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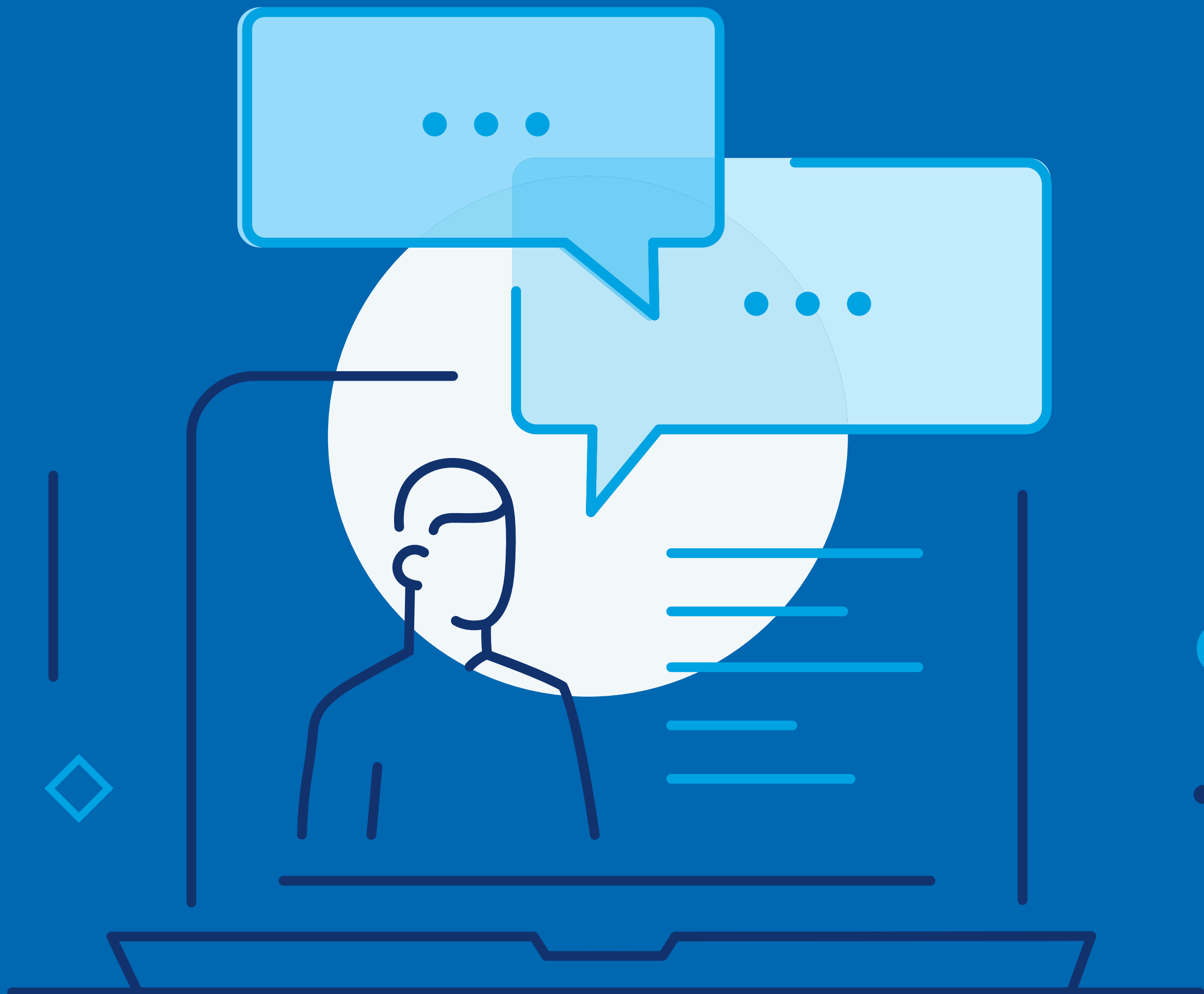

2020 Annual Conference of England LMC representatives

To be held virtually

27 November 2020

British Medical Association
bma.org.uk

Conference of England LMC Representatives

Agenda

To be held on

Friday 27 November 2020 at 9.00am
To take place virtually and a link to the virtual conference platform will be sent to all those who have registered to attend the conference.

Chair Rachel McMahon (Cleveland)
Deputy Chair Shaba Nabi (Avon)

Conference Agenda Committee
Rachel McMahon (Chair of Conference)
Shaba Nabi (Deputy Chair of Conference)

Matthew 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 18 September 2020. Although 18 September 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 emailed to the secretariat via the LMC conference inbox which is info.lmcconference@bma.org.uk **by 9am on Thursday 26 November.**

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

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

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

While the Agenda Committee has done the best job it can of prioritising motions for debate in the normal way, avoiding where possible existing policy, we know that some of the motions not prioritised for debate are also important to you, and you can use the chosen motions ballot form to nominate motions from Part 2 of the Agenda which you would like to see debated at the appropriate time during the conference. The online system will also be used to allow representatives to vote for their three preferences in advance. Further details will be sent to representatives nearer to the conference. **The ballot for chosen motions will close at 9am Wednesday 25 November.**

CONFERENCE OF ENGLAND LMCs ELECTIONS

The following elections will be held on Friday 27 November 2020.

Chair of conference

Chair of conference for the session 2020-2021 (see standing order 63) - nominations to be submitted no later than **10.00am Friday 27 November**.

Deputy chair of conference

Deputy chair of conference for the session 2020-2021 (see standing order 64) - nominations to be submitted no later than **12.00 Friday 27 November**.

Five members of LMC England conference agenda committee

Five members of the England conference agenda committee for the session 2020-2021 (see standing order 65) - nominations to be submitted no later than **13.00 on Friday 27 November**.

How to take part

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

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

Voting opens for all positions: 2pm Friday 27 November
Voting closes for all positions: 2pm Monday 30 November
Results announced soon after voting closes.

The reason for closing the vote after conference is to ensure representatives are able to focus on engagement on the virtual LMC England conference platform and reduce distraction on what we anticipate will be an intense day for all those participating.

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

Schedule of business
Friday 27 November 2020

Item	Time
Opening business	09.00
Chair of GPC England's report	09.20
COVID-19	09.30
Primary and secondary care interface	10.00
Chosen motions	10.20
Break	10.50
Role of NHSEI in supporting general practice	11.10
Digital first	11.30
Core funding	11.50
NHS 111	12.10
GP consultation	12.20
Lunch	13.00
Questions to GPC England	14.00
DDRB	14.40
Chosen motions	15.00
PCN ballot	15.10
Break	15.30
Sessional GPs	15.40
ARRS	16.00
PCN funding	16.10
Vaccination programme	16.30
Closing business	17.00

OPENING BUSINESS 09.00

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

Memorial and one minute's silence to remember colleagues and loved ones who lost their lives due to COVID-19.

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

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

* 3 AGENDA COMMITTEE: 'C' motions: That conference agrees to amend standing order 26 to read:

A ballot of representatives shall be conducted to enable them to choose motions, ('C' motions), amendments or riders for debate. Using only the prescribed form, which must be received by the GPC England secretariat by a time to be agreed and advertised by the agenda committee, each representative may choose up to three motions, amendments or riders to be given priority in debate. The three motions, amendments or riders receiving the most votes shall be given priority.

CHAIR OF GPC ENGLAND'S REPORT 09.20

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

COVID-19 09.30

* 5 AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference, in respect of the response of general practice to the COVID-19 pandemic, commends practices for stepping up to the unique challenges, and:

(i) congratulates GPs and clinicians for developing and using alternative consulting methods during the pandemic

(ii) believes that finding our way through the COVID-19 pandemic has been and continues to be a driver for modernisation and positive developments

(iii) believes general practice has demonstrated that the GP partnership model works and expects the government to remain committed to this model of primary care

(iv) instructs GPC England to inform the government that GPs will not accept the return to the previous conditions of micro management and central control once the pandemic is over

(v) mandates GPC England to use this to insist on investment in the core contract rather than the flawed PCN model.

5a TOWER HAMLETS: In response to COVID-19, conference:

(i) insists that government reimburses practices so that staff can be paid in full while they are unwell or self-isolating

(ii) instructs GPC England to inform the government that GPs will not accept the return to the previous conditions of micro management and central control once the pandemic is over

(iii) insists that government publicly recognises the amazing rapid response of general practice to the pandemic

(iv) requires any healthcare professional who publicly made unsubstantiated negative comments about the general practice response formally apologise to the profession or face being referred to the GMC by GPC England.

5b CLEVELAND: That conference, in respect of the response of general practice to the COVID-19 pandemic:

(i) commends practices for stepping up to the unique challenges

(ii) believes this demonstrates the value of investment in core general practice

(iii) mandates GPC England to use this to insist on investment in the core contract rather than the flawed PCN model.

5c AVON: That conference congratulates GPs and clinicians for developing and using alternative consulting methods during the pandemic.

5d WARWICKSHIRE: That conference endorses general practice as an environment of creativity and rapid change. That finding our way through the COVID-19 pandemic has been and continues to be a driver for modernisation and positive developments but that we need to find a position of balance between the old and new ways of working which is best for patients as well as protective for professionals.

5e LIVERPOOL: That conference believes that general practice working throughout the COVID-19 pandemic has demonstrated that the GP partnership model works and expects the government to remain committed to this model of primary care (amongst other established models).

5f NORTH YORKSHIRE: That conference recognises the positive impact at the start of COVID-19 to have a high level of trust / low level of bureaucracy from NHSE which allowed general practice to demonstrate how much it is capable of and instructs GPC England to negotiate with NHSE so this does not revert back, stifling innovation and reducing adaptability.

5g COUNTY DURHAM AND DARLINGTON: That conference notes the GP response to the COVID-19 pandemic has confirmed that GPs and the partnership model are trustworthy, responsive to patients' needs, and excellent value for money. As a result, conference demands that NHSE should stop micro managing general practice by abandoning QOF and the PCN DES and change to a low bureaucracy, high trust method of paying general practice by increasing the global sum by an equivalent amount; leaving GPs and their staff with more time for clinical care.

5h AVON: That conference congratulates general practice in organising their practices quickly and effectively during the first wave of the COVID-19 pandemic to deliver a safe and effective service to their patients and to protect their staff.

5i COVENTRY: That conference wants the Health Secretary and the Prime Minister to publicly thank GPs national media for their huge and rapid response to COVID-19 which has allowed patient care to continue whilst helping to protect our communities.

5j LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference recognises the achievements, flexibility, and forward thinking that general practice has clearly demonstrated during these unprecedented times and will likewise go above and beyond to protects its members against unconfounded expectations and political gamesmanship.

5k HERTFORDSHIRE: That conference instructs GPC England to run a positive publicity campaign setting out the vital role of general practice, the high level of care it delivers and how effectively and efficiently it has responded to the COVID-19 pandemic.

5l CUMBRIA: That conference:

(i) recognises that the ability of general practice to rapidly evolve working practices averted a national catastrophe in primary care provision during COVID-19

(ii) recognises that this entailed a great mental and financial effort, the brunt of which was borne by partnerships

(iii) believes that to avoid burnout and provide appropriate acknowledgement, GPC England should negotiate with NHSEI to provide recurrent funding for activities to promote mental wellbeing in practices and one days extra leave a year for partners.

5m HULL AND EAST YORKSHIRE: That conference calls on GPC England to:

(i) highlight that the public are uninformed about the impact of the COVID-19 pandemic on the NHS

(ii) deliver a full communications campaign to ensure patients understand their care will be delayed

(iii) lobby for the instant dismissal of complaints which relate solely to access choice

(iv) pursue a public apology where the damaging suggestion that GP surgeries are not open has been made.

* 6 AGENDA COMMITTEE TO BE PROPOSED BY OXFORDSHIRE: That conference believes the government has failed to provide sufficient funding or resources to general practice in a timely manner to fight the COVID-19 pandemic, and:

(i) believes the statement by Chancellor Rishi Sunak that “the NHS will get whatever it needs” is completely out of step with reality

(ii) believes it is far from business as usual in general practice and the current service needs significantly more investment if it is to provide the same levels of service provided prior to the COVID-19 epidemic

(iii) calls on GPC England to push NHSEI to ensure all income from item of service contracts, including national and local schemes, should be income protected until the pandemic is truly over

(iv) calls on GPC England to negotiate that no further requirements are stipulated as part of the PCN DES until practices have recovered from the COVID-19 pandemic

(v) demands that GPC England track and share, in real time, the proportion of additional NHS funding given to primary care as a result of COVID-19, winter or other pressures and hold NHSE to account on proportional spending commitments.

6a OXFORDSHIRE: That conference believes the government has failed to provide sufficient funding or resources to general practice in a timely manner to fight the COVID-19 pandemic and therefore believes the statement by Chancellor Rishi Sunak that “the NHS will get whatever it needs” is completely out of step with reality.

6b HEREFORDSHIRE: That conference believes it is far from business as usual in general practice and the current service needs significantly more investment if it is to provide the same levels of service provided prior to the COVID-19 epidemic.

6c OXFORDSHIRE: That conference recognises that the COVID-19 pandemic has significantly affected workload and sustainability within primary care, and that practices have faced significantly increased costs associated with Covid due to increased staff and other costs, and:

(i) recognises that practices have undergone a significant change in their normal working practice in their response to the COVID-19 pandemic

(ii) feels it is unfair for practices to be financially penalised as a result of putting their patients first

(iii) calls on GPC England to push NHSE to ensure all income from item of service contracts, including national and local schemes, should be income protected until the pandemic is truly over

(iv) calls on GPC England to negotiate that no further requirements are stipulated as part of the PCN DES until practices have recovered from the COVID-19 pandemic.

6d SUFFOLK: That conference demands GPC England track and share, in real time, the proportion of additional NHS funding given to primary care as a result of COVID-19, winter or other pressures and hold NHSE to account on proportional spending commitments.

6e SEFTON: That conference believes that the NHSEI COVID-19 exceptional costs reimbursement arrangements should be maintained for general practice the foreseeable future:

(i) as a national arrangement with central funding to meet the inevitable exceptional cost which will be incurred in the coming winter, and

(ii) include the additional cost of extra staff hours to secure the recovery of normal practice working in the meantime.

6f NORFOLK AND WAVENEY: That conference asks GPC England to ensure general practice receives appropriate, non-time limited financial support to meet the COVID-19 expenses incurred by general practice.

6g SOMERSET: That conference resents the inclusion of post payment verification (PPV) requirement on CCGs in the COVID-19 support fund letter as it implies that practices are untrustworthy and sets a higher standard for them than applies to trusts. Conference demands that in future either PPV requirements are removed or that they should apply to all providers equally.

6h LEEDS: That conference:

(i) commends general practice for its rapid and phenomenal response to the COVID-19 pandemic

(ii) condemns the government for failures to provide the necessary PPE practices needed to protect their workforce

(iii) condemns NHSEI for failing to provide full free occupational health service provision for general practice as part of risk assessment of the workforce and patients

(iv) demands that all additional costs relating to the general practice pandemic response must be reimbursed by government and NHSEI.

6i LAMBETH: That conference demands that the government assures income protection, without targets, for practices to ensure their sustainability during a pandemic to guarantee minimum income per patient for 2020 / 2021 and 2021 / 2022.

6j WORCESTERSHIRE: That conference supports adequate reimbursement for all practice COVID-19 related expenses without question as was promised by the government at the start of the pandemic.

6k WEST SUSSEX: That conference believes general practitioners should be reimbursed for all additional financial costs associated with responding to NHS England's guidance for general practice during the COVID-19 incident.

6l MERTON: That conference acknowledges the government's steps to support the NHS by annulling all acute trust debt allowing it to focus on the COVID-19 threat and calls upon government to:

(i) demonstrate the same kind of support by annulling all debt accrued by general practices caused by the imposition of "market value" rents and leases

(ii) ensure that costs of this kind are not imposed again by organisations, such as NHSPS or CHP, and

(iii) recognise that annulling these debts for general practice would reduce practice closures and help to improve retention of GPs.

6m DERBYSHIRE: New ways of working to deal with the COVID-19 pandemic has resulted in ongoing increased telephony and cleaning charges for practices. Conference demands that these additional costs must be covered by a properly costed uplift to the global sum.

6n NORTH ESSEX: That conference believes that general practice has been deliberately misled by NHS England with regards to COVID-19 related expenses and calls on GPC England to ensure that all costs are reimbursed as soon as possible.

6o CLEVELAND: That conference deplores the actions of NHS England that go against the spirit of the statement that "no practice will be out of pocket as a consequence of COVID-19", with a disproportionate level of scrutiny resulting in an administrative burden for practices, and mandates GPC England to negotiate proactive support and accessible resources to protect general practice workforce and capacity during the ongoing, unpredictable, and costly COVID-19 emergency.

6p NOTTINGHAMSHIRE: That conference warns of general practice becoming overwhelmed in the event of a second wave of COVID-19 and urges GPC England to halt NHSEIs move to a return to normal duties with some key principles to protect patient care for the remainder of 2020/21 at least:

(i) all DES / LES funding should be protected regardless of activity levels

(ii) PCN DES requirements should be halted until at least April 2021.

6q BUCKINGHAMSHIRE: That conference notes with concern the “triple whammy” of a potential second peak of COVID-19, winter pressures and the backlog of elective work suspended during the pandemic, in addition to embarking on the biggest flu vaccination campaign in history and calls on GPC England to demand that NHSE postpone all PCN DES workload that takes clinicians away from the front line until the pandemic is over.

PRIMARY AND SECONDARY CARE INTERFACE 10.00

* 7 AGENDA COMMITTEE TO BE PROPOSED BY HILLINGDON: That conference is concerned about the unfunded transfer of workload and responsibility from secondary care to GP during COVID-19, and calls on GPC England to:

(i) ensure all secondary care clinicians undergo an annual educational activity covering their duties and responsibilities under the NHS Standard Contract

(ii) urgently negotiate that NHSEI mandates that all investigations initiated in secondary care are followed up in secondary care

(iii) ensure that GPs are not held responsible if their patient’s clinical medical condition deteriorates whilst on unacceptably long waiting lists

(iv) insist that NHSEI formally engage with CCGs to provide clear guidance on how to define unacceptable workload shifts

(v) agree financial sanctions against providers who do not reduce this transfer, with resulting funds being paid directly to affected practices.

7a HILLINGDON: That conference is concerned about the unfunded transfer of workload and responsibility from secondary care to GP during COVID-19, ranging from patient waiting lists and managing highly complex needs in the community to prescribing medication that is traditionally specialist only and following up of secondary care investigations, and calls on GPC England to:

(i) urgently negotiate that NHSEI mandates that all investigations initiated in secondary care are followed up in secondary care

(ii) urgently negotiate that NHSEI mandates that all work for holding patient referral lists to secondary care is adequately resourced

(iii) agree with NHSEI what work would be appropriate to transfer to general practice on a temporary basis and the fees for such work.

7b DEVON: That conference recognises that in an extraordinary time, such as a pandemic, it may lead to extraordinary actions, conference does not accept that the wholesale shift of secondary care workload into primary care is an acceptable extraordinary action and believes that this unprofessional behaviour must stop. Conference thinks that GPC England must:

(i) insist NHSEI formally engage with CCGs to provide clear guidance on how to define unacceptable workload shifts

(ii) co-design a process with NHSEI to mandate regular reports from CCGs to NHSEI on what is being done to monitor and reduce these inappropriate behaviours, with these reports shared with LMCs and GPC England

(iii) mandate that, given the lack of incentive to reduce this for trusts on block contracts, sanctions for those providers that do not actively engage with reducing this should be nationally agreed and paid directly to the affected GP practices.

7c AVON: That conference requests that GPC England works on the behalf of general practice to ensure that GPs are not held responsible if their patient's clinical medical condition deteriorates whilst on unacceptably long waiting lists.

7d HULL AND EAST YORKSHIRE: That conference believes:

(i) primary care is operating at beyond full capacity

(ii) the inability of secondary care to manage their waiting lists is directly impacting on primary care

(iii) GPC England must co-ordinate action to report and reject inappropriate workload transfer

(iv) if unfunded workload transfer is not addressed, it will lead to the collapse of primary care.

7e LIVERPOOL: That conference believes that it is inexcusable that secondary care is using COVID-19 as the reason for treating GPs with contempt expecting them to undertake tests and investigations, which should be being organised by secondary care, and expects NHSEI to ensure that this surreptitious transfer of work ceases.

7f COVENTRY: That conference recognises that waiting lists have risen significantly as a result of the pandemic. This risks harm to patients and increased workload and risk management for GPs. NHSE must ensure a proper system of communication to all affected patients so they are fully informed and supported by secondary care, and that this workload does not fall back on practices. (Supported by Warwickshire)

7g KENT: That conference demands that, in order to address inappropriate transfers of workload that breach the NHS standard contract:

(i) commissioners must receive and act upon all near misses that have occurred as a result of the transfer

(ii) financial penalties must be imposed; and

(iii) all secondary care clinicians undergo an annual educational activity covering their duties; and responsibilities under the contract; or

(iv) practices are resourced to accept the transfer of workload.

7h BEDFORDSHIRE: That conference directs GPC England to negotiate with the NHSE for induction to include a mandatory education module for secondary care doctors in training explaining how primary care works, what the GMS contract covers, and what it does not cover, and that GPs are not "community house officers" for trusts. This to be repeated when a doctor is appointed to a consultant post.

7i NORFOLK AND WAVENEY: That conference asks GPC England to ensure the move to increase telephone triage and consulting in secondary care does not result in hospital workload shifting to general practice inappropriately and without appropriately funded resources.

7j CAMBRIDGESHIRE: That conference recognises the need for NHS systems to collaborate and provide mutual support in a pandemic - but notes with concern, the result of GPs taking on a significant burden of clinical risk beyond the remit of GMS; an unacceptable and inappropriate level of workload transfer from secondary care which falls foul of the NHS Standard Hospital Contract 2016; the perilous risk to general practice of managing ongoing; historic; and transferred demand in this crisis and calls on GPC England to:

(i) urgently address this dangerous and unacceptable situation with NHSEI in the interests of patient and GP/practice team safety

(ii) reinstate the workload policy group.

7k HULL AND EAST YORKSHIRE: That conference demands secondary care must be wholly responsible for managing their own waiting lists without recourse to primary care.

7l WORCESTERSHIRE: That conference rejects the unresourced transfer of work from secondary care to general practice and insists that general practice is protected to manage its own backlog of patient care.

7m BUCKINGHAMSHIRE: That conference deplores the ongoing and systematic denigration of general practice, and:

(i) is tired of our profession being regarded as community house officers by secondary care

(ii) continues to be exasperated by persistent contract breaches by secondary care dumping workload into primary care

(iii) believes the BMA template letters practices are encouraged to send in response to such breaches serve no useful purpose

(iv) calls on GPC England to demand contract breach action be taken by NHSE toward secondary care providers who continue this behaviour.

7n BRADFORD AND AIREDALE: That conference applauds the unprecedented flexibility in the provision of primary care over the pandemic in recent months, and recognises the future implications of some of these rapid changes; in response to the shift of secondary care work, conference calls for a realignment of resources for the work and the right for practices to decline to take on this work if this does not happen.

7o COUNTY DURHAM AND DARLINGTON: That conference deplores the shift of workload from secondary to primary care in the wake of the first COVID-19 peak in spring 2020. We call for GPC England to secure additional funding for primary care to account for this workload shift.

7p AVON: That conference calls for an immediate solution for the tsunami of unfunded work that is being transferred from secondary care to primary care under the auspices of the COVID-19 pandemic.

