

# Conference of Representatives of Local Medical Committees

## Agenda



**online**

**Tuesday 11 and Wednesday 12 May 2021**

# Conference of Representatives of Local Medical Committees

## Agenda

To be held on

**Tuesday 11 and Wednesday 12 May 2021** 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** Mark Corcoran (Hampshire & Isle of White)

**Deputy Chair** Katie Bramall-Stainer (Hertfordshire)

### **Conference Agenda Committee**

Mark Corcoran (Chair of Conference)

Katie Bramall-Stainer (Deputy Chair of Conference)

Matthew Mayer (Buckinghamshire)

Rachel McMahon (Cleveland)

Shaba Nabi (Avon)

Frances O'Hagan (Southern NI)

Elliott Singer (London)

Alastair Taylor (Glasgow)

## NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 19 February 2021. Although 19 February 2021 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the conference staff lead – Richard Pursand ([rpursand@bma.org.uk](mailto:rpursand@bma.org.uk)) - prior to the conference.

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 UK 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 UK 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.

### What's new for this year's UK LMC conference?

The deadlines for submission of chosen motions, notifications of riders and notifications of amendments will have deadlines as follows:

Item	Deadline for submission
<a href="#">Chosen motions</a> (see note below)	12noon on Friday 7 May
<a href="#">Notification of rider</a>	12noon on Friday 7 May
<a href="#">Notification of amendment</a>	12noon on Friday 7 May
<a href="#">Emergency motions</a>	12noon on Friday 7 May

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](#) process to nominate motions from Part 2 of the Agenda which you would like to see debated during conference. The virtual conference format has meant that we have been able to prioritise fewer motions than we normally would, so your opportunity to use the chosen motion process is even more valuable than ever.

## **Elections at LMC UK conference**

Every year, a certain number of positions are available for attendees of the conference to nominate themselves for elections. These positions are:

1. Chair of LMC UK conference 2022
2. Deputy chair of LMC UK conference for 2022
3. Seven members of the LMC UK conference agenda committee 2022
4. Seven members of the UK general practitioners committee 2021-2022
5. One 'early career' GP to be co-opted to the UK general practitioners committee 2021-2022

Additionally, the below seats are available, and nominations are open to all GPs, nominated by an LMC representative:

6. Three trustees to the Claire Wand Fund 2021-2024

### **Eligibility to vote in the elections**

All members of LMC UK conference are eligible to vote in these elections, excluding the election to GPC UK. Only LMC representatives are eligible to vote in the election to GPC UK.

### **Election schedule**

Nominations open for representatives to GPC UK – **12pm Tuesday 13 April**

Nominations close for representatives to GPC UK – **12pm Thursday 29 April**

Nominations open for trustees to the Claire Wand Fund – **12pm Tuesday 27 April**

Nominations open for all other positions – **10am Tuesday 11 May**

Nominations close for LMC UK conference chair – **3pm Tuesday 11 May**

Nominations close for all other positions – **5pm Tuesday 11 May**

Voting for representatives to GPC UK opens – **5pm Tuesday 11 May**

Voting for representatives to GPC UK closes – **11am Monday 17 May**

Voting for conference chair opens – **10am Wednesday 12 May**

Voting for conference chair closes – **10am Thursday 13 May**

Voting for other positions opens – **11am Thursday 13 May**

Voting for other positions closes – **11am Monday 17 May**

Results will be announced soon after the conclusion of voting.

For more information regarding the elections, please see the attached guidance.

## Schedule of business

**Tuesday 11 May 2021**

Item	Time
Opening business	09.00
Annual report from the Chair of GPC UK	09.20
The COVID-19 pandemic – experiences gained and lessons learnt	09.40
COVID-19 vaccinations	10.00
GP appraisal and revalidation	10.40
Creating and maintaining a workforce fit for the future	11.00
Break	11.20
Soapbox	11.30
Creating and maintaining a workforce fit for the future (continued)	11.45
15 minute consultations	12.05
GDPR and digital services	12.25
Electronic records	12.45
Lunch	13.00
Themed debate – Solutions to stem the ‘tsunami’ of workload	14.00
Break	15.30
The role of GPC and LMCs	15.50
LMC governance	16.10
Green general practice	16.40
Close	17.00

## Wednesday 12 May 2021

Item	Time
Questions to GPC UK	09.00
GP contract negotiations	09.30
General practice pay and conditions	09.50
DDRB	10.10
Break	10.30
Zero tolerance to racism	10.40
Indemnity	11.00
Soapbox	11.40
Charities Cameron Fund Annual General Meeting Dain Fund Claire Wand Fund	12.00
Lunch	12.10
BMA communications systems	13.00
Cross-border working	13.20
Chosen motions	13.40
Practice management	14.20
Contract funding	14.40
Closing business	15.20

## OPENING BUSINESS

09.00

## RETURN OF REPRESENTATIVES

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

## STANDING ORDERS

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

## REPORT OF THE AGENDA COMMITTEE

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

## ANNUAL REPORT FROM THE CHAIR OF GPC UK

09.20

- 4 RECEIVE: Report from the Chair of GPC UK.

## THE COVID-19 PANDEMIC – EXPERIENCES GAINED AND LESSONS LEARNT

09.40

- \* 5 AGENDA COMMITTEE TO BE PROPOSED BY AYRSHIRE AND ARRAN: That conference believes that honesty with the UK public is needed about the scale of the backlog in usual NHS care as a result of COVID-19, and the time it will take for this to revert to normal standards, and:
  - (i) believes that there will be some changes to what is available from the NHS which may result in rationing of care
  - (ii) requires GPC to enable and empower individual general practices to dictate the pace of return to 'business as usual' for all non-essential services
  - (iii) demands that governments provide clear public communication about which treatments and services are not available on the NHS and where to seek help otherwise
  - (iv) calls on governments to provide additional funding to enable access to, and support from, mental wellbeing services for the general practice workforce
  - (v) calls on GPC to continue to ensure that clinical time can be focused on delivering clinical care, not on meeting burdensome targets or indicators that do not directly promote safe, quality patient care.
- 5a AYRSHIRE AND ARRAN: That conference:
  - (i) believes that honesty with the UK public is needed about the scale of the backlog in usual NHS care as result of COVID-19 and the time it will take for this to revert to normal standards
  - (ii) believes that there will be some changes to what is available from the NHS which may result in rationing of care
  - (iii) demands that rationing of care should not take place by stealth or postcode but where access to services is to be restricted this should be uniform throughout the four nations
  - (iv) demands that governments provide clear public communication about which treatments and services are not available on the NHS and where to seek help otherwise.

- 5b CITY AND HACKNEY: That conference requires GPC to enable and empower individual general practices to dictate the pace of return to 'business as usual' for all non-essential services including appraisals, CQC assessments and public health assessment targets.
- 5c LEEDS: That conference believes that COVID-19 pandemic has had a major impact on the physical and mental health of many within the general practice workforce and calls on governments to provide additional funding to enable:
- (i) access to, and support from, mental wellbeing services
  - (ii) full sick pay to be paid for those with Long Covid
  - (iii) practices and other general practice providers to expand their workforce in order to reduce workload pressures
  - (iv) fully funded sabbaticals.
- 5d CAMBRIDGESHIRE: That conference believes that a tsunami of health need has built up, and that the NHS will take years to recover from the effects of COVID-19, and calls on GPC to continue to ensure that clinical time can be focused on delivering clinical care, not on meeting burdensome targets or indicators that do not directly promote safe, quality patient care.
- 5e LINCOLNSHIRE: That conference believes that COVID-19 pandemic has highlighted the huge strain on general practice staff and calls on GPC UK to negotiate that all future GP contracts include provision for funded wellbeing measures and occupational health for all practice staff.
- 5f LIVERPOOL: That conference believes that it will take at least two years for GP practices to recover from this pandemic and recommends that QOF either be:
- (i) suspended in its present form, to allow recovery
  - (ii) appropriately modified and bureaucracy reduced to facilitate recovery.
- 5g HARINGEY: That conference recognises and lauds the exceptional work general practice has done, and is doing, in addressing the challenges of the COVID-19 pandemic, it takes time to reflect upon and acknowledge that this has been at both a personal and professional cost for colleagues, and asks GPC to negotiate with NHSE/I a recovery package for general practice that will address workload implications and support and retain its GPs.
- 5h DORSET: That conference instructs the GPC to work with DHSC and NHSEI towards a public campaign highlighting the unwelcome but necessary effect of the pandemic on routine care and wait times.
- 5i LEWISHAM: That conference agrees that the continued focus on a return to "business as usual" risks missing opportunities to learn lessons and deliver meaningful care better.
- 5j DERBYSHIRE: That the GPCs seek that a coherent and consistent publicity campaign be urgently launched by the by governments to educate the public concerning the finite capacity of the National Health Service with particular reference to the fact that the NHS cannot return to routine "service as usual" at the same time as hotels restaurants and non-essential services recommence.
- 5k DERBYSHIRE: That the general practitioner committees must make it crystal clear to Health Ministers that general practice will take a considerable time to recover from the COVID-19 response and that in the absence of a suitable and timely reply containing acceptable proposals, reserve the right to inform the public unilaterally.
- 5l LOTHIAN: That conference recognises the front line role played by GPs and practice staff across the UK in dealing with the COVID-19 pandemic, and demands that if they are off work due to COVID-19 infection that they get full reimbursement of earnings for up to 12 months, on a par with the special leave arrangements for our secondary care colleagues and other directly employed NHS staff.
- 5m BRO TAF: That conference demands that sickness pay reimbursement from day one be available to practices for all workers in general practice who are away from work for COVID-19 related issues and who cannot work remotely.



- 5n NOTTINGHAMSHIRE: That conference recognises that looking after our people has been cruelly put under the spotlight during this pandemic. We urge conference to lobby NHS leadership to ensure that general practice is well resourced to support diversity, BAME and practitioner health initiatives and support programmes.
- 5o HERTFORDSHIRE: That conference calls on GPC to urge the governments of the UK to take into account the restrictions GPs have worked under during the pandemic and support the profession in any claim that results from this.

