Conference of England LMC Representatives
Agenda
22 November at The Light, at Friends House, London
Agenda

To be held on

22 November 2019 at 9.30am
At The Light at Friends House, 173-177 Euston Road, London SW1 2BJ

Chair
Rachel McMahon (Cleveland)

Deputy Chair
Shaba Nabi (Avon)

Conference Agenda Committee
Conference Agenda Committee
Rachel McMahon (Chair of Conference)
Shaba Nabi (Deputy Chair of Conference)
Richard Vautrey (Chair of GPC England)

Brian McGregor (Yorkshire)
Zoe Norris (Yorkshire)
Rakesh Sharma (Lancashire)
Elliott Singer (London)
Deborah White (Cleveland)
Notes

Under Standing Order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 20 September 2019. Although 20 September 2019 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the secretary – Stuart Abrahams – prior to the conference, or handed in, in writing, at as early a stage of the conference as possible.

The agenda committee has acted in accordance with standing orders to prepare the agenda. A number of motions are marked as those which the agenda committee believes should be debated within the time available. Other motions are marked as those covered by Standing Orders 25 and 26 (‘A’ and ‘AR’ motions – see below) and those for which the agenda committee believes there will be insufficient time for debate or are incompetent by virtue of structure or wording. Under Standing Order 20, if any local medical committee submitting a motion that has not been prioritised for debate objects in writing before the first day of the conference, the prioritisation of the motion shall be decided by the conference during the debate on the report of the agenda committee.

‘A’ motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chair of GPC 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 England 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. Under Standing Order 28, the agenda committee has scheduled a major issue theme debate.

Please note that a link to the ballot form for chosen motions is in the covering email sent to representatives. The ballot closes at 11am Friday 22 November 2019.
CONFERENCE OF ENGLAND LMCs ELECTIONS

The following elections will be held on Friday 22 November 2019.

**Chair of conference**
Chair of conference for the session 2019-2020 (see standing order 63)
– nominations to be submitted no later than **10.00am Friday 22 November**.

**Deputy chair of conference**
Deputy chair of conference for the session 2019-2020 (see standing order 64)
– nominations to be submitted no later than **12.00 Friday 22 November**.

**Five members of LMC England conference agenda committee**
Five members of the England conference agenda committee for the session 2020-2021 (see standing order 65) – nominations to be submitted no later than **13.00 on Friday 22 November**.
## Schedule of business

**Friday 22 November 2019**

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OPENING BUSINESS 9.30

RETURN OF REPRESENTATIVES

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

REPORT OF THE AGENDA COMMITTEE

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

STANDING ORDERS

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

4 AGENDA COMMITTEE: That conference agrees to amend standing order 46 to read: 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 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.

CHAIR OF GPC ENGLAND’S REPORT 9.50

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

NHS ENGLAND 10.10

AGENDA COMMITTEE TO BE PROPOSED BY LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference with reference to the recent NHS England strategy document on bribery and fraud:

i. condemns deliberate fraud but similarly condemns NHS England for producing a report implying widespread fraud exists in general practice
ii. considers NHS England to have knowingly brought general practice into disrepute and demands a public apology
iii. insists GPC England must raise a formal complaint with NHS England and the Secretary of State for Health and Social Care when such destructive narratives occur
iv. mandates GPC England to work with NHS England to address the offensive culture in NHS England which has allowed general practice to be referred to in this way.

* LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference condemns deliberate fraud but similarly condemns NHS England for producing a report implying widespread fraud in general practice whilst not recognising that the accuracy of the figure quoted is estimated as being only 25% to 50%, and assigns £35million to fraudulent access including general practice which is always free at the point of delivery.
6b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference condemns NHS England for bringing general practice into disrepute by making false claims, for example that stopping half day closing will create ‘hundreds of thousands of appointments, and that in each incident where this occurs the GPC England must:
   i. raise a formal complaint with NHS England and the Secretary of State for Health, and
   ii. report any doctor making any such claim to the General Medical Committee.

6c NORTHAMPTONSHIRE: That conference insists that any contract stating ‘potential fraud’ be removed from all GP contracts immediately and apology given to GPs for undermining their integrity which is vital in patient/doctor relationships.

6d BEDFORDSHIRE: With reference to the recent NHS England strategy document on bribery and fraud, conference wishes to make it clear that general assertions suggesting that most GPs are engaging knowingly in fraudulent activity is an unacceptable slur on a struggling profession. The implication that the majority are actively ‘gaming’ is distasteful to say the least.

6e BEDFORDSHIRE: That conference calls on GPC England to work with NHS England to address the offensive culture in NHSE which refers in PCN guidance to ‘potential fraud’ and sees ‘ghost patients’ as evidence of fraud by general practices.

MEDICATION SHORTAGES

* 7 AGENDA COMMITTEE TO BE PROPOSED BY SHROPSHIRE: That conference demands urgent action with regard to medication shortages to mitigate the impact: by recognising the adverse impact on patients on GP workload by pursuing additional resources to support practices having to do this work by exploring changes, including legislation, to make pharmacists responsible for identifying appropriate and available alternatives by GPC England urgently entering into discussions with relevant bodies to enable pharmacists, when medications are not available, to dispense an equivalent preparation or dosing regime without the need to return the prescription to the GP for amendment.

7a SHROPSHIRE: That conference, aware of the increasing frequency with which commonly used drugs become unavailable, often at short notice, and the significant additional workload this causes practices, instructs the GPC England to:
   i. pursue additional resources to support practices having to do this work
   ii. explore changes, including legislation, to make pharmacists responsible for identifying appropriate and available alternatives
   iii. ask government to consider measures, possibly punitive, to ensure the supply and flow of medication from pharmaceutical companies is maintained.

7b WALTHAM FOREST: That conference demands GPC England to urgently enter into discussions with DH and other relevant bodies to review the dispensing regulations to enable pharmacist, when medications are not available, to dispense an equivalent preparation or dosing regime without the need to return the prescription to the GP for amendment.

7c WIRRAL: That conference believe that the current shortage of commonly used medications in general practice eg HRT is not acceptable and demand that the government do something about it immediately.

7d SANDWELL: That conference accepts that the level of prescription medication shortages has reached a level that cannot be regarded as reasonable. Since our contract requires us to provide for the reasonable needs of patients, multiple medication changes cannot therefore constitute a GMS service. The changing of a BNF medication, due to unavailability, should be a commissioned service, and resourced as such.
7e CLEVELAND: That conference insists on urgent action to mitigate against drug shortages, including:
   i. prioritisation of this work by pharmacists over and above other CCG prescribing strategies
   ii. improves information to GPs and practices
   iii. an increased in funding to practices to recognise the sustained increased workload.

7f WIGAN: That conference demands that the Department of Health states clearly and accurately the reason for the pre-Brexit shortages in medicines supply which appear to have no satisfactory cause.

7g DORSET: That conference condemns the current supply issues for routine medication and calls for NHS England to act to mitigate the disastrous effects these are having on both our patients and our workload.

7h WORCESTERSHIRE: That conference is deeply concerned by the impact of a continued shortage of medicines on GP workload and encourages GPC England to address this with the department of health.

7i LEEDS: That conference is alarmed at the increased problem obtaining commonly prescribed medication, including many HRT products, and demands government takes urgent action to resolve this.

7j NOTTINGHAMSHIRE: That conference, while welcoming the publication of lists with ‘difficult to obtain’ medications, requests that the GPC England press the government to enable a constant supply of essential medicines to prevent constant change and confusion.

7k SESSIONAL GPs COMMITTEE: That conference condemns the current supply issues for routine medication and calls for NHS England to act and mitigate the disastrous effects these are having on both our patients and our workload.

7l OXFORDSHIRE: That conference is deeply concerned by increasing reports of medicines shortages across the country and calls for GPC England to work with NHS England to create a central national data resource to inform GPs of medication shortages and their alternatives, to avoid duplication of work.

| LIST CLOSURE 10.30 |

8 SURREY: That conference believes Commissioner approval should not be required for a GP contractor to close their list [as is the case under the current Regulations] for a cumulative maximum period of twelve months in any two years.

| HOME VISITS 10.40 |

9 KENT: That conference believes that GPs no longer have the capacity to offer home visits and instructs the GPC England to:
   i. remove the anachronism of home visits from core contract work
   ii. negotiate a separate acute service for urgent visits
   iii. demand any change in service is widely advertised to patients.
# GMS CONTRACT

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<th>AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference is disgusted with the lack of timely information provided in relation to the 2019 / 2020 GMS contract negotiation, and insists that in future years:</th>
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| i. final contracts must be provided at least 6 weeks prior to the commencement of that contract  
ii. any further annual changes to the PCN DES contract must also have associated adequate and timely legal and accounting advice prepared and released alongside the changes  
iii. QOF changes are only implemented once the QOF business rules have been updated on clinical IT systems to reflect the changes. |

| 10a | CLEVELAND: That conference is disgusted with lack of timely contractual information provided for the 2019/20 GMS contract negotiation, and insists that in future years, final contracts must be provided at least six weeks prior to the commencement of that contract. |
| 10b | NORTH YORKSHIRE: That conference instructs GPC England to ensure that any further annual changes to the PCN DES contract must also have associated adequate and timely legal and accounting advice prepared and released alongside the changes for PCNs, to avoid hundreds of PCNs having to pay for and do this work separately. |
| 10c | NORFOLK AND WAVENEY: That conference asks GPC England to ensure QOF changes are only implemented once the QOF business rules have been updated on clinical systems to reflect the changes. |
| 10d | NORFOLK AND WAVENEY: That conference asks GPC England to ensure new service and system changes only becoming a contractual requirement to deliver after appropriate training and operational changes have been provided to practices. |
| 10e | NORFOLK AND WAVENEY: That conference asks GPC England to ensure new system changes are road-tested within a wide range of general practices prior to being rolled out, to ensure they are fit for purpose. |
| 10f | CITY AND HACKNEY: That conference acknowledges that the timelines to deliver the changes in the 2019 contract have been unrealistic and hence unachievable and:  
i. this has caused stress and worry to GP practices  
ii. calls that in future, any timelines for delivering changes to contract changes must be both achievable and realistic. |
| 10g | NORTHUMBERLAND: The new contract arrangements are welcomed however the complexity of the financial settlement is leading to confusion and suspicion among grass roots GPs and is impeding the development of PCNs. We ask that the GPC England provides a comprehensive explanation of the checks and balances that comprise the new contract resourcing. |
| 10h | DEVON: That conference ask the GPC England to ensure that instigation of any changes in QOF do not occur until the GP IT system providers have updated the software required to support the changes. |
| 10i | WORCESTERSHIRE: That conference asks GPC England to argue the case to suspend the new QOF indicators immediately as the IT support software has not been updated to take account of them. |
| 10j | WAKEFIELD: That conference wishes the GPC England to negotiate for practices to be paid on historical QOF achievement rather than actual, if practices are failing to achieve because of delays in updated software for monitoring their performance against QOF. |
THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the GPC England report of progress on resolutions from the conferences of England LMCs 2017 and 2018 [pages 76-121] be received.

The agenda committee has noted a strong desire from LMCs to receive feedback from GPC England on the implementation of motions carried at previous conferences. The agenda committee has also noted a number of motions in the agenda expressing sentiments similar to existing conference policy, which we feel supports the need to receive more effective feedback on the implementation of previous policy by GPC England.

This section will be held under standing order 55.

Questions to the GPC England Executive team and Policy Leads will be taken from the floor, to be asked by a member of conference or lay executive of the LMC. One individual will be nominated to answer each question on behalf of GPC England. The member of conference or lay executive will then have the opportunity to ask follow-up questions to ensure that the specific detail within their original question has been covered in the answer. Each question topic will last for a maximum of 5 minutes, and the Chair of Conference will be responsible for facilitating a balanced discussion, by ensuring speakers offer precise questions and responses, rather than giving speeches.

Questions will be pre-selected by the agenda committee to ensure that a range of policy topics are included. Priority will be given to questions that specifically link to previous England LMC conference policy that has not been fully implemented, or UK conference policy that pre-dates the England LMC conference. The question topics will be published in the supplementary agenda.

All members of conference and lay executives of LMCs are invited to submit questions for consideration. These should be submitted by email to Karen Day (kday@bma.org.uk) by noon on Friday 15 November 2019.

AGENDA COMMITTEE TO BE PROPOSED BY SESSIONAL GPs COMMITTEE: That conference values the option of shared parental leave for all doctors, and therefore mandates GPC England to negotiate appropriately funded parental leave for:

i. salaried GPs
ii. contractor GPs
iii. locum GPs
iv. non-clinical NHS roles.

SESSIONAL GPs COMMITTEE: That conference values the option of shared parental leave for all doctors, and therefore mandates GPC England to negotiate appropriately funded parental leave for:

i. salaried GPs
ii. contractor GPs
iii. locum GPs.

CITY AND HACKNEY: That conference acknowledges the importance of equality in the workplace and demands that paternity leave rights are updated so as to be equivalent to the maternity leave rights.
12c LEEDS: That conference:
   i. believes that, compared with colleagues in secondary care, it is discriminatory that practices receive insufficient reimbursement to cover GPs taking maternity, parental and similar leave
   ii. demands that NHS England/CCGs fully reimburse the cost of maternity, parental and similar leave.

12d GLOUCESTERSHIRE: That conference calls upon the GPC England to ensure that NHS England provides unified terms and conditions to make provision for sickness and parental leave and other benefits usually applicable to GPs for:
   i. clinical directors of PCNs
   ii. appraisers
   iii. other ‘honorary contracts’ for example CCG work.

PENSIONS 12.20

13 AGENDA COMMITTEE TO BE PROPOSED BY LIVERPOOL: That conference deplores the failures to find workable solutions to the NHS pension crisis and:
   i. demands immediate action by GPC England to provide high quality GP-specific pension guidance, including information on withdrawal from the NHS Pension Scheme entirely
   ii. demands that NHS pension contribution rules are changed to place the onus on the NHS Pension Scheme to limit collection of employer and employee contributions to the pension annual tax allowance in any given year
   iii. is appalled at the proposed increase in employer pension contributions from April 2020 and instructs GPC England to negotiate either central payment or an increase in global sum payment in perpetuity to account for this increased liability, including all on-costs
   iv. calls on GPC England to address the delays in PCSE replying to complaints and enquiries and to hold them to account for their role in the mismanagement of NHS pensions
   v. demands that PCSE pay fair financial compensation to all members adversely affected by their mismanagement of NHS pensions.

13a LIVERPOOL: That conference is appalled at the proposed increase in employers pension contributions from April 2020 and has real concerns that practices will be forced to close as a result, and instructs GPC England to:
   i. negotiate either central payment of this increase in perpetuity, or a percentage increase in global sum equivalent to the increased liability including all on-costs
   ii. provide guidance for GPs to allow them to withdraw from the NHS pension scheme entirely.

13b KENT: That conference demands that all employer’s NHS pension contributions are fully reimbursed.

13c CLEVELAND: That conference, in respect of NHS GP pensions in England:
   i. is seriously concerned about the number of GPs who have experienced incomplete records
   ii. believes the number of organisations involved makes tracking payments excessively difficult
   iii. believes the incompetence of the system increases the risk of tax charges for GPs
   iv. believes it is excessively difficult for GPs to obtain refunds of excess superannuation payments
   v. demands that one organisation takes sole responsibility for all future administration.

13d HULL AND EAST YORKSHIRE: That conference condemns the ongoing failure of management of pension contributions by PCSE, NHS Pensions and by extension NHS England, and demands a comprehensive pro-active programme be put in place to guarantee no individual GP is financially disadvantaged as a result.
(Supported by NORTH AND NORTH EAST LINCOLNSHIRE)
13e SOMERSET: That conference demands that PCSE improve access to GP NHS pension account data so that it provides the basic functions expected from any other financial account. For example, the ability to see that a payment has been received and to be able to easily check an up-to-date balance, and that it should be held to account by the Department of Health if it fails to do so by April 2020.

13f BROMLEY: That conference calls upon the government to recognise the need to resolve the continuing problems in NHS pension provision for GPs, as a matter of urgency.

13g BEXLEY: That conference is concerned about the current management and future scope of NHS Pension Scheme and the uncertainty that this creates for GPs.

13h LEWISHAM: That conference demands that Capita (PSCE) be held publicly responsible and accountable for the mismanagement of NHS pensions and that it be made to pay fair financial compensation to all members adversely effected for the emotional distress caused.

13i GLOUCESTERSHIRE: That conference calls upon the GPC England to address the problems of PCSE/Capita which currently requests three months to provide an answer to complaints/enquiries raised via its website.

13j LIVERPOOL: That conference believes that NHS pension contribution rules must be changed to place the onus on the NHS Pensions Agency to limit collection of employers and employee’s contributions to the pension annual allowance in any given year.

13k CLEVELAND: That conference is dismayed at the lack of reliable information available for GPs in the NHS pension scheme following changes in April 2019 and:
   i. is concerned about the impact this is having on the long-term financial stability of the pension scheme
   ii. is concerned that GPs are putting themselves at financial risk by inappropriately withdrawing from the pension scheme
   iii. is gravely concerned that is causing the available GP workforce to further shrink, and that this will pose a significant risk to patient care
   iv. demands immediate action from GPC England and the BMA to provide high quality GP specific information in relation to this highly specialist area.

13l CAMBRIDGESHIRE: That conference recognises the work of the BMA with the consultants committee in developing a ‘pensions calculator’ tool, and the challenges of delivering an equivalent for the CARE pensions of GPs and calls upon GPDF to supplement the BMA’s project to expedite delivery of an equivalent tool to be made available for England’s GPs as soon as is feasible.

DEATH CERTIFICATION 12.30

* 14 KENT: That conference requires the GPC England to negotiate a change in law allowing allied health professionals to certify the cause of death.

SALE OF GOODWILL 12.40

* 15 GLOUCESTERSHIRE: That conference supports that medical general practices be allowed to include goodwill in their sale valuation. This would bring us into line with the many other private providers carrying out NHS contract work and who are traded freely incorporating goodwill into their market worth.

LUNCH 13.00
16 HERTFORDSHIRE: That conference wishes to give GPDF the mandate on behalf of England LMCs to use its reserves to provide ring-fenced funding to LMCs for the significant but vital extra work that they are being required to do, supporting the establishment and work of PCNs.

17 AGENDA COMMITTEE TO BE PROPOSED BY WARWICKSHIRE: That conference, with regard to the Additional Roles Reimbursement Scheme:

i. believes that it disproportionately disadvantages innovative practices who hired workforce ahead of the scheme

ii. believes it is unrealistic to expect PCNs to be able to appoint to the designated additional roles from day 1 of each DES Year and calls for the protection of the inevitable underspends for each PCN

iii. demands that there is allowance for alternative appropriate roles

iv. requires that PCNs who are unable to recruit into additional roles are allowed to retain the funding for other projects or staff

v. asks the GPC England to negotiate a per capita sum that a network can allocate to the workforce needed and available as it sees fit.

17a WARWICKSHIRE: That conference believes that the regulation around additional workforce roles of the Network Contract DES baseline unfairly disadvantages practices who were early adopters of those roles. Under regulations practices have to replace pre PCN roles before additional PCN posts can be filled and funded. There needs to be greater flexibility in how those roles can be replaced.

(Supported by COVENTRY)

17b CITY AND HACKNEY: That conference requires GPC England to ensure that:

i. the promised increase in workforce is ring fenced to cover existing work and is not for new work

ii. future workload increases will have additional role reimbursement funds to ensure that the workload does not place additional stress on the existing workforce.

17c BEDFORDSHIRE: That conference instructs GPC England to negotiate full funding for the additional roles for PCNs, ie to include backfill for long-term sickness, maternity, paternity leave etc.

17d OXFORDSHIRE: That conference believes the new Additional Roles Reimbursement Scheme of the PCN DES has created a perverse job market which is causing practices difficulty in usefully recruiting additional workforce, and:

i. believes this disproportionately disadvantages innovative practices who hired workforce ahead of the scheme

ii. calls on GPC England to take steps to increase the flexibility of the scheme in order to remedy this.

17e CORNWALL AND ISLES OF SCILLY: That conference believes that the additional roles specified in the network DES are too restrictive to allow networks to provide a flexible solution to their workforce needs and would ask the GPC England to negotiate a per capita sum that a network can allocate to the workforce needed and available as it sees fit.

17f AVON: That conference feels that whilst PCNs are welcome additional investment in practices, the workload required to set them up is destabilising practices from their core patient offering. Conference calls on the GPC England to renegotiate the PCN roles to all much greater flexibility to link with practice need.
17g NORTHUMBERLAND: The extreme inflexibility of requirements for the additional roles are a threat to the success of PCNs, due to the fact that appropriately qualified individuals will not be equally accessible in all areas. Conference demands that:
   i. there is allowance for alternative appropriate roles
   ii. allowance for the fact that the roles specified are not relevant where practices have already skill mixed
   iii. recognition that the arrangements may serve to increase inequalities of health provision.

17h NORTHUMBERLAND: The current rules on reimbursement of additional roles will inevitably lead to an underspend. Conference demands that the DES arrangements are adapted to ensure that the distribution of resources remains equitable.

17i BEXLEY: That conference recognises that whilst funding is available for the development of PCNs through the DES, it remains extremely difficult for networks and/or practices to meet the expectations of government and calls upon NHS England to set out realistic targets in relation to recruitment and retention of staff.

17j LAMBETH: That conference notes that the current PCN DES reimbursement for additional roles makes no allowance for any employment incentives including London weighting making it inequitable and unfairly disadvantaging London practices and requests that reimbursement for the additional roles should mirror all of the Agenda for Change pay scales.

17k SOMERSET: That conference instructs the GPC England to negotiate with commissioners to ensure that all employment on-costs are reimbursed under the Additional Roles Reimbursement Scheme, including the full costs of employing a replacement to work during periods of sickness and maternity leave.

17l ISLINGTON: That conference calls for GPC England to reconsider the PCNs requirements in what additional roles they can engage, and the commitment required in funding these roles, as these requirements carry financial risk and are restrictive in planning workforce needs.
   (Supported by HARINGEY, BARNET, CAMDEN AND ENFIELD)

17m DEVON: That conference is aware that many PCNs have experienced difficulties in recruiting clinical pharmacists and asks the GPC England to survey all PCNs to establish if:
   i. they have had recruitment problems
   ii. salary levels and reimbursement percentages need to be adjusted for the revised primary care network DES specifications for 2020-2021 and beyond.

17n DEVON: That conference with reference to the primary care network DES asks the GPC England to ensure that:
   i. in future PCNs are not required to deliver the full specifications of the DES if they have been genuinely unable to recruit into the roles specified for roles that be recruited reimbursement at the salary rates specified
   ii. there is more flexibility regarding salary reimbursement
   iii. PCNs are allowed to recruit more inventively
   iv. any monies held by CCGs for funding of PCNs that has not been used at the end of the financial year must remain ring-fenced for use in primary care and should be redistributed for use in areas of deprivation within the CCGs.

17o BRADFORD AND AIREDALE: That conference demands that the GPC England renegotiate the rules on additionality so all practices benefit and pre-existing roles can be funded.

17p BRADFORD AND AIREDALE: That conference demands that the Additional Roles Reimbursement Scheme is revised so no practice is penalised.
LANCASHIRE COASTAL: That conference believes it is unrealistic to expect PCNs to be able to appoint to the designated additional roles from day 1 of each DES Year and calls for the protection of the inevitable underspends for each PCN.

HULL AND EAST YORKSHIRE: That conference calls on GPC England to negotiate increased flexibility regarding the additional workforce funding for PCNs by:

i. allowing PCNs who are unable to recruit into additional roles to retain the funding for other projects or staff;

ii. not further penalising those PCNs who are unable to recruit by reallocating their funding to neighbouring PCNs creating a spiral of inequality.

AGENDA COMMITTEE TO BE PROPOSED BY CITY AND HACKNEY: That conference recognises the workload of the clinical director of the new PCNs and:

i. they must be empowered and supported to resist the unrealistic expectation of all organisations that seem to believe PCNs will solve the problem within NHS primary care

ii. rejects any attempt by commissioners to use clinical directors for the performance management of PCNs and constituent practices

iii. instructs GPC England to negotiate for clinical directors to be paid for the role they undertake independent of network size

iv. calls upon GPC England to negotiate with NHS England in ensuring parental and sickness leave reimbursements, in line with practice reimbursements, are available for PCN clinical directors.

CITY AND HACKNEY: That conference recognises the workload of the clinical director of the new PCNs is role dependent and not network size dependent and instructs GPC England to negotiate for clinical directors to be paid for the role they undertake independent of network size.

CAMBRIDGESHIRE: That conference calls upon GPC England to negotiate with NHSE/I in ensuring parental and sickness leave reimbursements, in line with practice reimbursements are available for PCN clinical directors.

KINGSTON AND RICHMOND: That conference believes that PCN clinical directors:

i. must be adequately resourced to fulfil the role as set out in the DES and that current resources are insufficient

ii. must be empowered and supported to resist the unrealistic expectation of all organisations that seem to believe PCNs will solve the problem within NHS primary care.

BRENT: That conference reaffirms that practices should determine the role of PCN clinical directors and:

i. rejects any attempt by commissioners to use clinical directors for the performance management of PCNs and constituent practices

ii. deplores the withdrawal of support to federations and the lack of recognition of their capacity and activity in providing essential support to PCNs.

LIVERPOOL: That conference believes that the sum allocated to PCNs for payment to primary care network clinical directors is insufficient to account for two sessions of time and instructs GPC England to negotiate a realistic level of remuneration for the clinical director role.

LIVERPOOL: That conference believes that the role of the primary care network clinical director is clearly exceeding two sessions per week and instructs GPC England to negotiate a more realistic financial package for GPs undertaking this important role.
18g NORTH YORKSHIRE: That conference believes a minimum time commitment is needed to successfully do the role of clinical director for a PCN, and instructs GPC England to negotiate:

i. an increase for some PCNs to the current ‘per patient’ calculation to ensure there is a minimum lower level of payment for clinical directors of at least one day a week regardless of network size, thereby not disadvantaging smaller networks

ii. an additional increased calculation for clinical directors that factors in those PCNs who have a higher number of practices in their network, in recognition of the additional workload this entails.

18h NORTH YORKSHIRE: That conference believes the current reimbursement for clinical directors is not adequate, and furthermore, that it should not be linked to PCN list size, and therefore instructs GPC England to negotiate an increase to clinical director reimbursement to ensure they all receive:

i. a level that allows a minimum time commitment of 1.5 days per week

ii. the same level as each other (regardless of PCN size).

18i CENTRAL LANCASHIRE: That conference believes that the sessional allowance for PCN clinical directors makes it impossible for them to give adequate priority to the internal development of their PCN when there are impossible demands placed on them to get involved in wider system issues.

18j CENTRAL LANCASHIRE: That conference believes that the development and success of PCNs is being impeded by the meagre sessional commitment for clinical directors and lack of resources to support PCN infrastructure.

**THEMED DEBATE – PCNs (PRIMARY CARE NETWORKS)**

The Primary Care Network (PCN) Themed Debate will be conducted under standing order 50. The motions submitted by LMCs that the Agenda Committee considers are best covered by this themed debate are included in the agenda here and are numbered TD1 to TD55.

The Agenda Committee have noted the intention that the PCN DES is a five year negotiated agreement, finishing in 2023/24 and have invited GPC England to provide a brief written summary of the nationally agreed components of this DES to date. This can be found on page 75.

The Agenda Committee have also noted the desire from LMCs for conference to consider the future vision of general practice and would encourage members of conference to use this opportunity to feedback positively to GPC England the way in which they would like to see PCNs develop over the coming four years.

All members of conference may take part in this debate by speaking from the microphones in the hall, rather than the podium, when called by the Chair, with a speaker time limit of one minute per speaker.