7q CITY AND HACKNEY: That conference commends general practice for undertaking additional work that is normally done in out-patient departments (OPD) as part of the response to the pandemic but insists that:

(i) secondary care must take back responsibility for undertaking all out-patient activity including investigations and prescribing

(ii) hospitals must be instructed not to transfer this work in the future

(iii) should there be another pandemic, clear guidelines need to be in place outlining what work would be acceptable to transfer on a temporary basis

(iv) GPC England clearly define the boundaries between hospital OPD work and general practice to prevent future unfunded transfer of workload

(v) as money is supposed to follow the patient, GPC England negotiate a contract that provides direct reimbursement to practices for the cost of carrying out this secondary care work.

7r BUCKINGHAMSHIRE: That conference is outraged at reports of requests by secondary care for GPs to "hold" referrals which have been duly made, and:

(i) strongly condemns this destabilising and inappropriate workload shift

(ii) believes this represents a serious patient safety issue and places patients at risk of severe harm

(iii) mandates GPC England to publish a statement forthwith reminding secondary care providers of their contractual and professional obligations

(iv) instructs GPC England to negotiate commensurate remuneration for any such work already undertaken by practices in dealing with this workload.

7s NORTH ESSEX: That conference believes that the unintended delay in routine NHS secondary and tertiary care as a consequence of the needed prioritisation of managing the pandemic is leading to significant impact on the health of patients.

7t NORTH ESSEX: That conference believes that inefficient systems in secondary and tertiary care and cost saving measures should not be used as an excuse to shift workload into primary care. Conference therefore calls for:

(i) an immediate stop to unfunded workload transfer from secondary to primary care

(ii) secondary and tertiary care to implement a robust system for electronic prescribing similar to EPS.

7u LANCASHIRE COASTAL: That conference recognises that, due to COVID-19, there has been an increase of requests from hospital consultants for practices to carry out tests, diagnostics and ongoing monitoring, and that the responsibility for these should still remain with the appropriate referring clinician and not be used as an intermediary between the consultant and GP and that GPC England should support this principle.

7v AVON: That conference requests that GPC England works on the behalf of general practice to ensure that any increase in workload due to a trust's inability to deal with waiting lists is resourced appropriately by secondary care.

7w CAMBRIDGESHIRE: That conference demands GPC England to:

(i) negotiate urgent action from NHSEI with regard to the significant workload shift from secondary to primary care during the recovery from the global pandemic

(ii) produce clear guidance to general practice around managing workload shift in the peri-COVID-19 commissioning environment

(iii) negotiate with NHSEI that any shift in workload should be accompanied by the appropriate resources

(iv) reinstate the GPC England workload policy group to ensure that general practice is properly represented in the BMA primary / secondary care interface.

7x SURREY: That conference believes all Acute Trusts should be required to:

(i) participate in a regular monthly meeting also involving the local CCG and LMC, with

(ii) the purpose of identifying and evaluating the cause of all Hospital Standard Contract breaches and

(iii) local CCGs should use contractual sanctions to penalise Acute Trusts for recurrent breaches of their contract.

7y DEVON: That conference believes that enquiries by patients regarding appointments in secondary care or interpretation of clinical letters and plans of care from secondary care are expected to:

(i) take place in secondary care, and not be passed onto GPs or their administration teams

(ii) be supported by patients being made aware of dedicated ways to contact specialist teams for these enquiries.

7z LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is dismayed that despite repeated efforts by the BMA, GPC England and LMCs the transfer of unfunded or inappropriate work from secondary and tertiary services to general practices is accelerating and insists that the NHS Standard Contract for hospitals is altered to include a schedule of:

(i) fines to be levied against hospitals by CCGs or their successors when such incidents are reported with evidence by general practices

(ii) punitive fees that practices can charge hospitals to include an administrative fee for each time a practice has to refer a task back to a hospital, and for any work that a practice decides to undertake on the hospital's behalf.

7aa LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference recognises unfunded, unsafe left shift of work into primary care with poor communication putting the patient and GP colleagues at serious risk. The conference calls on GPC England to:

(i) nationally agree guidance and process on transfer of care

(ii) nationally agreed funding to support this additional work in the form of DES (directly enhanced service)

(iii) empower primary care to invoice for the clinical or administrative time spent on taking over the work.

7bb OXFORDSHIRE: That conference believes that all activity generated in primary care by secondary care should have funding attached in the form of item for service contracts and calls on GPC England to negotiate for this.

7cc BRADFORD AND AIREDALE: That conference demands that if secondary care request primary care to perform then this automatically constitutes a contract and the GP can directly invoice them for the work.

7dd BEDFORDSHIRE: That conference:

(i) believes that funding should follow the patient

(ii) instructs GPC to negotiate a community tariff price for work such as a GP ordering an MRI at a consultant's request, where the community tariff price for each such activity would be deducted from the price of the hospital contract and paid to the GP practice actually doing the work.

7ee NORTH AND NORTH EAST LINCOLNSHIRE: That conference calls for GPC England to lobby for a separately commissioned service to co-ordinate and manage any workload generated by secondary care.

7ff NOTTINGHAMSHIRE: That conference sees a difference in the rigour with how CCGs manage GP contracts versus hospital contracts and demands that GPC England compels NHSEI to impose penalties for breaches of the hospital contract where it leads to unresourced shifting of work to general practice.

CHOSEN MOTIONS 10.20

BREAK 10.50

ROLE OF NHSEI IN SUPPORTING GENERAL PRACTICE 11.10

* 8 GATESHEAD AND SOUTH TYNESIDE: That conference finds abhorrent and insulting much of NHSEI's communications with the profession, the press and the public and:

(i) demands that NHSEI apologise and retract all communications that have implied general practitioners have not been fully involved in patient care throughout the pandemic, staining our reputation and inciting complaints

(ii) deplores the habit that appears to have developed of NHSEI briefing journalists, particularly those hostile to general practice, before communicating with the profession and its representatives

(iii) demands that general practice's contribution to the management of both the pandemic, and continuation of service whilst other parts of the healthcare system have stepped back from face-to-face work, be recognised, particularly given the general practitioners who have died in the course of their duties to the public.

8a LIVERPOOL: That conference is beyond appalled at the crass insensitivity and apparent intentional disrespect shown by NHSEI in its poorly handled communication regarding GPs and the way in which GPs have been working, professionally, sometimes at risk to themselves with certain face to face consultations, throughout this pandemic, and calls on those responsible for this communication to either resign or be dismissed.

8b DEVON: That conference, with respect to NHSEI's letter to GPs dated 14 September 2020, and released to the press on 11 September 2020, demands that NHSEI submit to GPC England a detailed root cause analysis explaining how they were able to present such an appalling, inaccurate, and insulting view of general practice to the media and clearly showing the changes they have made in process and personnel to ensure that no further attacks on the profession are made in this way.

8c NORTH STAFFORDSHIRE: That conference recommends that GPC England develops a:

(i) pro-active communication policy to refute and condemn NHSE communications about general practice

(ii) communication policy that takes active control of the media agenda with key issues that are relevant, important and truthful about general practice.

8d CLEVELAND: That conference has lost faith due to the behaviour of NHS England at the height of the COVID-19 pandemic, when changes to working practices were communicated by social media rather than being properly negotiated and agreed with GPC England. Conference demands an explanation from both GPC England, and NHS England, with timely implementation of lessons that have been learned.

8e BERKSHIRE: That conference believes that the prescriptive and centralised "command and control" approach by NHSE toward COVID-19 is devoid of context for local communities and hindering the pandemic response and calls for this to be devolved to local level.

8f NOTTINGHAMSHIRE: That conference believes that LMCs and many practices have lost respect for NHSEI due to damaging communications sent out recently and have shown themselves to be out of touch with the reality of pressures on general practice. We urge NHSEI to show that they recognise that practices are working in unprecedently difficult times and only write to practices / CCGs / media when the contents of such have been agreed with GPC England.

8g WAKEFIELD: That conference believes that the COVID-19 crisis has demonstrated that NHS England's leadership is poor and it is unfit for purpose, does not command the confidence of GPs and should be disbanded.

8h NORTH YORKSHIRE: That conference recognises the unique challenges the past few months during COVID-19 have brought for all organisations and instructs GPC England to inform NHSE / DHSC that their manipulation of communications has become disrespectful and damaging, particularly with retrospective information and inappropriate media briefings.

8i BUCKINGHAMSHIRE: That conference is appalled and insulted by the letter sent to practices by NHSE on 14 September, and:

(i) asserts in the strongest possible terms that this undermines the outstanding effort primary care has made

(ii) demands NHSE share what data they based this letter on, within 28 days of this conference

(iii) calls for support for practices rather than public denigration, especially toward those who may be struggling to deliver services during this pandemic.

8j DEVON: That conference, with respect to NHSEI's letter to GPs of 14 September:

(i) is appalled at the wording of the letter which will be seen as a rebuke to the hard working GPs across the country

(ii) demands that an apology is issued by NHSEI

(iii) demands that NHSEI publicise and highlight their standard operating procedures for general practice which specifically emphasise the use of various forms of non face to face consultations

(iv) demand that NHSEI publicly commend GPs for following their advice so well.

8k CAMBRIDGESHIRE: That conference notes with utter dismay the lack of adequate, timely protection for GPs and their practice teams in the pandemic for which some colleagues paid the ultimate price, and calls upon GPC England to influence the BMA and other stakeholders in calling for an enquiry into the handling of the COVID-19 pandemic by the DHSC, PHE and NHSEI and seeking a public apology from the CQC.

8l WEST SUSSEX: That conference was appalled at the behaviour displayed by NHS England in undermining the professionalism and reputation of general practitioners and has:

(i) no trust in the NHS England Director of Primary Care Dr Nikki Kanani and

(ii) demands a full apology, and

(iii) a detailed explanation of the incident, and

(iv) an assurance this will not occur again.

8m OXFORDSHIRE: That conference believes that there has been a lack of leadership, timely governance and management of the COVID-19 pandemic and that NHSE and CCGs must be mandated to co-ordinate, communicate and provide clinical services in the community for patients suffering or potentially suffering with SARS CoV2.

8n NEWHAM: That conference acknowledges the increased workload in primary and secondary care, due to the COVID-19 pandemic and instructs GPC England to:

(i) demand that this increased workload due to these extraordinary circumstances are publicly acknowledged by NHSEI

(ii) demand that where there have been failings, NHSEI asks the appropriate questions and the lessons learnt are shared widely and transparently

(iii) reject any attempt to blame system failings on general practice

(iv) reject any attempts to hold general practice accountable for the unacceptable high rate of care home deaths due to COVID-19.

8o CLEVELAND: That conference is frustrated and demoralised by the repeated messages that "GPs are closed" and calls on NHS England to mount a patient facing campaign to counter this wholly false and dangerous perception.

8p KENT: That conference deplores the lack of support afforded to practices by NHSE during the COVID-19 crisis and condemns the:

(i) failure to guarantee funding streams for additional work

(ii) unnecessary bureaucracy imposed

(iii) misleading of the public into believing practices were closed.

DIGITAL FIRST 11.30

✱ 9 AGENDA COMMITTEE TO BE PROPOSED BY LINCOLNSHIRE: That conference notes with deep concern the proposal of NHSEI to commission extended (eg 20 year) APMS contracts from providers to enable digital health provision in under-doctored or deprived areas and calls upon GPC England to:

(i) oppose the proposal to award longer term APMS contracts

(ii) seek a legal challenge around the impact on the provision and stability of GMS services in these areas

(iii) make this a ‘red line’ in any future contract negotiations.

9a LINCOLNSHIRE: That conference believes that allowing new APMS contractors to provide remote services in under-doctored areas will make the workforce issues worse and will not improve care for patients, so demands that:

(i) NHSEI stops pursuing this course of action

(ii) GPC England makes this a 'red line' in any future contract negotiation.

9b TOWER HAMLETS: That conference believes that patients are best served through GMS contracting mechanisms and:

(i) opposes the proposal to award longer term APMS contracts

(ii) requires GPC England to formally challenge the current NHSEI policy on only tendering GP contract as APMS contracts

(iii) instructs GPC England to negotiate a change to the current NHSEI policy, so that all future GP contracts being tendered are awarded as GMS contracts where the provider fulfils the requirements to hold such a contract. (Supported by all London LMCs)

CORE FUNDING 11.50

∗ 10 WALTHAM FOREST: That conference strongly believes that the current GP funding formula is both seriously flawed and outdated and demands that GPC England:

(i) urgently calls for NHSEI to review the GP funding formula

(ii) ensures that any future formula provides fair and full remuneration which recognises GP workload

(iii) ensures that a revised funding formula appropriately and proportionately accounts for differences in patient demographics, deprivation and health-seeking behaviour at individual practice level

(iv) ensures that any revision does not result in practices losing out.

NHS 111 12.10

∗ 11 CITY AND HACKNEY: That conference is concerned by recent moves to increase the number of GP appointments available to NHS 111 for direct booking and demands that GPC England ensures that the number of directly bookable GP appointments allocated to NHS 111 are not increased beyond what was agreed in the 2019 / 2020 GMS Contract.

11a DEVON: That conference notes that with the introduction of 111 first and its stated intent of reducing A&E attendance, conference demands central action and plans to ensure that:

(i) primary care is not negatively impacted by this shift of patient access and expectations

(ii) any shifts of patients towards general practice due to this system are monitored in real time and the impact on GP availability and workload mitigated through central action such as redirecting 111 First to send more patients towards hospital rather than fewer if general practice activity reaches agreed escalation points.

11b NORFOLK AND WAVENEY: That conference requests that the requirement for NHS 111 direct booking is removed, and that if this is not possible that it is reduced back to the 1 in 3,000 which is in the contract and that practices are given the flexibility to determine the type of appointment/referral made and to ask NHS 111 to utilise practice’s online consultation models where this is in place.

11c NORFOLK AND WAVENEY: That conference asks GPC England to seek assurances that if NHS 111 is used to triage A&E this will not result in a shift of work from A&E to general practice without sufficient resource being provided.

11d NORFOLK AND WAVENEY: That conference requires that general practice remains independent and that NHS 111 First is not progressed to become a front end of general practice but that patients are still encouraged to contact their GP practice directly in the first instance.

11e LIVERPOOL: That conference deplores the continually increasing access being granted to NHS 111 to GP appointment books, thus decreasing general practice's ability to determine its own workload and insists that now is the time to allow GP practices to be able to declare that they have reached full capacity.

11f OXFORDSHIRE: That conference believes that patients' safety is being put at risk by expecting general practice to take on an unlimited clinical workload and:

(i) urges GPC England to robustly protect practices from inappropriate workload dump from secondary care

(ii) demands a review into NHS 111 being able to book directly into practices

(iii) requests GPC England to work with relevant stakeholders to develop a clinical alert system applicable to primary care similar to those already in operation in secondary care to highlight the pressure primary care is under

(iv) believes an urgent review is required to define what is a safe workload for practices and PCNs to be expected to take on in terms of numbers of patient contacts each day.

11g CAMBRIDGESHIRE: That conference deplores the continued abuse of emergency legislation to allow increasingly unfettered access to primary care via the CCAS scheme, vis a vis its transformation into an NHSE access Trojan horse, and calls upon GPC England to immediately negotiate the return to the previously contracted numbers for direct NHS 111 booking.

11h CAMBRIDGESHIRE: That conference deplores the continued use of the CCAS scheme to prioritise the workload of the out of hours services and emergency departments, to the detriment of in hours general practice, and calls upon GPC England to immediately negotiate the return to the previously contracted numbers of direct bookings.

11i WAKEFIELD: That conference does not believe that general practice has elastic walls and that the continued provision of appointments for NHS 111 at 1 per 500 patients is untenable with the other pressures we are under and should end forthwith.

11j MID MERSEY: That conference believes that telephone calls to NHS 111 should be appropriately triaged by clinicians with a clear understanding of general practice. The current practice of direct booking of GP appointments by NHS 111 is neither appropriate or necessary.

GP CONSULTATION 12.20

∗ 12 BEDFORDSHIRE: That conference:

(i) deplores the action of NHSEI in failing to support GPs in the use of their professional judgement in deciding when and if a patient needs a face-to-face appointment

(ii) calls for a national campaign to explain why a face-to-face GP appointment is not always necessary or safe

(iii) following the words of the Secretary of State for Health and Social Care, agrees that the "new normal" will mean that more consultations will be done by telephone or video consultation rather than face-to-face

(iv) emphasises that if a doctor feels a patient needs to be seen face-to-face such an appointment will be arranged.

12a BARKING AND HAVERING: That conference believes that now that GPs are required to provide 25% of F2F consultations:

(i) this should not be a requirement

(ii) F2F consultations should be on clinical lead

(iii) the decision has to be of the clinician seeing the patient.

12b AVON: That conference endorses the view that post the COVID-19 pandemic, GPs should have the freedom to decide which are the most appropriate, safe and effective consulting methods for their patients.

12c GATESHEAD AND SOUTH TYNESIDE: That conference recognises the right for a GP to decide the most appropriate means of consulting with a patient and rejects attempts by NHS England to undermine that right.

12d LINCOLNSHIRE: That conference disagrees with Secretary of State Matt Hancock's desire that ninety per cent of consultations should be carried out remotely and calls upon GPC England to challenge this and agree a more acceptable ratio which is evidence based.

12e AVON: That conference agrees that NHSE and CCGs in England should not be able to impose as a model for future working in general practice whatever they considered worked well during the COVID-19 pandemic.

12f NORTHAMPTONSHIRE: That conference believes that NHS England and the Department of Health should stop their obsession with remote consulting as the answer to general practice and allow independent contractors to decide on the best model for their local population.

* 13 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference, considering the massive shift to remote consulting demonstrated during the pandemic, mandates GPC England to:

(i) lobby educational bodies and other stakeholders to recognise the need for GP training to reflect this

(ii) state that a digital consultation with a GP still takes up at least as much GP time as a face-to-face consultation

(iii) work with stakeholders to find sensible ways to limit and manage the workload from e-consultations

(iv) ensure that there is sufficient equipment to enable at least 50% of the workforce to work remotely

(v) ensure that IT support is available 24 hours a day nationally to all GP working environments.

13a DEVON: That conference, considering the massive shift to remote consultation and dependence on IT in general practice demonstrated during the pandemic, mandates GPC England to ensure that IT support is available 24 hours a day nationally to all GP working environments (include remote working), and offers a swift and practical response to IT issues in primary care whether based in rural or urban settings.

13b HERTFORDSHIRE: That conference:

(i) welcomes the significant change in digital access which has created more ways for GPs to meet patient needs

(ii) notes that a digital consultation with a GP still takes up at least as much GP time as a face-to-face consultation

(iii) calls on GPC England to press the government to ensure GP capacity is maintained, both through the recruitment of new GPs and the retention of existing GPs.

13c WALTHAM FOREST: That conference is appalled by the limitations of the NHS IT systems as highlighted during the current COVID-19 pandemic and demands that national funding must be available to ensure that:

(i) there is equity on the IT available to all practices

(ii) all practices have enough bandwidth and hardware to offer video consultations

(iii) all practices have sufficient mobile devices to enable at least 50% of their workforce to work remotely

(iv) hardware is upgraded at least every four years.

13d GP TRAINEES COMMITTEE: That conference calls for the BMA to lobby educational bodies and other stakeholders to recognise the changing landscape of general practice and the need for GP training to reflect this including use of remote consulting which will form a significant part of the future GP workforce's workload, and calls for:

(i) formal guidance from the RCGP on where remote consulting can be appropriately incorporated into GP training

(ii) GMC to consider and publish remote supervision requirements

(iii) relevant bodies to ensure GP trainees are provided with the equipment needed to consult remotely.

13e AVON: That conference calls on NHSEI to establish a primary care IT hub with the express purpose of accelerating and sharing the development of clinical tools across all GP clinical systems.

13f NORTH YORKSHIRE: That conference instructs GPC England to negotiate changes to the GPIT contract to:

(i) ensure it is sufficiently flexible to cope with recent digital changes

(ii) support primary care to do its job via rapidly responsive support answerable to general practice

(iii) trust practices to make appropriate changes themselves if able to do so.

13g CAMBRIDGESHIRE: That conference notes the transformation in the digital provision of GMS over the past year and calls upon GPC England to negotiate with NHSEI the certainty of choice around commissioning of online consultation tools for the practice or PCN to determine what needs its patients have and understand that a one size fits all approach across an STP / CCG fails to understand patient need and practice resource.

13h NOTTINGHAMSHIRE: That conference recognises that PCN staffing is increasing but IT budgets are not keeping pace hence finding staff unable to work effectively. We urge NHSEI to fund adequate IT hardware / software to enable all PCNs and their staff to work.

13i KINGSTON AND RICHMOND: That conference supports the option of remote consultations within general practice, but believes this can only ever be one part of the service available and deplores any move to a mandatory 'call centre type' first point of contact for registered patients, believing this would damage the:

(i) health and wellbeing of patients

(ii) professionalism and reputation of general practitioners.

13j KENT: That conference expresses concern that the move to a total triage model is:

(i) having an adverse effect on recruitment to general practice

(ii) reducing the educational experience of trainees

(iii) increasing health inequalities

(iv) putting some patients at risk.

13k NORFOLK AND WAVENEY: That conference asks GPC England to note concern at the unforeseen consequences of the introduction of digital first online consultations on GP wellbeing and burn out. GPs are in danger of becoming 'telesales clinicians' and that the current workload level post COVID-19 is unsustainable.

13l NEWHAM: That conference is very concerned by the NHSEI belief that telephone and online consultations are cheaper and could be handled by a central resource and calls for GPC England to:

(i) highlight the risk of centralised virtual consultations

(ii) acknowledge and actively promote the risk that a centralised system poses to long term patient care by destroying the GP / patient relationship.

13m LIVERPOOL: That conference remains unconvinced that remote consultations should be the contact of choice without robust research into harms as well as benefits such as duplication, fragmentation, equity of access, delayed management, repetition of work, over-treatment and over diagnosis, as well as under diagnosis and loss of opportunistic screening.

13n ENFIELD: That conference acknowledges that there are advantages to new electronic online consulting systems but recognises that these tools only work because GPs know their patients from previous face-to-face contacts and calls strongly for caution against these online consulting systems being seen as a replacement for the traditional face-to-face general practice consultation.

13o LIVERPOOL: That conference believes that the move to total triage, as well as undertaking telephone and video consultations has actually increased, rather than decreased, the number of patient contacts, has increased health inequalities and has resulted in dealing with more patients than pre-COVID-19, potentially diminishing quality of care.

13p BARNET: That conference acknowledges that although online consulting solutions can be useful tools, there is the risk that unlimited usage will result in an instant access transactional service, and that continuity of care and face-2-face consultations must remain at the heart of what we do.

13q HARINGEY: That conference repudiates the mantra from the Department of Health that Digital Solutions free up GP time, when the lived experiment on the ground and in daily practice confirms the opposite to be true.

13r LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference recognises the benefits created by increased telephone and video consultations during the pandemic but believes that a Digital First general practice where patient access is only provided through direct or indirect online portals is inappropriate and will increase health inequalities, and therefore demands that GPC England does not agree to or allow any compulsion for general practices to use such systems.

13 CENTRAL LANCASHIRE: That conference believes that remote consultation and increased use of technology, whilst improving access and patient experience, could accelerate a move towards the end of traditional general practice and implores GPC England to ensure that the digital agenda does not overly reduce the human touch and feel.

13t DEVON: That conference agrees that e-consultations have been key to the safe pandemic response for many practices but notes that the increasing workload coming from this quarter has no inbuilt capacity restrictions and asks that GPC England work with stakeholders to find sensible ways to limit and manage this workload before it overwhelms practices.