## COVID-19 VACCINATIONS

10.00

- \* 6 AGENDA COMMITTEE TO BE PROPOSED BY LEEDS: That conference:
- (i) believes that easy access for all individuals to their complete vaccination and immunisation record would help to improve uptake, provide evidence for employment and travel purposes and reduce the need for patients to request this from their GP
  - (ii) calls on UK governments to develop an electronic vaccination and immunisation record that includes all NHS, school-given, travel, private and employment related vaccinations and provides prompts when boosters are needed without the requirement to contact their GP practice
  - (iii) calls on UK governments to require schools to use a child's electronic vaccination record to promote complete uptake of all vaccinations at the time of school entry.
- 6a LEEDS: That conference believes that easy access for all individuals to their complete vaccination and immunisation record would help to improve uptake, provide evidence for employment and travel purposes and reduce the need for patients to request this from their GP, and therefore calls on government to:
- (i) develop an electronic vaccination and immunisation record that includes all NHS, school-given, travel, private and employment related vaccinations and provides prompts when boosters are needed
  - (ii) require schools to use a child's electronic vaccination record to promote complete uptake of all vaccinations at the time of school entry.
- 6b TAYSIDE: That conference calls for UK governments to ensure that patients are provided with, or can access directly, a record of their COVID-19 immunisation status without the requirement to contact their GP practice and calls on GPC UK to lobby governments on this issue.
- 6c LOTHIAN: That conference is concerned by the workload that will fall to GP practices if no other system is put in place to enable the public to show that they have received COVID-19 vaccinations, and calls on the GPCs to work with the UK governments to find a better solution.
- 6d NORTH WALES: That conference consider that the government should provide COVID-19 vaccination details directly to UK residents that may be required for international travel.
- 6e AYRSHIRE AND ARRAN: That conference deplores the statement of the Vaccine Minister that travelers should approach their doctor for proof of vaccination, and demands that government:
- (i) intimates that the provision of proof of vaccination is not the role of the GP
  - (ii) develops and provides appropriate "vaccination passports" to all persons completing the vaccination programme.
- \* 7 WALTHAM FOREST: That conference, with regard to the COVID-19 vaccination programme:
- (i) applauds the efforts of GPs and their teams who are the reason why the UK programme has been successful in rapidly vaccinating our population including those who are most vulnerable
  - (ii) believes that we need to start planning for an annual COVID-19 vaccination programme
  - (iii) requires GPC to proactively negotiate with NHS / DHSC a Direct Enhanced Service so that if an annual COVID-19 vaccination programme is required it will be contracted with and delivered by individual general practices.

- 7a MERTON: That conference calls upon government to recognise the flexibility and responsiveness of British general practice in the delivery of the COVID-19 vaccination programme and the expanded flu and recognise this contribution by committing to supporting and adequately resourcing locally based general practices, embedded in their communities.
- 7b MANCHESTER: That conference agrees the mapping of long term COVID-19 services needs to be undertaken to ensure the general practice workforce can operate a year round vaccination programme whilst still delivering on the existing general practice objectives.
- 7c GLASGOW: That conference acknowledges the extraordinary amount of work and planning across all parts of the NHS system including GP practices, that has facilitated the success of the COVID-19 vaccination programme, and thanks everyone involved in the programme for their dedication and hard work.
- 7d DERBYSHIRE: That the GP practices:
- (i) be applauded for their success in rolling out the COVID-19 vaccination programme
  - (ii) are best placed for arranging the resourced delivery of a recurrent vaccination programme.
- 7e NOTTINGHAMSHIRE: That conference recognises that the success of the coronavirus vaccination programme thus far is contingent largely on the ability of general practice to adapt to the needs of it and flex to lead local efforts. We implore conference to ensure that in any future campaigns that the lead provider of annual coronavirus vaccination is seen formally as general practice.
- 7f BUCKINGHAMSHIRE: That conference applauds the profession for its involvement in the COVID-19 vaccination programme but believes this level of involvement is unsustainable and calls on GPC to ensure vaccination programmes across all four nations are adapted to ensure general practice has time to recuperate, recover and focus on core essential services.
- 7g GLOUCESTERSHIRE: That conference congratulates UK general practice for its magnificent response to the COVID-19 pandemic and specifically vaccination efforts countrywide and reiterates that national governments must increase funding to primary care to bolster resilience and ensure the future needs of the population are met.
- 7h MORECAMBE BAY: That conference believes that practices should be congratulated on their pivotal role in COVID-19 vaccine delivery, as an excellent example of local planning and ownership in contrast to the woeful effort exhibited by nationally delivered services such as test and trace.
- 7i NEWCASTLE AND NORTH TYNESIDE: That conference congratulates the work of those NHS organisations including primary care which have been at the centre of the vaccine delivery programme and contrasts this service with the poorer quality of other services procured during COVID-19 from the private sector.
- 7j LEEDS: That conference:
- (i) applauds the rapid and significant response by GPs and the general practice workforce in successfully giving millions of COVID-19 vaccinations
  - (ii) is concerned about the lack of coordination between GP practices sites and booking arrangements for mass vaccination sites which has added to workload pressures and caused unnecessary confusion for some patients
  - (iii) believes the success of the COVID-19 vaccination programme delivered by GP practices is further evidence of the value of the independent contractor model for general practice
  - (iv) believes GP practices should be enabled to continue to vaccinate all adults if they choose to do so.
- 7k SEFTON: That conference applauds the remarkable effort and success of general practice in delivering the COVID-19 vaccination and notes that the COVID-19 test and trace initiative would have had similar success if the government and NHSE had allowed national and local public health officials to take charge of it.
- 7l TOWER HAMLETS: That conference believes that general practice is perfectly capable of managing COVID-19 vaccine roll out, and indeed many other initiatives without the top-down micro management to which some CCGs have resorted and:

- (i) is concerned that such behaviour bodes badly for future ways of working when we eventually emerge from the pandemic
  - (ii) demands that GPs as highly trained professionals are granted reasonable autonomy and flexibility to run our services in the manner which we determine will best meet the needs of our patients.
- (Supported by Lambeth)

**7m** CAMBRIDGESHIRE: That conference expresses huge pride and gratitude to the GP practice teams throughout the UK who have made such a success of the COVID-19 vaccination programme, but notes that this success has come at a significant price, both in terms of clinical time diverted from front line general practice, and levels of fatigue and burn-out among those delivering the programme, and calls upon GPC UK to run a patient-facing communication campaign to ensure public awareness of the pressures that general practice will be facing as we emerge from the pandemic.

## GP APPRAISAL AND REVALIDATION

**10.40**

- \* **8** AGENDA COMMITTEE TO BE PROPOSED BY SUFFOLK: That conference, in respect of GP appraisal:
  - (i) is delighted to have seen no evidence that turning appraisal into a light touch system has resulted in patient harm
  - (ii) recognises that GPs appear satisfied that a more formative system with minimal paperwork has helped them cope with the demands of the job without being overly intrusive
  - (iii) recognises that GPs are still very much on the front-line of fighting the pandemic and that a considerable recovery phase will follow when the virus is better contained, request that appraisals-lite are deferred until April 2023 at the earliest
  - (iv) requests GPC to negotiate that reversion to the former approach should not occur in the absence of demonstrable evidence that the needs of patients and doctors are less well served by the new way
  - (v) calls on GPC to work with NHS colleagues to restore the aim of appraisal as being a "facilitated self-review" with a peer and supporting the well-being of the appraisee.
- 8a** SUFFOLK: That conference acknowledges that the adjustment to the appraisal process for GPs in light of the significant pressures of the pandemic has been welcomed and conference:
  - (i) instructs GPC to press to maintain the new, more streamlined and efficient appraisal process for GPs given the ongoing demands of the pandemic and the large backlog of important primary care work that has been postponed due to the pandemic
  - (ii) further requests GPC to negotiate that reversion to the former approach should not occur in the absence of demonstrable evidence that the needs of patients and doctors are less well served by the new way.
- 8b** CLEVELAND: That conference, in respect of GP appraisal:
  - (i) welcomes the new 2020 light touch approach
  - (ii) rejects a return to the previous box-ticking format
  - (iii) expects clear and timely communication about any future changes to appraisal requirements
  - (iv) supports the 2020 tight touch approach as a fit for purpose appraisal format.
- 8c** GATESHEAD AND SOUTH TYNESIDE: That conference:
  - (i) is delighted to have seen no evidence that turning appraisal into a light-touch system has resulted in patient harm
  - (ii) recognises that GPs appear satisfied that a more formative system with minimal paperwork has helped them cope with the demands of the job without being overly intrusive
  - (iii) demands that there be no return to the previous system of box-ticking, form-filling and a process that lacked evidence and took days to prepare for.
- 8d** SCOTTISH CONFERENCE OF LMCs: That conference welcomes the change to a wellbeing focussed appraisal but should:
  - (i) have been deferred for 1 full year for every doctor due to the additional workload of COVID-19
  - (ii) not return to a bureaucratic non evidence-based model of appraisal which research has shown is a reason why doctors leave the profession.