At the conclusion of the debate a representative of the Chair of GPC England will have the opportunity to respond to the debate.
TD1 WALTHAM FOREST: That conference understands that system development requires investment and:
   i. is concerned that the PCN DES will be insufficiently resourced once the full service specifications are developed
   ii. instructs GPC England to share the budgetary calculations for any contract changes with the profession prior to the changes being finalised
   iii. requires the additional roles funded through the PCN DES address the core requirements for general practice not just the new service developments.

TD2 HAMPSHIRE AND ISLE OF WIGHT: That conference is concerned that primary care network baseline risks penalise both innovative GP practices and struggling GP practices and calls on GPC England to negotiate mitigation to address unintended consequences.

TD3 GREENWICH: That conference requests that NHS England provide continuing commitment to ensure that PCNs are adequately supported to develop and mature, so they support practice survival and resilience, as intended.

TD4 NORFOLK AND WAVENEY: That conference asks GPC England to negotiate:
   i. an improved PCN funding formula for the additional workforce as the current and proposed resources are inadequate to relieve the pressure on general practice and meet the expected future PCN requirements
   ii. that additional staff funding is set at 100%
   iii. that the workload requirements and expectations for the clinical director post is minimised.

TD5 NORFOLK AND WAVENEY: That conference believes there is a danger that essential funding is being directed to PCNs rather than core-general practice and taking GPs away from front line clinical care.

TD6 KINGSTON AND RICHMOND: That conference believes that PCNs:
   i. must be fully funded to provide and manage any services they are contracted to undertake
   ii. must be fully contracted nationally and not be used to undertake any unresourced local commissioning needs
   iii. are not the panacea for primary care that many seem to believe they are
   iv. are an adjunct to fully funded general practice and not a replacement for this.

TD7 BEDFORDSHIRE: That conference believes that PCNs are doomed to fail unless properly funded to commission and deliver the services they are asked to provide.

TD8 BUCKINGHAMSHIRE: That conference mandates the GPC England to ensure that the development of the PCN DES does not erode independent contractor status and individual surgeries due to lack of investment in core GMS finances.

TD9 NOTTINGHAMSHIRE: That conference is concerned that future services (e.g. enhanced care home support) already earmarked to be delivered at PCN level are unlikely to be appropriately resourced to help practices to take a full role in helping to deliver them. It urges a review of planning for these new services with a view to making payments via a DES for practices with extra incentives to deliver at scale across the PCN.

TD10 GREENWICH: That conference requests that:
   i. recognition be given by NHS England to the value of individual GP practices to providing care to the community; and
   ii. the dangers in seeing the value of practices only in terms of them being part of a primary care network.

TD11 BUCKINGHAMSHIRE: That conference believes there is loss of recognition of small surgeries being valuable in the quality of care for patients in the new PCN structure and calls on the GPC England to take action to prevent these surgeries being disproportionately financially disadvantaged compared to larger practices.
TD12 ISLINGTON: That conference requires GPC England to support local LMCs to ensure a unified approach is taken to supporting PCNs and that Federations do not become the voice of general practice. (Supported by HARINGEY, BARNET, CAMDEN AND ENFIELD)

TD13 NORTH YORKSHIRE: That conference demands assurance from GPC England that it will ensure that LMCs are not side-lined or by-passable in moving to represent PCNs at a system level.

TD14 EALING, HAMMERSMITH AND HOUNSLOW: That conference recommends that all PCN clinical directors maintain a close relationship with their local LMC representatives, who are the statutory elected representatives of general practice in their area, so that the message from both is consistent and protects the interests of general practice.

TD15 NOTTINGHAMSHIRE: That conference can already see that PCNs are under real threat of becoming overwhelmed with requests to cure the ills of the current system. We request that GPC England makes it clear to PCNs as well as commissioning colleagues that any new services must be negotiated via LMCs working with PCN colleagues to ensure consistent support for PCNs and their member practices.

TD16 BROMLEY: That conference recognises the importance of involving sessional and salaried GPs in the development of PCNs, as these practitioners will play a key role in the future general practice workforce.

TD17 LAMBETH: That conference opposes the devolution of prescribing budgets to PCNs.

TD18 NORTH YORKSHIRE: That conference believes that we need to wake up and realise that the NHS England/ the BMA cannot expect PCNs to solve every problem that faces general practice.

TD19 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference supports PCNs in their entirety but empowers them to say no when they are being manipulated to carry out the dirty work of other organisations.

TD20 NORTHAMPTONSHIRE: That conference insists that the national PCN contract must not be controlled by CCGs for their strategic aims, and investment in training be controlled directly through the clinical directors and not as directed by the authorities.

TD21 BEDFORDSHIRE: That conference wishes to express concern that far from allowing PCNs to be independent local groupings meeting local needs, the guidance they are receiving is prescriptive and appears non-negotiable and threatens the autonomy of the PCNs.

TD22 CLEVELAND: That conference mandates that future contractual developments within the primary care network must be a series of stand-alone DES’s.

TD23 CLEVELAND: That conference believes that for PCNs to succeed, there must be amendments to include PCN staff in the provisions of:
   i. premises reimbursements
   ii. GP IT.

TD24 CUMBRIA: That conference believes that the omission of mental health support workers from the additional roles reimbursement scheme is a major omission that needs to be corrected.

TD25 LINCOLNSHIRE: That conference is angry that the funding for mental health workers in general practice that was promised in the GP Forward View has not materialised, and that the Network Contract DES does not have funding for any mental health roles, so that mental health has again been neglected by commissioners and demands that GPC England Executive works with NHSE to identify new funding for mental health workers in general practice by 2020.
TD26 NORTHAMPTONSHIRE: That conference insists that PCN clinical directors cannot have their personal details and contact information released to the public by CCGs and other authorities without their express consent.

TD27 DEVON: That conference with reference to the Improved Access Scheme asks the GPC England negotiating team to ensure that:
   i. the provision of these extra appointments is not part of the primary care network DES
   ii. accountability for the provision should remain with CCGs
   iii. primary care network DES should have the ability to decline to provide these appointments while still providing the rest of the primary care network DES specified services.

TD28 CITY AND HACKNEY: That conference recognises that some GP practices will struggle to retain and recruit staff to provide the extended 8-8 hours now written in the PCN DES and that:
   i. not all practices will have a local demand from patients for this
   ii. the compulsory provision of 8-8 extended hours is removed from the DES contract where local need has not been demonstrated.

TD29 COVENTRY: That conference believes that the introduction of PCNs has unwittingly introduced yet another level of performance management for hard working GPs and so calls upon GPC England to address the current system to reduce the number of tiers at which a GP can be called to explain concerns regarding performance issues. (Supported by Warwickshire)

TD30 AVON: That conference wants to ask GPC England to remind NHS England and CCGs that PCNs are designed to enhance the resilience of individual GP practices and should not been seen by all and sundry as the answer to budgetary and secondary care problems.

TD31 BUCKINGHAMSHIRE: That conference believes the funding envelope for the PCN DES is wholly insufficient to cover costs to practices such as premises, management time and supervision and mandates GPC England to negotiate additional funding for 2020/21 over and above what has already been agreed, specifically:
   i. funding for premises to support the utilisation of additional staff
   ii. an uplift to the funding for clinical directors to allow adequately funded safe supervision of such staff.

TD32 OXFORDSHIRE: That conference believes the funding envelope for the PCN DES is inadequate to meet networks’ costs such as their 30% share of Additional Roles, management costs and other non-reimbursable on costs and instructs GPC England to:
   i. negotiate annual uplifts to the network level funding over and above what has already been agreed
   ii. negotiate an uplift to the practice level network entitlement over and above what has already been agreed
   iii. ensure any such negotiated uplifts are new money and not recycled from existing CCG budgets.

TD33 DERBYSHIRE: That conference:
   i. remains to be convinced that adequate funding exists to deliver the national specifications via the PCN DES
   ii. supports PCNs in not taking up this service until the funding stream is transparent.
TD34 SOMERSET: That conference believes the funding envelope for the primary care network directed enhanced service is inadequate to cover practice costs such as the share of the 30% not reimbursed by the Additional Roles Reimbursement Scheme (ARRS) and instructs GPC England to:

i. negotiate further annual uplifts to the £1.50 per patient network administration payment
ii. negotiate Network level funding that is not contingent on sharing targets with secondary care
iii. ensure all such funding uplifts represent new money and not recycled from existing budgets.

TD35 NORTH YORKSHIRE: That conference believes PCNs are at risk of collapse unless further ‘no strings attached’ funding is provided and instructs GPC England to negotiate an increase to the £1.50 DES payment from year 2 onwards.

TD36 NORTH YORKSHIRE: That conference believes the management resource for PCNs is inadequate in several areas and demands as a minimum:

i. clinical director funding is increased to a realistic level for the demand on their time
ii. a new practice manager funding, educational, support and development resource is introduced
iii. consideration is given to the administrative support needed within each PCN.

TD37 NORTH STAFFORDSHIRE: That conference believes that the lack of funding to facilitate the management costs of certain employees within a PCN (such as social prescribers) stifles their introduction and conference asks that GPC England negotiates a commitment from NHSE that CCGs will make funding available to break the deadlock.

TD38 SHEFFIELD: That conference welcomes the extra investment in primary care through the PCN DES but, in order to deliver the full DES specification and employ new staff, conference calls on the GPC England to negotiate with NHSE to produce a fully costed, funded and co-ordinated PCN infrastructure, including:

i. human Resources services for each PCN
ii. management services for each PCN
iii. administrative support for each PCN
iv. evaluation and delivery of premises needed to host new staff for each PCN
v. fully interoperable IT systems for each PCN.

TD39 NORTH YORKSHIRE: That conference believes that the clinical directors and PCNs do not have the capacity nor funding to be the saviours of primary care and by inference the NHS, they are already inundated with work and therefore GPC England should ensure financial and workload protection for these fledgling roles in negotiation.

TD40 WORCESTERSHIRE: That conference is alarmed that unrealistic expectations are being placed on PCNs who are being viewed as the solution to all health care problems and asks that GPC England:

i. robustly defend the right of PCNs to develop in their own time
ii. negotiate sufficient resource where there is transfer of work from other organisations
iii. promote the development of a unified GP provider voice within integrated care systems.

TD41 HERTFORDSHIRE: That conference:

i. believes that, in the new world of PCNs and staff being employed to work across practices, the VAT charge needs to be clarified and mitigated in the reimbursement figures, and
ii. urges the GPC England to agree clear advice and accountancy/financial support for PCNs to function and succeed.

TD42 BEDFORDSHIRE: That conference calls for more support for all PCNs in the development of some central nationally-produced formats which would give clarification on issues such as reimbursable services and VAT services.
TD43 COUNTY DURHAM AND DARLINGTON: That conference believes that PCNs went live without a full exploration of many practical issues around implementation such as legal and tax/VAT implications. PCNs risk costing rather than helping general practice if they become the dumping ground for work without the necessary framework, workforce and flow of adequate funding. The GPC England should seek to halt the mandatory aspects of the Network Contract DES until networks are in a position to realistically deliver them.

TD44 SOMERSET: That conference is appalled that the primary care network DES risks becoming a bonanza for lawyers writing bespoke schedules for PCNs.

TD45 CAMBRIDGESHIRE: That conference calls on GPC England to ensure that the profession’s increasing concerns regarding the ability of PCNs to solve the crisis in general practice are addressed in the 2020/21 PCN DES, and that the specifications:

i. reflect the crucial need for adequate, additional funding over and above the planned allied health professionals, to address the current GP workforce and workload crisis

ii. include greater recognition and ring-fenced funding in support of what has become essential, non-core work done by GPs caring for our frail, ageing, multi morbid patients in nursing and residential homes, to resource this work to continue when LES funding ceases in April 2020

iii. contain adequate funding for the mandated allied health professionals to ensure that practices are appropriately reimbursed to pay these additional staff at the AFC levels they expect

iv. reflect the intention that PCNs were created to support and protect general practice, not to facilitate the transfer of work from community and acute trusts into primary care.

TD46 CLEVELAND: That conference, in respect of the introduction of the Network DES:

i. believes that there has been an overall increase in practice workload

ii. believes that the net funding into general practice has not increased

iii. believes that the risk associated with being a GMS contractor has increased

iv. demands a proper evaluation process during the 5 year package to ensure that the aim of supporting general practice is being achieved

v. believes that a major overhaul of this DES is required from April 2020 for it to become acceptable to the profession as a whole.

TD47 ISLINGTON: That conference requires GPC England to ensure that PCNs are:

i. not being used as a vehicle to overload practices with an expectation that they will undertake uncontracted work

ii. not being used as performance management tools by CCGs in reducing variation in service delivery across practices

iii. not being used as a tool to deliver unrealistic outcomes based network targets

iv. not being used as the principal means to deliver CCG ‘efficiency’ savings

v. able to have funded, supported and protected time to develop as a network.

(Supported by HARINGEY, BARNET, CAMDEN AND ENFIELD)

TD48 BUCKINGHAMSHIRE: That conference calls on the GPC England to show evidence that the PCN DES multi-disciplinary professionals proposed over the next five years will provide a service that will improve the quality of care of patients across England.

TD49 GATESHEAD AND SOUTH TYNESIDE: That conference believes PCNs, unless adequately, indefinitely resourced, to be a threat to independent contractor status.
COVENTRY: That conference believes there has already been a creeping misappropriation of the original purpose of PCNs by acute trusts and CCGs. The PCN DES in the new contract was negotiated to stabilise general practice, repair some of the chronic underfunding and remove workload from hard pressed GPs, not to relieve pressure on secondary care. We wish to instruct the GPC England to insist that NHSE must make this unambiguously clear in a new statement as a matter of priority so as to avoid our funding from being hijacked. (Supported by WARWICKSHIRE)

AVON: That conference wants to remind the Secretary of State for Health and Social Care that PCNs cannot mean that GPs and their surgeries become the fall-back position for shortcomings in other providers such as the local authority, Public Health England and secondary care providers. Clinical directors of PCNs cannot hold the responsibility for the activities of these bodies.

NORTH YORKSHIRE: That conference believes that general practice resilience must be secured before PCNs can be expected to achieve the numerous other aims the NHS hopes, and instructs GPC England to instruct NHSE to stop their numerous additional demands of PCNs over and above the contractual DES requirements.

AVON: That conference is concerned about the extent to which CCGs are seeking to influence the creation, structure and management of PCNs and calls upon the GPC England to demand that NHSE reiterates its guidance to CCGs that the PCNs operate according to the national contract.

BRADFORD AND AIREDALE: That conference demands that the GPC England rein in NHS England, CCGs and ICSs’ with respect to their expectation of PCNs at such an early stage.

KENT: That conference demands that practices and/or PCNs should be fully funded for any new services they are expected to provide.

HILLINGDON: That conference, with regard to PCNs:

i. has no faith that they will result in a reduction in GP workload
ii. is concerned that they do not actually address the issue of the dwindling GP workforce
iii. has not seen any evidence that they will assist practices in supporting increasing numbers of patients with increasingly complex health needs
iv. believes they are the building blocks towards integrated care systems which will be to the detriment of local personal patient care
v. requires GPC England to reject this model in favour of developing a new GP contract that actually positively supports the current model of English general practice.

REDBRIDGE: The conference believes that the 2019 contract variation has not improved practice stability and:

i. contains such significant variations that it should be considered a new GMS contract
ii. is concerned that it was never agreed by grass roots GPs
iii. is concerned that it will increase practices workload with insufficient resources
iv. believes that it will cause further destabilisation to the profession and practices
v. demands a vote to enable the profession to either accept or reject these significant variations.
19b COVENTRY: That conference believes that the new contract in encouraging practices to form PCNs has made general practice more attractive for acute provider trusts to manage as part of an ICP contract increasing the risk of vertical integration, the demise of the Partnership Model and the introduction of a fully salaried GP service. (Supported by WARWICKSHIRE).

19c COVENTRY: That conference believes that No we have not been Mis- sold a PPI but we have been mis-sold PCNs as they were never intended to stabilise general practice but to do the work laid down by STPs and ICPs to achieve the priorities of the 5 year NHS plan. (Supported by WARWICKSHIRE).

19d NORTHAMPTONSHIRE: That conference recognises that CCGs and ICSs are using PCNs as a way of delivering KPI’s and that the PCN DES needs to remain ring fenced to protect GPs from becoming accountable for STP outcomes.

19e LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes PCNs should not continue beyond the initial 5 year period as they will not be the saviour of general practice and could hasten its demise, because of:
   i. the expectation of NHS England that PCNs will solve all of the NHS problems
   ii. the transfer of 30% of the cost of some community services like physiotherapy from community trusts to general practice
   iii. they will not improve GP recruitment and may make it worse, resulting in the remaining partners having an increasing management responsibility as services transfer to PCNs
   iv. diverting precious GP time away from clinical services to PCN meetings
   v. enforcement of extended hours, thereby spreading clinical resources more thinly, regardless of lack of evidence that this will improve health outcomes or patient satisfaction.

19f DERBYSHIRE: That conference:
   i. asserts that the process of introducing and developing PCNs in England has been ill-thought through and poorly supported
   ii. has no confidence that PCNs across the country will be effective conduits for care from April 2020.

If part (v) of motion 19 is carried, then the following statement will be voted on by the representatives using a 1-6 button vote. This is to guide the GPC England executive team’s future strategy. No requests to speak for or against this statement will be considered by the Chair.

1. I am completely happy with the development of PCNs as a means to sustain general practice.
2. I am happy with the development of PCNs but would also like other ways of sustaining general practice to be explored.
3. I am content with the development of PCNs but feel that other options should also be actively pursued to sustain general practice.
4. I am not happy with PCNs but feel too much work has been committed to these to change the direction of travel.
5. I am not happy with PCNs and would like to see a pause in developments in order to evaluate their efficacy in sustaining general practice.
6. I would like to see PCNs completely disbanded and a new GP contract negotiated for 2020/21 as a matter of priority.
**CLINICAL GUIDELINES**  15.30

* 21 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference believes that the proliferation of clinical guidelines is having a negative impact on the ability of GPs to deliver patient care and that:
  i. they should be recognised as guidelines not mandatory protocols or minimal standards of practice
  ii. GPs performance shouldn’t be judged against them
  iii. the BMA should have a role in accrediting guidelines for use in general practice
  iv. there needs to be careful consideration about the practicality and workload implication of clinical guidelines produced relating to clinical care in general practice before they are accredited
  v. NICE needs to recognise the difference between what can reasonably be expected to be delivered in primary care compared to secondary care.
(Supported by DORSET)

21a AVON: That conference deplores the expanding medicalisation of life, and urges caution on the part of NHS England, NICE and PHE in determining guidelines that will increase the size of the ‘haystack’ and consequently make it harder to identify the people who most need care and are likely to benefit from preventative treatment.

21b KENT: That conference demands any clinical pathways, protocols or service changes which have an impact on general practice are agreed by GPC England or LMCs before implementation.

**NHS ENGLAND PERFORMER INVESTIGATIONS**  15.40

* 22 DERBYSHIRE: That conference, noting the possibility of a career ending and/or bankruptcy generating outcome for a general medical practitioner who is the subject of an adverse PLDP meeting outcome, insists that at every PLDP meeting in England:
  i. the discipline-specific practitioner should be drawn from LMC nominees trained for such work
  ii. that an LMC nominee presence in some capacity must be mandatory and not discretionary.

**GPs WITH REGISTRATION CONDITIONS**  15.50

* 23 WALTHAM FOREST: That conference is appalled that there are no national schemes supporting GPs who have either NHSE or GMC conditions to help them find appropriate placements in order to support them to return to the work and:
  i. requires each area team to report on the number of GPs within their area who have conditions on registration
  ii. requires each area team to report on the number of GPs with their area who have conditions on registration but are being supported in a placement
  iii. demands a review of the Induction and Refresher scheme criteria to enable doctors with conditions to apply and be accepted onto this scheme.

23a LINCOLNSHIRE: That conference recognises the dire shortage of GPs across England and welcomes all attempts to increase GP numbers, and thus is disappointed that GPs who have not worked for some time due to GMC or performers list restrictions are unable to benefit from the support and training available to other doctors through the Induction and Refresher Scheme and calls upon HEE to reverse this position immediately.
**CCG SPENDING 16.00**

| 24 | NORTH STAFFORDSHIRE: That conference asks the GPC England to negotiate a standard framework which allows practices and LMCs to easily check that funding is being made available to practices as promised and as NHS England intended. |
| 24a | NORTHAMPTONSHIRE: That conference insists that primary care funding has a populated template stating all funding which is open and transparent, so that CCGs cannot manipulate funding streams to benefit their own organisations. |

**PRIMARY/SECONDARY CARE INTERFACE 16.10**

| 25 | AGENDA COMMITTEE TO BE PROPOSED BY NORTH YORKSHIRE: That conference is deeply concerned at the flagrant continued contravention of the standard hospital contract and asks GPC England to develop proposals to counter this including: |
| 25a | NORTH YORKSHIRE: That conference believes current contract arrangements have failed general practice, the standard secondary care contract to prevent transfer of work to primary care is ignored by both secondary care and CCGs, conference demands GPC negotiate with NHS England: |
| 25b | HULL AND EAST YORKSHIRE: That conference recognises the failure of secondary care providers to adhere to the NHS England Standard Hospital contract guidance 2017-2019 and calls on GPC to demand its full enforcement by NHS England as a red line in this year’s contract negotiations. |
| 25c | GLOUCESTERSHIRE: That conference is deeply concerned at the flagrant continued contravention of areas of the standard hospital contract and ask GPC England to develop proposals to counter this including financial penalties. |
| 25d | LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that NHS hospital trusts should be held to the terms of the standard contract and penalised by the commissioners if they fail to meet their obligations within the contract. It can seem that hospitals are considered too big to be allowed to fail, this can lead to contractual obligations not being met without apparent consequence, with the subsequent costs being passed onto general practice. This may include what appear to be relatively small matters such as provision of appropriate sickness certification, or appropriate medication on discharge; These commonly are expected to be resolved by general practice, which places additional burdens on GP services. |
| 25e | NOTTINGHAMSHIRE: That conference welcomes the change to the standard NHS hospital contract not only enabling but obliging trusts to refer onwards, to supply Med 3 certificates and other such sensible options. We do, however, deplore the constant lack of contract enforcement by CCGs who leave general practice under pressure to do extra work for the patients. To this end, conference asks that GPC England presses for penalties for repetitive breaches of the contract and funding extracted be used to mitigate the impact of the extra work put upon practices. |
KENT: That conference demands that all inappropriate transfers of work to primary care are:

i. associated with adequate item of service fees

ii. subject to financial penalty when national contracts are breached.

SOMERSET: That conference believes that, as all human beings 'require improvement', CQC inspectors should therefore be required to wear a Hi-Visibility jacket at work at all times emblazoned with the legend: ‘How’s my inspecting?’, together with a prominently displayed Freephone number to facilitate feedback.
Conference of England LMC Representatives

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

A and AR Motions

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

STANDING ORDERS

A 27 AGENDA COMMITTEE: That conference agrees to amend standing order 3.5 to read: those regionally elected representatives of the GP trainees committee who were elected from regions in England, together with its chair.

A 28 AGENDA COMMITTEE: That conference agrees to amend standing order 3.6 to read: those elected members of the sessional GPs committee of the GPC who were elected from regions in England.

A 29 AGENDA COMMITTEE: That conference agrees to amend standing order 64.2 to read: Nominations must be submitted on the prescribed form before 12 noon on the day of the conference. Nominees may provide on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

WORKFORCE

A 30 NORFOLK AND WAVENEY: That conference believes there is little confidence in the measures being taken by the government to attract GPs into partnership as the profession faces an ongoing crisis of workload escalating on the shoulders of a dwindling number of partners.

A 31 SURREY: That conference:
  i. reaffirms its support for the GP Partnership model of delivery of primary medical services
  ii. urges that any acceptable outcome of the current GP Partnership Review includes a direct financial uplift in GMS global sum and/or PMS global sum equivalent.

A 32 DEVON: That conference calls for NHS England to consider the reintroduction of ‘golden hello’ payments for general practitioners who take up a long-term partnership or salaried role in areas where recruitment has been deemed to be challenging.

A 33 LEEDS: That conference, whilst noting the workforce expansion planned as part of the primary care network DES, believes that there remains an urgent need to increase the number of GPs.

A 34 GREENWICH: That conference calls upon government to support the longer-term sustainability of the partnership model in general practice.
A 35 KINGSTON AND RICHMOND: That conference believes comprehensive NHS occupational health services should be available to all staff working in GP practices.

AR 36 CAMBRIDGESHIRE: That conference demands that NHS England is forcibly reminded of their self-commissioned Partnership Review, which concluded that ‘doing nothing cannot be an option’, and calls on GPC England to insist that NHS England & Improvement:

i. commit to enacting the recommendations of the Partnership Review in full, to protect and strengthen the partnership model and independent contractor status of GPs

ii. prove by their actions that the Review was a serious attempt to protect and strengthen the partnership model and independent contractor status of GPs, and was not an elaborate and expensive smokescreen

iii. reiterate the primary functions of PCNs from the outset, i.e. to stabilise general practice, and to encourage the investment into primary care to facilitate the long-term plan.

AR 37 NORFOLK AND WAVENEY: That conference whilst acknowledging the review recommendations of the GP Partnership Review, notes the continued reduction in GP partner numbers and calls upon GPC England to negotiate further practical measures and implement the existing recommendations within the partnership review to prevent the extinction of the ‘GP partners’.

AR 38 GLOUCESTERSHIRE: That conference is appalled that the number of partners has fallen by 5.3% in the year despite the partnership review and insists that NHS England take urgent action to improve the working life of partners.

WORKLOAD

A 39 LINCOLNSHIRE: That conference calls for NHSE to agree a maximum workload that a GP can be expected to safely carry out in a working day.

A 40 LIVERPOOL: That conference believes that Her Majesty’s Government must alter its advice to patients with pre-existing medical conditions intending to travel to Europe to speak to their GP for advice before travelling to Europe, in the event of a no-deal Brexit. Advice on travelling is outwith the NHS contract and expertise of practitioners and this recommendation is ill-thought out and factually incorrect. Patients should take out travel insurance and disclose pre-existing conditions.

A 41 DEVON: That conference calls on NHS England to intervene to make sure that due consideration is given to the local general practice provision before any new housing development aimed at the frail elderly is given planning approval.

AR 42 DEVON: That conference with respect to Prescription Medication Administration Record forms (PMARs), demands that:

i. GPs are not obliged to complete these forms for a third-party provider

ii. the responsibility for completion lies with the employer of the health care professional administering the medication

iii. any arrangement in place should not involve transcription of medication by hand.
AR 43 CROYDON: That conference:
   i. believes GP workload is unsustainable
   ii. demands a cap on the number of patient consultations that can be undertaken by each GP per working day
   iii. that commissioners are responsible for providing NHS services to patients requiring same day care once the cap is reached.

AR 44 WEST SUSSEX: That conference:
   i. notes the increased workload required of GP practices following identified NHS IT failures
   ii. demands that this workload must be appropriately recompensed by NHS England
   iii. demands that future NHS IT contracts should include a penalty clause securing funding for such future workload, if required.

PREMISES

A 45 LEEDS: That conference condemns the Department of Health and Social Care and NHS Property Services for their failure to resolve the longstanding dispute relating to GP premises and calls for fully funded fair rental arrangements.

A 46 NORFOLK AND WAVENEY: That conference believes that the primary care premises estate is inadequate and needs immediate updating and placed on equal footing with other providers in bids for general practice to provide the service that patients, doctors and the government expect.

A 47 NORTH YORKSHIRE: That conference believes that our national negotiators should be demanding investment into primary care estates to ensure that every area has premises suitable to allow the delivery of 21st century primary care services, PCN/at scale services and integration with community health and social care.