13u MID MERSEY: That conference believes that e-consult has added another layer of bureaucracy and workload to general practice who are struggling under the current workload and conditions. The elderly, disabled and patients with learning disabilities are finding it particularly difficult to access general practice services via this system.

13v COVENTRY: That conference endorses general practice as an environment of creativity and rapid change. That finding our way through the COVID-19 pandemic has been and continues to be a driver for modernisation and positive developments but that we need to find a position of balance between the old and new ways of working which is best for patients as well as protective for professionals.

13w 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.

LUNCH 13.00

QUESTIONS TO GPC ENGLAND 14.00

THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the GPC England report of progress on resolutions from the Conference of England LMCs 2019 and the Special Conference of England LMCs 2020 be received.

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

This section will be held under standing order 55.

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

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

All members of conference and lay executives of LMCs are invited to submit questions for consideration. These should be submitted by email to Karen Day (kday@bma.org.uk) by noon on Friday 20 November 2020.

DDRB 14.40

* 14 AGENDA COMMITTEE TO BE PROPOSED BY LINCOLNSHIRE: That conference believes any contract deal where public sector employees can receive a pay rise with no additional funding for their employer is a failure and:

(i) believes that 2.8% does not reflect the increase in workload experienced by GPs of all types

(ii) regrets the pay rise for independent contractor GPs and their administrative staff amounted to only 1.8%

(iii) that this is a pay cut for independent contractors who have funded a pay increase to 2.8% for salaried GPs

(iv) calls upon GPC England to negotiate an increase to at least the DDRB recommended raise of 2.8%, for all GPs, backdated to April 2020.

14a LINCOLNSHIRE: That conference welcomes the 2.8% increase in remuneration for doctors and:

(i) believes that 2.8% does not reflect the increase in workload experienced by GPs of all types

(ii) insists that the increase should be for all GPs

(iii) asks GPC England to work with NHSEI to ensure that future pay awards are equal for all GPs and reflect increasing workload.

14b LIVERPOOL: That conference is appalled that despite government plaudits at the efforts of GPs and primary care during the height of the pandemic, the pay rise for independent contractor GPs and their administrative staff amounted to only 1.8%, but in reality, a pay cut for independent contractors as they have funded a pay increase to 2.8% for salaried GPs, and calls upon GPC England to negotiate an increase to at least the DDRB recommended raise of 2.8%, for all GPs, backdated to April 2020.

14c HULL AND EAST YORKSHIRE: That conference believes any contract deal where public sector employees can receive a pay rise with no additional funding for their employer is a failure.

14d SHROPSHIRE: That conference is dismayed that, despite government promises, GP numbers in the UK continue to fall, as does GP remuneration and pensions. Improving the latter would help reverse the former and conference instructs GPC England to pursue the improvements in funding necessary to achieve this.

14e LANCASHIRE COASTAL: That conference recognises the disadvantage placed on GP partners, as employers, by national minimum wage increases owed to staff and DDRB recommendations, that are not met by current contract income and mandates GPC England to pursue the government to address.

14f NORTH YORKSHIRE: That conference recognises that COVID-19 has exacerbated the perfect storm of limited capacity / falling income / increased regulation / reducing workforce, and if primary care is to survive and thrive as the NHS evolves, conference instructs GPC England to negotiate additional global sum funding to truly reflect the rapidly increasing volume of work being done in the community.

CHOSEN MOTIONS 15.00

PCN BALLOT 15.10

✱ 15 DEVON: That conference notes that the GPC England has never secured a robust democratic mandate for the PCN DES and so again asks the GPC England to secure a firm mandate from the entire profession by means of ballot before negotiating any extension or changes to the PCN DES for the year 2021 / 2022.

15a KENT: That conference believes the PCN DES puts practices and primary care at risk and it must be abolished.

15b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is dismayed that the FTE number of GPs continues to plummet and insists that to avoid complete implosion of general practice:

(i) the PCN experiment is abandoned with all related funds transferred into the Global Sum

(ii) that all incentive schemes, including golden hellos or similar for new partners or clinical staff, are targeted at general practitioners only.

15c OXFORDSHIRE: That conference is concerned that practices who exercised what they thought was a genuine meaningful choice to opt out of the PCN DES are being financially penalised via other means as more and more services are rolled into the DES, and:

(i) instructs GPC England to honestly admit that the PCN DES was never truly optional in any meaningful sense of the word and was imposed upon the profession

(ii) mandates GPC England to provide centralised support to opted out practices to enable them to flourish outside of the DES.

15d NORTH YORKSHIRE: That conference recognises PCNs, in the right set of circumstances, do represent some opportunities for general practice, but currently they are being completely overwhelmed with unrealistic expectations placed on them by the rest of the system and demands GPC England to make it crystal clear at a national level to all other providers what PCNs are and are not commissioned to do with timescales.

15e CAMBRIDGESHIRE: That conference recognises the government’s efforts to mitigate the general practice workforce crisis through the creation of primary care networks (PCNs), but notes with concern the precious time taken up with recruitment; supervision; and additional cost to partners and diversion from funding GMS, and calls upon GPC England to drop PCNs and ring-fence funding into practices where collaboration can be organic rather than forced.

15f SUFFOLK: That conference regrets the notable silence from GPC England regarding primary care networks and requests:

(i) an immediate update on how GPC England policy has been shaped by resolutions 17 to 19 passed at the English LMC Conference 2019

(ii) that GPC England note that PCNs are not legal entities and should not be treated as such

(iii) system reflection and action on how investment of such magnitude might be better used to support practices and, by extension, patients

(iv) that the continued belief held by NHSE that practices should merge is erroneous and leads to ineffective policy.

BREAK 15.30

SESSIONAL GPs 15.40

✱ 16 DORSET: That conference acknowledges the economic and professional impact COVID-19 has had on locum GPs and calls for NHSEI to:

(i) prioritise locums for work over those GPs returning to practice from retirement
(ii) enable locums to work safely
(iii) ensure locums are equipped and trained for new ways of working
(iv) ensure locums are included in future discussions over primary care's response to and recovery from the crisis.

16a HERTFORDSHIRE: That conference values the contribution of GP locums and instructs GPC England to:

(i) ensure that CCGs and PCNs are mandated to communicate and engage with locum GPs

(ii) ensure that CCGs and ICSs are mandated to include locum GPs in leadership and commissioning

(iii) ensure NHSE mandates ICSs to fund self-directed learning groups for locum GPs

(iv) take action to help combat Locums' feelings of isolation, exclusion and 'otherism'

(v) encourage LMCs to make sure they communicate with their locum GPs, if they aren't already doing so.

16b MID MERSEY: That conference believes that flexible long-term positions should be offered to locum doctors.

16c SESSIONAL GPs COMMITTEE: That conference recognises that some locum GPs have experienced inequities throughout the COVID-19 pandemic, and mandates GPC England to negotiate:

(i) appropriate IT solutions to ensure all locum GPs have clinical remote access

(ii) access to independent and fully funded COVID-19 risk assessments for all locum GPs

(iii) appropriate facilitation of workplace adaptations for locum GPs at an above practice level when this is recommended in an independent COVID-19 risk assessment.

16d SOMERSET: That conference understanding the panic that seized government and NHSE at the onset of the pandemic, nevertheless:

(i) censures the decision to recall retired, superannuated GPs to service at the same time as younger sessional GPs with dependents to support were out of work and

(ii) instructs GPC England to publicly resist in future any such ill thought through knee jerk reaction detrimental to such a large part of the workforce.

ARRS 16.00

* 17 AGENDA COMMITTEE TO BE PROPOSED BY HERTFORDSHIRE: That conference instructs GPC England to negotiate for the Additional Roles Reimbursement Scheme element of the Network Contract to allow funding for:

(i) additional GPs including locums
(ii) practice nurses
(iii) advanced nurse practitioners
(iv) non-clinical staff / supportive staff outside the prescribed national roles.

17a HERTFORDSHIRE: That conference instructs GPC England to negotiate for the Additional Roles Reimbursement Scheme element of the Network Contract DES PCNs to be expanded to allow funding for additional GPs.

17b AVON: That conference calls for GP locums to be allowed to be engaged under the ARRS underspend in 2020/21.

17c CLEVELAND: That conference, with respect to the Additional Roles Reimbursement Scheme:

(i) believes that the roles included still do not offer sufficient flexibility to meet the needs of practices

(ii) demands the inclusion of nurse practitioners within the scheme

(iii) demands additional funding to support premises expansion for roles within this scheme

(iv) demands additional funding to support IT provision for roles within this scheme.

17d DEVON: That conference asks GPC England to ensure that the current restrictions on reimbursement of staff within the PCN DES are relaxed so as to include nurses, nurse practitioners and GPs and give flexibility to PCNs to use the reimbursement monies for other staff as needed, rather than lose this funding if it is impossible to recruit to the stipulated role descriptions.

17e AVON: That conference calls for PCNs to be allowed to engage one FTE GP per PCN to work as a sessional GP across the PCN practices. During the COVID-19 pandemic locum general practitioners were adversely affected by the changes in general practices.

17f NORTH ESSEX: That conference calls on GPC England to negotiate an end to all restrictions on the use of additional staff related to PCN funding and give authority to the PCNs to use ARRS funds in a way they see fit.

17g DEVON: That conference is concerned that there is no peer reviewed evidence that staff employed under the ARRS component of the PCN DES are more efficient than a GP or significantly reduce GP workload and so calls for PCNs to be able to use this money to pay GPs if they choose to do so.

17h OXFORDSHIRE: That conference believes GP practices are best placed to assess their own workforce needs and that the funding for ARRS should be made available to practices to use for the employment of additional clinical and non-clinical staff/supportive staff outside the prescribed national roles.

PCN FUNDING 16.10

* 18 CLEVELAND: That conference, in respect of the Core PCN Funding Payment (£1.50 / registered patient / year):

(i) believes this is woefully inadequate to fund all the schemes it has been allocated to cover and additional workforce it is anticipated to employ and manage

(ii) insists that this payment must be uplifted annually to reflect the expanding workforce and responsibility, as a minimum in line with core GMS contract uplifts

(iii) demands that this payment is renegotiated for 2021 / 2022, to accurately reflect the workload that it is supposed to support.

18a DEVON: That conference mandates that GPC England ensure that any future additional workload requirements for the PCN DES are secured on the basis of remuneration for work done rather than reimbursement of potential staff.

18b CENTRAL LANCASHIRE: That conference condemns the unrealistic expectation being placed on PCNs to deliver the solution to everything with minimal or non-existent management infrastructure and requires PCNs to be supported solely to deliver the PCN DES.

VACCINATION PROGRAMME 16.30

* 19 AGENDA COMMITTEE TO BE PROPOSED BY LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference, in respect of the 2020 / 2021 annual flu vaccination campaign:

(i) is disappointed that staff have not been universally offered from the wider healthcare system to support practices

(ii) believes that a higher payment should have been negotiated for this year's DES in light of COVID-19

(iii) mandates GPC England to negotiate an appropriate uplift in the DES payment for all future years that are impacted by COVID-19 or a similar situation that results in additional costs outwith the control of general practice

(iv) would particularly highlight for early examination the differences in requirements in the flu vaccine delivery contracts offered to GMS / PMS and pharmacy providers

(v) believes that announcing flu vaccination for 50-64 year olds without a plan for the supply or delivery of this programme was either simple incompetence or a cynical political ploy.

19a LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is concerned that GPC England has failed primary care in negotiating a national flu delivery programme in these unprecedented times of COVID-19 where practices have to manage unexpected demand in an undeliverable financial envelope. We strongly ask GPC England to negotiate enhanced payments for delivery of influenza vaccine for 2020 / 2021 due to the additional work involved which has taken more clinical and administrative time.

19b CLEVELAND: That conference, in respect of the 2020 / 2021 annual flu vaccination campaign:

(i) celebrates the achievements of practices in stepping up to deliver this

(ii) recognises the increased costs to practices of delivering this in a COVID-19 safe manner

(iii) is disappointed that staff have not been universally offered from the wider healthcare system to support practices

(iv) believes that a higher payment should have been negotiated for this year's DES in light of COVID-19

(v) mandates GPC England to negotiate an appropriate uplift in the DES payment for all future years that are impacted by COVID-19 or a similar situation that results in additional costs out with the control of general practice.

19c LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that it works with GPC England and other professional bodies to remove 'competition' with pharmacists and negotiate processes where the professions work with each other especially over the flu campaigns.

19d DEVON: That conference hopes that the government's announcements of flu vaccination for 50-64 year olds without a plan for supply or provision of this addition to the programme, nor a clear timeline, nor any communications to the public to make it clear that they should not increase GP workload by trying to book this intervention early in the flu season, was simple incompetence and not a cynical political ploy to make people feel they were safer this flu season given the ongoing pandemic.

19e ROTHERHAM: That conference feels that, where services are delivered by different classes of professional business, GPC England should provide a commentary on the difference in funding levels and how, if at all, this is justified. Conference would particularly highlight for early examination the differences in requirements in the flu vaccine delivery contracts offered to GMS/PMS and pharmacy providers.

19f WORCESTERSHIRE: That conference believes that practices must receive additional resource and support in order to carry out flu vaccinations this year at scale and that the complexity of this year's challenges is recognised in any negotiations.

19g LIVERPOOL: That conference believes that the COVID-19 pandemic has highlighted flaws in the current system for ordering seasonal flu vaccine by GP practices, and calls upon GPC England to insist that in future years, all seasonal flu vaccine is procured centrally, as for other nationally agreed vaccination programmes.

19h DEVON: That conference remains frustrated that for yet another year, despite promises otherwise, community pharmacies have received their deliveries of flu immunisations ahead of practices. This inequity is particularly galling in a year in which we are asked to deliver more immunisations than ever before and so clear planning of expected patient numbers is required. Conference asks that this be rectified before the next relevant immunisation season.

19i DEVON: That conference notes that due to the COVID-19 restrictions that have been put in place practices will incur extra costs and workload for delivery of the flu programme in 2020 / 2021. In some areas of the country it is not economical for a practice to deliver flu vaccinations. We would request that GPC England negotiate an uplift for this year and subsequent years where restrictions change the way we have to deliver enhanced services, basing funding on the time needed to provide a service under pandemic restrictions instead of normal working.

19j BEDFORDSHIRE: That conference deplores the fact that government has asked general practice to vaccinate more people against flu, in a more time-consuming process because of pandemic precautions, but without putting in adequate extra resources to make this deliverable.

∗ 20 HULL AND EAST YORKSHIRE: That, regarding a future COVID-19 vaccination programme, conference calls for:

(i) a centrally commissioned service to deliver such vaccinations

(ii) full associated data integration into all primary care clinical systems

(iii) no additional workload to be generated for primary care as a result.

CLOSING BUSINESS 17.00

Conference of England LMC Representatives

Agenda: Part II

(Motions not prioritised for debate)

Agenda: Part II
(Motions not prioritised for debate)

A and AR Motions

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

COVID-19

A 21 LIVERPOOL: That conference believes that it is completely unacceptable for NHSEI to expect general practice to return to normal working when hospitals are far from working normally and are unable to process tests and investigations within pre-COVID-19 time scales.

A 22 CLEVELAND: That conference condemns the inequity in the COVID-19 recovery phase between expectations for routine outpatient services, and expectations for routine practice based care.

A 23 BEDFORDSHIRE: That conference calls on GPC England to inform NHSEI that it is impossible for practices to do what is set out in the NHS's Third Phase of the response to COVID-19 - Restoration and Recovery, and to work in accordance with the Standard Operating Procedure, while still working under the COVID-19 restrictions to protect patients and staff and that the third phase document needs urgent review.

A 24 SHROPSHIRE: That conference believes that GPs deserve recognition for their efforts in keeping general practice open and working during the COVID-19 pandemic and requests GPC England to pursue government acceptance of GPs as specialists, together with necessary changes to the Medical Act.

PRIMARY AND SECONDARY CARE INTERFACE

A 25 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that GPC England works with NHSEI to clearly define and remove ambiguities from the standard hospital contract to clearly define the duties of secondary care to prevent the unresourced transfer of work into primary care.

A 26 HEREFORDSHIRE: That conference believes any transfer of work from secondary care to primary care must be funded on a cost per case basis.

A 27 NORFOLK AND WAVENEY: That conference asks GPC England to ensure NHSEI and delegated CCGs hold hospitals to account to deliver their contractual requirements.

A 28 NORTH YORKSHIRE: That conference recognises there is no uncommitted capacity / funding in general practice and demands GPC England negotiate general practice involvement in outpatient transformation at a national level alongside an appropriate increase of resources to facilitate general practice in delivering this NHS reorganisation.

A 29 NORTH YORKSHIRE: That conference recognises that workload traditionally done in secondary care may potentially be done in primary care, and this shift forms part of the NHS long term plan, but demands GPC England negotiate a stop to these until there is a clear mechanism for an accompanying shift in funding to support this, otherwise this issue alone has the potential to rapidly destabilise general practice.

A 30 MORECAMBE BAY: That conference recognises that the shift of workload from secondary care to primary care is putting excessive pressure on general practice with no redistribution of resources and ask GPC England to negotiate with NHSEI to develop a consistent national approach to resolve this.

A 31 MORECAMBE BAY: That conference asks GPC England to confirm NHSEI and subsequently CCGs are monitoring all aspects of the NHS national contract to ensure that secondary care providers are held to account to deliver their contractual requirements to prevent inappropriate workload being shifted without resource to general practice.

A 32 HERTFORDSHIRE: That conference instructs GPC England to ensure that the BMA negotiates that the hospital contract be amended so that trusts cannot shift work to primary care without appropriate financial penalties to the trust, and without appropriate transfer of resources to primary care.

A 33 NORFOLK AND WAVENEY: That conference GPC England to negotiate to enable hospitals to use the Electronic Prescription Service (EPS) to alleviate the demand on general practice.

A 34 HERTFORDSHIRE: That conference notes with concern the increasing pressures on the ambulance trusts in being able to meet demand and instructs GPC England to make sure that general practice is not forced or expected to take on the additional responsibilities of the ambulance trusts as a result.

A 35 HERTFORDSHIRE: That conference instructs GPC England to ensure the BMA negotiates as appropriate to mandate that all written communications from hospitals to general practices should be electronic, as is already the case for communications from general practices to hospitals.

A 36 HERTFORDSHIRE: That conference instructs GPC England to develop a clear list of all the secondary care tasks which should be done in secondary care and not shifted to primary care.

DIGITAL FIRST

A 37 NEWHAM: That conference is concerned by the increasing financial burdens faced by general practice as small businesses and demands that GPC England ensures that the financial analysis of any contract changes are fully considered, especially the costs of delivery and bottom lines and made widely available before implementation is agreed.

GP CONSULTATION

A 38 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that, in line with the Secretary of State for Health's assertion that all GP consultations should be remote by default, the Quality and Outcomes Framework is amended to explicitly state that all assessments and reviews can be undertaken remotely at the discretion of the practice.

A 39 AVON: That conference calls on the Department of Health to force GP IT clinical systems and all those associated with the development of QOF to have the relevant business rules ready for the start of the financial year. It is not acceptable for IT systems to lag several months behind the start of a QOF year.

A 40 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that providing data following a subject access request under GDPR should be cost neutral.

ARRS

A 41 KENT: That conference demands that with respect to ARRS staff PCNs must be:

(i) allowed the flexibility to recruit the staff that meets their needs

(ii) in receipt of full reimbursement for all salaries

(iii) able to access underspends in a timely and efficient way

(iv) reimbursed for maternity, paternity and sickness cover in line with the Statement of Financial Entitlements.

A 42 NORTHAMPTONSHIRE: That conference insists that NHSE should endorse commissioners to automatically transfer ARRS underspend to each PCN on a weighted population basis at the end of each financial year.

A 43 GATESHEAD AND SOUTH TYNESIDE: That conference recognises that the COVID-19 outbreak has significantly impaired the ability for PCNs to recruit under the ARRS scheme leading to large underspends on budgets and calls for NHS England to:

(i) protect current funding and ensure it is not lost to PCNs

(ii) change the timing of deadlines to reflect the fact that PCNs have in effect lost six months of development

(iii) make sure that CCGs do not use these funds to make up for shortfalls in other areas.

A 44 OXFORDSHIRE: That conference believes that practices and PCNs are being hamstrung with regards to utilising the ARRS due to a critical lack of appropriate estates and calls on GPC England to:

(i) urgently ensure adequate funding for primary care estates including having IT that is fit for purpose

(ii) demand from NHSE that unspent ARRS money is not lost to primary care but re-invested in other ways to safeguard practice sustainability.

A 45 WORCESTERSHIRE: That conference believes that training and supervision requirements for ARRS roles should be reviewed urgently to ensure that they are fit for purpose, proportionate and do not require excessive additional training for supervisors who already have a medical degree.

A 46 TOWER HAMLETS: That conference notes that the limits of the PCN DES ARRS payment does not take into account the high cost of living supplement that affects NHS employment in London and surrounding areas and:

(i) wishes to remind NHSEI that this is required so that the NHS workforce can afford to live close to work

(ii) believes that withholding this payment is to the detriment of the population who live in London and surrounding areas as they will not be able to benefit from the additional workforce that the ARRS is funding

(iii) recognises that although not affecting the whole of England, this situation is unethical

(iv) instructs GPC England to insist that the government agree to fund the high cost of living supplement for all practice staff.

WORKFORCE

A 47 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 the government and commissioners make access to occupational health services for general practice staff available without additional cost to practices.

A 48 HULL AND EAST YORKSHIRE: That conference believes the health and safety of all primary care staff must be prioritised as equally important to the provision of patient care.

A 49 WORCESTERSHIRE: That conference insists that general practice should now have a fully funded occupational health service for general practitioners and their staff.

A 50 DEVON: That conference is aware that the changes in primary care due to COVID-19 are leaving practice staff exhausted and demoralised with no real support mechanisms and so calls for urgent provision of appropriate occupational health services for both non-clinical and clinical staff.

A 51 HERTFORDSHIRE: That conference:

(i) welcomes the additional support for new partners from the New to Partnership Payment Scheme

(ii) believes that the retention of existing partners is at least as important as the recruitment of new partners

(iii) calls on GPC England to negotiate additional funding to support the retention of existing partners.

A 52 NOTTINGHAMSHIRE: That conference deplores the steady drift downwards of WTE GPs, particularly GP partners who are essential for the running of practices. We need government support to provide solutions to long standing issues such as “last man standing” and continuing premises problems and requests GPC England to open discussions on these immediately.

A 53 SOUTH ESSEX: That conference urges the government to extend the New to Partnership Scheme to all GPs joining a partnership and to also fund the training for all GP partners.

A 54 NEWCASTLE AND NORTH TYNESIDE: That conference is concerned that Foundation Trusts can disregard GP service when determining eligibility for maternity benefits and calls upon GPC England to take steps to ensure that trust HR departments cannot discriminate against portfolio GPs by considering their GP service as inferior.

A 55 SANDWELL: That conference would like to remind the GPC England that the haemorrhage of WTE providers (partners) continues unabated.

CLINICAL

A 56 LEEDS: That conference remains seriously concerned about medicine shortages and lack of availability and calls on the government to publish a detailed response outlining the reasons for the problems and what they will do to resolve them.

A 57 WEST SUSSEX: That conference believes all NHS England identified medication more suitable for 'over-the-counter' patient purchase should be removed from the prescribing formulary.

APPRAISAL AND REVALIDATION

A 58 CLEVELAND: That conference believes that the treatment of GP appraisers by NHS England has been appalling and demands:

(i) payments to appraisers to match the value of those appraisals that have been missed, as has been the case in the devolved nations

(ii) GPC England open formal negotiations with NHS England to ensure that the Appraiser Consultancy Agreement is fit for purpose.

