



Special Conference of England LMC Representatives Agenda

11 March at The Mermaid Conference Centre, London



Special Conference of England LMC Representatives

Agenda

To be held on

Wednesday 11 March 2020 at 10.30am

At The Mermaid Conference Centre, Puddle Dock, London EC4V 3DB

Chair Rachel McMahon (Cleveland)

Deputy Chair Shaba Nabi (Avon)

Conference Agenda Committee

Rachel McMahon (Chair of Conference)

Shaba Nabi (Deputy Chair of Conference)

Matt Mayer (Buckinghamshire)

Zoe Norris (Yorkshire)

Roger Scott (Liverpool)

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 21 February 2020. Although 21 February 2020 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 – Richard Pursand - 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 order 24 ('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'.

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.

Schedule of business

Wednesday 11 March 2020

Item	Time
Opening business	10.30
2020 / 2021 Contract Negotiations	10.50
GP Workforce	11.10
Vaccinations and Immunisations	12.10
Access	12.20
PCN DES	12.40
Lunch	13.00
PCN Opt Out	14.00
PCN Workload	14.20
PCN Specifications	14.30
Investment and Impact Fund	15.00
ARRS – Themed Debate	15.10
ARRS	16.00
Future of PCNs	16.20
Close	17.10

OPENING BUSINESS

10.30

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

STANDING ORDERS

- 2 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the standing orders (appended), be adopted as the standing orders of the meeting.
- 3 THE CHAIR: That GPC England have convened a special conference of representatives of local medical committees in England to "consider the outcome of the 2020 / 21 GP contract negotiations and what action the profession should take" be received.

REPORT OF THE AGENDA COMMITTEE

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

2020 / 2021 CONTRACT NEGOTIATIONS

10.50

- * 5 AGENDA COMMITTEE TO BE PROPOSED BY HULL AND EAST YORKSHIRE: That conference believes:
 - (i) the contract agreement of 2019/20 was mis-sold as a 'five year deal' when it was actually only a 'one year deal'
 - (ii) broader engagement with the profession on proposed GP contract changes is to be commended and to be repeated prior to commencing future negotiations
 - (iii) GPC England should not have agreed the 2020 / 2021 contract update, knowing that this special conference was to be held to debate the proposed agreement
 - (iv) for the 2021 / 2022 contract, a conference of England LMCs should be held to determine acceptance of the negotiated changes prior to any agreement by GPC England
 - (v) that only GPC England have the authority to negotiate on behalf of the profession.
- 5a HULL AND EAST YORKSHIRE: That conference believes:
 - (i) broader engagement with the profession by NHSE on proposed GP contract changes is to be commended
 - (ii) in future years, NHSE should repeat their consultation with the profession prior to commencing negotiations
 - (iii) changes to the 2021/22 contract should be presented to a Conference of England LMCs prior to any agreement by GPC England
 - (iv) that such conference of England LMCs are empowered to debate, and vote on any proposed contract.
- 5b HULL AND EAST YORKSHIRE: That conference believes GPC England should not have agreed the 2020 / 2021 contract update, knowing that this special conference was to be held to debate the proposed agreement.

- 5c LINCOLNSHIRE: That conference is angered that the "five year contract agreement" sold to the profession in 2019/20 was actually only a "one year deal" and insists that GPC England and NHSE do not make any further changes until 2024, as promised.
- 5d OXFORDSHIRE: That conference believes that the GPC England Executive has twice shown inability to negotiate a contract change in the best interests of general practice. As a result, for the 2021 / 2022 contract, a special conference should be held again to determine acceptance of the negotiated changes prior to any agreement by GPC England.
- 5e WALTHAM FOREST: That conference is dismayed at the lack of detail of the 'hailed' updated contract negotiations and finds it surprising that agreement is seemingly to have been accepted before being put to the profession.
- 5f DERBYSHIRE: That conference demands that any further significant changes to the GMS contract proposed by NHS England must first be ratified by a ballot of all GPs.
- 5g NORTHAMPTONSHIRE: That conference insists that the GPC England is the GP contract negotiating body and that other organisations should not play any significant role in contract design.
- 5h CLEVELAND: That conference rejects the public consultation on the PCN DES service specifications as a negotiating strategy and reaffirms that only GPC England have the authority to negotiate on behalf of the profession.
- 5i NORTH YORKSHIRE: That conference believes that if the wider view of LMCs or the profession is required to inform NHSE / GPC views this is done before negotiations take place so that we can then allow our elected representatives to freely negotiate on our behalf.
- 5j DEVON: Due to the recent disastrous NHSE/I DES specification consultation process, conference demands that:
- (i) the four specifications that are to be introduced in 2021 are consulted upon by the whole profession to inform the negotiation process
 - (ii) any consultation of the profession is undertaken by GPC England
 - (iii) any consultation is completed in adequate time to allow six months' notice of the intended start date of the specification following the end of negotiations.
- 5k CENTRAL LANCASHIRE: That conference:
- (i) fully supports the GPC England negotiating team in its endeavours to secure agreements with NHSE to protect, preserve and enhance general practice
 - (ii) believes that the Contract Agreement for 20 / 21 represents a positive step forward in supporting the partnership model within a PCN environment
 - (iii) believes that the agreement allows PCNs to develop at a pace commensurate with resources and without over prescriptive and arbitrary targets
 - (iv) accepts the apologies for non-attendance at this special conference from Lancashire & Cumbria LMC members in view of the need to maintain clinical cover in an area with severe workforce shortages.
- [Supported by Cumbria, Lancashire Coastal, Lancashire Pennine and Morecambe Bay LMCs]
- 5l NOTTINGHAMSHIRE: That conference regrets the wrecking of goodwill that NHSE/I perpetrated towards PCNs with their poor draft service specs and implores GPC England to push for future revisions to be negotiated correctly out of the public eye.
- 5m SOMERSET: That conference approves NHSEs submitting draft policies like the PCN DES for consultation to involve front line workforce but instructs GPC England to refuse to engage in such negotiations in future unless agreement in principle has been reached, citing the impact this can have on workforce moral and engagement.

- 5n LIVERPOOL: That conference is appalled at the timing of the release of the draft PCN specification for 2020 / 2021 and requires future specification consultations to be released distant from natural breaks such as Christmas and to allow sufficient time for meaningful assessment of the implications of the specifications for individual practices.
- 5o HERTFORDSHIRE: That conference instructs GPC England, as part of accepting the huge proposed changes planned for April 2020, to negotiate a four year block on any further contract changes (including QOF) in order to allow PCNs to thrive and develop.
- 5p LEEDS: That conference insists that the four service specifications to be introduced to the contract from 2021:
 - (i) must be negotiated and agreed with GPC England before introduction
 - (ii) must be significantly reduced in scope and requirement from the previous December 2019 drafts
 - (iii) must not include any targets for performance management
 - (iv) can only be delivered in line with the availability and capacity of ARRS funded workforce
 - (v) must not add additional burden to GPs or existing practice staff.
- 5q HULL AND EAST YORKSHIRE: That conference insists on meaningful consultation with the profession by GPC England and NHSE on all future PCN services specifications, in advance of any contract agreement.
- 5r CAMBRIDGESHIRE: That conference wishes to censure GPC England for prematurely voting to accept the 2020 / 2021 PCN DES update and not allowing the profession to exercise its judgement at this special conference.
- 5s HULL AND EAST YORKSHIRE: That conference calls for the removal of GPC England's ability to unilaterally agree future contract packages, and insists this responsibility moves to the LMC England conference.

GP WORKFORCE

11.10

Pay Transparency

- * 6 AGENDA COMMITTEE TO BE PROPOSED BY NORTH AND NORTH EAST LINCOLNSHIRE: That conference, regarding pay transparency:
 - (i) believes that the naming of individual GPs with total NHS earnings above a given threshold would be misleading, risk disincentivising the recruitment of partners, and encourage colleagues to work less
 - (ii) entirely rejects the naming of individual GPs with total NHS earnings above a given threshold
 - (iii) calls for earnings to be published anonymously by age band, gender, and HEE region, as for consultant colleagues.
- 6a NORTH AND NORTH EAST LINCOLNSHIRE: That conference, regarding pay transparency:
 - (i) entirely rejects the naming of individual GPs with total NHS earnings above £150,000
 - (ii) calls for such earnings to be published anonymously via age band, gender, and HEE region as for consultant colleagues.

- 6b BERKSHIRE: That conference believes that the naming of GPs who earn more than £150k is draconian, misleading given that it does not represent a true gross salary, and it serves no purpose other than to disincentivise the recruitment of partners and should be removed from the contract in 2021/22.
- 6c SUFFOLK: That conference reminds GPC England that any activity that encourages colleagues to work less will not improve capacity eg the GP salary reporting requirement.
- 6d WALTHAM FOREST: That conference rejects the agreement that GPs should have to declare earnings without reflection of the hours worked or the level of responsibilities for GPs.
- 6e LAMBETH: That conference:
 - (i) does not consider it appropriate that GPs have to declare their NHS earnings
 - (ii) demands that if the requirement for GPs to declare their NHS earnings goes ahead it should apply to all public sector workers
 - (iii) demands that when information about GPs' earnings are released it should be accompanied by an explanation that both employer and employee sides of the highest rate of superannuation have to be paid out of the total earnings.

Partnership Incentives

- * 7 AGENDA COMMITTEE TO BE PROPOSED BY BERKSHIRE: That conference welcomes the new partner financial incentive, and calls on GPC England to:
 - (i) negotiate for it to be made available to all new partners including those who have been in partnership before
 - (ii) work with relevant stakeholders to ensure that appropriate training options are commissioned to maximise the use of the business training allowance
 - (iii) negotiate that it only be tied to remaining as a partner for three years
 - (iv) negotiate that it be tax free.
- 7a BERKSHIRE: That conference welcomes the new partner financial incentive but:
 - (i) calls for it to be made available to all new partners including those who have been in partnership before
 - (ii) calls on GPC England to negotiate that it be tax free
 - (iii) calls on GPC England to negotiate that it only be tied to remain as a partner for three years.
- 7b CLEVELAND: That conference welcomes the business training allowance for new partners, and mandates GPC England to work with relevant stakeholders to ensure that appropriate training options be commissioned to maximise the use of this valuable funding.
- 7c LEEDS: That conference welcomes initiatives in the contract to encourage new GP partners and believes that seniority payment structures need to be revitalised to retain experienced GPs.
- 7d NOTTINGHAMSHIRE: That conference recognises that recruitment to partnership has been a problem for a long time. Therefore, conference mandates GPC England and Exec team to flex the £20,000 new to partnership incentive by:
 - (i) reducing that loan period for GPs who have never been partners to three years rather than five years
 - (ii) to include GPs who have been partners within the past 50 years, so that we continue to promote partnership model and to encourage GPs who have left partnership.
- 7e LEEDS: That conference supports the partnership model of working and believes the partnership premium scheme should be open to both new and former partners.