A 48 AVON: That conference is concerned to hear reports that CCGs are seeking to ‘quality assure’ and monitor building compliance in private GP owned premises and urges GPC England to resist additional bureaucracy with vigor.

A 49 NORTHUMBERLAND: The delay in revision of the Premises Cost Directions and lack of connection to primary care direction and strategy is significantly impeding the development of individual practices and PCNs. Conference demands that this situation is resolved urgently.

A 50 NORTHAMPTONSHIRE: That conference demands that funding be made available for premises development that will allow proper facilities for patient care and population increases, not be dependent upon integrated care strategic aims, and will allow the partnership model to continue with GP premises ownership where this is the partnership preference.

PRACTICE BASED CONTRACTS

A 51 HERTFORDSHIRE: That conference calls for GPs to be paid for undertaking any ad hoc home visits for patients registered under out of area arrangements if the local CCG has not commissioned a home visiting service for their area.
A 52 DEVON: That conference demands that the arrangements for home visits for out of area registered patients are reviewed such that:
   i. all such patients have a defined provider of home visits
   ii. that the arrangements meet the same standards as a fully registered patient
   iii. all such patients and the registering practice are informed as to those arrangements.

A 53 WORCESTERSHIRE: That conference calls on GPC England to formally assess and publish common commissioning gaps for local enhanced services and challenges them to demand appropriate funding for these nationally.

A 54 NORTHAMPTONSHIRE: That conference negotiates a radical uplift to all DESs to properly cover the real costs of sessional GPs, nurses and staff wages which is currently not offset against GMS uplifts against inflation.

A 55 CLEVELAND: That conference is concerned about the increased responsibility for GP access returning to practices via PCNs and reiterates that responsibility for the provision of out of hours GP service should never again become mandatory as part of the GMS contract.

A 56 BRADFORD AND AIREDALE: That conference believes that as digital remote consulting is rolled out to all practices the major reason for allowing out of area registrations has been removed and calls on GPC England to negotiate the removal of this scheme from the contract.

A 57 LAMBETH: That conference demands that the out of areas regulations are abolished.

A 58 LIVERPOOL: That conference believes that GPC England must actively campaign for a change in CCG procurement rules to enable CCGs to offer a GMS contract when either a practice vacancy arises or an APMS contract comes to the end of its term.

A 59 ROCHDALE AND BURY: This conference seeks access to flu vaccination under a DES for front line GP staff in line with front line health and social care staff.

A 60 CLEVELAND: That conference insists that in future, appropriate inflationary uplifts to core GMS funding can be accessed without practices having to agree to any additional work.

FINANCE

A 61 LEEDS: That conference notes the priority the Prime Minister placed on improving access to general practice services but believes that in order to achieve this he must ensure recurrent investment for:
   i. an increased number of GPs
   ii. an increased number of practice nurses
   iii. improved and new practice premises
   iv. improved IT and associated infrastructure.

A 62 DORSET: That conference is appalled at the ongoing gender pay gap for GPs as demonstrated in the recent NHS Digital publication of GP Earnings and Estimates and calls for urgent investigation into the causes and solutions. (Supported by SESSIONAL GPs COMMITTEE).
A 63 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes that
the number of requests has increased for reports by and on behalf of the
Department of Work and Pensions, especially by the Health Assessment
Advisory Service, and requires the GPC England to negotiate a significant
above inflation increase for that proportion of the global sum.

PCSE

A 64 TOWER HAMLETS: That conference notes that time after time Capita
demonstrate that they are not fit to provide services to the NHS and:

i. refuses to take on any more un-resourced work caused by
Capita's failures

ii. instructs GPC England to inform government and NHS England that GP
practices do not have the capacity to clear up after Capita's failures and in
future will not do so

iii. calls for Capita's contract to be immediately terminated and all of their
functions brought back 'in house'.

A 65 WAKEFIELD: That conference condemns the recurrent mismanagement by
PCSE and if they cannot be made fit for purpose, they should be replaced.

A 66 CLEVELAND: That conference is utterly fed up with the expectation that
practices will fix multiple and recurrent PCSE errors and condemns NHS
England for its failure to manage this.

A 67 KENT: That conference demands removal of all NHS contracts from Capita.

A 68 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference
demands that Capita are stripped of their provider contract to the NHS as
soon as is practicable.

AR 69 DORSET: That conference:

i. instructs GPC England to work with NHS England to find a suitable
replacement for Capita

ii. demands that Capita are stripped of their provider contract to the NHS as
soon as is practicable.

INFORMATION MANAGEMENT AND TECHNOLOGY

A 70 OXFORDSHIRE: That conference welcomes the funding negotiated into the
GMS contract in 2019 to support practices in the cost of SAR applications but
notes with concern the increasing workload these requests represent and
calls on GPC England to negotiate further increased funding for this work
going forward.

A 71 GLOUCESTERSHIRE: That conference demands that there is government
recognition of the unique challenges in general practice to fulfil increased
demand for unfunded data release, engendered by GDPR regulation and
balances this with additional reimbursement.

A 72 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference
agrees that the current IT infrastructure is:

i. not fit for optimal patient care

ii. a source of significant stress to GPs

iii. at times so poor as to be a danger to patient care

iv. in urgent need of rapid and major investment before any further
paperless projects are rolled out.
LAMBETH: That conference notes that for day to day effective working practices require suitable telephony infrastructure as part of the IT infrastructure and calls upon NHS England to:

i. invest and fund telephony infrastructure for primary care that will support the development of digital services
ii. provide VOIP telephony to PCNs and all practices.

LAMBETH: That conference demands that in order for primary care to continue to develop and deliver services that patients require, considerable investment in IT infrastructure be provided.

CLEVELAND: That conference mandates that no digital development are included in negotiated GMS contract, changes until the NHS provided IT can keep pace with the changes already negotiated, and not implemented.

GATESHEAD AND SOUTH TYNESIDE: That conference:

i. notes the recent changes in the guidance for firearms safety checks which have clarified where responsibility lies, but is still concerned about the safety of patients holding firearms licences if they experience deteriorating mental health
ii. calls on NHS Digital to ensure that clinical systems check for entries relating to holding of a firearms licence when codes are added relating to mental health and display a warning similar to a drug interaction alert, so that GPs are made aware of this potential risk.

NORFOLK AND WAVENEY: That conference asks GPC England to ensure the proposed new payment system must be extensively road-tested within general practice to ensure it is fit for purpose, prior to the decommissioning of Exeter.

HULL AND EAST YORKSHIRE: That conference demands that NHS England stipulate digital and remote providers of access to primary care appointments must undertake the same due diligence as GP practices in:

i. addressing inappropriate demands
ii. patient education at the first point of contact
iii. undertaking care navigation in line with local arrangements.

(Supported by NORTH AND NORTH EAST LINCOLNSHIRE)

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands that the GPC England reviews and renegotiates NHS regulations to ensure that online GP services providers provide the same level of care as traditional general practice in terms of chronic disease management, home visiting, and care to the vulnerable and elderly.

WORCESTERSHIRE: That conference rejects the move to use private online providers in preference to enabling GP practices to provide their own IT solutions to patients locally and demands that support and resource is channeled in to practices and PCNs for this purpose.
REGULATION

A 81 MID MERSEY: That conference following the vote of the conference of England LMCs in 2018 directing GPC to work to ensure that there is effective independent oversight and review of NHS England performance procedures, conference asks the Chair of GPC England to update conference on any progress to date and the actions planned to implement this decision.

AR 82 MID MERSEY: That conference believes that, as assessment of practices by the CQC relies uniquely on the personal opinion of individual inspectors, the GPC England must work to ensure that the CQC assesses all practices to known standards that are consistent and reproducible from one visit to another.

PENSIONS

A 83 LEEDS: That conference believes pension issues are having a major impact on GP retention and demands an end to:
   i. annual allowance
   ii. annual allowance tapering
   iii. annualisation
   iv. life time allowance.

A 84 LAMBETH: That conference deplores the failure of NHS England to find a workable solution to the NHS pension crisis and:
   i. believes that this is having an impact on waiting lists, patient care and outcomes
   ii. calls upon NHS England to find an immediate solution whereby senior GP partners do not feel the necessity to retire early or reduce their hours of work to avoid punitive tax charges.

A 85 NORTH STAFFORDSHIRE: That conference demands that the Treasury change the annual allowance and lifetime allowance thresholds to remove the income cliffs that are causing GPs to either decrease their work commitments or to prematurely retire.

A 86 WORCESTERSHIRE: That conference rejects the annualisation process used in the NHS pension scheme and asks GPC England to robustly challenge this as it threatens to reduce the GP workforce further.

CLINICAL

A 87 SURREY: That conference believes all Public Health England initiatives should be 'sense-checked' before release by the GPC England.

A 88 DEVON: That conference agrees that a change in policy to allow fit notes to be signed by competent clinicians as well as GPs would help reduce GP workload and we urge GPC England to petition for such a policy change.

A 89 MID MERSEY: That conference asks GPC England to take steps to ensure that advanced nurse practitioners working in general practice can, when appropriate, issue medical certificates (Med3s) for patients.
A 90 CORNWALL AND ISLES OF SCILLY: That conference believes that post mortem reports provide an invaluable source of formative feedback for GPs after the final years of their patient’s lives. We would ask the GPC England to petition the Chief Coroner to advise his regional coroners to release these reports to the deceased’s registered GP as a routine part of any inquest.

A 91 WORCESTERSHIRE: That conference believes that a change in the regulations should be made to allow dispensing doctors to provide electronic repeat dispensing to their dispensing patients.

A 92 CITY AND HACKNEY: That conference demands that gender identity clinics are properly funded to provide medication and monitoring to patients as the care of these patients falls outside the expertise of most general practitioners even in situations where shared care guidance exists.

AR 93 OXFORDSHIRE: That conference believes there is a lack of clarity on the requirements, responsibilities and liabilities on practices with regard to the Falsified Medicines Directive, is concerned by the potential impact on practice workload and mandates GPC England to:

i. ensure that any consequent increase in workload is financially remunerated
ii. ensure that the cost of equipment and software necessary to comply with the FMD are not borne by practices
iii. issue further clarifying guidance to practices to make them aware of their rights and obligations.

AR 94 NORTH ESSEX: That conference deplores the lack of properly commissioned specialist care for patients with gender dysphoria and advises all GPs to limit care provided under GMS to this vulnerable patient group to that which is within their clinical competence.

AR 95 HERTFORDSHIRE: The cuts to public health funded sexual and reproductive healthcare, with subsequent closure of many clinics across the country, is a violation of women’s rights to good sexual health and access to full contraceptive choices. Conference asks GPC England to:

i. urgently work with NHSE and public health to reverse this retrograde step in healthcare provision in England
ii. increase funding in primary care for the cost effective provision of LARCs
iii. lobby the government, making it aware that a healthier nation requires adequate provision of sexual and reproductive healthcare.

ICS/WORKING AT SCALE

A 96 CLEVELAND: That conference mandates that LMCs, not PCN based structures, are the representatives of general practice at a locality level.

AR 97 LIVERPOOL: That conference believes that GPs must be fully informed of developments within their STP with regards to creation of Integrated Care Systems and requests that GPC provides clear guidance on how to protect GMS practices from pressures placed upon practices and PCNs by Provider Alliances and emerging Integrated Care partnerships.

PRIMARY/SECONDARY CARE INTERFACE

A 98 WALTHAM FOREST: That conference requires a stop to the practice of hospitals giving patients paper requests for non-urgent prescriptions and either issues a prescription or communicates the request in a clinic letter.
A 99 KENT: That conference demands that the NHS Standard contract is amended to prevent one clinician ordering investigations in the name of another.

A 100 GLOUCESTERSHIRE: That conference insists that electronic prescribing to community pharmacies be developed and rolled out to hospital services as a matter of urgency and asks GPC England to strongly encourage this to take place.

A 101 GLOUCESTERSHIRE: That conference is concerned about the absence of a commissioned service for red drugs and insist that:
  i. blood results currently poorly accessible by hospital trusts other than the lab where testing has occurred be resolved to ensure better patient care and avoid needless blood tests
  ii. that clear funded mechanisms be established for the monitoring of them
  iii. that safe transfer of care from distant hospitals to local ones be properly established including the prescribing of red drugs.

A 102 DEVON: That conference asks the GPC England to seek clarification over the recording of a patient’s individual decision regarding advance directives and work to ensure that the onus for this transfer of information is shared by both primary and secondary care.

A 103 WORCESTERSHIRE: That conference is deeply concerned by the expectation on GPs to take on work beyond their level of competence from secondary care and:
  i. insists that formal consent is given in the form of shared care agreements for GPs choosing to take on additional work
  ii. calls on GPC England to ensure that funding for the transfer of work moves from secondary care to primary care
  iii. insists that GPs have access to specialist support and training when taking on specialist work.

A 104 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands that GPC England reviews and renegotiates NHS policy to ensure that only resourced and appropriate work is passed onto primary care by secondary care.

AR 105 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference recognises unfunded, unsafe left shift of work into primary care with poor communication putting the patient and GP colleagues at serious risk. The conference calls on the GPC England to:
  i. nationally agreed guidance/process on transfer of care
  ii. nationally agreed funding to support this additional work.

AR 106 NOTTINGHAMSHIRE: That conference deplores the winter planning which is heavily focused on secondary care with primary care attracting no extra resources and calls upon GPC England to:
  i. ensure adequate assessment of the winter pressures felt across general practice and not just in hospitals
  ii. stop hospitals from sending OPEL warnings to general practice and demand that system-wide warnings go out to the public instead
  iii. insist that all local A and E boards have GP provider representation to discuss alleviating winter pressures, not just in secondary care but also in primary care and ensure that there is adequate funding allocated to primary care for the same.
INDEMNITY

A 107 SESSIONAL GPs COMMITTEE: That conference demands that the Clinical
Negligence Scheme for general practice is extended to include all sessional
GPs providing NHS GP services in prisons and other secure environments,
regardless of their employing or contracting provider.

NHS ENGLAND PERFORMER INVESTIGATIONS

A 108 KENT: That conference demands that the NHS England performance review
processes are:

i. subject to national standardisation
ii. independently reviewed
iii. subject to a clear and fair appeals process
iv. based on a ‘beyond reasonable doubt’ level of proof.
Conference of England LMC Representatives

Agenda: Part II
(Motions relevant to UK LMC Conference)
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(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 24 February 2020.

EDUCATION AND TRAINING

109 NORFOLK AND WAVENEY: That conference asks GPC England to negotiate sufficient resources to undertake the increasing burden of ‘mandatory’ training. These training requirements need to be:
   i. evidence-based
   ii. proportionate
   iii. locally relevant
   iv. IT-based
   v. agreed through proper process.

110 WORCESTERSHIRE: That conference is appalled at the changes to mandatory safeguarding training requirements for GPs as detailed in the intercollegiate guidance and requests that GPC England address and reject the extension of hours required for compliance as being excessive and unnecessary.

111 DEVON: That conference whilst recognising safeguarding training is important asks the GPC England to recognise that the guidelines for hours of training expected are:
   i. burdensome and excessive
   ii. should not be mandated
   iii. recognised as an area for discussion at annual appraisal but not allotted annual targets.

112 BEXLEY: That conference calls for concerns over the prevent counter-terrorism strategy in the NHS be urgently addressed in Lord Carlile’s independent review, taking account of the following:
   i. the challenges facing healthcare professionals in identifying the early signs and risk factors that can lead to an individual being drawn into radicalisation
   ii. the role of multi-agency working and appropriate sharing of information in such safeguarding cases
   iii. the risk that care for more vulnerable patients can be compromised by implementing a strategy to counter radicalisation that GPs do not have the appropriate oversight, input and control over; and
   iv. the need for current safeguarding guidelines to adequately support GPs and other healthcare professions in undertaking this work.

113 LINCOLNSHIRE: That conference agrees with the policy of ‘no new work without new funding’ and thus asks the Education, Workforce, and Training policy group to work with Health Education England to increase funding for GP trainers who are being asked to perform ever increasing amounts of administrative work in this vital role.
114 NORFOLK AND WAVENEY: That conference believes that general practice should be at the heart of undergraduate training and asks GPC England to negotiate:
   i. all practices should be supported to train both undergraduates and postgraduates students with appropriate funding and infrastructure to accommodate this
   ii. support following training to retain the GPs in the area.

115 DORSET: That conference believes that all GPs should have access to a mentor on, at least, an annual basis.

116 COUNTY DURHAM AND DARLINGTON: That conference calls upon the RCGP and the GMC to scrap the existing format of the MRCGP and replace it with a more responsive format that encourages GP recruitment and relies more on workplace-based assessments.

WORKFORCE

117 KENT: That conference demands that all allied health professionals working in primary care must be subject to role specific appraisal and national regulation by an appropriate body.

118 SANDWELL: That conference requires the GPC England to make a report on their decision in May 2016 that GPFV and ‘urgent prescription’ would address concerns raised in the Special LMC Conference in January 2016. That report must include what measures have been implemented and the effect those measures have had on partner retention and workforce development.

119 SESSIONAL GPs COMMITTEE: This conference believes that salaried GP should be paid for all the hours they work for their practice.

120 NORFOLK AND WAVENEY: That conference believes recruitment in general practice to still be in crisis. Although not a solution, but merely an attempt to highlight both the extent of vacancies and the exploitative cost of advertising to its own members, this conference would urge the BMJ to allow all practices with vacancies to advertise for free in a one off special ‘recruitment crisis’ edition of BMJ careers whilst at the same time highlighting new and exciting career prospects in general practice.

121 COUNTY DURHAM AND DARLINGTON: That conference supports promoting NHS workers’ health, akin to the Veteran’s Health Covenant. The NHS needs to have a healthy workforce to deliver healthcare to the nation, and that all NHS workers (cleaners, doctors, nurses, managers etc) should have priority access to NHS services.

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

123 KENSINGTON, CHELSEA AND WESTMINSTER: That conference deplores the use of the term 'working at the top of their licence' when referring to GPs in NHS England documents and believes that the country would not be in the current mess if politicians were 'working at the top of their licence'.

124 DEVON: That conference recognises that the work involved for GPs completing Department of Work and Pensions forms is of little value and suggests the system could be made more efficient if replaced by an electronic or telephone inquiry with specific questions for specific patients if required.

FINANCE

125 HULL AND EAST YORKSHIRE: That conference is appalled by the ongoing willingness of the government and NHS England to repeatedly fund shortfalls in secondary care budgets, while refusing to extend the same support to primary care.

126 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference believes GPs should be paid equally for equal work done regardless of gender and:
   i. is appalled at reports of the findings from the Gender Pay Gap Review of a 33% GPG in general practice
   ii. demands measures are put in place to address the causes of the GPG such as making childcare tax deductible
   iii. demands that the GPG is not extended into retirement, by stopping current pension rules which may disproportionately negatively affect women such as the annualisation of pensions of locum GPs.

GPC ENGLAND/CONFERENCE OF ENGLAND LMCs/LMCs IN GENERAL

127 NORTH YORKSHIRE: That conference believes that GPC England must realise the significant wellbeing crisis within general practice and conference demands GPC England create a policy lead for wellbeing whom is mandated to promote GP wellbeing, stave off burnout and mental ill health in a pre-emptive framework.

128 CITY AND HACKNEY: That conference recognises the role we all have to play in the sustainability of the planet and requires:
   i. LMC conferences to be a single use plastic free conferences
   ii. supports LMCs in removing single use plastics from the workplace
   iii. BMA conferencing to insist that catering companies do not use single use plastics for any LMC or GPC England event.

129 CAMBRIDGESHIRE: That conference deplores, that at a time of continuing unsustainable workload in England general practice, the disbanding of the GPC England workload management policy group and calls for its immediate reintroduction.
130 CAMBRIDGESHIRE: That conference applauds, and recognises the importance of the GPDF commitment to be more transparent, accountable and representative of the profession, and calls for the England LMCs to:
   i. actively encourage nominees from our diverse and mixed profession to stand for election to the GPDF board when positions arise
   ii. provide a steer to GPDF in pressing for greater transparency regarding reimbursement and remuneration of GPDF board members
   iii. remind GPDF of the Task Group recommendations from 2016 to be enacted in full.

131 DEVON: That conference believes that climate change is hazardous and has the potential to obliterate any achievements made by the NHS to improve the health of our society and asks the GPC England to proactively help and support practices with projects that are recognised as countering these dangers.

132 BRADFORD AND AIREDALE: That conference recognises the irrefutable evidence of the climate crisis and in light of the BMA’s recent declaration of a climate emergency and a proposed target of carbon neutrality in our sector by 2030, calls for the government to fund GP practices to work towards reducing carbon emissions.

133 MANCHESTER: That conference agrees a working group should be established to:
   i. investigate whether GPDF Ltd is delivering value for money to LMCs and GPs
   ii. provide a report to an extraordinary general meeting to be held during the UK Conference of LMCs in 2021.

134 MANCHESTER: That conference is extremely concerned that NHS general practice is suffering an unmanageable surge in demand and instructs GPDF Ltd to initiate a deep and sustained defence of general practice in the form of a public education campaign.

135 NORTHUMBERLAND: The current role of the GPDF in relation to the BMA is unclear, and confusing to the primary care community. Conference demands that:
   i. there is a full explanation and clarification of organisational roles
   ii. the added value of the GPDF is transparent
   iii. that a justification is provided for the additional cost pressure on practices of the voluntary levy which equates to a ‘tax on partners’.

136 ROCHDALE AND BURY: This conference seeks more openness and transparency on how GPDF awards board and staff salaries.

137 BUCKINGHAMSHIRE: That conference calls on GPC England to proactively and urgently work to strengthen ties with other European equivalent organisations ahead of a possible hard Brexit in order to demonstrate our wish to maintain and enhance relations with our European neighbours in spite of the isolationist agenda of the current government.

138 MID MERSEY: That conference believes that the role of LMCs and the GPC England is to represent general practices and general practice rather than to narrowly represent GPs, and considers that non-medical clinicians, practice nurses and practice managers are core members of general practice teams who should be represented on LMCs and the GPC England.
INFORMATION MANAGEMENT AND TECHNOLOGY

139 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is appalled at the ever-increasing workload created by Subject Access Requests which diverts staff time and NHS resources away from patient care and demands that the GPC England:
   i. campaigns for a change in legislation to reflect the specific criteria included in recital 63 of the General Data Protection Regulations, that access under a SAR is only ‘in order to be aware of, and verify, the lawfulness of the processing’
   ii. publishes the proposed Code of Conduct without further delay and by February 2020 at the latest
   iii. supports a test case to prove the concept that providing a copy of the record directly to a patient as data subject fulfils all GDPR and DPA 2018 requirements.

140 DEVON: That conference ensures that patients who are unable to interact with the NHS via digital media, due to access or IT literacy difficulties, are considered and provided with alternatives routes of access.

141 DEVON: That conference asks the GPC England to ensure that introduction of any IT infrastructure into general practice takes into account the IT illiterate.

142 NORFOLK AND WAVENEY: The Department of Work and Pensions sends paper forms to practices, such as ESA 113, and requires these to be completed with a signature and practice stamp. This paper-based system is inefficient for practices and is not consistent with the digital agenda promoted by DHSC. Conference requests GPC England to negotiate with DWP and NHSE to develop secure digital means for practices to complete and send these forms.

REGULATION

143 KENT: That conference, in relation to GMC investigations, condemns:
   i. the use of covert recordings of doctor-patient consultations
   ii. the balance of probability standard in determining fault.

144 HERTFORDSHIRE: That conference believes that GPs, their staff and all NHS workers should not, unwittingly, be put at risk by known violent and sexual offenders and calls on GMC England and the BMA to work together with the Multi-Agency Public Protection Arrangements (MAPPA) bodies to:
   i. agree policies for ensuring GPs are informed of the higher risk people on the registers
   ii. advise on appropriate ways to flag medical records accordingly
   iii. guide staff, to minimise any risks to themselves and other patients, about the most appropriate ways to consult these people, whilst ensuring they receive appropriate treatment when necessary.

145 NOTTINGHAMSHIRE: That conference believes the GMC suffers from a top-down institutional lack of insight and demands that the GPC England works to ensure that:
   i. the GMC is reorganised with independent senior medical leaders overseeing its reorganisation
   ii. the GMC becomes simply a licensing body and all disciplinary matters become the remit of the MPTS
   iii. a final decision made by the MPTS is just that and cannot be appealed by the GMC
   iv. the GMC will be directly funded from taxation with no loss of income to any doctor.
146   MID MERSEY: That conference notes that Google offers a review facility allowing the public to provide star ratings and written reviews of GP practices, recognises that some reviews may be mistaken, malicious, vindictive, libelous and/or slanderous, and calls on GPC England to ensure that Google provides GP services with an accelerated right of appeal and appropriate redress for comments that are harmful and inappropriate.

PENSIONS

147   LIVERPOOL: That conference welcomes the change in the potential options for pension flexibilities, however insists that the balance of any employers’ pension contribution that is not paid to the pensions agency, is paid instead to the GP or employee on the grounds that the employers pension contribution, which is included in the global sum, is actually deferred income.

148   WAKEFIELD: That conference requires GPC England to negotiate pension changes so that GPs who opt out of the NHS scheme because of punitive taxes should still retain rights to death in service benefit and ill health retirement.

CLINICAL

149   NOTTINGHAMSHIRE: That conference deplores the provision of Mental Health services to citizens of the UK and calls upon the GPC England to negotiate:
   i.  an end to out of area in-patient care unless absolutely necessary for clinical reasons
   ii. the provision of MH practitioners within GP
   iii. improved access to CMHT teams
   iv. improved MH crisis services
   v.  a real increase in investment in MH services which is protected from CCG interference.

150   HULL AND EAST YORKSHIRE: That conference is concerned by the rise in pharmacy based health screening programmes, and demands that such programmes should:
   i.  be evidence based from high quality studies published in peer-reviewed medical journals
   ii. not screen for diseases unless an approved programme from the UK national screening committee is in place
   iii. be mandated to undertake impact assessments on the local primary care system prior to launch
   iv. have fully funded and locally agreed management pathways for patients requiring GP follow up
   v. not direct existing funding streams away from general practice in order to operate.

151   WEST PENNINE: That conference is mindful of the increase in allergic reactions and in deaths resulting from these and asks the GPC England to encourage the provision of adrenaline pens in restaurants and food outlets.

152   MID MERSEY: That conference believes, given the risk and associated cost of losing vaccine stocks as a result of power cuts, this conference recommends that all GP practices are advised and supported to install uninterruptible power sources for vaccine storage.
Conference of England LMC Representatives

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

PRIMARY CARE NETWORKS (PCNs)

153 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference is concerned about the current rushed implementation of PCNs in England and request that GPC England ensure that:

i. sufficient time and resources are given to networks to develop and meet the existing requirements
ii. the legal/financial implications and requirements of any future changes are worked out nationally before implementation to avoid the expense for each individual network of having to seek independent professional advice
iii. the financial liability of employing increasing numbers of staff is addressed
iv. the reimbursement for employment of new staff include costs associated with supervision and training
v. the barrier of the limited reimbursement of 70% salary and on-costs causing reticence to appoint large numbers of new staff in PCNs is addressed
vi. sufficient funding is provided to PCNs to enable them to employ sufficient manager and business support to make meaningful and well implemented change.

EDUCATION AND TRAINING

154 EAST SUSSEX: That conference requests GPC England to negotiate a nationally agreed set of mandatory GP training requirements that will meet both:

i. CQC Inspection, and
ii. NHS appraisal requirements.

155 DERBYSHIRE: That conference:

i. rejects the increasing number of extra post/peri-CCT academic, certification and recertification demands being made of general practitioners in order to undertake routine general practice
ii. notes the promulgation of such extra certification requirements is frequently championed by special interest groups, which while ostensibly driving quality are actually cash generating empire building schemes for such organisations
iii. re-emphasizes previous policy that GP training for a CCT equips a general practitioner to clinically undertake that work which GPs traditionally undertake.