REGULATION INCLUDING CQC

A 59 GLOUCESTERSHIRE: That conference is very disappointed that few if any PLDPs have an LMC representative sitting on the panel and insists that they must be invited forthwith.

A 60 GLOUCESTERSHIRE: That conference is deeply concerned that many performance advisory groups contain GP identifiable information at their meetings and insist that such data be anonymised.

A 61 COUNTY DURHAM AND DARLINGTON: That conference welcomes the BMA and NHS joint statement on improving GP performance management processes and demands that NHSE should strive for proportionate representation for BAME groups on PAG and PLDP.

A 62 COUNTY DURHAM AND DARLINGTON: That conference welcomes the BMA and NHS joint statement on improving GP performance management processes and demands that NHSE should record and publish of baseline data for the diversity of case investigators, PAGs and PLDP panels.

A 63 CLEVELAND: That conference acknowledges the pressures that GPs have faced during the COVID-19 pandemic and expresses its full support for any GPs facing complaints solely as a result of a change to COVID-19 safe working practices.

A 64 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that it is neither appropriate nor sustainable for only doctors to be able to complete 'Fit Notes' (MED3) and insists that the Social Security Acts are altered to extend the requirement to:

(i) dentists

(ii) physiotherapists

(iii) all independent prescribers.

A 65 KENT: That conference demands that the GPC ensures all performance action against GPs are:

(i) judged at a beyond reasonable doubt standard of proof

(ii) anonymised to eliminate unconscious bias and discrimination

(iii) required to consider and support the mental health of the doctor.

PRACTICE BASED CONTRACTS

A 66 WEST SUSSEX: That conference believes all general practice payments from NHS England, CCGs, and Public Health Departments should be automatically uplifted for inflation on an annual basis.

AR 67 LIVERPOOL: That conference believes that discussions should take place between the BMA and NHSEI, to ensure that consultation documents on contract changes are not issued in the few days prior to a major public holiday period.

FINANCE

A 68 NORFOLK AND WAVENEY: That conference asks GPC England to ensure funding for services follows the patient.

A 69 WALTHAM FOREST: That conference deplores the vast inequity in funding between primary and secondary care and demands that GPC England:

(i) investigates this funding inequity urgently

(ii) publicly campaigns to increase the level of general practice funding to 12% of the total NHS budget in line with existing policy.

PREMISES

A 70 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.

A 71 NORTHAMPTONSHIRE: That conference demands that urgent investment is needed in primary care premises to allow for expansion of the GP workforce.

A 72 MERTON: That conference recognises the impact of COVID-19 on the working environment of general practice and seeks a commitment from government to invest in general practice estate to ensure it is fit to safely meet the needs of patients and staff in the event of a further pandemic.

WORKLOAD

A 73 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that GPC England defines the role of the GP as a mechanism for controlling unresourced work coming into general practice.

A 74 NOTTINGHAMSHIRE: That conference believes that winter pressures are keenly felt in general practice as much as in any other sector and suggests that all practices use an OPEL system to flag resilience issues with promised emergency funding from NHSEI to aid resilience.

A 75 LIVERPOOL: That conference believes that NHSEI has not kept to its announced intention to reduce unnecessary bureaucracy and ask GPC England to negotiate on this as a priority.

EDUCATION AND TRAINING

AR 76 NOTTINGHAMSHIRE: That conference sees that the GP workforce needs better preparation for life as a partner / business owner and implores NHSEI to fund business management training for all GPs interested in becoming partners on an ongoing basis.

GPC ENGLAND / CONFERENCE OF ENGLAND LMCs / LMCs IN GENERAL

A 77 LEEDS: That conference calls on the BMA to work with GPDF to develop training resources and arrange events to support the training needs of LMC officers.

A 78 KENT: That conference demands that the GPC representatives speaking from the Chairs table are permitted to clarify factual points and not to influence the vote.

A 79 DORSET: That conference seeks to be as inclusive as possible and enable all members of conference to attend its events on an equitable footing and be funded to do so. Conference therefore calls upon GPDF to fully fund the attendance of eligible sessional GPs, who do not have recourse to other honoraria or practice expenses reimbursement.

PENSIONS

A	80	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 government to remove the annual allowance arrangements from the NHS pension scheme.

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

This section of the part 2 agenda contains motions that the England Agenda Committee felt pertained to UK-wide issues and would therefore benefit from debate at the UK LMC Conference. If your LMC has a motion in this section, it is strongly recommended that you re-submit your motions to the UK LMC Conference. **The deadline for submission of motions is noon 19 February 2021.**

COVID-19

81 LIVERPOOL: That conference believes that after the shockingly disorganised and political approach the government has taken to the COVID-19 pandemic, they should resign and call and election forthwith.

82 NORTH AND NORTH EAST LINCOLNSHIRE: That conference has no confidence that the proposed government response to the COVID-19 pandemic will genuinely address health inequalities.

83 SEFTON: That conference calls upon the Secretary of State for Health and Social Care to resign.

84 NORTH AND NORTH EAST LINCOLNSHIRE: That conference strongly supports NHS colleagues who refuse to offer face to face care to patients who are medically able to but refuse to wear face coverings.

85 BRADFORD AND AIREDALE: That conference is concerned that the government has not balanced the mortality risk of COVID-19 with the economic and social risks of lockdown when it is known that life expectancy is adversely affected by low income, and social isolation carries a high risk of premature death and morbidity and demands that the government:

(i) compares the mortality risk of COVID-19 with the mortality and morbidity risk from the social and economic consequences of lockdown

(ii) allows community groups, in particular for the elderly, to open and make it clear that it is down to the individual to assess their risk of COVID-19 versus their mortality and morbidity risk of social isolation.

86 WIGAN: That conference calls upon the Secretary of State for Health and Social care to recognise that extant public sector organisations are better equipped, better integrated and motivated to deliver the COVID-19 testing programme. It calls for an immediate additional investment in these facilities.

PRIMARY AND SECONDARY CARE INTERFACE

87 HERTFORDSHIRE: That conference notes that secondary care IT systems do not allow secondary care doctors to fully work remotely and the impact this has had on primary care workload and therefore instructs GPC England to ensure the BMA negotiates as appropriate to ensure:

(i) secondary care is mandated to develop IT infrastructure so they can manage remote appointments

(ii) secondary care clinicians are able to request blood forms, radiology requests, care plans or medical certificates remotely

(iii) secondary care clinicians have access to an electronic prescribing system so they can prescribe medication remotely

(iv) primary and secondary care IT systems are able to work together to facilitate information sharing and collaboration.

SESSIONAL GPs

88 COUNTY DURHAM AND DARLINGTON: That conference calls for BMA to campaign for humane immigration rules, especially adult dependent rules, that effectively prohibit the non-UK workforce looking after their elderly parents.

VACCINATION PROGRAMME

89 SOMERSET: That conference notes the demise of Public Health England (PHE) but:

(i) recognises and applauds the hard work of the staff of PHE in the pandemic

(ii) questions the wisdom of making a major public service reform during a pandemic

(iii) recognises that PHE had major funding reductions in recent years and so insists that these must be reversed for the Public Health Protection Agency, and

(iv) believes that a public health body should be chaired by a scientist.

90 LIVERPOOL: That conference that conference believes the disbandment of Public Health England, in the middle of a pandemic is an appalling act of political will over common sense; with regards to the new National Institute for Health Protection (NIHP) conference requires:

(i) a fully commissioned service for all elements of public health responsibility

(ii) an expectation that all public health activity will be undertaken by the NIHP without resorting to non-commissioned prescribing by primary care

(iii) that workload dumps on primary care by NIHP are robustly resisted with the full support of legislation.

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

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

(ii) increase funding to these essential community services

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

92 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that as the demarcation of work between general practice and pharmacists is continually being eroded in order to maintain fair competition GPC England should negotiate that all general practices are allowed to:

(i) sell General Sales List (GSL) medication to registered patients

(ii) sell Pharmacy-only (P) medication to registered patients

(iii) dispense Prescription Only Medication (POM) to registered patients.

93 LEEDS: That conference, following Brexit, calls on the government to:

(i) rescind the falsified medicines directive

(ii) only introduce arrangements related to barcoding medicines when all practices and pharmacists have the necessary equipment and technology in place.

REGULATION INCLUDING CQC

94 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that the General Medical Council alters Good Medical Practice and other documents to clearly state that now more than ever it is appropriate for a doctor to refuse to provide care to any patient:

(i) expressing a racist view

(ii) expressing a negative view regarding any of the Equality Act nine protected characteristics

(iii) acting in any way to endanger the health and / or safety of doctors or other staff working in general practice.

95 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that learning from the pandemic so far has demonstrated that the following need to be available as online processes as soon as possible:

(i) Medical Certificate of Cause of Death

(ii) cremation forms

(iii) Statement of Fitness to Work (Med3).

96 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that all guidance relating to Cremation and Medical Certificates of Cause of Death are updated to explicitly recognise that in this digital age:

(i) the term attendance should include telephone and video consultations with the patient or their representative

(ii) viewing of a deceased person can be by video for any legal purpose

(iii) all forms are available to be completed online.

97 BRADFORD AND AIREDALE: That conference demands that environmental impact and carbon footprint changes with compulsory mitigation should be an integral part of all new policies and system changes.

98 BRADFORD AND AIREDALE: That conference is alarmed by the climate crisis and calls for the government to incentivise GP practices to reduce carbon emissions, in order for us to meet the BMA's target of carbon neutrality in our sector by 2030.

99 NEWCASTLE AND NORTH TYNESIDE: That conference should:

(i) declare a climate emergency, to plan, campaign and cooperate to deliver carbon neutrality by 2030

(ii) instruct GPC England to work closely with the BMA, Royal Colleges and NHS England to make concrete plans to urgently start reducing the carbon footprint of primary care

(iii) instruct GPC England to form a subcommittee addressing climate issues in relation to primary care

(iv) instruct GPC England that its climate related subcommittee provides quarterly progress reports to LMCs on its climate related activities.

100 SHEFFIELD: That conference supports the promotion of addressing climate change and the current ecological crisis by asking GPC England to negotiate:

(i) incentivising the use of the "Green Impact Audit for Health" tools by general practices

(ii) the development of green prescription schemes accessible to all people living with long-term health conditions

(iii) mandating a national labelling system indicating the carbon footprint of all drugs and medical appliances, which can easily be incorporated into GP IT systems.

EDUCATION AND TRAINING

101 WEST PENNINE: That conference is worried about the '3 Year Doctor' and other such fast track programmes that replace the longer and more comprehensive training needed to be a doctor in today's NHS.

102 BUCKINGHAMSHIRE: That conference is shocked by recent media reports of discrimination and Islamophobia within the NHS, and:

(i) condemns discrimination in all its forms

(ii) urges GPC England to survey GPs to assess the extent of this problem in general practice

(iii) calls on GPC England to work with relevant stakeholders to develop equality and diversity training to address this problem.

103 LAMBETH: That conference demands that bursaries are available:

(i) for all staff who want to train for NHS careers including nurses and therapists, managerial and administrative staff, and

(ii) to remove the need for staff in training to take out a student loan.

104 GP TRAINEES COMMITTEE: That conference notes the ongoing issues with differential attainment in GP training and calls on BMA to lobby the RCGP and other stakeholders to:

(i) ensure any changes to the recruitment process do not widen nor perpetuate differential attainment

(ii) continue to work to narrow the differential attainment in college exams

(iii) investigate and explore differential attainment in ARCP outcomes

(iv) provide a full and transparent evaluation of the RCA

(v) ensure there is an independent equalities impact assessment of any proposed further change to recruitment, examination or appraisal processes, including longer term review of impacts.

105 GP TRAINEES COMMITTEE: That conference believes that the new RCA is a more environmentally sustainable form of assessment than the CSA and calls for all RCGP exams to be assessed for their environmental impact (including travel for candidates and examiners), with the explicit aim of reducing our carbon footprint.

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

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

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

GPC ENGLAND / CONFERENCE OF ENGLAND LMCs / LMCs IN GENERAL

109 LINCOLNSHIRE: That conference believes that BMA cannot adequately address the problems of the primary-secondary interface because it represents both general practice and secondary care doctors, and thus calls for GPC to break away from BMA and form an association which truly can fight for general practice.

110 LEEDS: That conference:

(i) supports the Romney report recommendation for multi member constituencies for GPC England elections

(ii) believes multi member constituencies should be at least the size of BMA regional council areas

(iii) that multi member constituencies should enable elections to take place including gender quotas

(iv) that multi member constituencies should enable elections to take place with partner and sessional GP quota

(v) believes that, in order for multi member constituencies and quotas to operate effectively and without making constituencies too large and distant from LMCs, GPC seats currently elected from the LMC Conference and ARM should be reallocated to expand the number of regionally elected members.

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

Agenda: Part II
(Motions not prioritised for debate)

COVID-19

112 SOMERSET: That conference, shocked by the ineptitude of the centralised COVID-19 command and control response at the beginning of the emergency and looking at the examples of devolved administrations in the UK, urges GPC England to demand more local public health influence in the making of decisions affecting the health, welfare, restrictions on freedom and economies in local English communities.

113 GATESHEAD AND SOUTH TYNESIDE: That conference calls upon NHS England to continually monitor the pressures COVID-19 infections are placing on primary care and take prompt action to suspend appropriate aspects of routine work in order to release the capacity required to meet those pressures.

114 LINCOLNSHIRE: That conference believes that NHSEI's insistence that general practices 'restore activity to usual levels' is unrealistic and inequitable, whilst hospitals are; refusing referrals, delaying appointments and procedures, and dumping work on general practices, and we instruct GPC England to demand that NHSEI withdraw this instruction.

115 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that the recent COVID-19 pandemic has resulted in too many emails. We call for the automatic deletion of any email that:

(i) is in excess of 50 words

(ii) has been sent 'for info only'

(iii) comes from any sender you do not personally know

(iv) includes excessive social niceties or personal information

(v) purports to be 'funny'.

116 OXFORDSHIRE: That conference recognises the national outpouring of support for the NHS and key workers during the COVID-19 pandemic, culminating in the weekly 'clap for key workers', however:

(i) believes that the PPE guidelines and provision provided by the government were significantly lacking and left front line clinicians and staff exposed to COVID-19 and betrayed the national support for the NHS and key-workers

(ii) notes that sadly many NHS staff, including over 30 doctors, lost their lives as a result of substandard PPE provision and recognises all those who lost their lives as NHS heroes

(iii) calls on the Prime Minister and the Secretary of State to publicly apologise to the families of the heroes who died as a result of inadequate PPE.

117 BERKSHIRE: That conference is deeply concerned about the protection of primary care workers in the context of rising cases of COVID-19 in the UK and the previous failure of the government to ensure secure supply of effective PPE, and:

(i) insists that stocks of suitable PPE sufficient to last several months of pandemic be built up and held within Great Britain

(ii) insists that there is a transparent ordering and distribution system maintained and that this is independently audited

(iii) calls on GPC England to lobby government to commit to prioritising contracting with PPE and potential PPE manufacturers within Great Britain to better avoid the tragic supply chain and quality issues seen earlier in the course of the pandemic

(iv) condemns the awarding of a £43 million government contract for hand sanitiser to a previously dormant energy company with no public evidence of competence in the field of health supplies and scant information about this company in the public domain

(v) calls for GPC England to lobby government an investigation into high value government contracts for emergency supplies issued during the pandemic to ensure the appropriate scrutiny inherent in a democracy and an opportunity for lessons to be learned.

118 SOUTH STAFFORDSHIRE: That conference believes doctors and nurses should have access to COVID-19 tests within 24 hours of appropriately applying for a test to keep the UK health system running.

119 SOUTH STAFFORDSHIRE: That conference acknowledges the devastating impact of one or more clinicians from a GP surgery having to unnecessarily self-isolate while the government is rationing or not providing COVID-19 tests.

120 DEVON: That conference, with increasing awareness of the long term effects of COVIDd-19 for some GPs, conference notes with alarm the disparity between NHS employers supportive stance for secondary care staff with long COVID-19, specifically encouraging employers to not engage normal sick leave limitations and the inflexibility of the sick pay coverage for GPs with long COVID-19. Conference demands that NHSEI clearly provide equitable support for GPs affected by long COVID-19 to allow them to recover without financial penalty.

121 ROTHERHAM: That conference believes that, although a series of tools were introduced following the prevalence of BAME deaths due to COVID-19, there is little evidence that there would have been fewer deaths if these tools had been applied any earlier.

122 CLEVELAND: That conference welcomes the priority testing for key workers and insists that essential COVID-19 testing programmes to protect the health service workforce and capacity remain in place and are accessible and properly resourced for the duration of the COVID-19 pandemic.

123 WIGAN: That conference calls upon the GPC England to actively petition the NHSEI and Department of Health for the creation of memorial fund / prize bestowed in recognition of colleagues from all health care professions who have fallen in the frontline fight against COVID-19.

PRIMARY AND SECONDARY CARE INTERFACE

124 KENT: That conference demands that all referrals to secondary care must:

(i) be assessed by an appropriate clinician in secondary care

(ii) not be rejected without a clinical explanation to the referrer that is copied to the patient

(iii) not be downgraded to advice and guidance when a full assessment is requested

(iv) transfer the medico-legal responsibility to the secondary care clinician.

125 DEVON: That conference is aware of the increase in, and value of, Advice & Guidance pathways promoted by secondary care but would also like to highlight the dangers of this leading to a transfer of work to primary care without the appropriate accompanying resources. Conference asks that any A&G pathway should require the specialist advising further investigation or management to agree to provide that service themselves if it is not readily available in general practice to encourage better understanding of primary care services by specialist teams.

126 LANCASHIRE PENNINE: That conference must ensure that with the national introduction of Advice and Guidance, whilst the idea behind it is very solid, that it is not to be used as a substitute for an outpatient referral in general practice and therefore shifting work there.

127 KERNOW: That conference is asked to support that some patients will always require reassurance of specialist input to manage their health worries and their GP is well placed to identify this. With this in mind, conference believes that if a GP requests direct specialist contact with a patient this should be honoured as a professional courtesy and obligation and now downgraded to advice and guidance.

128 MID MERSEY: That conference believes that general practice has been given a lot of workload from secondary care during the pandemic and that there should be more integration with secondary care eg joint consultations with primary and secondary care.

129 KENT: That conference deplores the fact that mental health services contracts permit the rejection of GP referrals without a clinical assessment.

130 AVON: That conference requests that GPC England works on the behalf of general practice to ensure that GPs are not restricted in referring patients who clinically need further imaging or secondary care assessment.

131 NORTHAMPTONSHIRE: That conference demands the continued right of GPs to refer to secondary care without hindrance by referral management systems and insistence on rigid protocols which include pre investigation to ease workload in hospital clinic services.

132 CLEVELAND: That conference is concerned about the risks posed by further waves of COVID-19 and mandates GPC England to work with appropriate stakeholders to:

(i) develop a cohesive strategy that balances the needs and resources of general practice with the rest of the healthcare system

(ii) protect community services to continue care for conditions other than COVID-19

(iii) ensure that GPs are able to continue to make appropriate referrals to secondary care

(iv) ensure that secondary care services take responsibility for communicating with patients about delays or limitations to their services.

133 NORTH ESSEX: That conference demands that steps should be taken for routine secondary and tertiary care services to be reinstated immediately before more patients die due to lack of safe NHS care rather than due to COVID-19.

134 GATESHEAD AND SOUTH TYNESIDE: That conference call on NHS England to review the terms of the optometrists' contract so that they can refer directly to secondary care services without the need for GP "approval". This is an anachronism which should be rethought, allowing optometrists to exercise their professionalism and save precious GP resources.

135 WEST PENNINE: That conference deplores the underfunding of our emergency services that leads to ambulances regularly breaching their target time to attendance so leaving practices and patients waiting for the help they can so desperately need.

136 HULL AND EAST YORKSHIRE: That conference believes that Patient Initiated Follow Up (PIFU) processes in secondary care must:

(i) be widely publicised and explained to patients prior to implementation

(ii) proactively direct patients away from primary care with any related queries

(iii) include clear systems to redirect any unforeseen workload shift back to secondary care

(iv) only be implemented after discussion with LMCs.

137 NORTH YORKSHIRE: That conference believes the term 'out of hospital' is outdated and an unhelpful narrative which artificially promotes the importance of the tiny fraction of NHS work done in hospitals, at the expense of the 90% of work in the community and instructs GPC England to start changing that narrative to 'out of community' to truly reflect where the majority of the work should and does occur.

138 BEDFORDSHIRE: That conference:

(i) believes it is necessary to resurrect the issue of electronic prescribing and investigation requests in secondary care, after the failure to meet the ARM policy targets from 2015 for all secondary care providers to employ these by 2020, and

(ii) believes that a secondary care consultant requesting a test should order it themselves and should have the same access to digital technology to be able to do this as a GP has, and

(iii) instructs that GPC England negotiate with the government that the relevant technology and training is made available for secondary care doctors to be able to undertake electronic prescribing, request tests via ICE, and issue Fit Notes digitally.

NHS 111

139 LAMBETH: That conference demands that NHS 111 does not have access to pathways for referrals that are not open to primary care clinicians.

140 SUFFOLK: That conference believes 'Think 111 First' is an ill-conceived idea and insists that:

(i) the concept duplicates and undermines effective triage systems run by practices

(ii) primary care is not designed to (and therefore cannot) respond to requests for urgent medical reviews within four hours

(iii) that primary care be given priority access to emergency department appointments

(ii) that GPC England seek and share reasoned reassurance that primary workload has been fully considered and accounted for

(iii) that any further extension of the scheme is blocked.

141 HERTFORDSHIRE: That conference:

(i) believes that NHS 111 is failing, as proved by its repeated disposition to "contact GP within 2 hours" for common, self-limiting conditions

(ii) instructs GPC England to work with NHS 111 to make their directory of services more realistic and clinically appropriate.

GP CONSULTATION

142 WAKEFIELD: That conference feels that the importance of continuity of care within general practice is key to its success and that it is important that is not lost with new ways of working.

143 BRADFORD AND AIREDALE: That conference is concerned by the Health Secretary's plan to make all GP appointments remote unless there is a 'clinically compelling reason not to', as this does not recognise the therapeutic impact of face to face consultations for the patient and that this policy will reduce job satisfaction for GPs, which is likely to have a detrimental impact on retention and recruitment.

144 DEVON: That conference has no doubts that in light of all the COVID-19 induced changes in primary care the political drive for 7/7 8 – 8 routine GP appointments should be considered as dead as Monty Python's parrot and any attempts to convince anyone otherwise should be responded to in an appropriate way by GPC England.

145 DEVON: That conference feels that the rapid and wide-ranging change in service provision undertaken by general practice during the COVID-19 response has demonstrated more improved access than any centrally mandated provision of non-core hours and so demands that the entirety of the extended access monies be paid to practices with no further requirement than that they continue to offer improved access during core hours in the manner they deem appropriate.

146 AVON: That conference calls for a complete rethink of the approach to improved access and extended hours. With the whole-sale move of general practice to remote consultation models in response to the COVID-19 pandemic, the need for consultations outside core hours has changed dramatically.

147 DEVON: That conference notes the intention to "transfer the funding for the provision of improved access" from CCGs to PCNs as from 01/04/2021 but mandates GPC England to ensure that this should not equate to requiring PCNs to be accountable as providers for delivering any specifications for such service.

148 NORTH YORKSHIRE: That conference believes current information sharing laws have not kept pace with new integrated working practices and instructs GPC to:

(i) review previous advice relating to data protection and update for developing general practice

(ii) ensure GPs, as data controllers, have clarity on what can be shared with who and when without fear of breaching data protection laws.