- 8e HULL AND EAST YORKSHIRE: That conference believes GP appraisal and revalidation should remain in its reduced, current form on a permanent basis.
- 8f LEEDS: That conference:
- (i) welcomes the changes made to GP appraisal in 2020
  - (ii) believes that appraisal should continue to provide an opportunity to focus on wellbeing
  - (iii) believes that appraisal should not require the collection of large amounts of evidence and preparation time should take no more than 30 minutes.
- 8g SOUTH STAFFORDSHIRE: That conference believes that the new supportive/empathetic appraisal system should continue after the current COVID-19 crisis as this will help GPs to remain in practice whilst maintaining professional standards.
- 8h NOTTINGHAMSHIRE: That conference recognises that GPs are still very much on the front-line of fighting the pandemic and that a considerable recovery phase will follow when the virus is better contained. To this end we request that appraisals-lite are deferred until April 2023 at the earliest.
- 8i HERTFORDSHIRE: That conference congratulates the appraisal team for ensuring appraisal returned to a more formative and supportive approach during the pandemic and calls on GPC to work with NHS colleagues to:
- (i) ensure these changes are embedded and maintained
  - (ii) remove the tick box requirement of the Patient Satisfaction Questionnaire
  - (iii) bring the Multi Source Feedback survey into the 21st Century by making it more supportive and formative for professional development.
- 8j CAMBRIDGESHIRE: That conference welcomes the changes in the appraisal process introduced since October 2020 in the context of the COVID-19 pandemic and believes GPC should push for:
- (i) a restoration of the aim of appraisal as being a "facilitated self-review" with a peer, and supporting the well-being of the appraisee
  - (ii) reducing the administrative burden of appraisal and revalidation on doctors, which has been shown to be both possible and successful
  - (iii) national governments and health bodies to represent the interests of GPs by continuing with this revised form of appraisal.
- 8k OXFORDSHIRE: That conference welcomes the 2020 "light" appraisal format introduced during the pandemic and calls on GPC to work with stakeholders across all four devolved nations to ensure this non-bureaucratic format of appraisal becomes the new status quo, rather than a temporary measure.
- 8l WEST SUSSEX: That conference believes that NHS GPs should not be paying companies to store the appraisal data required for a mandatory NHS appraisal.
- 8m DERBYSHIRE: That conference believes that the COVID-19 pandemic has helped to prove that the value of appraisal is in peer support and not in revalidation.
- 8n KIRKLEES: That conference believes that GP appraisal should assist with the professional development and personal wellbeing of the appraisee. It should have both formative and summative elements and encourage the safe retention of the appraised GP. The "appraisal lite process" goes a long way to rectify this situation which should include some of the core elements of coaching and mentoring.

## CREATING AND MAINTAINING A WORKFORCE FIT FOR THE FUTURE

**11.00**

### GP Retention

- \* 9 AGENDA COMMITTEE TO BE PROPOSED BY SCOTTISH CONFERENCE OF LMCs: That conference is concerned that the global pandemic and the work pressures that GPs have been under will lead to an increase in early retirements, and calls upon GPC UK to negotiate urgent measures to retain GPs which include:

- (i) access to support, psychological and careers advice to allow them to be safely supported in staying in work
  - (ii) an enhanced retention package to prevent early retirement
  - (iii) financial incentives to pursue a more portfolio existence
  - (iv) meaningful commensurate retention incentives for experienced senior GPs
  - (v) priority access to healthcare as is offered for armed services personnel and military veterans.
- 9a SCOTTISH CONFERENCE OF LMCs: That conference asks that within the next 12 months all GPs will have access to support, psychological and careers advice to allow them to be safely supported in staying in work.
- 9b GLASGOW: That conference is concerned that the global pandemic and the work pressures that GPs have been under will lead to an increase in early retirements and calls on GPC and governments to urgently roll out an enhanced retention package to prevent this.
- 9c WAKEFIELD: That conference is aware that a tsunami of early retirement will occur post COVID-19 and that urgent measures need to be put in place to retain GPs.
- 9d SCOTTISH CONFERENCE OF LMCs: That conference recognises the significant additional strain that the COVID-19 pandemic has put on general practice and NHS staff as a whole and calls on government to offer all NHS staff priority access to healthcare as is offered for armed services personnel and military veterans.
- 9e BARNET: That conference acknowledges the valuable contribution made by our trainee GPs in responding to the COVID-19 pandemic, but recognises that due to the continued disruption to training and the consequent low moral this has caused, taking time out with the risk of leaving training has become a significant problem, and calls upon GPC to work with the RCGP and HEE to provide workable solutions to retain this valuable workforce.
- 9f OXFORDSHIRE: That conference believes the removal of partner seniority payments and the lack of a pathway for meaningful pay progression for experienced partners has damaged the retention of experienced GP contractors and fails to recognise their value. Conference therefore calls on GPC to negotiate meaningful commensurate retention incentives for experienced senior GPs.
- 9g HERTFORDSHIRE: That conference urges GPC to progress conference policy as agreed in 2018 to negotiate a new system of seniority payments based on years of service in order to stem the haemorrhage of older, experienced GPs from the NHS.
- 9h NOTTINGHAMSHIRE: That conference supports GPs to work in the ways that they want to, in order to stimulate interest in the profession and enhance retention both through appraisals and with financial incentives made to help GPs to stay as partners but also pursue a more portfolio existence.

## BREAK

**11.20**

## SOAPBOX

**11.30**

## CREATING AND MAINTAINING A WORKFORCE FIT FOR THE FUTURE (continued)

11.45

### GP training - Fit for purpose

- \* 10 AGENDA COMMITTEE TO BE PROPOSED BY GP TRAINEES COMMITTEE: That conference calls for GPC UK to lobby educational bodies and other stakeholders to recognise the changing landscape of general practice and calls for:
  - (i) formal guidance from the RCGP on where remote consulting can be appropriately incorporated into GP training
  - (ii) improved and expanded support schemes such as GP fellowship schemes and mentoring schemes to mitigate against fewer face to face consultations during COVID-19
  - (iii) adequate training in important areas such as business management, accounts and GMS contracts and regulations
  - (iv) inclusion within the curriculum of skills in managing a multi-disciplinary team.
- 10a 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
  - (iv) MRCGP examination content to be relevant and updated to reflect the changing landscape and reality of working general practice.
- 10b CONFERENCE OF ENGLAND LMCs: 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.
- 10c NORFOLK AND WAVENEY: That conference asks that GPC negotiates support for trainees undergoing GP training who will not have experienced sufficient non COVID-19 face to face consultation skills during the pandemic and will be less well prepared for more substantive roles in general practice. The solutions lie within improved and expanded support schemes for new GPs such as GP Fellowship schemes and mentoring schemes.
- 10d DERBYSHIRE: The RCGP response to the effects COVID-19 has had on GP training has been slow and reactive. Conference requires GPC to work more closely with RCGP to ensure that a robust post COVID-19 recovery plan for training is developed speedily.
- 10e AVON: That conference is concerned about the impact of COVID-19 on the exposure of face-to-face assessments for GP trainees, and asks that GPC works closely with RCGP to ensure trainees are fit to practise in a post-COVID-19 world.
- 10f BERKSHIRE: That conference believes the current GP training programme does not adequately equip trainees for the world of partnership and independent contractor status and calls for GPC to work with the GP trainee committee, the RCGP and relevant stakeholders to ensure trainees receive adequate training in important areas such as business management, accounts and GMS contracts and regulations.

- 10g OXFORDSHIRE: That conference believes that the GP training programme is resulting in GP trainees becoming less prepared for a career in general practice than they have ever been, and that this poses an existential threat to the future of the partnership model.
- 10h CAMBRIDGESHIRE: That conference calls upon the UK GP trainees committee to work with the relevant bodies to facilitate the curriculum inclusion of:
- (i) skills in managing a multi-disciplinary team
  - (ii) skills in consulting safely across multimedia platforms
  - (iii) a special study module in contracts, business skills and practice finance to be developed in consultation with the GPDF
  - (iv) skills in consulting safely outside of core hours.

## 15 MINUTE CONSULTATIONS

12.05

- \* 11 GP TRAINEES COMMITTEE: That conference notes RCGP and BMA policy aiming for 15 minute appointments for standard face-to-face GP consultations, as well as the large disparity in consulting times GP trainees are expected to undertake consultations during their training. We call on BMA to lobby RCGP, HEE and other key stakeholders to:
- (i) develop a clear strategy to implement and achieve a standard 15 minute consultation time for face-to-face consultations in general practice
  - (ii) develop guidance for GP trainees and GP trainers to allow trainees to have clear minimum expectations in consultation lengths throughout the different stages of their GP training
  - (iii) ensure any change to the standard GP consultation are reflected in the expectations and marking criteria of MRCGP examinations.
- 11a AYRSHIRE AND ARRAN: That conference recognises that the content of the primary care workload has significantly changed in the past decade and therefore:
- (i) appointment times should be adequately resourced to support clinical need
  - (ii) structured face to face appointment times of ten minutes or less should be discouraged.

## GDPR AND DIGITAL SERVICES

12.25

- \* 12 AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference welcomes the increased innovation and flexibility afforded by new digital ways of working but notes the ongoing lack of clarity regarding resourcing of these products and services and calls on GPC to:
- (i) ensure that IT system add-ins enabling integrated remote consultations must be fully funded by departments of health as a core part of the NHS IT offer to general practice
  - (ii) insist that departments of health commission nationally a service that allows direct SMS based communication with patients with the ability for them to reply, with attachments such as photos, to ensure that no structural inequalities are created around such a key method of patient engagement
  - (iii) ensure that national minimum standard for locum IT access is established and embedded in the IT procurement process
  - (iv) ensure that the roll out of digital models of access develop in parallel with work to reduce inequity in those not digitally enabled
  - (v) conduct a full impact assessment of the effect of the roll out of uncapped instantly available e-consultations on the availability of more proven consultation models.
- 12a CLEVELAND: That conference:
- (i) welcomes the increase in digital access to general practice
  - (ii) mandates that all clinically appropriate IT solutions that have emerged to support practices in COVID-safe working be centrally funded in the long-term
  - (iii) expresses concerns at the ongoing inequity of access for sessional GPs to remote working, and demands this is addressed as a priority