156 KENT: That conference demands that the profile of LMCs be raised by including knowledge of the work and functions of LMCs in the GP curriculum.

157 DORSET: That conference calls for all GPs to be offered fully-funded regular mentoring/coaching to improve resilience and retention. (Supported by SESSIONAL GP COMMITTEE).

158 MID MERSEY: That conference notes that significant event analyses (SEAs) in general practice have strayed from their original purpose of enabling ‘a supportive discussion to allow reflection and learning in a blame-free culture’, to one where SEAs are expected to be available to appraisers, CCGs, the CQC, NHS performance investigators and the GMC, and are also actively sought by outside agencies such as solicitors in medicolegal cases, and that – bearing in mind the recent case of Dr Bawa-Garba — conference must now advise GPs to exercise extreme caution in recording SEAs of any type.
NOTTINGHAMSHIRE: That conference, despite recognising that many GPs find appraisal a useful and cathartic annual 'debrief' with a supportive third party, believes the process is both too costly to the NHS and too onerous for GPs and thereby calls upon the GPC England to facilitate:

i. a change in the period of appraisal evidence submission and discussion thereof from yearly to two-yearly
ii. a shift in emphasis of the non-evidence submission appraisal meetings from information gathering to pastoral care and mentorship by the NHS England GP appraisers
iii. a change in the period of the revalidation cycle from five to six years
iv. consistency in the appraisal process among clinical specialties.

NORTHUMBERLAND: The training regime for GP registrars no longer prepares them for a role in primary care. Conference demands a joint review of the educational requirements for doctors entering general practices.

GP TRAINEES COMMITTEE: That conference recognises in full the contractually enforced supernumerary status of GP trainees. This defines GP trainees as additional to the workforce in supernumerary settings at all stages of training, including those near CCT, as it pertains to working hours, leave requests and supervision. We call upon GPC England to recognise that a GP trainee must never be ‘the only doctor in the building’.

GP TRAINEES COMMITTEE: That conference recognises the significant racial disparity in RCGP exam outcomes, and that remedial action for BME/IMG GP trainees will require proactive action. We call upon GPC England to recognise that simply resitting the exam again and again is not the solution. We call upon GPC England to consider institutional factors that may be contributing to the disparity.

WORKFORCE

KENT: That conference demands that in order to prevent system wide collapse the partnership model must be supported by:

i. designated funding for those taking the responsibility of partnership
ii. exploration of pathways to encourage sessional GPs to become partners.

SANDWELL: That conference requires the GPC England to make a report on their decision in May 2016 that GPFV and ‘urgent prescription’ would address concerns raised in the Special LMC Conference in January 2016. That report must include what measures have been implemented and the effect those measures have had on partner retention and workforce development.

NORTHUMBERLAND: Current GP culture is to present an image of extreme negativity which is counterproductive to recruitment, retention and morale of those in the profession. Conference requests that the GPC England commission a ‘positive thinking’ campaign to cheer us all up.

BEDFORDSHIRE: Although conference called in 2017 for a comprehensive funded occupational health service for all general practice staff, Schedule III Occupational Health Services in the NHS England National Primary Care Occupational Health Service specification, are defined as the duty of the employer rather than the NHS. Conference demands that GPC England negotiates a comprehensive funded occupational health service for all GP practice staff.

SESSIONAL GPs COMMITTEE: This conference believes that salaried GPs should be paid for all the hours they work for their practice.
SESSIONAL GPs COMMITTEE: That given the current decrease in numbers of GPs choosing to work in permanent roles, conference believes that GPC England should analyse and promote the benefits of offering truly flexible working options within practices in order to improve retention.

BROMLEY: That conference requests that recognition be given to the workforce challenges in employing sessional and salaried GPs and ensuring that these practitioners are sufficiently incentivised in terms of remuneration, terms and conditions and development opportunities.

DEVON: That conference is disappointed that the IGPR scheme has not been the success that was heralded and implores GPC England to negotiate with NHS England for a new, more attractive scheme.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference addresses the retention and recruitment crisis with a clear emphasis on retaining and recruiting our very own registrars by:

i. making general practice a sustainable environment with more adequate funding
ii. confronting and standing up against wild suggestions from politicians that merely wanted to use the NHS as a political football
iii. valuing the work and commitment of existing GPs and ease their bureaucracy.

NOTTINGHAMSHIRE: That conference believes that the active retention of GPs who may be approaching retirement is essential to maintain GP services whilst workforce is being reconfigured and calls for:

i. incentives to encourage GPs to maintain defer retirement
ii. incentives for practices to employ retired GPs
iii. active help for “the last man standing” to prevent practices having to close as the only avenue left to enable retirement.

WORCESTERSHIRE: That conference expresses concern at the lack of focus on mid-career GPs to stay in post as part of a recruitment and retention drive and believes that:

i. general practice as a career does not allow for a healthy work/life balance at the current time
ii. more focus should be placed on making core general practice a less pressured environment by blocking workload transfer from other organisations
iii. greater flexibility must be promoted within job plans to draw back some of the workforce to general practice.

WORKLOAD

CAMBRIDGESHIRE: That conference notes the alarming downward trend of practice inspections reflecting increasing pressure upon practices and calls upon GPC England to work with CQC in recommending the profession moves to a general baseline of 15 minute appointments in the interests of patient safety.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference supports the multi-disciplinary model of healthcare that we now work in, but if we are sharing our workload with healthcare professionals then the 10 minute consultation in which we are expected to cover all the complex health needs of a patient whilst a 15 minute slot for a UTI needs to be reconsidered.

GREENWICH: That conference calls upon government to meet the pressing need to provide longer consultation times with patients, as standard, to reflect the increasing complexity of primary care presentations.
177 NORTHAMPTONSHIRE: That conference insists that any GP with a list size over 2000 be allowed to informally close their list.

178 DERBYSHIRE: That conference rejects the increasing tendency of ambulance services:
   i. requests for immediate GP clinical input either by telephone or attendance to back up their crew’s decision not to transport a patient
   ii. expectations that a GP can remain with a patient for an indeterminate time pending ambulance arrival.

179 WIGAN: That conference call upon the GPC England and Department of Health to introduce safe working hours regulations for GP principals with enforcement. It is insane that the majority of GP principals are working 50 - 60 hours per week whilst being expected to provide safe and attentive care to their patients. Reliance upon contract changes and long-term workforce expansion plans are not enough to tackle the crisis.

180 DERBYSHIRE: That conference reminds ambulance trusts that:
   i. the limit of a GP’s obligation is to recognise the need for care in an emergency and to make appropriate arrangements for care
   ii. it is their responsibility to secure physician back up and advice for their crews - such work NOT being part of GMS/PMS and instructs GPC England to negotiate accordingly.

181 HEREFORDSHIRE: That conference agree due to increasing demand and inadequate resources:
   i. the vast majority of practices are struggling to meet the terms of their GMS contract
   ii. that our patients are finding it increasingly difficult to access GP services
   iii. that the time practice staff have with patients is often inadequate and at times potentially unsafe
   iv. that the pressures within the working environment are now such that many doctors, nurses and other practice staff are shortening their hours, leaving the NHS or retiring early.

182 AVON: That conference calls upon the GPC England to negotiate with NHSE to return the professional workload to a position which is manageable. More than one thousand senior partners have retired from general practice during the last twelve months and more are proposing to retire within the next five years thus exacerbating the staffing crisis within general practice which, coupled with the increasing workload, creates an unsustainable situation.

183 SUFFOLK: That conference instructs GPC England to explore and implement measures designed to reduce inappropriate use of primary care by third party care agencies (including nursing and residential homes). Such measures should include, but not be limited to, development of a metric relating to healthcare resource use and feedback from NHS providers to be published in CQC reports of relevant care organisations.

184 GREENWICH: That conference demands that NHS England publicly recognise the effects of the constant system changes in the NHS, and:
   i. the need for general practice staff to have time to ensure effective understanding and engagement on NHS reforms, and
   ii. the potential problems that arise from this in terms of staff burnout and ‘change fatigue’.
185 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands that GPC England clearly defines the role of the GP and clearly defines ‘reasonable needs of the patient’ as a method way of controlling workload and providing GPs the ability of saying ‘No’.

**PREMISES**

186 NORTH STAFFORDSHIRE: That conference believes that the longstanding lack of progress on a clear agreement between NHS England and the BMA with regards to premises lease agreements, stamp duty and non-reimbursable premises charges compromises the GP partnership and that conference demands that the GPC commits to resolving this issue before the next UK LMC conference (May 2020).

187 WAKEFIELD: That conference requires GPC England to negotiate within a defined time frame, for all GP owned properties to have the right to have their buildings purchased back by the government.

188 LINCOLNSHIRE: That conference agrees with the NHS England Partnership Review that the financial risk associated with premises ownership or lease-holding is a major concern for partners and potential partners, and thus calls upon NHSE to remove this impediment, and to create a model of premises ownership similar to that in Scotland which has unshackled Scottish general practices.

189 WAKEFIELD: That conference believes that the current criteria for use of ETTF monies does not line up with the development of networks in primary care and should be revised.

190 AVON: That conference regrets the ongoing problems for GPs who are tenants in premises owned by NHS PS and who have no control over the costs of building maintenance and service charges which are invoiced to them through opaque mechanisms with questionable basis in fact. Because the costs threaten the viability of many practices conference directs GPC England to negotiate a national DES to cover the costs of maintenance and service charges as a pass-through transaction.

191 KENT: That conference demands that improvement and development of GP premises is 100% funded by the NHS.

192 BUCKINGHAMSHIRE: That conference believes surgeries remain at significant risk as a result of the current NHS England leasing process and:
   i. believes that leases should be no more than 15 years in length
   ii. believes that leases should be standardised to have regular break clauses for NHS properties
   iii. calls on GPC England to ensure that no GP should be liable for any excess rent costs above NHSE re imbursements for the leased property
   iv. believes that maintenance costs currently do not reflect the current costs to our buildings and leads to personal financial loss and calls on GPC England to take urgent action to correct this.

193 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference identifies the premises issue being discussed every year with very limited progress. We call on the GPC England to:
   i. issue guidance on extortionate service charges being charged by NHS property Ltd
   ii. appropriate funding for refurbishments to the premises to be able to compliant with CQC infection control policies, to be able to support services being moved out of secondary care.
194 HERTFORDSHIRE: That conference:
   i. notes that the most recent BMA GP premises survey shows that only 50% of premises are fit for present needs, and
   ii. deplores the fact that the premises funding promised in the Five Year Forward View is not reaching practices because of NHS England’s incompetence.

### PRACTICE BASED CONTRACTS

195 CAMBRIDGESHIRE: That conference is seriously concerned that UK digital accelerator sites have benefitted from a perverse incentive permitted by out-of-area regulations, and calls for GPC England to demand of NHS England & Improvement that, if forced disaggregation is pursued:
   i. each provider has an agreed practice area with no discrimination or ‘cherry-picking’ of patients
   ii. a reduced level of global sum, with a reproducible formula, be applied for out-of-area registrants
   iii. a capitated sum be added to the global sum in areas of deprivation to reflect minimum home-visiting costs over and above that offered by Digital-First providers
   iv. GMS/PMS providers are given opportunity to demonstrate that they can deliver on digital expansion before allowing mass entry of new APMS providers.

196 LEEDS: That conference opposes NHS England’s plans to automatically award APMS contracts to digital-first providers when a specific number of out-of-area registered patients is reached.

197 NORTHAMPTONSHIRE: That conference demands that the GPC England negotiates a basic practice allowance and seniority payment, as has been agreed in Wales, to incentivise partnership and GPs to stay in the profession.

198 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers how patients are registered out of areas. The current system allows cherry picking of patients and so all rules around delivering GMS services should be applicable across all providers of GP services.

199 GLOUCESTERSHIRE: That conference is concerned at the increasing amount of monitoring of conditions expected from general practice and asks GPC England to negotiate enhances services for these already occurring and preparedness for future monitoring of new services as they develop.

200 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes the current arrangements for registering patients from outside practice area are not fit for purpose and open to gaming and must be renegotiated to:
   i. allow providers only to be able to register patients under these rules who have previously been a fully registered patient with the same provider
   ii. set payment for patients registered through this scheme at 50% of the weighted payment for a similar fully registered patient.

201 BIRMINGHAM: That conference believes that whilst digital technology has the potential to provide massive benefits for patients and general practice, the solution to the cherry-picking of low-workload and low-cost patients by digital provider-based models of general practice which exploit the out of area registration regulations lies in a radical revision of capitation payments to ensure that resourcing of general practice fully reflects the costs of providing holistic as opposed to discriminatory care.
HERTFORDSHIRE: That conference calls for:

i. a comprehensive home visiting service to be available for all patients registered under out of area arrangements

ii. out of area arrangement to be stopped until NHS England can confirm that all CCGs are providing a home visiting service for such patients.

NORTHAMPTONSHIRE: That conference demands that the GPC England negotiates a basic practice allowance and seniority payment, as has been agreed in Wales, to incentivise partnership and GPs to stay in the profession.

LAMBETH: That conference opposes ‘shared savings’ schemes for so-called avoidable A&E attendances and admissions.

GLOUCESTERSHIRE: That conference notes the number of local enhanced services of similar flavours round the country and request that a more centralised process takes place to rationalise, enhance negotiations, and ensure equity of access to enhanced services across England.

DERBYSHIRE: That conference rejects:

i. the trend towards the requirements for ‘multiple diplomatosis’ in order that practices are able to contract for services under GMS/PMS including DES, NES and LES

ii. attempts by ‘authorities’ to ‘gold plate and diamond encrust’ LES and other contractual specifications.

DEVON: That conference calls for the Improved Access Scheme to be immediately withdrawn as:

i. there is no evidence that this scheme is producing any significant benefits

ii. in many areas the scheme is having deleterious effects on staffing emergency out of hours care

iii. incorporating it in the future primary care network DES is likely to lead to many GP Practices not signing up for the DES

iv. GPs providing routine appointments seven days a week is a political wish rather than a clinical need and in the light of the crisis facing general practice it is our professional responsibility to explain this to our patients.

NORFOLK AND WAVENEY: That conference believes that ‘extended hours’ and ‘improved access’:

i. are often a waste of resource and money and not what patients want

ii. poor evidence that meets the patient’s clinical needs

iii. PCNs need to determine locally what resources and services are required

iv. they often remove GPs ability to work for OOH services

v. they impact on practices ability to staff core hours

vi. there should be no attempt to increase core hours or bring in compulsory extended hours through PCNs

vii. continuity is more important than improved access

viii. both core and OOH need adequate funding but they require different skill mixes and staff mixes and must be treated separately, have separate functions and be managed and publicised differently.
LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that NHS 111 should not be allowed direct access to GP appointment booking systems, and that pressure for this to occur from NHS England should be resisted:

i. this will increase the pressures already in place on appointment systems by using appointments for inappropriate concerns which do not need urgent attention
ii. in addition, it removes the ability of experienced clinicians to triage and signpost to more appropriate sources of advice
iii. it runs the risk of setting a precedent that allows NHS England increasingly direct control of systems within practices and reduces the flexibility of the partners who own the practices to control what occurs within them.

TOWER HAMLETS: That conference:

i. would like to remind the GPC England that abolition of the out of area registration clause is conference policy
ii. demands that the abolition of the out of area regulations is a red line in negotiation with the government.

KENSINGTON, CHELSEA AND WESTMINSTER: That conference, in light of the recent NHS England Board Papers from June 19 which stated ‘by default becoming salaried to other NHS Providers’, does not believe the rhetoric that NHS England is supportive of the GP partnership model and:

i. rejects the notion that the announced increase in funding will support the partnership model
ii. believes that the only way to support the model is to fund core services through increases in the global sum
iii. instructs GPC England to only negotiate further contract changes if they include real and adequate global sum increases in addition to funding any ‘new scheme’.

REDBRIDGE: That conference, with regard to out of area registration:

i. believes it is not consistent with a local service and as such damages the cornerstone of the NHS
ii. believes it risks creating a service based on patient convenience rather than their health needs
iii. undermines the proposed aims of the PCN DES
iv. requires GPC England to lobby government to repeal the out of area regulation.

DERBYSHIRE: That conference reasserts the GPs right to delegate tasks to their employees within professionally accepted primary care norms.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference looks at the demand for fixed numbers of provision for online booking and consultation to make it more relevant for population groups and what patients want rather than fixed targets.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes a lot of time is there is inappropriate use of NHS services and wasted DNA appointments. It calls on the GPC England to negotiate some funding for these wasted appointments as being individual contractors GP partners still have to pay our staff.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference considers how patients are registered out of areas. The current system allows cherry picking of patients and so all rules around delivering GMS services should be applicable across all providers of GP services.
217 SANDWELL: That conference point out to NHS England/DHSC that the GMS contract has always been an all risks, population based contract. Any ‘cherry picking’ of well patients is a fundamental breach of that contract. Should that happen, conference requires the GPC England to declare NHS England in breach of contract and negotiate a fundamentally improved contract, reflecting this breach.

218 NORTHAMPTONSHIRE: That conference recognises the need to remove the archaic notion that prevents patients paying their own GP for services they provide. Patient choice is limited by preventing this, especially as consultants, dentists and opticians can offer private services to NHS patients. Why is there discrimination of GPs in this matter?

219 MANCHESTER: That conference instructs GPC England to:
   i. negotiate a contract that ensures increases in workload are automatically resourced by new funding
   ii. provide LMCs with a quarterly update on contractual elements negotiated but not yet implemented, for example changes to the Premises Costs Directions, to allow full reimbursement for estates investment.

220 SHEFFIELD: That conference has no confidence in the direct 111 booking system into GP appointments, as this is a recycling of patient demand into an already overloaded system. Conference demands GPC England urgently renegotiate this contract with NHS England.

221 WANDSWORTH: That conference calls for a review of the requirement for practices to have appointment slots available for NHS 111 to book into, as this has an impact on overall appointment availability and patient experience.

222 ROCHDALE AND BURY: This conference seeks NHS England assurance that NHS contracts with private providers involving GP engagement in delivery will seek GP input.

**FINANCE**

223 BRADFORD AND AIREDALE: That conference demands that GPC England negotiate with NHS England so the discriminatory rules that allow secondary care to charge overseas visitors but don’t allow GPs to charge are changed and made equal.

224 REDBRIDGE: That conference is amazed that 15 years since it was first devised the current funding formula is still incomprehensible and:
   i. requires NHS England to explain why even within STPs there is significant variation
   ii. reviews the formula to ensure that it appropriately incorporates the wider determinants of health.

225 NORTH YORKSHIRE: That conference believes the current weighted funding formula is not fit for purpose, and specifically has a detrimental effect on areas of high rurality, patient engagement, and demand, but low deprivation, and demands a review based on current circumstances.

226 WAKEFIELD: That conference believes that locum insurance should be increased in line with the real costs of this to practices.

227 GLOUCESTERSHIRE: That conference believes that in insolvency cases NHS England should compensate health care workers (HCW) for the work that they have done, rather than the HCW bearing the loss.
228 SHROPSHIRE: That conference requests a review of DVLA remuneration for medical reports, particularly failure to:
   i. increase the fee paid in line with inflation
   ii. pay postage – which was paid hitherto
   iii. reimburse VAT. Completing DVLA forms is not a medical service according to HMRC so VAT is payable’.

229 NORTHAMPTONSHIRE: That conference demands that collaborative arrangements are negotiated in scope and reasonable professional remuneration to support general practices in providing information to the authorities which do not form part of their GMS contract.

230 SUFFOLK: That conference is aware that GP income per capita has been falling in real terms over at least the last 12 years and by some calculations is now little more than half what it was. GPC England is requested to work with the government to improve GP retention and recruitment by arresting and reversing this trend together with attending properly to the pensions issue.

231 NORTH YORKSHIRE: The GP partnership model must continue. One of the barriers to this is the capital investment required, as banks are becoming less inclined to lend to general practitioners, conference asks GPC England to look into central funding options that can take on the debt and risk associated with partnership.

232 NOTTINGHAMSHIRE: That conference recognises that GPs and PCNs remain under resourced compared with secondary care and calls for a continued diversion of resource to services to permit more of the preventative work that is being asked of us at present with only very limited resources.

GPC ENGLAND/CONFERENCE OF ENGLAND LMCs /
LMCs IN GENERAL

233 HULL AND EAST YORKSHIRE: That conference calls for:
   i. increased accountability of the relevant GPC England policy leads and GPC England Executive team in fulfilling the conference motions from the previous year
   ii. the development of a mechanism to hold those responsible to account for any failure to deliver.
(Supported by NORTH AND NORTH EAST LINCOLNSHIRE)

234 BUCKINGHAMSHIRE: That conference calls on the GPC England to formulate comprehensive guidance to GP practices to assist in navigating the increasingly complex employment law environment.

235 NORFOLK AND WAVENEY: That conference believes and asks GPC England to acknowledge that almost all primary care policy decisions are aimed at and benefit urban practice but often harm or have no regard or knowledge to the effect on rural general practice.
236 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that as practice mergers become more commonplace, the support systems for larger practices and mergers need to be developed, and:

i. increased national recognition of the challenges of mergers would reduce practice isolation
ii. national programmes focusing on ‘Change Management’ would aid staff retention
iii. larger scale work would support local LMC offices who are doing sterling work in supporting their patches
iv. this support should be based on the experiences of practices which have already been through the process of merger
v. the support should not end at the point of merger but recognise that the issues which led to a decision to merge plus the process itself leads to a need for extra support for an extended period post-merger.

(Supported by DORSET)

237 DEVON: That conference believes with respect to the move in recent years to discourage the Chair of Committee to express their views fully whilst responding to a debate:

i. is a retrograde step which limits conference’s ability to understand the current GPC England expert viewpoint
ii. is unnecessary as conference is perfectly capable of forming its own independent opinion
iii. should be relaxed at the discretion of the Chair.

238 NOTTINGHAMSHIRE: That conference recognises that statutory and voluntary levies are calculated on a capitated list size with no weighting unfairly affecting some practices whose income is on a weighted basis; We therefore request that GPC England conducts a review of how levies are calculated with a view to considering the merits or otherwise of moving to receiving levies on a weighted list basis.

INFORMATION MANAGEMENT AND TECHNOLOGY

239 HAMPSHIRE AND ISLE OF WIGHT: That conference instructs GPC England to pursue an updated recognition of access to the traditional GP patient record:

i. which extends legally to the whole primary care team providing care
ii. and for a patient education campaign that explains the necessity for all primary care providers to be able to access their GP held record for the purpose of primary care.

240 DORSET: That conference believes:

i. that any health professional seeing a patient must have access to their record without the need for data sharing agreements and that all health professionals should use or have access to the one domain system
ii. and for a patient education campaign that explains the necessity for all primary care providers to be able to access their GP held record for the purpose of primary care.

241 COVENTRY: That conference believes that the wider public are not being adequately involved in, nor advised of the extent to which general practice is being pushed to share their GP-held records with other organisations and this puts individual practices at risk of a complaint to the ICO. (Supported by Warwickshire)
242 DEVON: That conference demands that where NHS England extracts patient data from general practice (or arranges a third party to extract data on NHS England's behalf):

i. NHS England should become a joint data controller for that data
ii. the financial or other consequences of any data breach are born by NHS England
iii. the practice may at their discretion audit the subsequent use of the data and the data processing practices.

243 BEDFORDSHIRE: Following policy agreed in 2018, conference calls for a centralised system, based at PCN or ICS level and with ring-fenced recurring funding and indemnity cover, for the scrutiny of records requested for SARs, as individual practices do not have the resources to do this in a safe or timely manner.

244 NORTH STAFFORDSHIRE: That conference believes that the lack of reliable access to IT systems and patient records in general practices puts patient care at risk. Conference asks that the GPC England demands that:

i. NHS digital shares the outcome of investigations to establish the root cause(s) of the problems
ii. NHS digital puts a business continuity plan in place should these problems reoccur
iii. both practices and the public are kept informed of outages and expected outcomes in a timely fashion
iv. a reimbursement system is put into place for practices who suffer financial loss, medico-legal risk and workload pressures as a result of inability to access the IT system and patient records
v. NHSE informs the ICO of events which lead to ‘availability breach’ under GDPR rules.

245 MANCHESTER: That conference agrees that investment in digital capabilities for general practice and PCNs should be:

i. increased
ii. given directly to PCNs for use by front line staff.

246 SURREY: That conference believes that:

i. IT innovation offers opportunities to facilitate patient consultations
ii. the GP core contract capitation payment arrangements must support the wider use of IT within general practice.

247 BERKSHIRE: That conference believes the Electronic Referral System (ERS) has considerably increased GP workload, frustrates patients, results in duplication of administrative workload and wastage of NHS resources and calls for it to be abolished.

248 GLOUCESTERSHIRE: That conference is concerned that patients’ full access to their records:

i. will result in enormous work for practices
ii. create potential safeguarding and criminal risk for vulnerable patients, and
iii. calls for the measure to be suspended until the implications are costed and fully understood.

249 BEDFORDSHIRE: That conference calls for social services to have access to patient records to enable them to write their own safeguarding report but only with full, detailed consent of the patient and when notes have been scanned by an appropriate redaction tool (such as iGPR).
**DIGITAL GENERAL PRACTICE**

250 AVON: That conference calls on NHS England to provide equal access to online consultations that at least match the reliability and user-friendliness of Babylon. If Babylon is here to stay then we need a level playing field for traditional GP surgeries to be able to compete for their livelihoods.

251 HEREFORDSHIRE: That conference agree that it is critical that NHS England provide resources to ensure each area is able to provide its own Digital First GP solution, that is embedded in local integrated care and does not destabilise local practices.

**REGULATION**

252 SOUTH STAFFORDSHIRE: That conference agrees that the CQC plays a vital role in maintaining GP standards, but also:
   i. feels that the current mechanism is worsening recruitment, retention and morale and
   ii. demands that inspection visits are conducted in a way that helps, rather than personally criticises GPs and
   iii. insists that expedient additional resources and support are offered to practices with a ‘requires improvement’ rating.

253 BRENT: That conference regrets the punitive, adversarial and inconsistent approach taken by CQC to GP practice inspections, and demands increased transparency, and use of reliable data for any future inspection regime.

254 SOMERSET: That conference, given that CQC has stated it is no longer looking to establish a safe standard of care exists in a general practice but rather to encourage continual improvement (so that a ‘Requires Improvement is the new Good’ rating), demands DHSC therefore publicly admit that the work involved for practices in meeting CQC requirements will have an impact on patient access.

255 NORTHAMPTONSHIRE: That conference demands that unless a significant event which endangers the lives of practices or staff, CQC should not be able to unilaterally close a practice with immediate effect.

256 NORTHAMPTONSHIRE: That conference insists CQC staff should have to have worked in the real practice setting for three months prior to becoming inspectors, so that they have a reality check.

257 MANCHESTER: That conference opposes the current practise of offering placatory responses to vexatious patient complaints and requests that NHS bodies and medical defence organisations commence a more robust methodology to support general practice.

258 NOTTINGHAMSHIRE: That conference recognises one of the key stressors for GPs being the NHS England stance of investigating low level complaints from patients thus causing unnecessary stress for GPs and their teams. We therefore implore GPC England to work with NHS England with the aim of agreeing sensible thresholds to investigate complaints that ensures learning from events but removes some of the strain on the profession.

259 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference looks at the way accusations against GPs are dealt with and why is the doctor presumed guilty even before any investigation has commenced!!
260 SOUTH STAFFORDSHIRE: That conference believes there is absolutely no place for bullying and harassment in the NHS and insists that:

1. bullying and harassment training is made a mandatory requirement for all doctors and managers in the NHS
2. every GP practice is encouraged to appoint a freedom to speak up guardian
3. victims of bullying and harassment are offered timely access to psychological support in a confidential environment
4. perpetrators of bullying and harassment are reported to the GMC for violation of their professional code of practice
5. the ‘How are you feeling today’ emotional wellbeing toolkit is immediately implemented in all GP practices www.nhsemployers.org/howareyoufeelingnhs.

