMCs. However, we still believe that the representation of general practice on ICBs is insufficient and that additional roles, including for LMCs, are required.</p> <p>Recent BMA analysis of all 42 ICB constitutions has found that very few make any formal provision for LMC involvement – though additional arrangements may have been made directly with LMCs. This indicates that ICBs are failing to engage with LMCs adequately and is something the BMA has been highlighting with NHSE and ICBs directly.</p> <p>GPCE has also been clear that in order for clinical involvement within ICBs to be effective, those taking up the roles need to be supported to do – including via funding and time. NHSE guidance on clinical leadership – which the BMA influenced - does reflect this and notes that support should be available for clinical leaders to take time away from their day-to-day roles.</p> <p>GPCE always remains adamant that GP and primary care budgets should be protected within ICBs and is monitoring ICB funding decisions closely. Likewise, we are monitoring and responding to work transfers within ICBs closely.</p>

	Motion	Update
	NHS 111	
(10)	<p>That conference, with respect to NHS 111:</p> <ul style="list-style-type: none"> (i) believes that general practice is not an emergency service and cannot safely receive one / two hour dispositions from NHS 111 services and demands that these stop (ii) recognises that it has become a conduit for patient flow, causing delays to ambulance services, A&E departments and NHS general practice for non-urgent issues (iii) calls for its wholesale review so that protocols, staffing, and funding are fit for purpose (iv) demands that all direct NHS 111 bookings into NHS general practice are suspended where an OPEL4 / Red alert (or equivalent) has been declared by the practice. <p>Proposed by Peter Holden, Derbyshire</p> <p>Carried</p>	<p>NHS 111 may presently directly book into GP appointment slots to a maximum of 1 appointment per 3000 patients. This originated in from July 2019. While these are into booked slots, it is for the practice to decide how to manage these patients, and they should be re-triaged by the practice. However, in April 2020, as a result of the Covid pandemic, temporary changes were made to the requirement and GP practices were told to free up at least 1 appointment in every 500 to NHS 111 direct booking. This remained in place until 30 June 2021.</p> <p>When we updated GPC England in February 2022, it was made clear that NHSEI would continue to discuss the practical implementation of direct booking from NHS 111 into EA hubs with GPC, as well as other IT requirements set out in the specification such as enhanced access appointment reminders.</p> <p>Referrals from NHS 111 have continued to rise, as calls to NHS 111 continue to increase, from 1 million in April 2014 to 1.7 million in March 2021, and a rise again across 2022. The BMA believes that a change in patient behaviour is driving this change, as patients were actively encouraged to call NHS 111 during the first two waves of the COVID-19 pandemic. The BMA has continued to call for adequate funding of NHS 111 services, as well as for urgent measures to be undertaken to properly support urgent and emergency care.</p> <p>GPCE have not been successful in influencing the 111 protocols and that this is still work to be done.</p>
	Environment	
(11)	<p>That conference, recognising our responsibilities to achieve carbon neutrality by 2030, calls for:</p> <ul style="list-style-type: none"> (i) a primary care clinical lead on every ICS sustainability board with a commitment to greater prioritisation of primary care in ICS Green Plans (ii) an evaluation of the environmental impact and clinical suitability of personal protective equipment procurement (iii) a review of the return, reuse and recycling of medicines, medical devices, and equipment to reduce un-necessary waste generation by the NHS including general practice (iv) GPC England to negotiate with NHSEI to provide sustainability funding to ensure all NHS GP surgeries are net carbon neutral by 2030 (v) the Department of Health and NHSEI to require a carbon neutral footprint of pharmaceutical products by 2030, preferentially procuring with 	<p>Each ICB (Integrated Care Board) is required to have a board-level lead responsible for net zero and delivering the greener NHS agenda. However, there is not currently a requirement for a dedicated GP or primary care lead on this issue.</p> <p>The BMA is currently developing a report on the NHS estate, which will include content relating to the condition and sustainability of GP premises.</p> <p><i>In 2020 we wrote a paper called ‘Climate change and sustainability: The Health Service and Net Zero’ where we looked at the state of play for sustainability in NHS Trusts and Health Boards and suggest steps that can be taken to make the NHS a less carbon intensive system. We are in the processing of updating this research through information collected through an FOI of NHS organisations across the UK. We will be publishing these results very soon.</i></p>

	Motion	Update
	<p>providers who can demonstrate this to purchasers, prescribers and patients.</p> <p>Proposed by Phil Trevail, Kernow</p> <p>Carried</p>	<p><i>We supported Glove Awareness Week in May this year, promoting the conscious use of gloves by health professionals.</i></p> <p>We should add Carbon Neutrality funding into our strategy document</p>
	Online consultations	
(12)	<p>That conference believes that GP practices should decide how they can provide the best service to their patients; the introduction of online consulting was inadequately planned and resourced, and:</p> <p>(i) insists on proper evaluation of the workload, safety, cost and impact on health inequalities of these before any further roll out is implemented</p> <p>(ii) directs GPC England to negotiate regulations that enshrine the rights of practices to choose which systems they use for their population</p> <p>(iii) believes that online consulting should not be a part of the GMS contract</p> <p>(iv) calls for the removal of all mandates and incentives regarding online consultations</p> <p>(v) is concerned that the 21 / 22 PCN DES includes a target for number of e-consultations per practice and calls for this target should be scrapped.</p> <p>Proposed by Abel Adegoke, Wirral</p> <p>Carried</p>	<p>It may take some long-term lobbying and negotiating to achieve all parts of this resolution, but GPC England has incorporated it into its negotiating strategy henceforth. GP resources are scarce and any initiative that is causing inefficiency should be reviewed and replaced with better processes. Evaluations could also lead to better decisions in terms of where resources directed. After all, could the money invested in NHS 111 and e-consultations be better spent by training more GPs and putting the remained funding into global sum?</p>
	Interface (recall and management plans)	
(93)	<p>That conference is concerned by the growing burden of targeted recall and individualised management plans being delegated to primary care, for delivery without adequate resource (for example follow-up imaging and echocardiography, or prostate specific antigen or monoclonal gammopathy monitoring), and:</p> <p>(i) rejects any implication that the GP's role is to deliver management plans recommended by specialists, without the GP's explicit agreement to this</p> <p>(ii) believes that individual targeted recall requires a robust national approach, with adequate IT databases which continue to deliver effective call / recall reminders even in the event of a patient moving GP surgery</p> <p>(iii) calls on GPC England to negotiate on GPs behalf to ensure that delivery of these personalised management plans is not delegated to GPs in the absence of robust call/recall systems being in place, and</p>	<p>GPCE has continued to stress to NHS England the importance of protecting GPs from the transfer of inappropriate and unresourced workload from secondary care and of the need for local commissioners to consistently enforce the requirements of the NHS Standard Contract in this regard, especially with the recent transfer from CCGs to ICBs. It remains a key area of ongoing discussions and negotiations with NHS England.</p> <p>The BMA has continued to advocate for investigations and similar which should take place in secondary care to take place in secondary care settings, and for GPs not to be pushed past the limits of their clinical knowledge. This has been of significant issue as part of the 'advice' element of the Advice and Guidance electronic referrals system, and the BMA has been an advisory stakeholder providing input into new guidance on this issue among others, which will be published soon.</p>

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	<p>(iv) calls on the BMA to promote collaborative working in this area, respecting the pressures and limitations of general practice, so that GPs and specialists retain clinical responsibility for the management plans they recommend to their patients.</p> <p>Proposed by Lynette Saunders, Oxfordshire</p> <p>Carried</p>	<p>Could refer back to responses for 5 and 6</p>
	PCN DES and contractual targets	
(127)	<p>That conference believes in light of ongoing patient demand; the unprecedented length of waiting lists for secondary services; and delays to blood testing; the Covid booster programme and the influenza vaccine deliveries; practices cannot realistically deliver their contractual targets for 2021/22 and calls upon GPCE to work with NHSEI to instead provide a guarantee of funding security for practices until 31.03.2022. Conference requires GPC England to produce, by 31 January 2022:</p> <p>(i) a practice and PCN facing campaign to outline to practices how they can facilitate their PCN serving their needs as a priority, and not the local Integrated Care System</p> <p>(ii) clear guidance around how to mitigate attempts to subvert GMS/PMS/APMS into vertically aligned systems and ICPs</p> <p>(iii) a reinvigorated review of the outstanding promises from NHSEI at the beginning of the PCN DES and the original partnership review, holding NHSEI's words against their own failed promises.</p> <p>Proposed by Diana Hunter, Cambridgeshire</p> <p>Carried</p>	<p>(i) and (ii)</p> <p>With the help of LMCs, GPCE can facilitate the sharing of guidance by producing it and disseminating it through its various communication channels for promulgation to practices, eg the fortnightly GP bulletin for members and our LMC update. Starting with the recently published safer working guidance and the opt-out window guidance, GPCE intends to consistently share further guidance setting out what practices contractual obligations are in relation to PCNs, including compared to core/essential GMS contract obligations, and where ICB imposed bureaucracy goes too far / should be rejected to ensure time is not wasted. A PCN DES exit package is also being considered for proposal during contract negotiations, with the idea being that liability for PCNs and Additional Roles Reimbursement Scheme staff is removed from GPs, without losing the capacity from general practice / primary care, so that practice viability and longevity can be restored and protected.</p> <p>(iii) The review of the 2019-24 GMS contract framework is being considered as part of GPCE's preparations for 2023/24 and 2024/25 contract negotiations.</p> <p>Elected members will also remember that NHSE imposed contract changes for 2022/23. Consequently, a message and explainer was published on the BMA website confirming "no agreement has been reached. These contract changes do not go far enough to support access, safe working or backlog pressures in the context of a raging pandemic that has impacted all matters of life across the world". Guidance for practices on safer working was published earlier in</p>

	Motion	Update
		<p>2022, which has recently been refreshed and shared with BMA members and LMCs across England. GPCE has suggested that practices consider implementing a patient waiting list to ensure a safe number of optimal patient appointments per day to preserve staff wellbeing / longevity and make sure patients get the best possible appointment to deal with the concerns they have in one go (instead of through multiple single issue 10-minute appointments).</p> <p>Whilst it is true that NHSE was implementing changes that had originally been agreed as part of the 2019-24 GMS contract framework, as the middle people, answering to Government/the Department of Health and Social Care, their priority will always be increasing patient access rather than practices/providers when under resourced. They do still attempt to explain the position of GPs and their staff to ministers, however (given many of their leaders are working GPs). The introduction of new indicators and “enhanced access” (EA) for 2022/23 was therefore very unwelcome. Although it remains far from the ideal, GPCE representatives have consistently engaged with NHSE representatives throughout 2022 and have since secured some further flexibility in terms of Additional Roles Reimbursement Scheme and staff recruitment, including retired/deferred Impact and Investment Fund indicator money being made available for recruitment of extra GP and nurse capacity over winter, and subcontracting of EA services by PCNs (including a template). Changes to the PCN DES specification in-year, due to the limited efforts made to support practices over winter (letter to the system from Amanda Doyle, NHSE Director of primary and community care), mean a new opt-out window has opened, so the GPCE has published guidance for practices considering their options. We intend to prepare further materials/tools for the April 2023 window too, and collective action in relation to PCNs is being considered as part of our preparations for any future ballot/industrial action (being considered by the Alternative Action Working Group).</p> <p>Letter from GPCE Officer Team to Amanda Doyle at NHSE outlining the measures general practices really need to see to be properly supported this winter and beyond:</p> <div data-bbox="948 1787 999 1854" data-label="Image"> </div> <p>22-23 PN099 - Network Contract DE</p> <p>Senior GPCE representatives now undertake regular liaison and engagement with LMC representatives and BMA members with regard to PCNs and their</p>

	Motion	Update
		obligations, and expect to develop further guidance over the coming weeks/months based on this feedback.
	Contract reform	
(13)	<p>That conference believes that GPC England is at risk of presiding and prevaricating over the slow death throes of GMS, and:</p> <p>(i) believes that the current GMS block contract of funding for general practice is outdated and inadequate for the current healthcare environment</p> <p>(ii) believes that the model of unrestricted workload for a fixed fee is a major disadvantage to general practice within the new ICS landscape</p> <p>(iii) calls on GPC England to negotiate a fee for service contract, including item of service payments for core general practice work, rather than the current block contract</p> <p>(iv) tasks GPC England with negotiating a contract that allows practices to offer private services alongside NHS services, where such services are not commissioned by the NHS for delivery in a general practice setting</p> <p>(v) tasks GPC England with exploring alternative contractual models for general practice in a post-NHS world.</p> <p>Proposed by Russell Brown, East Sussex</p> <p>Carried</p>	<p>(i) GPCE and LMCs are united in their view that the current GMS contract needs to be considerably refreshed and revamped. It does, however, remain the best avenue for the profession in terms of strength of collective bargaining/action. The current conditions are not dissimilar to those that preceded the 2004 GMS contract. The committee stands ready to negotiate far better and more appropriate terms for practices and patients.</p> <p>(ii) The profession, including GPCE, is united in accepting the contract needs to be considerably refreshed to make it fit for future provision of NHS primary medical services.</p> <p>(iii) Work is underway to consider various funding models in the coming weeks and months, so that the profession can choose from the most suitable / advantageous ones.</p> <p>(iv) This has been incorporated into the GPCE negotiating strategy henceforth.</p> <p>(v) Research considering alternative models has been underway for some months. An elected member-led working group, involving expert policy and legal staff, has also been established and is meeting. It will report on its findings in due course.</p>
	Covid-19 vaccination programme	
(14)	<p>That conference recognises the efforts made by practices across the nation to deliver a world-leading vaccination programme, saving lives and helping the country recover from the pandemic and:</p> <p>(i) applauds the fact that many GPs are prepared to deliver the booster programme in the face of an unprecedented workload burden</p> <p>(ii) questions the preferential terms given for delivery of small batches to pharmacies</p> <p>(iii) is concerned that the PCN model of delivery places an undue burden on practices and limits access for patients</p>	<p>General practice has been, and remains, the key delivery route for the Covid-19 vaccination programme. Whilst this has so far been a PCN level programme, largely due to logistics of vaccine supplies, NHS England is currently looking at ways to bring the programme into the regular vaccination schedule. GPCE are inputting into this process and will continue to work tirelessly with NHS England to push for the programme to be moved to a practice level, enabled by increase in the supply of relevant vaccines.</p>

	Motion	Update
	<p>(iv) demands that practices be given the freedom to deliver at practice level in order to increase .</p> <p>Proposed by Shaun Aval and Greg Place, Gateshead and South Tyneside</p> <p>Carried</p>	
	Wellbeing themed debate	
	<p>The agenda committee received 34 motions submitted from conference representatives on the issue of GP wellbeing. It was clear that this is single biggest concern for LMCs and by reflection to GPs across England. Morale in general practice has never been so low, and this was reflected in the language used in the motions. This themed debate was an opportunity for conference to share its experiences of working in this climate.</p> <p>At the end of the themed date, conference was asked to vote on 5 statements, using a 1-6 rating from strongly agree to strongly disagree, or you may abstain by not voting: (the full range being: Completely Agree/Somewhat Agree/Agree/Disagree/Somewhat Disagree/Completely Disagree):</p> <p>That conference supports our patients whose care is being compromised by insufficient resources to meet their needs. (CA 79% / SA 13% / A 7% / D 1% / SD / CD)</p> <p>That conference believes the abuse of primary care staff directly affects patient care and puts patient safety at risk. (CA 90 % / SA 4% / A 5% / D 1% / SD / CD)</p> <p>That conference believes when government and NHSEI choose not to support NHS staff, they directly affect patient safety and knowingly put lives at risk. (CA 81% / SA 10% / A 7% / D 1% / SD 1%/ CD)</p> <p>That conference empowers our representatives to prioritise the safety and wellbeing of general practice doctors in all discussions and negotiations with the government and NHSEI. (CA 90% / SA 7% / A 2% / D 1% / SD 1% / CD)</p> <p>That conference demands healthcare policy is decided based on high quality evidence on population health, and not the whims of a handful of vitriolic media. (CA 94% / SA 3% / A 3% / D / SD / CD)</p>	<p>Between March and June 2022, the BMA, in partnership with GPDF, ran the <i>Rebuild General Practice</i> campaign. Delivered by a third-party PR agency – BB Partners – the campaign was designed to shift the narrative around general practice, specifically, the negative portrayal through the media. Using a proactive approach including a series of creative interventions, behind-the-scenes media briefings, and GP-led content creation, the campaign generated 388 pieces of media coverage in just four months, including three front page stories. As well as media engagement, the campaign engaged with 103 LMCs in England, Wales and Scotland, 45 MPs at both a local level and at a campaign event held at Westminster and generated 736,000 impressions on Twitter.</p> <p>Following the suicide of a GP and related concerns over the pressures that general practice workload are placing on the mental wellbeing of GPs, GPC England decided to take further action to highlight the pressures on the GP workforce and the causes of these pressures. As such, we sent out an email to GPs in England on 31 August in the lead up to suicide prevention day on 10 September, focussing on the need for GPs to protect their mental wellbeing, and it was also highlighted in the GPCE bulletin on 8 September, asking practices to take some time to reflect on 9 September. We have created new wellbeing materials, produced guidance for practices on <i>How to improve the safety of your service and wellbeing on your workforce</i>, and updated our guide to Safe working in general practice. We have continued including wellbeing content in the fortnightly GP bulletins, including a focus on Mental Health ahead of World Mental Health Day on 10 October,</p>

	Motion	Update
	GPC England transparency	
(15)	<p>That conference is concerned about an apparent loss of connection between grassroots GPs and their elected representatives on GPC England and:</p> <ul style="list-style-type: none"> (i) requires that brief minutes be made available to constituents of GPC England meetings (ii) calls for a standing item on the conference agenda where GPC England reports successes and failures of negotiation and seeks conference's views on a way forward (iii) demands that the voting records of GPC England members from this point onwards be made available to constituents to enhance transparency (iv) requires a review of the function of GPC England, with a recommendation that, if needs be, professional negotiators are engaged for future negotiations, paid for by GPDF. <p>Proposed by Paul Evans, Gateshead and South Tyneside</p> <p>Carried</p>	<ul style="list-style-type: none"> (i) We implemented this for the GPCE meeting on 22 September and will continue with this initiative for all GPCE meetings going forward. We produced a summary report for GPCE reps, which we shared with them on the day, after the meeting to enable them to share an update with their constituents. (ii) This is for the conference agenda committee to decide, but the committee chair does provide a verbal report at conference updating conference on the work, including negotiations, of the committee and executive since last conference. In addition, we provide a written update on the progress made on all the motions passed at the previous year's conference, as can be seen here. (iii) BMA Council have looked at how to make Council voting records public, so we are liaising with them regarding how to approach this for GPCE. The function of GPCE is stated in standing orders. The remit of the Committee is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 2006, the National Health Service (Consequential Provisions) Act 2006 and the Health and Social Care Act 2012 and any Acts or Orders amending or consolidating the same and as from time to time extended to England. (iv) If LMCs want this reviewed this would need to be requested via BMA. In terms of "professional negotiators", the independent contractor team are professional negotiators, and all GPCE officers receive professional negotiator training from the BMA and external experts.
	PCN DES	
(16)	<p>That conference believes that PCNs are a Trojan Horse and a failed project which was mis-sold to the profession and:</p> <ul style="list-style-type: none"> (i) believes PCNs pose an existential threat to the independent contractor model (ii) that the workload, staffing, estate, supervision and HR issues outweigh any benefit derived from ARRS (iii) instructs GPC England to refuse to negotiate new work, funding for PCNs or an extension of the PCN contract beyond its 2023 end date 	<ul style="list-style-type: none"> (i) NHSE representatives have indicated they do not anticipate proposing any major contract changes in 2023/24, as the majority of the big-ticket items included in the 2019 framework have already been introduced. GPC England will establish a position on what the 2024/25 GMS contract should and should not contain in advance of the start of discussions on "Heads of Terms", ie negotiating scope or parameters

	Motion	Update
	<p>(iv) instructs GPC England to negotiate that PCN funding be moved into the core contract</p> <p>(v) instructs GPC England to ensure practices are able to easily withdraw from the DES in a straightforward way that will not destabilise the practice withdrawing, other local practices or the provision of patient services.</p> <p>Proposed by Manu Agrawal, South Staffordshire</p> <p>Carried</p>	<p>(ii) Further research and data are needed to establish whether there is a net benefit from the ARRS, but it will be included in the forthcoming negotiations. The PCN DES also incurs premises costs, mostly associated with 'housing' ARRS staff and with extended hours (e.g., additional cleaning and servicing costs), without funding or support tagged to deal with this. We will seek to include a related ask in negotiations.</p> <p>(iii) The GPC England approach to 2023/24 negotiations, which incorporates the wishes of conference, has been evolved over the past months and is being finessed prior to the start of negotiations in October/November 2022. Further feedback from conference this year can also still have influence over the outcome too. A second successive contract imposition may lead to efforts needing to move to the 2024/24 contract negotiating round, but the ongoing development of plans for potential future balloting and action go hand in hand with this. Meanwhile, the GPCE Officer Team has been lobbying and influencing political and policy decision makers continually since the beginning of this year, which goes a long way to securing consensus on how to protect and sustain general practice and the independent contractor model. An example of this can be seen in the recent report published by the Health and Social Care Select Committee report on the future of general practice.</p> <p>(iv) GPC England has included an objective for PCN funding to be moved into the core contract as part of its negotiating strategy henceforth.</p> <p>(v) GPC England has published guidance for independent contractor doctors who may be considering whether to opt out of the PCN DES. We also plan to produce further comprehensive guidance in time for the April 2023 opt-out window.</p>

	Motion	Update
	NHSE access plan	
(243)	<p>That conference rejects the NHSE plan for improving access for patients and supporting general practice published on 14th October 2021, will not accept the money and will not comply with the stipulations therein.</p> <p>Proposed by Jackie Applebee, Tower Hamlets</p> <p>Carried</p>	<p>It is clear that practices did make use of that money to expand capacity as much as they possible could. However, it of course was nowhere near enough. Despite GPCE's strong representations to ministers, the Department of Health and Social Care and NHS England, no such investment has been allocated for winter 2022/23 even though things are tougher than ever.</p> <p>GPCE and LMCs must prepare and stand ready to lobby ministers/MPs, ballot and take action if needed and negotiate change once the political turmoil the country is facing stabilises. The electorate is opening its eyes to the folly of years of bad government policies based on ideological austerity and underfunding, and still remains very much in favour of an NHS free at the point of use – 77% believe 'the NHS is crucial to British society and we must do everything to maintain it'. Resourcing general practice properly means better care for patients. The Health and Social Care Select Committee agree that the continuity of care GPs provide must be protected and allowed to thrive again. If the messaging from the profession's national and local leaders remains consistent, more and more policy and decision makers will start to listen to sense/reason as waiting times rightly become the problem of ministers/MPs instead of solely underfunded commissioners and providers.</p>
	Patient access to online medical records	
(244)	<p>That conference notes plans by NHSE for “accelerated” patient access to online medical records, notes previous GMS contractual obligations regarding online access to medical records, which ensure such schemes only go ahead if appropriate computerised clinical systems and redaction software allow, and:</p> <p>(i) condemns the timing of this move which demonstrates a complete lack of consideration of the workload pressures GPs are currently facing</p> <p>(ii) calls on GPC England to produce an estimate of how much practice time (GP/ clinician and administrative) will be required to perform necessary redaction</p> <p>(iii) mandates GPC England to negotiate adequate resources (including funding for necessary training and change management in primary care) before any “accelerated access” is rolled out</p> <p>(iv) demands “end-to-end” testing of any proposed redaction systems before they are implemented, to ensure software respects any redaction or visibility settings, and that they are fit for purpose</p>	<p>GPC England has worked extensively to engage with NHSE, D and a range of other stakeholders to seek a resolution to issues arising from NHSE's accelerated patient access programme. In the weeks leading up to the 1 November go-live date, GPCE issued guidance to practices outlining concerns with the programme and options available to practices wishing to delay the go-live date. The committee continues to push for clarity on issues including redaction, resourcing, information governance accountability, clinical safety and workload. GPC England has been clear that it is for practices to decide when they are ready to go live, taking into account the range of aforementioned factors and any has sought to reassure practices of this via regular engagement and communications.</p>

	Motion	Update
	<p>(v) instructs GPC England to negotiate that data controllers (GP practices) will be indemnified for any data breaches or harm resulting from their patients being granted online access to their medical records by default.</p> <p>Proposed by James McNally, Oxfordshire</p> <p>Carried</p>	

Schedule of business

Thursday 24 November 2022

Item	Time
Opening business	10.30
Chair of GPC England's report	10.50
Safety in general practice	11.00
Mental health services	11.20
Childhood immunisations	11.30
Gender dysphoria	11.40
Patient access to records	12.00
Energy / Inflation crisis	12.20
CQC bias	12.40
Lunch	13.00
Federated data platform	14.00
Fuller stocktake	14.10
Integrated care systems (ICS)	14.20
GP contract	14.40
Enhanced access	15.20
Interface	15.30
Defence of general practice	15.40
Workforce	15.50
Emergency business / chosen motions	16.10
GPC England	16.40
Close	17.00

OPENING BUSINESS

10.30

- 1 THE CHAIR: That the return of representatives of local medical committees (AC3) be received.
- 2 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the standing orders (appended), be adopted as the standing orders of the meeting.
- 3 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the report of the agenda committee be approved.

CHAIR OF GPC ENGLAND'S REPORT

10.50

- 4 THE CHAIR: Report by the Chair of GPC England.

SAFETY IN GENERAL PRACTICE

11.00

To submit a speaker slip for Motion 5 – please click [here](#)

- * 5 AGENDA COMMITTEE TO BE PROPOSED BY KENSINGTON AND CHELSEA: That conference believes general practice in England is unsafe due to a shortage of doctors and a lack of investment; that this problem must be owned by government, and:
 - (i) believes that focusing on patient safety is more appropriate than trying to meet high patient demand and therefore calls for GPC England to use “safe capacity” and avoid “access” in communications and negotiations
 - (ii) deems the scapegoating, moral injury and lack of psychological safety faced by GPs, in the context of whole NHS system failure, to be entirely unacceptable
 - (iii) calls for an effective mechanism for LMCs to escalate issues that impact on patient safety in general practice that are outside the gift of practices to address and have failed to be addressed locally
 - (iv) believes it is time that a workload sensitive contract for GPs was introduced without further delay which includes a proactive system of monitoring and wellbeing safeguards
 - (v) believes all practices should declare themselves to CQC as ‘requiring improvement,’ as they are unable to offer safe and effective care due to widespread system failings outside of primary care.
- 5a KENSINGTON AND CHELSEA That conference deems the scapegoating, moral injury and lack of psychological safety faced by GPs, in the context of whole NHS system failure, to be entirely unacceptable and calls for:
 - (i) GPC England to work with GMC on greater transparency regarding how the demand: workforce capacity context will be taken into consideration in investigations
 - (ii) GPC England to work with CQC to ensure the demand: workforce capacity context is taken into consideration to avoid the self-fulfilling impact on recruitment and retention

- (iii) an effective mechanism for LMCs to escalate issues that impact on patient safety in general practice that are outside the gift of practices to address and have failed to be addressed locally
 - (iv) a review of the patient satisfaction questionnaire required as part of GPs' revalidation so that GPs are not held responsible for system failings and pressures.
- 5b SHROPSHIRE: That conference believes all English GP practices should declare themselves to the CQC as 'requiring improvement', as they are unable to offer safe and effective care due to widespread system failings outside of primary care.
- 5c LINCOLNSHIRE: That conference recognises that the relentless political and media agenda on increasing patient access, exceeding safe capacity is a risk for patients but is also having a profound detrimental effect on general practice workforce numbers and morale by laying the blame of the wider system failure on general practice and inaccurately framing the situation for patients and calls for GPC England to:
- (i) use "safe capacity" and avoid "access" in communications and negotiations to change the narrative of the current GP access blame culture
 - (ii) request the use of "safe capacity" rather than "access" by political and media organisations
 - (iii) demand an immediate end to negative, non-contextual political soundbites and media headlines that simply serve to reinforce this blame culture
 - (iv) lobby government for a high-profile rolling national patient facing educational advisory for both accessing appropriate health care advice and to promote positive patient support for GP practices
 - (v) request any media articles about general practice, to include an infographic on where to seek medical advice and information.
- 5d HULL AND EAST YORKSHIRE: That conference believes general practice in England is unsafe due to a shortage of doctors and a lack of investment and must:
- (i) follow other NHS providers in adhering to maximum safe consultations per day
 - (ii) redirect patients to acute services when capacity in general practice is reached
 - (iii) normalise waiting lists for routine care to safely meet demand
 - (iv) prioritise staff retention to prevent the total loss of general practice for patients.
- 5e CLEVELAND: That conference welcomes the new focus on GP access and:
- (i) notes that access within general practice is being delivered at historically high levels
 - (ii) agrees that continuity of care is more important than instant access to a GP
 - (iii) agrees that focusing on patient safety is more appropriate than trying to meet high patient demand
 - (iv) believes that this problem must be owned by government, not by the profession.