- (iv) believes that the digitalisation of general practice has reduced access for a significant number of vulnerable patients, and mandates governments support to patients and to practices to address this inequality.
- 12b GLASGOW: That conference is frustrated at the slow roll out of hardware in practices required for remote video consultations and support direct reimbursement for practices that wish to purchase their own equipment to enable remote consultation functionality.
- 12c WELSH CONFERENCE OF LMCs: The AccuRX platform has been hugely beneficial to practices throughout the pandemic, with benefits far in excess of providing video consultations. AccuRx are planning to introduce charges for their full service from next year and conference calls for this to be funded centrally for all practices.
- 12d LIVERPOOL: That conference believes that service contracts with NHS digitally approved suppliers should be negotiated in such a manner that GPs do not have to worry towards the end of each financial year as to whether products that aid remote working will continue to be available to practices.
- 12e DERBYSHIRE: That IT system add-ins enabling integrated emailing and video consultation are now an essential feature of NHS operation and must continue to be fully funded by departments of health as a core part of the NHS IT offer to general practice and the general practitioner committees are instructed to negotiate accordingly.
- 12f BUCKINGHAMSHIRE: That conference asks GPC to negotiate an increase in primary care funding to meet the increasing costs of information technology hardware and software in primary care.
- 12g BUCKINGHAMSHIRE: That conference believes that platforms for remote consultation such as video and online must be provided to general practice on a fully funded basis in order to meet the growing needs of patients and to meet new contractual obligations and calls on GPC to ensure this is negotiated.
- 12h BERKSHIRE: That conference welcomes the increased innovation and flexibility afforded by new digital ways of working but notes the ongoing lack of clarity regarding resourcing of these products and services and calls on GPC to ensure GPs are not only funded for these products but also appropriately supported in their use.
- 12i DEVON: That conference notes that while the move to a more digitally enabled workforce has been accelerated by the pandemic, variability persists and some interfaces have been more useful and allowed better engagement with more digitally disadvantaged populations. In particular, conference believes that a well governed service that allows direct SMS based communication with patients with the ability for them to reply, with attachments such as photos, has been a step change in service provision and should be commissioned nationally and comprehensively to ensure that no structural inequalities are created around such a key method of patient engagement.
- 12j KENT: That conference demands that the GPC negotiates funding for practices to adopt whichever NHS approved SMS communication solution they choose.
- 12k SCOTTISH CONFERENCE OF LMCs: That conference believes that:
  - (i) the digital systems and infrastructure fall short of that required to facilitate full contract implementation
  - (ii) a single platform software system is needed to unite primary care, secondary care, social care and patient held record access systems for the future
  - (iii) significant further and sustained investment is required to provide the IT tools for patient care.
- 12l AYRSHIRE AND ARRAN: That conference believes COVID-19:
  - (i) has further exposed and magnified the inadequate IT infrastructure supporting primary care in all four home nations
  - (ii) demands a programme of sustained investment in all areas to allow efficient and reliable IT delivery in both practice settings and also via remote access.
- 12m LEWISHAM: That conference demands that the roll out of digital first needs to develop in parallel with work to reduce inequity in those not digitally enabled.



- 12n SCOTTISH CONFERENCE OF LMCs: That conference believes that the present systems for GP locums to access practice IT are poor and compromise patient safety and calls for a:
- (i) solution to be found to allow near immediate access to all required IT systems
  - (ii) national minimum standard for locum IT access is established and embedded in the IT procurement process.
- 12o HIGHLAND: That conference is concerned that while increasing some digital elements of healthcare will benefit some patients, it can also risk further exacerbating existing health inequalities.
- 12p SUFFOLK: That conference acknowledges that e-consultations appear to increase both health inequalities and demand for already saturated primary care services. The uncapped numbers and instant availability of such consultations is likely to lead to the demise, through lack of capacity, of more proven consultation methods. Conference instructs GPC to conduct a full impact assessment of the national roll out.
- 12q NORTHERN IRELAND SOUTHERN: That conference believes that, after the pandemic, online and telephone consultations should be seen as a useful tool, but NOT as a universal replacement for face-to-face consultations. Conference:
- (i) asks for speedy implementation of video consulting systems compatible with our clinical systems and student and junior doctor training that involves these new methods
  - (ii) directs GPC to ensure that telephony and communication options are available for general practice to engage with patients in the new ways of working since commencement of the COVID-19 pandemic
  - (iii) calls for the patient centered face to face consult to be valued and protected alongside new models.
- 12r LIVERPOOL: That conference believes that whilst it is claimed that beneficial changes in the way GPs work have been brought in on account of having to work differently during the pandemic, GPC must ensure that before any changes are contractually adopted there is:
- (i) a robust evaluation on whether changes in working practice have been beneficial or harmful or
  - (ii) their introduction will not increase health inequalities.
- 12s HIGHLAND: That conference recognises that multiple new digital tools and systems have been introduced or had their use accelerated during the response to COVID-19, and calls for:
- (i) training of clinicians and administrative staff
  - (ii) evaluation of the use of these systems in combination
  - (iii) work to demonstrate how this new environment can be built around people.
- 12t HIGHLAND: That conference recognises the importance role of the telephone during the response to COVID-19 and asks for GPC's assistance in ensuring that telephony systems are included in the IT support package that is provided to general practice, including an adequate number of lines and appropriate functionality.
- 12u LIVERPOOL: That conference believes that the move to having remote consultations as the preferred way of consulting with patients will increase the digital divide and expects GPC to ensure that remote consulting does not disadvantage those patients for whom access to IT is limited.
- 12v DERBYSHIRE: That patients should not be permitted to use email or texts as a means of jumping the queue for a general practitioner's attention and the uninvited use of email or texts by patients when contacting their practice should be restricted to administrative and routine matters which can be dealt with by reception staff or, if necessary by a booked routine GP appointment (Virtual or F2F) only and GPCs are instructed to negotiate accordingly.

## ELECTRONIC RECORDS

**12.45**

- \* 13 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is concerned about the transfer of electronic medical records between practices in the four different countries of the UK, and for patient safety and quality of healthcare, requires that:

- (i) GP2GP or similar interoperability is enabled to ensure whole electronic medical records including diagnoses, results, medications, sensitivities and allergies are transferred as coded items
- (ii) electronic prescribing is available from all general practices in the UK to all pharmacies in the UK
- (iii) all four countries convert to fully digitalised records by 2030 with no remaining manual records
- (iv) any hospital in the UK treating a patient under an NHS contract can send coded electronic correspondence directly to all UK GP clinical systems.

- 13a** GLOUCESTERSHIRE: That conference is very concerned at the often inadequate transfer of electronic patient records between the four UK nations and demands an urgent resolution to this.
- 13b** SCOTTISH CONFERENCE OF LMCs: That conference believes that a digital asynchronous consulting platform should be provided for all practices, including facility for both acute consultations and chronic disease management.
- 13c** SCOTTISH CONFERENCE OF LMCs: That conference is appalled by the lack of progress to implement a fully electronic prescribing system and:
- (i) the continuing need for a 'wet signature' causes unnecessary workload, hinders the progress of pharmacotherapy services and demands that 'wet signatures' become a thing of the past
  - (ii) calls on government to make this a priority especially in dealing with the current impact of the COVID-19 pandemic on services.

## LUNCH

**13.00**

## THEMED DEBATE - SOLUTIONS TO STEM THE 'TSUNAMI' OF WORKLOAD

**14.00**

The Agenda Committee has noted the ongoing increase in workload being experienced by GPs and practices across the UK. This was reflected in the 45 motions submitted in this section. The majority of motions focused around increased workload related to secondary care but also covered out of hours, unscheduled care and patient expectations. We are mindful that the post-COVID-19 recovery phase provides an opportunity for us all to reflect on how things could be different in the future and propose a major issue debate to be held under standing order 53. The motions submitted by LMCs that the Agenda Committee considers best covered by this themed debate are included in the agenda here and are numbered TD1 to TD45.

The themed debate will be introduced by a representative of the GPC UK Chair, who will report on recent GPC activity, followed by a representative from the BMA's Consultants Committee, who will provide a perspective on behalf of our secondary care colleagues.

All members of conference may take part in this debate when called by the Chair, with a speaker time limit of one minute per speaker. Speaker slips will be required in advance, and we ask that you **try to focus on solutions**, rather than problems.

At the conclusion of the debate, both introductory speakers will be invited to respond to the debate, with a time limit of two minutes per speaker. We shall then ask representatives to vote on the following statements, which will provide a steer to GPC UK as to further actions required by Conference.

All statements will have the voting options of:

- Strongly agree
- Agree
- Slightly agree

- Slightly disagree
- Disagree
- Strongly disagree

- A There is an urgent need to capture practice activity data.
- B Realistic patient expectations of what can be provided by both in hours and out of hours general practice is essential.
- C The benefit to patients by increasing the ways they can access general practice (online consultations, direct booking by urgent care services, etc) outweighs the increase in demand that this creates and the associated workload pressures.
- D All workload discussions must consider the system as a whole and not the needs of either general practice or secondary care in isolation.
- E The interface points between primary, secondary and intermediate care must be formally defined by GPC, not left to LMCs.
- F Assuming that the work is clinically safe, and appropriately funded, general practice should be accepting more work from secondary care.
- G Practices have all the tools they need to control workload, they just need to learn to say no.

- TD1 GLASGOW: That conference acknowledges that the pandemic has put pressure on many services and reduced the normal capacity and throughput of patients but:
- (i) strongly resists secondary care passing work such as bloods and physical monitoring back to GPs
  - (ii) opposes any proposals that patients on waiting lists should see the GP for a re-assessment before being appointed
  - (iii) strongly resists suggestions that referrals to specialties or imaging should be passed back to GPs for reconsideration.
- TD2 CITY AND HACKNEY: That conference notes the considerable strain that primary care, in line with other sectors of the NHS, is under due to the COVID-19 pandemic but:
- (i) insists that the COVID-19 pandemic should not lead to the unchecked passing of secondary care workload to primary care
  - (ii) requires safe, realistic and agreed systems to be put in place to allow for patient care to be maintained by secondary care.
- TD3 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires the GPC to negotiate to eliminate the unnecessary transfer of work from secondary care and to properly resource the reasonable transfer of work.
- TD4 GLASGOW: That conference believes that secondary care should have systems in place to answer directly patients' questions and concerns about services and waiting times and resists attempts by hospitals to pass this to GP practices.
- TD5 GATESHEAD AND SOUTH TYNESIDE: That conference:
- (i) is deeply concerned about the patient harm resulting from delayed investigation and treatment as a consequence of the pandemic
  - (ii) recognises that general practice has throughout been responsive to circumstances and continues to deliver primary care services
  - (iii) is concerned that already there is evidence of patient dissatisfaction resulting in complaints against GPs, despite this being a systemic problem
  - (iv) demands that GPs are indemnified and publicly supported against any and all harms resulting from delays largely attributable to other part of the system.