261 DEVON: That conference welcomes the secretary of state’s introduction of a ‘NHS violence reduction strategy’, however this is not a preventative approach so to guarantee the safety of NHS staff, we ask the GPC to work with NHS England to ensure that:

1. regional special allocation / violent patients’ schemes should share their registration list nationally
2. staff are able to register patients with a special allocation/ violent patients’ scheme without a police log number following an untoward event
3. all persons leaving prison following a sentence for a violent offence are registered with a special allocation scheme for a probationary period.

262 DEVON: That conference agrees that the identification of ‘at risk’ practices is a good thing but that using data as a performance management tool is not to be supported and we urge the GPC to ensure this does not happen.

PENSIONS

263 BUCKINGHAMSHIRE: That conference mandates the GPC England to solve the current pension crisis resulting in the loss of experienced GPs over the age of 50, and specifically calls on GPC England to:

1. push for the tapered annual allowance to be abolished
2. ensure that NHS pension contributions can be adjusted to individual circumstances
3. negotiate with the government to allow the current tax bills being demanded to be resolved and backdated.

264 SOMERSET: That conference believe the NHS pension payment service is not fit for purpose in that it:

1. is inequitable towards sessional GPs
2. is impossible to balance tax payments and pension contributions due to retrospective annual growth calculations thus impacting on workforce planning
3. thereby causes unnecessary and unreasonable distress to individuals by often requiring them to make unpredicted and unpredictable balancing payments.

265 SEFTON: That conference declares the present pension tax crisis, which is now severely affecting GP retention, to be one of the Treasury’s making. That meddling with ‘in-out’ options for Pension Scheme membership is not the answer. It calls for an immediate suspension of the annual allowance tapering tax rules, whilst the calamitous impact of these is properly sorted.
266 NOTTINGHAMSHIRE: That conference is appalled by the disproportionate and unfair way that annualised pension contributions are calculated. It believes that this unfairly biases against GPs who need to work less than full time or require increased flexibility due to personal circumstances such as single parents, carers, those with health problems and disabilities. It is therefore discriminatory. We demand that GPC England:

i. explores the legality of the current situation and considers a challenge to it on the basis of discrimination

ii. changes how FTE is assessed and described and this should be put into hours not days or sessions and sit at 35-40 hours a week – the same as other professions.

267 SUFFOLK: That conference believes the inequities and inconsistencies in the current NHS Pension system are unjust and unfair and demands that:

i. the qualifying definitions for death in service benefit be amended to embrace all locum GPs, thereby specifically including GPs who work limited sessions within general practice and/or work part-time in variable patterns

ii. full and equitable death in service benefits be payable to ALL active pension scheme members – including all locum GPs - irrespective of whether the GP dies on a working day or not

iii. GPs who have temporarily left the pension scheme due to the impact of taper or annual allowance limits, but who nevertheless continue to work in general practice, should retain their full rights to death in service benefits until they cease working altogether

iv. GPs who are unable to obtain pension estimates from NHSBSA due to PCSE incompetence in passing on contributions, should be compensated financially if the situation is not rectified within 30 days of the first request to PCSE.

CLINICAL

268 NOTTINGHAMSHIRE: That conference deplores the decision to allow public health budgets to be controlled by local authorities resulting in the continuing underfunding particularly of sexual health, drug and alcohol services, and:

i. calls on the government to urgently bring PH budgets under NHS control

ii. increase funding to these essential community services

iii. increase training provision in these areas enabling these GPs with a special interest in this area to more adequately treat these vulnerable members of our society.

269 BUCKINGHAMSHIRE: That conference condemns the use of delay, obfuscation, deflection and outright refusal of social services to fund the transfer of care home patients to nursing homes in spite of recommendations from healthcare professionals and care home managers. Furthermore, conference calls on GPC to perform the following:

i. investigate the causes for social services choosing to use such tactics and share its findings with the secretary of state

ii. investigate the impact that these tactics are having on primary care service workload

iii. quantify the harm caused to care home residents from being forced to remain in care facilities not equipped to meet their care needs.

270 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the variation of provision of services across county, or local authority borders should not be allowed to disadvantage patients. This can be particularly apparent for practices whose boundaries are not directly aligned to local authority borders and can lead to an inequity of provision of community services which are often now under the remit of public health and therefore controlled by local authorities rather than the health community.
271 NOTTINGHAMSHIRE: That conference deplores the failing of commissioners to adequately invest in Mental Health care thus causing a failure of service provision in many parts of the country and implores government to:
   i. recognise that poor mental health has a major impact on all strata of society to the detriment of the nation
   ii. massively increase spending in mental health training and provision through the NHS
   iii. increase spending in social care proportionately; recognising that many of the mental health problems we encounter are a direct result of inadequate social care provision.

272 MERTON: That conference recognises the inadequacies in the provision of essential mental health services including CBT, interpersonal psychotherapy, EMDR and behavioural therapy and demands that these inadequacies in mental health provision are addressed as a NHS England priority.

273 MID MERSEY: That conference believes that all child and adult patients with ADHD have the right to access specialist services for assessment, diagnosis, treatment and on going management of their condition, and presses GMC to liaise with NHS England to ensure that such services are commissioned in all areas.

274 LINCOLNSHIRE: That conference deplores that the government’s own independent review Modernising the Mental Health Act has not been acted upon and calls for this to be prioritised for action in the government’s next Queen’s speech.

275 MID MERSEY: That conference believes that all child and adult patients with autistic spectrum disorders have the right to access specialist services for assessment, diagnosis, treatment and on going management of their condition, and presses GMC to liaise with NHS England to ensure that such services are commissioned in all areas.

276 GLOUCESTERSHIRE: That conference welcomes the Hepatitis C screening proposal in the new pharmacy contract but insists that proper pathways to secondary care without the need to involve general practice be established before implementation.

277 CITY AND HACKNEY: That conference is concerned that patients are now able to order tests directly from private providers and:
   i. requires clarity from GMC as to who is responsible for interpreting these results
   ii. deplores the approach of some companies who provided standard print out information for the patient without putting this into a clinical context, appropriately counselling patients and arranging follow up if required
   iii. requires appropriate legislation of this industry so that providers take responsibility for comprehensively following up the results of any investigation and that this responsibility does not fall on general practice
   iv. that if their private provider after appropriately consulting with the patient thinks NHS follow up is required this should be communicated to the GP in an appropriate manner in line with best practice
   v. asks GPC England to develop national guidelines and resources to assist practices in responding to these requests.
278 LEEDS: That conference is alarmed at the increased number of children suffering from measles and calls for:
   i. a fully funded MMR catch-up scheme for all those not fully immunised
   ii. an electronic record of immunisations to be made available to all people to enable the use of prompts and alerts
   iii. Public Health England to develop a major public health campaign to encourage parents to protect their children through immunisation
   iv. all schools to regularly monitor their pupil’s immunisation status and to actively encourage full uptake.

279 DORSET: That conference is saddened that England has lost its WHO ‘measles-free’ status and calls for immediate action to counteract the false news spread by anti-vaxxers and re-establish levels sufficient to provide herd immunity.
(Supported by SESSIONAL GPs COMMITTEE)

280 WALTHAM FOREST: That conference continues to object to GPs being used as an occupation health service and demands are urgent review of Med3 regulations which must include:
   i. other registered clinicians being able to complete Med3s
   ii. practices only being required to issue Med3s for acute illness
   iii. certification for chronic conditions requiring occupational health assessment and ongoing certification so that it no longer is the responsibility of the GP.

281 BEXLEY: That conference is concerned about the amount of GP time taken-up with preparing fit notes especially for patients with long term conditions; it is requested that:
   i. the requirement that GPs sign fit notes be removed from GPs altogether, as this does not form part of the core GP contract, and
   ii. that responsibility for determining the fitness of a person for work reside with employers' occupational health services and/or the DWP.

282 SUFFOLK: That conference instructs the GPC to ensure that the representatives of dispensing doctors are included in the negotiations on the outcome of the current community pharmacy drug reimbursement reforms consultation and demands that:
   i. a full impact assessment is undertaken by NHS England/DHSC
   ii. the final proposals are ‘rural proofed’
   iii. GPC negotiates appropriate changes to the SFE.

283 WORCESTERSHIRE: That conference believes that all general practitioners should be funded for FMD and that dispensing doctors should not be discriminated against in this circumstance.

284 HERTFORDSHIRE: That conference believes that:
   i. the establishment of centres of excellence for sexual health is a good thing but that
   ii. sexual health centres of excellence should be supported by a network of local, satellite sexual health centres
   iii. local sexual health centres should not be closed, as this reduces access and puts patients at risk.
285 GP TRAINEES COMMITTEE: That conference notes that current guidance on school attendance for children is often prescriptive and inflexible. We believe that:

i. local authorities should be made aware of GPC advice on GP notes and revise their guidance to schools and parents in order to reduce GP workload
ii. current guidance is driving a culture of presenteeism, which runs the risk of considerable negative long-term impact on health and mental health for our children. We call on government to recognise this and review policy to take a more holistic view of children’s health.

286 WEST PENNINE: That conference thinks the preventative social screening information gained in general practice, should be exempted from declaration to health insurance companies and employers, as are STI screening tests.

ICS/WORKING AT SCALE

287 BERKSHIRE: That conference is concerned that despite past conference policy, representation of LMCs at board level on STPs and Integrated Care Systems remains poor and:

i. believes this is posing an existential threat to GMS practices and their autonomy
ii. instructs GPC to issue joint guidance with NHS England that involvement of LMCs in these organisations is mandatory
iii. instructs GPC to survey LMC officers around England to determine the extent of the problem and highlight particular areas of concern.

288 LEWISHAM: That conference demands that NHS England ensures that clarity and appropriate representation be given to GPs in relation to the future operation of place-based boards.

289 AVON: That conference wants to highlight to all partnership agencies that integrated care must mean parity in decision making, a distribution of funds commensurate with workload and that integrated care cannot be underpinned by the attitude of ‘go and see your GP’.

290 HERTFORDSHIRE: That conference is very concerned regarding proposed CCG mergers to align with STPs, as this is a disaster for general practice whose voice and influence will be lost within the STP. Conference asks GPC to:

i. oppose these mergers due to their detrimental effect on general practice
ii. ensure an LMC representative is mandated to be a voting member of the STP
iii. provide ongoing leadership training to PCN clinical directors ensuring they have the skills to adequately represent their network within the STP.

291 BROMLEY: That conference:

i. is concerned about the potential detrimental impact on local commissioning services of CCG mergers and the national requirement to make 20% savings on CCG budgets, and
ii. calls upon CCGs/STPs to produce clear local plans and directory of services and contacts for following any merger process; together with more visible, transparent leadership and assurances that support services are retained at local level.

292 LAMBETH: That conference with regard to CCG merger proposals:

i. believes these changes will reduce local accountability
ii. demands wider engagement and consultation for all groups, including patients and the wider public
iii. demands that the proposals account for investment in primary care and demonstrate no loss of funding relative to the precursor bodies.
293 LEWISHAM: That conference demands that where CCG mergers take place, GP commissioning functions remain at a borough level to ensure local sensitivities are understood and effective engagement takes place with local PCNs.

294 NORTH ESSEX: That conference deplores the arbitrary imposition of STP footprints in Essex, designed to protect and promote acute trusts, and believes they will damage and destroy primary care in the county.

295 DERBYSHIRE: That conference is concerned and highlights the fact that novel configurations of care provision designed to meet patient demand (rather than need) such as GP co-location in A&E and extended access provision are creating:

i. unnecessary demand for service
ii. poor value for money provision
iii. provision of care that is inappropriate, inconsistent and lacks continuity for the patient and as such current investment would be better spent supporting day time general practice.

296 SOUTH STAFFORDSHIRE: That conference recognises the ever increasing; unsustainable workloads placed on GPs and as a result:

i. sees that the proliferation of 'referral pro formas' is a way that hospitals are silently passing secondary care work to GPs, in a hidden fashion in terms of tests better interpreted by secondary care, and passing the work for these onto GPs to request and interpret them
ii. further agrees that even if a GP has not completed all the information on a pro forma or has chosen to write a traditional letter, this should never lead to a referral being declined or the GP having to transcribe the same information onto a pro forma having already sent a letter
iii. strongly urges in this time of madness that all GPs should set up their own practice specific pro formas and reject all hospital correspondence including discharge summaries and out patient letters that do not see all elements of the pro forma being completed, thereby requiring secondary care to deal with the same pointless administrative burden which is imposed on GPs.

297 WORCESTERSHIRE: That conference demands that there are sanctions for trusts who are in breach of the NHS Standard Hospital Contract and is alarmed and frustrated by:

i. the increasing use of complex and lengthy referral templates and processes which can block the ability of a GP to access secondary care support in a timely fashion
ii. the threat to downgrade referrals without GP involvement
iii. restrictions over which diagnostic tests can be accessed by the GP and primary care clinicians
iv. governance arrangements which restrict who can order diagnostics which in turn pose a risk to new models of care and a varied workforce.

298 DORSET: That conference recognises the crisis in staffing urgent and emergency care and calls for resources to be urgently directed to primary care to alleviate the pressures.

299 SESSIONAL GPs COMMITTEE: The conference recognises the crisis in staffing urgent and emergency care and calls for resources to be urgently directed to primary care to alleviate the pressures on A&E.
300 TOWER HAMLETS: That conference is appalled that North West London Collaboration of clinical commissioning groups has restricted referrals as part of a cost recovery process and:
   i. believes that doctors are highly trained professionals who are best placed to decide, in partnership with the patient, when a referral is required
   ii. calls upon the GPC to make clear to North West London Collaboration of clinical commissioning groups, to NHS England and to the government that GPs will not be bound by such dictates and will continue to refer on the basis of clinical need
   iii. conference also calls upon the GPC to make clear to North West London Collaboration of clinical commissioning groups, to NHS England and to the government that general practice will refuse to do any work that overspills into the community as a result of this policy.

301 KIRKLEES: That conference would welcome the improvements to patient pathways due to advances in technology and clinical management. We have significant concerns about the impact of outpatient transformation on general practice:
   i. no GP referral should be rejected by secondary care teams without contacting and seeking consent from the referring GP
   ii. outpatient transformation often requires more work, investigation and consultation in general practice prior to making a referral. The resultant costs of clinical and administrative time must be met in full, with sufficient margin
   iii. outpatient transformation often offloads the work of routine follow up onto general practice. This work must also be adequately funded.
   iv. the changes envisaged by outpatient transformation on clinical pathways must ensure that all members of the primary care team are provided with the necessary education training and accreditation
   v. clinical pathways should be developed and agreed in collaboration with patients, GPs and secondary care teams so that clinical risk is minimised and patient safety improved.

302 WALTHAM FOREST: That conference deplores the continued transfer of work from secondary to primary care and requires GPC England to confirm with NHS England that they will:
   i. halt the use of rating scales by CCGs, STPS and other organisations that utilise RAG ratings to measure how practices are performing in these areas which are outside their contractual requirements
   ii. put an end to performance managing practices based on the amount of secondary care work they are able to do
   iii. publicly state that the increase demand on hospitals is a multifactorial issue and not caused by GPs not adequately caring for their patients or inappropriately referring patients to hospital.

303 SOMERSET: That conference insists that NHS England recognise the critical capacity constraints in primary care by contractually instructing secondary care providers to begin all written communications to practices with a clear instruction labelled ‘information/action for GP team.’
INDEMNITY

304 CITY AND HACKNEY: That conference is disappointed by the details of the clinical negligence scheme for general practice and calls on GPC England to renegotiate this to ensure that the scheme:

i. fully indemnifies GPs and practices for providing NHS services
ii. covers all work related to the care of NHS patients and that is not directly paid for by the patient as a private service
iii. the scheme covers medicolegal advice so as to fully replace the previous fully comprehensive indemnity that practitioners were required to have.

305 NOTTINGHAMSHIRE: That conference, whilst welcoming the introduction of a national indemnity scheme, many issues around this remain unresolved and so calls upon the GPC to continue to push for full indemnity on all activities within general practice that are clearly seen to be NHS work. An example would be flu vaccinations for staff members which is seen by other NHS organisations as protecting their own front-line staff and encouraged.

306 DORSET: That conference calls for clarification from NHS Resolution and the Medical Defence Organisations wrt the need to purchase run-off cover for those GPs who had transitional indemnity.

(Supported by SESSIONAL GPs COMMITTEE)

NHS ENGLAND PERFORMER INVESTIGATIONS

307 GLOUCESTERSHIRE: That conference regrets that NHSE performer investigations often have poor quality controls in place and demands urgent evaluation:

i. on the validity of notes audits
ii. insistence on guideline adherence
iii. on gender and racial referrals and outcomes.

308 NOTTINGHAMSHIRE: That conference believes a pervasive ‘guilty until proven innocent’ attitude exists among the overbearing regulatory bodies, which is creating a culture of intimidation and harassment of GPs by the NHS, GMC, CCGs and CQC. It therefore calls upon GPC to:

i. demand that the regulators adopt the fairer stance to the contrary ie ‘innocent until proven guilty’
ii. put a mechanism in place to stop GPs leaving the profession due to anxiety, stress and burnout following punitive regulatory measures.
## 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 subcommittee who were elected from regions in England, together with its chair
   3.6. those elected members of the sessional GPs subcommittee of the GPC who were elected from regions in England.

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 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 day after 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, 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. ‘C’ motions: Prior to the conference, a ballot of representatives shall be conducted to enable them to choose motions, ('C' motions), amendments or riders for debate. Using only the prescribed form, which must be signed and received by the GPC England secretariat by the time notified for the receipt of items for the supplementary agenda, each representative may choose up to three motions, amendments or riders to be given priority in debate. Chosen motions must receive the vote of at least ten representatives. The first three motions, amendments or riders chosen, plus any others receiving the vote of at least twenty representatives, shall be given priority.

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

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. No amendment or rider which has not been included in the printed agenda shall be considered unless a written copy of it has been handed to the agenda committee. The names of the proposer and seconder of the amendment or rider, and their constituencies, shall be included on the written notice. Notice must be given before the end of the session preceding that in which the motion is due to be moved, except at the chair’s discretion. For the first session, amendments or riders must be handed in before the session begins.
32. No seconder shall be required for any motion, amendment or rider submitted to the conference by the GPC England, a local medical committee, or the joint agenda committee, or for any composite motion or amendment produced by the agenda committee under standing order 21. All other motions, amendments or riders, after being proposed, must be seconded.

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 should be seated except the one addressing the conference.

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

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. Except as provided for in standing orders 63 (election of chair of conference), 64 (election of deputy chair of conference), and 65 (election of five members of the agenda committee), only representatives of local medical committees may vote.

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 day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

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 1pm on the day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

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. All members of the conference are entitled to vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

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.
Conference of England LMCs 2019: Primary Care Networks

Background
PCNs were established as part of the GMS contract agreement 2019. This created a guaranteed entitlement of new funding for all practices using a DES. Their creation and funding were negotiated between GPC England and NHS England as part of a package deal which also included creation of a state funded indemnity scheme and annual increases to core funding/pay for five years (among other elements).

As of 1 July 2019
– 1,259 PCNs were created
– 99.6% of practices signed up, or committed to sign up, to a PCN
– 26 practices have not joined a PCN, with broad geographic spread
– Clinical director by contract type: 84.5% partners, 15% sessional (7.5% salaried, 1% locum, 6.7% other GP), 0.3% Pharmacists, 0.3% Nurses (based on a 30% sample).

Timeline
July 2018
GMS contract negotiations commenced alongside BMA input into the NHS Long Term Plan.

14 Dec 2018
Contract package and role of PCNs outlined to LMCs at LMC secretaries conference.

7 Jan 2019
Long Term Plan released, setting principles for the creation of PCNs and making commitment to guaranteed increase in proportion of NHS funding for primary and community services.

17 Jan 2019
GPC England agreement to 5-year GMS contract package. 31 Jan 2019: GMS contract agreement published, with summary of PCNs – aims, funding, workforce, services etc.

2 Feb 2019
GPC England guidance on contract agreement released, including summary of PCNs.

8 Feb–15 May 2019
GPC England roadshow events (over 50 in total).

15 Mar 2019
BMA PCN Handbook released.

29 Mar 2019
Amendments to the SFE released, including payment of £1.76 for practice participation in PCNs (payable in arrears from July 2019). PCN DES Specification, PCN DES guidance, PCN registration form, VAT information note, mandatory Network Agreement and Schedules released, providing detailed information about PCN requirements and entitlements.

5 Apr 2019
BMA PCN toolkit released (checklist, template meeting agenda, updated handbook).

15 May 2019
Deadline for PCNs to submit their registration form (including names of practices, total population size, names of clinical director, details of nominated payee, map of network area, meeting and decision-making processes).

31 May 2019
Deadline for CCGs to confirm PCN registration.

6 Jun 2019
BMA, NHSE, GPDF first annual PCN Clinical Directors Conference.

30 Jun 2019
Deadline for PCN to confirm completion of PCN schedules and formal signing of network agreement.

18 Jul 2019
GMS amendment regulations laid before parliament, including requirements for co-operation with PCNs.

31 Jul 2019
PCNs provided funding for £1.50 per patient entitlement, access to workforce funding depending on usage and take on responsibility for extended hours delivery.

31 Jul 2019
Practices provided funding for £1.76 per patient for network participation, backdated to 1 April 2019.

8 Aug 2019
Template DSA and DPA released.

11 Sep 2019
Contract negotiations for 2020/21 commence including PCN service specifications, ARRS, Investment & Impact Fund.

1 Oct 2019
GMS regulations came into force.

In addition to the BMA-NHSE documents, GPC has provided support for PCNs, practices and LMCs:
1. Contract briefing pack for LMCs (sent via email)
2. Contract webinar for LMCs
3. PCN Handbook
4. PCN listserver (now replaced by PCN Community app)
5. PCN blog series from GPC Exec members
6. Top Tips for creating PCNs guidance
7. Example 1 and Example 2 decision making schedules
8. VAT advice from our partners
9. Setting up a PCN checklist
10. Setting up a PCN template meeting agenda
11. PCN calendar (now outdated)
12. Myth-busting PCNs briefing for LMCs (via email)
13. Sessional GPs and PCNs working together
14. Social Prescribers guidance for PCNs
15. PCN funding infographic
16. PCN clinical directors conference
17. PCN insurance advice from our partners
18. Augmented DSA template and guidance
19. PCN Masterclass: leadership and management
20. PCN webinar: the network agreement schedules
21. PCN webinar: governance and decision making
22. PCN webinar: trust, collaboration & relationships
23. BMA PCN Hub
24. BMA PCN Services offer

PCN support services What’s next?

To find out more go to www.bma.org.uk/pcnservices
England LMC Resolutions from 2017

NEW MODELS OF CARE

(5) That conference asks GPC England to negotiate funding and statutory changes to ensure general practice can provide a strategic role in the development of new models of care and

i. ensure parity with other parts of the health and social care service
ii. ensure that they can be GP led organisations
iii. ensure equitable use of savings made,
iv. to explore other options for general practice holding core contracts.

(Proposed by Agenda Committee to be proposed by Herefordshire)
Parts (i), (ii) and (iii) carried
Part (iv) carried as a reference

Update
The creation of the Primary Care Network Directed enhanced services (DES), agreed as part of the 2019 contract, puts general practice at the heart of the development of these new care models, building them through the GMS contract and ensuring the centrality of and leadership by GP practices.

(6) That conference understands the value of independent contractor status but also recognises that not all GPs desire to work in this way and calls upon GPC to:

i. formulate a blueprint for the future of general practice that includes a plurality of contractual types and provides meaningful support to both sessional and contractor GPs
ii. lobby NHS England to investigate and invest in locum chambers as a proven GP retention model
iii. ensure that locum GPs are protected from large web based platforms and locum banks which attempt to impose unfair terms of work and rates of pay.

(Proposed by Agenda Committee to be Proposed by the Sessional GPs Subcommittee)
Parts (i) and (iii) carried
Part (ii) carried as a reference

Update
The template locum terms and conditions provide a framework for locums to ensure they receive appropriate terms for work and rates of pay.

GPC England successfully lobbied the government and the independent partnership review.
ONLINE CONSULTING

(7) That conference is concerned about the pressure to introduce on line consulting into general practice:

i. when there is no evidence that it will save time
ii. and believes it will decrease access to more vulnerable patients who may struggle to use the internet
iii. as it will add to an already unmanageable GP workload
iv. and calls on GPC England to make it clear to government and NHS England that GPs will not formally agree to begin on line consulting until there is clear evidence that it is beneficial to the health of patients.

(Proposed by Tower Hamlets)
Parts (i), (ii), (iii) and (iv) carried

Update
Online consulting is a key priority for NHS England and government, to increase the means of access to general practice. We continue to argue for evidence based decision making.

CAPITA

(8) That conference calls upon GPC England to:

i. make the return of the delivery of primary care support functions to the public domain a central demand in the next round of contract negotiations
ii. urgently address Capita’s failure to correctly collect superannuation contributions in England and seek recompense for those practitioners affected
iii. demand that NHS England prioritise PCSE service improvement with regard to financial statements so that practices can undertake informed business planning.

(Proposed by Agenda Committee to be proposed by Waltham Forest)
Parts (i), (ii) and (iii) carried

Update
GPC England has repeatedly called for PCSE services to be brought back in-house. We have successfully lobbied for the cervical screening services being brought back under NHSE’s responsibility. Resolving pension issues has been a priority for GPC England. NHSE have brought in additional external expertise to improve the process and we continue to work with them to ensure issues are being resolved.

GPFV

(9) Given the vote of no confidence in the GP Forward View at the Conference of LMCs in Edinburgh earlier this year, conference insists that GPC England negotiates improvements in the GP Forward View to ensure that money reaches practices directly without additional bureaucracy or additional workload requirements, and adequate improvements cannot be achieved within one year, GPC England must publicly dissociate itself from GP Forward View.

(Proposed by Oxfordshire)
Carried

Update
GPC England has negotiated a new 5 year contract framework which overtakes the GP Forward View, and continues to negotiate to reduce bureaucracy and limit workload.
CAPPED EXPENDITURE PROCESS

(10) That conference deplores the imposition of the capped expenditure process (CEP) and calls on GPC to negotiate with NHS England and NHS Improvement to abandon this process because:

i. GP providers are already struggling to provide services within what is already a limited financial envelope
ii. general practice and GP service provision will necessarily and disproportionately experience the impact of this cost cutting exercise
iii. even with economies of scale this has the potential to destabilise general practice to the overall detriment of patient care
iv. the CEP is likely to significantly increase workload in general practice without any additional funding, or any consideration being given to the impact or sustainability of this transfer of work.

(Proposed by Agenda Committee to be Proposed by Tower Hamlets)
Part (i) carried unanimously
Parts (ii), (iii) and (iv) carried

Update
The BMA will consistently lobby the government for more funding for the NHS.

CLINICAL AND PRESCRIBING

(11) That conference demands that individual CCGs should not be able to impose restrictions on prescribing and calls upon:

i. Department of Health to undertake a national review of prescribing regulations and entitlements
ii. Delegated CCGS to remove pressure on GPs to reduce or limit clinically appropriate prescribing.

(Proposed by Agenda Committee proposed by Hertfordshire)
Parts (i) and (ii) carried

Update
We have contributed to the low clinical value medicines group to try and maintain a national commonality. However, much like the surgical procedure/interventions, CCGs continue to “enhance” what is agreed and make further restrictions.

REGULATION

(12) That conference deplores the over-regulation of general practice and it calls upon GPC England to lobby government to:

i. abolish the NHS Choices reporting system
ii. abolish the Friends and Family test reporting system
iii. review the current procedure for GP complaints so that trivial complaints can be taken out of the system, as the practice time and resources they consume are disproportionate.