- 5f SEFTON: That conference mourns the recent tragic suicide of a much valued colleague which was caused in large part by the relentless work demand and the strain it imposes on dedicated GPs. It believes it is time that a workload sensitive contract for GPs was introduced without further delay which includes a proactive system of monitoring and wellbeing safeguards. It calls upon the new Secretary of State and her team negotiate this with GPC England.
- 5g KENSINGTON AND CHELSEA That conference believes that the political drive for greater access to general practice in the midst of a workforce crisis has:
- (i) reduced safety of care
 - (ii) reduced the quality of care
 - (iii) diverted resources away from those with the most need
 - (iv) resulted in tipping of the balance of proactive preventative care to reactive care
 - (v) exacerbated the workforce crisis due to untenable workloads with GPs leaving the profession.
- 5h DERBYSHIRE: That conference believes workload capacity in general practice is finite and calls on GPC England to negotiate suitably commissioned external provision for patients to access when their registered practice has reached its capacity on any given day.
- 5i HEREFORDSHIRE: That conference asks GPC England to define a safe workload cap for GPs and demands that it is included in future contract negotiations.
- 5j MID MERSEY: That conference demands that GPC England must support practices in a practical way to deal with the continuing shifting of unresourced workload to help them focus a provision of much needed care to patients in primary care.
- 5k LINCOLNSHIRE: That conference believes that workload in general practice has become unsustainable and thus to protect both patients and clinicians the maximum number of consultations done by clinicians in general practice should be capped at a maximum of 20 per half day worked.
- 5l GLOUCESTERSHIRE: That conference is concerned about the unsustainable increase in consultation rates per individual in England and asks that the GPC negotiates measures to mitigate this including:
- (i) a nominal cap on the rate of consultation at a practice per individual per annum
 - (ii) a standing charge for any additional consultations
 - (iii) an appropriate additional consultation allowance for long term condition monitoring and ongoing care requirements for specific episodes of care.
- 5m KENSINGTON AND CHELSEA That conference believes that the mismatch in demand and workforce capacity is compromising GPs' ability to deliver safe patient care and calls on GPC England to:
- (i) work with CQC to ensure that capacity and resourcing limitations are taken into account in conclusions about practices to avoid the self-fulfilling impact on recruitment and retention

- (ii) use modelling to quantify the general practice demand based on population numbers and demographics, with the aim of aiding discussions about the estimated required workforce capacity required to meet this safely
- (iii) gather and address operational failings of national programmes and initiatives, with clear processes and reporting
- (iv) be a key partner in the development of the NHS Patient Safety Strategy.

5n NOTTINGHAMSHIRE: That conference is concerned that safe working guidance is not being followed by many practices because of a fear that doing so will reduce the capacity of practices to serve their population. We request that GPC England highlights the potential impact of all practices moving to 15 minute appointments and capping appointment numbers to NHS England within workforce modelling and future funding calculations to normalise safer working for practices.

5o NORTH ESSEX: That conference requires the BMA to alter the standard GP salaried contract in order to include precise restrictions on workload via a limit to the number of patient contacts per day.

5p SESSIONAL GPS COMMITTEE: That conference is concerned about unsafe workloads in general practice that are exacerbating the retention and recruitment crisis and calls on GPC England to ensure that:

- (i) GMS contractual changes are sought to enable practices to implement BMA safe working guidance for all GPs
- (ii) BMA safe working guidance is introduced as a condition in the salaried GP model contract.

5q DEVON: That conference recognises the current workload and demand faced by general practice is unsustainable and general practice will fail unless work is done quickly to save the profession.

5r DEVON: That conference recognises that newly qualified GPs often want a fixed volume of workload during a session and that most contracts do not allow for work to be capped at levels we would consider safe.

5s GLOUCESTERSHIRE: That conference believes that there are insufficient GPs to safely do the job that's required of them in England and insists GPC England instructs practices with great vigour to ensure that they stick to the imposed contract and no more.

5t BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference notes that GPs have significant amounts of education and training required of them that needs to be done in addition to clinical work but the additionality is often unrecognised. This conference calls on GPC England to negotiate for dedicated funding to provide adequate backfill to allow GPs to attend education and training in working hours.

5u BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference believes that all NHS workers have the right to safe working conditions and a realistic workload and:

- (i) the current workload and workforce crisis have made working conditions for GPs and their teams unsafe and unsustainable and this is having a direct impact on the mental and physical health of GPs and their staff

- (ii) offers of resilience support whilst welcome, may foster a perception that the ‘problem’ lies with the GP when in fact the major factor driving mental illness and burnout in the profession is an unsafe and unrealistic workload and so we call for government to publicly acknowledge this and take urgent action to address the root cause to prevent further harm
- (iii) any negotiations around a new contract must be based around ensuring safe working conditions with realistic workload expectations
- (iv) calls on GPC England to take legal advice on a possible class action for industrial injury for all those GPs whose health has been adversely affected by current working conditions.

(Supported by Dorset and Hampshire and Isle of Wight)

- 5v NORFOLK AND WAVENEY: That conference notes that the proliferation of online courses have grown exponentially in the last few years and mandatory training requirements having increased in volume and complexity without appropriate protected time being for GPs to carry this out within the GP contract. Protected time for training needs to be written into the contract along with appropriate resource to enable this.
- 5w OXFORDSHIRE: That conference believes current workloads in general practice are unsustainable and demands that any new contract intended to replace GMS must include:
 - (i) a cap on daily workload, set at a maximum of 25 patient contacts, per doctor, per day, in line with BMA recommendations
 - (ii) additional resource allocated to core practice funding, to be triggered where daily patient contacts exceed the recommended limit of 25 per doctor per day.

MENTAL HEALTH SERVICES

11.20

To submit a speaker slip for Motion 6 – please click [here](#)

- * 6 AGENDA COMMITTEE TO BE PROPOSED BY DERBYSHIRE: That conference, whilst recognising their staffing crisis, is concerned about the diminishing access to mental health services and:
 - (i) does not accept the near automatic rejection of GP referrals or insistence on completion of lengthy proforma before acceptance
 - (ii) does not accept referral responses which simply consist of a list of websites that the patient can consult
 - (iii) abhors the almost complete absence of CAMHS services for those who need such services but have not (yet) attempted suicide
 - (iv) calls on GPC England to look at ways of ensuring that the current service inadequacies do not fall to general practice
 - (v) calls on GPC England to negotiate investment in children’s mental health services.
- 6a DERBYSHIRE: That conference whilst recognising the staffing crisis especially in mental health services does not accept:

- (i) the near automatic rejection of GP referrals or insistence on completion of lengthy proforma before acceptance
 - (ii) responses which simply consist of a list of websites that the patient can consult
 - (iii) the almost complete absence of CAHMS services for those who need such services but have not (yet) attempted suicide.
- 6b DORSET: That conference is concerned about the diminishing access to childhood mental health services and calls upon GPC England to:
- (i) look at ways of ensuring that the current service inadequacies do not fall to general practice
 - (ii) negotiate investment in children’s mental health services
 - (iii) work with the Department of Education (and therefore indirectly schools) to provide local access to mental health services.
- 6c DERBYSHIRE: That conference noting the increasing subspecialisation within both secondary care and the community psychiatric services mandates the GPC England to negotiate with NHSEI to ensure that any referral to the wrong subspecialty is automatically referred to the correct subspecialty without recourse back to the GP.
- 6d DERBYSHIRE: That conference notes the increasing tendency of mental health providers to play “pass the parcel” amongst their different departments when a GP attempts to make an emergency referral and insists that NHSEI enforces a Single Point of Access process upon mental health providers.

CHILDHOOD IMMUNISATIONS

11.30

To submit a speaker slip for Motion 7 – please click [here](#)

- * 7 TOWER HAMLETS: That conference recognises the importance of childhood immunisations and applauds the work that general practices have done in the last year despite many knowing that this work would go unrewarded through QOF payments. Conference demands that:
 - (i) NHSEI and the government recognise that patients can make informed decisions
 - (ii) NHSEI recognise the difficulties in achieving QOF targets, particularly in areas with high patient turnover and areas with marginalised communities thereby discriminating against practices in inner cities and high levels of deprivation
 - (iii) GPC England negotiate with NHSEI a QOF target with a lower threshold for payment for childhood immunisations
 - (iv) GPC England negotiate with NHSEI that exception reporting should be incorporated into all QOF targets.

- 7a DEVON: That conference, regarding the childhood immunisation element of QOF, agrees that:
- (i) the new model unfairly penalises practices that have spent time and workforce resources to persuade parents of children who subsequently refuse vaccination of their children
 - (ii) exception reporting should be reinstated for this financial year.
- 7b LEEDS: That conference believes the current QOF V&I indicators:
- (i) are undermining the uptake vaccinations
 - (ii) are putting children and communities at risk of serious infection
 - (iii) must be changed to allow for shared decision making and patient/parental choice, the result of which does not financially penalise practices
 - (iv) must be removed from QOF.
- 7c CLEVELAND: That conference believes that general practice is the home of vaccination.
- 7d GLOUCESTERSHIRE: That conference is very concerned at the inability to allow personalised adjustments to patients in the QoF immunisation domain and demands that practices must be able to adjust patients for good reason.

GENDER DYSPHORIA

11.40

To submit a speaker slip for Motion 8 – please click [here](#)

- * 8 KENT: That conference is dismayed by the lack of adequate gender dysphoria services and believes it is imperative that GPC England ensures NHSEI:
- (i) formally acknowledge that it is not appropriate for general practice to prescribe medication without specialist initiation and only then when supported by a shared care agreement and if a GP believed they are competent to prescribe
 - (ii) ensure appropriate services are commissioned at a local level that provide ongoing prescribing and support for patients with gender dysphoria
 - (iii) ensure that any shared care arrangements are appropriately resourced with mechanisms in place if a GP chooses to decline to accept shared care.
- 8a DORSET: That conference notes the closure of the Tavistock Gender Identity Development Service (GIDS) Clinic and deplores the lack of timely investment in Specialist Services commissioned for the management of Gender Dysphoria. The conference calls on GPC England to:
- (i) negotiate an immediate and appropriate interim solution to provide care for patients under the GIDS Clinic
 - (ii) negotiate a service to communicate with and support patients on the waiting list for GIDS specialist care
 - (iii) ensure that the inadequacies of the system do not place unfair burden on GPs

- (iv) ensure that patient safety is not risked as a result of inappropriate specialist care being requested of GPs due to an inadequate service provision.

(Supported by Hampshire and Isle of Wight and Bath & North East Somerset, Swindon & Wiltshire)

- 8b NORTH YORKSHIRE: That conference demands that, where local and national commissioning gaps exist (eg gender services, eating disorders, dentistry), GPs are not made to feel medico-legally vulnerable as the "provider of last resort", and that GPC England must highlight this as a serious issue to NHSEI and commit to protecting general practice from medico-legal threats arising from lack of appropriate commissioning.

PATIENT ACCESS TO RECORDS

12.00

To submit a speaker slip for Motion 9 – please click [here](#)

- * 9 AGENDA COMMITTEE TO BE PROPOSED BY WORCESTERSHIRE: That conference, with regard to the implementation of accelerated patient access to full primary care records:
 - (i) has serious concerns regarding the implementation of patient access to full primary care notes
 - (ii) notes the programme is unfunded, lacks safeguards against patient harm or data loss, and thus has the potential to cause patient harm and distress
 - (iii) laments the lack of relevant training and support that has been given to practices
 - (iv) believes the programme poses unacceptable risk to general practice in terms of workload, complaints, and liability
 - (v) tasks GPC England to ensure that the programme is paused until all outstanding issues have been addressed.
- 9a WORCESTERSHIRE: That conference believes the Accelerated Access to Patient Records Programme poses unacceptable risk to general practice in terms of workload, complaints and liability and insists that it is paused until all outstanding issues have been addressed.
- 9b DEVON: That conference has serious concerns regarding the implementation of patient access to full primary care notes from 1 November 2022 and:
 - (i) there is a potential for significant anxiety and distress for patients
 - (ii) there is an unfunded and potentially huge workload increase for primary care
 - (iii) the system lacks the current safeguards against patient harm or divulging third party information
 - (iv) demands further work to be done with NHSX and NHS Digital to review the potential impact of full note access.
- 9c DEVON: That conference requests that the wholesale access to primary care notes be reconsidered and pared back to not include real time access to GP consultation notes from 1 November deadline.

- 9d KENT: That conference demands that NHS England and Improvement reverses the plan to automatically switch on full prospective patient online access, particularly document access, due to the significant impact on practice workload.
- 9e CLEVELAND: That conference is deeply concerned by the imminent switch on of prospective patient access to records and laments the lack of relevant training and support that has been given to practices.
- 9f SURREY: That conference calls for an urgent review of the current arrangements for prospective access to patient records, currently due to commence on 1 November 2022, and to defer this date in view of the likely increase in workload for general practice this policy will create.

ENERGY / INFLATION CRISIS

12.20

To submit a speaker slip for Motion 10 – please click [here](#)

- * 10 SHROPSHIRE: That conference believes that the rise in energy prices is having a catastrophic impact on the financial viability of English GP practices and calls for in-year intervention to address these inflationary pressures, which were unforeseen at the introduction of the current GP core contract.
- 10a CAMBRIDGESHIRE: That conference recognises the exceptional financial risk placed upon GP partners with the fuel and cost of living crisis and calls upon GPCE to urgently produce an action plan before Christmas 2022 to mitigate practice non-viability including options for branch closure and limited working hours to maintain staff and patient safety, in addition to seeking that NHSEI underwrite any additional costs due to the increase in the energy price cap from 1 October 2022.
- 10b MANCHESTER: That conference notes the financial pressures on general practice in England are becoming overwhelming and risking a total service collapse in the coming months. We call on NHSEI and GPC England to deliver emergency solutions to the following problems to be agreed no later than 28 February 2023:
 - (i) funding of nationally mandated staff pay rises (eg Agenda for Change, DDRB)
 - (ii) increasing cost of retail energy
 - (iii) superannuation and pension tax charges
 - (iv) general rate of inflation; and
 - (v) other priorities identified by GPC England , its subcommittees and its executive.
- 10c LIVERPOOL: That conference believes that the increases in energy costs runs the risk of destabilising practices and:
 - (i) calls on GPC England to secure emergency fuel funding for practices until a more permanent solution is in place
 - (ii) asks GPC England to negotiate additional funding for sustainable infrastructure to mitigate future fuel cost rises.

- 10d CLEVELAND: That conference notes that there is a “cost of running a GP surgery crisis” as much as there is a “cost of living crisis” and mandates GPC England to continue to lobby for this to be recognised and for GPs in England to be appropriately supported.
- 10e KERNOW: That conference believes that the rise in energy prices will force several GP surgeries to close, leading to patients not having access to GP services therefore calls upon GPC England / BMA to negotiate an energy price package for GP surgeries.
- 10f NORTH YORKSHIRE: That conference recognises the crisis in practice income and the significant threat this poses to the independent contractor model going forward, and that GPC England negotiates for
- (i) pay restoration for all GPs, including GP partners
 - (ii) an uplift in global sum to allow an inflation adjusted pay increase for all clinical and non-clinical practice staff
 - (iii) urgent financial support for practices from NHSEI to address rising fuel and other utilities expenses.
- 10g LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that unless the global sum is significantly increased the increases in costs for practices due to premises costs, electricity and gas, staffing costs etc will result in many practices closing, and demands that NHS E&I recognises this and undertakes to financially support practices without further delay.
- 10h HAMPSHIRE AND ISLE OF WIGHT: That conference acknowledges the cost of living crisis is affecting large portions of society. Most businesses in England have accordingly increased their prices to ‘pass on the cost to the customer’. English NHS general practice is unable to do this and therefore conference calls upon GPC England to negotiate with the government to support English general practice by:
- (i) negotiating a maximum cap English GP’s will have to pay for gas and electricity
 - (ii) backdating to April 2022 a 4.5% increase into the global sum to allow GP partners to pass on the recommended pay rise to their salaried GP’s without unfairly disadvantaging themselves.
- 10i MERTON: That conference calls upon the government to ensure that general practice is supported with the increasing cost of energy, as there is a significant risk that practices may be unable to cover the costs and forced to close, or even to hand back their contracts.
- 10j NOTTINGHAMSHIRE: That conference is concerned about the financial viability of practices with poor pay progression through the contract and unmitigated rises in energy costs and requests that the following is negotiated on behalf of the profession:
- (i) extra funding to be injected through the global sum to mitigate the drain of staff leaving practices due to uncompetitive wages / conditions
 - (ii) one-off funding for practices to offset rising energy prices which is easy to access
 - (iii) cost-of-living support for practices to help to combat the extraordinary inflationary rises

- (iv) investment in audits and professional advice to help practices to understand where they can save money and become more energy efficient, potential support with implementation eg green energy grants.
- 10k GLOUCESTERSHIRE: That conference notes that energy prices have soared primarily as a consequence of war in Ukraine and holds that such consequences of war should be fully reimbursed to preserve practices viability.
 - 10l BARNET: That conference expresses its deep concern for general practice existence and stability due to the impact of the cost of living and inflation and calls upon GPC England to work with NHSEI to provide resources to support and maintain GP practices during the evolving crisis.
 - 10m WEST PENNINE: That conference recognises that the cost of living crisis will impact practices of all sizes and may lead to the closure of many; it will also significantly contribute to health inequalities.
 - 10n DERBYSHIRE: That conference acknowledges the dire state of staffing within the general practice workforce and that frequently neither practices nor PCNs can compete with the terms and conditions of secondary care. Conference calls upon GPC England to negotiate:
 - (i) an increase in core funding to cover annual cost of living rise
 - (ii) additional recurrent funding to practices so that Agenda for Change terms and conditions including ongoing uplifts can be applied
 - (iii) a fully funded occupational health service for ALL members of the general practice team.
 - 10o DEVON: That conference demands that action must be taken to ensure that payments to practices are in line with the rate of inflation.
 - 10p TOWER HAMLETS: That conference recognises that, with the current rate of inflation, practices are becoming increasingly unviable and demands that annual core funding is increased by the rate of inflation plus a negotiated percentage increment to enable real investment in staff and services.
 - 10q LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is appalled that general practices will receive no increase in the Global sum and / or other income to cover the additional cost of living increases for ARRS staff, salaried GPs, and other staff and insist that GPC England negotiates for these costs to be included in next year's income.
 - 10r DERBYSHIRE: That conference in the light of inflation rates unfamiliar to many, mandates the GPC England to negotiate such that practice expenses are explicitly calculated (as pre-2004) and that despite public policy to hold down GP pay, GP expenses must be reimbursed to the profession in full.
 - 10s DERBYSHIRE: That conference warns that unless the government yields and permits a limited renegotiation of the current five year PAY deal to accommodate unforeseen practice EXPENSES increases, there is a real risk / near certainty that significant numbers of GP practices will either close or go bankrupt in the run up to the 2024 general election.

- 10t SUFFOLK: That conference recognises the damaging effects of climate change and the rising cost of utilities and requires GPC England to negotiate financial capital support and direct incentivisation for practices to invest in environmental sustainability.
- 10u LEEDS: That conference is seriously concerned about the impact rising energy prices are having on practice expenses, which could lead to the closure of some practices, and demands immediate action from NHS England with full reimbursement of utility costs.
- 10v HERTFORDSHIRE: That conference calls on GPC England to negotiate with NHS England for increased funding for general practices to deal with rising inflation and increased energy bills.
- 10w NORFOLK AND WAVENEY: That conference believes that the current remuneration / DDRB settlement for GP partners is inadequate for recruitment and retention of GP partners, as the increasing cost of utilities, and increased staff pay is far higher than the current deal allows for .A new contract / funding allocation is needed, with a link to CPI to future proof against high rates of inflation going forward ,otherwise the current GP partnership model is not going to survive more than a few years.

CQC BIAS

12.40

To submit a speaker slip for Motion 11 – please click [here](#)

- * 11 **AGENDA COMMITTEE TO BE PROPOSED BY DEVON:** That conference notes, in practices with minority ethnic CQC Registered Managers, the evidence of adverse outcomes arising from CQC inspections and calls for:
 - (i) publication of CQC inspection outcomes stratified by the protected characteristics of practice CQC leads including ethnicity and gender
 - (ii) publication of diversity data including protected characteristics of CQC inspectors
 - (iii) publication of CQC’s plan to improve its representation of the population should its data demonstrate a diversity gap
 - (iv) local intelligence to be used to support CQC inspections where their searches indicate concerns
 - (v) a practising NHS GP Specialist Advisor to be part of every CQC inspection team inspecting NHS general practice.
- 11a DEVON: That conference notes that CQC mandates practices to provide evidence of equality, diversity, and inclusion training in practice staff but does not provide publicly available evidence that its teams have undergone the same training nor that it is seeking to improve its representation of the profession it inspects. As anecdotal evidence of disproportionate adverse outcomes from CQC inspections arise from practices with BAME CQC leads is increasing, conference requests that GPC England negotiate for:
 - (i) publication of diversity data including protected characteristics of CQC inspectors
 - (ii) publication of CQC inspection outcomes stratified by the protected characteristics of practice CQC leads including ethnicity and gender

(iii) CQC’s plan to improve its representation of the population should its data demonstrate a diversity gap.

11b KENT: That conference demands that GPC England meet with CQC and call for:

- (i) recognition that general practice is still suffering the effects of the pandemic, the blood bottle shortage and the ongoing workforce crisis
- (ii) removal of the non-safety and administrative elements from their pedantic tick boxes
- (iii) additional flexibility to their process so practices do not end up as ‘requires improvement’ for factors outside of their control
- (iv) a proportionate inspection regime, recognising that general practice is not a hospital or care home and therefore, the risks associated with delivery of service in general practice are entirely different and the focus of inspections should reflect that.

11c WORCESTERSHIRE: That conference believes that current CQC inspections focus on fault finding rather than championing high quality care and insists that:

- (i) local intelligence is used to support inspections where CQC searches indicate concerns
- (ii) medical advisers are practising doctors working in general practice
- (iii) the same criteria cannot be used to reduce ratings in more than one domain
- (iv) inspectors engage proactively with LMCs on all matters relating to CQC inspections
- (v) routine inspections are halted with immediate effect until the workforce and capacity is in place to resume a “ normal service” for patients.

11d SOUTH STAFFORDSHIRE: That conference believes CQC is wreaking havoc on GP morale, worsening recruitment and retention issues and not improving patient care, so should be disbanded, with any new replacement having an ethos of supportive care helping surgeries to access funding to improve for the benefit of their patients.

LUNCH

13.00

FEDERATED DATA PLATFORM

14.00

To submit a speaker slip for Motion 12 – please click [here](#)

- * 12 GPC ENGLAND: That conference notes with concern NHS England’s plans to procure a £360m contract for a Federated Data Platform from a single supplier, raising questions over the safety of patient data and the oversight of any company that might potentially seek to exploit that data. In order to maintain the highest level of public trust this conference calls on the BMA to work with NHS England to:

- (i) determine if the four existing secure data platforms supported by the BMA / RCGP Profession Advisory Group can provide some or all of the requirements of the proposed platform
- (ii) scrutinise organisations submitting tenders to ensure a demonstrable positive track record on security, privacy and ethics
- (iii) mitigate from the outset against vendor lock-in and ensure the commitments to modern, open working methods from the 13 June paper Data Saves Lives and 6 September paper on Secure Data Environments, both of which draw on the Goldacre review, are enshrined.

FULLER STOCKTAKE

14.10

To submit a speaker slip for Motion 13 – please click [here](#)

- * 13 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes the implementation of the Fuller Stocktake report is failing and calls upon NHSEI and the government to:
 - (i) mandate LMC involvement for all ICS work streams concerning the report
 - (ii) provide immediate funding to deliver an emergency primary care estates solution
 - (iii) acknowledge that isolated, acute presentations make up a tiny percentage of general practice workload and their removal risks fragmentation of continuity of care
 - (iv) instruct ICSs to publish their progress and evidence of primary care engagement on a quarterly basis.

- 13a LANCASHIRE PENNINE: That conference believes that alongside recommendations from the Fuller Report, NHSPS should be transparent on details of the public estate that is potentially available to practices, given the dire lack of space that some practices contend with.

- 13b WESTMINSTER: That conference insists that GPC England, alongside the whole BMA, is publicly vocal in highlighting that the aspirations in the Fuller review cannot be achieved without:
 - (i) significant culture and policy change
 - (ii) distributed clinical leadership
 - (iii) full understanding of the role of general practice in patient care and population health by decision makers
 - (iv) full understanding of the value of the relationship between GP and patient and the place of the practice within the local community by decision makers.