149 KERNOW: That conference believes that leaving negative social media reviews might help to focus the minds of businesses who can significantly change the way that they provide a service in the private sector but that leaving negative reviews regarding patient care is counter-productive for patients. One star reviews with negative narrative can reduce staff morale and negatively impact on recruitment and retention of clinical and administrative which is a struggle at the best of times. Public facing messages

should be published centrally urging patients that there best redress for concerns is a direct approach via a complaints procedure rather than the moral sapping negative Facebook or google review

150 SUFFOLK: That conference deplores the lack of funded EPS provision for dispensing doctors and instructs GPC England to seek immediate resolution.

PCN BALLOT

151 NORFOLK AND WAVENEY: That conference asks GPC England to negotiate changes to PCN DES in order that:

(i) more focus needs to be given to supporting general practice and reducing workload pressures on individual GPs

(ii) the ARRS needs to be expanded to cover a wider workforce determined by the PCN.

152 NORTHAMPTONSHIRE: That conference believes that ARRS reimbursement should reflect total employment "on costs" rather than simply NI and pension contributions.

153 DEVON: That conference calls on the GPC England negotiators to ensure any future iteration of the PCN DES is simplified to avoid unnecessary box ticking and coding but concentrates on delivering services to patients.

154 NORTH YORKSHIRE: That conference fears PCNs are being set up to fail due to inadequate resources, being too tightly managed, and through unrealistic expectations being placed on them too soon, in order for them to have a chance of succeeding and realising their opportunities conference demands:

(i) the ARRS scheme is made considerably more flexible, trusting practices to employ who they need

(ii) unspent ARRS funding is recycled into general practice rather than lost to other parts of the system

(iii) more management funding be provided to support PCNs and CDs

(iv) more funding be given to CDs to reflect the increasingly demanding role and expectations placed on them.

155 CLEVELAND: That conference, in respect of funding flows associated with the PCN DES:

(i) insists that the full funding allocation is held at CCG level to ensure that underspends remain within that locality

(ii) believes that the delay in reimbursement with the ARRS scheme can cause significant cash flow problems for lead practices, and mandates GPC England to find a solution to mitigate this.

156 OXFORDSHIRE: That conference believes that the PCN DES has failed to support primary care and calls on GPC England to negotiate that:

(i) the funding within the PCN DES be devolved to CCGs to create locally commissioned PCN services which better serve local health needs

(ii) the funding attached to the PCN DES be increased to meet the legal, business, accounting and development costs in order to reflect all the costs associated with setting up and delivering PCNs.

157 DEVON: That conference is concerned that the infrastructure funds available to practices are not sufficient to enable provision of sufficient clinical infrastructure for the planned increase in additional staff working in PCNs and calls for this imbalance to be addressed swiftly and comprehensively.

158 DEVON: That conference notes that the intention of setting baseline staffing levels for PCNs was benign however it has become a rod for general practice's back as staff continue to move jobs and roles as they have always done. Conference calls for this section of the DES to be retired and any subsequent staffing changes to be treated in good faith and reimbursed accordingly regardless of where the now historic baseline was.

159 DEVON: That conference notes the discretion awarded to CCGs in allowing flexibility of implementing the ARRS has not been used as intended. Conference moves that GPC negotiate to remove the restrictions on numbers of staff for the ARRS scheme to enable more flexibility with employment in areas where the workforce varies and ARRS recruitment can be a challenge.

160 MERTON: That conference:

(i) recognises the commitment and good work being undertaken by colleagues in forming and leading primary care networks and the importance of the ARRS roles

(ii) demands that GPC England negotiate an agreement with NHSE regarding covering the costs of sick leave, maternity leave and similar for ARRS roles, to ensure PCN viability.

161 COUNTY DURHAM AND DARLINGTON: That conference believes that the assumptions about the cost of employing staff under the Additional Roles Reimbursement (ARR) scheme are seriously flawed and that the associated guidance fails to recognise the overhead costs of employing staff in these roles. Conference demands that the guidance is revised to provide greater flexibility and recognition of market forces so that PCNs can cover the whole cost of employment without asking practices to subsidise the ARR scheme.

162 LIVERPOOL: That conference believes that in bringing the care home element of the PCN DES forward by two months, NHSEI devalued the funding for 2020/21 from £10 per bed per month to £7.50 per bed per month and expects GPC England to renegotiate this element of funding for the PCN DES.

163 NORTHAMPTONSHIRE: That conference demands that funding and contractual obligations remain with GP practices and are not devolved to PCNs.

164 HERTFORDSHIRE: That conference:

(i) believes that locum GPs should be part of PCN boards mandatorily, and

(ii) instructs GPC England to renegotiate the PCN DES so that the phrase "The PCN could include locum GPs, or groups of locum GPs, as non-core members of the PCN" becomes "The PCN should include locum GPs, or groups of locum GPs, as non-core members of the PCN".

165 KERNOW: That conference is asked to recognise the very challenging recruitment environment faced by PCNs in large parts of the country in seeking to employ staff under the ARRS. While funding is immensely welcome, Cornish general practice continues to struggle to engage these additional roles and so access the funds needed to engage these additional roles and so access the funds needed to manage the increased workload presented under the PCN DES. We ask conference to support the concept that the ARRS funding must be used flexibly to cope with demand, bringing in roles as determined by the PCNs and not as determined by the contractual year in which the specific roles currently fall. We ask conference to support this flexibility - recognising that the risk of destabilising other system stakeholders in so doing is great but

that the risk to general practice, of not agreeing to complete flexibility in the timing of employment of the described roles, will be catastrophic.

166 DEVON: That conference notes that while the EHCH component of the PCN DES has formalised the way PCNs engage with care homes, the majority of services mentioned in this component were designed to be provided by community service providers not practices and so conference is disappointed by the tone taken by many CCGs in demanding that practices and PCNs should provide more than the DES covers and damaging practices relationships with care homes in doing so. Conference moves that for all similar pieces of work, GPC England should arrange national campaigns clarifying for the public which services are GP responsibility and which are not.

SESSIONAL GPs

167 NOTTINGHAMSHIRE: That conference applauds the establishment of the GP health service and urges a coaching / mentoring solution for all GPs to access for free on an ongoing basis for at least the next five years.

168 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.

169 CAMBRIDGESHIRE: That conference restates its support for the GPC England negotiated 2016 Retainer Scheme; GMS parental reimbursement provision and GMS sickness reimbursement provision, but notes with concern how funding has been shifted into CCG delegated commissioning budgets, exacerbating workforce shortages in deprived areas, and mandates GPC England to negotiate with NHSEI the return to a central ring-fenced funding allocation for these purposes.

170 NEWCASTLE AND NORTH TYNESIDE: That conference believes that the current NHS England National GP Retention scheme is not fit for purpose and GPC England should press for it to be radically overhauled to ensure that:

(i) funding is removed from CCG baselines and ring-fenced so that posts are available equitably and where need is greatest

(ii) the process for advertising of and approval of posts is made transparent and significantly speeded up

(iii) overall resource available to the scheme is massively increased to enable far larger numbers of posts to be available.

171 NEWHAM: That conference acknowledges that a significant proportion of nursing staff in general practice are nearing retirement age and is deeply concerned by the difficulties of retaining practice nurses, following training in certain areas and demands that GPC England:

(i) compares and contrasts retention rates across England

(ii) urgently investigates reasons for non-retention of nurses

(iii) negotiates for a national retention programme for general practice nursing staff

(iv) in order to improve recruitment and retention, negotiates that ARRS funding is not limited to certain roles but made available to support the employment of all healthcare professionals working in general practice.

172 NOTTINGHAMSHIRE: That conference applauds the efforts to engage and nurture GPs at the beginning and end of their working lives, it is increasingly alarmed that mid-career GPs (the 'inbetweeners') are being deprived of the same opportunities and tasks GPC England to lobby for:

(i) new fellowship programmes to be created which are open to GPs of all career stages; and

(ii) the opening up of access to existing fellowship schemes to all GPs.

173 CLEVELAND: That conference demands that the NEW to Partnership Payment Scheme is extended to include practice managers from April 2021.

174 COUNTY DURHAM AND DARLINGTON: That conference believes judgement of competence by the appraisal system is a burden. Easy access to support or mentoring where it may be needed, by individual self-request, possibly through RCGP or occupational health services, should be available and would be valuable.

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

PCN FUNDING

176 KENT: That conference recognises the hard work of PCN CDs and demands that:

(i) they are each funded to receive the support of a full-time administrator

(ii) all requests for their input or attendance are reimbursed

(iii) their time is priced as the cost of a backfill locum plus associated administrative expenses.

177 NOTTINGHAMSHIRE: That conference appreciates that PCNs are growing with extra staffing but also recognises that to make the larger teams successful good management is crucial. To this end, we demand that NHSEI makes available extra funding outside of the £1.50 allocation purely for managerial roles to support PCN clinical directors in their roles.

VACCINATION PROGRAMME

178 SOMERSET: That conference reflecting on events after NHSE called for more Treatment Escalation Plans (TEPs) at the beginning of the COVID-19 emergency:

(i) is appalled that Section 42 Inquiries were invoked after some practitioners were accused of making "blanket DNARs"

(ii) believes that the first resort of some care providers to grandstand on social and mainstream media to "name and shame" practices falsely was so unprofessional as to warrant investigation itself

(iii) urges GPC England to ensure that patients and carers should always be the main architects of, and take responsibility for, TEPs, and

(iv) demands that, in the spirit of removing vestiges of paternalism, any requirement for a GP to sign off or approve a TEP agreed by others should be removed.

179 NORTH STAFFORDSHIRE: That conference calls upon GPC England to challenge NHSEI about the continued service gaps in the care of people with gender dysphoria and:

(i) acknowledge that this group of patients are vulnerable and their care deserves specialist centres/care which are lacking across the country leading to widespread delays in diagnosis, treatment and follow up

(ii) confirm that unsatisfactory commissioning by NHSE has led to the burden of care to over flow into primary care, including non-core specialised care and treatment

(iii) condemn 'bridging the gap' arrangements which are transferring the clinical responsibility from the gender identity clinic to the primary care team without funding or support

(iv) advise GP colleagues to refrain from 'pressurised prescribing' of hormonal preparations beyond their competences which may lead to medico-legal complications.

180 OXFORDSHIRE: That conference notes that NHS England has issued "Specialised Services Circulars" (SSCs 1417, 1620 and 1826) directing that "General Practitioners should collaborate with Gender Identity Clinics in the initiation and on-going prescribing of hormone therapy, and for organising blood and other diagnostic tests as recommended by the Gender Identity Clinics", and:

(i) believes that these NHS circulars have led to a situation whereby GPs are expected to make up a shortfall in commissioning of specialist high quality services for trans people and those with gender incongruence

(ii) believes that current provision of specialised Gender Incongruence Services puts both patients and GPs at risk

(iii) asserts the BMA's "Focus on gender incongruence in primary care" document, which states that confirmation of diagnosis and commencement of initial treatment for gender incongruence should be made by a specialist service

(iv) calls on GPC England to reject any suggestion that "first prescriptions" and associated investigations should happen in routine general practice, and advocate instead for adequate specialist services provision for this patient group.

181 NORTHAMPTONSHIRE: That conference demands that gender dysphoria services are properly commissioned and funded at specialist level, the GMC withdraw statements made regarding GP obligation to treat and supervise such specialist work and that where GPs are asked to provide such services there is appropriate training and funded contracts and shared care arrangements to support this highly sensitive and difficult work.

182 NOTTINGHAMSHIRE: That conference compels NHSEI to commission services such as for gender dysphoria and mental health that are fit for purpose as GPs are repeatedly signposted to despite often neither being trained nor funded in many of these complex areas.

183 NOTTINGHAMSHIRE: That conference realises the possible value of prescribing incentives schemes to NHS finance and in promoting good prescribing practices, but tasks GPC England to negotiate a guaranteed level of re-investment back into general practice to recompense practices for the hard work it is saving the commissioners.

184 COUNTY DURHAM AND DARLINGTON: That conference agrees with The Kings Fund report on Health Inequalities (Feb 2020) that "interventions to tackle health inequalities need to reflect the complexity of how health inequalities are created and perpetuated otherwise they could be ineffective or even counterproductive". To expect that GPs can tackle health inequalities using capacity realised through a modified QOF during a global pandemic is both unrealistic and unachievable.

185 AVON: That conference supports the legislative change that has allowed the prescribing of abortion medications from home and the taking of these medications in the patient's home. These changes are essential to support women's health and rights and should continue after the emergency legislation has expired.

186 MID MERSEY: That conference believes that GPs should not be asked to complete blanket capacity assessments.

187 SOMERSET: That conference recognises that the backlogs caused by the NHS response to COVID-19 will lead to more patients seeking a private opinion but believes that an episode of private care should not be a cause of extra work for practices. In particular a private prescription should never be presented to be converted into an FP10 whether a GP would normally prescribe the drug(s) or not.

188 LEEDS: That conference, following Brexit, calls on the government to:

(i) rescind the falsified medicines directive

(ii) only introduce arrangements related to barcoding medicines when all practices and pharmacists have the necessary equipment and technology in place.

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

190 AVON: That conference calls for an immediate injection of resource to address the mental health effects (including children's services and dementia care) of the COVID-19 pandemic that is equivocal to the expenditure on the physical effects (Nightingale Hospitals, for example) of COVID-19.

191 SOUTH STAFFORDSHIRE: That conference recognises the impact of "long COVID-19" and calls on government to provide priority access to recovery programmes for doctors and clinicians as a recognition of the frontline nature of their work in the same way that ex-servicemen are prioritised for health care.

192 KENT: That conference demands that frailty services are commissioned to:

(i) ensure that any decision to admit is subject to a best interests discussion

(ii) truly reflect the time spent caring for patients

(iii) to improve patient outcomes and care rather than tick boxes.

193 BEDFORDSHIRE: That conference calls on the GPC England to negotiate a specific structure and funding for the provision of specialist allergy services.

APPRAISAL AND REVALIDATION

194 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes that GP appraisal and revalidation should remain 'input light' with verbal reflections, on a permanent basis.

195 BERKSHIRE: That conference endorses an appraisal system which supports doctors in their professional activities without diverting their attention from clinical duties and hopes that Appraisal 2020 will satisfy that aim, and:

(i) urges GP appraisers to hone their skills to capture verbal supporting information offered by the doctors in an Appraisal 2020 conversation to write summaries which are effective in fulfilling GMC appraisal requirements and can inform RO revalidation recommendations

(ii) calls on the BMA, GMC, RCGP, AoRMC and NHS England to collaborate to evaluate the outputs of Appraisal 2020 format appraisals with view to continuance of this format beyond the pandemic

(iii) calls on the profession to engage with the “input light” Appraisal 2020 format for the coming year such that there is sufficient volume and quality of feedback evidence to assess acceptability to GPs and ROs.

196 CAMBRIDGESHIRE: That conference notes the short notice of the resumption of appraisal and revalidation following the cessation during the initial phase COVID-19 pandemic and calls upon GPC England to ensure:

(i) seizes the opportunity to ensure that the process is formative and supportive

(ii) that the workload in preparing for the process is minimal and will not take tired GPs away from essential patient-facing care

(iii) that GPs’ revalidation and ability to practise is not jeopardised by changes in process.

197 SUFFOLK: That conference notes that pandemic induced modifications to appraisals coupled with GMC recognition of system pressures as a factor has been of immense benefit to GPs and instructs GPC England to:

(i) quantify the benefits of the ‘light touch’ appraisal in terms of numbers of GPs retained

(ii) specifically resist any attempts to return to mandatory targets for CPD, safeguarding and other metrics

(iii) seek explicit recognition of non-COVID-19 related system pressures as mitigating factors in fitness to practice proceedings and other performance reviews.

198 WORCESTERSHIRE: That conference supports the recent change in approach to appraisal and seeks assurance from NHSE that providing support to general practitioners will remain the focus following the pandemic with less of a requirement to accrue evidence of learning and written reflection.

199 LIVERPOOL: That conference believes that if it was reasonable to abandon appraisals and revalidation because of the pandemic, it is now reasonable to ensure that the appraisal system, and requirements for revalidation are greatly modified, with bureaucracy reduced to make it more meaningful for GPs.

200 SOUTH STAFFORDSHIRE: That conference welcomes the changes in appraisal during the pandemic towards the supportive and empathetic process it was intended to be at the outset, and request that it continues to be so, as we move out of the crisis instead of returning to an onerous bureaucratic exercise.

201 NORTHAMPTONSHIRE: That conference believes that the current proposals for a simplified approach to appraisal documentation and the appraisal process during the pandemic response should be continued indefinitely.

202 MANCHESTER: That conference supports the introduction of the light touch appraisal approach.

203 MANCHESTER: That conference believes postponements and changes to appraisal and revalidation dates have been necessary due to the COVID-19 pandemic.

204 NORTH STAFFORDSHIRE: That conference recommends that:

(i) GP appraisers' pay during COVID-19 is protected – in line with Scottish colleagues

(ii) GP appraisers' training is funded.

205 SOMERSET: That conference recognise the significant continuous professional development (CPD) burden of the pandemic and the response to it and

(i) demands the awarding to all clinicians of 200 hours of CPD, which can be rolled over for the next ten years, and

(ii) believes a simple one-line reflection such as, "it's been an omnishambles" should meet the standard for reflection.

206 KERNOW: That conference is asked to support the emphasis of appraisal that has been summative and regulatory whilst levels of stress and poor mental health are high amongst GPs. Conference demands that the NHS starts to look after it's GP workforce and funds an obligatory annual physical and mental health review through a stand-alone service that is entirely supportive and confidential.

207 COUNTY DURHAM AND DARLINGTON: That conference demands that GP appraisals should be scrapped. GPs have risen to the challenge of the current pandemic and demonstrated their ability to educate themselves and develop in a timely and professional manner in the absence of appraisals. This demonstrates that appraisal is not needed and simply increases bureaucracy.

208 SANDWELL: That conference makes it clear to NHSE that appraisal has no evidence base, and the increase from 25 points (with doubling for reflection) to 50 points (still with reflection) was an unwarranted intrusion on GP's vital clinical time and a pointless drain on practitioner morale.

209 MID MERSEY: That conference that there is no need for appraisals in the current COVID-19 crisis as this is adding extra stress and pressures on general practice that is struggling.

210 MANCHESTER: That conference is concerned that the changes made to appraisal and evaluation dates are inadequate because:

(i) postponing only one year of revalidation will lead to a bulge in the system in the coming year

(ii) postponing only appraisals due between March and September will risk some doctors losing the support of a well led appraisal system.

211 MANCHESTER: That conference calls for all doctors' appraisal and revalidation dates to be postponed by the same duration.

REGULATION INCLUDING CQC

212 SOMERSET: That conference:

(i) believes that the "light touch" and supportive approach to general practice inspections adopted by the Care Quality Commission during the COVID-19 pandemic has been good for practices and has not resulted in an increase in patient harm, and

(ii) demands that GPC England negotiate with the CQC a continuation of this approach to inspection beyond the COVID-19 crisis period.

213 WORCESTERSHIRE: That conference believes that CQC inspections must be delayed by a minimum of 12 months to allow practices to focus on providing care to patients and to relieve pressure on practice staff during the pandemic.

214 TOWER HAMLETS: That conference agrees with Matt Hancock that our healthcare system could do better without many of "the barnacle-like encrustations of rules and regulations" and:

(i) congratulates general practice for not imploding due to the lack of CQC inspections during the pandemic

(ii) believes that CQC inspections fit this definition and that they distract from patient care

(iii) requires GPC England to work with NHSEI in agreeing a review and rationalisation of all general practice regulatory requirements.

215 SOUTH STAFFORDSHIRE: That conference demands that the CQC process becomes less onerous and bureaucratic and more inclined to support and indeed celebrate the great work done in primary care during the COVID-19 pandemic and beyond.

216 MID MERSEY: That conference believes that given the current COVID-19 pandemic that all CQC reviews and visits should be abandoned until the NHS has returned to what we remember as normal.

217 NORTH YORKSHIRE: That conference believes the COVID-19 pandemic has clearly demonstrated how CQC is not fit for purpose and should be disbanded in favour of a more appropriate light touch regulatory mechanism.

218 BARKING AND HAVERING: That conference believes that there should be a support system available to protect primary care staff from:

(i) malicious complaints

(ii) demand of F2F consultations

(iii) CCG being heavy handed on practices.

219 COVENTRY: That conference believes that bureaucratic regulation of practices and clinicians has been a huge and increasing burden on GPs and a brake on the ability of practices to be flexible and innovative as well as affecting recruitment and retention. Conference wants this formally acknowledged by NHSE, and a firm commitment to prioritise a review and scrapping of such 'red tape'. (Supported by Warwickshire)

220 GLOUCESTERSHIRE: That conference holds that Datix from other services require proper investigation before automatically carrying out a formal PAG enquiry.

221 SOMERSET: That conference recognises that under COVID-19 restrictions healthcare professionals cannot come to work with viral symptoms as they used to and so demands that any patient complaint about a short notice cancellation or postponement of a booked, routine appointment under these circumstances must be dealt with by NHSE, CQC and/or CCGs at once, in favour of the practice and explaining to complainants what “new normal” really means.

222 SOMERSET: That conference, considering the Coronavirus Act 2020 provisions on issuing a Medical Certificate of Cause of Death, urges:

(i) that the new “28 day rule” for a GP having seen a person before death (including by video link) to issue a MCCD will be retained in future, and

(ii) that this will be extended to allow for an “attending GP” to include one who, as part of a multi-disciplinary team, was directly involved in supervising care but who may not have seen the patient in person within 28 days.

223 AVON: That conference calls for the legislative changes for death certification and the processing of cremation forms to continue after the COVID-19 pandemic has concluded.

224 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is concerned that whilst doctors are over regulated there continues to be no regulation of health service managers and calls upon the government to rectify this as soon as practicable.

225 CENTRAL LANCASHIRE: That conference believes that general practitioners should be formally accepted as a specialist of primary care and lead the MDT, as consultants function in the secondary care setting, and this should be acknowledged by GMC and all relevant organisations.

226 BERKSHIRE: That conference believes COVID-19 has demonstrated that CQC adds no value to healthcare and to general practice in particular, and:

(i) believes that during the pandemic, when CQC attempted to transform itself into a provider by organising COVID-19 testing, the organisation would have earned a “requires improvement” rating

(ii) regards the “Emergency Support Framework” calls as a perfect demonstration of Orwellian doublespeak and completely pointless

(iii) declares no confidence in the CQC

(iv) calls on the government to disband the CQC

(v) urges the government to divert the funding from CQC into core primary care so that meaningful improvements in patient care may be facilitated.

227 SHEFFIELD: That conference supports the promotion of addressing climate change and the current ecological crisis by asking GPC England to negotiate:

(i) incentivising the use of the “Green Impact Audit for Health” tools by general practices

(ii) the development of green prescription schemes accessible to all people living with long-term health conditions

(iii) mandating a national labelling system indicating the carbon footprint of all drugs and medical appliances, which can easily be incorporated into GP IT systems.

228 KENT: That conference applauds the duty of confidentiality which exists as an obligation under both common law and data protection legislation and demands that:

(i) GPs who seek advice in negligence cases should have their privacy respected and their details not passed to regulators

(ii) all managers handling performance cases be bound by the same rules as clinicians.

229 KENT: That conference demands that an independent judicial review into fatalities occurring whilst GPs are undergoing performance processes be conducted.