- 7f NORTH ESSEX: That conference believes partnership premiums should be available to all GPs returning to partnership after a significant break.
- 7g GATESHEAD AND SOUTH TYNESIDE: That conference welcomes the recognition by NHSE of the value of partnership but deplores the limitation of it to only those who have never before been partners and calls for the partnership incentive to be widened appropriate to the value and experience that former partners bring.
- 7h KENT: That conference demands that the new partnership payment be extended to:
- (i) GPs working for limited companies that hold a GMS contract
 - (ii) include GPs returning to partnership after a break
 - (iii) include salaried GPs
 - (iv) include part-time GPs on a pro-rata basis.
- 7i SESSIONAL GPs COMMITTEE: That conference, in regards to the new to partnership payment:
- (i) welcomes any financial support to GPs who wish to make a new commitment to GP partnership
 - (ii) condemns the exclusion of GPs who have previously been partners from this scheme
 - (iii) demands that the scheme is immediately amended to make it available to all sessional GPs who have not held a GP contractor position within the past two years.
- 7j NORTHAMPTONSHIRE: That conference insists that, despite the recently agreed changes to the GMS contract, there should be more incentives to attract and retain GPs particularly in the partnership model.
- 7k SUFFOLK: That conference welcomes the direction of travel of encouragement for GPs to become partners.
- 7l HERTFORDSHIRE: That conference calls on GPC England to negotiate that an annual payment (pro rata) per partner should be made to practices to recognise the additional workload and responsibility associated with partnership.

Fellowships

- * 8 GP TRAINEES COMMITTEE: That conference believes fellowships as outlined in the new English GP contract may offer positive opportunities for newly qualified GPs, however these posts must:
- (i) not be mandatory or an extension to training
 - (ii) have safeguards of continued NHS service (including, but not limited to, maternity pay, shared parental leave and pension contributions)
 - (iii) attract the appropriate salary reflecting expected earnings of a comparable salaried post
 - (iv) have a clearly defined and agreed job plan that is not solely focussed on service delivery
 - (v) offer the same contractual safeguards and provisions as the BMA model contract for salaried GPs.
- 8a CLEVELAND: That conference has grave concerns that the new Fellowship Programme will force fully qualified GPs into poor quality roles focussed on service delivery and will be undeliverable due to premises problems and insists that making general practice in England a more attractive place to work is the long-term solution to workforce gaps.
- 8b LAMBETH: That conference welcomes the elements regarding newly qualified GPs but notes that one size does not fit all and requests that the appropriate funding be devolved for local solutions.
- 8c NORTH ESSEX: That conference believes GP fellowships should be optional and available to any interested GP.

GP Head Count

- * 9 REDBRIDGE: That conference insists that only fully qualified GPs should be counted when reporting the number of GP whole time equivalents and that including doctors in GP training or the term 'doctors working in general practice' is misleading to the public and creates unrealistic expectations.

Premises

- * 10 NORTHAMPTONSHIRE: That conference demands that funding for premises be made available urgently to house additional workers in general practice.
- 10a COUNTY DURHAM AND DARLINGTON: That conference recognises that many practices lack the facilities to accommodate additional staff and insists that there is easily accessible substantive investment in GP premises.
- 10b COUNTY DURHAM AND DARLINGTON: That conference recognises that many practices lack the facilities to accommodate GP registrars spending more of their time in general practice and insists that there is easily accessible substantive investment in GP premises.
- 10c CLEVELAND: That conference has grave concerns that increased numbers of GP training posts will be undeliverable due to premises and workforce capacity issues and demands additional contractual support to fill gaps in these areas.
- 10d LEEDS: That conference, in order to be able to accommodate the increase in workforce supporting general practices, increased training requirements and provision of services for an increased population, calls on the government to significantly increase investment into general practice premises.
- 10e MERTON: That conference welcomes the somewhat improved financials around ARRS but calls upon government to immediately commit to investing in primary care and general practice premises, without which there is nowhere to accommodate the increasing size of the workforce.
- 10f BERKSHIRE: That conference is deeply concerned that general practice is not adequately supported in managing the growth of ARRS staff over the next 4 years - particularly in regard to investment in premises, professional development and clinical supervision of the new staff and calls for further funding to be negotiated to cover these costs.

VACCINATIONS AND IMMUNISATIONS

12.10

- * 11 DERBYSHIRE: That conference believes that clawing back vaccination payments when 80% targets have not been met is punitive and should be replaced with an additional reward payment for practices that achieve over 90% uptake.

Continuity of Care

- * 12 AGENDA COMMITTEE TO BE PROPOSED BY NORTH ESSEX: That conference instructs GPC England to ensure that the new patient quality access scheme:
 - (i) places greater value on fewer but better quality consultations
 - (ii) gives incentives to practices for increasingly offering 15 minute and variably timed appointments.
 - (iii) values access that improves continuity of care
 - (iv) should be refused until sufficient new capacity is in post and trained to meet any predicted increase in demand.
- 12a NORTH ESSEX: That conference instructs GPC England to ensure that the new patient quality access scheme gives incentives to practices for increasingly offering 15 minute and variably timed appointments.
- 12b LEEDS: That conference believes the simplistic counting of general practice appointments as a measure of improving access is misleading and could be counterproductive, and calls on the government to:
 - (i) recognise the complexity of consultations
 - (ii) place greater value on fewer better quality consultations.
- 12c NORTH YORKSHIRE: That conference demands any call for improved access be refused until sufficient new capacity is in post and trained to meet any predicted increase in demand.
- 12d LEWISHAM: That conference notes the intention that the Investment and Impact fund for 2021/22 is intended to reward 'better access' and demands that this should be defined as improved continuity of access.
- 12e HULL AND EAST YORKSHIRE: That conference demands the removal of references to '50 million more appointments' from the 2020 / 2021 contract as an unrealistic and politically driven target.
- 12f BERKSHIRE: That conference is concerned that the constant drive to improve access is putting too much strain on general practice partners at a time when they have never been busier and that the pledge in the GP contract deal document to provide an extra 50 million GP appointments is completely undeliverable unless and until significant funding is invested into the core GMS contract.
- 12g CAMBRIDGESHIRE: That conference supports the use of the quality access survey to promote and reward the minimum 15 minute length of a GP appointment.
- 12h BEDFORDSHIRE: That conference asks GPC England to explain to the Department of Health that:
 - (i) "50 million more appointments in general practice" does not equate to 50 million more appointments with a GP
 - (ii) there needs to be a massive re-education program for patients to accept an advanced nurse practitioner, physician's assistant or experienced physiotherapist is as good at, or better than, a GP in managing the cold that's "gone to my chest" or "crippling back pain"
 - (iii) robbing Peter to pay Paul will not work, as poaching paramedics to work in primary care will only leave a failing ambulance service, unless we train many more paramedics
 - (iv) supply of doctors is only part of the problem and doesn't address the issue of rising demand.

Out of Hours

- * 13 HULL AND EAST YORKSHIRE: That conference demands that any future proposal to give PCNs responsibility to deliver out of hours care is a red line for GPC England negotiators.

PCN DES

12.40

- * 14 AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference, in respect of future contract negotiations, mandates that:
 - (i) there must be a genuine financially viable option to enable practices to decline to sign up to future versions of the PCN DES
 - (ii) PCN involvement must always remain a DES, not to be moved to core GMS services
 - (iii) the priority area for investment must be the core contract, not the PCN DES
 - (iv) there remains a clear demarcation between core GMS services and enhanced services including the PCN DES
 - (v) any changes to the PCN DES must not impact negatively on core GMS funding.
- 14a CLEVELAND: That conference, in respect of future contract negotiations, mandates that:
 - (i) any DES options must be genuinely financially optional
 - (ii) there must be sufficient uplift within global sum to cover reasonable practice expenses, and also deliver a pay uplift for partners
 - (iii) the priority area for investment must be the core contract, not the PCN DES
 - (iv) there should never be blurring of lines between essential services and the contents of any DES agreement
 - (v) PCN involvement must always remain a DES, not be moved to core GMS services.
- 14b HULL AND EAST YORKSHIRE: That conference insists:
 - (i) there must remain a genuine option for practices to decline to sign up to future versions of the PCN DES
 - (ii) work which has been introduced via the PCN DES must not be moved into core GMS contract without additional and adequate new funding
 - (iii) any changes to the PCN DES must not impact negatively on core GMS contract funding.
- 14c BUCKINGHAMSHIRE: That conference is increasingly concerned by the blurring of core GMS with the PCN DES, and:
 - (i) believes that core GMS obligations must not be conflated with optional DES requirements
 - (ii) demands that all references to the PCN DES are removed from GMS contract variations where these variations in practical terms merge core GMS and PCN DES obligations
 - (iii) ensure that all future contract negotiations maintain a clear demarcation between core GMS and all enhanced services, including the PCN DES
 - (iv) that no future negotiation attempts to roll the obligations of the PCN DES into the core GMS contract.
- 14d CLEVELAND: That conference believes that the negotiations for the core GMS contract and the PCN DES should take place separately, and the outcomes of these negotiations be announced to the profession separately.
- 14e BERKSHIRE: That conference welcomes the increased financial input in to the PCN DES but calls on the government to match this with the same investment into the core contract to improve the resilience of the partnership model and independent contractor status.
- 14f NORTH ESSEX: That conference believes primary care networks should remain a voluntary DES and not be rolled into the core GP contract.