- 13c NORTH STAFFORDSHIRE: That conference is disappointed by the lack of progress on industrial action since the indicative ballot in November 2021, and calls on GPC England to:
 - (i) demand in its negotiations with NHSEI / DHSC that existing conference policy of a tariff based contract is part of the new 24/25 contract
 - (ii) demand in its negotiations with NHSEI / DHSC that existing conference policy of PCN into core is part of the new 24/25 contract

- (iii) demand in its negotiations with NHSEI / DHSC that existing conference policy of more flexibility for private services is part of the new 24/25 contract
 - (iv) formally ballot members for industrial action once the outcome of negotiations for the new 24/25 contract with NHSEI / DHSC are known
 - (v) rejects the Clare Fuller report and instead invests and submits a report with a sensible and realistic vision for general practice.
- 13d** DEVON: That conference believes the Fuller Report is seriously flawed in relation to its assessment of:
- (i) continuity of care
 - (ii) access
 - (iii) sustainable general practice
 - (iv) estates.
- 13e** CENTRAL LANCASHIRE: That conference believes that the Fuller Stocktake is a useful reference document but needs to be considered and actioned in a local context by local practices.
- 13f** KENT: That conference is disappointed by the lack of progress on industrial action since the indicative ballot in November 2021, and calls on GPC England to ensure:
- (i) that existing conference policy of a tariff based contract is part of the negotiations for the 24/25 contract
 - (ii) that existing conference policy of transferring all PCN funding to the core contract is part of the negotiations for the 24/25 contract
 - (iii) that existing conference policy of giving practices increased flexibility to deliver private services to their patients is part of the negotiations for the 24/25 contract
 - (iv) that the BMA formally ballots members for industrial action once the outcome of negotiations for the 24/25 contract are known
 - (v) the Fuller report is rejected and instead, GPC England proposes a realistic vision for general practice.
- 13g** NORTH YORKSHIRE: That conference recognises the estates crisis in primary care and that this impacts on the successful delivery of core and PCN DES clinical provision, and that GPC England negotiates:
- (i) an agreement from NHSEI to fund and resource premises expansion to allow sufficient, suitable space for all clinical staff within practices and across PCNs, in line with the recommendations of the Fuller Stocktake
 - (ii) a commitment from NHSEI to fully fund IT infrastructure and support costs that facilitates remote working for all clinical staff
 - (iii) a commitment for all general practice IT infrastructure related to ARRS to be funded centrally.

- 13h CAMBRIDGESHIRE: That conference recognises the detrimental outcomes to managing acute and planned care separately as suggested in the Fuller Review, and believes in a need for transactional, opportunistic, essential health promoting episodes to take place alongside the patient's acute presentation, to prevent widening of health inequalities and the perpetuation of poor health outcomes.

INTEGRATED CARE SYSTEMS (ICS)

14.20

To submit a speaker slip for Motion 14 – please click [here](#)

- * 14 AGENDA COMMITTEE TO BE PROPOSED BY WESTMINSTER: That conference instructs GPC England to ensure that:
- (i) GMS / PMS monies and pre-existing general practice budgets must be ring fenced within all ICSs for exclusive use in general practice
 - (ii) distribution of funding at place, system and ICB level should be proportional based on the amount of activity delivered by each sector
 - (iii) representation at place, system and ICB level should be proportional based on the amount of activity delivered by each sector
 - (iv) all proposals at ICS, system or place level must include a GP practice workload, stability, and clinical risk impact assessment, and address any adverse implications that are identified before agreement
 - (v) ICSs are held accountable for local system operational failings and for safe GP / patient ratios.
- 14a WESTMINSTER: That conference believes that the mismatch in demand and workforce capacity is compromising GPs' ability to deliver safe patient care and calls for ICSs to be:
- (i) accountable for local system operational failings that impact on the effectiveness of the use of our clinical time or result in workload shift from other providers
 - (ii) mandated, for all proposals, to undertake a GP practice workload, stability and clinical risk impact assessment, and address any adverse implications that are identified
 - (iii) responsible and held to account for safe GP: patient ratios.
- 14b DEVON: That conference believes that GMS / PMS monies must be ring-fenced within an ICS for exclusive use in general practice.
- 14c KERNOW: That conference demands that GMS / PMS monies must be ring-fenced for exclusive use in general practice and therefore be unavailable for wider utilisation in the ICS.
- 14d NOTTINGHAMSHIRE: That conference recognises that system changes at secondary care level can make a significant adverse impact on patients and practices. In the spirit of integration, we request that GPC England negotiates a requirement of Integrated Care Systems to be that secondary care trusts must discuss any potential service changes in advance with the local LMC, committing to plan ahead together.

- 14e WIRRAL: That conference noted with keen interest that the establishment of ICS is predicated on improving integration of health and social care, and calls on GPC England to:
- (i) negotiate a better and binding primary / secondary care interface working document
 - (ii) ensure that general practice contracts and resources are not jeopardised by the introduction of ICS.
- 14f GATESHEAD AND SOUTH TYNESIDE: That conference is aware of significant discrepancies in commissioning around the country and:
- (i) respects the need for local commissioning to meet local need but has concerns about the gaps created for practices and patients
 - (ii) requires that a comprehensive database of enhanced services be created and maintained in order that GPs and LMCs alike can easily compare services and funding in order to argue for better locally
 - (iii) requires that GPCE negotiate for a patient-facing website to be created and maintained by each ICB, in order to explain what they have chosen to fund and not to fund at local level.
- 14g MORECAMBE BAY: That conference is concerned at the emerging practice of ICBs in imposing change to general practice through contractual routes rather than through enabling GP practices, as the prime providers of healthcare, to be empowered and supported to achieve change themselves.
- 14h CAMDEN: That conference resolves that in order to ensure that services are commissioned in a way that puts patients at the centre of care and are best for patients, GPC England must seek to establish that appropriately elected GP representation on the ICB becomes the norm and not the exception.
- 14i BEDFORDSHIRE: That conference:
- (i) is concerned that the ICS model seems to see PCNs as representing local GPs, despite the fact that many practices are minimally engaged in their PCN and some have opted out altogether, and
 - (ii) believes that it is essential that it is made clear that LMCs, as statutory bodies, are seen as the voice of general practice and that ICSs engage with them as such.
- 14j AVON: That conference is concerned by the membership of many ICB Boards and believes that GPC England should ensure that government understands that without a strong primary care voice on the boards, then the delivery and business case of primary care will be adversely affected.
- 14k NORTH YORKSHIRE: That conference asks GPC England to petition NHSEI to mandate an LMC representative is invited to sit on all ICB place-based boards and that no decision regarding primary care at place can be agreed without agreement with a suitable GP representative.
- 14l GATESHEAD AND SOUTH TYNESIDE: That conference condemns the loss of local knowledge and decision-making resulting from the abolition of CCGs and implementation of ICBs and demands the restoration and guarantee of at place commissioning.
- 14m GLOUCESTERSHIRE: That conference notes the very large number and variety of enhanced services within England commissioned in different ICB areas, all need to be standardised with minimal local

variation to ensure that all additional services are properly remunerated allowing practices to increase their workforce.

ICS - STATEMENTS

S1 DEVON:

- ICBs should be genuinely independent.
- General practice should have parity of esteem and parity of representation on the ICB.
- LMC's should be mandated advisors to ICBs in order to derive benefit to the ICS from their statutory role.
- New patient pathways should be agreed via the LMC and resourced appropriately (resource = funding, workforce, infrastructure and governance).

S2 BEDFORDSHIRE: What does your LMC think is needed regarding general practice within the ICS?

- Recognition of general practice within ICS, not PCNs
- Strong LMC presence / influence / involvement
- Clear locality operational support for practices so they (and the LMC) know who to speak to on a specific issue
- Recognition of primary care within pathways – almost all decisions made within the ICS will have a knock-on impact on general practice – therefore, assessing the impact on general practice needs to be built into every decision-making process
- Absolute protection of central general practice (not primary care) budgets within the ICS.

S3 HERTFORDSHIRE: What does your LMC think is needed regarding general practice within the ICS?

- Recognition of general practice within ICS, not PCNs
- Strong LMC presence / influence / involvement
- Clear locality operational support for practices so they (and the LMC) know who to speak to on a specific issue
- Recognition of primary care within pathways – almost all decisions made within the ICS will have a knock-on impact on general practice – therefore, assessing the impact on general practice needs to be built into every decision-making process
- Absolute protection of central general practice (not primary care) budgets within the ICS.

S4 NORTH STAFFORDSHIRE: The ICS must statutorily engage with LMCs and ensure general practice has equivalent representation and investment to trusts. This will require appropriate representation on relevant committees and education and understanding of the GP partnership model within the NHS monopoly system.

S5 AVON: Avon LMC is of the opinion that it is essential that there is representation of general practice by LMCs having a seat on each ICB and this should be mandated by NHSEI/I.

- S6 HEREFORDSHIRE: General practice needs to have a peer relationship with other providers in an ICS. It must have equal influence and these representative roles must be funded outside of GMS.
- S7 HILLINGDON: There needs to be a seat for LMCs to be at the table in the ICS. LMCs seems to have been side-lined as the representative voice for general practice and there seems to be a divide and rule agenda. A ring fenced sum is needed to maintain the integrity of primary care within the ICS and funding of £7.46 per patient weighted is not adequate to maintain nor sustain current services especially with the frail, elderly population being high users of the GPs .
- S8 LEEDS: There is a need for ringfenced baseline general practice funding with a clear expectation from NHS England to increase the proportions spent on general practice further by each ICS: Integrated working should reduce GP workload, not add to it, and all community delivered services should be properly priced to fully cover costs of delivery.
- General practice and LMCs should be properly represented at all levels of the ICS.
- S9 BRENT: ICPs may represent dilution of practice based ARRS roles - clinical pharmacists, social prescribers, linked social workers. There is a dearth of mental health practitioners within practices. Some PCNs have Complex Patient Management teams in which appropriate general practice actions are supported and moderated. These include colleague GPs. Extension of these teams would represent building teams from the ground up. Suggest increase in practice practitioners roles, while PCN multi-disciplinary teams strengthened.
- S10 MORECAMBE BAY: General practice needs to be recognised as a major provider of health care within the ICB, playing its full part, alongside partner organisations in planning and delivering health care. New GP Provider Leadership Teams need to form around clinical leads, LMC officers, PCN CDs and Federations to provide a coherent voice at Place and System level. Practice engagement must be secured through GP Assemblies being established in each Place to which the GP Leadership Teams are accountable. GP time is not a free good and needs to be appropriately reimbursed in participating in ICB business.
- S11 BRADFORD AND AIRESDALE: Work is needed both by LMCs and ICSs – there should be a unified LMC voice that is the Representative voice of General Practice. ICSs need to recognise and support that unified voice. Any other system of Representation is a repeat of the failures of the last 20 years – selecting what they want to hear, not what they need to hear. Decisions need to be made close to the patients. General practice can no longer be seen as a free, inexhaustible resource for the system, and should only absorb workload if they add value, and that value should be funded.
- S12 NORTH YORKSHIRE: 95% of care occurs in general practice, the authority related to the voice of general practice should reflect that, a cultural change is needed within the NHS re the respect offered general practice. ICSs need to understand what GPs do and protect primary care to facilitate protecting the rest of the system. Failure to maintain and restore general practice as a foundation of the NHS will result in the collapse of the whole house of cards – as such, LMC leaders need to be at the forefront of all major decisions within the ICS.
- S13 LINCOLNSHIRE: Representation, representation, representation. Despite the overwhelming majority of NHS activity being in general practice, we have historically been side-lined. Our expertise and understanding of our communities and how organisations interface is crucial to a well-functioning

ICS. ICS was to be a new dawn, but old habits die hard and slow progress in forming robust general practice representation in the ICS / ICB is a concern.

S14 DORSET: What does your LMC think is needed regarding general practice within the ICS?

- GPs who still work at the coal face need a leadership voice at the ICB / ICS at all levels
- A greater proportion of the ICS clinical budget should go towards primary care 90% of patient contact occurs in the community so surely this has the biggest potential for impact in terms of patient care and system efficiency.
- Develop of primary care alliances to give a unified provider voice within the ICS alongside the LMC.

S15 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: What does your LMC think is needed regarding general practice within the ICS?

- Ensure the voice of GP is heard at the highest level
- Fewer targets imposed by the ICS.
- More freedom to use funding originally allocated to the PCN within primary care at partnership discretion.

S16 HAMPSHIRE AND ISLE OF WIGHT: What does your LMC think is needed regarding general practice within the ICS?

- General practice needs to be at the front of the vision of the ICS
- Strong representation of primary care on the ICB and throughout the ICS structure
- Adequate funding for GPs is vital. Acknowledgement that there simply aren't enough GPs.
- Vital that the limited NHS service that we have available is appropriately understood and used by patient groups and the system.
- More information and education for patients about the roles available to support general practice and what CAN and CANNOT be done by general practice and in the community.
- Funding should go to the most efficient processes in the system
- We need to end the current culture of 'pass the parcel' of demand.

S17 NORFOLK AND WAVENEY: Decisions about and with general practice should be open to full public scrutiny, in order that primary care funds are properly used and not diverted to secondary and social care deficits. Primary care policies and decision-making should be at the heart of an ICS agenda.

S18 HARROW: Explicit recognition that investment in general practice is key to ensuring improved health outcomes and cost-efficient healthcare provision across the ICS. It requires adequate representation from GPs- via LMCs - in policy development and ICSSs. ICSS should prioritise ensuring that GPs are not burdened with inappropriate workload transfer or bureaucratic tasks since this is taking away from GPs being accessible to treat patients.

- S19 EALING: The new ICS structure need to be committed to investing in general practice. There is no magic bullet that will suddenly make primary care better, only the provision of resources, staff and a stable organizational structure will deliver a better service.
- S20 SHEFFIELD: It is felt that GP representation in the ICS should be aligned not to budget, but as a proportion of measurable workload. Decision-making bodies should always have general practice (provider) representation based in clinical, managerial and business expertise. Primary care must continue to be supported in stemming the workload transfer. In doing so it must look to support what is currently deliverable, whilst looking towards aspirational future development for mid to longer term planning. Practices may need to accept a degree of loss of autonomy to support / facilitate at scale timely commissioning.
- S21 WIRRAL: It has always been said at various fora that general practice is the crown in the jewel of NHS. Highest proportion of NHS activities/services take place in general practice even though it's funding does not reflect this truth. Our LMC believes that a strong and adequately funded GP representation, with voting rights, is a must within the ICS at all boards and managerial levels. GP contracts and resources should be safeguarded and not be jeopardised in any way.
- S22 SANDWELL: ICS will be moot in 12 months if general practice does not have a viable future.
- S23 GREENWICH: It is argued that because general practice has the most clinical patient contact within primary care, the voice of general practice should carry more weight than other primary care services (eg community pharmacy, optometry, etc). We are not all equal partners in that sense.
- S24 LEWISHAM: The formation of ICBs offers an opportunity for better communication and collaborative working; however, it needs adequate GP representation and a commitment from partners within the system to help address some of the challenges facing general practice. If the ICBs allow general practice to fail then all parts of the ICB will fail.
- S25 CLEVELAND: We need to see genuine parity of esteem, and funding being moved recurrently into general practice rather than invested into secondary care. It should feel like a genuine professional partnership, not top-down control via management structures.
- S26 SUTTON: A fair and proportionate general practice voice so that it is involved in transparent decision-making processes at the outset rather than once key policy decisions have been made. General practice has the highest proportion of patient contacts so funding, decision-making and services adequately need to match this. The autonomy of practices must be respected and maintained. Whilst acknowledging ICS principles, the struggle for general practice is undertaking proactive care when there is such demand for reactive care, some of which is due to unreasonable patient expectations consequently adversely affecting those who need more GP time not able to receive this.
- S27 WANDSWORTH: Following the shift in decision making with the transition from CCGs to ICSs it is imperative that general practice voice is not lost and is represented appropriately on the ICS. General practice is the foundation of the NHS and GPs' long-term relationships with patients and it must be acknowledged that GPs are valuable contributors to the ICS. General practice requires adequate funding, remuneration and resources to aid recruitment and retention and GPs' roles

cannot be replaced by ARRS. Adequate remuneration and workforce should also follow any shift of work from secondary to primary care.

- S28 MERTON: Greatly improved representation of general practice at ICS level in recognition that it manages the great majority of patient contacts. Parity of esteem and influence for general practice as presently it feels that the system is currently integrated in name only. Genuinely improved team working and mutual respect.
- S29 LAMBETH: We need a proper GP voice, not just a token individual. We need representatives with strong links back into the communities they represent, and real influence in the ICB / ICS. We need to have our budgets to be increased, ring fenced and not at risk. We need colleagues in secondary care to take time to really understand how primary care works, and the degree of both clinical and financial risk that we hold. We need clear processes and accountability re contract monitoring and performance management at practice level.
- S30 BERKSHIRE: Regarding GPs within the ICS, the main concern with the new organisation is that although we carry out 90% of the consultations in the NHS and are responsible for looking after virtually the whole population, there seems to be a culture of only having one representative at Board level. We note the same issues applied with the HEE Board and it took a lot of lobbying to get two general practice reps one being LMC and one being from the CCG.
- S31 ENFIELD: General practice needs to be represented to the same level as secondary care within the ICS. Collaborative solutions need to be sought, where we work together to improve patient care, rather than the current model of pushing work away from one organisation to another as a means of solving workload issues eg secondary care to primary care transfer.
- S32 CROYDON: Colleagues believe the ICS statutory framework undervalues and under represents the contribution of general practice, mirroring NHS England's perceived attitude. Addressing this locally by LMCs depends on local relationships. General practices are disadvantaged compared with trust organisations, being small, managerially diverse, and without effective levers preventing them being overwhelmed as default providers of care. Few colleagues believe the ICS model, decision-making by stakeholder collective agreement, is credible and fails to provide transparency and accountability. Colleagues believe that unless the value of general practice is genuinely recognised, which it is currently not, it will inevitably 'punch below its weight' within the ICS.
- S33 EAST SUSSEX: Colleagues believe the ICS statutory framework undervalues and under represents the contribution of general practice, mirroring NHS England's perceived attitude. Addressing this locally by LMCs depends on local relationships. General practices are disadvantaged compared with trust organisations, being small, managerially diverse, and without effective levers preventing them being overwhelmed as default providers of care. Few colleagues believe the ICS model, decision-making by stakeholder collective agreement, is credible and fails to provide transparency and accountability. Colleagues believe that unless the value of general practice is genuinely recognised, which it is currently not, it will inevitably 'punch below its weight' within the ICS.
- S34 KINGSTON AND RICHMOND: Colleagues believe the ICS statutory framework undervalues and under represents the contribution of general practice, mirroring NHS England's perceived attitude. Addressing this locally by LMCs depends on local relationships. General practices are disadvantaged compared with trust organisations, being small, managerially diverse, and without effective levers preventing them being overwhelmed as default providers of care. Few colleagues believe the ICS

model, decision-making by stakeholder collective agreement, is credible and fails to provide transparency and accountability. Colleagues believe that unless the value of general practice is genuinely recognised, which it is currently not, it will inevitably 'punch below its weight' within the ICS.

- S35** SURREY: Colleagues believe the ICS statutory framework undervalues and under represents the contribution of general practice, mirroring NHS England's perceived attitude. Addressing this locally by LMCs depends on local relationships. General practices are disadvantaged compared with trust organisations, being small, managerially diverse, and without effective levers preventing them being overwhelmed as default providers of care. Few colleagues believe the ICS model, decision-making by stakeholder collective agreement, is credible and fails to provide transparency and accountability. Colleagues believe that unless the value of general practice is genuinely recognised, which it is currently not, it will inevitably 'punch below its weight' within the ICS.
- S36** WEST SUSSEX: Colleagues believe the ICS statutory framework undervalues and under represents the contribution of general practice, mirroring NHS England's perceived attitude. Addressing this locally by LMCs depends on local relationships. General practices are disadvantaged compared with trust organisations, being small, managerially diverse, and without effective levers preventing them being overwhelmed as default providers of care. Few colleagues believe the ICS model, decision-making by stakeholder collective agreement, is credible and fails to provide transparency and accountability. Colleagues believe that unless the value of general practice is genuinely recognised, which it is currently not, it will inevitably 'punch below its weight' within the ICS.
- S37** BUCKINGHAMSHIRE: Regarding GPs within the ICS, we need:
- All "Shared Care" to include financial remuneration to resource the work, recognising this work falls outside the core GP role.
 - Review of funding of general practice to reflect increased transfer of workload from secondary care.
- S38** KENT: Currently general practice is under represented at ICB level. In Kent and Medway the LMC has created a GP board with LMC reps, PCN CDs and GP partners on the ICB. We believe that this GP board, coordinated by the LMC, should feed directly into the governance structures of the ICS / ICB. We would like LMCs to be recognised formally as the representative voice of general practice as a provider body, on parity with acute, mental health and community trusts.
- S39** SEFTON: Protection from top-down enthused transformers. A clear and unambiguous guarantee that no decision re plans and schemes which affects the funding and organisation of a general practice can be taken without the express agreement of the practice or it's delegated its representatives.
- S40** OXFORDSHIRE: Regarding GP within the ICS:
- We see the value of the GP voice in commissioning but this must be adequately supported – with backfill / resource, and administrative support.
 - We see GPs main role as providers rather than as commissioners.

- S41 DERBYSHIRE: Strong representation at the highest level, a genuine understanding of what general practice does for the system and recognition of the real and dramatic pressures currently faced. A genuine partnership approach that values general practice as an equal partner in the ICS.
- S42 LIVERPOOL: That conference is concerned that ICBs are really only interested in hospitals and hospital episodes of care, and the agenda being set will fund general practice to ensure that hospitals don't collapse rather than celebrate what general practice can offer. The ICB footprint has resulted in the ICB being too distant from general practice, reversing the efforts made by PCTs and CCGs to place general practice at the heart of delivery of care locally. The presence of one GP on the ICB and lack of LMC involvement at ICB level doesn't instil confidence that the ICB is interested in general practice.
- S43 WIGAN: Protection from top-down enthused transformers. A clear and unambiguous guarantee that no decision re plans and schemes which affects the funding and organisation of a general practice can be taken without the express agreement of the practice or it's delegated its representatives.
- S44 NEWHAM: General practice needs to be a truly equal partner within the ICS, with general practice representatives being independent of the ICS, in the same manner as general practice is independent of the NHS. The ICS needs to recognise the independent nature of general practice and must create the environment in which a unified voice of general practice develops from the ground up. Mandatory representation at all levels of the ICS by LMC members is essential, so that the needs of individual GP practices are considered as well as "at scale" general practice, with LMC seated alongside PCN and federation representatives.

(Supported by City and Hackney, Redbridge, Tower Hamlets and Waltham Forest)

- S45 GLOUCESTERSHIRE: Greater understanding that general practice is key in the overall healthcare system when general practice splutters hospitals catch a life threatening cold and are swamped. We need proper board representation with training from the BMA. Full analysis of appointments and data to identify when general practices are experiencing unsustainable levels of workload eg Devon's GPAS. The myth that A&E attendance correlates to failure to get GP appointments must be exposed as a falsehood . The ICS needs to understand that general practice cannot take on extra work without appropriate funding, every duplicated referral means one less patient seen per day.
- S46 NOTTINGHAMSHIRE: General practice needs to be at the forefront of leading ICS strategy as it is the bedrock of the NHS. No other part of the NHS delivers the return on investment for every tax payer's pound compared to general practice. If the foundations are laid right, then the rest of the system can be built upon a sound footing. If we ignore the voice of general practice in service design, by being too secondary care-centric, then the system will soon topple.
- S47 WORCESTERSHIRE: What does your LMC think is needed regarding General Practice within the ICS?
- There is a risk of a diluted voice for general practice within an ICS so there must be GP representation on all boards and across all meetings that affect practices. Federations , Clinical Directors and LMCs need to work together whilst retaining their own unique roles and responsibilities in order to protect the interests of general practice as a whole. The system will not engage with numerous entities on behalf of general practice so we must work together to ensure we cannot be played off against each other or have our interests undermined. This will require strong partnerships and trust between GP organisations. Success will be underpinned by a willingness to transfer resources from other organisations where general practice is able to provide

a better service for patients. General practice must be able to quantify the work it currently does and the resource needed for new initiatives. A strong focus on workforce initiatives and wellbeing is an immediate requirement.

- S48 CHESHIRE: A strong and effective GP voice. Considering something like 90% of patient contacts occur in general practice, we need to ensure we are well represented when decisions are made about commissioning services, funding etc.

GP CONTRACT

14.40

To submit a speaker slip for Motion 15 – please click [here](#)

- * 15 GATESHEAD AND SOUTH TYNESIDE: That conference views core hours as a relic of history and:
 - (i) notes that they total 52.5 hours per week, starting earlier and finishing later than most other jobs, including childcare
 - (ii) believes that they indirectly discriminate against GPs who wish to have families
 - (iii) is concerned that due to the still-patriarchal nature of English society, this is discrimination that mostly affects female GPs
 - (iv) requests that any new contract reduce core hours to 0900-1700hrs, but with practices to start earlier/finish later on some days, as per extended hours, in order to meet local need and practice ability to staff this.

- 15a BEDFORDSHIRE: That conference calls upon GPC England to make the case that patient care could be improved by taking the following steps to address the workload/workforce mismatch:
 - (i) looking to reduce core hours because the increasing requirement to extend consulting hours and services only spreads a limited workforce ever more thinly and there is no evidence that it improves patient care
 - (ii) promoting the condensing of the working day to create a more positive, focused and responsive workforce
 - (iii) conducting an impact assessment of such changes, which should acknowledge that there needs to be a clear definition of the division of the roles of general practice and the wider health system.

To submit a speaker slip for Motion 16 – please click [here](#)

- * 16 OXFORDSHIRE: That conference:
 - (i) believes referring to GPs as “full time”, “part time”, or “full time equivalent” in terms of numbers of “sessions” worked fails to capture the real hours worked by many GPs
 - (ii) demands that any new BMA model contracts (such as may be required alongside any new GMS contract) define GP working schedules in terms of hours rather than sessions
 - (iii) demands that any workforce data collection (eg for NHS workforce planning) be done on the basis of hours worked, not contracted sessions.

- 16a GP TRAINEES COMMITTEE: That conference recognises the findings of the “Eleventh National GP Worklife Survey 2021”, specifically that GPs working greater than six but less than or equal to seven sessions a week report working over 42 hours a week, on average. This is incompatible with the BMA definition of full time working for a sessional GP (nine nominal sessions being 37.5 hours). We call on GPC England, working alongside Sessional GP Committee and GP Trainees Committee to:
- (i) review the definition of “full-time general practitioners”
 - (ii) amend the model contract for employed GPs to reflect a definition of “full-time general practitioners” that better represents current working conditions
 - (iii) produce a position paper for the aforementioned committees which highlights the benefits and pitfalls in moving to an exclusively hours based payment model for employed GPs.
- 16b DERBYSHIRE: That conference notes for wider public consumption that the GP workforce figures published by NHS Digital counts a full-time equivalent GP as 37.5 hours per week and that the GP contract requires 52.5 hours per week thus resulting in an immediate 40% underestimate of the number of GPs required or available.
- 16c GP TRAINEES COMMITTEE: That conference notes that NHS Digital define a full time NHS worker as one who works 37.5 hours week. As a full-time GP Registrar works 40 hours a week minimum, this means NHS Digital report 16 full-time equivalent GP Registrars for every 15 full-time GP Registrars working in practices in England. We call on GPC England to publicly address this factitious representation of GP Trainee numbers.
- 16d CAMBRIDGESHIRE: That conference notes the increase in size, age, morbidity, need and demand across England’s population and demands GPC England works with key stakeholders to develop a workforce strategy informed by data to support:
- (i) an accurate ratio of suggested appointments required per week
 - (ii) a realistic calculation of number of patients allocated per FTE GP
 - (iii) an end to the anachronistic notion of a GP "session" to be replaced with hours and substantive job plans
 - (iv) a proposal to reintroduce seniority payments to mitigate attrition of experience
 - (v) a new funding formula to replace Carr-Hill which acknowledges the historic loss of MPIG.
- 16e GLOUCESTERSHIRE: That conference requests a careful investigation by GPC England and the GPDF into the terminology to demonstrate GPs workload, as one session can represent up to 10 hours work yet count as far less statistically, and "part time" in general practice often means well in excess of 50 hours per week.