230 CAMBRIDGESHIRE: That conference notes the funding disparities evident in the commissioning of SAS contracts across the country, causing a worrying rate of provider turnover; instability and uncertainty for practice teams and safety concerns for patients - and calls upon GPC England to negotiate for the provision of these services to be sourced from a central ring-fenced budget to be weighted for each CCG/STP area.

231 KENT: That conference requires that all complaints submitted to GP practices:

(i) are dealt with at local level only

(ii) cannot be escalated to multiple regulatory bodies CCG, NHSE or GMC following resolution at local level

(iii) be subjected to one complaints process in total

(iv) treated fairly in an unbiased proceeding which is neither doctor nor patient centric.

232 KENT: That conference demands that:

(i) GPs are not coerced into signing away their privilege and legal protections when seeking support from NHS resolution to answer any civil litigation requests

(ii) NHS resolution accords GPs FULL confidentiality when dealing with negligence claims

(iii) NHS resolution is forbidden from reporting GPs to NHS England and any other regulatory bodies when approached by GPs for assistance in negligence claims.

233 BEDFORDSHIRE: That conference:

(i) recognises that the NHS is prepared to continue treating overseas visitors for unplanned and emergency conditions, but

(ii) urges the GPC England to persuade the government to encourage overseas visitors to come to the UK with proof of Insurance or self-funding for treatment of pre-existing condition - this should include treatment in general practice.

234 BEDFORDSHIRE: That conference calls on GPC England to ask government to put in place a mechanism to distinguish between needful emergency treatment and cases of blatant health tourism, which should be in place at point of entry to the UK.

235 BEDFORDSHIRE: That conference, making reference to the policy formed at the ARM of 2016 and the LMC conference of 2016, asks GPC England to re-state the necessity for qualified staff in professions allied to medicine to be permitted to issue Fit notes for areas covered by their defined competencies, which has been highlighted by the increased roles of allied staff in response to COVID-19 and the GP shortages.

PRACTICE BASED CONTRACTS

236 CAMBRIDGESHIRE: That conference notes with deep concern the proposal of NHSEI to commission extended (eg 20 year) APMS contracts from providers to enable digital health provision in under-doctored or deprived areas and calls upon GPC England to seek a legal challenge around the impact on the provision and stability of GMS services in these areas and the appropriate use of the public pound given the delivery of such technology by mainstream general practice.

237 KENT: That conference demands the negotiation of a co-payment model.

238 DORSET: That conference believes that coaching is an integral part of the future of GPs and instructs the GPC England to negotiate its inclusion in the GP contract for 2021 / 2022 onwards.

239 NORTHAMPTONSHIRE: That conference demands that home visits should no longer be part of core contract work and should be an enhanced service.

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

241 GATESHEAD AND SOUTH TYNESIDE: That conference welcomes the Secretary of State for Health's promise that NHS personnel will have the right to turn away abusive patients from non-urgent care and:

(i) seeks contractual clarity on how this would work in general practice, given current NHSEI rules on removal of patients

(ii) is concerned about the current limitations of the violent patient programme, which does not currently cover patients who are abusive but have committed no physical assault on healthcare staff.

FINANCE

242 WORCESTERSHIRE: That conference insists that partners' income is recognised in the next DDRB review in order to reflect their hard work during the pandemic and to prevent a loss in earnings in applying uplifts for practice staff.

243 SHROPSHIRE: That conference views as unacceptable, in light of additional work undertaken in the COVID-19 pandemic, the contract clause about a balancing mechanism which will adjust between the global sum and workforce reimbursement sum in the Network Contract DES depending on real terms partner pay levels, and calls on GPC England to demand that any additional funding for additional work is not subsequently clawed back from the practices' core income.

244 NORTH STAFFORDSHIRE: That conference recommends:

(i) that GP payments/reimbursements are marked / coded in a way that they are clearly identifiable and can be reconciled

(ii) that GP payment terms are strictly 30 days to avoid cash flow problems, and additional charges will automatically be applied / added where payments are delayed to recompense practices for additional costs.

245 NORTH ESSEX: That conference urges CCGs to proactively engage with LMCs and ensure that practices payments are transparent and timely.

246 NOTTINGHAMSHIRE: That conference demands greater scrutiny on how CCGs use funds intended for general practice schemes and initiatives. It therefore requests that NHSEI makes it compulsory for CCGs to:

(i) publish spend against LES / DES on a quarterly basis to LMCs and reports back that they have

(ii) consults with the local LMC on any new local schemes prior to implementation and reports back that they have.

247 KERNOW: That conference is asked to support the following:

(i) a commitment from NSHEI to provide MIG funding that is timely in its publication and purpose and available in perpetuity, to avoid the prevailing scramble required of practices, for investment in eligible projects

(ii) a commitment from NHSEI to properly fund clinical space in premises for those valued community services such as midwifery, podiatry and community public health clinics which are being squeezed from GP premises due to lack of space through inadequate funding.

248 AVON: That conference calls for the plan to publish a list of healthcare workers earning more than £150000 to be rescinded as general practitioners have demonstrated they are worth every penny of income as they have been a pillar of consistency and access during the COVID-19 pandemic.

249 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference acknowledges that discretionary services is underfunded and variable across the practices / CCGs in England:

(i) propose a guidance on tariff/ fee structure

(ii) publish varying tariff's across different CCGs (name and shame).

250 NOTTINGHAMSHIRE: That conference believes that general practice remains the bedrock on which the NHS is built. Whilst realising the during the present crisis there has been an increase in health care funding we believe that:

(i) general practice remains woefully underfunded

(ii) investing in general practice will improve care throughout the entire NHS

(iii) investing in general practice would improve the health of the nation, and

calls upon HMG to increase core funding into general practice as soon as is practicable.

PREMISES

251 AVON: That conference regrets that little progress has been made towards negotiating a settlement for tenants in NHS Property Services. This is having a deleterious effect on affected practices and requests that GPC England urgently takes steps to resolve this issue.

252 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference works with NHSE such that state owned GP premises are offered, for sale, to the occupying practices.

253 BEDFORDSHIRE: That conference calls on GPC England to:

(i) acknowledge that the expansion of the general practice workforce through the additional PCN roles is welcome, but

(ii) emphasise that many practices have difficulties finding space to accommodate the additional roles staff available to them and to

(iii) negotiate for funding for premises expansion or to rent additional space where needed.

254 NOTTINGHAMSHIRE: That conference calls for a joint NHSEI / GPC England nationwide review of primary care premises with a view to identifying premises needs and potential for solutions for the next five years as a minimum. LMCs to be engaged in local conversations to produce this review.

255 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that GPC England works with NHSEI to negotiate a substantial infrastructure fund directed into general practice.

256 AVON: That conference calls for ring-fenced investment in general practices. The general practice estate is inadequate for the services our contracts expect us to deliver.

257 MANCHESTER That conference agrees there should be a national response to invest in the estates in primary care, creating more space consistent with increasing work and workforce, due to:

(i) the significant change in the way the NHS is managing public health with greater emphasis on primary and community care management, co-ordinated care and out of hospital care

(ii) additional stress on diversification of workforce with increasing numbers of associate roles being recruited

(iii) increasing and ageing population with several chronic diseases resulting in a growing need for extra space in primary care

(iv) a lack of investment in primary care estates over a significant period of time resulting in reduce space in primary care settings stretched further by COVID-19.

WORKLOAD

258 HARINGEY: That conference, despite a number of previous motions regarding unsustainable GP workload that have been previously carried by conference:

(i) believes that it is no coincidence that GP workload continues to increase, and the numbers of GP continues to fall

(ii) calls on government to stop producing patronising panaceas for the workload crisis that we are in and works with LMCs and GPC England to provide solutions to unsustainable workload that help us now.

259 NOTTINGHAMSHIRE: That conference believes a GP who works three 12.5-hour days works full-time and should be treated the same as any other healthcare employee who chooses to work their 37.5 hour week over a three-day period. We therefore demand that GPC England:

(i) conducts a review of how GP work is tallied up

(ii) recognises that what we currently think of as full-time GP working hours are, in fact, approximately 33% higher than what are considered full-time hours for a non-GP worker

(iii) works to change this erroneous perception of GPs' working hours and seeks to redefine it such that both the profession itself and the public better value a GP's time.

260 LIVERPOOL: That conference believes that the increase in the number of patients consultations, the decrease in ability to undertake investigations in a timely manner, and the inability to get patients seen in secondary care, has inadvertently increased GP workload, decreased quality of care, and increased anxiety/stress levels amongst the workforce.

261 NORFOLK AND WAVENEY: That conference calls upon GPC England to take into account, when negotiating, the increase in workload caused by online consultations opening up access for patients to be 24/7/365 and that the model of open 24/7 access is reconsidered to ensure the sustainability of general practice, and that conference ensures that any additional workload is fully funded.

262 NORFOLK AND WAVENEY: That conference ask GPC England to raise concerns about NHSEI's return to a focusing on high levels of performance management and data gathering rather than a flexible approach enabling practices to determine how to provide the best care for their patients.

263 OXFORDSHIRE: That conference believes that patient demand on GPs and their practices is not matched by the resources and funding made available from NHSE and that a media campaign should be run by government and/or NHSE addressing public expectation of NHS services [that they are finite and if you want more, please pay more] and calls on GPC England to negotiate this.

264 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference will protect general practice and actively look at delivering safe, sustainable care by our practices and recognise that GPs can reach their limits and hit critical mass just like our secondary care colleagues and will seek to support and appropriately fund this discrepancy.

ICS / WORKING AT SCALE

265 AVON: That conference is supportive of the development of integrated care partnerships, but calls upon GPC England to negotiate with:

(i) NHSE to ensure that GPs and providers will determine with whom they form alliances in developing an integrated care partnership

(ii) NHSE to ensure clinical commissioning group's do not become concerned about the model of individual integrated care partnerships, but are assured by outcomes that the commissioner determined of the ICP

(iii) ICPs are developed in a timely manner and require adequate resourcing to succeed

(iv) ICPs should not be an enabler of vertical integration with trusts.

266 NEWHAM: That conference acknowledges national moves towards ICS formation and greater working at scale and demands that GPC England negotiates with NHSEI to ensure that:

(i) general practice representation and influence within the ICS is at least equivalent to the hospital trusts

(ii) the general practice remains a major decision maker at ICS level.

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

268 WEST PENNINE: That conference demands that the wishes of CCG member practices must be elicited, understood and followed before any CCGs merge - and that they are only permitted to do so with evidence of that support.

269 LIVERPOOL: That conference believes that the decrease in the number of CCGs will place a significant burden on already overstretched primary care networks and insists that GPC England negotiates for an increase in management costs to support PCNs in the modified NHS landscape.

270 LIVERPOOL: That conference believes that the NHSEI stated intention to reduce the number of CCGs to one per Integrated Care System will greatly reduce the influence of local GPs in strategic commissioning, potentially resulting in increased health inequalities and calls upon GPC England to ensure that within each CCG there is at least one GP board member from each 'place' within the new CCG, taking into account diversity or representation.

271 WALTHAM FOREST: That conference believes that CCG mergers, ICS and STP formation are another unnecessary NHS reconfiguration and that GPC England should:

(i) advise NHSE that this reconfiguration will not improve general practice

(ii) explicitly warn NHSE that these changes risk crucial NHS funding being misspent

(iii) demands that any funding earmarked for this reconfiguration is invested into the global sum payments.

272 WALTHAM FOREST: That conference is concerned by the increasing loss of GP autonomy, due to centralisation of decision making through the ICS and demands that GPC England ensures that:

(i) GP autonomy is upheld

(ii) wherever possible, decisions directly affecting practices are made locally, with active contribution from the LMC.

273 LANCASHIRE PENNINE: That conference expresses serious concern that the future reconfiguration of the NHS into integrated care systems, strategic CCGs and integrated care partnerships may take place on the back of the COVID-19 legislation and demands that GPs and their practices are fully involved in deciding the future of their CCGs as member organisations.

274 CUMBRIA: That conference:

(i) supports the integration of community services and general practice

(ii) believes that this will strengthen general practice

(iii) will enable the majority of care to be provided locally

(iv) insists that it is predicated on funding and resources following this care into the community.

EDUCATION AND TRAINING

275 KERNOW: That conference is asked to recognise the continuing workforce crisis facing those undertaking the vital role of practice management within general practice. Conference is asked to support the creation

of a nationally-resourced and updated electronic practice management handbook into which relevant published templates, basis processes, useful contacts and guidance can be amassed. This would support those practice managers new in post, isolated in role or aspiring to that role, to have a nationally-recognised and accurate resource to which they could refer.

276 COVENTRY: That conference believes all of our colleagues, whether in training or post-CCT have a positive contribution to make to our profession. That becoming factionalised is divisive and will be used against us and that we must continue to stand united in both our words and actions. (Supported by Warwickshire)

277 NOTTINGHAMSHIRE: That conference recognises the need for increased funding but realises that without a highly skilled workforce we cannot treat our patients as well as we should be able to. We call on HMG to increase funding for training across the primary care sector to enable better patient care in the community.

278 MID MERSEY: That conference believes the RCGP curriculum only touches on well-being briefly - would you agree that wellbeing should be a recognised component of the curriculum for GP trainees?

GPC ENGLAND / CONFERENCE OF ENGLAND LMCs / LMCs IN GENERAL

279 DEVON: That conference asks itself, following the Special Conference of England LMCs in March 2020 whether:

(i) it truly represents the majority of English GPs

(ii) the Standing Orders need review and rewriting

(iii) this method of debating and directing GPC England is archaic and no longer fit for purpose.

280 DEVON: That conference requests that it has a good look at itself and who it represents – the Special Conference in March voted to reject the PCN DES but over 99% of practices have signed up for it in England. Conference requests a review of how LMCs represent their grassroots GPs is performed to assure that the electorate at conference is representative of the profession.

281 CAMBRIDGESHIRE: That conference deplores the lack of a clear, energetic, national voice to represent all GPs, so sadly demonstrated in the early months of the COVID-19 pandemic, which has opened the profession up to uninformed, unfair and deeply insulting attacks from government and our own patients, and mandates GPC England to form a focus group of LMC CEOs to initiate an options appraisal to explore the benefits of creating a trade union for England LMCs.

282 HARINGEY: That conference, despite several previous motions regarding the considerable challenges posed by the PCN DES, the continued inability to recruit to ARRS, GPs being asked to perform to unrealistic deadlines and targets across areas of service delivery and the unabated fall in GPs numbers:

(i) reaffirms its important role in representing the voice of GPs and its part in setting negotiating policy and

(ii) calls for there to be a 'reset' in our relationships that will address the level of disillusionment pervading the profession and we can indeed represent the wishes of our GPs going forward.

283 BEDFORDSHIRE: That conference calls for a standing item on the conference agenda where GPC England reports failures of negotiation and seeks conference's views on a way forward.

284 MID MERSEY: That conference notes that general practice teams are increasingly comprised of multi-disciplinary clinical teams, and that nurses, advanced nurse practitioners, pharmacists, physiotherapists, and mental health practitioners (amongst others) are eligible to become partners in GP practices under the New to Partnership Scheme; and therefore considers that the statutory role of LMCs to represent only medical practitioners is now anachronistic, and that it is time for the GPC to take the lead in ensuring representation of non-medical practitioners and practice managers on national and local committees.

285 LEEDS: That conference:

(i) supports the Romney report recommendation for multi member constituencies for GPC England elections

(ii) believes multi member constituencies should be at least the size of BMA regional council areas

(iii) that multi member constituencies should enable elections to take place including gender quotas

(iv) that multi member constituencies should enable elections to take place with partner and sessional GP quota

(v) believes that, in order for multi member constituencies and quotas to operate effectively and without making constituencies too large and distant from LMCs, GPC seats currently elected from the LMC Conference and ARM should be reallocated to expand the number of regionally elected members.

286 HERTFORDSHIRE: That conference deplores the lack of diversity at the senior management levels within the NHS and calls on GPC England to show leadership by:

(i) reviewing its own policies regarding diversity

(ii) calling on the BMA to review its policies and the make-up of BMA council and the senior management of BMA

(iii) fully supporting Dr Mo Sattar's work recently published in the BMJ to ensure that all practices adopt NHS England's Workforce Race Equality Standard.

287 CAMBRIDGESHIRE: That conference:

(i) mandates GPC England to feedback directly to the following year's conference, where they have been unable to deliver what has been democratically asked of them at previous conferences and special conferences

(ii) commends the clinicians who provided services to the COVID-19 Clinical Assessment service (CCAS) but regrets the shift from providing triage for COVID-19 patients in an emergency pandemic, to additionally covering non-COVID-19 111 dispositions and calls upon GPC England to negotiate the remit with NHSEI of CCAS, to ensure that a cheap national out of hours service is not created by stealth.

PCSE

288 WEST SUSSEX: That conference believes Primary Care Services England will never be a competent organisation and their incompetence is causing anxiety and stress for general practitioners and their staff on a daily basis.

PENSIONS

289 SOMERSET: That conference holding it to be self-evident that the NHS Pensions should be managed effectively but having no confidence in the current contractor, demands that compensation offered for mismanagement of pension contributions should not be subject to non-disclosure agreements.

290 DEVON: That conference is relieved and pleased that the Cervical Screening Programme administration has been taken back under central control by the NHS, rather than being left in the hands of a private provider who have a proven track record of failing to achieve KPIs and of leaving chaos in their wake. As the same provider has shown at least equal ineptitude with the management of GP pensions, we request that GPC England negotiate for GP pension scheme administration to also move back under a central NHS control.

291 WAKEFIELD: That conference believes that the life of an English GP had equal value to that of a Scottish GP and wants death in service benefit to be reinstated in England for GPs who have opted out of the NHS pension scheme as has happened in Scotland.

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.

England LMC A and AR Resolutions from 2019

		WORKFORCE	UPDATE
A	27.	NORFOLK AND WAVENEY: That conference believes there is little confidence in the measures being taken by the government to attract GPs into partnership as the profession faces an ongoing crisis of workload escalating on the shoulders of a dwindling number of partners.	The update to the GP contract agreement 2020/21 – 2023/24 saw the introduction of the New to Partnership Payment Scheme.
A	28.	SURREY: That conference: (i) reaffirms its support for the GP Partnership model of delivery of primary medical services (ii) urges that any acceptable outcome of the current GP Partnership Review includes a direct financial uplift in GMS global sum and/or PMS global sum equivalent.	The update to the GP contract agreement 2020/21 – 2023/24 saw the introduction of the New to Partnership Payment Scheme.
A	29.	DEVON: That conference calls for NHS England to consider the reintroduction of 'golden hello' payments for general practitioners who take up a long-term partnership or salaried role in areas where recruitment has been deemed to be challenging.	The update to the GP contract agreement 2020/21 – 2023/24 saw the introduction of the New to Partnership Payment Scheme.
A	30.	LEEDS: That conference, whilst noting the workforce expansion planned as part of the primary care network DES, believes that there remains an urgent need to increase the number of GPs.	We agree with the motion and continue to lobby government to deliver on their manifesto commitment to increase the number of GPs
A	31.	GREENWICH: That conference calls upon government to support the longer-term sustainability of the partnership model in general practice.	The update to the GP contract agreement 2020/21 – 2023/24 saw the introduction of the New to Partnership Payment Scheme.
A	32.	KINGSTON AND RICHMOND: That conference believes comprehensive NHS occupational health services should be available to all staff working in GP practices.	We agree with the motion and have raised this repeatedly with government and NHSE/I and included in our submission to the Treasury spending review.
AR	33.	CAMBRIDGESHIRE: That conference demands that NHS England is forcibly reminded of their self-commissioned Partnership Review, which concluded that "doing nothing cannot be an option", and calls on GPC England to insist that NHS England & Improvement: (i) commit to enacting the recommendations of the Partnership Review in full, to protect and strengthen the partnership model and independent contractor status of GPs	The update to the GP contract agreement 2020/21 – 2023/24 saw the introduction of the New to Partnership Payment Scheme.

		(ii) prove by their actions that the Review was a serious attempt to protect and strengthen the partnership model and independent contractor status of GPs, and was not an elaborate and expensive smokescreen (iii) reiterate the primary functions of PCNs from the outset, i.e. to stabilise general practice, and to encourage the investment into primary care to facilitate the long-term plan.	
AR	**34.**	NORFOLK AND WAVENEY: That conference whilst acknowledging the review recommendations of the GP Partnership Review, notes the continued reduction in GP partner numbers and calls upon GPC England to negotiate further practical measures and implement the existing recommendations within the partnership review to prevent the extinction of the "GP partners".	The update to the GP contract agreement 2020/21 – 2023/24 saw the introduction of the New to Partnership Payment Scheme.
AR	**35.**	GLOUCESTERSHIRE: That conference is appalled that the number of partners has fallen by 5.3% in the year despite the partnership review and insists that NHSE take urgent action to improve the working life of partners.	The update to the GP contract agreement 2020/21 – 2023/24 saw the introduction of the New to Partnership Payment Scheme.
		WORKLOAD	**UPDATE**
A	**36.**	LINCOLNSHIRE: That conference calls for NHSE to agree a maximum workload that a GP can be expected to safely carry out in a working day.	In its *Controlling workload in general practice strategy*, GPCE has made public a recommendation that all GP appointments should be a minimum of 15 minutes. This is the minimum amount of time required to ensure patients can get the care they require, first time of asking and will improve preventative care drastically. In terms of appointments per GP per day, this should be a safe optimum of 25 per day. An absolute daily maximum must be no more than 35, but this should be an infrequent occurrence and will depend on the complexity of each patient's care needs. It is worth noting, however, that as we push to achieve this, it cannot happen overnight. Training GPs takes 10 years, so the support of other clinical and non-clinical professionals is the only realistic way to achieve this goal. The alternative is to have a drop in the standard of care until such time as we can train enough GPs. It is unlikely patients will support this.
A	**37.**	LIVERPOOL: That conference believes that Her Majesty's Government must alter its advice to patients with pre-existing medical conditions intending to travel to Europe to speak to their GP for advice before travelling to Europe, in the event of a no-deal Brexit. Advice on travelling is outwith the NHS contract and expertise of practitioners and this recommendation is ill-thought out and	We agree with the motion and have encouraged government to act on it.

		factually incorrect. Patients should take out travel insurance and disclose pre-existing conditions.	
A	**38.**	DEVON: That conference calls on NHS England to intervene to make sure that due consideration is given to the local general practice provision before any new housing development aimed at the frail elderly is given planning approval.	We agree with the motion and have encouraged government to act on it.
AR	**39.**	DEVON: That conference with respect to Prescription Medication Administration Record forms (PMARs), demands that: (i) GPs are not obliged to complete these forms for a third-party provider (ii) the responsibility for completion lies with the employer of the health care professional administering the medication (iii) any arrangement in place should not involve transcription of medication by hand.	This is a statement of current policy. Post Covid, some Community Trusts have agreed they do not need to be completed.
AR	**40.**	CROYDON: That conference: (i) believes GP workload is unsustainable (ii) demands a cap on the number of patient consultations that can be undertaken by each GP per working day (iii) that commissioners are responsible for providing NHS services to patients requiring same day care once the cap is reached.	In its *Controlling workload in general practice strategy*, GPCE has made public a recommendation that all GP appointments should be a minimum of 15 minutes. This is the minimum amount of time required to ensure patients can get the care they require, first time of asking and will improve preventative care drastically. In terms of appointments per GP per day, this should be a safe optimum of 25 per day. An absolute daily maximum must be no more than 35, but this should be an infrequent occurrence and will depend on the complexity of each patient's care needs. It is worth noting, however, that as we push to achieve this, it cannot happen overnight. Training GPs takes 10 years, so the support of other clinical and non-clinical professionals is the only realistic way to achieve this goal. The alternative is to have a drop in the standard of care until such time as we can train enough GPs. It is unlikely patients will support this.
AR	**41.**	WEST SUSSEX: That conference: (i) notes the increased workload required of GP practices following identified NHS IT failures (ii) demands that this workload must be appropriately recompensed by NHS England (iii) demands that future NHS IT contracts should include a penalty clause securing funding for such future workload, if required.	Given the changing ways of working and immediate pressures from the current period it is unlikely we will make progress in this area. Having said that, BMA sits on the expert advisory board for GP IT futures where many new digital solutions are scrutinised and will work to ensure that any solutions given approval are less prone to failures. Where failures do happen, GPCE engages with suppliers and/or central bodies to ensure a solution as soon as possible.