- 14g HERTFORDSHIRE: That conference instructs GPC England to urgently reverse the pouring of funds into a voluntary DES at the expense of the core contract which has been starved for so many years that it is on the verge of collapse.
- 14h KENT: That conference demands that PCNs cannot be held accountable for the performance of its constituent practices' delivery of core general practice services.
- 14i NORTH YORKSHIRE: That conference believes PCNs thus far have not provided significant resilience to general practice and it is vital that whilst they are getting established to try and do so the precarious position of core GP is not forgotten, and conference instructs GPC England to immediately prioritise this.
- 14j GREENWICH: That conference is concerned to note in the agreement that the level of reimbursement drawn down to support new staff employed by a PCN will be treated as part of the core general practice cost base beyond 2023/24 and requests that this be clarified as it implies a blurring between the DES and the core contract.
- 14k LEICESTER, LEICESTERSHIRE AND RUTLAND: That the conference moves to keep the PCN DES and the contract as separate. It's very confusing to have it all together as it makes the assumption that everyone will sign up to PCNs, whereas we can still provide GMS core contract and not be part of a PCN.
- 14l DEVON: That conference believes that PCNs should not become entrenched in the GMS contract, undermining the ability of a contract holder to thrive without PCN engagement. Conference therefore demands that the GPC England Executive negotiate a sustainable GMS contract, independent of PCN workforce, funding, and engagement.
- 14m LEICESTERSHIRE AND RUTLAND: That conference believes that PCN DES should not be used as way of dumping work on general practice. GPC England should issue appropriate guidance and appropriate funding should follow the work. Funding allocated for PCNs should now go directly to PCNs.
- 14n NORTH YORKSHIRE: That conference believes that the overall contract package, whilst offering some very helpful strategies, does not do enough for core general practice resilience separate to PCNs and instructs GPC to focus on much needed individual practice stability so that practices (as PCN member organisations) are not allowed to fall at the first hurdle.
- 14o NORTH YORKSHIRE: That conference believes it would be foolish to think PCNs alone can deliver the much needed stability in general practice in the time frame required, and instructs GPC England to focus on practice resilience now, in order to ensure the profession / PCNs can then have the opportunity to deliver on some wider NHS objectives.
- 14p TOWER HAMLETS: That conference demands that due to the unrelenting workforce and workload crisis in general practice:
- (i) no further changes are made to the PCN DES specifications in subsequent years including the reintroduction of the currently postponed anticipatory care and personalise care specifications
 - (ii) the money that would have funded additions to the PCN DES is invested in the core general practice budget.
- 14q WAKEFIELD: That conference wants the negotiators to ensure year on year that practices are able to walk away from the PCN DES if they choose without incurring financial liabilities.
- 14r WORCESTERSHIRE: That conference believes that core GMS should not absorb the PCN network DES in future years and that this should remain voluntary for practices.

LUNCH

13.00

PCN OPT OUT

14.00

- * 15 REDBRIDGE: That conference has significant concerns regarding some of the clauses in the Network Agreement and demands that GPC England:
 - (i) urgently amends the opt out arrangement clause to ensure there can be no ambiguity in the interpretation that arrangements for the alternative provision of core GMS will automatically apply if a practice opts out of the PCN DES
 - (ii) negotiates the removal of the clause which would enable a CCG to assign a practice to a PCN.
- 15a BUCKINGHAMSHIRE: That conference believes that GPC England has not acted in GPs' best interests by handing over control of PCN membership to CCGs and insists that LMCs be consulted on any such processes and given a veto on any CCG imposition decisions.
- 15b HERTFORDSHIRE: That conference believes that if CCGs can assign practices to a PCN then PCNs should be able to remove a practice if there is a breakdown in the relationship between the members of a PCN and one of the practices and calls on GPC England to negotiate for this arrangement.
- 15c BRENT: That conference instructs the GPC England to negotiate a safe pathway for practices to opt out of the PCN DES, without repercussions.
- 15d LIVERPOOL: That conference is concerned that the concessions gained in the second round of this year's contract negotiations have only gained a temporary reprieve from the onerous and unworkable draft specification. Future contract and PCN specifications must:
 - (i) be widely consulted on
 - (ii) include the option for practices to hand back the PCN DES with no threat to practice finances regarding redundancy or other liabilities for staff employed on behalf of the PCN DES.
- 15e COUNTY DURHAM AND DARLINGTON: That conference calls for an inquiry into the development of the first draft of the 2020 / 2021 PCN DES so that both NHSE and GPs can better understand how the proposal was drawn up and learn lessons for future contract development.
- 15f CAMBRIDGESHIRE: That conference insists that a direct enhanced service is an additional; voluntary; time limited contract that may be terminated at any time by providing the necessary contractual written notice to the other party, and that a contractor's decision not to become a core network practice cannot be met with a breach notice.

PCN WORKLOAD

14.20

- * 16 LIVERPOOL: That conference believes that GPC England must remind NHS England and CCGs that the additional workforce being recruited with PCN resources is expected to assist with GP workload, not manage secondary care's workload problems, nor the shift in care from secondary to primary care.

- 16a NORFOLK AND WAVENEY: That conference asks GPC England to stipulate that supporting core general practice delivery of services is a legitimate workload for all the additional roles and this workload can be included when PCNs are establishing the capacity of their additional roles workforce to deliver the service specifications.
- 16b BERKSHIRE: That conference seeks to make it clear that the provision of additional staff is not a blank cheque to allow un-costed work to be dumped on general practice with the excuse that the funding has already been provided through the ARRS.
- 16c NORFOLK AND WAVENEY: That conference believes that whilst the PCN additional workforce is welcomed it will not reduce GP workload sufficiently to be the saviour of general practice.
- 16d WORCESTERSHIRE: That conference believes that if additional roles staff are unable to be recruited to the PCN DES the focus of such staff must be to support practice workload first and foremost.

PCN SPECIFICATIONS

14.30

Care Homes

- * 17 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference is concerned that the care home premium of £120 is per bed, not per patient, and therefore does not give any consideration to new patients, which attract higher workload, or high turnover of patients such as respite care, and demands that:
 - (i) the value of this premium be increased for 2021 / 22
 - (ii) the requirement for a GP or geriatrician to do home rounds for patients in care homes is removed, and that this work be undertaken by an AHP under the supervision of a GP
 - (iii) payment should be per patient and not per bed to recognise homes with high turnover
 - (iv) the funding and specification is extended to include frail patients living in their own home
 - (v) GPC England Executive should therefore renegotiate this specification once more.
- 17a DEVON: That conference believes that the renegotiated care home specification remains unworkable and overly bureaucratic. Conference believes that:
 - (i) an annual payment per bed ignores the significantly increased workload involved with high turnover beds used for palliative care and respite
 - (ii) care homes are not distributed homogeneously throughout the country and so many PCNs will be unfairly burdened with very high workload destabilising general practice for other patients
 - (iii) care home patients are not always the most vulnerable frail patients, less availability to care for frail patients in their own homes in order to provide an unrealistic unnecessary level of care in care homes will be an unintended consequence of this specification
 - (iv) GPC England Executive should therefore renegotiate this specification once more.
- 17b BUCKINGHAMSHIRE: That conference is concerned that the care home premium of £120 is per bed, not per patient, and therefore does not give any consideration to new patients, which attract higher workload, or high turnover of patients such as respite care, and demands that:
 - (i) the value of this premium be increased for 2021 / 22
 - (ii) payment should be per patient and not per bed
 - (iii) payment should reflect turnover of patients.

- 17c KENT: That conference demands that the PCN care home specification must:
- (i) ensure that functional existing schemes are maintained
 - (ii) include a new patient fee to recognise homes with high turnover.
- 17d KENT: That conference demands that the requirement for a GP / geriatrician to do home rounds for patients in care homes is removed, and that this work be undertaken by an AHP under the supervision of a GP.
- 17e LINCOLNSHIRE: That conference welcomes the Care Home Premium but believes that the flat rate of funding does not recognise the workload for general practice of beds which have high turnover, and thus demands that NHSE monitor the arrangements that CCGs commission for transitional care arrangements to ensure that all CCGs do commission such services.
- 17f HULL AND EAST YORKSHIRE: That conference believe that the enhanced health in care homes service specification:
- (i) remains a significant additional workload for PCNs
 - (ii) is likely to widen the divide between more and less advanced networks
 - (iii) is inadequately funded for the work required.
- 17g OXFORDSHIRE: That conference believes that the care home premium of £120 is insufficient and should be a per patient payment rather than a per bed payment to reflect the workload associated with turnover of patients.
- 17h GATESHEAD AND SOUTH TYNESIDE: That conference with respect to the care homes specifications:
- (i) notes with gratitude the removal from the DES of a weekly GP round of each care home, but is uncertain what purpose there would be in utilising some of the AQPs suggested, given that it is likely they would generate actions requiring further GP action and likely visits
 - (ii) is concerned that failure to recruit said AQPs would result in a requirement for GPs to conduct weekly rounds in order to not breach contract
 - (iii) believes that the suggestion that CCGs should maintain funding for care home LESs is likely to be ignored and should be mandated if care for this population is not to deteriorate.
- 17i COUNTY DURHAM AND DARLINGTON: That conference asks that consideration is given to modelling the 'care home premium' on number of beds versus number of patients to recognise the additional work involved in supporting care homes with high turnover of patients.
- 17j SHEFFIELD: That conference believes that the enhanced health in care homes specification in its current form is not fit for purpose and:
- (i) risks destabilising practices who are already undertaking a care homes locally commissioned service (LCS) as there is no guarantee that this funding will continue on top of the national funding
 - (ii) will increase inequality between practices and primary care networks (PCNs) because of the geographical variation in the number of care homes in PCNs
 - (iii) £120 does not adequately address the increase in workload required in vulnerable patients with complex medical problems and palliative care needs.
- 17k KENT: That conference demands the replacement of the comprehensive geriatric assessment required in the enhanced health in care homes specification, as this is too onerous and complex.
- 17l GLOUCESTERSHIRE: That conference recognises the difficulties with the suggestion that every care home be supported by a single PCN.

- 17m BRENT: That conference:
- (i) condemns the revised PCN DES specifications as it does not include provision for housebound or severely frail patients, such as that offered for nursing homes specifications
 - (ii) condemns the revised PCN DES as it does not include any of the required resource for practice supervision and support for the extended role practitioners
 - (iii) calls upon NHSE to directly resource funding for housebound and severely frail patients through core GP funding
 - (iv) calls upon GPC England to negotiate with NHSE funding to recognise the indirect costs of employing extended role practitioners.