- TD6** OXFORDSHIRE: That conference is concerned by the ongoing shift of workload from secondary care and other providers, exacerbated by at scale integration of health and social care and calls on GPC to emphasise in all negotiations that we are primary medical practitioners and not responsible for social care or specialist care.
- TD7** HIGHLAND: That conference asserts that unresourced transfer of secondary care work to primary care, exacerbated and enabled by the coronavirus pandemic, is unacceptable and must be stopped.
- TD8** HERTFORDSHIRE: That conference notes that the pandemic has exposed the cracks between primary and secondary care and calls on GPC to ensure that:
- (i) any shifts of work from secondary to primary care as a result of the pandemic are recognised, remunerated and prioritised for return to secondary care
  - (ii) advice and guidance processes introduced under the pandemic are reviewed to make sure they are not increasing work for general practice
  - (iii) all clinicians will be fully supported in medico-legal cases brought by patients due to hospitals delaying referrals or discharging patients early.
- TD9** LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires GPC to negotiate national standards and terms to resource discretionary services such as ECGs and Spirometry.
- TD10** 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.
- TD11** NORTHERN IRELAND SOUTHERN: That conference demands GPC ensures minimum clinical governance standards are enforced by the DOH / Commissioner in any present or future reset / reform of secondary care services so that patients are not discharged from services without being seen nor dependent upon a validation exercise that displaces workload to general practice.
- TD12** KENT: That conference welcomes the proposed changes to the NHS Standard Contract requiring liaison providers to work with the LMCs concerning interface with primary care, and demands:
- (i) no new work is transferred to primary care without LMC approval
  - (ii) all transfers of work are accompanied by appropriate resource
  - (iii) punitive action is taken against providers in breach.
- TD13** NORTHAMPTONSHIRE: That conference believes that there should be a pump priming for any transfer of work to enable practices to prepare for any such transfer.
- TD14** SCOTTISH CONFERENCE OF LMCs: That conference directs that:
- (i) secondary care should have systems in place to directly answer patients' questions and concerns about services and waiting times and resists attempts by hospitals to pass this to GP practices
  - (ii) all clinical letters, including email and electronic correspondence, should be provided with contact details either an email and/or telephone number so that the GP can discuss patient cases with secondary and tertiary care directly.
- TD15** NORTH AND NORTH EAST LINCOLNSHIRE: 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.
- TD16** HERTFORDSHIRE: That conference notes that secondary care IT systems proved to be less able than GP systems to allow full remote working and the impact this has had on primary care workload and therefore instructs GPC to ensure the BMA negotiates as appropriate to ensure:
- (i) secondary care is mandated to develop IT infrastructure so they can manage fully 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.
- TD17** LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires the GPC to ensure that the increasing burden of pre-referral work required of GPs is both recognised and resourced.
- TD18** AYRSHIRE AND ARRAN: That conference, as a result of the COVID-19 pandemic:
- (i) notes that there are dramatic rises in waiting times for secondary care services
  - (ii) recognises that this rise in waiting times will mean many more unwell people will need support and medical care in the community for extended periods
  - (iii) recognises that many primary care services are already at or beyond capacity
  - (iv) recognises that without a coherent plan for how the need for increased community services is to be addressed, health and access to care for all will inevitably deteriorate and pressure on primary care teams increase
  - (v) insists that the governments acknowledge the problems in service delivery in the community and urgently develop a plan to address this.
- TD19** LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that GPC should negotiate a national fee or block payment for discretionary services / local enhanced services). There is so much variance in LES payments between CCGs (for example phlebotomy, ECG, ear syringing, spirometry).
- TD20** WALTHAM FOREST: That conference notes that despite the NHS Standard Contract, hospital trusts are not held to account by CCGs over the inappropriate transfer of work to general practice and:
- (i) recognises the frustration this is causing to patients and GPs throughout the UK
  - (ii) requires GPC to lobby the BMA Council to publicly acknowledge how such requests by hospital colleagues fails to recognise the importance and quantity of the work that general practice does despite finite capacity
  - (iii) calls on GPC to work with DHSC in developing clauses within the NHS Standard Contract which enable CCGs to have sufficient leverage to prevent inappropriate work transfer.
- TD21** 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:
- (i) believes that an episode of private care should not be a cause of extra work for practices
  - (ii) insists that a private prescription should never be presented to be converted into an NHS prescription whether a GP would normally prescribe the drug(s) or not
  - (iii) insists that a private test should never be converted into an NHS test whether a GP would normally organise the test or not, and
  - (iv) insists that private consultants should be able to refer back to NHS colleagues without involving a GP.
- TD22** NORFOLK AND WAVENEY: That conference asks GPC to negotiate the following for ongoing unfunded transfer of workload and responsibility from secondary care to general practice during COVID-19 crisis that:
- (i) ensure all secondary care clinicians are advised to arrange necessary investigations, onward referrals to other departments and follow up and not delegate work to primary care
  - (ii) ensure that GPs are not held responsible if their patient's clinical medical condition deteriorates whilst on unacceptably long waiting lists
  - (iv) insist that all patient queries on investigations and follow up initiated by secondary care should be the responsibility of the hospital clinician
  - (v) agree financial sanctions against providers who do not reduce this transfer.
- TD23** CENTRAL LANCASHIRE: That conference believes that use of the CCAS service has been shown to be a Trojan horse for 111 direct access to GP appointments, negatively impacting on the ability of general practice to control their own workload, but most importantly is dangerous in wrongly placing patients with urgent needs into slots of which the practice is unaware.

- TD24**    **LOTHIAN:** That conference notes the plans of governments across the UK to redesign and schedule urgent care and requests the GPCs work with the governments to establish the final destination of these redirected patients and the demands these policies place on general practice.
- TD25**    **BRADFORD AND AIREDALE:** That conference believes that the disposition codes to contact a primary care service within one and within two hours should be scrapped and replaced with attend the emergency department.
- TD26**    **SCOTTISH CONFERENCE OF LMCs:** That conference is concerned about the development of scheduling to unscheduled care and asks that:
- (i)        general practices are not expected to provide staff for this development
  - (ii)       there is a clear messaging campaign for the public so they can understand the new ways of accessing care.
- TD27**    **SOUTH STAFFORDSHIRE:** That conference believes that as the overwhelming numbers of patient consultations are taking place in general practice, allowing other organisations to book patients onto our system must be resisted.
- TD28**    **GLASGOW:** That conference believes that GP workload is unsustainable at current levels and calls for:
- (i)        a government led campaign for the responsible use of GP services
  - (ii)       public understanding of what service can be delivered at the time of a pandemic.
- TD29**    **AVON:** That conference continues to be concerned about the length of the GP working day, effectively resulting in a pay cut when the hourly rate is considered and demands that the workload policy group is reinstated to seek solutions to this ongoing problem.
- TD30**    **SUFFOLK:** That conference instructs that GPC request that a programme be launched to explore and implement viable alternative means (such as EPS or a modernised version of FP10H) for patients to receive hospital driven medications which do not default to the involvement of the GP. The aim is to control out-patient urgent prescriptions (exacerbated during the pandemic) and help solve the increasing problems associated with shared care drugs when drug groups become more and more specialised and need monitoring.
- TD31**    **GLASGOW:** That conference believes that revisions for clinical and referral pathways should be a joint exercise between primary and secondary care and must involve the LMC.
- TD32**    **DERBYSHIRE:** That with reference to GP referrals to hospital departments, community based health services and social care agencies conference:
- (i)        insists that any referral may be made by ordinary letter transmitted electronically
  - (ii)       rejects all attempts to enforce completion of complex or lengthy referral pro-formae before a GP referral can be accepted
  - (iii)      rejects all attempts by organisations to reject a GP referral on the basis of a multi-disciplinary team decision before that team have seen the patient
  - (iv)      reminds the NHS that part of the compact of general practitioners absorbing potentially unlimited patient demand and thus protecting secondary care, is the GPs absolute right of referral to secondary care particularly where a patient's needs are outside the terms of the GP contract or beyond the resource or skills of general practitioners and that GPCs negotiate accordingly.
- TD33**    **KIRKLEES:** That conference would welcome the improvements to patient pathways due to advances in technology and clinical management. We have significant concerns about the impact of outpatient transformation on general practice:
- (i)        no GP referral should be rejected by secondary care teams without contacting and seeking consent from the referring GP
  - (ii)       outpatient transformation often requires more work in general practice prior to making a referral. The resultant costs of clinical and administrative time must be met in full
  - (iii)      outpatient transformation often off-loads the work of routine follow up onto general practice. This work must also be adequately funded