		PREMISES	UPDATE
A	**42.**	LEEDS: That conference condemns the Department of Health and Social Care and NHS Property Services for their failure to resolve the longstanding dispute relating to GP premises and calls for fully funded fair rental arrangements.	Court case ongoing with NHSPS to resolve dispute re service charges. Continued discussions with NHSE/I, significant changes requiring capital expenditure delayed by ongoing comprehensive spending review.
A	**43.**	NORFOLK AND WAVENEY: That conference believes that the primary care premises estates stock is inadequate and needs immediate updating and placed on equal footing with other providers in bids for general practice to provide the service that patients, doctors and the government expect.	Continued discussions with NHSE/I significant changes requiring capital expenditure delayed by ongoing comprehensive spending review. 3-Facet survey underway by NHSE/I to assess estate stock.
A	**44.**	NORTH YORKSHIRE: That conference believes that our national negotiators should be demanding investment into primary care estates to ensure that every area has premises suitable to allow the delivery of 21st century primary care services, PCN/at scale services and integration with community health and social care.	GPCE has sought significant investment in primary care estates in submissions on spending review - £1bn over three years.
A	**45.**	AVON: That conference is concerned to hear reports that CCGs are seeking to “quality assure” and monitor building compliance in private GP owned premises and urges GPC England to resist additional bureaucracy with vigor.	GPCE continues to resist bureaucratic processes and is a key part of the DHSC review into this.
A	**46.**	NORTHUMBERLAND: The delay in revision of the Premises Cost Directions and lack of connection to primary care direction and strategy is significantly impeding the development of individual practices and PCNs. Conference demands that this situation is resolved urgently.	Continued discussions with NHSE/I with PCD as standing item, significant delays with DH lawyers.
A	**47.**	NORTHAMPTONSHIRE: That conference demands that funding be made available for premises development that will allow proper facilities for patient care and population increases, not be dependent upon integrated care strategic aims, and will allow the partnership model to continue with GP premises ownership where this is the partnership preference.	GPCE has sought £1bn investment in primary care estates in submissions for spending review. Spending allocations should be made with respect to patient care and population needs.

		PRACTICE BASED CONTRACTS	UPDATE
A	48.	HERTFORDSHIRE: That conference calls for GPs to be paid for undertaking any ad hoc home visits for patients registered under out of area arrangements if the local CCG has not commissioned a home visiting service for their area.	To be included in the upcoming contract negotiations. NHSE/I has indicated that they are not inclined to remove home visits from the core contract. GPCE is working on guidance for practices/PCNs about local home visit services.
A	49.	DEVON: That conference demands that the arrangements for home visits for out of area registered patients are reviewed such that: (i) all such patients have a defined provider of home visits (ii) that the arrangements meet the same standards as a fully registered patient (iii) all such patients and the registering practice are informed as to those arrangements.	To be included in the upcoming contract negotiations.
A	50.	WORCESTERSHIRE: That conference calls on GPC England to formally assess and publish common commissioning gaps for local enhanced services and challenges them to demand appropriate funding for these nationally.	GPCE has published a list of common LESs across the country and continues to support practices and LMCs where commissioning gaps are identified.
A	51.	NORTHAMPTONSHIRE: That conference negotiates a radical uplift to all DESs to properly cover the real costs of sessional GPs, nurses and staff wages which is currently not offset against GMS uplifts against inflation.	This will be considered for future contract negotiations.
A	52.	CLEVELAND: That conference is concerned about the increased responsibility for GP access returning to practices via PCNs and reiterates that responsibility for the provision of out of hours GP service should never again become mandatory as part of the GMS contract.	To be included in the upcoming contract negotiations – a combined access offer with maximum flexibility. Outcome of access review not yet published, but this will be a priority.
A	53.	BRADFORD AND AIREDALE: That conference believes that as digital remote consulting is rolled out to all practices the major reason for allowing out of area registrations has been removed and calls on GPC England to negotiate the removal of this scheme from the contract.	The use of remote consultations has significantly increased during the last seven months and GPC England believes this means there is no justification for additional digital first practices. GPCE have repeated our opposition to this policy to government and NHSEI. At the time of writing the previously planned roll-out of this policy has been delayed.
A	54.	LAMBETH: That conference demands that the out of areas regulations are abolished.	The use of remote consultations has significantly increased during the last seven months and GPC England believes this means there is no justification for additional digital first practices. GPCE have repeated our opposition to this policy to government and NHSEI. At the time of writing the previously planned roll-out of this policy has been delayed.

A	55.	LIVERPOOL: That conference believes that GPC England must actively campaign for a change in CCG procurement rules to enable CCGs to offer a GMS contract when either a practice vacancy arises or an APMS contract comes to the end of its term.	We have argued for this previously, but the response of NHSE/I is they are bound by EU procurement rules when offering contracts. There are indications of change once the UK has left the EU.
A	56.	ROCHDALE AND BURY: This conference seeks access to flu vaccination under a DES for front line GP staff in line with front line health and social care staff.	This has been called for previously in contract negotiations and we will continue to push for it. NHSE/I's view is that it's an occupational health matter and therefore a practice responsibility
A	57.	CLEVELAND: That conference insists that in future, appropriate inflationary uplifts to core GMS funding can be accessed without practices having to agree to any additional work.	This is already the case.
		FINANCE	**UPDATE**
A	58.	LEEDS: That conference notes the priority the Prime Minister placed on improving access to general practice services but believes that in order to achieve this he must ensure recurrent investment for: (i) an increased number of GPs (ii) an increased number of practice nurses (iii) improved and new practice premises (iv) improved IT and associated infrastructure.	GPCE has highlighted this with NHSE/I and continues to liaise regarding recruitment scheme, IT and premises funding.
A	59.	DORSET: That conference is appalled at the ongoing gender pay gap for GPs as demonstrated in the recent NHS Digital publication of GP Earnings and Estimates and calls for urgent investigation into the causes and solutions. (Supported by Sessional GPs Committee)	The national gender pay gap review is due to be published, which has investigated these causes.
A	60.	LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes that the number of requests has increased for reports by and on behalf of the Department of Work and Pensions, especially by the Health Assessment Advisory Service, and requires the GPC England to negotiate a significant above inflation increase for that proportion of the global sum.	This will be considered for future contract negotiations and is also being taken forward as part of the DHSC bureaucracy review.
		PCSE	**UPDATE**
A	61.	TOWER HAMLETS: That conference notes that time after time Capita demonstrate that they are not fit to provide services to the NHS and: (i) refuses to take on any more un-resourced work caused by Capita's failures (ii) instructs GPC England to inform government and NHSE that GP practices	GPCE continues to highlight to NHS England and government the many shortcomings of the PCSE service delivered by Capita. Cervical smear services have now been removed from PCSE and transferred back to NHSE. We continue to lobby for improvements to pension information management. However, there appears to be no appetite to terminate their contracts and replace them.

		do not have the capacity to clear up after Capita's failures and in future will not do so (iii) calls for Capita's contract to be immediately terminated and all of their functions brought back 'in house'.	
A	62.	WAKEFIELD: That conference condemns the recurrent mismanagement by PCSE and if they cannot be made fit for purpose, they should be replaced.	GPCE continues to highlight to NHS England and government the many shortcomings of the PCSE service delivered by Capita. Cervical smear services have now been removed from PCSE and transferred back to NHSE. We continue to lobby for improvements to pension information management. However, there appears to be no appetite to terminate their contracts and replace them.
A	63.	CLEVELAND: That conference is utterly fed up with the expectation that practices will fix multiple and recurrent PCSE errors and condemns NHS England for its failure to manage this.	GPCE continues to highlight to NHS England and government the many shortcomings of the PCSE service delivered by Capita. Cervical smear services have now been removed from PCSE and transferred back to NHSE. We continue to lobby for improvements to pension information management. However, there appears to be no appetite to terminate their contracts and replace them.
A	64.	KENT: That conference demands removal of all NHS contracts from Capita.	GPCE continues to highlight to NHS England and government the many shortcomings of the PCSE service delivered by Capita. Cervical smear services have now been removed from PCSE and transferred back to NHSE. We continue to lobby for improvements to pension information management. However, there appears to be no appetite to terminate their contracts and replace them.
A	65.	BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference demands that Capita are stripped of their provider contract to the NHS as soon as is practicable.	GPCE continues to highlight to NHS England and government the many shortcomings of the PCSE service delivered by Capita. Cervical smear services have now been removed from PCSE and transferred back to NHSE. We continue to lobby for improvements to pension information management. However, there appears to be no appetite to terminate their contracts and replace them.
AR	66.	DORSET: That conference: (i) instructs GPC England to work with NHS England to find a suitable replacement for Capita (ii) demands that Capita are stripped of their provider contract to the NHS as soon as is practicable.	. GPCE continues to highlight to NHS England and government the many shortcomings of the PCSE service delivered by Capita. Cervical smear services have now been removed from PCSE and transferred back to NHSE. We continue to lobby for improvements to pension information management. However, there appears to be no appetite to terminate their contracts and replace them.
		INFORMATION MANAGEMENT & TECHNOLOGY	**UPDATE**
A	67.	OXFORDSHIRE: That conference welcomes the funding negotiated into the GMS contract in 2019 to support practices in the cost of SAR applications but notes with concern the increasing workload these requests represent and calls on	Discussions over how SAR application costs are covered are taking place within GPCE. As we move towards full digitisation of GP records, we expect that some of these costs will naturally fall, however where this isn't the case GPCE will work to secure either a reduction in workload, cost or both of processing SAR applications.

		GPC England to negotiate further increased funding for this work going forward.	
A	**68.**	GLOUCESTERSHIRE: That conference demands that there is government recognition of the unique challenges in general practice to fulfil increased demand for unfunded data release, engendered by GDPR regulation and balances this with additional reimbursement.	Same as above and, as part of the response to Covid, over 90% of GPs have signed up to a fortnightly GPES extract allowing data to flow through NHS Digital to requesting organisations, thereby reducing the burden on general practice.
A	**69.**	BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference agrees that the current IT infrastructure is: (i) not fit for optimal patient care (ii) a source of significant stress to GPs (iii) at times so poor as to be a danger to patient care (iv) in urgent need of rapid and major investment before any further paperless projects are rolled out.	Discussions over IT infrastructure within general practice are ongoing between BMA and NHS Digital, NHSX, NHSE/I and suppliers. Where risks to patient safety have been identified, swift action to find workarounds or solutions to ensure safety standards are upheld has been taken. The BMA has secured exemptions to requirements for GPs to meet certain expectations during the Covid period including on access to records as one way of mitigating some of the safety issues with poor IT infrastructure.
A	**70.**	LAMBETH: That conference notes that for day to day effective working practices require suitable telephony infrastructure as part of the IT infrastructure and calls upon NHS England to: (i) invest and fund telephony infrastructure for primary care that will support the development of digital services (ii) provide VOIP telephony to PCNs and all practices.	A suite of new remote working tools have been rolled out and made available to general practice during the pandemic including asynchronous web consultation services and video consultation solutions, GPC England has worked with NHS England and others to ensure that rollout of these services takes place with minimal disruption and burden to GPs. In time, we expect to see what the 'new normal' will look like for general practice and will review the set of asks put forward to NHSE at that time.
A	**71.**	LAMBETH: That conference demands that in order for primary care to continue to develop and deliver services that patients require, considerable investment in IT infrastructure be provided.	GPCE has representatives on the GP IT Futures expert advisory group to ensure that new IT solutions advance, rather than limit IT infrastructure in primary care. However, the extraordinary circumstances that have been imposed upon general practice since March have called for immediate action on remote consulting, which is where the majority of BMAs influencing has taken place. In this regard, GPCE has secured over 10,000 imaged laptops along with VPN tokens and smart card readers. GPCE is now working to secure virtual desktop infrastructure solutions to enable even greater and more flexible remote working going forward.
A	**72.**	CLEVELAND: That conference mandates that no digital development are included in negotiated GMS contract, changes until the NHS provided IT can keep pace with the changes already negotiated, and not implemented.	The focus of ongoing discussions and negotiations within GP IT have been more reactive given the circumstances and solutions to support GPs in the current situation are being sought as a priority, whether or not these solutions represent further digital development.
A	**73.**	GATESHEAD AND SOUTH TYNESIDE: That conference: (i) notes the recent changes in the guidance for firearms safety checks which have clarified where responsibility lies, but is still concerned about the safety of patients holding firearms licences if they experience deteriorating mental health	Discussions will take place on this issue with NHS Digital, but to date no progress has been made.

		(ii) calls on NHS Digital to ensure that clinical systems check for entries relating to holding of a firearms licence when codes are added relating to mental health and display a warning similar to a drug interaction alert, so that GPs are made aware of this potential risk.	
A	**74.**	NORFOLK AND WAVENEY: That conference asks GPC England to ensure the proposed new payment system must be extensively road-tested within general practice to ensure it is fit for purpose, prior to the decommissioning of Exeter.	The new system has now been delayed following performance issues, GPC England will be engaging with relevant stakeholders to ensure these issues are fully resolved before a national rollout.
		DIGITAL GENERAL PRACTICE	**UPDATE**
A	**75.**	HULL AND EAST YORKSHIRE: That conference demands that NHS England stipulate digital and remote providers of access to primary care appointments must undertake the same due diligence as GP practices in: (i) addressing inappropriate demands (ii) patient education at the first point of contact (iii) undertaking care navigation in line with local arrangements.	GPC England is opposed to further roll-out of digital first providers and has made this clear to NHSE/I and government. Plans to do this has so far been delayed.
A	**76.**	LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands that the GPC England reviews and renegotiates NHS regulations to ensure that online GP services providers provide the same level of care as traditional general practice in terms of chronic disease management, home visiting, and care to the vulnerable and elderly.	GPC England is opposed to further roll-out of digital first providers and has made this clear to NHSE/I and government. Plans to do this has so far been delayed.
A	**77.**	WORCESTERSHIRE: That conference rejects the move to use private online providers in preference to enabling GP practices to provide their own IT solutions to patients locally and demands that support and resource is channelled in to practices and PCNs for this purpose.	GPCE is working to channel funding into PCNs for IT solutions. Where a practice develops its own solution and this meets the criteria applied to other similar solutions from private providers, due consideration must be given to it. Where a practice has a digital solution that works and is encountering resistance from NHS bodies, BMA will always take this case up provided these criteria have been met.

		REGULATION	UPDATE
A	78.	MID MERSEY: That conference following the vote of the conference of England LMCs in 2018 directing GPC to work to ensure that there is effective independent oversight and review of NHSE performance procedures, conference asks the Chair of GPC to update conference on any progress to date and the actions planned to implement this decision.	GPCE representatives have secured a range of commitments from NHSE/I to significantly improve its performance management processes and procedures. This includes commitments to encourage early resolution, improve NHSE/I's consistency of approach, improve performance management data capture and analysis, and ensure equal treatment of GPs with protected characteristics. GPC England and NHSE/I will continue to work together during 2020 and beyond to fully implement the commitments with the shared aim of promoting patient safety, practitioner development and organisational improvement.
AR	79.	MID MERSEY: That conference believes that, as assessment of practices by the CQC relies uniquely on the personal opinion of individual inspectors, the GPC must work to ensure that the CQC assesses all practices to known standards that are consistent and reproducible from one visit to another.	GPCE continues to regularly meet with CQC to achieve these and other important reforms to CQC's regulation and inspection processes. GPCE has provided robust feedback to CQC regarding its Transitional Monitoring and Regulatory Approaches and the standardized data sets used to assess practices remotely.
		PENSIONS	**UPDATE**
A	80.	LEEDS: That conference believes pension issues are having a major impact on GP retention and demands an end to: (i) annual allowance (ii) annual allowance tapering (iii) annualisation (iv) life time allowance.	GPCE continues to work closely with the other Branch of Practice Committees of the BMA to campaign for the removal of the iniquitous annual and lifetime allowance pension regulations which act as a perverse disincentive to our most experienced doctors to continue working at a time when GP workload is already at breaking point. The BMA has produced detailed guidance to help doctors navigate this system, including advice on pensionable and non-pensionable pay, the complexities of NHS pension schemes, retirement, ill health and death in service benefits. The BMA has written many letters to the different secretaries of state for health, chancellors, ministers and prime ministers, including: • letter to the chancellor of the exchequer Phillip Hammond • letter to the prime minister Boris Johnson. In addition, more than 2,500 doctors have written to their local MP to outline their own concerns. This has influenced parliamentary debates and has been raised during prime minister's questions.
A	81.	LAMBETH: That conference deplores the failure of NHSE to find a workable solution to the NHS pension crisis and: (i) believes that this is having an impact on waiting lists, patient care and outcomes	This has been enacted.

		(ii) calls upon NHSE to find an immediate solution whereby senior GP partners do not feel the necessity to retire early or reduce their hours of work to avoid punitive tax charges.	
A	82.	NORTH STAFFORDSHIRE: That conference demands that the Treasury change the annual allowance and lifetime allowance thresholds to remove the income cliffs that are causing GPs to either decrease their work commitments or to prematurely retire.	This has been enacted.
A	83.	WORCESTERSHIRE: That conference rejects the annualisation process used in the NHS pension scheme and asks GPC to robustly challenge this as it threatens to reduce the GP workforce further.	We have raised this robustly with government. The BMA Pensions Committee is now taking this forward.
		CLINICAL	**UPDATE**
A	84.	SURREY: That conference believes all Public Health England initiatives should be 'sense-checked' before release by the GPC.	GPCE is working closely with public health committee of BMA and putting things in perspective.
A	85.	DEVON: That conference agrees that a change in policy to allow fit notes to be signed by competent clinicians as well as GPs would help reduce GP workload and we urge the GPC to petition for such a policy change.	This has been taken forward through the bureaucracy review.
A	86.	MID MERSEY: That conference asks GPC to take steps to ensure that advanced nurse practitioners working in general practice can, when appropriate, issue medical certificates (Med3s) for patients	This has been taken forward through the bureaucracy review.
A	87.	CORNWALL AND ISLES OF SCILLY: That conference believes that post mortem reports provide an invaluable source of formative feedback for GPs after the final years of their patient's lives. We would ask the GPC to petition the Chief Coroner to advise his regional coroners to release these reports to the deceased's registered GP as a routine part of any inquest.	This issue is on the PFC (Professional Fees Committee) agenda, but due to the pandemic it has been pushed forward but will be revisited.
A	88.	WORCESTERSHIRE: That conference believes that a change in the regulations should be made to allow dispensing doctors to provide electronic repeat dispensing to their dispensing patients.	We have repeatedly pushed NHSE/I to find the resources to fund practice IT and internet connections to allow dispensing doctors to make use of eRD (electronic Repeat Dispensing).
A	89.	CITY AND HACKNEY: That conference demands that gender identity clinics are properly funded to provide medication and monitoring to patients as the care of these patients falls outside the expertise of most general practitioners even in situations where shared care guidance exists.	GPCE fully agrees with this and continues to lobby for NHSE/I to commission a service. GPCE is also working closely with the Equality and inclusion team, and Ethics team, in taking this forward.

AR	90.	OXFORDSHIRE: That conference believes there is a lack of clarity on the requirements, responsibilities and liabilities on practices with regard to the Falsified Medicines Directive, is concerned by the potential impact on practice workload and mandates GPC to: (i) ensure that any consequent increase in workload is financially remunerated (ii) ensure that the cost of equipment and software necessary to comply with the FMD are not borne by practices (iii) issue further clarifying guidance to practices to make them aware of their rights and obligations.	GPCE has published guidance on this, and are working with colleagues in the public affairs team who are leading on Brexit related issues.
AR	91.	NORTH ESSEX: That conference deplores the lack of properly commissioned specialist care for patients with gender dysphoria and advises all GPs to limit care provided under GMS to this vulnerable patient group to that which is within their clinical competence.	GPCE fully agrees with this and continues to lobby for NHSE/I to commission a service. GPC is also working closely with the Equality and inclusion team, and Ethics team, in taking this forward.
AR	92.	HERTFORDSHIRE: The cuts to public health funded sexual and reproductive healthcare, with subsequent closure of many clinics across the country, is a violation of women's rights to good sexual health and access to full contraceptive choices. Conference asks GPC to: (i) urgently work with NHSE and public health to reverse this retrograde step in healthcare provision in England (ii) increase funding in primary care for the cost effective provision of LARCs (iii) lobby the government, making it aware that a healthier nation requires adequate provision of sexual and reproductive healthcare.	Sexual health services are commissioned by local authorities/public health services and not subject to national negotiations. However, we have lobbied government on the need to increase funding for local government and public health services to try to address the issues highlighted by the motion.
		ICS/WORKING AT SCALE	**UPDATE**
A	93.	CLEVELAND: That conference mandates that LMCs, not PCN based structures, are the representatives of general practice at a locality level.	We have made clear the role of LMCs in the PCN Networks and have set this out in the Handbook.
AR	94.	LIVERPOOL: That conference believes that GPs must be fully informed of developments within their STP with regards to creation of Integrated Care Systems and requests that GPC provides clear guidance on how to protect GMS practices from pressures placed upon practices and PCNs by Provider Alliances and emerging Integrated Care partnerships.	We would expect LMCs to support PCNs' engagement with STPs and ICSs to shape their strategic direction and improve and align population care on a wider scale.