(Proposed by Agenda Committee to be proposed by Avon)
Parts (i) and (ii) carried
Part (iii) carried unanimously

Update
We are continuing to engage with NHS England on resolving concerns related to NHS Choices. We continue to lobby for appropriate changes and improvements.
(13) That conference demands that GPC works with NHS England to:

i. ensure the standards set for appraisal and revalidation are the same across the country and are not open to interpretation by individual Responsible Officers

ii. that appraisal remains a supportive, formative tool for professional development, in line with current RCGP guidance and not a performance management tool

iii. ensure that confidentiality is an integral part of the appraisal process and that performance management groups do not have the right to access an appraisal without a GP’s written consent

iv. reject any attempt by NHS England or others to introduce minimum activity levels on the Medical Performers List.

(Proposed by agenda committee to be proposed by Derbyshire)
Parts (i), (ii) and (iv) carried
Part (iii) carried as a reference

Update
GPC England continue to work to improve and reduce the burden of appraisals. We have successfully opposed the introduction of minimum activity levels for Medical Performers List.

LIST CLOSURES

(14) That conference asks GPC England to enter into discussions with NHS England:

i. to develop a new category of list closure that would allow a practice to close its list in agreement with the commissioners, and in the interest of patient safety, so that it can, for a period, decline to accept new registrations from patients who have not changed address

ii. to improve financial support to practices taking on patients following a list dispersal with the creation of a centrally negotiated payment per patient

iii. to work towards funding to practices taking on patients after a list dispersal flowing in ‘real time’ and not in arrears at quarter-end,

iv. so that commissioners must agree the terms of any list dispersal with the LMC(s) involved to ensure neighbouring practices taking on extra workload are supported appropriately and not destabilised.

(Proposed by agenda committee to be proposed by Cleveland)
Parts (i), (ii), (iii) and (iv) carried

Update
GPC England is working with NHS England to produce good practice guidance for CCGs in the event of list dispersal.

WORKLOAD LIMITS

(16) That conference:

i. believes tired doctors are potentially unsafe doctors

ii. calls on GPC England to issue guidance to support GPs to limit their working day to ensure patient safety

iii. calls on NHS England and the government, working with GPC England, to make patients aware of the importance of reducing GP workload to safe levels

iv. believes GPs should be supported to say “NO” without feeling guilt.

(Proposed by Agenda Committee to be Proposed by Leeds)
Carried
Update

We are continuing to highlight concerns through a number of GPC and BMA initiatives. LMCs can refer to the BMA Care and Collaborative Project and secured funding through the 5 year contract package. The BMA now has a three nation – Wales, Scotland and England – safe staffing project, sponsored by David Wrigley, Deputy Chair of BMA Council UK, with a specific GPC task and finish group. As part of its 2019 election manifesto, the BMA has made safe staffing legislation a key element of its lobbying efforts. The task and finish group are pulling together recommendations for safe working practices, including live examples, and safe working limits.

INDEMNITY

(17) 302
Amended

That conference believes that the rising cost of medical indemnity in England is making general practice unsustainable and adding to the workforce crisis in England, and calls upon GPC England to:

i. ensure that inflationary reimbursements made by NHS England are recurrent and made directly to the individual GP or practice that is paying the indemnity
ii. demand that the government must introduce a system of indemnity comparable with secondary care which covers all GPs on the performers list and all NHS GP practice staff
iii. welcome the government’s intention to provide indemnity cover to all GPs and their teams, and insists that this must be funded by new money.

(Proposed by AGENDA COMMITTEE to be Proposed by Gateshead And South Tyneside)
Parts (i), (ii) and (iii) carried unanimously

Update

We have been successful in reducing the impact of the rising costs of medical indemnity scheme through the clinical negligence scheme for general practice. (CNSGP)

PRIMARY/SECONDARY CARE INTERFACE

(18) That conference recognises the right and responsibility of general practitioners to refer patients for specialist opinion and regarding referral management systems:

i. requires legal confirmation that the clinical responsibility will rest with the individual making the decision that a referral may or may not proceed
ii. believes they are an unacceptable barrier to patients accessing appropriate secondary care
iii. believes the time involved is a poor use of the GP workforce
iv. demands that the government takes measures to ensure that the postcode lottery these create ceases immediately
v. calls upon the GPC England to oppose this false economy and allow GPs as highly skilled generalists to continue to act with professional autonomy.

Proposed by Agenda Committee to be proposed by Northamptonshire
Parts (i), (ii), (iii), (iv) and (v) carried
Update 2017-19, which clinicians and managers across the NHS need to be aware of.

These changes guide how clinicians work across the primary and secondary care interface and have been described in a Key messages guidance published in July 2017.

In 2018 the BMA contributed to the production of an implementation toolkit for local systems. This document sets out practical ways in which organisations can collaborate locally to implement the NHS Standard Contract provisions relating to primary and secondary care.

The BMA has expressed concerns regarding referral management centres and post code lottery, and we continue to lobby for uniform standards.

We have consistently apposed these changes where we have encountered them and will continue to do so.

(19) That conference is concerned that with the increase in use of ‘advice and guidance’ by trusts on Electronic Referral System (ERS) that:

i. GPs will be required to take on more secondary care work without an increase in resources
ii. GPs will be exposed to further clinical risk
iii. clear guidance must be produced to clarify who holds the clinical risk
iv. national financial modelling is required to ensure appropriate financial resourcing of this new workload.

(Proposed by Lewisham)
Carried


GPC and the Consultants Committee represent the BMA on the Electronic Referrals Advisory Board and in meetings with NHS Digital and NHS England to try to resolve the ongoing functionality issues, which has led to the development of a technical upgrade and a new NHS Digital e-RS advice and guidance toolkit.

It is likely, however, that e-RS will be overhauled now that NHSX has been formed, although support for it and efforts to improve it will not cease until a better system has been identified and implemented.
(20) That conference welcomes the recent hospital contract changes which empower GPs to reject inappropriate work from secondary care but feels it does not go far enough and demands that:
   i. NHS England and CCGs hold secondary care providers to account for compliance with the requirements
   ii. an identified email address is provided for every hospital to receive and act upon breaches
   iii. GPC England negotiates with NHS England that hospitals publicise their arrangements for fulfilling their contractual obligations to patients
   iv. GPC England works with others to introduce a formal national programme that educates clinicians joining trusts of their obligations
   v. GPC England negotiate a tariff system which can be used to assign value and, consequently, payment to work carried out by practices, which should be done by secondary care providers.

(Agenda Committee to be Proposed by Kent)
Carried

Update
We have published template letters to CCGs and NHS Trusts as well as other guidance and template documents on the BMA website, to empower and encourage LMCs to engage with local CCGs and to challenge transfer of work / advice and guidance work.

URGENT CARE

(21) That conference believes the new Integrated Urgent Care (IUC) agenda will have significant impact on primary care services and the profession has not been adequately consulted on this, and demands:
   i. a proper impact assessment be carried out of the effect on primary care
   ii. a proper consultation takes place between commissioning boards and LMCs
   iii. no new service demands are imposed on already overstretched, under-resourced and understaffed primary care teams
   iv. no staff are redirected from current service provision to support an untried and untested idea.

(Proposed by North Yorkshire)
Carried unanimously

Update
We have raised this issue and shared the motions from the conference with NHS England and continue to monitor the development of this important area not least with development of Primary Care Networks (PCNs).
Amended That conference recognises the inconsistent out-of-hours arrangements in GP training across the country and requires GPC, through the GP trainees subcommittee, to engage with the RCGP curriculum review and HEE review of OOH to ensure that:

i. OOH work for GP trainees is for training and not service provision

ii. hours requirements for OOH work is consistent across the country

iii. trainees are supernumerary and supervised when managing patients in the OOH setting by a GP, and should not be expected to work as independent practitioners during their training.

(Proposed by the GPC)
Carried unanimously

Update
The GP trainee’s committee has been inputting heavily into the COGPEd review of OOH training and the final position paper (COGPEd Position Paper: Supporting the Educational Attainment of Urgent and Unscheduled Care Capabilities in General Specialty Training), that was approved by the RCGP Specialty Advisory Committee (SAC) in May 2018.

Jointly working with the ETW policy lead, we have been challenging the recommendations, including the expectation that all trainees, by the end of training, should be working with remote, telephone supervision only. Following persistent lobbying, this was addressed with an explicit statement that remote supervision is optional and not an expectation.

The committee has also been meeting with Urgent Health UK, a federation of organisations that provide OOH/urgent care and are commissioned to provide training for GPVTS in OOH setting. Concerns were raised about the lack of clarity and structure of OOH training in some organisations, flexibility of and access to shifts and the risks of remote supervision. Promoting good practice through the federation was being considered.

That conference instructs the GPC to work with the RCGP to develop the GP curriculum so that trainees are taught and assessed on relevant aspects of practice management.

(Proposed by Camden)
Carried

Update
The GP trainees committee jointly responded with ETW to the updated version of the curriculum for the GP specialty training programme in 2019, as part of the RCGP consultation. Our response mentioned that the revised curriculum was underdelivering on content, by not fully capturing the expertise and attributes required for GPs to move into either a partnership role or salaried-based role in the current model of general practice. Non-clinical aspects of general practice continued to fall behind in the curriculum.
PREMISES

(24) That conference instructs GPC England to negotiate with government:

i. an extension to the deadline for the reimbursement package including contributions to Stamp Duty Land Tax, VAT, legal costs and service charge management fees

ii. a guarantee that the ‘last man standing’ in a partnership will have the building either bought back or the remaining lease taken over by the government

iii. that the lease liability for non-NHS Property Services (NHS PS) should be accepted by NHS England in the same way as for NHS PS premises

iv. to ensure equivalent investment in partner owned premises as in purpose built and NHS Property service buildings.

(Proposed by agenda committee to be proposed by Bedfordshire)

Parts (i), (ii), (iii) and (iv) carried

Update

GPC England has been addressing this issue in negotiations with NHSE and DHSC over the PCDs - which have been subject to ongoing delays on DHSC’s part.

GPC England has also pushed for these as part of the GP Premises Review. The published review moves in the right direction but does not go far enough. GPC will continue to negotiate on this.

(25) That conference believes that Estates, Technology and Transformation Fund (ETTF) monies are not reaching sufficient numbers of practices and calls on the GPC urgently to discuss how NHS England can guarantee this money reaches practices immediately.

(Proposed by Kent)

Carried

Update

GPC England has had several discussions with NHS England about the ETTF funding and funding flows seem to have improved although remain inadequate.

We have recently written to the Prime Minister for the urgent need for investment in general practice premises.
INFORMATION TECHNOLOGY

(26) That conference requires GPC England to:

i. negotiate with relevant bodies on the development of a standardised overarching data sharing template and data sharing agreement format
ii. ensure that NHS England/CCGs recognise the importance of information governance provider development arrangements
iii. work to ensure that properly resourced regional information governance and data sharing support arrangements are put in place to provide expert support and advice to GP provider organisations
iv. appoint regional data sharing experts to provide advice and support to all LMCs on all data sharing agreement.

(Proposed by Agenda Committee to be Proposed by Haringey)
Parts (i), (ii), (iii) and (iv) carried

Update
As part of the development of PCNs and following GDPR implementation, GPC England has agreed a data sharing template and also for support for practices on data sharing issues.

NHS England and the BMA agreed on a non-mandatory, high-level data sharing template for use by PCNs which was published in September 2019.

As data controllers GPs receive multiple requests for patient data and it is their role to satisfy themselves that they are appropriate for the release of data. In April 2019, the BMA ethics team developed guidance for LMCs on responding to requests for patient data. There are also discussions taking place at a national level about how the collection of and access to GP data for secondary purposes can be improved to minimise the burden on GPs.

(27) That conference supports the piloting of artificial intelligence health systems but insists that, prior to further rollout:

i. all systems need to be piloted and assessed against set national criteria
ii. the systems need to demonstrate a sustainable reduction in GP workload
iii. any system needs to fully integrate with GP clinical systems.

(Proposed by Waltham Forest)
Carried

Update
Through the Joint GP IT Committee the GPC has been able to feed these concerns into national proposals for new systems – for example, the use of AI to improve the collection of GP appointments data.
CQC

(28) That conference demands that the procedure be far easier for GPs to become a CQC ‘registered manager’, and that possession of GMC registration and placement on the Medical Performers List alone should be sufficient requirements for this post.

(Proposed by Gloucestershire)

Carried unanimously

Update

We have continued to have regular meetings with CQC to reduce the burden on general practice.

CHosen Motion – New Business

(303) That conference, with regard to the ‘GP at Hand’ service launched this week and any other similar services:

i. deplores the use of public funds, including any GP Forward View monies, to promote inequitable access to NHS branded GP services
ii. demands that GPC commences urgent negotiations with the Secretary of State for Health to compensate practices from which registrations are switched for the loss of practice income incurred as a result of any patient registering with such services
iii. demands that the GPC seeks urgent legal advice regarding the options available and the potential for a judicial review, to challenge the decision to introduce this service.

(Proposed by Derbyshire)

Carried

Update

GPC explored the possibility of a Judicial Review regarding the establishment of GP at Hand and its expansion from West London to Birmingham. GPC England took senior legal advice and the conclusion was that success, was low and the BMA decided not to take this forward. We have lobbied on the GP digital first agenda.
A and AR Motions 2017

**A 32 CAMBRIDGESHIRE**: That conference notes the many ambitious plans to move towards Accountable Care Systems or organisations and believes that it is vital that GPC England and LMCs work to ensure that:

i. the general practice registered list is a fundamental building block of all such systems
ii. new arrangements do not threaten the continuity of contracts to provide general practice care
iii. GPs are not constrained in their ability to speak with independence and integrity.

*Update* We have responded to this through PCNs and made progress to address payments for safe guarding and continue to push on other issues.

**A 33 EALING, HAMMERSMITH AND HOUNSLOW**: That conference is appalled by some local authorities refusing to pay GP practices for work performed under the collaborative funding arrangements and demands that the GPC inform these organisations of their financial obligations for non-contractual work performed by general practitioners.

*Update* We have made progress on addressing payment for safeguarding in relation to collaborative funding.

**AR 34 KENT**: That conference condemns the illogical contribution rate penalty for GP locums if they have a three-month gap between sessions.

*Update* GPC England and the Sessional GPs Committee are lobbying for resolution of problems relating to annualisation and these were included in the BMA’s response.

**A 35 SOUTHWARK**: That conference believes that the disparity of earnings between salaried GPs and contractors is too wide, and calls on the GPC to:

i. ensure that contractors do not become rich at the expense of their salaried employees
ii. find a way to create more opportunities for salaried doctors to become partners, particularly in prospering practices
iii. ensure that supermarket-style contractors are held to account if the respect of salaried colleagues is not deemed to be adequate.

(Supported by Tower Hamlets LMC)

*Update* We have secured significant new investment through the 5 year contract package and based on the partnership model in line with the partnership review.

**A 36 DORSET**: That conference asks NHS England to ensure that all sessional GPs doing NHS work are entitled to NHS pensions, regardless of contractor.

*Update* This is covered by ongoing work with by the BMA Pensions Committee.
A 37 GATESHEAD AND SOUTH TYNESIDE: That conference believes that in relation to salaried GPs routinely working in excess of their contracted hours:

i. the GPC should support and empower them to raise the issue of unpaid work with their employer

ii. that it is inconsistent for the GPC not to support salaried GPs in deflecting unremunerated work back to their employers

iii. that such support could highlight improved systems of delegating administrative work away

iv. that supporting salaried GPs to claim for extra contractual hours is consistent with the GPC’s policy of encouraging practices to negotiate enhanced services for noncontractual activity.

Update

Safe working s included as a key workstream as part of the BMA Chair of Council’s safe staff working project.

A 38 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee: That conference agrees with the principle that GPs should be paid for the work that they do and calls upon GPC to support Sessional GPs to claim payment or time in lieu for extra contractual hours they are asked to undertake by their employers.

Update

The model salaried GP contract allows for overtime to be worked where both parties agree, and if so then the salaried GP is paid on a pro rata basis for the extra time. Salaried GPs may wish to negotiate a higher rate of pay to recognise any unsocial overtime hours that they may work. We advise that agreed overtime payments should be settled (such as the start and finish date and the date by which payment will be settled) or to specify the arrangement when time in lieu will be taken. We continue to support all members in receiving appropriate pay or time in lieu for work done, in line with the salaried GP handbook and the model salaried GP contract.

AR 39 NORTH ESSEX: That conference calls on GPC to ensure that the definition of what constitutes core GP IT equipment is updated to reflect new working arrangements and thereby ensuring that CCGs retain responsibility for meeting the full cost of system purchases, upgrades, support and cyber security.

A 40 MANCHESTER: That conference believes the new General Data Protection Regulation will have an adverse impact on practice workload and resources, and an exception should be made to copies of patient records being free of charge.

AR 41 COVENTRY: That conference believes that support must be made available from NHS England to ensure that GP2GP transfer of patient records must be available for the records of those patients that do not register elsewhere until after their original practice has closed.

Update

GPC has fed into the development of a Primary Care Digital Services Operating Model (previously the GP IT Operating Model) which covers the key standards and operating procedures that CCGs are obliged to work with to fulfill their obligations under the delegated arrangements. The Joint GP IT Committee is regularly liaising with NHS England regarding the implementation of full GP2GP functionalities across all practices in England and we have produced guidance for managing GDPR issues and negotiated £20 million through the 5 year contract package.
A 42 HERTFORDSHIRE: That conference calls on GPC England to procure an urgent renegotiation of the GP contract to empower GPs to provide more choice to patients by allowing them to offer their patients treatment privately when it is not available on the NHS.

**Update**  We have consistently raised this with NHS England and they have consistently refused to engage on this matter.

A 43 CAMBRIDGESHIRE: That conference agrees with NHS England in its guidance note: ‘GP practices serving Atypical populations’, that using the GMS funding formula would not ensure the delivery of an adequate general practice service for this cohort of patients and demands that GPC ensures that NHS England directs CCGs to implement its recommendations.

**Update**  We continue to highlight the funding problems for practices related to a typical population.

AR 44 NORTH ESSEX: That conference requests GPC to ensure that the maximum amount payable to GP performers covering maternity leave is increased to a realistic level that properly takes account of current locum costs and prevents the discrimination against GPs working full time that currently exists.

**Update**  We have secured maternity pay and will continue to seek improvements to this.

AR 45 LAMBETH: That conference believes that negotiations in relation QOF should be done at a national level and not at a local CCG level.

**Update**  We agree with this motion and have secured this as part of the 5 year contract agreement.

A 46 NORTHAMPTONSHIRE: That conference demands that where GPs are asked to provide a written, detailed, professional report for safeguarding conferences that this is remunerated by the requesting body to reflect the professional and administrative time, expertise and sensitive nature of the work involved.

**Update**  GPC England has obtained counsel’s opinion on the refusal of some CCGs and LAs to pay for this work (as part of the collaborative fees), which was favorable and suggested legal action to compel them to comply with their obligations would probably be successful.

AR 47 WAKEFIELD: That conference wants the payments GPs currently receive from NHS England when ill to be able to be used more flexibly than just for like for like replacement.

**Update**  We continue to discuss and negotiate with NHS England about fair levels of locum reimbursement to practices.

A 48 BUCKINGHAMSHIRE: That conference believes that the government and NHS England are negligent in not addressing the inadequacies of the average per capita payment for a year of GMS care because:

i. £142.62 (NHS Digital figures for 2015/16) per patient per year does not match the demands made on practices under GMS

ii. £142.62 per patient per annum does not permit the employment of a workforce of adequate size

iii. the resourcing to workload mismatch has produced stresses that have made general practice increasingly unpopular and difficult to recruit to.
Update: We have been securing additional investment through the 5 year contract package and continue to seek the reduction in costs as well as keeping investment secured as far as possible.

A 49 CLEVELAND: That conference demands that the government recognises that the costs of running a practice continues to rise at a rate above the annual increase in the global sum and insists that these costs should be fully reimbursed so that GPs receive a deserved pay rise rather than a pay cut.

Update: We have secured investment through the 5 year contract package and reduce indemnity costs to practices.

A 50 BRENT: That conference opposes the inclusion of any unfunded new requirements in the national contract, and calls upon the GPC to explain to government that general practice has no spare capacity within its current budgets.

Update: We have explained the implications of this to government including NHS England and relayed the views of conference.

A 51 DEVON: That conference calls for GPC to ensure all practices in England continue to have the automatic right to return from local PMS to a national GMS contract at any point of their choosing and will not be prevented from making this choice by any local attempts by NHS England or CCGs to alter their PMS contract.

Update: Current GPC guidance reflects this right and we would defend any practice that was denied it by NHS England or their CCG.

A 52 CAMBRIDGESHIRE: That conference calls on GPC to insist that NHS England should not continue to put GPs, practice staff and patients at risk from violent patients by re-allocating patients who have been violent back to the original practice where the violence occurred, because of minor procedural errors.

Update: This has been raised with NHS England through the Operational Group and continues to be monitored.

A 53 NOTTINGHAMSHIRE: That conference is appalled at the gross incompetence of Capita in managing the transition of PCSE services and seeks to mitigate the damage by:

i. lobbying NHS England to make payments to practices for monies still due to them

ii. requesting that NHS England (not Capita) sends regular updates to practices about its progress on all areas of activity handed over to Capita and accepts responsibly for clear failings in the service delivery.

Update: The BMA successful negotiated £2m to be invested into GMS in 2017 for issues related to Capita and this has been recurrent each year since, until such time as the negotiations agree that it is no longer necessary. We have also repeatedly lobbied for improved communications to practices and they have committed to improving the information disseminated.

AR 54 NORTH ESSEX: That conference requests GPC to ensure that the maximum amount payable to GP performers covering maternity leave is increased to a realistic level that properly takes account of current locum costs and prevents the discrimination against GPs working full time that currently exists.

Update: We continue to secure extra investment for this area.

AR 55 LAMBETH: That conference believes that negotiations in relation QOF should be done at a national level and not at a local CCG level.
<table>
<thead>
<tr>
<th>Update</th>
<th>We agree with this motion and have secured this as part of the 5 year contract agreement.</th>
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<tr>
<td><strong>A 56 AVON</strong>: That conference believes that the GP forward view has been a failure in that it has promised much and delivered little. It calls on GPC to negotiate and campaign for an effective programme, which is properly and appropriately resourced and funded, directly to practices, in order to stabilise and rebuild general practice.</td>
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<td>Update</td>
<td>We agree and have now secured a 5 year contract framework. The GP Forward View has been largely superseded by the five year GP contract framework.</td>
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<td><strong>A 57 KENT</strong>: That conference demands a national enhanced service for care homes.</td>
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<td>Update</td>
<td>We are continuing to negotiate with NHS England a secure specification for care.</td>
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<td><strong>A 58 SUFFOLK</strong>: That conference affirms that the 2016 Special Conference resolved that sustainable medical care for patients in nursing homes required ‘different contractual arrangements’ from those currently pertaining. Conference instructs GPC England to accelerate the negotiations necessary to achieve these different arrangements by the end of the financial year.</td>
<td></td>
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<tr>
<td>Update</td>
<td>We are continuing to negotiate with NHS England a secure specification for care.</td>
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<tr>
<td><strong>AR 59 TOWER HAMLETS</strong>: That conference believes that the routine antenatal appointment is the best time for pregnant women to receive pertussis and influenza immunisation and calls on GPC to lobby NHS England to commission this service from midwives.</td>
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<tr>
<td>Update</td>
<td>As part of the 5 year contract agreement we have secured a vaccinations and immunisation review which is ongoing which will continue to work to make progress on the issues highlighted in this motion.</td>
</tr>
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<td><strong>AR 60 WALTHAM FOREST</strong>: That conference believes that the NHS should not continue contracting with private sector support companies which have failed to deliver NOR should they pay them off.</td>
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<td>Update</td>
<td>We agree and are seeking to use the wording of this motion in discussions with NHS England regarding the performance of Capita.</td>
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<td><strong>A 61 GATESHEAD AND SOUTH TYNESIDE</strong>: That conference believes that the £6/head directed to extended access across England is misdirected and is based upon a political wish list and not patient need. It is believed that this £6/head should be allocated to the global sum in order to try to address the under investment in general practice at its core.</td>
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<tr>
<td>Update</td>
<td>We have secured this funding at PCN level to be used locally with much greater discretion. This enables practices to use this as part of their core practice activity.</td>
</tr>
<tr>
<td><strong>AR 62 COVENTRY</strong>: That conference believes that NHS England should ensure that any funding streams announced for general practice are administered with clear criteria, clarity as to where the funding sits and with a minimum time frame of three weeks for practices or organisations to apply for the funds. When funds are available they should be released promptly.</td>
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<tr>
<td>Update</td>
<td>We have tried to address this concern through a guaranteed 5 year funding programme. GPC England did complain regarding this area and this was upheld.</td>
</tr>
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</table>
A 63 TOWER HAMLETS: That conference:

i. is opposed to private GP services advertising themselves as NHS doctors
ii. calls on GPC to complain to the Advertising Standards Authority about any misleading adverts of this nature.

Update We have raised this with NHS England who are taking this forward.

A 64 MID MERSEY: That conference believes that the independent contractor model of general practice provides the best continuity of care for patients and the best value for money for the NHS.

Update This has been taken forward through the partnership review.

A 65 WILTSHIRE: That conference demands government urgently lists general practice as a job in the medical practitioners ‘shortage occupation’ code.

Update This has now been addressed and forms part of the shortage occupation list.

A 66 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee: That conference believes that in order to sustain and retain the GP workforce in new ways of working, leadership and engagement opportunities must be made available to all GPs and calls on GPC, working with LMCs, to lobby for equal access to these roles within CCGs and at scale providers.

Update This has been taken forward as part of the development of PCN and encourages sessional GPs to participate.

A 67 NOTTINGHAMSHIRE: That conference is becoming increasingly concerned with a trend of GPs being refused the renewal of their indemnity cover by the medical defence organisations leading to a worsening of the GP workforce crisis. We implore the GPC to:

i. negotiate with the MDOs to change the rules that they do not have to give reasons for refusals to the GP
ii. request that an appeals process is put in place to allow a right of reply for the individual GPs involved
iii. call upon the government to make alternative arrangements possible when the usual firms will not or cannot supply indemnity or provide an overreaching indemnity cover in the form of a ‘national indemnity scheme’.

Update This has been resolved through the state funded indemnity scheme.

A 68 CLEVELAND: That conference believes that general practice should be under no obligation to provide GMS services to hospital in-patients, and calls on GPC England to work with the relevant bodies to enact this.

Update We have issued guidance to support practices in this situation.

A 69 GREENWICH: That conference believes that it remains the responsibility of secondary care to determine patients’ eligibility for secondary care treatment.

Update We have continued to issue guidance to this effect.

AR 70 CAMBRIDGESHIRE: That conference calls upon GPC to ensure that specialist services in the community should be recommissioned with the facility to prescribe rather than all prescribing requests defaulting to general practice.