PCN Modelling

- * 18 AGENDA COMMITTEE TO BE PROPOSED BY DERBYSHIRE: That conference is concerned that, despite a radical overhaul of the PCN service specifications, there remains a significant funding gap, and demands:
 - (i) to know as soon as possible whether an impact assessment, including PCN level and practice level modelling, was carried out by the BMA prior to the agreement of the GP contract
 - (ii) that there is an urgent costing exercise undertaken which will better inform primary care networks as to the financial viability of signing up to the scheme
 - (iii) that the deadline for practices to sign up to the 2020 / 21 PCN DES be deferred until 1 October 2020 to allow time for all associated details to be published
 - (iv) a moratorium of one year on the implementation of all specifications within the DES to allow time for PCNs to begin to develop the required workforce, and to scope the required workload for feasibility and viability in the longer term.
- 18a DERBYSHIRE: That conference is concerned that, despite a radical overhaul of the PCN service specifications, there remains a significant funding gap and insists that there is an urgent costing exercise undertaken which will better inform primary care networks as to the financial viability of signing up to the scheme.
- 18b CITY AND HACKNEY: That conference is concerned that the PCN DES may present more liability than opportunity, and calls on GPC England to demand:
 - (i) a moratorium of one year on the implementation of all specifications within the DES to allow time for PCNs to begin to develop the required workforce, and to scope the required workload for feasibility and viability in the longer term
 - (ii) full funding of the workforce components of PCNs and ARRS, without strings, so that PCNs can start to deploy the work streams in shadow form without fear of failure to meet specification requirements
 - (iii) a further period of formal consideration and wider debate towards the end of the moratorium, in order to gather PCNs' 'lived experience' of roll out and to inform whether commitment to the PCN DES is viable for general practice.
- 18c OXFORDSHIRE: That conference is concerned that the more onerous aspects of the original draft specifications have simply been deferred until next year, that there remains significant uncertainty as to what new workload will be added in 2021 / 22 onward and calls for the DES opt out window to be 3 months for all years, as it is for 2020 / 2021.
- 18d KENSINGTON, CHELSEA AND WESTMINSTER: That conference demands the deadline for practices to sign up to the 2020 / 21 PCN DES be deferred until 1 October 2020 to allow time for all associated details to be published, appropriate practice-level modelling to be commissioned to enable each practice to understand its own financial risk, and to assist core primary care network practices with their decision making. (Supported by all Londonwide LMCs)

- 18e CAMBRIDGESHIRE: That conference calls for the sign-up deadline for the 2020 / 2021 PCN DES to be delayed until 1 October 2020 to allow for an opportunity for appropriate modelling to be commissioned and all associated details published, to assist core network practices with their decision making.
- 18f SOUTH ESSEX: That conference demands the rejection of any PCN service specifications until PCNs have been appropriately resourced to meet their primary aim of stabilising primary care.
- 18g CLEVELAND: That conference requires written guidance explaining the expected contractual obligations of community service providers in delivering the 2020 / 2021 contract to allow LMCs to effectively monitor this at a local level.
- 18h GATESHEAD AND SOUTH TYNESIDE: That conference calls for any and all further additions to the DES to be both well evidenced in terms of clinical benefits, adequately resourced and requiring only staff who are readily available, noting that failure to do so will leave practices and PCNs with poorly evidenced work of little value, falling to existing staff.
- 18i HERTFORDSHIRE: That conference calls for all of the changes negotiated for the GP contract in 2020 to be deferred until 2021.
- 18j BUCKINGHAMSHIRE: That conference demands to know, as soon as is possible:
- (i) whether an impact assessment, including PCN level and practice level modelling was carried out by the BMA prior to the agreement of the GP contract in order to determine the impact of the PCN DES on practices
 - (ii) whether any impact assessment and/or modelling was made available to the GPC England before they voted on the negotiated contract agreement
 - (iii) the detail of any impact assessment, including PCN level and practice level modelling done by the BMA by way of publication which is made available to the profession within seven days of the end of this conference.

INVESTMENT AND IMPACT FUND

15.00

- * 19 CLEVELAND: That conference, in respect of the Investment and Impact Fund:
- (i) believes that the 2020 / 21 targets would be better assessed at practice level, rather than at PCN level
 - (ii) is concerned that the performance management of practices by other practices within a PCN introduces a new layer of regulation
 - (iii) believes this scheme to be discriminatory to practices who choose not to participate in the PCN DES
 - (iv) rejects the 2020 / 21 iteration of this fund
 - (v) mandates that the funding within this scheme is moved into a practice level scheme immediately.
- 19a OXFORDSHIRE: That conference, with regard to the Investment & Impact Fund (IIF):
- (i) believes the work required is excessive and out of proportion to the funding available
 - (ii) opposes the fact that funds cannot be drawn down as profit by individual practices
 - (iii) believes that this sets a worrying precedent for QOF to be moved from practice level to PCN level and the corresponding income associated with QOF to be taken out of practice profit which would lead to an unsustainable model of general practice
 - (iv) believes it is a means of forcing practices to performance manage each other, which goes against the principles of collaborative working
 - (v) calls for it to be removed from the DES with the funding instead reinvested into the core contract.

- 19b NEWHAM: That conference rejects the impact and investment fund criteria of over 65 flu vaccine payment going through PCNs at the present time.
- 19c HULL AND EAST YORKSHIRE: That conference believes the Investment and Impact fund:
 - (i) is insufficient to support meaningful change
 - (ii) will increase the divide between early stage and more mature PCNs
 - (iii) should be removed and distributed in its entirety as part of the Network Payment.
- 19d LEEDS: That conference believes that all social prescribing referrals, including self-referrals from patients or carers, should be counted towards any IIF target.

THEMED DEBATE - ARRS

15.10

The Additional Roles Reimbursement Scheme (ARRS) 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 TD32. The Agenda Committee have noted the large number of motions on the ARRS submitted by LMCs, both on the current scheme and future options for it. We would encourage members of conference to use this opportunity to feedback to GPC England on the ARRS and suggest possible solutions. 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. A representative of the Chair of GPC England will have the opportunity to respond to the issues raised during the debate.

At the conclusion of the debate, conference will be asked to vote on the related statements below using the electronic voting system.

You will be asked to choose your top three options from the list below.

- (1) Agenda for change banding is insufficient
- (2) Employment liability concerns
- (3) Lack of available staff to recruit into roles
- (4) The staff recruited do not reduce workload
- (5) Lack of funding for training, supervision and management
- (6) Quantity and type of role are too prescriptive
- (7) The ARRS doesn't include the right roles for our PCNs
- (8) Lack of premises
- (9) There are no problems with ARRS.

- TD1 NORTH STAFFORDSHIRE: That conference asks the GPC Executive to find a way to reinvest additional roles investment back into primary care that is not used due to recruitment issues.
- TD2 BEDFORDSHIRE: That conference notes that "if a PCN and a CCG agree that a PCN is unlikely to use its year's full allocation, this funding may then be made available to other PCNs within that CCG area to bid for to enable them to undertake additional recruitment" but is concerned this may deprive practices in a PCN which is slower to develop its services or whose practices are less engaged at the expense of a thriving one.

- TD3 LAMBETH: That conference is concerned that those practices which invested in additional roles before the PCN DES will not obtain 100% reimbursement for those additional roles which is inequitable and should be corrected.
- TD4 GLOUCESTERSHIRE: That conference believes that fears over GP practices failing to invest in ARRS staff are resolved by the pay balance mechanism, and therefore calls for moneys allocated to PCNs for these posts be placed into GP practices.
- TD5 DEVON: That conference remains concerned that a lack of recruitment is being used as a proxy measure of a lack of engagement from PCNs rather than a marker of deprivation and geographical variation. As such, redistribution of unspent ARR funding will only exacerbate inequality. Conference therefore mandates that all unspent funding should remain within a PCN and be used for whatever the PCN feels would improve their ability to recruit, including higher pay banding, relocation fees, on costs, and any similar costs deemed reasonable by the PCN with the support of their LMC.
- TD6 HULL AND EAST YORKSHIRE: That conference believes that:
- (i) a nationally supported programme for appropriate training for additional roles must be implemented immediately
 - (ii) responsibility for the training of additional roles must not fall to PCNs or be at their expense
 - (iii) all additional roles must be provided with centrally funded level 3 safeguarding training.
- TD7 LEEDS: That conference calls for PCNs to be funded to be able to provide clinical supervision, learning and development support for all employed staff.
- TD8 HULL AND EAST YORKSHIRE: That conference calls for the time spent on training and supervision of additional roles by PCN members to be recognised and remunerated as part of future PCN DES contracts.
- TD9 COUNTY DURHAM AND DARLINGTON: That conference recognises that additional appropriately trained staff envisaged under the PCN DES are not always available and that mechanisms to facilitate training should be explored.
- TD10 HERTFORDSHIRE: That conference is aware of the significant obligations on PCNs with regards to induction, training and supervision of Additional Roles Reimbursement Scheme staff which is not recognised within the PCN DES and therefore calls on GPC England to negotiate with NHSE to ensure that appropriate additional resources are available to cover these additional costs.
- TD11 NOTTINGHAMSHIRE: That conference welcomes 100% funding for additional roles but asks that funding is sought for clinical supervision of those additional staff to prevent a disproportionate drain on existing development management funding.
- TD12 NORTHAMPTONSHIRE: That conference insists that management fees should be reimbursed for all additional role staff.
- TD13 BROMLEY: That conference welcomes the 100% reimbursement for the Additional Roles from April but is concerned that it does not cover the extra practice nurse and nurse practitioner time that will be required to achieve the new cervical screening, immunisations, post-natal and asthma requirements set out in the new contract agreement.
- TD14 LAMBETH: That conference believes that the reimbursement for ARRS should extend to all nurses and HCAs in addition to those roles already identified.
- TD15 LAMBETH: That conference is concerned that the emphasis placed on the additional roles within primary care does not address the substantial and significant support required to encourage nurses into primary care.

- TD16 HERTFORDSHIRE: That conference asks GPC England to urgently negotiate with NHSE to expand the Additional Roles Reimbursement Scheme to include GPs and practice nurses, which would positively impact the current workload/recruitment/retention issues current causing a crisis in general practice.
- TD17 LAMBETH: That conference believes that all pharmacists working in primary care should be 100% reimbursable.
- TD18 LIVERPOOL: That conference believes that it is discriminatory to reduce PCN funding for the Additional Roles Reimbursement Scheme when a practice in the network is unable to replace a practice funded pharmacist and insists that the three month grace period is extended indefinitely.
- TD19 HULL AND EAST YORKSHIRE: That conference believes that community paramedics must be provided with a nationally funded training programme before working in primary care.
- TD20 NORTH STAFFORDSHIRE: That conference asks the GPC Executive to negotiate to include mental health practitioners for additional roles from April 2020.
- TD21 GATESHEAD AND SOUTH TYNESIDE: That conference rejects the concepts of time equivalence used to produce the PCN DES and:
- (i) requests that GPC England and NHSE clarify which elements of 'routine general practice' they believe non-prescribing, non-independent practitioners such as physician associates can safely take over in order to free up GPs' time
 - (ii) calls for the evidence used to calculate equivalence to be publicly released
 - (iii) believes it to be unrealistic to expect non-prescribers to be able to operate without GP supervision, and demands that this burden be costed and factored into the DES.
- TD22 LEEDS: That conference welcomes the change to 100% reimbursement for all ARRS workforce and:
- (i) recommends practices consider directly employing staff to ensure they are full members of their practice team
 - (ii) calls for nurses to be included in the ARRS
 - (iii) advises practices and PCNs not to employ podiatrists or occupational therapists if there is any risk of undermining or becoming liable for the delivery of the local community provided service which should not be resourced through GMS funding.
- TD23 NORFOLK AND WAVENEY: That conference believes that current PCN Workforce recruitment of paramedics, pharmacists and other allied health professionals risk destabilising health services competing to recruit from the same limited workforce pool.
- TD24 HARINGEY: That conference asserts that the quantity of the workload required in the PCN DES exceeds the utilisable capacity of the workforce provided by the Additional Roles Reimbursement Scheme (ARRS) and insists that GPC England works with NHSE to model and assess capacity before implementing the changes within the PCN DES.
(Supported by Islington LMC)
- TD25 LIVERPOOL: That conference welcomes the commitment to fund additional staff 100%, however, has concerns that the:
- (i) level of capped remuneration will result in staff who are not capable of fulfilling the roles specified
 - (ii) funding does not include the management costs associated with employing the additional staff
 - (iii) opportunity cost of supervising and training these staff remains with practices
 - (iv) liability for redundancy pay potentially remains with practices if they opt out of the PCN DES in future.
- TD26 KENT: That conference demands that PCNs must have adequate workforce in place before they are required to deliver the PCN service specifications.