ENHANCED ACCESS

15.20

To submit a speaker slip for Motion 17 – please click [here](#)

- * 17 AGENDA COMMITTEE TO BE PROPOSED BY HERTFORDSHIRE: That conference with regards to the enhanced access requirements of the PCN DES:

- (i) believes that extending the times of providing services is not a solution but exacerbates the problems faced in primary care
- (ii) has enormous concerns that this will destabilise existing out-of-hours GP services, with harm resulting to patients
- (iii) demands that this scheme be repealed from April 2023.

17a HERTFORDSHIRE: That conference, with regard to the PCN Network Standard Hours and the patient survey results:

- (i) is disappointed that patient survey results were not taken into full account for PCNs to tailor the Network Standard Hours (NSH) to the outcomes realised
- (ii) believes that, at a time of GP shortage and exhaustion in addition to an absolute crisis with regard to patient access, extending the times of providing services is not a solution but indeed exacerbates the problems faced in primary care, and
- (iii) mandates GPC England to negotiate for PCNs to renegotiate NSH with ICBs to reflect patient survey results, and for an allowance for more flexibility of delivery of services to patients which allows for innovate proactive health initiatives.

17b BROMLEY: That conference:

- (i) reject the imposition within the Network Contract DES that PCNs be required to provide enhanced access appointments between the hours of 6.30pm to 8pm Mondays to Fridays and between 9am and 5pm on Saturdays; and
- (ii) challenge any notion of making the extended hours in the PCN contract into new network core hours.

17c GATESHEAD AND SOUTH TYNESIDE: That conference, with regard to the extended access requirements of the PCN DES:

- (i) is alarmed by the spread of 'routine' work into Saturdays
- (ii) believes that, in areas where PCNS are to deliver this, it is likely to accelerate burn-out
- (iii) is concerned that, by removing the 'urgent issue-only' provisions in previous extended access schemes, GPs working in this scheme, particularly for federations, are being set up to fail
- (iv) has enormous concerns that this will destabilise existing out-of-hours GP services, with harm resulting to patients
- (v) demands that this scheme be repealed from April 2023.

17d WALTHAM FOREST: That conference deplores the action of local primary care contracting managers in how they have interpreted the requirements of the PCN DES enhanced access specification and:

- (i) insists that national specification should not be open to local interpretation
- (ii) requires NHSEI to implement a system to enable individual practices and LMCs to formally complain to the national NHSEI leadership when local managers try to change the requirements of national contracts, so that they are held to account.

- 17e KENT: That conference rejects the imposition of 'Network Standard Hours' and:
- (i) is concerned that this further undermines independent contractor status
 - (ii) demands individual practices are given the freedom to plan services to meet their patient's needs.

INTERFACE

15.30

To submit a speaker slip for Motion 18 – please click [here](#)

- * 18 AGENDA COMMITTEE TO BE PROPOSED BY LEEDS: That conference notes the increase in attempted shifting of work from secondary to primary care since the introduction of block contracts for trusts and calls for:
- (i) all trust-employed staff to request prescriptions, investigations and referrals from within their team, and to promote this by the creation of educational materials for use in their induction of new staff
 - (ii) LMC approved audits to be conducted to demonstrate that trusts' annual action plans result in improvements
 - (iii) all trusts to have a standardised 'work-dump' email for use by practices, to be monitored and actioned daily
 - (iv) all trusts to have a dedicated telephone and online portal to deal with patients who are experiencing delays in secondary care treatment, without recourse to their general practitioner.
 - (v) data to be collected and published, in order to publicly shame Trusts which persist in shifting work onto GPs without agreement or resource.
- 18a LEEDS: That conference demands that the national NHS Standard Contract is amended to:
- (i) require the secondary care providers annual action plan to be formally approved by the relevant LMC
 - (ii) ensure that LMC approved audits are conducted to demonstrate that action plans result in improvements
 - (iii) require secondary care providers to address issues raised by LMCs in their action plans
 - (iv) require commissioners to develop pathways that address issues raised by action plans.
- 18b GATESHEAD AND SOUTH TYNESIDE: That conference notes the increase in attempted shifting of work from secondary to primary care since the introduction of block contracts for trusts and:
- (i) is aware that there is significant variability in the attitudes of trusts and LMCs, leading to many practices being overwhelmed
 - (ii) is aware that some trusts have sought to improve finances by gapping doctor posts and de-skilling certain services since this change
 - (iii) reiterates previous demands for financial penalties for trusts attempting to dump work upon GPs

- (iv) calls for all trusts to have a standardised 'work-dump' email for use by practices, to be monitored and actioned daily
 - (v) requests that data be collected, and published, in order to publicly shame Trusts who persist in shifting work onto GPs without agreement or resource.
- 18c** LEEDS: That conference believes that many of the longstanding problems with the primary-secondary care interface, and which seriously impact patient care, could be resolved with secondary care use of electronic prescribing systems (EPS) and therefore demands that NHS England rapidly implement EPS in all NHS Trusts to enable secondary care specialists to be able to maintain continuity of care with their patients and prescribe medication for them which can be dispensed in the community.
- 18d** REDBRIDGE: That conference recognises that the current NHS contract does not stop the inappropriate workload transfer from secondary care to general practice and recommends that NHSEI amends the NHS standard contract so that a proportion of hospital and community trust funding is linked to receiving satisfactory feedback from a general practice satisfaction survey.
- 18e** GATESHEAD AND SOUTH TYNESIDE: That conference requires GPC England to create a patient-facing website that patients can be directed to, with both explanation of relevant contractual details and working contact details for relevant trusts, when a secondary care clinician has failed to fulfil their contractual duties.
- 18f** CAMBRIDGESHIRE: That conference recognises general practice is sinking under a tsunami of inappropriate and unfunded workload transfer, and whilst awaiting negotiation of a nationally funded hospital discharge system, GPC England must support general practice to immediately implement emergency measures in supporting LMCs to help create GP capacity to include:
- (i) adding the Cambridgeshire LMC pushback letters to the BMA suite of workload resources
 - (ii) publishing models of capped same day urgent care provision
 - (iii) advising practices how to close their lists
 - (iv) advising practices how to close their branch surgeries.
- 18g** HERTFORDSHIRE: That conference:
- (i) believes that the current fractured system of “passing the buck” between secondary and primary care needs to stop to enhance patient care and clinical efficiency
 - (ii) calls on GPC England to work with the BMA Consultants Committee and the Government to create contracts that require clinicians in secondary and primary care to take full ownership of their clinical assessment and management plans, including prescribing, investigating and responding to the results of their investigations, and
 - (iii) calls on GPC England to negotiate that processes are in place that the ICSs will follow to ensure that secondary care abide by their contractual duties as set out above.
- 18h** WIGAN: That conference lauds the sterling work which many LMCs have undertaken to produce secondary / primary care interface agreements which control and manage the handling of referrals and discharges etc across the sectoral boundary. These are not a bulwark against the off-loading of

unfunded work and the pressure in the system for GPs to maintain extended preoperative - backlog-case management needs to be addressed and specifically resourced.

- 18i** COVENTRY: That conference strongly recognises that despite repeated calls and agenda submissions, secondary care work that should be dealt with under the hospital contracts continues to be passed onto primary care. Conference insists that NHSEI takes committed steps to:
- (i) ensure that all Acute Trusts reissue clear guidance to their staff
 - (ii) specialist nurses must request prescriptions, investigations and referrals from within their team, not from primary care
 - (iii) ensure that patients should not be made to suffer, so they should support hospitals in having the staff and systems in place so that requests that should be dealt with in secondary care can be returned and dealt with promptly
 - (iv) audit examples of inappropriate work transfers themselves, as it is not the role of Primary care to have to regulate this.
- (Supported by Warwickshire)
- 18j** BERKSHIRE: That conference notes that patients receiving care from secondary care (eg for invasive procedures or surgery) are often discharged directly after treatment, with a recommendation that the GP may re-refer in case of post-procedure complication, and:
- (i) believes this trend may have reduced workload in hospitals to the detriment of GP workload and patient safety
 - (ii) believes that the patient can often recognise when a post-operative complication is or may be occurring, without requiring input from a GP
 - (iii) calls for this suboptimal trend to be recognised by our specialty colleagues
 - (iv) calls for future standard hospital contracts and other specialty contracts to include a standard for post-operative “open access” whereby such patients have a clear route of return to their specialist, or a member of the same team, for a minimum period of 2 weeks from the date of the procedure.
- 18k** DERBYSHIRE: That conference objects to the increasing rejection of referrals by secondary care and calls on GPC England to work with Department of Health / NHSEI to ensure that inappropriate rejection of referrals is prevented.
- 18l** MID MERSEY: That conference demands an urgent end to unfair, inappropriate and unresourced transfer of secondary care work to primary care.
- 18m** CUMBRIA: That conference believes:
- (i) primary care can no longer prop up a failing secondary care system which treads on the dreams of GP partners, and not softly
 - (ii) the current unfettered access to primary care through an “all you can eat model of general practice” promotes an unfunded work dump for secondary care

- (iii) as such we call upon practices to only perform work on behalf of secondary care when it is both funded and resourced.
- 18n SOMERSET: That conference calls for all communication to GP practices from other health and social care organisations to come via an approved nationally designed template form:
 - (i) GP actions to be stated clearly in bold at the top
 - (ii) any other communication would be rejected as not on the appropriate form.
- 18o DORSET: That conference acknowledges the current climate is creating difficult times for all in the NHS. Poor communication between interfacing providers causes risks to patient safety. Conference asks GPC England to lobby NHS England to make it a requirement that all acute and community providers have standardised and adequate communication channels as judged by end users.
- 18p NORTH STAFFORDSHIRE: That conference demands that the GPC England do a full complexity and workload transfer analysis of the new burden on general practice from delayed and virtual secondary and tertiary care and then negotiates fair and rigorous investment for this burden, which is the single biggest stressor on the GP role.
- 18q NOTTINGHAMSHIRE: That conference recognises that practices are being drowned by the increasing volume of shifting/dumping of work from secondary care into general practice. This abuse of good will and the exploitation of the contractual systems and GPs need to stop. Conference calls for:
 - (i) support and investment into creation of educational materials for use in induction for junior doctors on the primary / secondary care interface
 - (ii) backing from the profession to implement contractual levers and contract management that has teeth.
- 18r NORFOLK AND WAVENEY: That conference requests that GPC England lobby NHSEI to ensure that the new Integrated Care Systems insist, that secondary care organisations allow and facilitate the expanded primary care workforce allied professionals rights, to order appropriate pathology and radiological investigations under their own professional standing rather than requiring this to be done through general practitioner surrogacy.
- 18s AVON: That conference requests that as we move into a world of more integrated working that barriers to referral or communication with colleagues in trusts and different organisations are dissolved. Furthermore, where new referral pathways are implemented, these have to be co-designed with general practice and not implemented by the party who can hide behind the barrier.
- 18t CENTRAL LANCASHIRE: That conference believes that general practice should not make use of any new referral forms from providers that introduce unfunded work and are designed to limit referrals from GPs and, moreover, that general practice should resist any transfers of work from other providers by mandating its own referral forms for their use.
- 18u SUFFOLK: That conference recognises that general practice is exasperated by the tidal wave of inappropriate and unfunded transfer of work from secondary care and calls upon GPC England to negotiate a mechanism by which practices can send invoices for this work to the providers responsible.

- 18v** CUMBRIA: That conference believes that the accepted definition of delegation from the few to the many is directly in conflict with national NHS practice where secondary care, with 90% of the workforce and 24% of the activity, is constantly delegating work to primary care with 10% of the workforce and 76 % of the activity.
- 18w** CLEVELAND: That conference believes that patients in England on long waiting lists for tests, operations, specialist assessments and therapies have been failed, but not by their GPs, and that communication to patients about this needs to be improved to ameliorate the workload burden secondary care waits are causing in general practice.
- 18x** BERKSHIRE: That conference notes a trend for NHS community and secondary care services to reduce their provision, citing capacity and staffing issues, with corresponding reliance on the NHS GP to make up the shortfall, and demands that commissioners of such services take urgent steps to ensure alternative provision, which may include offering additional funding to the GP to provide these services as truly optional additions to the GP's core contracts, but must not assume that all GPs will be able to provide the services required.
- 18y** DERBYSHIRE: That conference reminds NHSEI that GPs do not refer patients to hospital for frivolous reasons nor out of idleness but for reasons of:
- (i) reaching their limits of skill, knowledge, expertise as generalists
 - (ii) need for specialised equipment procedures or investigations
 - (iii) need for interventions of a frequency or depth for which general practice is either unable to provide or is not commissioned
 - (iv) reasonable patient request or the GP seeking reassurance of being on the right track.
- 18z** HERTFORDSHIRE: That conference:
- (i) believes that referral pathways need a structural reform, as the current system with its endless forms acts as a barrier to patients being referred in a timely manner, impacting on patient safety, and
 - (ii) calls on GPC England to negotiate with the government that ICSs should review referral pathways and that any changes can only be made in consultation with GPs.
- 18aa** GLOUCESTERSHIRE: That conference is deeply concerned at the desperate situation in hospital trusts and calls on GPC England to launch a widespread publicity campaign to highlight the many problems that the workload shift is causing in general practice Including access to GPs.
- 18bb** DEVON: That conference recognises the unprecedented level of demand and workload in English general practice and demands:
- (i) a national NHS media campaign highlighting this dilemma and encouraging patients to use our services appropriately and when there is no viable alternative
 - (ii) that all acute trusts have a dedicated telephone and online portal to deal with patients who are experiencing delays in secondary care treatment, without recourse to their general practitioner.

- 18cc HERTFORDSHIRE: That conference:
- (i) believes that the NHSEI target that at least 25% of OP appointments should be via telephone is further worsening the crisis within general practice, and
 - (ii) calls on GPC England to negotiate with the BMA Consultants Committee and the Government to have the NHSEI target on OP appointments via telephone to be ended.
- 18dd DERBYSHIRE: That conference reinforces the GMC concept that the art of good medical practice is utterly dependent on speedy accurate and free flowing communications with both patients and professional colleagues; and is gravely concerned that this process is being seriously compromised by NHS trusts and other agencies operating electronic fortresses impenetrable by general practice utilising emails and management by voicemail as poor substitute for a rapid brief phone call. It calls upon NHSEI to develop with the GPC better more flexible and personal communications protocols as a matter of urgency.
- 18ee DERBYSHIRE: That conference objects to the increasing use of excessively bureaucratic referral proformas and calls on GPC England to lobby the Department of Health / NHSEI to ensure the NHS standard contract precludes their use.
- 18ff COVENTRY: That conference believes that increased levels of secondary care rejecting referrals of patients is causing unnecessary workload, delaying patient care and putting patients at risk of harm. GPs are being increasingly asked to fill in frequently changing referral proformas that have not been agreed with primary care. GPs should not be obliged to fill in proformas to refer their patients. Rejections of referrals must not be accepted as when a GP refers to secondary care, they clearly believe that the patient requires specialist care.
- (Supported by Warwickshire)
- 18gg WORCESTERSHIRE: That conference believes that non adherence to the NHS Standard Contract interface requirements by secondary care is resulting in unacceptable levels of workload being transferred to general practice which is impacting on access to routine care for patients. Conference demands that GPC England explore other options around enforcing the contract and insists that payment be made to general practice for work carried out on behalf of secondary care until this is resolved.

DEFENCE OF GENERAL PRACTICE

15.40

To submit a speaker slip for Motion 19 – please click [here](#)

- * 19 LIVERPOOL: That conference believes the relentless denigration of general practice continues to drive a crisis of recruitment and retention and that GPC England:
 - (i) must respond in a robust and timely manner to news reports which unfairly target general practice
 - (ii) needs a dedicated PR budget to provide a robust and timely defence of general practice.
- 19a SUTTON: That conference notes that gaps in communication can arise when there is unilateral way of working and calls upon NHSEI to:

- (i) respect general practice for the hard work it delivers and communicate directly with the workforce instead of via the media especially the morning news bulletins on TV
 - (ii) build trusting, working relationships with the LMCs and BMA to discuss planning and delivering additional services and in those exceptional circumstances like the Polio vaccination in children in London
 - (iii) be cognisant of the fact that gaps in communication do not aid workforce recruitment or retention and adversely affects morale in GP as it demonstrates a breaking system.
- 19b** SUFFOLK: That conference is enraged by the repeatedly hateful anti-GP comments made in the media. As this not uncommonly echoed by NHS England and members of the government, conference calls GPC England to impress upon them the need to:
- (i) recognise the damaging effect this is having on workforce recruitment and retention
 - (ii) accept responsibility for their own failures in addressing the GP workforce crisis
 - (iii) work with the BMA to develop and deliver a strategy to recover some of the damage already caused by their toxic communication.
- 19c** WANDSWORTH: That conference believes that whilst there are many crises and challenges currently facing general practice there is still much to celebrate and calls upon the GPC England to mount a campaign to celebrate the achievements and contributions of general practice including the delivery of the largest vaccination campaign in history.
- 19d** DEVON: That conference acknowledges the negative impact that the media is having on the profession and asks GPC England to take steps to counter the untruths that are being fed to the population This may even include a full media boycott.
- 19e** MID MERSEY: That conference deplores selected media campaigns set out to derail general practice and calls upon our representative bodies collectively to fight for our profession, in a sustained and meaningful way, in order to prevent catastrophic and irreparable damage to the profession and patient care.
- 19f** LIVERPOOL: That conference believes that the BMA media team should be providing members of GPC England and its executive with the tools that they need to form a far more robust response to the constant barrage of negative and inaccurate reporting in the press and social media of GPs being lazy, part-time and overpaid.
- 19g** BUCKINGHAMSHIRE: That conference notes newspaper headlines such as “GPs in England get green light to provide less care and join Covid jab drive” (the Guardian, 3 December 2021), and:
- (i) believes this suggests a concerning media tendency to undermine general practice, even when England needs it most
 - (ii) believes that existing relationships between the media, NHS England and Her Majesty’s Government do not result in a fair depiction of general practice in England
 - (iii) demands that the BMA seek an apology from, and holds accountable, those who depict the profession unfairly.

- 19h GATESHEAD AND SOUTH TYNESIDE: That conference deplores the actions and words of NHS England throughout the pandemic and to this day, and:
- (i) believes that said actions have resulted in a public increasingly hostile to GPs, with verbal and physical assaults resulting
 - (ii) is aware that at no point have NHS England personnel apologised to GPs for misleading statements resulting in said hostility
 - (iii) is concerned that the policy of bypassing GPC England appears to continue, using the right-wing press for announcements of un-negotiated policy
 - (iv) condemns NHS England's senior staff responsible for primary care utterly for the harms they have knowingly inflicted and calls for their resignation
 - (v) notes that, were NHS England a patient, then due to their own behaviour, according to their own policies, any GP surgery would be within their rights to off-list them due to breakdown of relationship.
- 19i SEFTON: That conference notes that the election of the new Prime Minister means that the £12B pa additional funding for the NHS and social care through NI contribution increases is unlikely to materialise. In view of the imminent crisis in the NHS posed by the coming winter and the need for increased real terms funding in excess of that promised by the last Prime Minister - it calls for an extensive dedicated campaign to inform the / patient public of the true depth of the crisis and call upon them to support a call for a real term funding settlement for the NHS.
- 19j CITY AND HACKNEY: That conference deplores the release of new contractual obligations for general practice and national public health responses to national media without prior communication to general practice and:
- (i) demands that any future communications related to general practice are discussed and agreed with GPC England prior to release
 - (ii) insists NHSEI informs GPs of any contract changes in advance of any media releases.
- 19k TOWER HAMLETS: That conference has had enough of unhelpful communications from NHSEI which inappropriately raise patient expectation, impose ridiculous deadlines and unnecessarily increase general practice workload and demands that NHSEI do not send out any communication until it has been agreed with GPC England or with the local LMC to which it pertains.
- 19l SUFFOLK: That conference demands an end to the double standards displayed by NHS England and the government through both simultaneously promoting development of Digital First healthcare behind closed doors, and then unashamedly and publicly abusing general practice on the media altar of "face-to-face appointments".

WORKFORCE

15.50

To submit a speaker slip for Motion 20 – please click [here](#)

- * 20 CROYDON: That conference believes that doctors who are not on the NHS England Medical Performers List should be allowed to undertake general practice primary medical services under the clinical supervision of a general practitioner.

EMERGENCY BUSINESS / CHOSEN MOTIONS

16.10

To submit a speaker slip for emergency business/chosen motion – please click [here](#)

GPC ENGLAND

16.40

To submit a speaker slip for Motion 21 – please click [here](#)

- * 21 AGENDA COMMITTEE TO BE PROPOSED BY CAMBRIDGESHIRE: That conference believes that general practice will be best represented by a united GPC England, and:
 - (i) calls on GPC England to review the impact of the Meldrum report
 - (ii) believes that the interests of principals and non-principals will be best served by subcommittees representing contract holders and non-contract holders
 - (iii) directs GPC England to meet at least six times a year and that all meetings should have in-person and hybrid options for attendance
 - (iv) calls upon GPC England to urgently restructure its membership to be composed of LMC officers aligned with the 42 ICS footprints for maximum accountability.
- 21a CAMBRIDGESHIRE: That conference believes that compared with the three devolved nations, the mapping of regional representatives in England is ineffective, and calls upon GPC England to urgently restructure its membership to be composed of LMC officers aligned with the 42 ICS footprints for maximum accountability.
- 21b MANCHESTER: That conference believes that general practice will be best represented by a united GPC England but that the interests of principals and non-principals will be best served by subcommittees representing contract holders and non-contract holders. We oppose any division of general practice and instruct GPC England to bring modernisation proposals consistent with these principles to this conference in 2023.
- 21c BEDFORDSHIRE: That conference calls on GPC England to review the impact of the Meldrum report, with particular attention to the unexpected consequences of Covid-19 that fewer meetings increase the isolation of reps and, with remote meetings, the cost saving is not an issue.
- 21d LEEDS: That conference, noting the scope and significance of the issues relating to general practice, directs GPC England to meet at least six times a year and that all meeting should have in-person and a hybrid option for attendance.

- 21e CAMBRIDGESHIRE: That conference notes the astonishing inequity of English GP representation, receiving one representative per 1.5 million population on GPC England, compared with one per 130k population in other devolved nation GPCs of the UK and calls upon GPDF to produce a report on national disparities of representation and proposed solutions, prior to the 2023 UK Conference of LMCs.
- 21f GP TRAINEES COMMITTEE: That conference recognises the benefits that can only come from face to face or hybrid committee meetings. We therefore call on GPC England to work with the BMA and GPDF to ensure funding is supplied to all meetings of GPC England, GP Trainees Committee and Sessional GP Committee to ensure that all meetings of those committees can be held face to face or hybrid.
- 21g NOTTINGHAMSHIRE: That conference acknowledges that the GPC England / LMC axis needs to be strengthened. We would like LMCs to be more involved in the process of nominating and electing GPC England representatives locally and ask that GPC England makes it mandatory that GPC England local representatives are elected conducted through LMCs.

CLOSE

17.00

Conference of England LMC Representatives

Agenda: Part II
(Motions not prioritised for debate)

Agenda: Part II

To be considered in break out room session of special conference

22. HERTFORDSHIRE: That conference calls on GPC England to ensure that there are break clauses / breaks for exceptionalities negotiated into any future multi-year deals.
23. NORTHUMBERLAND: Continuity of care has been shown to improve outcomes and increases clinician satisfaction. Conference demands that this is enshrined in all future policy applicable to primary care.
24. LAMBETH: That conference instructs GPC England to negotiate GP contracts which reward continuity of care.
25. SHEFFIELD: That conference notes that the five year GP contract reform changes announced in 2019 are due to come to an end soon and there is significant concern about the lack of clarity of what the future arrangements will be for general practice. The conference therefore requests an urgent update from GPC England in relation to:
 - (i) how the PCN funding streams will be incorporated into the global sum
 - (ii) plans to secure additional funding exclusively for premises improvements and developments for the next decade
 - (iii) how the practices that are struggling to recruit staff via the ARRS scheme due to shortage of premises will be mitigated for in any future arrangements.
26. GATESHEAD AND SOUTH TYNESIDE: That conference believes the GMS model provides excellent value for the taxpayer but:
 - (i) believes that this comes at the expense of the GP partners delivering it at significant personal cost, with tolls exacted upon mental and physical health
 - (ii) recognises that the English public and the nature of medicine have changed since the days of five minute surgeries and a 50-page BNF
 - (iii) does not see this model as sustainable unless significant investment is made into general practice
 - (iv) requests that the contract be renegotiated to fund general practice by item of service means, in order to reward work done.
27. LIVERPOOL: That conference believes that continuity of care is the secret ingredient that makes general practice so effective and expects GPC England to negotiate a contract that recognises and rewards continuity as a priority.
28. BARNET: That conference recognises that GP contracts and associated funding streams are unnecessarily complex and calls upon GPC England to go back to NHSEI and negotiate a 'simplified' contract, more easily managed and which ensures increased investment into core.

29. BUCKINGHAMSHIRE: That conference notes the expiration of the five year contract in 2024 and demands that current workforce funding is guaranteed for at least another five years in any further contracts, in order to allow GPs to recruit and retain staff beyond 2024.
30. OXFORDSHIRE: That conference believes general practice has been overlooked for far too long, and now urgently requires:
 - (i) stability and fortification of the NHS contract
 - (ii) financial stability with guaranteed income of salaried GPs and GP partners
 - (iii) removal of block contract work and replacement with a "fee for service" model in order to free up GP time to focus on such necessary patient outcomes as are determined by the GP and patient, rather than by NHS England.
31. HERTFORDSHIRE: That conference calls on GPC England to ensure that there are break clauses / breaks for exceptionalities negotiated into any future multi-year deals.
32. NORTHUMBERLAND: Continuity of care has been shown to improve outcomes and increases clinician satisfaction. Conference demands that this is enshrined in all future policy applicable to primary care.
33. LAMBETH: That conference instructs GPC England to negotiate GP contracts which reward continuity of care.
34. SHEFFIELD: That conference notes that the five year GP contract reform changes announced in 2019 are due to come to an end soon and there is significant concern about the lack of clarity of what the future arrangements will be for general practice. The conference therefore requests an urgent update from GPC England in relation to:
 - (i) how the PCN funding streams will be incorporated into the global sum
 - (ii) plans to secure additional funding exclusively for premises improvements and developments for the next decade
 - (iii) how the practices that are struggling to recruit staff via the ARRS scheme due to shortage of premises will be mitigated for in any future arrangements.
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39. SOMERSET: That conference calls for simplifying the content and length of documents and contracts relevant to commissioning general practice.
40. LAMBETH: That conference believes that with regard to general practice funding:
- (i) it should be simplified and included in the GMS contract
 - (ii) that additional GP funding for temporary schemes should be added to the core contract rather than the current inefficient complexity of having multiple small funding pots to bid for / claim.
41. NORFOLK AND WAVENEY: That conference asks GPC England to ensure patient continuity of care is the bedrock of the GP contract whether using personal lists or other systems.
42. SOMERSET: That conference instructs GPC England to negotiate incentivisation of the primary prevention agenda through the core contract.
43. BUCKINGHAMSHIRE: That conference:
- (i) believes that GPs are best placed to decide how to design their appointment systems
 - (ii) demands that existing contractual mandates, which require practices to offer a set minimum number of "appointments per practice list size" to be available for direct booking online by patients, be removed from future contracts
 - (iii) demands that existing contractual mandates, which require practices to offer a set minimum number of "appointments per practice list size" to be available for direct booking by NHS111, be removed from future contracts.
44. CAMBRIDGESHIRE: That conference notes the changes to England's economic landscape over the past twelve months and with an eye to the year ahead determines that in contract negotiations, GPC England should:
- (i) retain the flexibilities afforded by GMS
 - (ii) seek AfC parity for primary medical services staff via ring-fenced funding
 - (iii) determine the national cost of organisational development across the 42 ICSs over the past three years as leverage
 - (iv) seek capital and revenue funding for explicit primary medical services premises and estates separate to ICS budget.