- (iv) the changes envisaged by outpatient transformation on clinical pathways must ensure that all members of the primary care team are provided with the necessary education training and accreditation
  - (v) clinical pathways should be developed and agreed in collaboration with patients, GPs and secondary care teams so that clinical risk is minimised and patient safety improved.
- TD34** NORTHERN IRELAND EASTERN: That conference notes with concern that with increasing delay in outpatient review and apparent lack of scrutiny that trusts are increasingly not delivering their part in the monitoring arrangements around amber list drugs – this is not shared care. GPC is directed to seek a mechanism by which:
- (i) GPs can repatriate unsafe work back to trusts coordinated through interface pharmacy trust reps another appropriate route
  - (ii) amber meds can be reconsidered to become red if clear evidence that shared care agreements aren't working.
- TD35** 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.
- TD36** AYRSHIRE AND ARRAN: That conference recognises the urgent need for improved data capture about primary care activity.
- TD37** WELSH CONFERENCE OF LMCs: That conference insists GPC use this extraordinary time when secondary care services are hugely restricted as an opportunity to redesign the health care landscape for the benefit of patients and negotiate sensible transfer of services to primary care with appropriate resources.
- TD38** OXFORDSHIRE: That conference believes the COVID-19 pandemic has provided an opportunity for a “reset” in patient expectation and demand, and calls on GPC to assert in the strongest terms that:
- (i) the evidence shows access to general practice in the UK has been increasing over time
  - (ii) we are contracted to meet reasonable needs of patients and not simply their wants
  - (iii) home visits are not an automatic entitlement but rather an exception to be indicated at the absolute discretion of the GP
  - (iv) general practice needs real investment in core GMS rather than repeated non-evidence-based gimmicks.
- TD39** GLOUCESTERSHIRE: That conference reiterates that demand for general practice is far higher than comparable nations, notes the reduction in demand to manageable levels during the early phase of the pandemic and instructs GPC to explore ways to return demand to that of comparable nations.
- TD40** NORTHERN IRELAND SOUTHERN: That conference calls on the DOH to direct healthcare trusts to reprofile their services to support community healthcare during any future COVID-19 surge to enable patients not having to default to secondary care settings.
- TD41** AYRSHIRE AND ARRAN: That conference recognises with expanding multi-disciplinary teams in primary care:
- (i) there are now new and increased routes to access healthcare
  - (ii) the system has become increasingly complex for patients to navigate
  - (iii) calls for urgent new support and resource to be directed towards helping patients to access the right care at the right time.
- TD42** DERBYSHIRE: That conference demands that the inexorable increase of 111 booked appointments into general practice does not improve patient care and should be withdrawn.
- TD43** WIGAN: That conference believes that the NHS 111 First protocol which requires patients to be seen in general practice within tight timescales eg one hour, places an unnecessary and unwelcome burden on overstretched GPs. Patients requiring attention in such timescales are by definition urgent and or emergencies. It calls on GPC to aid LMCs which are pushing back locally on this by taking this up at a national

level with the architects and overseers of the NHS 111 scheme to seek a review of the protocols being applied.

**TD44** DERBYSHIRE: That in the interests of patient safety urgent clinical requests must continue to be made clinician to clinician in person or by telephone and not rely on the passive communication methods such as email and that general practitioner committees should lobby the professional regulation bodies to support such a policy.

**TD45** NOTTINGHAMSHIRE: That conference makes clear that the move towards integrated care structures spreads the responsibility for effective use of health spending. As such, the local systems should be made responsible for sorting out inefficiencies such as the unresourced shift of work from secondary care to primary care with lead roles in each system designated to deal with such interface issues.

## **BREAK**

**15.30**

## **THE ROLE OF GPC AND LMCs**

**15.50**

### **The GPC**

- \* **14** AGENDA COMMITTEE TO BE PROPOSED BY OXFORDSHIRE: That conference believes that the recent reforms made to the GPC have distanced it from LMCs and the frontline profession, and:
  - (i) believes that as part of the BMA the GPC is naturally conflicted in its ability to truly represent the interests of GPs and lacks accountability to LMCs and to LMC Conference
  - (ii) demands more transparency and accountability from GPC UK and requests that GPC UK member voting behaviours are circulated within LMC weekly updates
  - (iii) calls on GPDF to commission a thorough review of the current representative structure, particularly seeking the views of LMCs
  - (iv) mandates GPDF to explore alternative options to the current structure, including the formation of a National Council of LMCs
  - (v) asks GPDF to consider whether general practice would be better served by a body politic independent of the BMA.
- 14a** OXFORDSHIRE: That conference believes that the recent reforms made to the GPC have distanced it from LMCs and the frontline profession, and:
  - (i) believes the GPC lacks accountability to LMCs and to LMC Conference
  - (ii) believes that as part of the BMA the GPC is naturally conflicted in its ability to truly represent the interests of GPs
  - (iii) calls on GPDF to commission a thorough review of the current representative structure, particularly seeking the views of LMCs
  - (iv) mandates GPDF to explore alternative options to the current structure, including the formation of a National Council of LMCs
  - (v) asks GPDF to consider whether general practice would be better served by a body politic independent of the BMA.
- 14b** CAMBRIDGESHIRE: That conference believes that the pandemic has reinforced the need for an authoritative UK GPC voice, but acknowledges that the Meldrum Review changes have had a significant, negative impact on the workings of GPC UK and calls for a review to pay particular attention to:
  - (i) ensuring adequate time to ensure debate and represent the four nation specific issues
  - (ii) enacting the full Romney recommendations in the 2021-22 session
  - (iii) reflecting the make-up of the GP workforce



- (iv) reviewing how cost savings from virtual meetings could facilitate more engaged working relationships between the committee and the chairs/executives
  - (v) the review is brought back to UK LMC conference 2022 to vote upon.
- 14c** AVON: That conference demands more transparency and accountability from GPC UK and requests that GPC UK member voting behaviours are circulated within LMC weekly updates.
- 14d** LINCOLNSHIRE: That conference commends GPC on the excellent work that has been done to improve the primary secondary care interface, but also notes that secondary care colleagues continue to move work to general practice inappropriately and thus:
- (i) calls on GPC to engage further with consultants committee to rectify this
  - (ii) and if this does not adequately resolve the issues calls for GPC to break away from BMA to form a separate GP Association so that these issues can be resolved without the inherent conflicts of interest which prevent this at present.
- 14e** LEEDS: That conference believes that elections for GPC membership should be held at the respective national LMC conferences, and no longer at the UK LMC conference.
- 14f** MID MERSEY: That conference considers that non-medical clinicians, practice nurses and practice managers are now core members of the general practice team who should be represented on LMCs and GPC, notes that motions to this effect have been submitted to previous LMC conferences and not debated, and is disappointed that the Agenda Committee has not previously prioritised this topic for debate.
- 14g** KENT: That conference notes the concern that racism in the UK is growing and accordingly acknowledges that black lives do indeed matter and demands:
- (i) that the practice of anonymous feedback questionnaires from colleagues and patients is abolished due to the risk of vexatious submissions tainted by racism or other bias
  - (ii) the GPC open a significant number of BAME priority GPC seats to increase BAME diversity and representation of the profession.

## LMC GOVERNANCE

**16.10**

- \* 15** AGENDA COMMITTEE TO BE PROPOSED BY CAMBRIDGESHIRE: That conference recognises the increasing importance for LMCs to be the unimpeachable voice of the local profession and to facilitate this calls for:
- (i) LMCs to ensure that all GPs, whatever their GP role or protected characteristics such as race and gender, are not excluded from representing their members at LMC board or director level
  - (ii) LMCs to agree and adopt a minimum availability and range of service and support for all GPs providing care for registered patients
  - (iii) LMCs to agree that asking for additional levy payments from sessional GPs is misguided
  - (iv) GPDPF to commission and fund a UK Association of LMCs to support LMCs.
- 15a** CAMBRIDGESHIRE: That conference recognises the increasing importance for LMCs to be unimpeachable voice of the local profession and to facilitate this, calls on GPDPF to commission and fund a UK Association of LMCs with the explicit remit of improving organisational governance in LMCs; quality assurance of LMCs; specialist training for LMCs; providing a repository of up to date information gathering and sharing across the UK that each LMC can benefit from, working in synchronicity with and complementing the work of inter alia, the GPC and the BMA.
- 15b** AVON: That conference has concerns about the overarching governance of LMCs and asks that GPC UK works with LMCs and encourages them to:
- (i) include all GP roles to be eligible for board or director level appointments so that locum GPs are not excluded from representing their members
  - (ii) ensure that all GPs, including those with protected characteristics such as race and gender, may be represented at LMC board or director level
  - (iii) agree and adopt a minimum availability and range of service and support for their GPs.

- 15c DEVON: That conference welcomes the role of the LMC in statute of representing all GPs, and believes that as levies paid to LMCs are determined by the number of registered patients:
- (i) LMCs should acknowledge that they represent all GPs providing care for registered patients
  - (ii) that the CNSGP criteria for indemnity cover provides a good reference point for which individual GPs can be said to be providers of levy covered care
  - (iii) asking for additional levy payments from sessional GPs is misguided.
- 15d CAMBRIDGESHIRE: That conference calls for the GPDF to commission and fund the formation of a UK GP charity, to join NHS Charities Together to become eligible to receive charitable monies to invest in practices and practice teams, UK wide.
- 15e NOTTINGHAMSHIRE: That conference recognises that GPC / GPDF have been styling themselves as being support to general practice and development needs of those working within the sector. We would like clear leadership on how GPC / GPDF can better help to provide workforce support and training.
- 15f GLOUCESTERSHIRE: That conference believes that interactions between LMCs are vital for general practice but believes that the time has come for a more user friendly searchable platform for this purpose and instructs the BMA to institute a system more in tune with modern needs.