Update This is part of our discussions on primary and secondary care interface group.
<table>
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<tr>
<th>Resolution</th>
<th>Description</th>
<th>Update</th>
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<tbody>
<tr>
<td>A 71 CLEVELAND</td>
<td>That conference believes NHS England should no longer hide behind CCGs to implement the changes NHS England want in the system and calls on GPC England to demand greater transparency and clarity.</td>
<td>We have called for greater transparency and clarity in this area.</td>
</tr>
<tr>
<td>A 72 LEWISHAM</td>
<td>That conference believes that cuts to funding for public health and associated local authority services pose a serious health risk for generations to come.</td>
<td>We agree and the BMA have been more vocal in calling for more public health funding.</td>
</tr>
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<td>A 73 NOTTINGHAMSHIRE</td>
<td>That conference notes the inconsistencies of the CQC inspection approach and urges the GPC to take a more active role in supporting practices, through their LMCs, who feel that they are victims of this.</td>
<td>We are regularly engaging with the CQC, calling for the reduction in bureaucratic burden and greater consistency.</td>
</tr>
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<td>A 74 GATESHEAD AND SOUTH TYNESIDE</td>
<td>That conference congratulates the GPC on negotiating reimbursements of CQC fees for 2017/18 but calls upon GPC to ensure that this is paid indefinitely.</td>
<td>We have secured the reimbursement of CQC fees indefinitely.</td>
</tr>
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<td>AR 75 GLOUCESTERSHIRE</td>
<td>That conference, with respect to ‘mandatory training creep’, insists that the BMA and RCGP together need to issue the strongest possible joint guidance that a trained GP who is on the performers list and is required to participate in the NHS annual appraisal process to ensure they are revalidated by the GMC is, by the nature of their qualification and registration, not required to undergo further specific training for these purposes, and commissioners as well as GMC and CQC must cease to require them to do so.</td>
<td>We have recently secured confirmations from NHS England and their responsible officer seeking clarity regarding safeguarding training.</td>
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<td>A 76 NOTTINGHAMSHIRE</td>
<td>That conference is concerned that swinging cuts to Health Education England budgets demonstrates that education and training is becoming a lower priority for investment by the government.</td>
<td>We are concerned about cuts to funding for education and training and have been lobbying for increased amounts as part of the remit of the NHS Peoples Plan.</td>
</tr>
<tr>
<td>AR 77 DEVON</td>
<td>That conference requests that consideration be given to supporting back to work UK trained GPs who previously left due to family commitments by utilising some of the monies recently allocated to recruitment &amp; training of international doctors to augment the GP workforce.</td>
<td>We have highlighted the challenges of international recruitment under this programme.</td>
</tr>
<tr>
<td>A 78 SUFFOLK</td>
<td>That conference requests that an annual summary of action taken on the previous year’s resolutions be made available to all LMCs, following the practice of the BMA Annual Representative Meeting.</td>
<td>This has been implemented and we would encourage feedback from this report.</td>
</tr>
</tbody>
</table>
A 79 NORFOLK AND WAVENEY: That conference asks GPC to develop proposals and guidance on how GPs in future Accountable Care Organisations and MCPs are represented by LMCs.

**Update** This has been superseded by the development of PCNs which retain the independent contractor status and secure GMS practice arrangements.

AR 80 WILTSHIRE: That conference requires GPC to arrange that the GPC England and LMC list servers are amalgamated within the next three months. (Supported by Avon, Devon, Cornwall, Gloucestershire, Somerset, Hampshire & IOW and Dorset LMCs).

**Update** The LMC list is used by the chair to post weekly updates to keep all members so they are aware of GPC activity.

A 81 KENT: That conference with respect to Sustainability Transformation Partnerships (STPs) condemns:

i. them as a thinly disguised vehicle for the privatisation of the NHS and the introduction of savage cuts to health and social care

ii. the fees paid to private consultants that support the process.

AR 82 DERBYSHIRE: That conference is frustrated to hear how many millions of pounds have been spent on management consultants for STPs and demands that GPC negotiate that all STP moneys are spent locally and not on such consultants.

AR 83 LEWISHAM: That conference believes that STPs across England continue to exclude appropriate representation from general practice and this exclusion threatens the sustainability of NHS services. (Supported by Bexley LMC).

**Update** We agree. The BMA have been lobbying for changes to the NHS Act, we have consistently called for the removal of any aspects that would lead to privatisation and have asked the government to give greater focus on collaboration.

A 84 LEEDS: That conference:

i. reaffirms the essential role that LMCs play in supporting all GPs and in the development of general practice

ii. recognises the benefit of LMCs learning from one another to improve their effectiveness

iii. calls on GPC England to coordinate an annual LMC audit to provide benchmarking information for all LMCs to use.

A 85 CAMBRIDGESHIRE: That conference believes in this time of crisis in the NHS that local medical committees and their executive remain pivotal to the survival of general practice by continuing to:

i. represent the ever changing needs in general practice

ii. support all doctors in general practices regardless of contractual status

iii. work closely with GPC to secure a fair and positive future for the profession

iv. remain a reliable and stable presence in times of change.

**Update** We agree and recognise the essential role that the LMCs play, having agreed roadshows over the last two years and continue to learn and explore the best way to support LMCs and the best way to learn from each other.
A 86 THE GPC: That the GPC seeks the views of conference on the following motion from the Sessional GPs subcommittee: That conference calls for LMCs to have robust systems in place to ensure that they are able to ballot all Sessional GPs within their region for regional GPC elections.

Update  The BMA continues to improve through the use of electronic elections but is dependent on all GPs providing up to date contact information.
England LMC Resolutions from 2018

**GP AT HAND**

(5) That conference with regard to the Secretary of State for Health and Social Care:

i. welcomes NHS England’s independent evaluation of GP at Hand service

ii. is shocked and dismayed by his flagrant endorsing of the GP at Hand model within the Babylon headquarters

iii. calls upon him to publicly retract his comments that GP at Hand was “good for NHS patients, clinicians... and relieved pressure on other NHS services” until such a time as the report commissioned by his own ministerial department is completed

iv. cannot have confidence in him if he continues to demonstrate his ignorance of the value, worth and function of general practice by his support for a virtual system incapable of providing holistic care.

(Proposed by Agenda Committee to be proposed by Yorkshire)

Parts (i), (ii), (iii) and (iv) carried nem con

**UPDATE**

GPC issued a press release in February 2019 criticising the decision to allow GP at Hand to expand to Birmingham calling on the Secretary of State to improve investment in practice IT infrastructure and a further one in May 2019 when the independent evaluation was published noting its findings that the GP at Hand service could widen health inequalities and increase demand on already overstretched services.

(6) That conference believes that the rise of out of area alternate primary care providers:

i. has the potential to destabilise the local health economy, threatening the viability of the current model of general practice

ii. urges the government to halt the roll out of these models before it has considered the impact on primary care

iii. requires the government to reassess the benefits of online consulting to the patients

iv. instructs the GPC to insist that all providers must offer and deliver a full range of services, equitably, to all patient groups without any exceptions based on age, sex and morbidity or technological competence

v. calls for the abolition of the out of area registration clause in the GMS contract.

(Proposed by Agenda Committee to be proposed by Redbridge)

Part (i) carried unanimously

Parts (ii) and (iii) carried nem con

Parts (iv) and (v) carried

**UPDATE**

We expressed the concern of conference in line with the LMC conference resolution. GPC England responded to the Digital First consultation in July 2019 arguing the out of area regulations should be withdrawn, as they allow digital providers to prioritise largely healthy patients and short-term care over patients with more healthcare needs and continuity of care for a local population in order to profit from this arrangement.
CLINICAL

(7) That conference believes that due to gaps in commissioning GPs are being encouraged to work beyond their competencies in a number of clinical areas and calls on GPC England to:

i. ensure that no GP is pressurised by NHS England into prescribing medication outwith their competence due to failures of NHS England specialist commissioning
ii. call on the GMC to amend their guidance on Trans Healthcare as their current guidance is in neither patients nor doctors best interests
iii. negotiate for safe and effective secondary care high risk medical monitoring for patients with eating disorders to be available in all parts of England
iv. ensure appropriate services are commissioned for the management of substance misuse.

(Proposed by Agenda Committee to be proposed by Hampshire and Isle of Wight)
Parts (i), (iii) and (iv) carried unanimously
Part (ii) carried

UPDATE This is ongoing work with NHS England – we are lobbying them to commission services and publish prescribing guidance, and we fed in to their guidance Responsibility for prescribing between primary and secondary/tertiary care.

We have published guidance on gender incongruence in primary care, and working with NHS England to publish shared care guidance and interim arrangements for prescribing and provision of services for gender dysphoria patients.

(8) That conference remains concerned by the introduction of barriers which block GPs from making clinically appropriate referral to secondary care colleagues, so conference instructs GPC to:

i. give guidance on the actions they should take when referrals pathways are created requiring GPs to undertake work or actions outwith of their agreed contracts before being able to refer
ii. tackle the surfeit of referral templates and protocols which are resulting in a subtle transfer of workload from secondary to primary care
iii. publicise that CCG referral management schemes and procedures of low clinical value are only about cost cutting and rationing
iv. negotiate with NHS England and government the need to agree an England wide list rather than have postcode lottery decisions.

(Proposed by Agenda Committee to be proposed by Sefton)
Parts (i) and (iv) carried unanimously
Part (ii) carried nem con
Part (iii) carried
UPDATE In May 2018, the BMA has supported the publication of the Clinical Guidance on Onward referral led by the Academy of Royal Medical Colleges.

This document refers to the main NHS Standard Contract changes and offers some guidelines which can be used to inform and guide clinicians locally.

The BMA has lead representatives from GPC (Gaurav Gupta) and the Consultants Committee (Simon Walsh) for electronic referrals. A joint BMA, NHS Digital and NHS England e-RS guide for GPs was published in early 2019. Gaurav and Simon also represent the BMA on the Electronic Referrals Advisory Board and in ad hoc meetings with NHS Digital and NHS England colleagues to try to resolve some of the ongoing functionality issues with the e-RS, e.g. issues with urgent referrals, which has led to the development of a technical upgrade with input from medical and clinical representatives, problems with referrals from private GPs to NHS hospitals, and a new NHS Digital e-RS advice and guidance toolkit, upon which the BMA has been invited to provide ongoing feedback.

(9) That conference states, general practice is NOT an emergency service and calls upon GPC England to:

i. condemn those ambulance services who downgrade calls from GP practices for emergency ambulance, thereby putting seriously unwell patients at risk due to delay in response times

ii. address the mission creep in out of hours general practice in providing stop-gap, unsafe emergency care to plug deficiencies in our under-funded ambulance service

iii. demand an evaluation of 111 in England to ensure value for money and appropriate signposting to other services

iv. declare that the diversion of GPs or practice staff to immediately attend local emergencies in place of ambulance staff is a misuse of primary care resources.

(Proposed by Agenda Committee to be proposed by Hampshire and Isle of Wight)
Parts (i) and (iii) carried
Part (ii) and (iv) carried unanimously

UPDATE We wrote to, and had meeting with, NHS England to raise concerns by the conference and this led to changes in the draft National Framework for Healthcare Professional Ambulance Responses, specifically about the timing for ambulance transport when called by a GP surgery. The published guidance sets clear standards for response times. We secured changes to the initial set up.
PARTNERSHIP

(10) That conference calls on GPC England to reduce the inherent risks in the current partnership model that are alienating GPs and pushing experienced GPs into early retirement by negotiating with the government to:

i. introduce a form of Limited Liability into the partnership model for contract holders
ii. recognise the financial burden of taking on a partnership by seeking full reimbursement of necessary costs incurred in providing NHS premises
iii. require NHS England to cover staff redundancy costs in the case of list dispersal.
iv. ensure NHS England is obligated to take over the lease of a collapsed practice and act as a tenant of last resort
v. introduce a statutory cap to the liability which can befall a contractor who finds themselves in the position of being “last partner standing”

(Proposed by Agenda Committee to be proposed by Cambridgeshire)
Carried

UPDATE
The contracts and regulation policy group has included this within its workplan for the year and is drafting a paper setting out the potential pros and cons of limited liability partnerships.

Many of the issues raised by conference have been taken on board fed into the partnership review. We continue to lobby Government to implement these recommendations.

WORKING AT SCALE

(11) That conference believes that working at scale is just one potential solution for the GP crisis and instructs GPC to:

i. robustly defend a practice’s ability to explore other solutions
ii. challenge NHS England when any practice feels coerced into working at scale
iii. negotiate with NHS England to prevent Local improvement Schemes (LiS) being offered on a population basis rather than to individual practices.

(Proposed by Waltham Forest)
Parts (i), (ii) and (iii) carried

UPDATE
Through the contract agreement we have retained the practice based contract. The contract now builds upon the GMS/PMS contract and enables practices to support one another without compulsion to merge.

Working at scale, including the recent introduction of PCNs, is a voluntary process for practices.

No practice should be coerced into joining an at-scale system against their wishes and practices that find themselves in this situation will be supported, including challenging NHS England.

LiS’s can be offered at various levels — with the introduction of PCNs, it is up to the PCN and its practices to decide whether to accept at population or practice level.
(12) That conference, with regard to Integrated Care Systems:
   i. demands LMCs are recognised in all potential “ICS” GP Integration agreements as the legitimate representative organisation for general practice
   ii. believes they are yet another national scheme based on little or no evidence of benefit
   iii. demands they cannot be established without robust documentary evidence demonstrating a significant level of practice support
   iv. demands practices should not be financially disadvantaged by declining a voluntary ICP contract.

(Proposed by Agenda Committee to be proposed by North Essex)
Parts (i), (ii), (iii) and (iv) carried

UPDATE We have lobbied NHS England to encourage ICSs to engage with LMCs and continue to lobby against the development of the ICP contract.

REGULATION

(400) That conference believes CQC visits add an unnecessary burden to the GP workload, contributing to the current workforce crisis, and demands:
   i. a minimum interval of five years between visits for practices achieving ‘good’ or ‘outstanding’, unless serious safety concerns have been raised
   ii. a minimum 14 day notice period prior to a practice inspection, unless serious safety concerns have been raised
   iii. removal of the requirement for DBS checks for every change in practice registration status, instead accepting inclusion on the national performers’ list as adequate proof
   iv. GPC England clarify where the responsibility lies in following up patients who choose not to accept invitations to national screening programmes
   v. GPC England work with the CQC and Health and Safety Executive in absolving practices being censured for premises safety issues where the Landlord is responsible for rectification.

(Proposed by Agenda Committee to be proposed by Wakefield)
Parts (i) and (iii) carried
Parts (ii) and (iv) carried unanimously
Part (v) carried as a reference

UPDATE We continue to work with CQC to reduce the burden of regulation. GPC England Executive continue to meet regularly with the new lead of CQC.

(14) That conference directs GPC to work to ensure that there is effective independent oversight and review of NHS England performance management procedures in primary care, including performance investigations and the functions of Performance Advisory Groups and Performers List Decision Panels.

(Proposed by Mid Mersey)
Carried unanimously

UPDATE We have met with NHS England and there is ongoing work on their performance; how they work, how they are constituted and how to introduce anonymisation. The joint BMA/NHSE England working group will take this forward.
PRACTICE BASED CONTRACTS

(15) That conference believes core funding for general practice has been eroded to the point that it is now unsustainable and unsafe, and
i. that annually negotiated adjustments to the GMS contract is a method of negotiation which is failing to address the crisis in general practice
ii. mandates GPC England to negotiate a recurrent global sum uplift at least over and above inflation
iii. proposes that payments for enhanced services are index linked.

(Proposed by Agenda Committee to be proposed by Oxfordshire)
Parts (i), (ii) and (iii) carried

UPDATE GPC England has negotiated a five year contract agreement with recurrent uplifts to global sum, at least in line with inflation. These are in addition to new funding for workforce expansion in PCNs.

We also have been successfully in getting NHS England to commit in the long term plan to increase investment which will ensure closer scrutiny of CCG investment including enhanced services.

WORKLOAD

(16) That conference, mindful of the clinical risks of excessive workload, believes that an assessment of a GP’s commitment should be based on total hours worked rather than sessions.

(Proposed by the Agenda Committee to be proposed by Shropshire)
Part (i) carried as a reference

UPDATE The workload dataset we collected was on a minimum basis and is based on hours not sessions.

GP RETENTION

(17) That conference agrees with NHS England that it is important to keep experienced GPs working in primary care and:

i. urges GPC to negotiate an incentive scheme with NHS England to acknowledge the expertise of senior doctors
ii. that this should be through a new system of seniority payments based on years of service.

(Proposed by Somerset)
Parts (i) and (ii) carried

UPDATE The idea of a new system of seniority payments was raised with NHS England, but as the government’s policy remains that there should be no automatic recognition for length of service in the public sector, this was not fruitful. The GPC has been involved in developing the National GP Retention Scheme, which currently benefits around 500 GPs (including many who would otherwise have retired) and NHS England allocated £12 millions for 2019/20 for ICSs and STPs to support the implementation of a practical toolkit for the retention of GPs.
EDUCATION AND TRAINING

(18) That conference believes that access to protected learning and professional development for GPs, allied health professionals, practice managers and staff are vital to maintain quality care and requests that GPC England:

i. negotiates a separate ring-fenced budget to fund these sessions in addition to GMS or CCG provision
ii. applies what influence it can to ensure that appropriate material is included in the core curriculum for allied professionals
iii. negotiates a fully funded GP mentoring programme be set up by Health Education England (HEE).

(Proposed by the Agenda Committee to be proposed by Shropshire)
Parts (i) and (ii)
Part (iii) carried as a reference

UPDATE
This is an important issue which we continue to lobby NHS England to address.

INFORMATION MANAGEMENT AND TECHNOLOGY

(19) That conference insists that IT infrastructure must:

i. provide proper function for clinical use by practices before introducing political wants such as WiFi for patients
ii. meet basic standards agreed with the GPC for connectivity and speed provide appropriate recompense to practices for failure
iii. include the full reimbursement of practice costs incurred by system and provider changes including the purchase of systems and services for any proposed future working at scale environment
iv. include a penalty clause in all future NHS IT contracts securing funding for any unforeseen workload required of general practice following a system failure.

(Proposed by the Agenda Committee to be proposed by Cleveland)
Carried unanimously
UPDATE  
GPC has fed into the development of a Primary Care Digital Services Operating Model (previously the GP IT Operating Model) which covers the key standards and operating procedures that CCGs are obliged to work with to fulfil their obligations under the delegated arrangements.

GPC has regularly raised the issue of IT failures with NHS England and has lobbied for CCGs to make available adequate support for practices to help with incidents. The new GP IT Futures framework will include new standards around safety, security and interoperability for suppliers to adhere to which hopefully reduce the frequencies of these incidents.

Within the 2019/20 GP contract agreement, GPC secured a commitment for a recommended specification for IT and digital for commissioners, which should ensure that all IT and digital support is functional and appropriate. Changes to support electronic access, to appointment booking, to consultations and to information will be phased across five years. A programme to digitalise paper records will commence to enable the creation of a complete electronic record for each patient.

The BMA also published a report in March 2019 – Technology, infrastructure and data supporting NHS staff, which includes recommendations, following feedback from members, for upgrading IT infrastructure, new national standards, ring-fenced funding and appropriate procurement specifications. We are now lobbying for additional improvements beyond the contract agreement through regular engagements with senior representatives from NHSX, the Department for Health and Social Care, NHS Digital and NHS England / Improvement.

FUNDING

(20) That conference, with regard to procedures of limited clinical value:

i. calls for proper, evidence-based evaluation of all treatments given this title, taking into account the cost consequences of not providing treatment

ii. calls for an end to acute trusts and CCGs insisting on prior approval being sought before referral for procedures of ‘limited clinical value’

iii. welcomes the NHS England consultation on procedures of limited value but demands that the evidence base for its implementation is approved by all stakeholders, including consultants, GPs and the public

iv. believes that many CCGs are inappropriately using the concept of “procedures of limited clinical value” to simply save money.

(Proposed by the Agenda Committee to be proposed by Avon)  
Carried

UPDATE  
We have taken these points into discussions with Group (ANDY GREEN).
**DDRB**

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

*(Proposed by Leeds)*
Parts (i), (ii), (iii) and (iv) carried unanimously
Part (v) carried

**UPDATE**
The BMA has reiterated these messages in its response to the DDRB process outcome. GPC England will no longer be using the DDRB for contractor Pay during the 5 year period of the contract but we will continue to use for sessionals and trainees.

**PREMISES**

(23) That conference insists NHS Property Services, a wholly owned subsidiary of the Department of Health and Social Care:
   i. is destabilising general practice through unilateral increases in service charges
   ii. should immediately withdraw the demands for these unsubstantiated and unfair service charges
   iii. should pay compensation to the affected GPs for the expense and distress caused by the dispute over service charges
   iv. is recognised by NHS England as an NHS body.

*(Proposed by the Agenda Committee to be proposed by Kent)*
Carried unanimously

**UPDATE**
The BMA wrote to NHS Property Services in June asking for an urgent response to concerns over the worrying rise in service charges faced by GP practices, failing which the BMA will be forced to consider legal action. BMA lawyers have since set out in detail the reasons why it believes NHSPS is acting unlawfully in a letter of claim. The BMA intends to take NHSPS to court if an immediate resolution cannot be agreed. GPC England has repeatedly asked for clarification on this matter. NHSE has declined to provide clarification.
**PENSIONS**

(24) That conference believes that following the identification of GP pension earning discrepancies that:

i. NHS England’s management of GP pensions has been wholly unacceptable

ii. NHS England must rectify any discrepancies as a matter of urgency

iii. NHS England must pay compensation to any GP who has been affected.

(Proposed by Norfolk And Waveney)
Carried unanimously

**UPDATE** The BMA continues to pressure NHS England to rectify discrepancies, and provide compensation to GPs adversely impacted by these changes.

**PRIMARY CARE SUPPORT ENGLAND (PCSE)**

(25) That conference believes that the way Capita Primary Care Support England has mismanaged the GP pension scheme is unacceptable, falling well below expected professional standards and calls:

i. for Capita to be stripped of its PCSE contract immediately

ii. on the GPC to issue a formal complaint regarding Capita PCSE to the Pensions Ombudsman

iii. on GPC to demand that any workload or time commitment required on the part of GPs and practices to correct these errors will be financially compensated for.

(Proposed by Buckinghamshire)
Carried

**UPDATE** GPC has repeatedly called for Capita to be stripped of its PCSE contract, and we have now been successful in achieving this for the cervical screening service line.

Resolving pension issues has been a key priority for GPC England and we have monitored progress closely with our monthly meetings. The Ombudsman has been notified in the work to resolve the issues. We have also secured £2m to be invested into GMS in 2017 for issues related to Capita and this has been recurrent each year since, until such time as the negotiations agree that it is no longer necessary.
NEW BUSINESS

(410) That conference is outraged and deeply concerned at the statement of 22 November 2018 from the department of health and social care that the new ‘state-backed’ indemnity scheme may be funded from ‘existing resources allocated for general practice’ and instructs GPC England to work with the government in ensuring that:

i. the scheme is supported by new funding
ii. no GP is financially disadvantaged by a change to a state-backed scheme
iii. all GPs and practices are protected from any future increases in the cost of the state-backed scheme.

(Proposed by Buckinghamshire)
Carried unanimously

UPDATE

The five year contract deal includes the provision of a state funded indemnity scheme, as well as more than £2.8bn of additional funding over five years. The scheme will protects GPs and practices for all future increases. This agreement will significantly benefit and protect practices for future increases.
A and AR Motions 2018

**A 26 WEST PENNINE**: That conference tasks GPC to demand NHS England sets a level playing field during the flu vaccination season, resulting in fairer distribution and availability of flu vaccines to GP Practices and pharmacies.

**Update**  
We continue to engage with NHS England and PCSE and this is part of the Vaccinations and Immunisations Review.

**A 27 GLOUCESTERSHIRE**: That conference demands that the Electronic Prescribing System (EPS) be introduced urgently for dispensing doctors, to ensure that rural patients get access to the same service as their urban counterparts.

**Update**  
We continue to lobby for EPS to be fully funded by the NHS for all practices, irrespective of their IT system.

**A 28 EAST SUSSEX**: That conference requests GPC to negotiate a nationally agreed DNAR template for use across England, and agreed national protocols for its implementation.

**A 29 WORCESTERSHIRE**: That conference demands that:

i. dispensing doctors should be entitled to the same reimbursement for IT for the Electronic Prescription Service (EPS) as pharmacists

ii. the GPC to negotiate full funding for EPS for dispensing doctors by NHS England.

**Update**  
Our joint guidance states that there are clear benefits in having such decisions recorded on standard forms.

We continue to lobby for EPS to be fully funded by the NHS for all practices, irrespective of their IT system.

Currently, dispensing practices are unable to use the EPS for medicines dispensed by the practice dispensary, as there are no EPS-compliant systems on the market. GPC England continues to lobby NHS England to find the resources to fund practice IT and internet connections.

Nationally recognised template for DNAR.

**A 30 DEVON**: That conference recognises the increasing amount of clinical work falling into the gap between primary and secondary care and asks the GPC to formally define this as Intermediate Care within any new contract negotiations with NHS England.

**A 31 MERTON**: That conference calls for an integrated and connected health service with a commitment to delivering care in the community with adequate and supported care organised by a primary health care team.

**Update**  
This is part of our discussion with the Primary and Secondary Care Interface Group.

**A 32 LANCASHIRE PENNINE**: That conference believes that understanding and mutual respect between consultants and GPs is hindered by workload pressures and calls on the BMA to promote national and local programmes to facilitate networking and understanding between the two branches of medicine.

**Update**  
The BMA published in September the Caring Supportive Collaborative report calling NHS organisations create opportunities and protected time for staff to meet, share experiences and build strong and supportive relationships.  
Academy of Medical Royal Colleges: Professional Behaviours and Communication Principles set the parameters for working across Primary and Secondary Care Interfaces.
A 33 KENT: That conference believes that communications to primary care should be paperless.

Update We support this motion, this is being undertaken through the Future GP IT Systems and Services.

A 34 KENT: That conference demands that any clinical pathways, protocols or service changes which have an impact on general practice are agreed by GPC or LMCs before implementation.

Update We encourage NHS England to engage with LMCs on this area.

A 35 LEWISHAM: That conference believes that general practice needs to be perceived as an equal partner in integrated healthcare systems, rather than a conduit for work and risk that other parties are reluctant to take on.

Update As above. We continue to stress the need for ICSs to engage with LMCs.

A 36 DEVON: That conference is concerned that in an attempt to reduce hospital bed occupancy in some areas of England palliative care patients are being discharged into nursing homes and community hospitals as temporary residents forcing GPs to take on important end of life care without the appropriate funding and resources.

Update We recognise this concern and are seeking to secure significant support for community based care as part of the long term plan as well as under our contract agreement.

A 37 DEVON: That conference is aware that in some areas two week wait does not mean what it says and demands NHS England step in to enforce this when required.

Update The BMA has been providing regular updates and have been calling on government to address this area.

A 38 REDBRIDGE: That conference calls for an end to the continued squeeze on health and social care budgets and that government realises that innovation, primary care at scale and joint working across health and social care cannot in itself be successful in delivering the government’s health and social care agenda without adequate resources, financial, educational, clinical and managerial.

Update We continue to lobby for investment in primary based care and the BMA has been lobbying for improvements to social care funding.

AR 39 HERTFORDSHIRE: Given the level of morbidity in nursing homes, conference urges GPC to negotiate for the NHS to commission a multidisciplinary care service, overseen by a community geriatrician, for patients in nursing homes.

Update We are working with NHS England for a service agreement for nursing care and residential homes.

AR 40 BRADFORD AND AIREDALE: That conference demands that all hospitals, including single specialty ones such as psychiatry, should provide primary care services for their in-patients and not expect this to be done by local general practices as part of their PMS/GMS contracts.

Update BMA guidance has been produced for this area.
A 41 LEEDS: That conference believes for primary care networks to function they must be provided with recurrent funding for:

i. GP leadership
ii. all practices to engage in its activities
iii. practice manager involvement
iv. administrative support.

Update  We have taken these issues forward as part of the ongoing discussions for the development of PCNs.

A 42 NORTH YORKSHIRE: That conference demands that for general practice to integrate with other services and work at scale it requires recurring funding thereby allowing organisation development and a resilient community based management structure to become the new norm.

Update  This work taken forward as part of the development of PCNs.

A 43 REDBRIDGE: That conference calls for an end to the continued squeeze on health and social care budgets and that government realises that innovation, primary care at scale and joint working across health and social care cannot in itself be successful in delivering the government’s health and social care agenda without adequate resources, financial, educational, clinical and managerial.