45. LIVERPOOL: That conference believes that the funding provided to practices is increasingly inadequate to provide the services requested and requires GPC England to negotiate:
- (i) a minimum initial uplift of £50 to the global sum
 - (ii) an uplift of at least CPI annually on an ongoing basis
 - (iii) that all DDRB mandated pay awards must be fully funded, including on costs, via the global sum.
46. LEEDS: That conference insists that the following principles must apply to any new GP contract. It must:
- (i) enhance the independent contractor model
 - (ii) be high trust low bureaucracy
 - (iii) not include performance management targets
 - (iv) be supported predominately by capitation payments with a significant increase in funding compared with the current global sum
 - (v) be underpinned by a workload related funding formula
 - (vi) be properly priced item of service fees for services all practices have a first option to provide.
47. CAMBRIDGESHIRE: That conference demands GPDF jointly fund with GPC England, an analysis of market valuations of GP workload across England with a third-party specialist consultancy firm ahead of any new contract negotiations to appropriately value the cost of providing:
- (i) same day urgent care including triage, consultation models, treatments, and visits
 - (ii) preventative and population health outcomes
 - (iii) long term conditions – including proactive patient contact, reviews, tests, consultations, and management.
48. GATESHEAD AND SOUTH TYNESIDE: That conference recognises the benefits of the partnership model for GPs, patients and secondary care and demands:
- (i) the unequivocal support of GPC England for the partnership model
 - (ii) all new resource to be directed to practice-level
 - (iii) the restoration of ties between GP and community services, permitting greater continuity and variety that will help retain GPs with special interests
 - (iv) the development of part-time GPwSI posts in secondary care, to enable better retention and skill transfer.
49. LEEDS: That conference believes that a future contract should not include an out of hours funding deduction and that any practice choosing to deliver any aspect of out-of-hours service should be paid separately for this.
50. LEEDS: That conference insists that a future GMS contract:
- (i) must not include a pay for performance quality scheme such as QOF

- (ii) should include a small number of professionally led, developed and agreed indicators of quality clinical care that enable peer review but are not linked to funding
 - (iii) will require computer system clinical prompts that are implemented at the time and no later than any indicator is introduced.
51. HOUNSLOW AND HAMMERSMITH: That conference recognises that the GP partnership model is currently under severe strain and:
- (i) with the demographic time-bomb of GP retirements in the next five years , this will severely worsen
 - (ii) believes that the widespread employment of GPs by hospitals is not the answer and will end the independence of general practice
 - (iii) an urgent 'plan B' for the future model of employment for GPs needs urgent discussion , debate and formulation
 - (iv) consideration needs to be given to general practitioners becoming a 'new category' of NHS employee, represented by the LMCs and BMA, with GPC England as their negotiating body.
52. BEDFORDSHIRE: That conference believes that, for the allocation to general practice, the system needs to look into new ways of funding deprived areas, taking account of the broad Marmot principles if it is serious about addressing health inequalities and levelling up and believes that new ways of funding must take account of:
- (i) multi morbidity, irrespective of age
 - (ii) GP consultations happening on a daily basis in languages other than English without interpreters
 - (iii) number of GP contacts for issues other than medical problems, such as social prescribing issues.
53. MID MERSEY: That conference demands a new fair contract for general practice that recognises the falling numbers of GPs, increased workload and increasingly complex patients.
54. KENT: That conference believes the current formulation of the GMS contract based on centrally defined performance measures has standardised outcomes for patients and demands GPC England to negotiate a new contract that trusts GPs to exercise professional judgement and innovation to improve outcomes for the communities they serve.
55. EALING: That conference has grave concern and unequivocally opposes postulated future models for mainstream general practice, in which GPs are either employed by hospitals or by large scale profit driven commercial healthcare providers.
56. BERKSHIRE: That conference demands that:
- (i) any new contract to replace current GMS move to a "fee-for-service" model rather than block payment or capitation
 - (ii) any new contract to replace current GMS allow practices to offer private services to all of their registered patients, in a manner to be determined by the practice in agreement with the patient

- (iii) current contracts that result in GP practices chasing multiple small sources of funding be consolidated into core funding.
57. BRADFORD AND AIREDALE: That conference recognises the independent contractor model has proven itself to be the most efficient form of general practice, we demand GPC England negotiate a new contract from 2024:
- (i) which supports the independent contractor model by increased investment in core funding
 - (ii) that allows improved continuity and by this improved quality of care in general practice
 - (iii) provides flexibility allowing individual practices to deliver care in the most appropriate way for their individual patient population.
58. HERTFORDSHIRE: That conference calls on GPC England to negotiate a GP contract which:
- (i) acknowledges the professionalism of GPs, with a focus on patient care
 - (ii) abolishes QOF, IIF and other target-driven initiatives
 - (iii) allows population health management (PHM) measures to tailor initiatives with local input and in negotiation with general practice.
59. WEST SUSSEX: That conference is disappointed by the lack of progress on implementing a plan for Industrial Action since the Indicative Ballot of GPs in November 2021, and calls on GPC England to negotiate with NHSEI / DHSC:
- (i) a tariff based primary medical services contract commencing in April 2024
 - (ii) all funding for the PCN DES to be incorporated into core [primary medical service contract global sum] commencing in April 2024
 - (iii) that the current restrictions on general practice private practice are removed from any new primary medical services contract commencing in April 2024.
60. GATESHEAD AND SOUTH TYNESIDE: That conference recognises the failure of GPC England to progress previous conference policy on home visiting and:
- (i) believes that with an ageing, impoverished population, continuation of the status quo will increase workload and prove unsustainable for practices
 - (ii) is concerned that an increase in preventable admissions will have wider system implications affecting patients and GPs alike
 - (iii) calls for additional resource to be allocated to practices with significant need for home visits
 - (iv) stipulates that home visit provision may be provided by whoever is deemed clinically suitable, rather than the GP as default
 - (v) affirms the right of all GPs to visit only the housebound and reject all other requests.
61. HULL AND EAST YORKSHIRE: That conference believes the only viable model for a new GP contract must limit either the number of patients that each whole time equivalent GP is responsible for to no more than 1500 or provide an increase in core funding sufficient to provide adequate services for the patient population.

62. NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes any new funding model must be based on a minimum number of staff required to safely and effectively provide care to a defined patient population. For any increase in patient numbers due to patient registrations or loss of clinicians, care cannot be provided until the required staff are in place to do so safely.
63. OXFORDSHIRE: That conference demands that in the upcoming contract negotiations:
- (i) the core GMS contract be maintained, as a viable contract for general practice in England, in its own right
 - (ii) the Network Contract DES remains a separate, optional contract which practices may freely decide to opt in or opt out of
 - (iii) commissioners, who are currently required to ensure total population coverage for the Network Contract DES specification, be required to assist practices with any staff liability arising from a practice decision to opt out of the Network Contract DES.
64. LIVERPOOL: That conference believes that the LMC would want to support the partnership model of care and would want to see APMS contracts revert to GMS or be capable of reverting to GMS contracts. The LMC would not support vertical integration with hospital trusts as this will destroy the essence of general practice.
65. DEVON: That conference needs to instruct the GPC England to recognise PCNs are evidently here to stay as a pivotal building block within the new NHS structures and, as such they are a strong negotiating tool that needs to be utilised quickly.
66. DEVON: That conference believes continuity of care is the bedrock of the sustainable delivery of excellent primary care provision but the concept that this can be done at scale with 7-day access is clinical nonsense.
67. DEVON: That conference is not representative as it has voted on numerous occasions to oppose the concept of enhanced access but the vast majority of PCNs have chosen to deliver it.
68. DEVON: That conference makes NHSEI aware that the exponential rise in duplication of data requested from that PCNs needs to stop and they need to recognise the dangers for the NHS in:
- (i) the paradox of attempting to micromanage general practice at scale
 - (ii) falsely naming assessment questionnaires as surveys with short deadline turn arounds
 - (iii) asking PCNs to complete regular national workforce data when this is all clearly visible to them via ARRS claiming systems
 - (iv) allowing NHS Digital to continue without a proper detailed published audit of their activities.
69. BEDFORDSHIRE: That conference urges that existing conference policy to widen the scope of the Additional Roles Reimbursement Scheme to include GPs, nurses and ANPs should be pushed urgently in any forthcoming negotiations.

70. BEDFORDSHIRE: That conference calls on GPC England to:
- (i) acknowledge that the expansion of the general practice workforce through the additional PCN roles is welcome, but
 - (ii) emphasise that there have been decades of government neglect and failure to invest in GP premises, with the result that GP premises are totally inadequate for the larger, multi-disciplinary teams that are crucial to managing the complexities of modern practice, and to
 - (iii) negotiate for funding for premises expansion or to rent additional spaces where needed for additional roles staff.
71. AVON: GPC England needs to ensure that the government understands that promoting the collective working of practices in PCNs / localities whilst beneficial can also be to the detriment of practices, continuity of care, and the efficiency of patient care.
72. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that PCN Enhanced Access will result in destabilising core services, increasing services which are unsafe, decrease patient satisfaction, increase health inequalities, and be a further reason for practices to close. GPC England must negotiate for this ill-conceived project to be abandoned.
73. MID MERSEY: That conference demands the funding for ARRS should be directed to core funding in general practice rather than PCNs to sustain general practice.
74. MID MERSEY: That conference notes that it is time to reinvent the wheel again! and that the time of PCNs has to come to a much-awaited end and demands that PCN funding is shifted into general practice.
75. FULHAM: That conference notes that in relation to non-GP clinical supervision of staff, urgent attention is needed to recognise the role and address both funding and training of that role.
76. KENT: That conference recognises the limitations of the very prescriptive Additional Roles Reimbursement Scheme (ARRS), and requires the GPC England negotiates that PCNs have the freedom to recruit into roles that meet the needs of their patients.
77. KENT: That conference demands that GPC England negotiates greater freedom for PCNs to determine how to deliver Enhanced Access for their populations.
78. KENT: That conference requests that GPC England negotiate:
- (i) for practices to be able to exit the PCN DES at any point without financial penalties
 - (ii) reimbursement for VAT costs incurred from being part of a PCN
 - (iii) reimbursement for the significant management costs incurred in employing and managing ARRS roles.
79. KENT: That conference demands that GPC England works with NHSEI to produce a standardised coding system for PCN payments to enable practices to easily identify PCN funding streams.

80. SOMERSET: That conference believes that any practice or PCN that can demonstrate an inability to recruit to unfilled clinical vacancies should not be penalised for the inability to comply with contract changes requiring additional clinical work.
81. BRADFORD AND AIREDALE: That conference supports the BMA resolution that PCNs are an existential threat to Independent Contractor Status. Conference also believes that the PCN DES is a threat to:
- (i) continuity of care, in that the suggestion that personal care planning is best achieved by practices grouping together is clearly ludicrous
 - (ii) patients having their own surgery, as PCNs progress and care is dispersed patients will not only no longer have their own GP they will no longer have a surgery to call their own
 - (iii) doctor led general practice, due to the only new funding streams for general practice are clearly designed to replace GPs with other health professionals
 - (iv) financial viability of practices, as the absence of any increase in the cap on funding for individual ARRS roles is just the beginning.
82. BRADFORD AND AIREDALE: That conference believes that Extended Access is an expensive way of providing additional capacity with a clinician with whom the patient is unfamiliar, at a location and time that are inconvenient to the patient and this funding should be transferred to Global Sum to increase capacity there.
83. NORTH YORKSHIRE: That conference rescinds the policy to withdraw from the PCN Des in April 2023 and supports those practices and PCNs that choose to continue to provide the DES.
84. NORTH YORKSHIRE: That conference agrees that the PCN DES in its current form is restrictive and asks GPC England to ensure that the renegotiated DES allows for flexibility, innovation and for PCNs to determine how best to utilise funding to meet their own service and population needs.
85. HAMPSHIRE AND ISLE OF WIGHT: That conference acknowledges that primary care networks if utilised appropriately can have benefits for both patients and general practice. Conference also acknowledges one of the great strengths of English general practice is the entrepreneurial nature that allows flexibility and autonomy to react to local population needs. With this in mind conference calls on GPC England to increase flexibility of PCN ARRS roles by negotiating additional:
- (i) GP sessions become an ARRS role
 - (ii) advanced nurse practitioner sessions become an ARRS role
 - (iii) practice nurse sessions become an ARRS role.
86. NORFOLK AND WAVENEY: That conference asks that the rules for ARRS funding are changed so that hard to filled posts can be backfilled by other disciplines and providers.
87. NORFOLK AND WAVENEY: That conference asks GPC England to negotiate to end the PCN DES and have the funding reallocated into core GMS payments to practices as PCNs are an ineffective way of improving workforce resilience and dealing with demand in general practice and the attached staff work mainly to fulfil the requirements of the PCN DES.

88. NOTTINGHAMSHIRE: That conference calls for increased proportionate investment into general practice estates to help support the ARRS MDT working in a way that is fair, intuitive and free from bureaucracy.
89. HERTFORDSHIRE: That conference calls on GPC England to negotiate that the PCN DES includes a new, additional funding stream to cover the employment of a PCN manager.
90. WORCESTERSHIRE: That conference insists that performance indicators beyond the control of general practice are removed from IIF indicators with immediate effect and that contractors should not be financially penalised where IT systems are not in place to support contractual requirements such as in the enhanced access aspects of the Primary Care Network Directed Enhanced Service.
91. SUFFOLK: That conference recognises that many practices are already heavily invested in PCN workforce. Conference asks GPC England to consider that as a result, PCN contract withdrawal may not be a viable mechanism for potential industrial action.
92. NOTTINGHAMSHIRE: That conference is concerned about the growing requirements on practices through the PCN DES and requests that GPC England negotiates with NHS England to ensure that a significant proportion of funding is ring-fenced out of PCN budgets for practices individually to decide how to use on joint working.
93. LIVERPOOL: That conference believes that networks have the potential to facilitate locality based care planning and address local health inequalities. In order to do this networks must:
- (i) be adequately funded to recruit and employ a clinical leadership team and the associated administrative support
 - (ii) not be funded as an alternative to a fully funded GMS contract
 - (iii) be sufficiently autonomous to be able to make local decisions for local issues.
94. BEDFORDSHIRE: That conference believes that although some PCNs are like relationships made in heaven, many more were formed like a shotgun wedding and are in no way functional institutions. It therefore calls on GPC England to explain to NHSEI that if PCNs are to be successful they need:
- (i) more freedom to decide on local priorities
 - (ii) fewer dashboards / targets
 - (iii) more flexibility in the staff they can employ and the skill mixes to meet local needs or fill gaps where other ARRS staff can't be recruited, in particular nurses, ANPs and GPs.
95. SEFTON: That conference demands that NHSEI and GPC England agree to suspend primary care network performance indicators, allowing practices to use these staff to support patient access rather than chase targets.
96. HERTFORDSHIRE: That conference appreciates the wider additional primary workforce available through the ARRS scheme but notes that their introduction has come at a cost to general practice and believes that there is now an urgent requirement for:
- (i) an overview of all ARRS salaries

- (ii) an in-built salary increment scheme
 - (iii) funding for GP supervision and training of ARRS staff.
97. CITY AND HACKNEY: That conference recognises that a diverse set of health care professionals have been recruited into general practice through the PCN DES and recommends that:
- (i) GPC England negotiates with NHSEI England to guarantee full funding for the continued employment of ARRS staff beyond the current contract period, regardless of whether the PCN DES continues, and that funding arrangements are confirmed by 1 April 2023
 - (ii) GPC England negotiates with NHS England that any future ARRS funding makes allowance for annual wage increases in line with inflation.
98. GLOUCESTERSHIRE: That conference is very disappointed at the overall ability of allowable ARRS staff to take workload off practice nurses and GPs and insists that all posts including GPs and nurses should be available under the ARRS scheme forthwith.
99. GLOUCESTERSHIRE: That conference recognises the significant responsibility that practices, and in turn GPs have for supervising ARRS staff and asks the BMA to call for:
- (i) increased guidance on support and oversight models for all ARRS roles
 - (ii) specific funding to be allocated to practices to provide support and oversight for ARRS roles
 - (iii) clarification of the responsibilities that practices have in employing these staff within their roles.
100. KENSINGTON AND CHELSEA That conference believes that the ARRS scheme should be evaluated including:
- (i) quantifying any proportion of the fund not invested in practices
 - (ii) the impact of the new roles in addressing the mismatch between demand and GP workforce capacity.
101. SUTTON: That conference notes that there is a phenomenal amount of work involved for PCNs to deliver the PCN DES and demands that:
- (i) responsibility shouldered on PCN CDs should be in line with their contractual duties as they are at risk of potential burnout adding to further workforce issues
 - (ii) the ARRS workforce needs training after recruitment and a period of settling into general practice as many may work across a number of practices
 - (iii) having created an internal market for ARRS roles funding needs to be realistic to recruit into these roles.
102. GATESHEAD AND SOUTH TYNESIDE: That conference believes the IIF to have been an unmitigated disaster and:
- (i) has concerns about the ethics of medicines being included in a performance / funding measure without health outcomes to back this up
 - (ii) is dismayed that the box-ticking nature of IIF work detracts from both patient care and the constructive use of practice managers' time

- (iii) believes that the harm done to inter-practice relationships by forcing them to performance manage each other will set back attempts to collaborate in the future
 - (iv) requires that any new contract keep payment-by-performance at practice level
 - (v) demands that all current IIF monies be distributed to practices on a weighted, pro-rate basis for use as they see fit to meet patient need.
103. WEST SUSSEX: That conference believes that funding of the PCN DES poses an existential threat to the independent contractor status of general practice and patient care by diverting such funds from the Primary Medical Services Core Contract.
104. GATESHEAD AND SOUTH TYNESIDE: That conference condemns the expensive failure of PCNs to either relieve workload or improve retention and calls for the:
- (i) recognition that PCNs were ill-conceived, poorly executed and have proven popular with neither patients nor GPs
 - (ii) repatriation of ARRS funds into GMS, to be increased in line with inflation
 - (iii) freedom for practices to spend said funds on the members of staff both available and useful to them, without limitation.
105. SEFTON: That conference calls upon NHSEI and the GPC England to agree moving primary care network funding into core contracts, allowing practices to recruit and retain more GPs by making the job doable again.
106. CITY AND HACKNEY: That conference acknowledges the controversial nature of the PCN DES and the variability in satisfaction with the DES across general practice in England, and:
- (i) insists that GPC England actively engages with all GP practices in England, in advance of any contract negotiations regarding the potential continuation of the PCN DES
 - (ii) requires NHSEI to undertake and share a comprehensive analysis of the impact of the PCN DES from 2019-2023, including but not limited to clinical outcomes, in parallel with the workload required to meet the obligations of the service specifications and IIF.
107. CLEVELAND: That conference reminds secondary care colleagues, NHS England, Integrated Care Boards and the government that the GP practice is the core unit for service delivery, not the PCN.
108. MANCHESTER: That conference notes general practice in England needs stability and opportunity to plan instead of the repeated need to respond to last minute announcements. We call on GPC England and NHSEI to provide at least six months' notice for their proposals for the future or replacement of the PCN DES.
109. CITY AND HACKNEY: That conference:
- (i) strongly believes that it is imperative for the PCN DES to remain within the 2024 GP contract
 - (ii) advises that GPC England prioritises the PCN DES for discussion with NHS England

- (iii) recommends that GPC England confirms with NHS England by 1 April 2023, whether the PCN DES will remain within the 2024 GP contract
 - (iv) recommends that GPC England confirms with NHS England by 1 July 2023, the complete details of the PCN DES, including all service specifications
 - (v) suggests that GPC England negotiates that from 1 January 2023 onwards, there should be no deadline for withdrawing from the PCN DES and any practice wishing to withdraw from the PCN DES should be able to do so at any time.
110. BUCKINGHAMSHIRE: That conference believes that:
- (i) the NHS is broken
 - (ii) the NHS is broken beyond repair.
111. GATESHEAD AND SOUTH TYNESIDE: That conference is concerned that the ending of the free-at-the-point-of-use model in England is approaching and:
- (i) is concerned that this will be disastrous for many of our more deprived patients in terms of late presentations and early mortality
 - (ii) notes the increasing number of patients who present with preventable dental disorders as a result of being unable to afford routine dental treatment
 - (iii) requires that, with BMA assistance if needed, GPC England model and present publicly the likely consequences of insurance based or pay-as-you-go models of general practice upon English patients, both at national and regional levels
 - (iv) demands that any such findings be actively promoted, in order that GPs and the English public be aware of the likely implications to both health and finances of any changes to the model of healthcare funding.
112. GLOUCESTERSHIRE: That conference believes regrettably NHS general practice is unsustainable in its current format now and in the future unless significant changes are made urgently that support general practice therefore GPC England need to make alternative plans for general practice within England as a matter of urgency.
113. SANDWELL: That conference has grave concerns that all previous efforts by GPC England to alert NHSEI to the parlous state of general practice have been fruitless. The stated intention of NHSEI is that, absent a new agreement, they intend to roll over the existing contract. Conference indicates:
- (i) this is unacceptable to providers
 - (ii) in the event that a new sustainable contract is not agreed, mandate that GPC England prepare a contingency plan for members to protect them from further economic, professional and psychological detriment.
114. LIVERPOOL: That conference believes that In any discussion on future funding, the LMC would not support any move towards co-payments or insurance based funding. Any change to the funding mechanism would inevitable affect the poorer more deprived members of society, widening health inequalities. We would vehemently oppose any suggestion of charging patients for attending (or not attending) a GP appointment as this will lead to an end to NHS general practice as has occurred with NHS dentistry.

115. GLOUCESTERSHIRE: That conference believes there has been a persistent and ongoing failure of successive governments to adequately resource NHS primary care. We call on the BMA to commission a study on the feasibility of general practices transitioning to a privatised, “dental” model of GP and publish guidance and a roadmap for practices who wish to explore this route.
116. BUCKINGHAMSHIRE: That conference notes that unlike dentists and pharmacists, GPs cannot under existing contracts offer many private services to their NHS patients, and believes that:
- (i) GP surgeries should at their discretion be allowed to offer their NHS patients paid-for services if these services are not routinely offered by the NHS
 - (ii) GP surgeries should at their discretion be allowed to offer their NHS patients paid-for services if these services are routinely offered by the NHS but are not accessible in a time frame that the patient deems reasonable
 - (iii) ICS have a role in defining which services are not routinely offered by the NHS
 - (iv) GPs can be trusted to manage potential conflicts of interests arising from offering paid-for services to their NHS patients.
117. ENFIELD: That conference calls upon GPC England to strongly reject the proposal for a £10 charge to see a GP, as this would further widen health inequalities, increase administrative burden for practices and distance GPs from their patients.
118. BERKSHIRE: That conference believes the private healthcare sector in England has the potential to destabilise NHS general practice by expecting that the GP will pick up the pieces arising from fragmented, non comprehensive private healthcare models, and:
- (i) demands that the BMA make an assessment of the true costs to GPs of facilitating patients' movements in and out of the NHS
 - (ii) insists that any new contract allows GPs to bill for the time taken to facilitate patients moving into the private sector for an episode of care or returning to the NHS after an episode of care, these costs to be borne by the insurers where the patient's policy allows, or the patient themselves where it does not.
119. SANDWELL: That conference has previously mandated GPC England to prepare a fee per service contract to replace the unrestricted and unrestrictable block contract currently destroying GMS services and providers. Conference is:
- (i) dismayed that no such proposal appears to have been prepared or presented to the membership
 - (ii) insist that GPC England urgently bring all resources to bear to realise that vision
 - (iii) bring a fully worked alternative to special conference prior to any further negotiation with NHSEI.
120. SUFFOLK: That conference recognises the perilous financial position of many general practices and demands of GPC England to negotiate a mechanism whereby non-NHS private clinical services (such as minor cosmetic procedures or ear micro suction) can be offered to registered patients.

121. CUMBRIA: That conference believes:
- (i) the current state of general practice runs a very serious risk of GP practices seceding from their contracts and instead contracting directly with their patients
 - (ii) such a secession from contract may be attractive to GPs financially and in terms of workload but would be detrimental to population health and would radically change the NHS in a potentially fatal way.
122. DERBYSHIRE: That conference believes that practices should be able to charge their registered patients for private services where it can be demonstrated this improves access for NHS provision of care and where the patient is happy to pay.
123. GLOUCESTERSHIRE: That conference notes that consultation rates in England are double that of most comparable countries and agrees:
- (i) that a small charge per consultation with appropriate reimbursement for deprivation would reduce demand and free up time to see more patients in general practice
 - (ii) calls for the GPDF to vigorously promote implementation of this policy as fast as possible.
124. NORFOLK AND WAVENEY: That conference asks GPC England to oppose any political plan to charge patients who fail to attend their GP appointment, because it is unworkable, unnecessary, and wrong.
125. LIVERPOOL: That conference believes that in light of the growing concern over the cost of living crisis:
- (i) a move to co-pay or a private model of GP provision would be potentially detrimental to the health and well-being of the most vulnerable members of society
 - (ii) the most equitable system for primary care is an adequately funded, free at the point of use service.
126. BERKSHIRE: That conference:
- (i) demands that GPC England look at all available options for Industrial Action in the case that an agreement cannot be reached on a new contract
 - (ii) expects that if full industrial action is considered not to be an option for the profession, GPC England will advise England's GPs to work within BMA safe working guidance until such time as agreement can be reached on a contract. This would necessarily include a recommendation that GPs have at least 15 minutes per appointment, and provide no more than three hours consulting per session, leaving 1 hour 10 mins for all other clinical administration per 4 hour 10 minute session
 - (iii) recommends that clinical administration time should be ringfenced and not be used to increase capacity for direct patient contact activities.
127. TOWER HAMLETS: That conference believes that the current crisis in general practice is unprecedented and:
- (i) calls on GPC England to provide clear guidance to practice on how they close their practice list on the grounds of patient safety

- (ii) requires GPDF to fund legal support to any practice who receives a breach notice or other contractual action in relation to closing their practice list on the grounds of patient safety
- (iii) requires GPC England to negotiate that any practice whose list is closed on the basis of patient safety is still eligible to undertake and receive funding for any enhanced services
- (iv) calls on the unions to ballot the profession for willingness to collectively close their practice lists on the grounds of patient safety.

Agenda: Part II (Motions not prioritised for debate)

A and AR Motions

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

PRACTICE BASED CONTRACTS

- A 128.** LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference welcomes the GPC England list of services which should be commissioned as enhanced services, but insists that:
- (i) the list is kept up to date
 - (ii) GPC England provides a public facing web resource advising what services are included via the standard GMS contract, and what services a practice may or may not be commissioned to provide.
- A 129.** GLOUCESTERSHIRE: That conference demands that all DDRB uplifts for salaried GPs must in future result in equal uplifts in the global sum.
- A 130.** WORCESTERSHIRE: That conference believes that GP partners face an unacceptable pay cut without renegotiation of the GMS contract to include an uplift for GP partners to cover cost of living increases and DDRB recommendations for staff salaries and insists that government act now to address this issue to prevent further damage to the independent contractor model .
- AR 131.** CAMBRIDGESHIRE: That conference believes without funding the DDRB recommended 4.5% staff pay rise within the global sum, the government are deliberately pitting partners against their employees, thus exacerbating the exodus of GPs from our profession and putting patients at risk, and mandates GPC England to take action against NHSEI in demanding a sustainable funding solution restoration.