## GREEN GENERAL PRACTICE

**16.40**

- \* 16 AGENDA COMMITTEE TO BE PROPOSED BY LEEDS: That conference supports the promotion of addressing climate change and the current ecological crisis and:
- (i) approves of active travel to improve health outcomes by increasing exercise
  - (ii) recognises the opportunity to improve recycling within the NHS
  - (iii) calls on the UK Government to commit to invest in GP infrastructure and premises, including installing charging points for electric cars, to make general practice estate carbon neutral by 2030
  - (iv) calls on the UK government to commit to support and resource GP practices to return to re-usable medical equipment to reduce the carbon impact of disposal equipment
  - (v) calls on the UK government to commit to implement a nationwide medication returns and recycling scheme.
- 16a LEEDS: That conference welcomes the GPC's 2020 sustainable and environmentally friendly general practice report and, in advance of COP26 in Glasgow, calls on the UK Government to commit to:
- (i) invest in GP infrastructure and premises, including installing charging points for electric cars, to make general practice estate carbon neutral by 2030
  - (ii) provide the necessary IT infrastructure to enable more remote working for staff to decrease the carbon impact of travel of both staff and patients
  - (iii) support and resource GP practices to return to re-usable medical equipment to reduce the carbon impact of disposable equipment
  - (iv) implement a nationwide medication returns and recycling scheme
  - (v) require all medications to include information that clearly displays their carbon footprint.
- 16b SHEFFIELD That conference supports the promotion of addressing climate change and the current ecological crisis by asking GPC 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.
- (Supported by Glasgow, Cheshire, Bradford and Airedale, Islington and Tower Hamlets)
- 16c GLASGOW: That conference supports the promotion of addressing climate change by asking for GPC to negotiate:
- (i) mandating a national labelling system indicating the carbon footprint of all drugs and medical appliances, which can be easily incorporated into the GP IT systems

- (ii) the development of green prescription schemes accessible to all people living with long-term health conditions
  - (iii) incentivising the use of 'Green Impact Audit for Health' tools by general practice.
- 16d** CHESHIRE: That conference supports the promotion of addressing climate change and the current ecological crisis by asking GPC to negotiate:
- (i) incentivising the use of the 'Green Impact Audit for Health' tool 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.
- 16e** BRADFORD AND AIREDALE: That conference supports the promotion of addressing climate change and the current ecological crisis by asking GPC 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.
- 16f** ISLINGTON: That conference supports the promotion of addressing climate change and the current ecological crisis and asks GPC to negotiate:
- (i) incentivising the use of the "Green Impact for Health" tool kit in general practice
  - (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.
- 16g** TOWER HAMLETS: That conference supports the promotion of addressing climate change and the current ecological crisis by asking GPC 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.
- 16h** HAMPSHIRE AND ISLE OF WIGHT: That conference supports the urgent priority of addressing the climate change emergency within primary care and enabling general practitioners to act as role models for our patients. We would ask conference to negotiate NHSE incentivising the use of the 'Green Impact Audit for Health' tool by practices and by commissioning a mandatory eLFH module to educate the NHS workforce on health, the environment and associated issues such as greener prescribing and lifestyle modifications.
- 16i** GLASGOW: That conference acknowledges that heating and lighting, and transport are significant contributors to the carbon footprint of primary care and
- (i) calls on government to switch NHS owned health premises to low carbon electricity supplies and
  - (ii) calls national and local government to improve active travel and low carbon transport options to health care facilities.
- 16j** SCOTTISH CONFERENCE OF LMCs: That conference:
- (i) approves of active travel to improve health outcomes by increasing exercise
  - (ii) recognises the opportunity to improve recycling within the NHS
  - (iii) approves of analysis of GP premises and working environments to reduce our carbon footprint
  - (iv) urges government to accelerate the transition from fossil fuel vehicles to decrease pollution
  - (v) supports the Scottish Government in declaring a climate emergency.
- 16k** HIGHLAND: That conference supports a green COVID-19 recovery plan from government and believes that this is vital to sustain a healthier population and planet.

- 16l 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.

**CLOSE**

**17.00**

## QUESTIONS TO GPC UK

09.00

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

The agenda committee has noted a strong desire from LMCs to receive feedback from GPC UK 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 UK.

This section will be held under standing order 55.

Questions to the GPC UK 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 UK. 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 UK LMC conference policy that has not been fully implemented. 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](mailto:kday@bma.org.uk)) by noon on Wednesday 5 May 2021.**

## GP CONTRACT NEGOTIATIONS

09.30

- \* 17 CAMBRIDGESHIRE: That conference calls upon GPDF to commission and fund research into the creation of an options paper for GPC UK to review prior to April 2022 that will investigate:
  - (i) the benefits / risks options and costs associated with the provision of UK general practice outside of the GMS / PMS / APMS contract model
  - (ii) how those independent contractors who wish to become employed GPs may be facilitated to do so with regard to their estates and premises across a number of examples on a local, national or UK basis
  - (iii) modelling around the longer term consequences of risks/benefits to practices of having aligned contracts with staff and / or premises with other NHS providers / trusts
  - (iv) how the future of a separately negotiated model around NHS and non NHS provision of general medical services could be facilitated.
- 17a DEVON: That conference notes that annual negotiations on core primary care contracts take place for each of our four nations and are often followed by informal feedback but that this is not formally sought and so calls for the GPC of each nation to:
  - (i) survey their membership immediately after each contract settlement to gain feedback on what the membership are pleased with and what they are not
  - (ii) publish such feedback in the spirit of true democracy
  - (iii) build this feedback into any future negotiations.

## GENERAL PRACTICE PAY AND CONDITIONS

09.50

- \* 18 AGENDA COMMITTEE TO BE PROPOSED BY LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference welcomes the Dacre and Romney reports, and calls for:
  - (i) the GPC to produce an annual report to this conference to include up to date data on the gender pay gap, what actions have been implemented and what change in the pay gap has resulted
  - (ii) the GPC to negotiate changes to all general practice contractor contracts to encourage and support part time and flexible working in partnerships

- (iii) the GPC to provide an annual report to this conference to include the number and type of all relevant complaints and outcomes, and all actions taken that year to ensure and assure appropriate behaviour by members and staff.
- 18a LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference welcomes the Dacre report highlighting the significant gender pay gap in general practice and insists:
  - (i) the GPC produces an annual report to this conference to include up to date data on the gender pay gap, what actions have been implemented and what change in the pay gap has resulted
  - (ii) the GPC negotiates changes to all general practice contractor contracts to encourage and support part time and flexible working in partnerships.
- 18b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that the Romney report is not forgotten, that there is no place for sexual harassment or discrimination in LMCs or GPCs, and requires GPC UK to provide an annual report to this conference to include the number and type of all relevant complaints and outcomes, and all actions taken that year to ensure and assure appropriate behaviour by members and staff.
- 18c 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)

## DDRB

10.10

- \* 19 AGENDA COMMITTEE TO BE PROPOSED BY SESSIONAL GPs COMMITTEE: That conference is frustrated that both partners and salaried GPs repeatedly fail to receive real term pay uplifts and:
  - (i) believes that 2.8% does not reflect the increase in workload experienced by GPs of all types
  - (ii) demands that any promised uplift is matched by an appropriate increase in total practice income so as not to result in a drop in GP partner pay
  - (iii) believes that the annual DDRB pay review process should be extended to non-practice based salaried GPs
  - (iv) condemns any employer who does not provide the full annual pay uplift to their GPs, in accordance with the government's decision following the recommendation of the DDRB, where this is contractually required.
- 19a SESSIONAL GPs COMMITTEE: That conference endorses full engagement with the DDRB process for salaried GPs, and:
  - (i) believes that the annual uplift should be extended to non-practice based salaried GPs
  - (ii) condemns any employer who does not provide the full DDRB uplift to their GPs where this is contractually required.
- 19b HERTFORDSHIRE: That conference notes that the government has made public declarations regarding pay rises for NHS staff in recognition of their incredible work and dedication during this pandemic, but is frustrated that promised uplifts to both partners' and salaried GPs' pay repeatedly fail to be covered by real term uplifts in total practice income and demands that any promised uplift is matched by an appropriate increase in total practice income so as not to result in a drop in GP partner pay.
- 19c CONFERENCE OF ENGLAND LMCs: 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 to negotiate an increase to at least the DDRB recommended raise of 2.8%, for all GPs, backdated to April 2020.

- 19d DORSET: That conference with respect to the DDRB pay recommendations:
- (i) calls for an extension of the annual pay uplift to non-practice based sessional GPs
  - (ii) condemns any employer who does not provide the full DDRB uplift to their salaried GPs.

## BREAK

10.30

## ZERO TOLERANCE TO RACISM

10.40

- \* 20 HULL AND EAST YORKSHIRE: That conference calls on health ministers across the UK to:
  - (i) publicly and repeatedly deliver the message that no patient is entitled to refuse care based on a clinician's ethnicity
  - (ii) identify and publicise the daily examples of racism that NHS colleagues are subjected to
  - (iii) commit to a zero tolerance approach to any patient complaints that arise from challenging racism.

## INDEMNITY

11.00

- \* 21 SESSIONAL GPs COMMITTEE: That conference, in respect of the All Wales Locum Register/ Locum Hub Wales:
  - (i) expresses concern about the data collection changes required for indemnity implemented on 1 February 2021
  - (ii) requires absolute clarity on how data collected through this route is being used
  - (iii) believes that recent changes could have a significant financial impact on locums
  - (iv) mandates that all future changes must be agreed by both the Sessional GPs committee and GPC Wales before implementation.
- \* 22 NORTHERN IRELAND SOUTHERN: That conference is seeking assurance that an indemnity solution is found for GPs in Northern Ireland and agreed with NI Department of Health in the near future. This is urgent as the upcoming decision on the discount rate could increase indemnity subscriptions to a level where it would not be viable to work as a GP in NI.

## SOAPBOX

11.40

## CHARITIES

12.00

### Cameron Fund Annual General Meeting

- 23 RECEIVE: Report by the Chair of the Cameron Fund (Dr Gary Calver).

### Dain Fund

- 24 RECEIVE: Report by the Chair of the Dain Fund (Dr Bill Strange).

## Claire Wand Fund

- 25 RECEIVE: Report by a Trustee of the Claire Wand Fund (Dr Russell Walshaw).

## LUNCH

12.10

## BMA COMMUNICATIONS SYSTEMS

13.00

- \* 26 DEVON: That conference notes that multiple reviews of GPC functioning have highlighted the BMA listservers as a barrier to inclusion and to a digitally responsive system. Conference believes that GPC UK should immediately terminate its use of archaic email listservers, replacing them with a modern, professional, sensitively moderated and technologically appropriate forum resourced by the GPDF, with subsequent roll out to the four national GPCs as appropriate.

## CROSS-BORDER WORKING

13.20

- \* 27 WELSH CONFERENCE OF LMCs: Following the debacle of the commissioning between BCUHB and the Countess of Chester Hospital earlier this year conference calls for Welsh Government to:
- (i) recognise the contribution that care providers on the English side of the border make to the provision of healthcare to the Welsh population
  - (ii) ensure that ideology does not jeopardise this element of capacity within the Welsh healthcare system, and
  - (iii) ensure that there is effective contingency planning in place to ensure continuity of provision in the event that the commissioned service is withdrawn.