		PRIMARY / SECONDARY CARE INTERFACE	UPDATE
A	95.	WALTHAM FOREST: That conference requires a stop to the practice of hospitals giving patients paper requests for non-urgent prescriptions and either issues a prescription or communicates the request in a clinic letter.	GPCE and the BMA's Consultants Committee have written to and met with Prof Steve Powis, NHSE/I medical director, about the need to address this and other primary-secondary care interface issues.
A	96.	KENT: That conference demands that the NHS Standard contract is amended to prevent one clinician ordering investigations in the name of another.	GPCE and the BMA's Consultants Committee have written to and met with Prof Steve Powis, NHSE/I medical director, about the need to address this and other primary-secondary care interface issues.
A	97.	GLOUCESTERSHIRE: That conference insists that electronic prescribing to community pharmacies be developed and rolled out to hospital services as a matter of urgency and asks GPC to strongly encourage this to take place.	GPCE and the BMA's Consultants Committee have written to and met with Prof Steve Powis, NHSE/I medical director, about the need to address this and other primary-secondary care interface issues.
A	98.	GLOUCESTERSHIRE: That conference is concerned about the absence of a commissioned service for red drugs and insist that: (i) blood results currently poorly accessible by hospital trusts other than the lab where testing has occurred be resolved to ensure better patient care and avoid needless blood tests (ii) that clear funded mechanisms be established for the monitoring of them (iii) that safe transfer of care from distant hospitals to local ones be properly established including the prescribing of red drugs.	Red drugs should, by definition be specialist initiated, monitored and prescribed. The transfer of care between hospitals needs to be delete with through wider commissioning arrangements and is out of the scope of GPCE.
A	99.	DEVON: That conference asks the GPC to seek clarification over the recording of a patient's individual decision regarding advance directives and work to ensure that the onus for this transfer of information is shared by both primary and secondary care.	The responsibility for making the existence of an ADRT known rests with the patient, and they should ensure that those family members or friends who are likely to be consulted in an emergency are aware of its existence and can easily locate it. It is the patient's responsibility to ensure that the document is available when needed and doctors do not need to spend time searching for an ADRT if there is no indication that one exists. However, there is a significant role for GPs here when they are aware of the existence of an ADRT and when they are asked for information about them; this has been confirmed in recent case law, including NHS Cumbria CCG v Rushton [2018] EWCOP 41 where the judge made clear what is expected of GPs. GPCE will be ensuring awareness of these responsibilities within the profession.
A	100.	WORCESTERSHIRE: That conference is deeply concerned by the expectation on GPs to take on	GPCE and the BMA's Consultants Committee have written to and met with Prof Steve Powis, NHSE/I medical director, about

		work beyond their level of competence from secondary care and: (i) insists that formal consent is given in the form of shared care agreements for GPs choosing to take on additional work (ii) calls on GPC to ensure that funding for the transfer of work moves from secondary care to primary care (iii) insists that GPs have access to specialist support and training when taking on specialist work.	the need to address this and other primary-secondary care interface issues.
A	101.	LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands that GPC reviews and renegotiates NHS policy to ensure that only resourced and appropriate work is passed onto primary care by secondary care.	GPCE and the BMA's Consultants Committee have written to and met with Prof Steve Powis, NHSE/I medical director, about the need to address this and other primary-secondary care interface issues.
AR	102.	LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference recognises un-funded, unsafe left shift of work into primary care with poor communication putting the patient and GP colleagues at serious risk. The conference calls on the GPC to: (i) nationally agreed guidance / process on transfer of care (ii) nationally agreed funding to support this additional work.	GPCE and the BMA's Consultants Committee have written to and met with Prof Steve Powis, NHSE/I medical director, about the need to address this and other primary-secondary care interface issues.
AR	103.	NOTTINGHAMSHIRE: That conference deplores the winter planning which is heavily focused on secondary care with primary care attracting no extra resources and calls upon GPC to: (i) ensure adequate assessment of the winter pressures felt across general practice and not just in hospitals (ii) stop hospitals from sending OPEL warnings to general practice and demand that system-wide warnings go out to the public instead (iii) insist that all local A and E boards have GP provider representation to discuss alleviating winter pressures, not just in secondary care but also in primary care and ensure that there is adequate funding allocated to primary care for the same.	Some CCGs do utilise winter planning funding to support general practice and we would encourage LMCs where this happens to share examples with others. We continue to lobby government and NHSE/I for greater investment into general practice for the whole year, not just winter.
		INDEMNITY	**UPDATE**
A	104.	SESSIONAL GPs COMMITTEE: That conference demands that the Clinical Negligence Scheme for general practice is extended to include all sessional GPs providing NHS GP services in prisons and other secure environments, regardless of their employing or contracting provider.	All services provided in a secure environment that are delivered under the GMS, PMS or APMS contract or subcontract are covered by CNSGP. Progress is not to be expected on extending CNSGP cover to services not covered by the contracts noted above.

		NHS ENGLAND PERFORMER INVESTIGATIONS	UPDATE
A	105.	KENT: That conference demands that the NHS England performance review processes are: (i) subject to national standardisation (ii) independently reviewed (iii) subject to a clear and fair appeals process (iv) based on a 'beyond reasonable doubt' level of proof.	GPCE representatives have secured a range of commitments from NHSE/I to significantly improve its performance management processes and procedures. This includes commitments to encourage early resolution, improve NHSE/I's consistency of approach, improve performance management data capture and analysis, and ensure equal treatment of GPs with protected characteristics. GPC England and NHSE/I will continue to work together during 2020 and beyond to fully implement the commitments with the shared aim of promoting patient safety, practitioner development and organisational improvement.

Resolution Updates Conference 2019

	NHS ENGLAND	UPDATE
(6)	That conference with reference to the recent NHS England strategy document on bribery and fraud: (i) condemns deliberate fraud but similarly condemns NHS England for producing a report implying widespread fraud exists in general practice (ii) considers NHS England to have knowingly brought general practice into disrepute and demands a public apology (iii) insists GPC England must raise a formal complaint with NHS England and the Secretary of State for Health and Social Care when such destructive narratives occur (iv) mandates GPC England to work with NHS England to address the offensive culture in NHS England which has allowed general practice to be referred to in this way.	We raised our serious concerns about this with both government and NHS England. There have been no further allegations related to this since.
	MEDICATION SHORTAGES	**UPDATE**
(7) amended to motion (310)	That conference demands urgent action with regard to medication shortages to mitigate the impact: (i) by recognising the adverse impact on patients (ii) on GP workload (iii) by pursuing additional resources to support practices having to do this work (iv) by exploring changes, including legislation, to make pharmacists responsible for identifying appropriate and available alternatives (v) by GPC England urgently entering into discussions with relevant bodies to enable pharmacists, when medications are not available, to dispense an equivalent preparation or dosing regime without the need to return the prescription to the GP for amendment.	GPC England responded to the serious shortage protocol consultation and made clear that their introduction must not result in increased workload for GP practices, and urging for it to be adopted more widely and in a more responsive manner. We argued that pharmacists should consult GPs when dispensing an alternative drug or preparation, but if the drug is being dispensed in different quantities or formulations, GPs will not need to be notified. GPC England escalated the need for urgent review of the SSP shortly into the pandemic. In addition, we have written to PNSC to ask them to encourage DHSC to improve matters. In September 2020, BMA sent a joint letter to the Secretary of State for Health and Social Care calling for Government to amend medicines legislation to allow pharmacists to make changes to prescriptions and provide a different quantity, strength, formulation or generic version of the same medicine, if it is in short supply. DHSC provides regular medicine supply updates for GPC to share with practices and LMCs, and also notifies us when an SSP is being developed.

	HOME VISITS	UPDATE
(9)	That conference believes that GPs no longer have the capacity to offer home visits and instructs the GPC England to: (i) remove the anachronism of home visits from core contract work (ii) negotiate a separate acute service for urgent visits (iii) demand any change in service is widely advertised to patients.	This will be included in the upcoming negotiations (which are delayed due to COVID). The Secretary of State for Health and Social Care has publicly indicated that the government would not remove home visits from the core contract. GPCE is working on guidance for practices/PCNs about local home visits services which are increasingly being used across the country.
	GMS CONTRACT	**UPDATE**
(10)	That conference is disgusted with the lack of timely information provided in relation to the 2019 / 2020 GMS contract negotiation, and insists that in future years: (i) final contracts must be provided at least 6 weeks prior to the commencement of that contract (ii) any further annual changes to the PCN DES contract must also have associated adequate and timely legal and accounting advice prepared and released alongside the changes (iii) QOF changes are only implemented once the QOF business rules have been updated on clinical IT systems to reflect the changes.	The issue of releasing information in a timely manner has been pushed with NHSE/I and GPCE is committed to releasing information with enough time for it to be considered and actioned before changes come into effect, as well as time for system suppliers to make and test the necessary changes. Updates to clinical systems following QOF changes are dependent on clinical system suppliers and both NHSE/I and GPCE have raised this with them, insisting on quicker implementation.
(401) Rider to motion 10	(iv) QOF changes are only implemented once applicable clinical IT updates have been tested to ensure there are no negative patient safety consequences.	
	PARENTAL LEAVE	**UPDATE**
(12)	That conference values the option of shared parental leave for all doctors, and therefore mandates GPC England to negotiate appropriately funded parental leave for: (i) salaried GPs (ii) contractor GPs (iii) locum GPs (iv) non-clinical NHS roles.	The GP contract agreement document published in February stated the following: "We are committed to agreeing arrangements that will allow practices to make a more generous offer of Enhanced Shared Parental Leave to employed GPs, starting as soon as possible in 2020/2021". Due to COVID, progress on this matter has been slow, but there have been several meetings between GPCE, and NHSE/I on this matter.
	PENSIONS	**UPDATE**
(13)	That conference deplores the failures to find workable solutions to the NHS pension crisis and: (i) demands immediate action by GPC England to provide high quality GP-specific pension guidance, including information on withdrawal from the NHS Pension Scheme entirely (ii) demands that NHS pension contribution rules are changed to place the onus on the NHS Pension Scheme to limit collection of employer and employee	A BMA Pensions Committee has been established that is now leading on these issues and is regularly issuing advice and guidance. There were no increases to employer pensions contributions in 2020. We continue to lobby PCSE, NHSE/I and government to make improvements to the management of pension

	contributions to the pension annual tax allowance in any given year (iii) is appalled at the proposed increase in employer pension contributions from April 2020 and instructs GPC England to negotiate either central payment or an increase in global sum payment in perpetuity to account for this increased liability, including all on-costs (iv) calls on GPC England to address the delays in PCSE replying to complaints and enquiries and to hold them to account for their role in the mismanagement of NHS pensions (v) demands that PCSE pay fair financial compensation to all members adversely affected by their mismanagement of NHS pensions.	contributions by PCSE. Should any GP incur additional expenses as a result of PCSE failures they should contact the BMA Pension team directly for us to address this.
	PRIMARY CARE NETWORKS (PCNs)	**UPDATE**
(16)	That conference wishes to give GPDF the mandate on behalf of England LMCs to use its reserves to provide ring-fenced funding to LMCs for the significant but vital extra work that they are being required to do, supporting the establishment and work of PCNs.	This motion has been referred to GPDF.
(17)	That conference, with regard to the Additional Roles Reimbursement Scheme: (i) believes that it disproportionately disadvantages innovative practices who hired workforce ahead of the scheme (ii) believes it is unrealistic to expect PCNs to be able to appoint to the designated additional roles from day 1 of each DES Year and calls for the protection of the inevitable underspends for each PCN (iii) demands that there is allowance for alternative appropriate roles (iv) requires that PCNs who are unable to recruit into additional roles are allowed to retain the funding for other projects or staff (v) asks the GPC England to negotiate a per capita sum that a network can allocate to the workforce needed and available as it sees fit.	The ARRS roles were much expanded for 2020/21 allowing a whole host of healthcare workers to be employed under the scheme. Since April, GPCE has negotiated the expansion the scheme further to allow Nursing Associated and Trainee Nursing Associates. GPCE continues to discuss with NHSE/I the inclusion of Nurse Practitioners in the scheme going forward. GPCE continues to discuss the use of any ARRS underspend. PCNs that are unable to recruit are able to bid for any underspend for specific purposes. PCNs have access to their ARRS pot to spend on the ARRS roles as they see fit.
(18)	That conference recognises the workload of the clinical director of the new PCNs and: (i) they must be empowered and supported to resist the unrealistic expectation of all organisations that seem to believe PCNs will solve the problem within NHS primary care (ii) rejects any attempt by commissioners to use clinical directors for the performance management of PCNs and constituent practices (iii) instructs GPC England to negotiate for clinical directors to be paid for the role they undertake independent of network size (iv) calls upon GPC England to negotiate with NHS England in ensuring parental and sickness leave reimbursements, in line with practice reimbursements, are available for PCN clinical directors	BMA has provided a package of support for PCN Clinical Directors, including significant L&D courses and an App to share information and experiences to learn from each other. We continue to explore the issue of CD pay and will include this in negotiations with NHSEI. As the PCN DES is an extension of the GMS/PMS/APMS contracts, the normal SFE provisions for parental and sickness leave will apply.

<table>
<tr><td>(19)</td><td>That conference, with regard to PCNs:
(i) has no faith that they will result in a reduction in GP workload
(ii) is concerned that they do not actually address the issue of the dwindling GP workforce
(iii) has not seen any evidence that they will assist practices in supporting increasing numbers of patients with increasingly complex health need.</td><td>We regularly monitor GP workload through BMA tracker surveys and will be assessing the impact of PCNs through a survey of Clinical Directors.</td></tr>
<tr><td></td><td>CLINICAL GUIDELINES</td><td>UPDATE</td></tr>
<tr><td>(21)</td><td>That conference believes that the proliferation of clinical guidelines is having a negative impact on the ability of GPs to deliver patient care and that:
(i) they should be recognised as guidelines not mandatory protocols or minimal standards of practice
(ii) GPs performance shouldn't be judged against them
(iii) the BMA should have a role in accrediting guidelines for use in general practice
(iv) there needs to be careful consideration about the practicality and workload implication of clinical guidelines produced relating to clinical care in general practice before they are accredited
(v) NICE needs to recognise the difference between what can reasonably be expected to be delivered in primary care compared to secondary care.</td><td>GPCE agrees with parts i and ii although it would be difficult not to consider them or be aware of them when a judgement is deemed necessary.

Although it is not within GPCE's scope to be involved in the accreditation or production of all GP related clinical guidelines, we do have opportunity to comment on draft NICE clinical guidelines, and recently led the BMA's response to the NICE consultation about chronic pain.

We have also been invited by NICE to feed into their draft guideline on Gender Incongruence in Children and Young Adults, and we are waiting for the draft guidelines and meeting date to be set.</td></tr>
<tr><td></td><td>NHS ENGLAND PERFORMER INVESTIGATES</td><td>UPDATE</td></tr>
<tr><td>(22)</td><td>That conference, noting the possibility of a career ending and/or bankruptcy generating outcome for a general medical practitioner who is the subject of an adverse PLDP meeting outcome, insists that at every PLDP meeting in England:
(i) the discipline-specific practitioner should be drawn from LMC nominees trained for such work
(ii) that an LMC nominee presence in some capacity must be mandatory and not discretionary.</td><td>Significant progress has been made with the engagement of LMCs on the performance processes within NHSE/I. Work continues to improve NHSE systems relating to performance matters.

We have encouraged LMCs to take up the nominee option.</td></tr>
<tr><td></td><td>GPs WITH REGISTRATION CONDITIONS</td><td>UPDATE</td></tr>
<tr><td>(23)</td><td>That conference is appalled that there are no national schemes supporting GPs who have either NHSE or GMC conditions to help them find appropriate placements in order to support them to return to the work and:
(i) requires each area team to report on the number of GPs within their area who have conditions on registration
(ii) requires each area team to report on the number of GPs with their area who have conditions on registration but are being supported in a placement
(iii) demands a review of the Induction and Refresher scheme criteria to enable doctors with conditions to apply and be accepted onto this scheme.</td><td>Regarding i and ii: GPCE representatives have secured a commitment from NHSE/I to improve its NHS performance management processes, including significantly improving its data collection to allow for regular and meaningful analysis and publication. The revised data management system will allow for data on doctors with NHS conditions to be scrutinised and shared.

The BMA's Professional Regulation Committee has also raised with the GMC the issue of doctors with conditions placed on them by medical tribunals. Work is ongoing to address the impact of conditions of all doctors.</td></tr>
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	CCG SPENDING	UPDATE
(24)	That conference asks the GPC England to negotiate a standard framework which allows practices and LMCs to easily check that funding is being made available to practices as promised and as NHS England intended.	This has been agreed with NSHE/I and we are now discussing how this will be implemented this with NHSE/I, but there have been delays due to COVID.
(25)	That conference is deeply concerned at the flagrant continued contravention of the standard hospital contract and asks GPC England to develop proposals to counter this including: (i) a formal audit of unresourced work that should be done elsewhere (ii) transfer of appropriate funding to general practice with each identifiable breach (iii) financial penalties when standard hospital contracts are breached (iv) full enforcement by NHS England as a red line in the 2020/2021 contract negotiations.	This issue has been raised again with government ministers and NHSE/I and widely publicised due to its exacerbation over the pandemic period. The BMA released a position paper about how to resolve these issues. Our proposals relating to community based diagnostic services have been taken up as part of the report by Prof Sir Mike Richards. LMCs should encourage CCGs to work on implementation.
	CHOSEN MOTIONS	**UPDATE**
(207)	That conference calls for the Improved Access Scheme to be immediately withdrawn as: (i) there is no evidence that this scheme is producing any significant benefits (ii) in many areas the scheme is having deleterious effects on staffing emergency out of hours care (iii) incorporating it in the future primary care network DES is likely to lead to many GP Practices not signing up for the DES (iv) GPs providing routine appointments seven days a week is a political wish rather than a clinical need and in the light of the crisis facing general practice it is our professional responsibility to explain this to our patients	The IA schemes are all due to end from April 2021. A new access offer will be developed as part of the upcoming negotiations, which has been delayed due to COVID.
(316)	That conference accepts the independent report by Daphne Romney QC on sexism in the BMA and demands the publication of a formal action plan from GPC, with timescales, before the UK conference of LMCs in May 2020.	GPC England agreed the formal action plan for the implementation of the Daphne Romney QC report at its meeting in November 2019. All of the committee specific recommendations of the Romney report have now been included in the workplan of the GPC Gender Task and Finish Group as actions for implementation. GPCUK discussed proposals to move to multimember constituencies for regional elections but did not support this, with members expressing concern about the impact this would have on the link between LMCs and regional representatives.

(290)	That conference is very concerned regarding proposed CCG mergers to align with STPs, as this is a disaster for general practice whose voice and influence will be lost within the STP. Conference asks GPC to: (i) oppose these mergers due to their detrimental effect on general practice (ii) ensure an LMC representative is mandated to be a voting member of the STP (iii) provide ongoing leadership training to PCN clinical directors ensuring they have the skills to adequately represent their network within the STP.	BMA has provided a package of support for PCN Clinical Directors, including significant L&D courses and an App to share information and experiences to learn from each other. We have written to NHSE/I to call for LMC representatives to be involved at senior levels within each ICS.
	AND FINALLY …..	**UPDATE**
(26)	That conference believes that, as all human being creatures ‘require improvement’, CQC inspectors should therefore be required to wear a Hi-Visibility jacket at work at all times emblazoned on the back with the legend: ‘How’s my inspecting?’, together with a prominently displayed Freephone number to facilitate feedback.	Noted. The concerns and issues underpinning this resolution continue to be raised with CQC on an ongoing basis. GPCE has strongly challenged CQC on its handling of GP regulation and inspection since the onset of the pandemic

Resolutions from Special England LMC Conference 2020

	2020 / 2021 CONTRACT NEGOTIATIONS	UPDATE
5.	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) that only GPC England have the authority to negotiate on behalf of the profession.	The five year deal provided a framework for contract changes for the next five years. It was clear within the initial agreement that the details on specific areas would still need to be negotiated on an annual basis but provided practices with information about the direction of travel. The five year agreement has however provided guaranteed funding increases each year for the period of the agreement.
	GP WORKFORCE - Pay Transparency	**UPDATE**
6.	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.	We agree with the motion and this is our approach across all BMA publications. We routinely remind NHS bodies and government of the importance of this distinction in relation to their communications. GPCE will return to this topic in the upcoming negotiations, delayed due to COVID.
	GP WORKFORCE - Partnership Incentives	**UPDATE**
7.	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 be tax free.	GPCE continues to push for the scheme to be made available to all new partners. BMA is exploring the provision of business training for new partners. It is not possible to make it tax free without changing tax rules, over which we have little control.
	GP WORKFORCE - Fellowships	**UPDATE**
8.	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	The BMA has achieved a great deal as part of this programme of work to make sure Fellowships are fit for purpose. (i) Fellowships will not be mandatory, and all newly qualified GPs will be offered a place. The BMA has also insisted that those that do not undertake fellowships are not discriminated against.

	(v) offer the same contractual safeguards and provisions as the BMA model contract for salaried GPs.	(ii) All contractual and employment safeguards will continue to apply. (iii) There is no set or unique employment contract for Fellows. The individual participant should be recruited in the usual way, utilising the respective practice's usual employment contract. (iv) Job plans will include education and mentorship as part of an agreed plan development, alongside normal qualified GP duties Salaried GPs will be offered the same contractual safeguards and provisions as the BMA model contract.
	GP WORKFORCE - GP Head Count	**UPDATE**
9.	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.	We agree with the motion and only focus on fully qualified GPs in media briefings and comments we make when highlighting the need for more GPs.
	GP WORKFORCE - Premises	**UPDATE**
10.	That conference demands that funding for premises be made available urgently to house additional workers in general practice.	GPCE and NHSE/I have both sought significant investment in primary care estates as part of the BMA submission to the Government spending review (GPCE's call was for £1bn over three years). We await the outcome of the spending review.
	VACCINATIONS AND IMMUNISATIONS	**UPDATE**
11.	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.	This will be raised in this year's negotiations.
	ACCESS - Continuity of Care	**UPDATE**
12.	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.	The access scheme will be subject to upcoming negotiations, delayed due to COVID.
	ACCESS - Out of Hours	**UPDATE**
13.	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.	We rejected previous suggestions that PCNs could have taken on responsibility to deliver out of hours care. There has been no proposal to do this since.

150.	That conference is concerned that if the potential pandemic of Covid 19 occurs, practices will be required to suspend normal practice to cope with the increased workload and the potential decrease to the workforce and in such a scenario they require GPCE to urgently negotiate that: (i) all contract payments including DES and QOF payments will be paid in full but utilised to fund essential services only (ii) no contractual sanctions or remedial/breach notices will be issued to practices as a result of the forced changes to normal practice whilst the national emergency persists (iii) any additional costs relating to infection control for Covid 19 infections in general practice including personal protection equipment and additional training will be readily available in sufficient quantities and directly reimbursed (iv) practices are able to prioritise frontline work and suspend other requirements including appraisals and CQC inspections (v) practices should be entitled to claim for reimbursement of all expenses incurred covering for a sick doctor, without any requirement for a practice funded period.	GPCE negotiated the relaxation of contractual and non contractual services at national and local level, with income protection and additional support funding. This included the relaxation of remedial/breach notices over the pandemic period. PPE, in line with IPC guidance, will be reimbursed and will be provided free of charge to all practices going forward. GPCE negotiated suspension of appraisals and CQC inspections We continue to liaise with NHSE/I over the provision of funding for the whole pandemic period.
	PCN WORKLOAD	**UPDATE**
16.	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.	We have repeatedly reminded NHS England about this and expect PCNs to utilise additional workforce to support practices as a priority.
	PCN SPECIFICATIONS – CARE HOMES	**UPDATE**
17.	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.	GPCE successfully resisted imposed regulatory changes relating to practice involvement with care homes. These issues have been raised with NHSE/I and will be discussed as part of current negotiations.

	PCN MODELLING	UPDATE
18.	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.	Detailed analysis was done of all aspects of the contract as part of negotiations. Information and guidance were provided to PCNs and 98% of practices subsequently signed up to the DES. Many elements of the DES were delayed or modified in response to the COVID-19 pandemic.
	INVESTMENT AND IMPACT FUND	**UPDATE**
19.	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.	The fund has been changed significantly as a result of Covid-19. The first six months of 2020 saw it paid in full as a PCN support payment made directly to all PCNs.
	ARRS	**UPDATE**
20.	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.	GPCE has argued for London weighting, but NHSE/I remain adamant it will not be applied. From April 2020 only part of the ARRS funding has been provided to CCGs, with the rest being able to be drawn down from NHSE/I if needed. This means the majority of any underspend would be held centrally and cannot be moved into CCG baselines.

	TAX ADVICE	UPDATE
21.	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.	We continue to lobby government and work with AISMA to try to address these issues. We will use the changes to VAT following Brexit as a further opportunity to resolve this.
	FUTURE OF PCNs	**UPDATE**
22.	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.	There has been no transfer of practice DESs to PCNs. GPCE discussed whether to survey the profession but concluded that it was not appropriate to do at the height of the first wave of the COVID-19 pandemic. LMCs were informed of this. 98% of practices have signed up to the DES.

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