GPC E / LMC / GPDF

- A 132.** BERKSHIRE: That conference demands that professional negotiators be engaged to assist GP representatives in any new contract negotiations, in order to secure the best possible outcome for England's GPs.

NHSEI / GOVERNMENT

- A 133.** LIVERPOOL: That GPs partners, salaried and sessionals:
- (i) have provided millions of appointments each month despite falling GP numbers
 - (ii) should be applauded for their efforts rather than denigrated by elements of the press and politicians.

- A 134. KENT: That conference demands that GPC England request NHSEI resolve the onerous challenges of the tier two sponsorship application process both to aid the recruitment and retention of GPs and to reduce costs for practices.

WORKLOAD

- A 135. KENT: That conference requests GPC England to negotiate additional resources to support general practice to tackle the backlog of care that has arisen during the pandemic as well as the additional demand placed on general practice because of the backlog in secondary care.
- A 136. NORFOLK AND WAVENEY: That conference believes that the government obsession with numbers of patient contacts fails to adequately portray the hidden workload such as teaching, training and healthcare improvement programmes undertaken by general practice in supporting the NHS infrastructure.
- A 137. HAMPSHIRE AND ISLE OF WIGHT: That conference notes that alongside clinical workload there is an 'invisible' but essential administrative workload as a GP. Conference calls on GPC England to negotiate that future contracts recognise this vital administrative work needs to be costed in to any core funding allocations now and future.

CLINICAL / PRESCRIBING / DISPENSING

- A 138. KENT: That conference is frustrated by the continued absence of GP surgeries and dispensaries from the EPS scheme and demands their immediate inclusion.
- A 139. GLOUCESTERSHIRE: That conference deplores NHS England's failure to fund immunisation of flu vaccines for frontline general practice staff and insists that flu immunisation for staff should be reimbursed as a matter of urgency before workforce shortages through sickness take place.
- AR 140. DEVON: That conference insists that all members of staff in general practice have the same eligibility to vaccination programs as front-line NHS hospital staff.

PENSIONS

- A 141. AVON: That conference proposes that GPC England should seek urgent action from government to promote the good working practices and pensions for GPs so that the exodus of GPs is reversed.
- A 142. AVON: That conference calls for an extension of the Annual Allowance Charge Compensation Policy to mitigate against inflationary pressures forcing GPs to reduce their hours or stop clinical commitments all together.
- A 143. SURREY: That conference calls for an urgent review of NHS general practitioner pension arrangements, believing those currently encourage:
- (i) early retirement
 - (ii) colleagues to reduce their NHS commitment earlier than might otherwise be the case.

- A 144. SEFTON: That conference demands a solution to the pension annual / lifetime allowance problem where GPs (and specialists for that matter) end up paying to work additional sessions.
- A 145. KENT: That conference demands that Capita is removed from dealing with pension payments and administration and GPs should be protected from any financial tax liabilities that have arisen from their negligence and incompetency.

PREMISES

- A 146. SUTTON: That conference recognises healthcare delivery in general practice is adversely impacted by the shortcomings of existing GP estates and asks that:
 - (i) support is given to enable premises to be fit for purpose with adequate number of clinical rooms for the practice population and that the improving access agenda with online consultation and other non FTF consultations is not seen as a means of cost savings on practice premises
 - (ii) the negative impact on workforce by those practices not able to consider taking up GP trainees, medical students or training of other GP workforce is addressed urgently
 - (iii) if ARRS are here to assist with workload and be a part of the workforce ARRS roles need to have somewhere to work from and patient choice for FTF needs to be respected
 - (iv) if ICSs are about improving outcomes and reducing inequalities in delivery of healthcare, there is a need to investigate the impact of the limited number of disability adapted GP consultation rooms on the care of this cohort of patients.
- A 147. BUCKINGHAMSHIRE: That conference:
 - (i) believes that primary care infrastructure has been neglected at a national level
 - (ii) believes that NHS Property Services has failed to support general practice in England
 - (iii) believes that under investment in primary care estate is now a safety risk to our patients and staff
 - (iv) demands that alternatives to NHS Property Services GP premises' ownership be explored
 - (v) demands that the Department of Health ringfence central resources to modernise the GP estate in England, equal to or greater than their existing investment in "40 new hospitals".

WORKFORCE

- A 148. DERBYSHIRE: That conference recognises the acute shortage of GPs and rising locum costs and mandates GPC England to urgently negotiate that maternity locum cover funding can be used for roles other than just a general practitioner.
- A 149. KENT: That conference believes that solving the workforce challenge is the most important factor in resolving the crisis in the NHS and requests that GPC England negotiate a clearly articulated plan that supports the retention of GPs at all stages of their careers.
- A 150. NOTTINGHAMSHIRE: That conference recognises that international medical graduates (IMG) are often unaware of opportunities to work in general practice where tier 2 sponsorship is held, sometimes

choosing to leave general practice. We call upon GPC England / NHS England to launch a campaign linking into GP training programmes to help IMGs to become more aware of where they can work across the country.

- A 151. DERBYSHIRE: That conference believes medically qualified doctors on the general practice specialty register should be renamed “consultants in primary care”.
- AR 152. SOMERSET: That conference demands that in the case of GP sickness or parental leave, when it can be demonstrated that a GP cannot be recruited to fill the vacancy, then the funding should be available to employ an alternative health care professional.
- AR 153. HULL AND EAST YORKSHIRE: That conference calls for a funded national support scheme to address the inequities that international GPs face when joining the workforce in order to retain these vital colleagues.
- AR 154. WARWICKSHIRE: That conference believes that NHSEI reimbursements for sick leave and maternity / shared parental leave which are available for partners and salaried GPs should now be extended to the wider general practice team including practice administrative staff and all clinical staff. This would help practices to recruit staff during the present workforce crisis and would assist practices in providing good quality care to patients.

(Supported by Coventry)

REGULATION AND REGULATIONS

- A 155. CAMBRIDGESHIRE: That conference believes there should be parity of access to free appraisal and revalidation platforms throughout the UK and seeks GPC England to reverse the discrimination against English GPs, by negotiating a free platform for England based medical performers with NHSEI.
- A 156. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that following Brexit there must be no reduction in the protection of data as defined in the European General Data Protection Regulations and the Data Protection Act 2018.
- A 157. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that Subject Access Requests are limited only to be used for the singular purpose as defined by paragraph 63 of the preamble of the General Data Protection Regulations, that they are “in order to be aware of, and verify, the lawfulness of the processing” and that access for any other reason is chargeable.
- A 158. WORCESTERSHIRE: That conference demands that LMC representatives are in attendance at all Performance Advisory Group meetings involving doctors from their region and that representatives have the freedom to contribute to the discussion, challenge and influence decision making during those meetings.

PRIMARY SECONDARY INTERFACE

- A 159. DERBYSHIRE: That conference whilst recognising the need to evolve better ways of working insists that an Advice and Guidance response is only acceptable at the request of the general practitioner and cannot be the sole response of a hospital trust or other agency to a referral by a GP.

- A 160. BERKSHIRE: That conference demands that private healthcare providers make their own referrals back into NHS secondary care, without requiring input from the patient's NHS GP.
- AR 161. NORFOLK AND WAVENEY: That conference requests that firm rules regarding Advice and Guidance is negotiated nationally to avoid secondary to primary workload shift and inconsistency between hospitals and between departments of individual hospitals.

CLIMATE AND ENERGY CRISIS

- A 162. MERTON: That conference calls upon government to recognise the potential impact of the current unprecedented cost of living crisis by guaranteeing that any pay awards given to staff and clinicians is reflected in an increase in the Global Sum.
- AR 163. BRADFORD AND AIREDALE: That conference is committed to the principle of striving for carbon net zero as soon as possible and embeds this into future conference planning.
- AR 164. HULL AND EAST YORKSHIRE: That conference believes the provision of practical and social support to help patients through the cost of living crisis is best delivered outside general practice.

Agenda: Part II (Motions relevant to UK LMC Conference)

This section of the part 2 agenda contains motions that the England Agenda Committee felt pertained to UK-wide issues and would therefore benefit from debate at the UK LMC Conference. If your LMC has a motion in this section, it is strongly recommended that you re-submit your motions to the UK LMC Conference. **The deadline for submission of motions is noon Tuesday 28 February 2023.**

PRACTICE BASED CONTRACTS

165. HERTFORDSHIRE: That conference calls on GPC England to ensure that DDRB recommendations will only be supported by the BMA if they are linked to total practice income uplifts such that the higher percentage award applies across both, and there is no subsequent erosion of partner drawings.

NHSEI / GOVERNMENT

166. BUCKINGHAMSHIRE: That conference:
- (i) calls on HM Government to review relevant legislation, to allow traditional partnerships to carry funds forward into future tax years, without incurring significant tax liabilities
 - (ii) believes current tax rules may limit GP partnerships' ability to make significant financial multi-year commitments to projects necessary to long-term survival
 - (iii) calls on NHSEI to require ICBs to project and ringfence practice incomes to allow better future planning for practices.

WORKLOAD

167. LIVERPOOL: That conference believes that the principle of universal registration and GP continuity of care lies at the core of effective population healthcare, and:
- (i) is concerned that current publicity about general practice fails to acknowledge rising workload
 - (ii) believes expectations of general practice are unrealistic amid rising registrations and falling GP numbers
 - (iii) believes the flat or worse real terms funding to general practice is insufficient to resource the service
 - (iv) calls upon the government to recognise that general practice is the jewel in the NHS crown and short-term expediency may lose this forever.

CLINICAL / PRESCRIBING / DISPENSING

168. DERBYSHIRE: That conference believes it should not fall to general practice to sort out the stock availability issues that increasingly affect pharmacist colleagues and mandates GPC England to negotiate changes to the prescribing regulations that would allow pharmacists to replace an unavailable but prescribed item with an appropriate alternative wherever possible without recourse to the prescriber.

169. LIVERPOOL: That conference believes that due to issues with various medications being in short supply that pharmacies should be able to offer alternative medications, without recourse to the prescriber, where any nationally recognised shortage occurs.

WORKFORCE

170. KENT: That conference believes that to support all newly qualified GPs to establish themselves in independent working, they should spend five years in a substantive post, and demands a centrally funded supplement on their remuneration to recognise their commitment.
171. GP TRAINEES COMMITTEE: That conference notes that GP registrars in England are only scheduled to spend 70% of their working hours in clinical work, see significantly less patients per clinic than post-CCT colleagues, and are supernumerary. Thus we find the inclusion of GP Registrars in reporting GP numbers is often misleading. We call on GPC England to:
- (i) ensure all reporting of GP workforce numbers highlights where GP Trainees are being included
 - (ii) develop a mechanism to accurately represent the clinical input of GP Trainees, when reporting GP workforce numbers.
172. GP TRAINEES COMMITTEE: That conference recognises the difficulties in the practical implementation of the English Junior Doctors contract within general practice. This is often due to a lack of information and miscommunication, and we, therefore:
- (i) commend the good work done by Wessex LMC in publishing template working patterns and advice for practices, especially LTFT working patterns
 - (ii) call on the BMA and GPC England to promote the standardisation of this approach across England, to ensure trainees get consistent best practice in their GP practice placements across the country.
173. GP TRAINEES COMMITTEE: That conference recognises the damaging effects to the GP workforce that come from a demoralised GP Trainee cohort, specifically a cohort subject to sustained real terms pay cuts since 2008. We call on GPC England to support GP Trainees by:
- (i) making annual submissions to the DDRB detailing the likely effects to the GP workforce due to any further attacks on real terms pay for GP Trainees
 - (ii) vigorously oppose any attempts to reduce the GP Flexible Pay Premium or Targeted Enhanced Payment Scheme for GP Trainees in England.
174. GP TRAINEES COMMITTEE: That conference believes that a CCT in general practice should be appropriately valued, and that all Sessional GPs should be paid a rate greater than that of a full time equivalent GPST3. We therefore call on GPC England and the Sessional GPs Committee to:
- (i) lobby practices in England to offer rates of pay for all Sessional GPs greater than that of a full time equivalent GPST3
 - (ii) ensure central funding is achieved to deliver these rates of pay.

REGULATION AND REGULATIONS

175. NEWHAM: That conference, with regard to the legislation (Coroners and Justice Act 2009) for completion of a medical certificate of cause of death (MCCD):
- (i) believes that the definition of an ‘attending practitioner’ is too restrictive to apply to modern general practice and multidisciplinary teams
 - (ii) believes that the current restriction on who can complete a MCCD is causing unnecessary delays and adding to the distress of the bereaved
 - (iii) requires GPC England to work with the BMA in lobbying government to amend the Coroners and Justice Act, so that any registered doctor, who has full access to the deceased patient’s electronic health record and has seen the deceased either prior to or following death, is able to prepare a MCCD.
176. BRADFORD AND AIREDALE: That conference calls for “Fit notes” to be a self-certification process by patients no longer requiring medical involvement, the increased use of on-line consulting has meant that requests are self declarations that are most often merely transcribed from one form to another taking up GP time.
177. MANCHESTER: That conference welcomes the introduction of medical examiners and the extension to community deaths. We call on:
- (i) the RCPATH and NHSEI to ensure that the ME workforce includes a balance of consultant doctors and general practitioners that reflects the wider medical workforce; and
 - (ii) ME departments to ensure that LMCs are consulted meaningfully to develop local processes that are consistent with statutory obligations whilst not overloading/destabilising general practices.
178. NOTTINGHAMSHIRE: That conference is appalled by and condemns by the regulatory racial discrimination that GPs from ethnic minority backgrounds face and the devastating impact it can have on their work, family and personal lives. Conference requests:
- (i) a comprehensive external independent inquiry of the GMC’s regulatory decision-making processes which is followed by a subsequent commitment to implement its findings
 - (ii) implementation of external safeguards to ensure fairness and transparency in its handling of any disciplinary referrals.

PRIMARY SECONDARY INTERFACE

179. BUCKINGHAMSHIRE: That conference believes that:
- (i) a requirement to seek NHS GP approval prior to allowing a patient to see a private healthcare provider is a triage tool of the insurance industry to reduce its costs without appropriately reimbursing the NHS or NHS GP surgeries for the time and workload such requests generate
 - (ii) patients should not be required to seek approval from the NHS GP prior to being referred to a private healthcare provider
 - (iii) patients who wish to be referred to a private healthcare provider should be able to have this approved directly through their insurance provider's internal processes without the need to seek any form of unpaid approval from the NHS GP

- (iv) any involvement of the NHS GP by the private insurance provider should be remunerated appropriately.

CLIMATE AND ENERGY CRISIS

180. GATESHEAD AND SOUTH TYNESIDE: That conference believes the current energy crisis is the direct consequence of our dependence upon fossil fuels and:
- (i) recognises the impact that current ways of working in the NHS have upon the environment and the health of our patients
 - (ii) demands a full assessment of the above, on the understanding that recommendations will be followed-through
 - (iii) requires GPC England to negotiate funding for practices to achieve carbon neutral status by 2025
 - (iv) demands that GPC England request the BMA to lobby relentlessly for the full decarbonisation of UK energy and transport by 2030.
181. SUTTON: That conference asks to support general practice become more energy efficient and reduce net carbon emissions that NHSEI:
- (i) ensures that all clinical correspondence from Trust and healthcare services is sent electronically
 - (ii) provides funding to improve energy efficiency for practice premises
 - (iii) NHSEI subsidises recycling waste collection from practices.

PENSIONS

182. DEVON: That conference understands that GP pensions are a UK wide issue but due to the gravity of the situation for GPs in England we:
- (i) deplore the arcane pension regulations that act as an incentive against long term retention of GPs
 - (ii) demand that an immediate review is conducted concerning GP pensions as part of the NHS Scheme. Specific attention should be paid to issues which give rise to perverse incentives causing GPs to leave the profession early or pay huge tax bills for benefits that they have not received.

Agenda: Part II

(Motions relevant to Annual Representative Meeting (ARM))

This section of the part 2 agenda contains motions that the England Agenda Committee felt pertained to UK-wide issues and would therefore benefit from debate at the ARM. If your LMC has a motion in this section, it is strongly recommended that you re-submit your motions to the ARM.

GPC E / LMC / GPDF

183. LEEDS: That conference believes the current arrangements for election to GPC England, with links to GPC UK, the UK LMC conference and UK BMA ARM, require reform and demands that:
- (i) only GPs working in England should be able to vote to elect representatives for GPC England
 - (ii) that conference of LMCs in England should elect representatives to GPC England, rather than the UK LMC conference
 - (iii) as the BMA ARM, which is multi-branch of practice, is not sufficiently representative of GPs working in England, that the 10 GP seats elected by the ARM are instead elected either by this conference or used to expand regional constituencies.

NHSEI / GOVERNMENT

184. TOWER HAMLETS: That conference abhors the policy of deportation of asylum seekers to Rwanda and recognises the very significant contribution that international migrants have made to the NHS and in particular general practice. It calls on GPC England to:
- (i) state publicly its opposition to this policy
 - (ii) highlight the health risks of this policy
 - (iii) demonstrate how the significant resource this policy is using could be repurposed in the NHS.
185. GLOUCESTERSHIRE: That conference regrettably believes that the NHS in England is too often not a safe place for patients or staff and insists on a royal commission to urgently convene to address this situation and return healthcare to the standards that existed in the not too distant past.
186. LAMBETH: That conference believes that NHSEI should only fund healthcare or direct enablers of healthcare (such as estates, IT) and that money from the NHS should not be siphoned into social care to fund things such as the Better Care Fund, because these should be funded separately.
187. KENT: That conference abhors the requirement for providers of palliative care to rely so heavily on charitable donation and believes the Department of Health must fund end of life care as a pillar of NHS care, from cradle-to-grave.

WORKFORCE

188. NORFOLK AND WAVENEY: That conference calls for government to focus on long-term staff planning and retention. The UK has one of the lowest numbers of GPs per head of population in Europe. A long-term

strategy from undergraduate numbers right through to general practice needs to be implemented with government being formally required to report yearly on progress.

DIGITAL

189. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires that all documents as listed below (or their equivalents) can be created electronically from all GP clinical systems and transferred electronically:
- (i) cremation forms
 - (ii) medical certificate of cause of death
 - (iii) UC113
 - (iv) DS1500.

REGULATION AND REGULATIONS

190. AVON: That conference calls for other clinicians to be able to complete the medical certificate of cause of death. As roles of general practice and community medicine continue to expand with nurse practitioners, paramedics and clinical pharmacists, more clinicians should be able to complete the MCCD as they are often more involved in the care than the GP.
191. BRADFORD AND AIREDALE: That conference recognises that due to the huge diversification in our primary healthcare teams, pragmatically, it is appropriate and timely to permit and train other healthcare professionals to complete death certificates.
192. ENFIELD: That conference agrees that death certification does not need to or should be carried out solely by a GP and calls for GPC England to negotiate an agreement which will allow allied health professionals to certify death, the death certificate then countersigned by a GP.

CLIMATE AND ENERGY CRISIS

193. TOWER HAMLETS: That conference:
- (i) notes the unprecedented heat waves and wild fires that have blighted Europe and the UK this summer and recognises the catastrophic threat that climate change poses to health
 - (ii) further notes that far too little is being done by government to stem the worst of climate change and limit warming to 1.5 degrees
 - (iii) believes that far more radical action is needed and demands that government immediately invest in comprehensive home insulation, renewable energy provision, active transport infrastructure and widespread frequent, reliable and very cheap public transport to encourage people to leave their cars at home
 - (iv) demands that government abandons any plans for oil and gas expansion in line with the UN recommendations.

194. TOWER HAMLETS: That conference:
- (i) deplores the fact that the lungs of children in highly polluted inner city areas are 10% smaller than those growing up breathing cleaner air.
 - (ii) demands immediate, meaningful investment in active transport options
 - (iii) further demands heavily subsidised frequent and safe, reliable public transport throughout the country.
195. BRADFORD AND AIREDALE: That conference is committed to the BMA's goal of carbon net zero and argues for the climate crisis and sustainability to be considered as a specific dimension in all areas of policy debate.

Agenda: Part II

(Motions not prioritised for debate)

PRACTICE BASED CONTRACTS

196. WEST SUSSEX: That conference calls for a ballot of all general practitioners before the outcome of any new contract negotiations on the GMS primary medical services due to be implemented in April 2023, is agreed by GPC England.
- (Supported by Croydon LMC)
197. KINGSTON AND RICHMOND: That conference does not support the delivery of general practice by:
- (i) hospital trust held primary medical services contracts
 - (ii) shareholder owned organisations holding primary medical services contracts.
198. TOWER HAMLETS: That conference, whilst supporting and promoting the independent contractor model, recognises that across the country partners are handing back their contracts and:
- (i) requires a commitment from NHSEI that any tendering process is fair to all providers so that corporate, profit driven organisations who have the infrastructure to undertake a complex tendering process are not at an unfair advantage in being awarded these practice contracts
 - (ii) that any provider of primary care services must employ staff on contracts that are at least equivalent to the NHS contract for that role including the ability to enrol in the NHS pension scheme
 - (iii) insists that all GPs' workload is capped including adequate protected administrative time.
199. GLOUCESTERSHIRE: That conference notes the concerning trend of struggling partnerships being purchased by private companies who negotiate a contract novation, incur debts against the highly valuable NHS contract, strip the assets of the practice and then declare insolvency. Considering this conference calls on GPC England to:
- (i) investigate this asset stripping of general practice and report on its prevalence
 - (ii) seek to estimate the costs to the NHS of setting up alternative provision after insolvency is declared
 - (iii) compared this cost to that of supporting a struggling partnership to maintain its contract, thus providing a clear example of the value for money that the partnership model provides
 - (iv) campaign to ensure that any GMS contract novation's include provision to prevent this disturbing practice from occurring
 - (v) negotiate a change in the GMS contract to allow the automatic novation of GMS contracts to Limited Liability Partnerships, so that those who have an active interest in the care of their patients are afforded the same protections as those who simply see them as assets to be exploited.
200. NORTH STAFFORDSHIRE: That conference believes that core GMS and the partnership model are unsustainable unless the following are addressed the:

- (i) 2.4% unfunded portion of the DDRB 22/23 pay rise, only in England
 - (ii) one year in arrears CPI tax charge unfairly driving annual allowance tax levels
 - (iii) collapse of NHS dentistry with inappropriate workload transfer to general practice
 - (iv) complex workload transfer from delayed and virtual out-patients
 - (v) non-transferable utility costs increases.
201. BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference with respect to the recent DDRB award:
- (i) notes that the pay award and on costs have not been matched by an increase in funding for expenses in the global sum
 - (ii) laments the divisive nature of recommending pay increases for employed doctors without a commensurate increase in practice remuneration
 - (iii) believes this will adversely affect the attractiveness of the partnership model of general practice
 - (iv) we therefore call on GPC England to negotiate a fully costed automatic rise in global sum commensurate with national review body recommendations.
202. KINGSTON AND RICHMOND: That conference notes with huge concern the:
- (i) increasingly intolerable workload pressures on NHS general practitioners
 - (ii) imminent retirement of many general practitioners from NHS practices
 - (iii) increasing challenge of recruiting practice based general practitioners to partnership and salaried posts, and
- calls on GPC England to negotiate a new fit for purpose national primary medical services contract.
203. GATESHEAD AND SOUTH TYNESIDE: That conference notes the real terms pay cuts taken by GMS partners as a result of DDRB recommendations and NHSEI choosing not to fund these and:
- (i) is concerned that this is contributing to the exodus of said partners
 - (ii) is aware of the evidence that continuity of care results in better outcomes for patients, and that the partnership model delivers this better than alternatives
 - (iii) calls for GMS income to rise with inflation, this to be guaranteed in perpetuity.
204. TOWER HAMLETS: That conference:
- (i) is appalled that the DDRB recommended just a 4.5% pay rise for salaried GPs and has failed to provide the full money to fund this to contract holders
 - (ii) believes that negotiations have clearly failed and calls for the unions to ballot for industrial action.
205. DEVON: That conference recognises that the previously negotiated contract never envisaged inflation to be at its current level and renegotiate with NHS England sufficient uplift in year to prevent further loss of staff and financial difficulty for practices.

206. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is appalled that general practitioners earning over the threshold will still be required to publicly declare their income annually from April 2023, and notes that:
- (i) as this is not being applied to other similar workers suggests that the government is deliberately undermining general practitioners
 - (ii) the first year published will include income from Coronavirus vaccinations, and insists that GPC England negotiates for this income not be included
 - (iii) remaining partners who cannot recruit additional or replacement partners will have increased income due to the increased capital investment needed to keep practices open, and the policy will create further pressure on these practices to close.
207. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands that any cost saving proposal - for example reducing medication costs or reducing patient admissions - must include the cost to general practice of any initial and ongoing additional work. GPC England must ensure such costings are provided for all national proposals and provide support to LMCs to similarly cost local schemes.
208. AVON: That conference GPC England needs to work with government to ensure that the independent contractor status of general practice is preserved at a time when more financial support is being given to PCNs.
209. NORTH STAFFORDSHIRE: That conference believes the ongoing NHSEI investment only in to PCNs and not core GMS will soon trigger the demise the partnership model of general practice, leading to a rolling wave of contract hand-backs, which will be unsustainable for the NHS system.
210. SOUTH STAFFORDSHIRE: That conference believes that the increased cost of inflation at 10-12% and energy bill rises of up to 50% in some practices, along with absolute deafening silence by NHSEI to support practices, with no increase in core general practice funding and a critical shortage of GP workforce has created a perfect storm which will leave a lot of practices no choice but either to cut services, make staff redundant or to hand back their contracts, putting some partners potentially facing bankruptcy. The conference thereby instructs GPC England and BMA to immediately support and negotiate:
- (i) reduction in core hours of practice opening to 9-5, whilst maintaining the current levels of GMS funding, thereby allowing practices to reduce running costs
 - (ii) identifies that practices can still open longer if they so wish
 - (iii) allow practices to agree opening hours with their PPG. The GMS contract allows you to deliver services "in the manner determined by the contractor's practice in discussion with the patient"
 - (iv) negotiate with NHSEI for urgent financial support to practices, allowing unused ARRS funding and IIF target funding to be moved to core until March 2024 without any targets
 - (v) immediately outline what services practices can stop providing.
211. HAMPSHIRE AND ISLE OF WIGHT: That conference feels strongly that as a society we should be welcoming to all refugees in genuine need regardless of nationality (or none), colour, culture. Refugees often have acute and chronic health needs which differ from the general population. Conference notes the emergence of Ukraine specific contracts and services, and whilst these are helpful, consideration needs to be given to the refugee population as a whole, not a conflict / nation specific group. Conference calls for all:

- (i) local and national specifications to be extended, and where required amended, to include service provision to all refugees coming to our shores in genuine need
 - (ii) refugee specific contracts and services to be adequately resourced to truly reflect their level of need from health professionals.
212. SUFFOLK: That conference demands that GPC England request that NHS England indemnify practices against missing targets and breaching contracts as a result of wider system disruption. Practices should not be penalised with the NHS supply chain runs out of blood sample bottles and when computer systems are non-functioning.
213. LANCASHIRE COASTAL: That conference believes, given the present crisis in primary care, with demand far in excess of capacity that QOF should be suspended, enhanced service micro management reduced, and the funding reallocated to the Global Sum to allow practices to focus on seeing ill patients in a timely manner.
214. GLOUCESTERSHIRE: That conference rejects the notion of pay transparency as imposed by NHS England and calls for support for GPs who choose to exert mass disobedience by not declaring their pay until other comparable professions are also within this scheme.