- TD27 HERTFORDSHIRE: That conference believes that the payment within the PCN DES for the clinical director reimbursement should increase annually at least in line with inflation and taking into account the increasing responsibilities of the role.
- TD28 NORFOLK AND WAVENEY: That conference calls on GPC England with regards to PCNs to negotiate:
- (i) PCNs should be able to assess clinical need for allied health professionals within a PCN area and recruit appropriately from a ring-fenced pot of funding rather than be restricted to the current criteria
 - (ii) ensure the associated risk of employing staff through the ARRS does not lie with individual practices so practices can choose at any point to cease PCN membership without the risk of associated liabilities
 - (iii) improved funding for PCN clinical directors to recognise the personal and practice pressures
 - (iv) ensure the stabilisation of general practice is at the heart of the PCN DES and the resource provided is appropriate to support this.
- TD29 LINCOLNSHIRE: That conference believes that basing reimbursement for additional roles on Agenda for Change bandings does not reflect market forces and thus prevents realistic chance of recruiting to these roles and demands that the reimbursement should be based on locally agreed accepted rates of pay for each role.
- TD30 NORFOLK AND WAVENEY: That conference believes that pharmacist recruitment is made more difficult by the differential payrates between PCN posts and those within hospital and community pharmacies. Some of the specifications for SMRs require a higher level of training which is not fully reimbursed at these salary levels.
- TD31 LIVERPOOL: That conference welcomes the commitment to fund additional staff 100%, however, has concerns that the:
- (i) level of capped remuneration will result in staff who are not capable of fulfilling the roles specified
 - (ii) funding does not include the management costs associated with employing the additional staff
 - (iii) opportunity cost of supervising and training these staff remains with practices
 - (iv) liability for redundancy pay potentially remains with practices if they opt out of the PCN DES in future.
- TD32 MERTON: That conference welcomes the somewhat improved financials around ARRS, but:
- (i) calls upon government to commit to automatic adjustments to capped pay scales to reflect inflation and centrally directed pay awards
 - (ii) requires the government to commit to covering the cost of leave entitlements such as maternity leave, parental leave and sick leave.

ARRS

16.00

- * 20 AGENDA COMMITTEE TO BE PROPOSED BY LINCOLNSHIRE: That conference believes that current rules regarding ARRS must be modified to specifically state that:
 - (i) any underspend cannot be moved into CCG baselines
 - (ii) all funds allocated to a PCN for workforce should remain for that PCN to use
 - (iii) London weighting should be applied to ARRS reimbursement.

- 20a LINCOLNSHIRE: That conference believes that rules regarding ARRS worsen the inverse care law, so patients in deprived dispersed rural areas are disadvantaged, and demands that:
 - (i) all funds allocated to a PCN for workforce should remain for that PCN to use
 - (ii) the use of any ARRS funds for a PCN not used for workforce should be agreed by the PCN, the CCG, and LMC.
- 20b NEWHAM: That conference demands that the ARRS roles:
 - (i) have training monies attached
 - (ii) recognise the need to fund London Weighting in addition to the proposed cap on each role and banding.
- 20c NORTHAMPTONSHIRE: That conference insists that any underspend within agreed contracts will remain in the hands of GPs and not CCGs.
- 20d LAMBETH: That conference demands that London weighting should be applied to the ARRS reimbursement.
- 20e ISLINGTON: That conference calls upon government to recognise the specific financial pressures affecting health care workers in London by allowing for PCNs to claim London Weighting to the ARRS provision.
- 20f MERTON: That conference calls upon government to recognise the specific financial pressures affecting health care workers in London by allowing for PCNs to claim London Weighting to the ARRS provision.

Tax Advice

- * 21 OXFORDSHIRE: That conference believes the support and information available to PCNs and clinical directors regarding tax, VAT and PAYE has been confusing and inadequate, and:
 - (i) the lack of good advice has placed practices at risk
 - (ii) it is not acceptable that PCNs are having to fund this advice themselves
 - (iii) conference demands to know, as soon as possible, what negotiations, consultations and discussions were had with HMRC by the BMA prior to approval of the PCN DES
 - (iv) calls for fit for purpose tax advice to be provided to PCNs funded by NHSE.
- 21a HULL AND EAST YORKSHIRE: That conference, regarding additional roles:
 - (i) is incredulous that detailed nationally agreed guidance on tax and VAT implications has still not been produced by NHSE and GPC England:
 - (ii) insists that national guidance on the tax and VAT implications for each additional role must be produced before 1 April 2020
 - (iii) rejects that individual PCNs must find and resource their own advice on what are national issues.
- 21b NORFOLK AND WAVENEY: That conference asks GPC England to seek clarification of the VAT rules on employment of staff to PCNs believing that this uncertainty poses risks to those practices currently not VAT registered.
- 21c BRADFORD AND AIREDALE: That conference believes requiring GP partners to take on employment responsibility for an ever increasing range of health professionals is an increasing threat to the partnership model rather than a supportive move.
- 21d HERTFORDSHIRE: That conference asks the GPC to review and update its guidance on PCN models taking into account the experiences of PCNs that have formed since the guidance was first written, different and sometimes conflicting advice from legal and accountancy firms and the pensions agency, and the requirements of CQC registration.

- 21e GATESHEAD AND SOUTH TYNESIDE: That conference is concerned that, with only a few weeks left of the financial year, there is a lack of clarity around the tax issues affecting PCNs and their constituent practices, with mixed messages from NHSE, CCGs and accountants leaving practices uncertain of how to manage unspent monies in a way that is both contractually sound and does not leave them vulnerable to being taxed on money that they cannot draw.
- 21f HERTFORDSHIRE: That conference deplores the failure of NHSE and GPC England to have clarified the tax implications of PCN finances before the introduction of the PCN DES, which has resulted in PCNs seeking and receiving conflicting and confusing advice from different organisations and which continues to cause huge stress and concern amongst clinical directors.
- 21g HULL AND EAST YORKSHIRE: That conference believe no future contract changes should be proposed without a full and detailed assessment of potential tax liabilities and VAT implications for PCNs.
- 21h SUFFOLK: That conference instructs GPC England to ensure as a matter of urgency that the tax, VAT and employment liability barriers for PCNs employing staff are properly explored and appropriate solutions found.
- 21i CENTRAL LANCASHIRE: That conference urges NHSE to reach a nationwide agreement with HMRC on a defined solution that PCNs can adopt in relation to the additional roles reimbursement scheme that will not attract VAT to avoid the current situation of delay and confusion caused by imprecise rules that require close scrutiny of every arrangement in every PCN.
- 21j GLOUCESTERSHIRE: That conference recognises the need for PCNs to receive fully funded employment law advice.

FUTURE OF PCNs

16.20

- * 22 COUNTY DURHAM AND DARLINGTON: That conference asks that the legal status of primary care networks should be explored and consideration should be given to enabling them to become NHS bodies.
- 22a KENT: That conference demands that PCNs be allowed to become NHS bodies.
- * 23 AGENDA COMMITTEE TO BE PROPOSED BY BERKSHIRE: That conference believes the PCN DES is a Trojan horse to transfer work from secondary care to primary care and that:
 - (i) this strategy poses an existential threat to the independent contractor model
 - (ii) there should be immediate cessation of LES and DES transfers from practice responsibility to that of PCNs
 - (iii) GPC England is mandated to urgently survey the profession to get feedback on whether they intend to sign the new PCN DES
 - (iv) GPC England must urgently negotiate investment directly into the core contract as the only way to resolve the crisis in general practice is by trusting GP partners with realistic investment
 - (v) the profession should reject the PCN DES as currently written.
- 23a BERKSHIRE: That conference believes the PCN DES does little to nothing to support general practice, exposes practices to significant financial risk and that it should be rejected by the profession.

- 23b NORTHAMPTONSHIRE: That conference insists that PCNs are a Trojan horse to transfer secondary care to primary care and that GPs should withdraw from such obligations to deliver general practice services to local populations as originally intended.
- 23c GATESHEAD AND SOUTH TYNESIDE: That conference has concerns about the stated intention of more enhanced services being delivered through PCNs, seeing this as forcing practices to sign the DES for fear of immediate financial failure and calls for the:
- (i) immediate cessation of LES and DES transfers from practice responsibility to that of PCNs
 - (ii) removal of the suggestion that enhanced services are to be delivered with community partners where this will have a negative financial impact upon practices
 - (iii) repatriation of any and all LES/DES whose transfer to PCNs has already been agreed back to practices
 - (iv) explicit rejection of any future transfer of work to PCNs that has scope to make GMS independent contractor status less viable.
- 23d NOTTINGHAMSHIRE: That conference urgently surveys the current profession to get feedback on whether they intend to sign the new PCN DES.
- 23e BERKSHIRE: That conference believes the PCN DES is simply a way in which GP practices can be forced into Integrated Care Systems, and that:
- (i) these changes offer no meaningful remedy to the crisis in general practice
 - (ii) this strategy poses an existential threat to the independent contractor model
 - (iii) the only way to resolve the crisis in general practice is by trusting GP partners with realistic significant investment in core GMS
 - (iv) the profession should reject the PCN DES.
- 23f NORTHAMPTONSHIRE: That conference insists that the strategic direction of the NHS towards an Integrated Care System is damaging general practice and that the PCN based contract should be abandoned.
- 23g SHEFFIELD: That conference urges GPC England to:
- (i) declare its support for independent practices of all sizes
 - (ii) declare that PCNs are not the vehicle to resolve contractual problems of struggling practices
 - (iii) urgently negotiate investment directly into core contract to support practices and prevent further unnecessary closures and mergers
 - (iv) demand NHSE prioritise premises developments at practice level to support the expanding workforce
 - (v) renegotiate the 2020 / 2021 contract as it does not sufficiently support investment at individual practice level.
- 23h LAMBETH: That conference:
- (i) rejects the PCN DES specifications as they are currently written
 - (ii) recommends that they be reviewed to set out what the expected outcomes are rather than be prescriptive about how they are to be delivered so that decisions can be taken locally about the best way they can be delivered to fit best with local needs.
- 23i SANDWELL: That conference acknowledges that the revised PCNs DES does nothing to make general practice more resilient, it creates more unnecessary work and makes it very un-attractive for doctors to join a partnership. GPC England are advised to reject the DES unless it is fully resourced.
- 23j HULL AND EAST YORKSHIRE: That conference demands that the supporting early cancer diagnosis specification must be removed with no loss of funding for those areas where local secondary care providers are not meeting cancer referral and investigation targets.