Update  We strongly agree and point to the significant lobbying the BMA has done on the need for more NHS and social care investment by government and the achievement we secured within the NHS Long Term Plan of an NHS first commitment to increase the proportion of investment in primary and community care.

A 44 EALING, HAMMERSMITH AND HOUNSLOW: That conference demands that if GP at Scale is to be successful then the NHS England needs to ensure that there is adequate recurrent funding made available to pay for these organisations to exist and that GP practices should not be funding such initiatives which are the chosen direction of NHS England.

Update  This has been taken forward as part of the recurring funding over 5 years with the development of PCNs.

A 45 HAMPSHIRE AND ISLE OF WIGHT: That conference calls for the GPC to negotiate that the New Care Models be adequately funded and properly re-numerate GP’s for their involvement.

Update  This has been taken forward as part of the recurring funding over 5 years with the development of PCNs.

A 46 LAMBETH: That conference demands that if the drive is to merge practices as part of the working at scale agenda:

i. additional resources and investment must be provided to enable clinical leadership engagement with the process
ii. ring-fenced resources, including backfill for clinicians, is essential.

Update  Through our 5 year agreement we have enabled practices to continue with the GMS and PMS contracts.
A 47 HERTFORDSHIRE: That conference values continuity of care and the registered list above passing trends for provision at scale: which lacks long term evidence of both improvements in patient care and practitioner morale alike.

Update  We agree on the importance of continuity of care and have reflected this as part of the work on PCNs and the Partnership Agreement.

AR 48 GLOUCESTERSHIRE: That conference is not surprised that continuity of care has been scientifically shown to provide a greater life expectancy and requests that the importance placed on primary care networks be thoroughly and scientifically evaluated and continuity of care maintained before all practices are coerced into adopting this method of working.

Update  We agree on the importance of continuity of care and have reflected this as part of the work on PCNs and the Partnership Agreement.

AR 49 NORFOLK AND WAVENEY: That conference asks for GPC guidance in dealing with the emergence of large super-practices and GP federations in order that LMCs may effectively represent general practice and individual GPs.

Update  We have focused on the support for practices working as part of PCNs who are also supported through GP federations.

A 50 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that GPs have no contractual responsibility for outbreak management, including mass prescribing for prophylaxis, and that this task is a responsibility of Public Health England. Conference instructs GPC to take all steps necessary to ensure that GPs are not coerced into undertaking this inappropriate work.

Update  This is being discussed as part of the Immunisations and Vaccinations Review.

A 51 DERBYSHIRE: The conference demands that GPC inform NHS England that their short-term approach to balancing the books in year, is a profoundly short-sighted approach to funding that risks patient safety and results in commissioning decisions that have the potential to cost substantially more in future years.

Update  We continue to share the concerns expressed by conference and have lobbied for this change. There is no current sign of the government moving away from annual budgeting.

A 52 BRENT: That conference condemns the underfunding of care for long term conditions in primary care and calls upon commissioners to ensure patient safety by adequately funding appropriate services and care pathways in general practice.

Update  We are seeking to address this through the £2.8 billion funding and additional funding as part of the long term plan.

A 53 DEVON: That conference demands that engagement of STPs with general practice is not seen as lip service by ensuring there is specific funding within their budgets for GP representatives to attend meetings at all levels within their developing management structures.

Update  The BMA’s work on STPs and ICSs is continuing with an explicit focus on the need for, and importance of, genuine clinical engagement. In October 2019, we published new guidance for members to support them in engaging with their local STPs and ICSs, which included a number of practical tips and tools. Earlier this year we also published a specific briefing on ICSs, which set out the BMA’s five principles for integration – including the need for demonstrable and meaningful engagement with clinicians. We are currently planning further work in this area, including on the state of clinical engagement.
A 54 MORECAMBE BAY: That conference believes that commissioners see the primary care estate as a free good and have ignored the need to develop the estate as part of the strategic Integrated Care Partnership intentions to transfer services out of hospital.

Update: We continue to engage with government on the importance of investment in GP Premises.

A 55 DERBYSHIRE: That conference calls upon GPC to highlight to NHS England and patients that whilst there is some protection of core GP funding, QIPP schemes that take funding away from secondary care and community services risks general practice picking up the shortfall to maintain patient safety.

Update: We are aware of this risk and are lobbying NHS England to preferentially invest in general practice and other community based services. This was reflected in the long term plan.

A 56 DERBYSHIRE: That conference believes that the funding for care in the community is inadequate and that:
   i. patients are suffering
   ii. general practice cannot be the safety net for deficiency in provision of services.

Update: We agree and have lobbied NHS England on this.

AR 57 DERBYSHIRE: The conference deplores the use of emotional blackmail and coercion by CCGs as means to compel general practice to provide unfunded, non-contractual work and calls upon GPC to empower GPs to say ‘no’.

Update: We continue to be clear to NHS England about the limits of the GMS contract and what work is contractual and what is not contractual.

AR 58 SOMERSET: That conference deplores the cuts forced upon local government to sexual and other public health services and:
   i. acknowledges that this is putting more pressure on already overstretched practice teams
   ii. instructs GPC to call out this unacceptable but entirely predictable result of the fragmentation of health services, and
   iii. instructs GPC to reiterate demands for properly funded public health services as being essential to a civilised, modern society.

Update: The BMA have been lobbying for increased investment in health and sexual other public health services.

AR 59 KENT: That conference urges the GPC to investigate ways of preventing the deleterious knock-on effects on practices neighbouring those that have access to greater CCG resources because they are failing.

Update: We have been seeking additional resources for all practices as part of the 5 year contract package.

A 60 SURREY: That conference believes in the light of the successful appeal by Dr Bawa Garba, has no confidence in the GMC as a professional regulator.

Update: Noted as BMA Policy.
A 61 CLEVELAND: That conference seeks a change to the Regulations to enable GPs on the Performers List in Scotland, Wales or Northern Ireland to work for up to eight weeks in England from the date that they have submitted an application for the England Performers List, or, if longer, such other period as the application takes to be approved.

Update Work Ongoing.

AR 62 OXFORDSHIRE: That conference believes the multiple jeopardy system of complaints against GPs within the NHS is iniquitous, onerous and disproportionately punitive, and:

i. believes the system of allowing multiple simultaneous complaints to be made in parallel promotes a blame culture within the NHS
ii. calls on GPC to work with stakeholder agencies to develop a streamlined and fair hierarchical pathway for GP complaints
iii. calls on GPC to demand a system which allows vexatious complaints to be identified as such and more easily refuted.

Update Noted as Policy / Work ongoing. This is also been taken forward under the caring and collaborative project and this includes the impact on mental health and well being of GPs.

AR 63 MANCHESTER: That conference notes the increasing numbers of ‘complaints’ submitted to NHS general practice surgeries that have no justification based on the NHS contract held by the surgery, published professional standards, or requirements under the Health and Social Care Act and:

i. is concerned that responding to these ‘complaints’ takes resources away from patient care and negatively affects the morale of doctors and other surgery staff
ii. has no confidence in the NHS complaints process
iii. calls for a complete overhaul of the NHS complaints process

Update Noted as Policy and work is ongoing in this area to try and address these concerns.

AR 64 NORFOLK AND WAVENEY: That conference believes that NHS Choices patient feedback is demoralising rather than constructive and calls on GPC to negotiate changes to protect practices and individuals from illfounded criticism.

Update We are currently working with NHS England on resolving long standing concerns about NHS choices.

A 65 CLEVELAND: That conference asserts that the time take to process Performers List applications in England in England is unacceptably long and exacerbates the workforce crisis; conference therefore demands a maximum allowance time target of six weeks and that this be no longer than the time taken in the other UK countries.

Update We share the concerns of conference and are continuing to work with NHS England and Capita to manage the performers list.

A 66 NORTHAMPTONSHIRE: That conference demands that general practices have the right to close their patient list when they consider that they have reached capacity to deliver safe patient care.

Update GMS and PMS practices can apply formally to close the practice list, and may choose to do so if they find their level of workload is jeopardising their ability to provide safe care for their registered patients, or to carry out their contractual obligations to meet their patients’ core clinical needs.
**A 67 LEICESTER, LEICESTERSHIRE AND RUTLAND**: That conference calls upon GPC to define core and non-core GP services.

**Update**  
As part of the current contract agreement, we have been clear about what work is part of the GMS agreement. Through development of services specs as part of the 5 year contract agreements we will be making clear what is additional to core GMS.

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**A 68 NORFOLK AND WAVENEY**: That conference instructs the GPC negotiating team that they cannot allow our core GMS contract opening hours to go beyond 8-6.30 Monday to Friday.

**Update**  
We have achieved this through the contract agreement.

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**AR 69 NORTHAMPTONSHIRE**: That conference demands that the process for closing lists is simplified, made transparent and not at the arbitrary judgement of NHS England.

**Update**  
GPC has raised concerns with NHS England about list closure and dispersal processes adopted by local commissioners and asked NHS England to review and investigate these and develop supporting guidance/best practice which could be shared with local commissioners and LMCs. These concerns were reviewed and discussed with NHS England local teams, including dedicated follow up meetings with North and London regional teams.

In addition, local teams identified opportunities to improve the dispersal procedure identified in NHS England’s Policy and Guidance Manual.

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**AR 70 HERTFORDSHIRE**: That conference believes that, where a practice is handing back its GMS contract, the money currently made available for the procurement and delivery of new APMS contracts (including caretaker contracts) should be made available to local practices to take over the running of the practice terminating its contract, under their existing GMS contract.

**Update**  
We hope as part of the development of PCNs that practices in difficulties be supported to avoid the potential for their contracts to be lost.

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**AR 71 SURREY**: That conference believes commissioner approval should not be required for a GP contractor to close their list [under the current regulations] for a cumulative maximum period of six months in any two years.

**Update**  
This is something the contract and regulation policy group are taking forward.

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**AR 72 BIRMINGHAM**: That conference believes that GP out of hours services:

i. should remain defined as Primary Medical Services

ii. should not be separated into a collection of sub-specialist services under the title of “urgent care”

iii. should principally be aimed at supporting GP practices in providing appropriate patient access to primary medical services at all times

**Update**  
We agree with this motion and this continues to be the current situation.
AR 73 MID MERSEY: That conference believes it is wrong that practices do not receive a quarterly payment for newly registered patients who die before the end of a quarter and that this particularly disadvantages practices providing palliative care for patients in the end stages of life and asks GPC to negotiate a quarterly payment for patients in this final period that is at least proportionate to the number of weeks lived prior to death.

**Update** We have raised this issue with NHS England but they are reluctant to move away from current payment arrangements.

All practices have the contractual right to decline to register any new patients without having to go through the formal processes and without needing to obtain area team permission.

The legal position regarding the grant of APMS contracts is not clear, but EU procurement rules suggest they must be offered in the event of a GMS contract being handed back.

AR 74 LEICESTER, LEICESTERSHIRE AND RUTLAND: The conference considers that GP appointments are increased from 10 to 15 minutes as a minimum.

**Update** There is no stipulation for practices to offer 10 minute consultations, those wanting to move away will require additional workforce and we are continuing to push for this.

AR 75 WEST SUSSEX: That conference:

i. believes GP workload is unsustainable
ii. demands a cap on the number of patient consultations that can be undertaken by each GP per working day is introduced
iii. that commissioners are responsible for providing NHS services to patients requiring same care once the cap is reached.

**Update** We are continuing to seek additional resources and expand the workforce to better manage workloads and determine the number of consultations they offer.

AR 76 KENT: That conference demands a GP contract which sets a safe daily limit of all patient contacts with

i. overflow being funded/provided by additional/enhanced services
ii. the ability for practices to declare a black alert and close to further activity.

**Update** We have secured additional funding not only in global sum but also for PCNs.

AR 77 HARINGEY: That conference supports GPC to demand an end to the “all you can eat buffet” view of general practice propagated by the Department of Health and NHS England and calls for the recognition of the increased workload in general practice by increased investment into the global sum.

**Update** Increased training has been provided to general practice.
AR 78 BEXLEY: That conference with regards to sick certification:
notes that a large proportion of time is spent in general practice preparing sick notes for
the benefit of DWP
i. notes that most patients with ongoing chronic issues need occupational health
assessment to assess their fitness to work
ii. recognises that GPs are not trained to do this work and there can be untoward medico-
legal consequences of signing a sick note when it can be considered fraudulent
iii. requires sick notes for chronic conditions be removed from the GP remit
iv. requires hospital teams to fulfil their contractual obligation and generate sick notes for
patients under their care.

Update: The Contracts and Regulation policy group is currently developing guidance
on non-contractual letters and reports in conjunction with the Professional
Fees Committee.

A 79 SEFTON: That conference calls upon the GPC to engage with the GMC and HEE to
agree a reduction of the bureaucratic burden on appraisers of conducting GP appraisal(s).

Update: Working on appraisals.

A 80 KENT: That conference proposes that GP trainees should be primarily based in
general practices with shorter secondments to secondary care for specialist experience.

Update: We are engaging with NHS and Government on securing increased training in
GP settings.

A 81 THE GPC: That the GPC seeks the views of conference on the following motion from
the GP Trainees subcommittee: That conference is concerned that junior doctors are
burning out and struggling with their workload. With the King’s fund announcing qualified
GPs work on average 3.5 days we call upon GPC to work with relevant bodies to:

i. allow trainees to work at less than full time for any reason
ii. allow trainees to work at any percentage with appropriate notice
iii. encourage the filling in of exception reporting for heavy workloads.

Update: Work ongoing.

A 82 THE GPC: That the GPC seeks the views of conference on the following motion from
the GP Trainees subcommittee: That conference mandates that GPC England to work
with relevant bodies to ensure that all Foundation Year doctors have a placement in the
community as required by the Collins report.

Update: Work ongoing.

A 83 THE GPC: That the GPC seeks the views of conference on the following motion from
the GP Trainees subcommittee: That conference recognises that ways of working in GP
have changed, and that full time equivalent hours are often worked in less than 5 days. This
conference calls on GPC to recognise that:

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

Update: Noted as policy.
AR 84 HERTFORDSHIRE: That conference notes with concern, examples where GPs working in secure environments are being asked by employers to forward their NHS GP appraisal outputs as a reference tool and test of competence, conference:

i. believes this is a gross misuse of the appraisal process and that there are no such requirements for outputs to go to new employers, and

ii. calls on the GPC to work with NHS England and employers in insuring appropriate appraisal systems are in place with community providers employing GPs in particular roles, and that these are appropriate, reasonable and resourced.

Update  Noted as policy/work ongoing

A 85 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon GPC to negotiate a change in the GP contract to allow GPs to charge their patients for services not supplied by the NHS including minor surgery not provided by the NHS, acupuncture where not provided by the NHS and flu vaccinations to patients that are not entitled to a NHS flu vaccination.

Update  This has been raised with NHS England to secure these changes.

A 86 OXFORDSHIRE: That conference mandates GPC to negotiate the contractual freedom for GPs, as independent contractors, to provide and directly charge their registered patients for treatment not available on the NHS.

Update  This issue was raised as part of the 2018/19 contract negotiations. GPC England is concerned about the confusion for patients of seeing their NHS GP but still having to pay for certain services, without this being made explicitly clear.

A 87 NORFOLK AND WAVENEY: That conference asks GPC to renegotiate the GP contract to allow practices to charge their own registered patients for services not included in this contract.

A 88 HAMPSHIRE AND ISLE OF WIGHT: That conference instructs GPC to end the anomaly whereby general practitioners are unable to provide services privately to their registered list due to the constraints of the GMS contract. (Supported by Bath & North East Somerset, Swindon & Wiltshire)

Update  The five year GP contract agreement provided £2.8bn of additional funding to general practice over the next five years, increasing the GP proportion of NHS spend.

A 89 LEEDS: That conference believes general practice will be the foundation on which other NHS services are developed within NHS England's long-term plan and therefore insists that general practice is prioritised for funding from the £20bn committed by government.

Update  We have secure £2.8 billion for additional funding with an extra 4.5 billion being invested over the next 5 years

AR 90 BEDFORDSHIRE: Given that in 2017 conference resolved that it ‘insists that as independent contractors, GPs should be permitted to provide and directly charge their registered patients for treatment not available on the NHS’ we now call on GPC England to make this a key issue in negotiations for the GMS contract.

Update  We have lobbied on this area but NHS England are not engaging with us in this area.
AR 91 DEVON: That conference requests that GPC ensures that NHS England proactively invests in general practice in areas on the brink instead of waiting until contracts are handed back.

Update  We have secured a 5 year agreement for £2.8 billion.

A 92 NORTHAMPTONSHIRE: That conference insists that serious consideration be given to the appalling state of some primary care estate and that pressure is brought to bear centrally to properly fund it.

Update  We have recently written to the Prime Minister to seek investment in primary care premises.

A 93 NORTHAMPTONSHIRE: That conference insists that NHS England arranges to buy practice premises off struggling partners who are unable to continue to practice.

Update  The BMA submission for the 2019 spending round urged HM Treasury to direct vital funding into primary care to support premises, which was also called for in the premises review.

GPC pushed for this as part of negotiations over development of the GP Premises Review. The published review moves in the right direction stating that NHSE will stand behind practices as a last resort where they have been identified as having ongoing importance for delivery of services in the STP or ICS’s estates strategy.

A 94 SOMERSET: That conference believes that sessional doctors should enjoy the same NHS Pension rights as the rest of the workforce and in particular death in service benefits.

Update  GPC England and the new BMA Pensions Committee continues to push for this.

A 95 WOLVERHAMPTON: That Conference believes with the Data Protection Act 2018 removing the ability to charge up to £50 for the provision of Medical Records, the extra costs incurred by practices in providing such records should now be matched by an uplift in funding from NHS England and that GPC should assess the extra costs to practices and negotiate with NHS England to secure such funding to bridge the gap.

A 96 HILLINGDON: That conference is concerned about the increase cost to practices in implementing GDPR and instructs the GPC to negotiate an increase in the global sum to negate this cost.

A 97 GATESHEAD AND SOUTH TYNESIDE: That conference directs the GPC to enter into negotiations with NHS England to remunerate practices for the additional unresourced work arising from GDPR, in particular the burden of subject access requests.

A 98 MID MERSEY: That conference believes that providing data following a Subject Access Request under General Data Protection Regulations should be cost neutral.

A 99 NORTH ESSEX: That conference instructs GPC to devise a national assurance process with NHS England that ensures all Data Sharing Agreements are GDPR compliant, have a legal basis and are ethically sound before being circulated to practices.

A 100 GATESHEAD AND SOUTH TYNESIDE: That conference believes that the role of data controller is no longer compatible with modern general practice because:

i. the time and financial resources taken up by this activity impede the ability of practices to deliver clinical care

ii. it causes an unacceptable risk to individual practices who may inadvertently breach regulations

iii. the role would be better taken over by a dedicated team at NHS England allowing practices to concentrate on clinical care.
**A 101 BEDFORDSHIRE:** That conference feels that the problems around processing medical records for the many people who can and do request them creates impossible burdens for the dwindling numbers of GPs who are already overworked and calls for GPC England to put the case to the government to relieve GPs of the role of data controllers for medical records, or call for provision of centralized clinically trained staff to check records for third party references or clinically sensitive information.

**Update**
Under the new GP contract GPC has secured £20 million of additional funding to help practices deal with SARs for the next three years. The extra funding ends in 2022, by when three changes will have happened that remove the burden on subject access requests: (i) the digitalisation of Lloyd-George paper records is completed; (ii) patients have access to these full digital records; and (iii) DHSC guidance makes clear that patients or their representatives can now access all the necessary information directly.

Under the contract, CCGs are responsible for offering a Data Protection Officer (DPO) function to practices in addition to their existing DPO support services, whether by the CCG directly or through its commissioning support service.

**A 102 NORTH ESSEX:** That conference requests GPC ensures that NHS England Area Teams provide a named person to address any patient safety concerns raised by patients or LMCs in order to alleviate increasing problems caused by blurred lines of accountability between NHS England and CCGs.

**Update**
GPC has condemned the statements made by NHS England about small practices and NHS England has also stated their intention for all practices, no matter their size, to be able to thrive.

**A 103 NORTHAMPTONSHIRE:** That conference supports the benefits of small local GP surgeries, and calls on NHS England to publicly support their survival in view of the comments of Dr Arvind Madan in his previous role.

**Update**
The 5 year contract agreement is built on the existing GMS/PMS contract thereby enabling practices to support each other, particularly for smaller practices.

**A 104 AVON:** That conference is appalled by the comments of the recently resigned Director of Primary Care for NHS England and demands that NHS England makes a public statement in support of small practices.

**A 105 HERTFORDSHIRE:** That conference asks GPC to celebrate general practice in all its shapes and sizes, as it is precisely this individuality which enables practices to continue to provide world class primary care tailored to their unique populations. GPC cannot allow NHS England to undermine this very essence of primary care.

**A 106 HAMPSHIRE AND ISLE OF WIGHT:** That conference notes that NHS England does not publish their own complaints procedures for individuals or organisations that wish to make a complaint about NHS England. We believe in the interests of transparency that this complaints procedure should be given equal prominence to their publication of the procedure for complaints against GPs.

**AR 107 LAMBETH:** That conference calls upon all policy decisions made by NHS England/Department of Health to be properly founded on an evidence based rationale, rather than the latest ideas and whims of the Secretary of State.

**Update**
We have highlighted this to NHS England
A 108 KENT: That conference calls for regulation of the MDOs and demands:
  i. transparency from MDOs in the processing of applications and calculation of indemnity fees
  ii. independent and unified appeal process for doctors whose application for indemnity cover is rejected.

A 109 DERBYSHIRE: That conference believes that with an increasingly mobile workforce and salaried GP indemnity often being paid by practices, conference is concerned about the impact of the requirement for run-off cover for claims based indemnity which could leave both practices and GPs with inadequate medical indemnity. Whilst a state backed indemnity scheme is pending, we urge GPC to create some robust guidance on this issue for practices.

Update This issue has been largely superseded by the new stated funded indemnity scheme allowing all GPs to receive indemnity cover.

A 110 AVON: That conference is dismayed about the lack of information about the state funded indemnity scheme for GPs, which is due to commence in April 2019. It requests the GPC to seek reassurance and public confirmation from government that the scheme will commence on time and as planned.

A 111 HAMPSHIRE AND ISLE OF WIGHT: That conference demands the issue of indemnity is sorted once and for all.

A 112 CLEVELAND: That conference welcomes the state backed indemnity scheme expected to commence in April 2019 and requires:
  i. clarity on the content of the scheme several months prior to its implementation
  ii. adequate run off cover for those who have recently left NHS general practice
  iii. a scheme which is equitable to all GPs, regardless of their current indemnity provider
  iv. a scheme which ensures adequate cover for all practice staff and trainees working within practices.

Update We have secured a state funded indemnity scheme to cover all GPs work.

A 113 CHESHIRE: That conference recognises the need to ensure that all locally agreed levies are collected and forwarded to LMCs whatever the future primary medical services contractual relationships may be.

Update There has been no changes to primary care medical services contract as part of our 5 year agreement.

A 114 MANCHESTER: That conference agrees GPC should provide formal feedback on actions taken as a result of carried motions from the previous conference.

Update We are proceeding as per the report.
A 115 NORTH YORKSHIRE: That conference instructs GPC to demand that CCGs demonstrate their engagement with sessional/locum GPs working in their area. This engagement should at the very least include:

i. establishing direct communication of updates/bulletins/local developments with sessional/locum GPs via CCG email distribution lists
ii. inviting sessional/locum GPs to CCG educational events
iii. providing equitable access to mandatory training for sessional/locum GPs as they would to GP partners for personal development
iv. offering equitable opportunities for learning and development to sessional/locum GPs as they would to GP partners for personal development
v. allowing sessional/locum GPs to contribute to local general practice via the CCG even if they are not aligned with a practice by inviting them to local development events and advertising CCG roles to them.

Update GPC England and the Sessional GPs Committee provide regular updates to LMCs to support this work

A 116 DERBYSHIRE: That conference believes that with general practice transforming to create new models of care, the make-up of our practice workforce is changing. We ask GPC to negotiate with NHS England to ensure that the SFE for sickness cover and maternity leave extends to all allied health professionals as a matter of urgency.

Update We have been seeking cover but as of yet NHS England and the government have limited funds to cover this area, but we will continue to take this issue forward.

A 117 BRADFORD AND AIREDALE: That conference instructs that policy makers should prioritise improving GP continuity of care over extended access as there is mounting evidence in the past year that this is a more cost-effective way of achieving positive health outcomes including improved mortality, patient satisfaction and reduced A+E admission

A 118 NORFOLK AND WAVENEY: That conference believes that the current Improved Access pilot scheme poses risks to the supply of clinical staff to both in-hours and OOHs by spreading a depleted workforce even more thinly and asks for a proper impact assessment.

Update We have made these points repeatedly to NHS England and Government

A 119 DERBYSHIRE: That conference is deeply concerned that with 2020 less than 18 months away rather than achieving a net increase of 5000 new GPs, recent figures have shown both Headcount and FTE numbers are continuing to drop.

Update We have highlighted the need to recruit and retain GPs.

A 120 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon the poor performance of the International GP recruitment scheme and the waste of valuable research. Conference calls upon GPC to negotiate transfer of resources local initiatives to ease workload.

Update We continue to work with Government to fund better ways to recruit, including for overseas medical graduates.

A 121 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference calls upon the GPC to make the process easier and simpler for GPs returning back to the UK, as currently they are finding the paperwork and retraining involved a challenge

Update We continue to seek improvements to reduce the burden of bureaucracy that prevents GPs returning to the UK
A 122 GLOUCESTERSHIRE: That conference is dismayed at the large sums of money spent on trying to recruit overseas doctors yet failing to prioritise recruitment and retention of GPs who have been trained and are often well-established in the UK.

Update: We continue to work with Government to fund better ways to recruit, including for overseas medical graduates.

A 123 NORFOLK AND WAVENEY: That conference asks GPC to hold the government to account for the promised provision of 5000 extra whole time equivalent GPs by 2020.

A 124 REDBRIDGE: That conference, having welcomed the previous Secretary of State’s announcement of 5000 extra GPs are dismayed that at present there are 1000 fewer and move that the current Health Secretary take urgent action to address the significant workforce issues facing general practice.

Update: We are holding government to account and continue to push for increase in GP numbers.

A 125 KINGSTON AND RICHMOND: That conference believes comprehensive NHS Occupational Health Services should be available to all staff working in GP practices

Update: We continue to push for comprehensive occupational health service and believe that this is essential general practice.

A 126 SURREY: That conference has no confidence in the GP Forward View as the vehicle to provide the required investment needed to safeguard the future of NHS general practice.

AR 127 DERBYSHIRE: That conference notes GPCs own report of GPFV which showed a multitude of deficiencies, hoop jumping and failure to deliver promised funding. This affirms conference’s previous vote of no confidence in the GPFV. Conference therefore asks again for GPC to declare that the GPFV has failed.

AR 128 HEREFORDSHIRE: That conference agree that the GP Forward View has yet to deliver any substantive investment direct to practices to allow the expansion of the professional teams needed to provide primary care services fit for the future.

Update: The GPFV has been superseded by the five year GP contract framework.

AR 129 AVON: That conference calls on NHS England to make it mandatory that CCGs publish transparently and accurately how GP Forward View monies are being spent or wasted.

AR 130 GREENWICH: That conference believes that the aspirations of the GP Forward View have not materialised, with most practices not seeing any significant benefits on the ground; to make general practice sustainable we need funding which is directed to practices, who should also be involved in how resources are used.

AR 131 NORTH YORKSHIRE: That conference believes given the ongoing failure of the GPFV to provide the much needed lifeline directly to general practice and the failure of adequate improvements being achieved within the last year, conference demands that GPC England publicly dissociate itself from GP Forward View.

Update: We continue to monitor this area including historic spend on GPFV