ICS

215. HERTFORDSHIRE: That conference calls on GPC England to negotiate that, as part of GP commissioning, ICSs should be required to ensure that there is regular, funded, protected learning time for practice training when the practice can close.

GPC E / LMC / GPDF

216. DERBYSHIRE: That conference request GPC England explore with GPDF the possibility of developing:
- (i) a compendium of FAQs connected with everyday general practice
 - (ii) a financial skills and knowledge course(s) for GPs, practice managers and LMC staff
 - (iii) a practice management course(s) for GPs practice managers and LMC staff
 - (iv) a programme of education on running a practice during high inflation
 - (v) an LMC management course to aid and strengthen the LMC-GPC axis.
217. WEST SUSSEX: That conference notes that a GPC England Executive Team member spoke against a London Regional Council Motion at the BMA's Annual Representative Meeting calling on "GPC England and the BMA to organise the withdrawal of GP practices from the PCN DES by 2023" and
- (i) considers that holding a PCN Clinical Director role represents an untenable Conflict of Interest for GPC England Executive Officers
 - (ii) considers this undermines the ability of an Executive Team Officer to undertake their role of "participating in negotiations of national GP contracts in England"
 - (iii) has no confidence in the GPC England Executive Officer Team to deliver the will of conference, the BMA ARM and GPC England, with regards to the PCN DES.

218. NORTH STAFFORDSHIRE: That conference notes that a GPC England executive officer spoke against a (carried) motion at ARM calling on 'GPC England and the BMA to organise the withdrawal of GP practices from the PCNs by 2023', and that two of the executive officers hold PCN clinical director roles. In the context of existing conference policy, ARM policy to withdraw from the PCN DES, and the carried GPC England motion that PCNs pose an existential threat to the independent contractor model, conference:
- (i) considers it a conflict of interest for an executive officer to perform their role of 'Accurately and fairly representing the views of GPs in England and GPC England' whilst being a PCN CD
 - (ii) considers it a conflict of interest for an executive officer to perform their role of 'Participating in negotiations of national GP contracts in England' whilst being a PCN CD
 - (iii) has no confidence in the executive officer team to deliver the will of conference, ARM and GPC England with regards to the PCN DES
 - (iv) calls on GPC England to take steps to mitigate this conflict of interest.
219. SOUTH STAFFORDSHIRE: That conference believes that the current leadership has ignored the will of the conference, LMCs and ARM relating to the PCN DES, and have still not produced any timelines of action for withdrawal of funding from this DES, moving it into core funding and therefore instructs GPC England and conference to:
- (i) acknowledge whether the current leadership values and acts on the will of the conference
 - (ii) requests that format of the conference should have a timeline attached to agenda motions passed and name of responsible and accountable executive officer as soon as the motion is passed
 - (iii) provide monthly updates to GPC England and LMCs until action on the motion has been taken and its outcomes.
220. NORTH STAFFORDSHIRE: That conference reminds GPC England that conference exists to formulate policy which GPC England should endeavour to implement, and calls for GPC England to publish:
- (i) an annual action plan, incorporating conference policy
 - (ii) a formal biannual report against the action plan, published on the BMA website, and made available to LMCs at least one month prior to the closing date of motion submissions to conference
 - (iii) a quarterly report against the action plan to LMCs.
221. NORTH STAFFORDSHIRE: That conference recognises that the pause suggested for general practice coinciding with world suicide prevention day is nothing more than gaslighting the profession suggesting we should be more resilient when in fact the onus is on NHS England to remedy the toxic culture it has created.
222. KENT: That conference notes that a GPC England executive officer spoke against a (carried) motion at ARM calling on 'GPCE and the BMA to organise the withdrawal of GP practices from the PCNs by 2023', and that two of the executive officers hold PCN clinical director roles. In the context of existing conference policy, ARM policy to withdraw from the PCN DES, and the carried GPC England motion that PCNs pose an existential threat to the independent contractor model, conference:
- (i) considers it a conflict of interest for an executive officer to perform their role of 'Accurately and fairly representing the views of GPs in England and GPC England' whilst being a PCN CD

- (ii) considers it a conflict of interest for an executive officer to perform their role of 'Participating in negotiations of national GP contracts in England' whilst being a PCN CD
 - (iii) has no confidence in the executive officer team to deliver the will of conference, ARM and GPC England with regards to the PCN DES
 - (iv) calls on GPC England to take steps to mitigate this conflict of interest.
223. NORTH STAFFORDSHIRE: That conference demands that the GPC England executive commissions a rigorous performance analysis of itself (through a respected neutral independent mechanism that is immune to single issue political correctness) and then completely resets its game with NHSEI and Department of Health negotiations for the preservation of the GP partnership model.
224. KENT: That conference reminds GPC England that conference exists to formulate policy which GPC England should endeavour to implement, and require GPC England to publish:
- (i) an annual action plan, incorporating conference policy
 - (ii) a formal biannual report against the action plan, published on the BMA website, and made available to LMCs at least one month prior to the closing date of motion submissions to conference
 - (iii) a quarterly report against the action plan to LMCs.
225. KENT: That conference recognises that the pause suggested for general practice coinciding with world suicide prevention day was nothing more than gaslighting the profession, by suggesting we should be more resilient, when in fact the onus is on NHS England to remedy the toxic culture, it has created.
226. WEST SUSSEX: That conference reminds GPC England that conference formulates policy which GPC England should use its best endeavours to implement, and calls for greater accountability by requiring GPC England to publish:
- (i) a formal action plan each year, incorporating conference policy
 - (ii) a report describing progress against the action plan, published on the BMA website, and made available to LMCs at least one month prior to the closing date for submitting motions to LMC conference
 - (iii) a quarterly report to LMCs describing progress against the action plan.
227. DEVON: That conference is powerless as a result of:
- (i) a disunited GPC England
 - (ii) poor leadership from the GPC England Executive team
 - (iii) a disconnect between conference representative's views and those of grass root GPs
 - (iv) the development of PCNs.
228. DEVON: That conference can vote for whatever it chooses but the reality is that our current negotiators have little influence.

229. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference welcomes the Dacre report highlighting the significant gender pay gap in general practice and insists that GPC England:
- (i) produces an annual report to this conference to include up to date data on the gender pay gap, what actions have been implemented and what change in the pay gap has resulted
 - (ii) negotiates changes to all general practice contractor contracts to encourage and support part time and flexible working in partnerships.
230. WEST PENNINE: That conference accepts that it is time for a top to bottom review of GP representation and is brave enough to test whether conference decisions represent the views of grass roots, general practice or find if there is any disconnect between jobbing GPs and their LMC leaders.
231. BEDFORDSHIRE: That conference:
- (i) values the knowledge of general practice that the GPC England Executive bring to their roles, but
 - (ii) requires GPC England to engage an expert public relations team to put better information to the public about the situation in general practice.
- Conference believes, despite passing a motion in 2021 to look into whether we need professional negotiators, that it is now imperative that professional negotiators be appointed, as it is unrealistic to expect a part-time Executive, however skilled, to be able to parley fairly with professional negotiators on the other side.
232. DEVON: That conference agrees that non clinicians who are partners in general practices with a signed partnership agreement and are LMC representatives are fully able to enjoy the same rights of voting and proposing at conference as GPs are.
233. SOMERSET: That conference agrees that non-clinician partners in general practices with a signed partnership agreement and are who LMC representatives are fully able to enjoy the same rights of GPs to vote and propose at conference.
234. LEEDS: That conference believes there remains a need to improve the representative membership of GPC England and demands the immediate implementation of the Romney Report recommendation to set a time limit for GPC England membership.
235. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that the Romney report is not forgotten, that there is no place for sexual harassment or discrimination in LMCs or GPCs and requires GPC England to provide an annual report to this conference to include the number and type of all relevant complaints and outcomes, and all actions taken that year to ensure and assure appropriate behaviour by members and staff.

NHSEI / GOVERNMENT

236. SUFFOLK: That conference would propose that GPC England ask HM Treasury if they would support proposals for MPs surgeries to be tasked directly with assessment of whether individual constituents "should be eligible for the financial support for help with their bills, either because they are sick, elderly or otherwise in need, before issuing a 'prescription'". If not, to demand further explanation why the Treasury

saw it fit to leak to the media the proposals that would indicate that GP surgeries be landed with their own abject failure to protect consumers from inexorable energy price rises and energy company profiteering?

237. SUTTON: That conference condemns last year's Winter Access Fund being linked to performance data which could not be substantiated, and agrees that:
- (i) it is both manipulative and disingenuous to GP have such data in the public domain with no apology following such an act
 - (ii) GP should be informed in advance of any such data being collated and being presented in this way and at the very least be accurate
 - (iii) using media to inform GP of its strengths and weakness encourages those users who have been abusive to practices to continue with this behaviour and should stop at once.
238. KENSINGTON AND CHELSEA That conference invites Therese Coffey to meet LMCs, supported by GPC England, with the aim of helping our new secretary of state for health and social care to:
- (i) increase her insight into the role of the GP and the practice team in meeting patient and population need
 - (ii) gain understanding that patient need cannot be met through prioritisation of access to book-on-the-day appointments
 - (iii) gain insight into how GPs could be enabled to maximise the use of finite clinical time to add the most value to patients and local communities.
239. DEVON: That conference deplores the ever increasing and unrealistic demands from the public, partly driven by a rhetoric fed by politicians that GPs are to blame!
240. NORTH STAFFORDSHIRE: That conference believes that NHSEI policy has achieved a tipping point where it has almost destroyed the inter-generational GP faith and sustainability of general practice partnerships. This then is a cliff edge for the NHS system that is then also driving poorer and poorer recruitment and retention of GPs. Therefore this needs one final heroic GPC England attempt at explanation and attempted mitigation.
241. DEVON: That conference is impotent in the face of a Department of Health who have the ability to impose a contract that GP practices adopted without protest.
242. SEFTON: That conference calls upon government to address the resourcing crisis at the front line of NHS services by top slicing NHSEI management funding by 50%, and hand this over to it over to general practice and adult social care.
243. OXFORDSHIRE: That conference:
- (i) believes NHSEI has failed in stabilising the GP workforce in England, as per the 2021 Lancet report, "securing a sustainable and fit-for-purpose UK health and care workforce" which notes a significant drop in GPs per 1000 people in England
 - (ii) believes that NHSEI's support for general practice has resulted in micro management and systematic breakdown of GP autonomy

- (iii) demands that NHSEI acknowledge that their micro management has not been successful and shift their focus to supporting GPs to deliver their clinical services with autonomy.

244. WALTHAM FOREST: That conference:

- (i) is appalled that government has failed to learn from the pandemic
- (ii) acknowledges the recent experience in London, relating to Polio, is another example of government not understanding the finite capacity of general practice
- (iii) recognises that general practice operates best when is given the autonomy to design how services are delivered
- (iv) requires GPC England, in preparation for the next public health emergency, to negotiate with NHSEI a standardised response package that includes funding per capita
- (v) requires GPC England, in preparation for the next public health emergency, to negotiate with NHSEI trigger points for clinical prioritisation and suspending existing services whilst protecting income.

WORKLOAD

245. LEEDS: That conference demands that the GANFYD (get a note from your doctor) culture is addressed by:

- (i) providing a national approved statement and letter that can be displayed on websites and given to patients stating that their practice do not provide non NHS certification or reporting
- (ii) asking government to require the organisations that ask for the GANFYD to be responsible for meeting the cost not the patient
- (iii) introduce a national minimum fee for any private document requiring a GPs signature
- (iv) run a national campaign highlighting just how much time that could be devoted to patient care is spent covering other people's risks with unnecessary paperwork.

246. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is concerned about rumours that additional remuneration earned by practices working extra hours, often meaning working weeks without any break, to provide Coronavirus vaccinations could be clawed back. We note that this would undermine any remaining goodwill, would mean that practices are highly unlikely to take on any additional work in the future, and demand that GPC England resists any proposal that this is implemented.

247. DEVON: That conference asserts that general practice is overwhelmed due to the unlimited access and calls for better access to alternatives for on the day care to be commissioned. This may include but is not limited to, more walk in centres, urgent treatment centres and improved 111 triage.

248. SUFFOLK: That conference notes that Section 88 of the Road Traffic Act currently allows driving after the expiry of a licence and pending the issue of a new one following application provided your doctor has told you that you are fit to drive. GPs do not have the time to provide cover for delays at the DVLA or any other national body that is running slow and the responsibility involved seems excessive and the work burdensome; GPC England is requested to negotiate the provision of alternative arrangements not inviting recourse to a GP for patients in this situation.

249. BERKSHIRE: That conference calls on the BMA to:
- (i) carry out a comprehensive analysis of GP workload that includes inappropriate transfers of care into general practice; hours worked per G; and non direct-patient care duties such as but not exclusive to: administration, supervision, teaching, research, business management, quality improvement and audit
 - (ii) develop a coherent media strategy and campaign that highlights the disproportionate workload of general practice, in the context of the workforce and financial resource it has available.
250. MANCHESTER: That conference notes with much concern how the NHS in England is struggling universally to ensure that supply matches demand but is concerned to note that the response towards acute trusts and primary care providers reporting service pressures is fundamentally different and must change, or we risk a wholesale collapse of primary care in England. We call on GPC England to lobby NHSEI to issue directions to ICBs across England to use sit-rep tools constructively and start supporting practices that declare themselves to be under pressure.

CLINICAL / PRESCRIBING / DISPENSING

251. BEDFORDSHIRE: That conference:
- (i) notes that more and more patients are seeking private opinions, because of backlogs, resulting in requests for GPs to undertake a number of investigations or make onward referral into the NHS, and placing additional pressure on GPs and on NHS resources
 - (ii) asks GPC England to clarify if GPs have a right to decline to make a request for which they cannot see a clinical need, even if the procedure is available on the NHS, and
 - (iii) asks GPC England to advise patients that requests from private practitioners cannot automatically be dealt with ahead of NHS requests, despite the fact that patients often expect requests from private practitioners to be fast tracked.
252. DERBYSHIRE: That conference believes the Quality and Outcomes Framework (QOF) year end on 31 March puts unnecessary additional pressure on practices during the busier winter period and calls on GPC England to negotiate a change to the QOF year end on 30 June.
253. MID MERSEY: That conference demands the urgent reset of Covid-19 Autumn vaccination programme as the present one is likely to increase health inequalities by failing to reach vulnerable patients.
254. KENT: That conference demands that GPC England works with key stakeholders to develop an expansion of the Pharmacy First scheme that enables patients to self-refer to community pharmacy for treatment of minor illnesses.
255. KENT: That conference demands a Covid vaccination enhanced service that allows individual surgeries to receive vaccinations to administer for their own patients.
256. SUFFOLK: That conference is fed up with the repeatedly delayed (and often last-minute) changes to the Quality and Outcomes Framework (QoF) and demands that GPC England ensures that changes:
- (i) are negotiated and agreed with them and appropriate opprobrium is expressed on occasions when this is not done

- (ii) to QoF are clearly communicated to practices at least six months in advance of the start of each QoF year
 - (iii) are kept to a minimum, and are always based on a sound clinical rationale
 - (iv) to IT systems are prepared in advance with new indicators.
257. SUTTON: That conference acknowledges that as general practice workload soars to record levels, safe delivery of health care is important to enable Long term and proactive care to be delivered and demands that:
- (i) pharmacists are directly able to consult with patients instead of mandating a referral for minor ailments and the CPCS fee or an equivalent can be paid directly to the pharmacy for this
 - (ii) prescribers in pharmacy can consult and prescribe where it is felt appropriate
 - (iii) general practice is not asked to accept one and two hour dispositions from 111 for patient safety reasons
 - (iv) there is a limited number of patient consultations for each clinician for a session/ day worked to ensure both quality and safety of care delivered
 - (v) all work from secondary care and other health care providers is not transferred to general practice.
258. HERTFORDSHIRE: That conference calls on GPC England to run an education campaign to:
- (i) help GPs say No when asked to prescribe medication they do not have the expertise to prescribe
 - (ii) educate the media and private doctors about the problems of recommending non-licensed prescriptions, with the subsequent deleterious effect on the doctor-patient relationship when a GP says No
 - (iii) ensure patients understand that a GP has a right and a duty to say No if they feel they cannot prescribe something safely.
259. LIVERPOOL: That conference believes that public health messaging has become ineffective at helping patients choose well for their care needs and:
- (i) campaigns outlining which clinical presentations should seek urgent/emergency care have been lacking
 - (ii) consistent messaging regarding self-care options and expected length of common symptoms is essential
 - (iii) that the default position being "see your GP" is unhelpful and adding to GP workload.

260. WORCESTERSHIRE: That conference believes that the Community Pharmacy Consultation Service has:
- (i) widened health inequalities by charging the poorest in society for medications that they might otherwise have received on prescription
 - (ii) medicalised individuals by promoting and charging for medicines that are not always evidence based or necessary
 - (iii) resulted in investment and impact fund targets within the PCN DES that are unattainable due to lack of participation of community pharmacies
 - (iv) increased practice workload rather than reduced it.
261. CAMBRIDGESHIRE: That conference calls upon the BMA to negotiate for twice yearly Covid vaccinations for frontline primary medical services staff until 31.03.2024 given the critically deplete workforce across English general practice.

PENSIONS

262. LIVERPOOL: That conference believes that the growing crisis around NHS pensions is driving GPs to retire early and calls on GPC England to:
- (i) support BMA calls for a tax unregistered scheme
 - (ii) negotiate full recycling of employers contributions when opting out of the pension scheme
 - (iii) demand a government backed scheme pays reimbursement until the pension issue is resolved.
263. NORFOLK AND WAVENEY: That conference asks GPC England to negotiate an “exceptional clause” to the pension scheme to mitigate the loss of highly skilled NHS manpower. UK inflation has resulted in unintended consequences to the NHS pension scheme for general practitioners potentially resulting in large tax bills but more importantly an increase in workforce crisis through early retirement.
264. SUFFOLK: That conference requests GPC England to ask the government if they are prepared to publicly accept personal accountability for the worsening GP workforce crisis, given their abject failure to address the GP pensions debacle?
265. GLOUCESTERSHIRE: That conference is appalled that despite high-level representation for a number of years the pension problems for GPs and their staff have not been addressed, leading to loss of key members of staff prematurely and demoralisation of the workforce that remains we call for urgent reforms which are simple to implement.
266. DERBYSHIRE: That conference believes Capita Primary Care Support England has mismanaged the GP pension scheme falling well below expected professional standards and calls for:
- (i) Capita to be stripped of its PCSE contract immediately
 - (ii) GPC England to issue a formal complaint regarding Capita PCSE to the Pensions Ombudsman
 - (iii) GPC England to ensure that any time commitment required on the part of GP practices to correct these errors will be financially compensated for.

267. CLEVELAND: That conference notes the ongoing mismanagement of GP pensions by PCSE and the increased impact of the annual allowance tax charge due to inflation, and therefore mandates that any GP who is adversely affected because of PCSE incompetence have their tax charges financially underwritten by NHS England.

PREMISES

268. LEEDS: That conference expects a future GMS contract to include a premises scheme similar to that in Scotland with the NHS becoming the tenant or owner of last resort for premises when a practice partnership requests this.
269. TOWER HAMLETS: That conference notes the threat to practice viability caused by ever increasing uncapped service charges and requires GPC England to negotiate with government so that NHS property services can only apply inflationary increases to the annual practice service charges.

WORKFORCE

270. CAMBRIDGESHIRE: That conference believes in light of recent tragic GP suicides, a single well-being event is inadequate and calls upon GPC England to embed a formal regular process across England to mark the tragic loss of colleagues across primary medical services alongside continuing to prioritise well-being advice and support for practices.
271. WANDSWORTH: That conference is saddened by the suicide of a GP colleague as a result of unsustainable work pressures that may have contributed towards her death, and calls for:
- (i) NHSEI to conduct an inquiry into the circumstances leading to her death
 - (ii) NHSEI to conduct an inquiry to look into the effects of the public complaints procedure
 - (iii) NHSEI to provide additional support for partners
 - (iv) NHSEI to consider preventative measures eg funding for national Balint / peer support groups for everyone as standard
 - (v) funded time for regular reflective spaces / an hour with a psychotherapist / coach at least quarterly for every GP to be written into the contract.
272. NORFOLK AND WAVENEY: That conference views the expansion of commercial remote GP companies having a detrimental effect on continuity of care and recruitment into general practice and calls upon GPC England to engage in negotiations to regulate and limit this expansion.
273. CHESHIRE: That conference believes that to help with retention of GPs in the workforce, the National GP contract should reflect the need to improve long-term sickness management and return to work provision in general practice and thus supports:
- (i) standardised and regulated employment and long-term sickness procedures in general practice
 - (ii) occupational health input that can be accessed in a structured and timely manner
 - (iii) provision to practices to allow the GP role if needed to be adapted to one where reasonable adjustments of appointment length, rest breaks, work environment, flexible working and caseload are a real possibility and are seen in a positive light

- (iv) GPs who are no longer able to offer the full complement of requirements needed to fulfil the grassroots job demands of them, are still able to be accommodated in an inclusive workplace, where they can continue to provide a meaningful contribution to both the NHS and its patients.
274. LEEDS: That conference is seriously concerned at the government and NHS England's failure to support the retention of experienced GPs and therefore demands:
- (i) urgent pension scheme reform to remove the disincentives of annual allowance and life time allowance
 - (ii) payments to be paid to GPs, practice nurses and other clinicians working in general practice based on years of NHS experience.
275. DEVON: That conference welcomes the support in place for younger general practitioners such as mentoring and coaching. Conference asserts that there is little or no support for practitioners in their mid or late career, many of which are retiring early or leaving primary care:
- (i) conference demands:
 - (a) coaching and support services be easily available for all practitioners
 - (b) that incentives to remain in practice are reintroduced such as seniority payments
 - (ii) that IIF targets unfairly penalise practices in multi-practice PCNs due to variation in performance, demographics, and workforce availability. Conference asks that these targets be renegotiated urgently.
276. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that practice managers should have a regulatory body to help make sure that there is consistency in accountability.
277. AVON: That conference calls for the urgent development of a range of measures to help retain GPs in the workforce. GPs leaving English general practice should be surveyed to establish what steps would keep them providing clinical sessions.
278. AVON: That conference supports GPC England in requesting that the government explains how it has not been successful in recruiting 6000 GPs and to explain how the government proposes to deal with the workforce crisis in primary care?
279. AVON: That conference ask GPC England to negotiate a satisfactory pay rise for general practice so that general practice remains a viable career choice for doctors and practices do not close.
280. BRADFORD AND AIREDALE: That conference calls on GPC England to publicly call out the contradiction between the government's pledge of 6000 extra GPs and the imposition of a contract in 2022 that offers no funding in GMS / PMS for additional GP workforce and that all new funding in the last four years has specifically excluded investment in GPs or nurses.
281. NORTH YORKSHIRE: That conference recognises the current threat of potentially catastrophic personal financial insecurity to GP partners and urgently seeks NHSEI to mitigate the impact of widespread practice instability and unlimited liability for partners to protect a workforce that has personally and financially invested themselves in supporting the NHS, particularly over the Covid-19 pandemic.

282. HAMPSHIRE AND ISLE OF WIGHT: That conference is appalled that there is currently no link between NHS England's contract demands and any assessment of the actual current GP workforce. Conference asks that GPC England demands that:
- (i) GPC England works with appropriate other organisations to accurately determine GP workforce that is actually needed for current population demands and contractual requirements
 - (ii) that there is an honest communication with the public about what care can realistically be provided given the current state of the workforce
 - (iii) workforce implications are taken into account in any contractual requirements by NHS England.
283. DORSET: That conference recognises the invaluable impact of the GP retainer scheme in supporting GP numbers, increasing gender diversity, and enabling individual careers to continue and develop. As such we ask GPC England to negotiate:
- (i) an immediate extension to this scheme beyond the current permitted five years
 - (ii) a reduction in paperwork needed to roll the scheme on year after year
 - (iii) an increase in practice reimbursement that reflects the uplifts awarded to Salaried GPs
 - (iv) binding assurances that a retainer can continue their status indefinitely providing their circumstances for becoming a retainer have not changed
 - (v) an acknowledgement from NHSEI regarding the crucial role of retainers in the workforce and ask them to reaffirm this to the ICBs.
284. NORFOLK AND WAVENEY: That conference request that GPC England negotiates with NHSEI to reintroduce seniority payments to encourage stability in practices, acknowledge the commitment to the NHS and reward those GPs to remain and develop practices given that the few remaining incentives have been abolished.
285. NORFOLK AND WAVENEY: That conference asks for an added session of salaried GP funding to be given to all practices specifically to free up all clinicians during working hours to meet once a week so they can have well attended GSF / clinical governance and other meetings. There are PA's for CPD built into the job plans for consultants. In contrast GP workload means that even lunchtime meetings at practices are attended poorly in most practices.
286. NORFOLK AND WAVENEY: That conference believes that the GP workforce is still being decimated at times by Covid cases hitting staff both clinical and admin / managerial and protective measures are still inadequate for safe-working environments.
287. WIRRAL: That conference believes that recruitment and retention of GP workforce is being seriously hampered by the ongoing unrelenting erosion of traditional model of general practice, and calls on GPC England to work with the:
- (i) profession to clearly define GP roles now and in the future NHS
 - (ii) government in securing a contract that clearly defines GP roles and provide adequate and commensurate resources for GP to perform these roles.

288. CLEVELAND: That conference mandates that a solution is negotiated as a matter of urgency to allow GP locums to access the GP fellowship programme in an equitable way.
289. HARINGEY: That conference affirms that general practice should be valued and supported by the government in the same way as secondary care and calls on GPC England to insist that NHSEI recognises that workforce planning is placed at the centre of NHS planning.
290. CAMBRIDGESHIRE: That conference calls on the GPC England to draft a comprehensive workforce strategy for general practice across England, recognising that the political hot potato of “GP access” is the combination of a record workforce crisis; inadequate estate and premises, and patient demand facing insufficient and unsafe capacity.
291. CAMBRIDGESHIRE: That conference notes the GP online research into GP partner attrition across the 42 ICSs in the past three years and calls upon GPC England to investigate and publish the findings of the correlation of GP partner attrition with the total locally commissioned budgets at system level across England.
292. BEDFORDSHIRE: That conference asks GPC England to:
- (i) undertake a review into the factors contributing to the drop in FTE GPs in recent years, and
 - (ii) develop a plan to address these factors and to work with other relevant organisations to put this plan into action and to reverse this decline.
293. BEDFORDSHIRE: That conference calls on GPC England to explain to government that although the recruitment and retention of GPs is a dire problem immediate action on several fronts would help, namely:
- (i) incentivising young doctors to enter general practice, supporting the re-training and registration of those who have taken career breaks or worked overseas, and incentivising GPs in their late 50s and early 60s to remain or return
 - (ii) to make appraisal and revalidation a supportive, positive and uplifting process, and immediately suspend present appraisal and revalidation requirements until the necessary redesign of the system is achieved
 - (iii) in line with the current avowals to cut red tape, to create a single regulatory body for general practice rather than the plethora of bodies we currently have to comply with and, at the same time, relieve GPs of the many pointless admin task that are currently statutory
 - (iv) to relieve GPs of the risks and responsibilities of financing their own premises, as equipping all practices with suitable premises at no expense or risk to the doctors who work there should be a matter of course, and
 - (v) to replace the current gargantuan complaints system with one that is fair, efficient, reaches decisions promptly, and does not blame doctors for the failings of a dysfunctional system.