- 23k KENT: That conference demands the removal of the requirement to use clinical decision support tools under the supporting early cancer diagnosis specification as this serves only to performance manage and audit the referral habits of PCNs.
- 23l LEWISHAM: That conference recognises and resolves to publicise to all practices and CCGs that:
- (i) the Structured Medication Reviews required by the PCN DES need not be delivered if the PCN does not have the pharmacist resources to do them
 - (ii) the nature of medical input in the care home specification in the PCN DES is for local clinical judgement.
- 23m KENT: That conference demands the:
- (i) abolishment of the PCN DES and its funding invested in the core GMS contract
 - (ii) GPC England members involved in negotiating the PCN DES be held accountable.
- 23n DEVON: That conference believes the 'basket' approach to any enhanced service is an inflexible choice, creating an inability for practices to manage workload according to local need. Therefore conference mandates that the PCN DES be reworked into a series of individually funded specifications that practices and PCNs can choose to engage with as suits local circumstance, with LMC support.
- 23o CAMBRIDGESHIRE: This conference believes the PCN DES has failed and will continue to fail in supporting core general practice, and instead threatens the long term viability and autonomy of our profession by:
- (i) exposing practices and partners to significantly greater financial risk, liability and workload
 - (ii) providing NHSEI with an alternative non-evidence based vehicle to invest in other than a practice's core contract
 - (iii) inextricably linking the PCN DES to the core contract
 - (iv) setting a precedent of involving third parties in the negotiation of our contracts
 - (v) setting practices up to fail.
- 23p CLEVELAND: That conference requires increased clarity from GPC England on the funding available to practice through the 2020 / 21 contract agreement should they choose not to sign up to the PCN DES.
- 23q HARINGEY: That conference recognises the significant concerns that this DES poses a threat to the independent contractor model, the core GMS contract, and the autonomy of individual constituent practices and calls for the contract to be rejected.
- 23r BIRMINGHAM: That conference believes that whilst general practice must now operate at scale and that all additional investment achieved in recent negotiations is welcome, the new contract deal sadly fails to address the crisis engulfing general practice, and:
- (i) adequate additional investment must be diverted to core general practice
 - (ii) the very prescriptive, top-down PCN model of at scale working will not resolve current challenges or improve practice sustainability
 - (iii) GPC England must reopen negotiations to seek increased funding to core general practice and the incentivisation of fit for purposes models of at scale general practice
 - (iv) should these negotiations fail, the profession must consider the option of mass withdrawal from the PCN DES.
- 23s HARINGEY: That conference acknowledges that the PCN DES, rather than reducing general practice workload and preserving/increasing core capacity, is designed to shift the workload and liability of various other providers onto general practice and calls for its renegotiation.

- 23t BERKSHIRE: That conference believes that since 2004 there has been an institutional refusal by the government to trust GP contractors with any meaningful uplift to core GMS funding, and that:
- (i) this strategy is reflected in the 2020 / 2021 negotiated contract agreement
 - (ii) this is causing an erosion in essential services to the detriment of patient safety
 - (iii) enough is enough and if the government wishes the independent contractor model to continue then it must properly invest into core essential services, unconditionally.
- 23u NORTH YORKSHIRE: That conference recognises that PCNs are currently a tiny part of general practice daily life and insists that the PCN DES remains voluntary for practices, and that contract negotiations focus on delivering vital support to core general practice as well as additional funding for PCNs in order to ensure all practices thrive, and prevent those choosing not to participate being starved of funding and support.
- 23v LIVERPOOL: That conference believes that NHS England and GPC England must undertake an impact assessment of any PCN DES changes with regard to the financial risk that the changes will have on the average PCN and practices within the PCN.
- 23w NORTH YORKSHIRE: That conference has no faith the staff required to fulfil the Additional Roles Reimbursement Scheme are available or qualified to carry out the expectations of the contract, and as such the PCN DES is a castle built on sand.
- 23x OXFORDSHIRE: That conference believes the greatest element of GP workload and patient demand lies in the core contract/essential services, and that the:
- (i) PCN DES has failed to address this workload
 - (ii) profession should reject the PCN DES
 - (iii) funding invested into the PCN DES should instead be invested into core GMS.
- 23y CLEVELAND: That conference, in respect of the 2020 / 2021 contract:
- (i) believes that the contractual monitoring and bureaucracy has vastly increased
 - (ii) believes that core practice workload has increased
 - (iii) demand clarity on the duration of the schemes within this agreement and a structured timetable of when associated support will be available to ensure success
 - (iv) does not believe that this is sufficient to support general practice
 - (v) mandates GPC England to conduct a major internal review of the negotiating outcomes expected by the profession following this special conference.

CLOSING BUSINESS

17.20

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

- A 24. CAMBRIDGESHIRE: That conference calls for a comprehensive occupational health service to be commissioned to serve general practitioners and primary care clinicians and teams as per secondary and tertiary level NHS organisations.

- A 25. NOTTINGHAMSHIRE: That conference welcomes the start of digitisation of Lloyd George records from 2020 and asks for a roll out plan to all regions to enable practices to plan ahead for their usage of the space freed up.

- A 26. LEEDS: That conference is deeply concerned at the inequality of occupational health service provision between general practice staff and all others in the wider NHS workforce and:
 - (i) believes all practice staff should be able to access locally provided NHS occupational health services
 - (ii) demands that governments and commissioners make access to occupational health services for general practice staff available without additional cost to practices.

- A 27. HULL AND EAST YORKSHIRE: That conference believes, with regards to digital-first services:
 - (i) GP practices should have a choice of provider and not be limited by central or regional commissioning
 - (ii) equitable access to ongoing IT support should be available to practices regardless of the digital-first provider chosen.

Agenda: Part II (Motions not prioritised for debate)

Agenda: Part II

28. SUFFOLK: That conference acknowledges that general practice is working flat out and agrees that GPC England needs to help increase capacity. It is therefore vital that the implementation of the new contract does not attract a shift in workload.
29. LAMBETH: That conference is disappointed that there is no mention of continuity of care which is a proven benefit to patients in the GP contract agreement.
30. WORCESTERSHIRE: That conference believes that the risk to practices of retaining their data controller role is now too great and that NHSE and CCG must hold the liability for primary care.
31. KENT: That conference that the PCN DES should stabilise general practice and not add additional responsibilities.
32. NOTTINGHAMSHIRE: That conference recognises that the primary care estate is stretched and that the onus in the DES is to work with community partners to identify additional space. Conference asks GPC England to provide a national template in agreement with NHSE/I and NHSPS/CHP to allow for agreements over use of space for PCNs.
33. SHROPSHIRE: That conference believes the PCN DES specification and contract changes accepted by the GPC England will do little to improve unsustainable GP workload and inadequate income from GMS, and that, until these issues are addressed, recruitment and retention of GPs, particularly principals, will continue to deteriorate.
34. CLEVELAND: That conference welcomes the contractual obligation for CCGs to provide an annual report to the LMC on spending against its primary medical care funding allocation but demands more detail through the year on the actual allocation, such that funding can be reinvested in an appropriate and timely manner.
35. SUFFOLK: That conference instructs GPC England to ensure that any further contract developments reflect the needs and circumstances of rural practices.
36. CAMBRIDGESHIRE: That conference has no confidence in:
 - (i) the ARRS reducing the workload of GPs in managing their most complex, multi morbid patients
 - (ii) clinical pharmacists remaining in PCN roles if forced to repetitively deliver the SMR specification
 - (iii) CDs remaining in role given the under-resourcing and over-expectation placed upon them
 - (iv) clause 9.5 as the opt out from a DES should not ever impact upon a practice contract
 - (v) the signing up of a practice to the PCN DES bringing any tangible improvement to the working lives of independent contractors or reducing their financial liabilities.
37. NOTTINGHAMSHIRE: That conference sees PCNs engaging within their ICS/ICPs as crucial and supports an engagement fund and support to help GPs to attend additional meetings and receive coaching on board behaviours, negotiating skills etc.
38. AVON: That conference applauds the approach of NHS England in producing the specifications for the Primary Care Network DES Specifications by producing a draft version and inviting and listening to feedback. Co-production of the service specifications with grass-root GPs should be adopted model for all four home nations.

39. HERTFORDSHIRE: That conference:
- (i) is concerned that the locum GPs have not been given any significant roles in the PCN DES, and
 - (ii) calls for the PCN DES to include a mandate that there should be at least one locum GP as a member of a PCN.
40. BEDFORDSHIRE: That conference notes that many of the changes in the new contract are predicated on the successful functioning of PCNs. Since PCNs are new and unproven entities, conference calls for careful monitoring and special support measures for struggling PCNs, to ensure that the contract reforms are facilitated throughout the country.
41. KENT: That conference that in the event of PCN DES contract termination all liabilities are underwritten by the NHS.
42. LINCOLNSHIRE: That conference insists that when patients are assigned to a practice under changes proposed to the regulations, that CCGs and NHSE/I are mindful of previous removals and relationship breakdowns, so that patients are not assigned to practices where relationships have previously broken down.
43. LIVERPOOL: That conference is concerned that the GP workforce is being earmarked to reduce pressure on a struggling secondary care system and requires:
- (i) GPC England to resist moves to benchmark primary care performance on secondary care metrics
 - (ii) future primary care workforce initiatives to be geared solely towards reducing primary care workload
 - (iii) any benefit to secondary care should be a secondary effect and not the primary end point.
44. KENT: That conference demands that the supporting mentors' scheme is extended to:
- (i) allow any GP on the performers list to be considered as a mentor
 - (ii) allow mentors to conduct as many sessions per week in the role as demand requires
 - (iii) include practices in difficulty
 - (iv) include practice managers.
45. NOTTINGHAMSHIRE: That conference welcomes the offer of free CPD session for locums working in a PCN and whilst the details of this offer are being finalised, mandates GPC England and Exec to negotiate for:
- (i) the extension of this offer to existing partners and salaried GPs
 - (ii) extension of this CPD offer to enable practice managers and other admin staff to up skill their existing skills.
46. LINCOLNSHIRE: That conference believes that the government's promise to "urgently to review the pensions annual allowance taper problems" is too little too late, and that to prevent the exodus of senior GPs from the profession, the annual allowance and lifetime allowance need to be immediately increased.
47. LEEDS: That conference notes the initiatives directed at GPs at the beginning and end of their careers and calls in addition for dedicated resource and career development for those GPs in the middle of their career.
48. HERTFORDSHIRE: That conference welcomes the plans to improve recruitment and retention of GPs but is disappointed that there are no schemes that would encourage GPs who are nearing, but not yet at, the end of their careers to remain in general practice beyond their mid-fifties, and calls on GPC England to work with NHSE to find more solutions to for this group of GPs to encourage them to stay in practice until at least 62 years of age.
49. DERBYSHIRE: That conference welcomes the initiative to encourage new GP partners, however the current support programmes for mid and late career GPs must both be enhanced and continue to be fully funded.

50. NORTH ESSEX: That conference believes mentoring and coaching should be made available to all GPs and practice staff.
51. WEST PENNINE: That conference is worried that what had been put forward as support for general practice is now being utilised as support to the rest of the NHS system i.e. community and secondary care, whilst general practice continues to be underfunded and expected to carry on regardless.
52. BEDFORDSHIRE: That conference welcomes the Fellowship, Mentoring, Training and Refresher and Locum support schemes but wonders who is going to deliver care to patients while practitioners deliver these much needed services.
53. LEEDS: That conference believes, with the development and spread of Covid-19 viral infection, practices should be able to suspend online booking of appointments without contractual sanction.
54. SANDWELL: That conference advise GPC England they were wrong to accept GPFV as a solution to the ongoing crisis in general practice. As the statutory representatives of the profession GPC England must now formulate a full remedial plan that will be put to the membership within three months.
55. NORFOLK AND WAVENEY: That conference asks GPC England to urgently work with NHSE&I to unpick existing funding mechanisms that prevent funding following the patient.
56. DEVON: That conference welcomes the encouragement for CCGs to maintain existing services that may be affected by the PCN specifications, however, feels this does not go far enough. Conference mandates that GPC insist that NHSE/I mandate CCGs to produce clear evidence of what funds have been spent for the last three years on these and similar services and then ring-fences those funds.
57. CLEVELAND: That conference insists that all schemes must be fully funded at NHS England level, with transparent transfer of ring fenced money to CCGs, to avoid any postcode lottery in long-term CCG primary medical care funding.
58. LIVERPOOL: That conference believes that CCG mergers should cease until such time that PCNs are fully established as entities as the obsession for CCGs to save 20% running costs is placing an unnecessary additional burden on PCNs at a time when CCGs should be supporting GP practices and nurturing PCNs.
59. LEEDS: That conference believes the government has failed to address the problem created by the annual allowance tax charge and believes this will continue to impact adversely on GP retention and therefore calls on the UK government to remove the annual allowance arrangements from the NHS pension scheme.
60. SUFFOLK: That conference agrees that the digitalisation of records needs to be done once and done right.
61. CLEVELAND: That conference believes that our national negotiating team should work more closely with the Pharmaceutical Services Negotiating Committee to produce contracts that complement each other.
62. BEDFORDSHIRE: That conference calls on GPC England to work on better local solutions for patients and GPs, rather than assigning a patient outside a practice area and requiring a practice to offer 'out of area registration' services to such a patient.
63. BEDFORDSHIRE: That conference instructs GPC England to take account of the effect of PCNs on GP workforce, both in terms of GP time spent working for PCNs and the consequence of some GPs, who are not happy within the PCN model, leaving general practice altogether. As future contract developments add more things to the remit of PCNs, these issues will worsen, and must be addressed.
64. NORTH YORKSHIRE: That conference believes there will not be any increase in GP numbers in the next five years due to workload, excessive hours and strain of additional demand; as GPs leaving the profession outnumber those joining, it demands any future agreement specifically targets retention.

65. WORCESTERSHIRE: That conference demands that there must be a mechanism in place to ensure that clinical commission groups do not micromanage PCNs in carrying out the DES.
66. TOWER HAMLETS: That conference:
- (i) acknowledges that £20,000 for attracting new partners represents some recognition of the value of partnership to the success of primary care
 - (ii) notes that massive housing costs in some parts of the country discourages long term commitment to these areas
 - (iii) calls on GPC England to lobby the government to put specific policies in place to address the problem of unaffordable housing for essential professionals, both in the short and long term.
67. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference moves that ARRS money not used in year should be rolled into the next year. This year PCNs still haven't got their budget and even by the time they actually recruit they will have lost a few months. The actual figures per PCN still haven't been published so PCNs still don't know exactly how much they have hence will inevitably be back in the realms of slippage money!!!
68. LINCOLNSHIRE: That conference welcomes the Investment and impact fund, but is concerned that achievement of targets will be more difficult in hard-to-recruit-to-areas, again reinforcing the inverse-care-law, and thus calls for IIF funds to be retained by PCNs whether or not they hit higher targets, to be used in ways to be agreed by PCN, CCG, and LMC.
69. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference moves that PCN development money is paid directly to PCNs rather than going through the CCGs. As in some areas this still hasn't been made available to PCNs or maybe mandate LMCs to oversee that the money really does go into PCNs and not CCGs.
70. BROMLEY: That conference is concerned about the proposed QOF indicator changes (AST002) which requires two tests to be done on patients on the register with asthma between three months before or six months after diagnosis as:
- (i) this will lead to an increase in workload
 - (ii) not all parts of the country have access to FeNO testing
 - (iii) PEFr and reversibility can be variable.
71. BEDFORDSHIRE: That conference calls on GPC England to be alert for mission creep in new QOF areas.
72. BEDFORDSHIRE: That conference is concerned that the number of new QOF areas noted to be under development or review suggests a likelihood of more difficult to achieve targets and reduced income for even the most efficient of practices.
73. DEVON: That conference welcomes the proposals about Releasing Time to Care but notes that, four years on, GPs continue to have to fight against the workload that was supposed to be taken back by hospitals in their 2016 contract. Conference therefore insists that as well as clarity about responsibility for workload, GPC England negotiates clarity about penalties for trusts and CCGs that do not ensure these processes are working well.
74. GREENWICH: That conference is concerned that the releasing time to care component of the agreement does not acknowledge the administrative burden for practices caused by medication shortages and alerts and calls upon the GPC England to undertake an evaluation to quantify this workload with a view to reflecting the funding for this in the contract.

75. GLOUCESTERSHIRE: That conference demands that the detail of the implementation of the contract, if agreed, has adequate and transparent consultation with clinically practising general practitioners, to ensure that there is no additional workload burden that might further destabilise the profession:
- (i) changes should be evidence based
 - (ii) pilots are used where necessary provided that
 - (a) results are independently validated
 - (b) rolled out in a staged manner to further test universal suitability
 - (iii) there is recognition of recruitment gaps in the workforce
 - (iv) allow for lack of local provision of investigative and supportive services.
76. CLEVELAND: That conference rejects the proposal for all practices to offer a core digital service offer to all patients, until current IT infrastructure has caught up with previous contractual agreements and is fully and recurrently funded through the global sum.
77. GLOUCESTERSHIRE: That conference:
- (i) is concerned that the proposed changes to the GP VTS will deprive trainees of valuable time and experience in hospital training posts; and
 - (ii) calls for a properly funded and real-terms extension to the training scheme to four years, of which a minimum of two should be spent in general practice.
78. LAMBETH: That conference recognises that online access has the potential to allow GPs to work more efficiently, but:
- (i) asserts that we do not have the tools to offer existing services robustly
 - (ii) insists that more time is allowed to allow proper evaluation and safe implementation of online access to medical records
 - (iii) insists that more time is allowed to allow proper evaluation and safe implementation of online consultation.
79. REDBRIDGE: That conference recognises the change to the online access to medical records so that it is now just for prospective records unless specifically requested by the patient but requires NHSE to indemnify practices for any claims relating to third person disclosures resulting from access to the retrospective medical record.
80. LINCOLNSHIRE: That conference believes that extended hours provision detracts from patient continuity and is therefore harmful. NHSE must allow PCNs and CCGs to be flexible and use funding for extended hours to bolster in-hours provision and improve continuity of care.
81. BEDFORDSHIRE: That conference notes the observation that “We will look at how third-party redaction software could be made available to general practice as a matter of course to further support practices deliver full historic online access to records for their patients” and asks GPC England to point out that:
- (i) such software has limitations and requires a highly trained administrator (and sometimes a GP) to double check its work, and
 - (ii) unless practices are promised indemnity from prosecutions arising from the consequences of the use of such redaction software, they will be unable to comply fully with its use.
82. LIVERPOOL: That conference is frustrated by the suggestion that improving access to general practice will automatically moderate demand at A&E, and:
- (i) expects GPC in future negotiations to reinforce to government that the drivers to increased A&E attendance are multi factorial and often societal rather than medical
 - (ii) abhors the use of factors outwith general practice's control as a stick with which to beat a service in crisis.
83. NORTH YORKSHIRE: That conference demands that recognition of LMCs as the representatives of general practice be explicitly written into all future contracts at all levels within the healthcare system, to avoid the development of doubt or NHS management manipulation with regards to who has authority to make agreements on behalf of general practice as providers.