NHS 111

294. WIRRAL: That conference believes that the NHS 111 as it is currently operating is not a good value for money; and therefore, proposes that:
- (i) it should be scrapped

- (ii) all the current resources being expended on it be transferred to funding general practice
 - (iii) that the role of GPs as the gatekeepers should be properly safeguarded and adequately resourced.
295. CENTRAL LANCASHIRE: That conference believes that the goodwill of the profession to rise to the challenge of the national emergency of the pandemic with the CCAS / 111 slots has been cynically exploited by the continuing direct access to GP appointments, as it facilitates the bypassing of practice booking and care navigation, undermines the GP-patient relationship, and threatens the ability of general practice to clinically prioritise its already unsafe level of workload.
296. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the 111 contract should be relooked at and be made fit for purpose. Currently the pathways are always ending at general practice instead of all the other services that are available to primary care at large.
297. DERBYSHIRE: That conference rejects the pressure on practices to ensure that 111 calls are triaged within a defined time period and calls on GPC England to work with Department of Health / NHSEI to ensure that 111 algorithms are clear that it is the patient's role to contact the GP practice within a defined period and after that the practice will be free to respond as it deems clinically necessary.
298. LINCOLNSHIRE: That conference believes NHS111 is a waste of taxpayer's money as it does not reduce workload for trusts or community providers, and thus calls for these funds to be moved to local systems to commission locally designed and delivered service.
299. WALTHAM FOREST: That conference acknowledges the recent Adastra failure that prevented direct booking by 111 into GP appointment systems and:
- (i) notes that there have been no reports of any patient harm caused by this
 - (ii) is concerned that the current system of direct booking is widening health inequalities
 - (iii) believes this is an opportunity to reconsider the need for practices to reserve appointments for use by 111
 - (iv) believes that, for non-urgent conditions, 111 should advise patients to directly contact appropriate services including their GP but should not be disempowering patients by direct booking
 - (v) calls on GPC England to work with NHSEI in redefining 111 dispositions into urgent and non-urgent so that the outcome from non-urgent dispositions is that the patient is advised on services that they can contact.
300. NOTTINGHAMSHIRE: That conference acknowledges that the NHS 111 CCAS scheme where 111 can directly book onto our lists is primarily designed to help ease pressure on pre-hospital services and A&E departments. General practice is facing an unparalleled workforce/workload crisis, the 111 triaging process and the rationale used to prioritise the nature of the problem and time frame in which the patient must be seen is an utter failure. Conference demands that this scheme is abolished post-haste.

DIGITAL

301. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is astounded that a national repository for orphaned medical records is being planned, and this must be resisted by GPC England.

302. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is concerned that replacement of 'The Good Practice Guidelines for GP electronic patient records' is being developed without professional oversight by the BMA and RCGP and insists that unless the final version receives unqualified support by the JGPITC, GPC England must ensure that general practices will not have any contractual requirement to have regard to them.
303. AVON: That conference calls for a systematic improvement to general practice IT systems. The clinical software in general practice used to be the envy of other organisations in the NHS. Unfortunately, this reputation has stagnated and the GP IT systems have not kept pace with the evolving complexity of care delivered in the community nor the expectations of patients, regulators or commissioners.
304. KENT: That conference believes that due to the pandemic, the accelerated implementation of technology in general practice has realised some tangible benefits for practices and calls on GPC England to negotiate that future IT procurements must be determined by the priorities of individual practices and their patients.
305. KENT: That conference recognises that the requirement for laptops will remain and demands that every practice must have requisite access to NHS funded laptops to facilitate better access to remote and flexible working, multi-practice working and workforce resilience and capacity and that ICBs are required to commission appropriate IT support which recognises the changing working hours of general practice.
306. EALING: This conference believes that the NHSEI withdrawal of funding for AccurX and MJOG is a retrograde step and will affect the excellent use to which these communication platforms are used by practices to communicate with patients to ensure their safety.
307. SUFFOLK: That conference demands that GPC England requests that the government develop a digital consultation service whereby constituent queries can be submitted to MPs and concerns are addressed by the latest at the end of the next working day. Conference also demands that this service is available 8am-8pm 7 days per week and be delivered with no additional financial resource provided.
308. LIVERPOOL: That conference believes that the digital first agenda runs the risk of increasing health inequalities and:
- (i) requires GPC England to seek an assessment of the impact of digital first
 - (ii) expects an impact assessment of digital first to guide future contract negotiations.

REGULATION AND REGULATIONS

309. WEST SUSSEX: That conference calls for nationally negotiated provision of protected time for all general practitioners for:
- (i) appraisal preparation
 - (ii) the appraisal itself, and
 - (iii) reimbursement of fees for the use of NHS recognised IT platforms.
310. DEVON: That conference is confused as to why GPs in England have to pay to be appraised as the MAG form no longer works properly and NHSEI are advising the use of commercial appraisal systems whereas this is not the case in the other nations.

311. KENT: That conference requires GPC England to demand NHS Resolution:
- (i) ceases to coerce GPs to abandon legal privilege and protections when seeking support with civil litigation requests
 - (ii) accords GPs full confidentiality when dealing with negligence claims
 - (iii) is forbidden from reporting to NHS England and any other regulatory bodies, any GPs that have acted in good faith when seeking assistance in negligence claims.
312. SANDWELL: That conference has concern that the transfer of responsibility for malpractice claims from MDOs to NHS Resolution has left a deficit in feedback to practices and LMCs, and an educational deficit for practices previously catered for by MDOs. We ask that GPC England liaise with NHSEI to:
- (i) improve feedback to practices and LMCs
 - (ii) make adequate alternative provision to update practitioners on medical – legal issues.
313. KENT: That conference recognises the workload and stress caused by multiple avenues for patient complaints and demands that all complaints are referred to practices for local resolution primarily, and no action is taken by other organisations until local resolution has run its course.
314. CAMBRIDGESHIRE: That conference notes with concern the critical issue of newly qualified GPs facing delays accessing the national medical performers’ list, and demands that GPC England with the GP Trainees Committee, takes action urgently to hold HEE and PCSE to account for their roles in this and co-ordinate with Responsible Officers to anticipate GP trainees about to complete training to ensure the transition to the NPL is as smooth and swift as possible.
315. SEFTON: That conference calls upon NHSEI to eliminate the burden of bureaucratic drag on general practice - specifically unnecessary regulation, poorly thought through national diktats, and inappropriate requests from other providers.
316. BRADFORD AND AIREDALE: That conference believes that one of the main causes of low morale in general practice is complaints to external organisations and demands that:
- (i) any patient complaint that cannot be resolved at practice level can be regarded as a “breakdown in the doctor / patient relationship” and should lead to removal from the practice list
 - (ii) patients should only be permitted to escalate a complaint if their concern is serious enough that they would rather seek care elsewhere.
317. DORSET: That conference recognises the increased workload within general practice as a result of increasing numbers of subject access requests under GPDR and calls on GPC England to:
- (i) negotiate continued additional funding for provision of records of deceased patients under Access to Health records legislation
 - (ii) to provide and publicise clear guidance on the circumstances under which patients or third parties can be charged for access requests
 - (iii) negotiate an increase in global sum to account for the increasing costs of undertaking this work.

318. WIRRAL: That conference observes that general practice in England is over-regulated with several layers of regulators from CQC and now to the introduction of medical examiners. It calls on GPC England to:
- (i) alert the government of the burdens of these regulatory activities and their effect of recruitment and retention of GPs
 - (ii) work with the RCGP to streamline the regulatory activities in general practice and make it lighter and proportionate
 - (iii) call for delay in the implementation of use medical examiners in deaths occurring in the community.
319. BERKSHIRE: That conference calls on HEE to:
- (i) develop and ensure that all relevant minimum mandatory training, as specified by NHS England, CQC and any other relevant body for a GP to be on the performers list, is freely available to all GPs as e-learning resources
 - (ii) work with NHS England to make these resources portable and accepted by all employers
 - (iii) conduct an evaluation on the effectiveness of such mandatory learning, and what if anything is achieved by asking GPs to repeat it at regular intervals.
320. HERTFORDSHIRE: That conference calls on GPC England to negotiate the updating of the Annual Patient Survey in relation to digital first/online/telephone appointment access rather than the customary face-to-face related questions still being asked.
321. MANCHESTER: That conference notes the positive outcomes arising from the peer based clinical audit programme at the National Coronavirus Clinical Assessment Service and calls on stakeholders (including GPC England, NHSEI, and the RCGP) to further develop this system for the benefit of all GPs and patients in England.
322. BERKSHIRE: That conference calls on the BMA to:
- (i) explore the scale of complaints received by GPs, and the extent to which some of these may be considered “vexatious”, and consider possible mechanisms to tackle this
 - (ii) commission or provide a service to support individual GPs and practices who are subject to such complaints
 - (iii) conduct an analysis on the workload each complaint produces, and survey general practice to understand disparities in which GPs and practices receives complaints
 - (iv) lobby NHS England, CQC and the GMC to simplify and streamline complaints handling.

PRIMARY SECONDARY INTERFACE

323. NOTTINGHAMSHIRE: That conference rejects the apparent adoption of advice and guidance to manage/triage referrals. We call on GPC England to work with NHS England to ensure that advice and guidance is used where requested and that referrals are managed appropriately.

324. DERBYSHIRE: That conference believes the move to increased use of advice and guidance in place of referral is misguided and has medico-legal and workload implications. Conference calls on GPC England to negotiate:
- (i) an urgent cessation of the enforced use of advice and guidance in place of referral
 - (ii) urgent clarification of the medico-legal standing of general practitioners when using advice and guidance
 - (iii) an appropriate funding mechanism that reflects any additional work transferred to general practice because of the use of advice and guidance.
325. BRADFORD AND AIREDALE: That while conference supports the concept of Advice and Guidance when a GP wishes support to continue to take responsibility for the care of a patient, conference believes the centrally mandated rapid expansion of this service:
- (i) is not in the best interest of patients or GPs
 - (ii) is mainly a waiting list management scheme by declining patients access to those lists
 - (iii) is not supported by consultants and GPC England should work with the consultants to moderate this development
 - (iv) has concerns that from November 2022 patients have / will have full access to the records of all the discourse over attempted referrals in real time.
326. HERTFORDSHIRE: That conference calls on GPC England to recommend to practices that they refuse to engage with Advice and Guidance in its current guise. Conference would like to remind GPs, secondary care, ICSs and the government that Advice and Guidance is voluntary and asks that GPC England:
- (i) ensure GPs know they have a right to refuse to engage with Advice and Guidance
 - (ii) remind secondary care that they must accept referrals in whatever form they are made
 - (iii) reject any targets mandating the use of Advice and Guidance
 - (iv) reject any targets set by secondary care to convert standard referrals into Advice and Guidance.
327. DERBYSHIRE: That conference alerts patients to the fact that hospital issued Advice and Guidance not agreed by their GP:
- (i) clinically short-changes them in a process where their GP who has seen and examined them, has been informed by correspondence from a consultant who has neither seen the patient nor in most cases even discussed their case with their GP
 - (ii) is a means of covering up the true state of waiting lists by delaying actual referral
 - (iii) is a means of hospitals acquiring NHS funds grossly disproportionate to their cost of provision of service
 - (iv) results in GPs being overburdened with extra responsibility and work sometimes beyond their skills or training causing even greater delays in patients being able to consult with their GP.
328. KENT: That conference believes that the funding for GPs to engage with Advice and Guidance in the Investment and Impact Fund is derisory and requires GPC England to negotiate funding that reflects the additional workload and risk involved.

329. NOTTINGHAMSHIRE: That conference accepts the need for comprehensive referrals to be made to help secondary care colleagues to assess the need of patients but rejects any commissioner led mandated use of pre-referral proforma or checklists / templates.
330. DEVON: That conference deplores dangerously long waiting times for 999 ambulance attendance, with patients calling GPs in states of distress whilst waiting for an ambulance to attend. Conference demands that ambulance staff have access to and utilise their own senior clinicians in on site decision making rather than place GPs in tricky medico-legal situations.
331. DERBYSHIRE: That conference insists that as a last resort and in the interests of patient care and safety a general practitioner has the absolute right to refer a patient to hospital by hard copy letter either hand delivered, sent via courier or by post.
332. COVENTRY: That conference believes the failure to commission follow up services for patients who have bariatric surgery in either the private sector or outside the UK should not impact on general practice. In particular the system assumption that we will pick up this element of working without shared care from our secondary care colleagues is a form of moral blackmail and should not be tolerated.

(Supported by Warwickshire)

333. DERBYSHIRE: That conference rejects the increasing practical obstructions including for example Advice and Guidance being introduced by hospital trusts and other agencies which:
- (i) prevent the general practitioner from making a proper, timely, appropriate referral of a patient for care and services which lie beyond the GP practice skills, resources, or contract
 - (ii) fails to accommodate the GMS contractual regulations for GP contractors
 - (iii) fails to accommodate General Medical Council Guidance to doctors
 - (iv) fail to deliver proper care to patients

and requires GPC England and the BMA to negotiate to remove all obstructions to referral and to reinforce the GPs ABSOLUTE right of referral to secondary care.

334. DERBYSHIRE: That conference:
- (i) insists that in return for the GP accepting potentially unlimited workload arising from protecting hospitals and other agencies from wasteful or needless direct access by patients to specialist care; general practitioners must retain the ABSOLUTE right of referral to secondary care
 - (ii) reminds all parties that each patient has about 45 minutes of a GPs time per annum to include consultations and ALL clinical administration and that transfer of follow up care to general practice can only be undertaken by agreement with the GP AND with a corresponding transfer of resources
 - (iii) reminds all parties that shared care is BY AGREEMENT WITH the GP in each individual case and is NOT a process simply imposed ex cathedra by secondary care onto primary care and GP practices
 - (iv) reminds all parties that general practitioners are:
 - (a) neither an ever elastic free good to be plundered by all and sundry
 - (b) nor are they peripatetic community based house officers there to do the hospital's bidding.

335. SOMERSET: That conference believes that NHS / general practice is unable to support requests by private healthcare providers to prescribe or arrange investigations on their behalf.
336. BUCKINGHAMSHIRE: That conference notes a move towards increased usage of “advice and guidance” routes to obtaining specialist input for our patients, and:
- (i) believes this increased usage of “Advice and Guidance” is not in the interests of either GPs or their patients
 - (ii) believes this increased usage of “Advice and Guidance” may blur the lines of clinical responsibility for patients
 - (iii) demands that any new contracts to replace GMS maintain the GP’s right to refer patients directly to secondary care where the GP deems the patient’s needs to fall outside of their scope of practice.

CLIMATE AND ENERGY CRISIS

337. SHEFFIELD: That conference notes the rising likelihood of increased temperature extremes and flooding due to the climate crisis, and asks that GPC England should review their premises strategy and urgently seek contractual and/or policy changes to support practices by:
- (i) negotiating amendments to the premises cost directions to incentivise and support the highest environmental standards in premises extensions and new builds
 - (ii) negotiating increased investment in to premises projects either solely to improve the environmental impact of the premises (such as solar panels, bicycle storage, EV charge points, air source heat pumps and improved insulation) or to mitigate against the risk of flooding (where geographically appropriate)
 - (iii) working with stakeholders including the government and NHSEI to promote and guide general practice in improving the energy efficiency, flood protection and sustainability of their buildings.
338. TOWER HAMLETS: That conference notes the record breaking heatwave that occurred in July, and recognises the climate crisis as a health emergency and:
- (i) notes that there are only two contractual incentives for general practice to act in response to the climate crisis which are buried in the Investment and Impact Fund
 - (ii) believes that the general practice investment in the climate crisis is grossly inadequate given the scale and pace of change that is needed
 - (iii) demands that, in the forthcoming negotiations with NHSEI, environmental sustainability is embedded at the core of these discussions
 - (iv) that only contractual or policy changes that have either a neutral or positive effect on environmental sustainability are progressed
 - (v) insists that significantly more funding is diverted to both clinical and non-clinical incentives for general practice to reach net zero in line with the Greener NHS targets.

339. BRADFORD AND AIREDALE: That conference is committed to the BMA's goal of carbon net zero, and argues for resourcing to:
- (i) measure each practice's carbon footprint
 - (ii) action the carbon saving changes to be made from this mapping.
340. WIGAN: That conference recognises with alarm the impact which the cost-of-living surge will have upon low waged and benefit dependant patients and their families. The serious health consequences of increased deprivation amongst the already impoverished will create a short and long-term pressure on the NHS at every level and an enduring damage to public health. It calls upon GPC England / BMA to seek with urgency a safety net of provision to guard against malnutrition and self-neglect which will soon become the next health care crisis.
341. NORFOLK AND WAVENEY: That conference supports on environmental grounds, the reduced travel costs, and reduced emissions, of the current move towards more virtual and phone consultations in primary and secondary care.
342. MID MERSEY: That conference demands that the government addresses the very real issue of heating and eating that is affecting practices all across England to provide safe care for its patients.
343. MERTON: That conference calls upon government to recognise the potential impact of the unprecedented increases in the cost of energy both on private households and on businesses. The impact on the physical and mental health of the population must not be underestimated and has the potential for putting considerable extra pressure on NHS and social care resources.
344. TOWER HAMLETS: That conference:
- (i) is deeply concerned about the effect of the cost of living crisis on our patients as it will plunge many people into poverty
 - (ii) denounces tax cuts which redistribute wealth to the affluent
 - (iii) demands that government increase public spending to levels that would slay the five giants described by William Beveridge in 1942.

STANDING ORDERS

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STANDING ORDERS

CONFERENCES

Annual conference

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

Special conference

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

Membership

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

Representatives

4. All local medical committees in England are entitled to appoint a representative to the conference.
5. The agenda committee shall each year allocate any remaining seats for representatives amongst LMCs. Allocation of additional seats shall be done in such a manner that ensures fair representation of LMCs according to the number of GPs they represent. Each year the agenda committee shall publish a list showing the number of representatives each LMC is entitled to appoint and the method of allocating the additional seats.
6. Local medical committees may appoint a deputy for each representative, who shall be a registered medical practitioner, 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 until the following annual conference, unless the GPC is notified by the relevant local medical committee of any change.

Observers

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

Interpretations

10. A local medical committee is a committee recognised by a PCO or PCOs as representative of medical practitioners under the NHS Act 2006.
11. 'Members of the conference' means those persons described in standing order 3.

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

Motions to amend standing orders

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

Suspension of standing orders

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

Agenda

17. The agenda shall include:
 - 17.1 motions, amendments and riders submitted by the GPC England, and any local medical committee. These shall fall within the remit of the GPC England, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and any Acts or Orders amending or consolidating the same
 - 17.2 motions submitted by the agenda committee in respect of organisational issues only.
18. When a special conference has been convened, the GPC England shall determine the time limit for submitting motions.

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

19. In two parts; the first part 'Part I' being those motions which the agenda committee believe should be debated within the time available; the second part 'Part II' being those motions covered by 24 and 25 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording.
20. 'Grouped motions': Motions or amendments which cover substantially the same ground shall be grouped and the motion for debate shall be asterisked. If any local medical committee submitting a motion so grouped objects in writing before the day of conference, the removal of the motion from the group shall be decided by the conference.
21. 'Composite motions': If the agenda committee considers that no motion or amendment adequately covers a subject, it shall draft a composite motion or an amendment, which shall be the motion for debate. The agenda committee shall be allowed to alter the wording in the original motion for such composite motions.
22. 'Motions with subsections':
 - 22.1 motions with subsections shall deal with only one point of principle, the agenda committee being permitted to divide motions covering more than one point of principle
 - 22.2 subsections shall not be mutually contradictory
 - 22.3 such motions shall not have more than five subsections except in subject debates.
23. 'Rescinding motions': Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters 'RM'.
24. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chair of the GPC England as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.
25. 'AR' motions: Motions which the chair of the GPC England is prepared to accept without debate as a reference to the GPC England shall be prefixed with the letters 'AR'.

26. 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 received by the GPC England secretariat by a time to be agreed and advertised by the agenda committee, each representative may choose up to three motions, amendments or riders to be given priority in debate. The motions, amendments or riders receiving the most votes shall be given priority. A maximum of three motions, amendments or riders shall be given priority.
27. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 42, 43, 44, and 45 shall not apply and the debate shall be held in accordance with standing order 50.

Other duties of the agenda committee include:

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

Procedures

29. An amendment shall seek to change a motion but not significantly alter its purpose and/or meaning. It shall remove and/or add words to the original motion and shall be considered before a motion is debated.
30. A rider shall – add words as an extra to a seemingly complete statement, provided that the rider is relevant and appropriate to the motion on which it is moved.
31. An amendment or rider must be submitted in writing to the Agenda Committee, preferably for inclusion in the supplementary agenda by the published deadline, or before the end of the session preceding that in which the motion is due to be moved (for the first session, amendments or riders must be submitted before the session begins.)
32. An amendment or rider may be submitted by an LMC, GPC England, the Conference Agenda Committee, or any two members of Conference. If submitted by two members of conference, the names of the proposer and seconder, and their constituencies, shall be included on the written notice.
33. No amendments or riders will be permitted to motions debated under standing order 27.

Rules of debate

34. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.
35. Every member of the conference shall conduct themselves in a professional and respectful manner both during and outside the debate.
36. A member of conference shall address conference through the chair.
37. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.
38. Members of the GPC England, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.
39. The chair shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.
40. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.

41. The chair shall take any necessary steps to prevent tedious repetition.
42. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.
43. Amendments shall be debated and voted upon before returning to the original motion.
44. Riders shall be debated and voted upon after the original motion has been carried.
45. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 42, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.
46. If it is proposed and seconded or proposed by the chair that the conference adjourns, or that the debate be adjourned, or 'that the question be put now', such motion shall be put to the vote immediately, and without discussion, except as to the time of adjournment. The chair can decline to put the motion, 'that the question be put now'. If a motion, 'that the question be put now', is carried by a two thirds majority, the chair of the GPC England or their representative and the mover of the original motion shall have the right to reply to the debate before the question is put. The chair of GPC England or their representative shall limit their reply to the content of the debate, relevant policy work and the feasibility of enacting the motion under debate. They shall not express any personal opinions.
47. If there be a call by acclamation to move to next business it shall be the chair's discretion whether the call is heard. If it is heard then the proposer of the original motion can choose to:
 - (i) accept the call to move to next business for the whole motion
 - (ii) accept the call to move to next business for one or more subsections of the motion
 - (iii) have one minute to oppose the call to move to next business.

Conference will then vote on the motion to move to next business and a 2/3 majority is required for it to succeed.
48. All motions expressed in several parts and designated by the numbers (i), (ii), (iii), etc shall automatically be voted on separately. But, in order to expedite business, the chair may ask conference (by a simple majority) to waive this requirement.
49. If by the time for a motion to be presented to conference no proposer has been notified to the agenda committee, the chair shall have the discretion to rule, without putting it to the vote, that conference move to the next item of business.
50. In a major issue debate the following procedures shall apply:
 - 50.1 the agenda committee shall indicate in the agenda the topic for a major debate
 - 50.2 the debate shall be conducted in the manner clearly set out in the published agenda
 - 50.3 the debate may be introduced by one or more speakers appointed by the agenda committee who may not necessarily be members of conference
 - 50.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
 - 50.5 subsequent speakers will be selected by the chair from those who have indicated a wish to speak. Subsequent speeches shall last no longer than one minute.
 - 50.6 the Chair of GPC England or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
 - 50.7 at the conclusion of the debate the introductory speakers may speak for no longer than two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
 - 50.8 the response of members of conference to any major debate shall be measured in a manner determined by the agenda committee and published in the agenda.

Allocation of conference time

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

52. 'Soapbox session':
- 52.1 A period may be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
 - 52.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
 - 52.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
 - 52.4 GPC England members shall not be permitted to speak in the soapbox session.
53. Motions which cannot be debated in the time allocated to that block shall, if possible, be debated in any unused time allocated to another block. The chair shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.
54. Motions prefixed with a letter 'A', (defined in standing orders 24 and 25) shall be formally moved by the chair of conference as a block to be accepted without debate during the debate on the report of the agenda committee in the first session of the conference.
55. Other periods of time may be allocated by the Agenda Committee for other purposes as indicated in the Agenda.

Motions not published in the agenda

56. Motions not included in the agenda shall not be considered by the conference except those:
- 56.1 covered by standing orders relating to time limit of speeches, motions for adjournment or "that the question be put now" motions that conference "move to the next business" or the suspension of standing orders
 - 56.2 relating to votes of thanks, messages of congratulations or of condolence
 - 56.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association
 - 56.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned
 - 56.5 prepared by the agenda committee to correct drafting errors or ambiguities.
 - 56.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions
 - 56.7 that may arise from a major issue debate; such motions must be received by the agenda committee by the time laid down in the major issue debate timetable published under standing order 50.

Quorum

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

Time limit of speeches

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

Voting

60. Only representatives of local medical committees may vote on conference business and in elections.

Majorities

61. Except as provided for in standing order 46 and 47 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:
- 61.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC England structure, or
 - 61.2 a decision which could materially affect the GPDF Ltd funds.

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

Elections

63. Chair
- 63.1 At each conference, a chair shall be elected by the members of the conference to hold office from the termination of the conference. All members of the conference shall be eligible for nomination.
- 63.2 Nominations must be handed in on the prescribed form before 10am on the opening day of the conference. Nominees may enter on the form an election statement of no more than 100 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
64. Deputy chair
- 64.1 At each annual conference, a deputy chair shall be elected by the members of the conference to hold office from the termination of the conference. All members of the conference shall be eligible for nomination.
- 64.2 Nominations must be handed in on the prescribed form before 12 noon on the day of the conference. Nominees may enter on the form an election statement of no more than 100 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
65. Five members of the conference agenda committee
- 65.1 The agenda committee shall consist of the chair and deputy chair of the conference, the chair of GPC England and five members of the conference, not more than one of whom may be a sitting member of GPC England at the time of their election. In the event of there being an insufficient number of candidates to fill the five seats on the agenda committee, the chair shall be empowered to fill any vacancy by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected and shall continue in office until the end of the following annual conference.
- 65.2 The chair of conference, or if necessary the deputy chair, shall be chair of the agenda committee.
- 65.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by 1.00pm on the day of the conference. Any member of the conference may be nominated for the agenda committee.. Nominees may enter on the form an election statement of no more than 100 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

Returning officer

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

Motions not debated

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

Distribution of papers and announcements

68. In the conference hall, or in the precincts thereof, no papers or literature shall be distributed, or announcements made, or notices displayed, unless approved by the chair.
69. Mobile phones may only be used for conversation in the precincts of, but not in, the conference hall.

The press

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

Chair's discretion

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

Minutes

72. Minutes shall be taken of the conference proceedings and the chair shall be empowered to approve and confirm them.