84. CAMBRIDGESHIRE: That conference urgently mandates the GPC England executive team to revoke clause 7.12 from the GMS contract update prior to 01 April 2020.
85. HERTFORDSHIRE: That conference is concerned that the additional resources put into primary care are being used in a wasteful manner to support a totally unnecessary new management structure via PCNs and federations.
86. CAMBRIDGESHIRE: This conference calls upon GPDF to commission and fund research into the creation of an options paper for:
- (i) investigating the benefits/risks, options and costs associated with the provision of general practice outside of the GMS/PMS/APMS contract model
 - (ii) investigating how those independent contractors who wish to become employed GPs may be facilitated to do so with regard for their estates and premises at a local or national level
 - (iii) investigating the modelling around the longer term consequences of risks/benefits to core network practices of having aligned contracts with staff and/or premises with other NHS Providers/Trusts as per the PCN DES update 2020 / 2021
 - (iv) investigating how the future of a separately negotiated model around NHS and non NHS provision of general medical services could be facilitated
 - (v) presentation to GPC England for scrutiny upon completion within the next calendar year, and potential further debate with the profession.
87. NORTH YORKSHIRE: That conference instructs GPC to negotiate a formal mandatory role for LMCs at ICS level so that general practice can truly have an equal seat at the table and avoid decisions being made about it, without being involved.
88. BROMLEY: That conference notes that the contract states that GPs must provide all necessary maternity medical services to female patients where their pregnancy was terminated as a result of miscarriage or abortion. Given that many women arrange their termination via a central booking service and the GP may not be informed conference demands clarity regarding this issue.
89. BEDFORDSHIRE: Our politicians have concluded that a fixed term government is in the national interest. Conference proposes similarly that a fixed term contract (also of four years) is essential to allow nascent PCNs to develop into healthy and thriving organisations.
90. HERTFORDSHIRE: That conference supports the replacement of the Seniority Allowance with a Partnership Allowance to reflect the extra responsibility and value for money offered to the NHS and patient care.
91. SOMERSET: That conference welcomes the proposed expansion of GP training places and the extra time to be spent by trainees in primary care but recognises the risks to the quality and supervision that such a huge expansion may bring and calls upon GPC England to:
- (i) negotiate with NHSE, HEE and the RCGP for a commensurate increase resources and support for GP trainers and a reduction in the bureaucracy of GP training
 - (ii) obtain reassurance that the resulting loss of training doctors to secondary care clinical rotas will not impact on primary care by shifting more work onto general practice.
92. NOTTINGHAMSHIRE: That conference thanks GPC England and Exec team for negotiating 24 months of mandatory training in general practice, for trainees and it is vital that we use this opportunity to promote leadership and interest in partnership model. Therefore conference mandates GPC England and Exec team to negotiate:
- (i) protected learning time for trainees in their final year (ST3) to spend time for leadership development ie with PCN leaders and other clinical leaders
 - (ii) HEE to work with local strategic bodies to design a structured programme for trainees in their final year towards understanding the partnership model.

93. BEDFORDSHIRE: That conference is concerned as to how the extra trainees and the extended training periods will be possible, given trainers in the current system are finding it too time consuming and are considering stopping training in order to manage to offer sufficient appointments to shore practices up.
94. BEDFORDSHIRE: That conference instructs GPC England to seek assurance that:
- (i) recruitment does not focus on countries with their own shortages of doctors
 - (ii) genuine effort and emphasis is placed on recruiting locally trained graduates first
 - (iii) training in non-clinical skills needed to become a partner is reinstated into the GP training programs.
95. GP TRAINEES COMMITTEE: That conference supports the 24 month training in primary care that the new English GP contract has established. We ask GPC England, through the GP trainees committee, to ensure that GP trainees are able to access relevant hospital departments and clinics to enhance and tailor their training needs.
96. HERTFORDSHIRE: That conference calls on GPC England to negotiate a system whereby non-training practices in a PCN where there is one or more training practices can be fast tracked to become full or partial training practices in order to help train the increasing numbers of trainees.
97. CLEVELAND: That conference believes that premises are a major barrier to the development of practices and demands the publication of the Premises Cost Directions before 1 April 2020.
98. DERBYSHIRE: That conference demands that childcare costs to support GPs returning to work after parental leave should be available to all salaried GPs, not just those on the induction and refresher scheme.
99. LEEDS: That conference welcomes the initiative to provide support for GPs on the I+R scheme with children under 11 years and calls for NHSE/I and government to provide greater support for working GPs with dependent children under 16 years.
100. BERKSHIRE: That conference welcomes the introduction of financial help towards childcare in the new contract but:
- (i) feels it is too little too late
 - (ii) believes it is inadequate as an incentive to retain valuable GP's in the workforce
 - (iii) calls for it to be increased to £500 per day worked.
101. NORTH YORKSHIRE: That conference demands GPC England refuse all further negotiation on PCNs until the pension issues are resolved to the satisfaction of the profession.
102. NORTH STAFFORDSHIRE: That conference demands the GPC Executive to make NHSE's promised funding streams in the GP contract as new investment and not to make CCGs identify this funding in their baseline.
103. HULL AND EAST YORKSHIRE: That conference recognises the wide variation in CCG support being given to PCNs, and calls on GPC England to negotiate a nationally agreed, compulsory level of support to enable PCNs to successfully progress.
104. NORTH YORKSHIRE: That conference demands that PCNs control the pace of integration bottom up and be given sufficient permission and support to push back on unwelcome top down integration where required.
105. NORTH ESSEX: That conference believes nursing homes of today are akin to cottage hospitals of the past and should not be included in core GMS or PCN services.

106. OXFORDSHIRE: That conference believes that where a CCG currently funds a service which will now be part of the DES, to a level greater than the DES:
- (i) it is not acceptable to simply recommit those funds into other services as this will result in greater work for the same money
 - (ii) such funding must be used to provide true real terms uplifts to locally commissioned services with no associated increase in workload.
107. SUFFOLK: That conference directs GPC England to ensure that if general practice is to hold more risk, it should be rewarded for this.
108. CAMBRIDGESHIRE: That conference insists that PCN funds are not made available to NHS trusts for as long as the PCN DES is extant.
109. DEVON: That conference believes that it is unacceptable for the PCN DES to continue to require additional work from GPs and practice teams with no direct remuneration, instead we mandate GPC England to negotiate specific funding directly to practices for each specification of the DES, in particular noting that even in areas where recruitment is straightforward, workforce development is not linear and increases existing teams' workload before improving it.
110. GATESHEAD AND SOUTH TYNESIDE: That conference notes with concern that the primary care network vision presented in 2019 has deviated greatly from the partnership review it was based upon and, noting good audit cycle practise, calls for the partnership review to be run again by the same author, suggesting that:
- (i) no further changes to the DES take place until this has been conducted and assessment made of the early effects of PCNs on practice and partnership function, stability and morale
 - (ii) the recommendations be used as the basis for a complete re-evaluation of the PCN project and five year plan
 - (iii) GPC and NHSE be reminded that PCNs were sold to the profession as a means of easing our increasing workload, rather than adding to it.
111. NORFOLK AND WAVENEY: That conference calls upon GPC England not to agree further enhancements to PCN enhanced services until the promised 6000 extra GPs are delivered by government.
112. MERTON: That conference regards the imposition of auto-enrolment and the abbreviated reflection time available to be inappropriate, unnecessary and potentially very destabilising to PCNs and to the member practices and demands that GPC England remove this from the contract.
113. NORTH YORKSHIRE: Clinical directors are clearly key players in the future of the NHS long term plan, but they are not LMCs and may have limited experience and capacity wise regarding how much they can truly represent the profession and conference demands that LMCs statutory representative role is better integrated into PCNs to ensure every GP has grass roots representation at PCN/place/ICS level.
114. NORTH YORKSHIRE: That conference believes clinical directors / PCNs form a tiny fraction of the overall GP contract and it is essential that the historic statutory role of LMCs is not side lined in preference to PCNs and instructs GPC to further enshrine our representative role in the PCN DES contract to support practices and clinical directors.
115. DORSET: That conference recognises the value of the National GP Retention Scheme and urges GPC England to negotiate for its funding to be centralised in order to prevent CCGs 'capping' the number of retainer posts or varying the scheme due to local budgetary constraints.
116. LEWISHAM: That conference recommends that the GP Retention Scheme be changed so that approval for new retainers is no longer discretionary, so that CCGs must fund applicants who fulfil the requirements of the scheme.
117. NORTH YORKSHIRE: That conference demands a lift of nonsensical limitations on recruiting locum GPs (eg the restriction of continuous work for more than six months) to help ease manpower problems.

118. LEICESTERSHIRE AND RUTLAND: That conference moves that it is made compulsory that CCGs, ICS and other NHS bodies involve LMC in oncoming redesign of NHS to safeguard the interests of general practice.
119. NORFOLK AND WAVENEY: That conference asks GPC England to ensure NHSE national is holding local NHSE&I, STP/ICS' and CCGs to account to ensure stabilisation of general practice is their priority and practices and PCNs are supported sufficiently to lead on this.
120. NORFOLK AND WAVENEY: That conference asks GPC England to ensure NHSE&I national are scrutinising all CCGs to ensure the investment that is intended for general practice and PCNs is provided to them in line with the requirements and the intent of the PCN DES.
121. NORFOLK AND WAVENEY: That conference asks GPC England to ensure NHSE&I are scrutinising the commissioning of all areas of the NHS to ensure every area is appropriately resourced and held to account to deliver their contract to avoid inappropriate workload being shifted without resource to general practice and PCNs.
122. LEEDS: That conference:
- (i) welcomes the commitment to introduce enhanced shared parental leave for salaried GPs
 - (ii) demands that all GPs working in practices and NHS organisations should be eligible for enhanced shared parental leave.
123. HERTFORDSHIRE: That conference instructs GPC to negotiate that the specialist skills and roles of general practitioners be recognised as a speciality in its own right.
124. NOTTINGHAMSHIRE: That conference believes that although new funds are being invested in primary care networks, and the latest contract round has also invested in general practice, that continuing to invest predominantly in secondary care is not affordable and calls for redistribution of the NHS pot towards general practice and primary care.
125. SESSIONAL GPs COMMITTEE: That conference believes that salaried GPs should be entitled to enhanced parental leave on terms no less favourable than agenda for change and junior doctor colleagues.
126. NORTH STAFFORDSHIRE: That conference is concerned about the proposed new roles under the Additional Roles Reimbursement Scheme (ARRS) of the PCN DES and urges the GPC England to:
- (i) allow individual PCN to choose their utilisable workforce as specified in 2019 and consider to increase their numbers viz clinical pharmacist +/- social prescribers than non recruitable roles proposed in the new specs
 - (ii) protect the PCN/ lead practice from bearing the cost and risk liability for training and supervision of such staff and their clinical governance
 - (iii) clarify status of those practices who would like to opt out from this DES for reason of lack of space and necessity or poor recruitment or retention of such staff.
127. HULL AND EAST YORKSHIRE: That conference believes no further contractual changes should be implemented for 2021/2022 until all PCNs have a fully updated and functioning IT infrastructure with consistently fast internet speeds.

STANDING ORDERS

STANDING ORDERS

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STANDING ORDERS

CONFERENCES

Annual conference

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

Special conference

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

Membership

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

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 until the following annual conference, unless the GPC is notified by the relevant local medical committee of any change.

Observers

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

Interpretations

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

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

Motions to amend standing orders

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

Suspension of standing orders

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

Agenda

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

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

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

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

Allocation of conference time

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

Motions not published in the agenda

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

Quorum

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

Time limit of speeches

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

Voting

60. 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 12 noon 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.

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