## CHOSEN MOTIONS

13.40

## PRACTICE MANAGEMENT

14.20

- \* 28 AGENDA COMMITTEE TO BE PROPOSED BY KERNOW: That conference is asked to recognise the continuing workforce crisis facing those undertaking the vital role of general practice management and calls upon GPC UK to facilitate:
- (i) the creation of nationally resourced and updated electronic practice management handbook(s)
  - (ii) less bureaucracy in practice management during 2021
  - (iii) closer working with representative bodies of practice management, especially during contract negotiations.
- 28a 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.
- 28b HAMPSHIRE AND ISLE OF WIGHT: That conference receives and notes with dismay and concern that in a recent survey of practice managers, 55% responded that they were considering leaving their role in the next 12 months or had already resigned due to the increasing plus expanding workload and lack of recognition of their skills and expertise. Conference therefore instructs the GPC to work with all stakeholders including



LMCs, the BMA, NHSEI / Health Service Scotland / NHS Wales / HSCNI, the Department of Health and Social Care and Secretary of State for Health to recognise the important role practice managers play and to recognise the emerging Institute of General Practice Management as a body to be consulted during contract negotiations.

- 28c WEST PENNINE: That conference demands recognition of the increasing pressures yet decreasing numbers of practice managers with many set to retire in the near future. NHSE/I must support and implement an agenda of less bureaucracy during 2021.

## CONTRACT FUNDING

14.40

- \* 29 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference notes legislative proposals in some of our home nations which seek to reform the provision of core GP contracts, including where they are held and how they are funded and mandates the GPC to ensure that:
- (i) GP core contracts in each nation remain nationally negotiated with GPC
  - (ii) the GP practice remains the unit at which core contracts are negotiated ensuring practices are not forced to integrate into corporate entities with other practices or organisations without their specific agreement and consent
  - (iii) GP contracts are funded from ring fenced funds, with specific provision that they are excluded from being redirected to support secondary care or support overspends elsewhere in the system
  - (iv) there is a requirement that all bodies commissioning health services have a legal requirement to consult appropriate local medical committees.
- 29a DEVON: That conference notes legislative proposals in some of our home nations which seek to reform the provision of core GP contracts, including where they are held and how they are funded, and mandates the GPC to represent and ensure on our behalf that an overriding principle of any such reform should be that GP core contracts in each nation remain:
- (i) nationally negotiated with GPC
  - (ii) funded from ring fenced funds, with specific provision that they are excluded from being redirected to support secondary care or support overspends elsewhere in the system
  - (iii) with the GP practice remaining the unit at which core contracts are negotiated, ensuring practices are not forced to integrate into corporate entities with other practices or organisations without their specific agreement and consent.
- 29b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference welcomes that there are plans for the disastrous Lansley Reforms to be swept away but require that any health service in UK countries must be based upon evidence and must:
- (i) never again represent an unpiloted wholesale reform so large it is visible from space
  - (ii) recognise that primary care-based healthcare reduces inequalities and improves efficiency
  - (iii) have a requirement that all bodies commissioning health services have a legal requirement to consult appropriate local medical committees.
- 29c LIVERPOOL: That conference believes that the fragmentation of delivery of general practice across the UK has been exacerbated by the pandemic and believes the GPC should act to restore the word national in the National Health Service.
- 29d BUCKINGHAMSHIRE: That conference is alarmed by government plans to tear up the Health and Social Care Act in the middle of a global health emergency. Conference hopes that the UK government has realised the limits of its own competence and will therefore show suitable restraint to avoid adding to its litany of catastrophic errors during the ongoing COVID-19 pandemic crisis.
- 29e BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference requests that NHSE delay any further major organisational change within primary care for at least 24 months to allow recovery from the COVID-19 pandemic, in order to refresh and retain a fatigued and exhausted workforce.
- 29f AVON: That conference mandates the GPC to make the strongest possible representations to government that conference is deeply concerned that the time-honoured principle that there should be no changes to

NHS legislation without full public consultation has occurred at the present time when the nation is dealing with COVID-19 and mass vaccination.

- \* 30 KIRKLEES: That conference believes that additional funding should be made available to meet the extra needs of deprived communities and that:
  - (i) the Carr Hill formula is no longer fit for purpose
  - (ii) the impact of the Carr Hill formula on weighted capitation disadvantages practices serving the areas with the highest levels of deprivation
  - (iii) seeks additional funding to specifically mitigate against the increased healthcare risks demands and needs of deprived communities.
- 30a NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes to genuinely address health inequalities, solutions must be decided upon, funded and delivered at neighbourhood level.
- 30b WORCESTERSHIRE: That conference believes that significant investment into core general practice will be required in order for practices to recover from the impact of the pandemic and the delivery of the COVID-19 vaccination programme and insists that no additional work without additional resource must be expected during this time of recovery.
- 30c BRADFORD AND AIREDALE: That conference is deeply concerned about widening social and health inequalities and argues for GP funding to reflect the degree of deprivation in local populations.
- 30d NOTTINGHAMSHIRE: That conference recognises that the pandemic has put health inequalities in sharp focus and moves to push for reappraisal of the Carr-Hill formula as well as dedicated budgets outside of core GMS for closing the gap in equality for patients.

## CLOSING BUSINESS

15.20

# Conference of Representatives of Local Medical Committees

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

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

### **A and AR Motions**

LMCs every year send very many topical and relevant motions to conference which for reasons of space cannot be included. While every LMC can submit its unreached motions to the GPC for consideration, few do so. 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.

#### **THE COVID-19 PANDEMIC - EXPERIENCES GAINED AND LESSONS LEARNT**

- |          |           |   |
|----------|-----------|---|
| <b>A</b> | <b>31</b> | SCOTTISH CONFERENCE OF LMCs: That conference believes that the response to the global pandemic by GP practices has demonstrated the vital importance of general practice to the NHS and wider society and applauds the extraordinary efforts of GPs and practice staff who have continued to provide a vital health service to patients over the course of the pandemic.  |
| <b>A</b> | <b>32</b> | AYRSHIRE AND ARRAN: That conference recognises the tremendous and overwhelming contribution that primary care teams across the four nations have made in response to the pandemic.  |
| <b>A</b> | <b>33</b> | GLASGOW: That conference believes that the response to the global pandemic by GP practices has demonstrated the vital importance of general practice to the NHS and wider society.  |
| <b>A</b> | <b>34</b> | GLASGOW: That conference applauds the extraordinary efforts of GPs and practice staff who have continued to provide a vital health service to patients over the course of the pandemic.   |
| <b>A</b> | <b>35</b> | GLASGOW: That conference supports the Covid Community Pathway that has enabled GPs to provide medical services to the population whilst minimising the risks of exposure to COVID-19.   |
| <b>A</b> | <b>36</b> | LEEDS: That conference thanks the general practice workforce for all that they have done, and continue to do, to care for their patients throughout the COVID-19 pandemic.  |
| <b>A</b> | <b>37</b> | NOTTINGHAMSHIRE: That conference recognises the unprecedented burden placed upon senior leaders and colleagues during the pandemic and thanks them for their devotion to duty.  |
| <b>A</b> | <b>38</b> | GLASGOW: That conference is grateful to our colleagues in LMCs who have worked hard over the pandemic to ensure that GPs and practices are represented in the planning and implementation of the COVID-19 response.   |
| <b>A</b> | <b>39</b> | AVON: That conference would like to congratulate the entire GP profession and its leadership for the extraordinary achievement seen across all four nations, with both the COVID-19 response and the COVID vaccination programme.   |
| <b>A</b> | <b>40</b> | GREENWICH: That conference:<br>(i) recognises the amazing, effective response of general practice to the COVID-19 challenge<br>(ii) urges GPC to do whatever it can to ensure funding for general practices remains protected in order to enable general practice to deal with the significant challenges ahead as patients present with poorly managed chronic disease; and<br>(iii) urges GPC to ensure that that any additional funding is prioritised to general practice to manage the fall-out of the pandemic. |

- A 41 CAMBRIDGESHIRE: That conference believes the future of general practice will look very different across the UK in the next decade foreseeing GPs being the ‘consultants of the community’ with much less traditional face-to-face surgery work, and more senior clinical oversight of the wider primary care team, and:
- (i) commends to the profession to start changing practice organisational governance to reflect the way primary care is to be commissioned
  - (ii) calls upon GPDF to work with GPC UK in publishing a solutions paper into the UK wide GP workforce shortage / workload burden to postulate how practices may respond to the unresourced workload shift resulting from NHS COVID-19 restoration and recovery
  - (iii) recognises and applauds the speed with which general practice moved to remote consulting at the start of the pandemic, but calls on GPC to ensure that the various UK governments are aware of the limitations of remote consulting, and that consulting in person remains a vital part of effective and safe patient care
  - (iv) calls on the BMA’s GPC to run a visible, powerful four nation information campaign to promote access to general practice services on the basis of need rather than want, especially considering the needs of digitally disenfranchised patients.
- A 42 GLASGOW: That conference is concerned about the mental health burden on the population over the pandemic and calls for:
- (i) improved access to mental health support workers in practices
  - (ii) self-referral pathways for patients who need supportive counselling.
- A 43 SCOTTISH CONFERENCE OF LMCs: That conference is concerned about the mental health burden on the population over the pandemic and that this is putting significant additional pressure on general practice, and calls for:
- (i) improved access to mental health support workers in practice
  - (ii) self-referral pathways for patients who need supportive counselling.
- A 44 WAKEFIELD: That conference feels that the inadequacy of PPE during the pandemic put the lives of health care workers at risk and demands that occupational safety standards for GPs and their staff are comparable with those in other industries.
- A 45 NORFOLK AND WAVENEY: That conference asks GPC to determine the minimum amount of appointments a practice should be required to offer per day/week. Both emergency and routine (per thousand patients) in order to determine a satisfactory and safe working environment especially as online access has opened up unlimited demand for GP services.

## GP APPRAISAL AND REVALIDATION

- A 46 DYFED POWYS: That conference is appalled at the lack of reasonable adjustments to the appraisal and revalidation process for neuro-diverse GPs and calls on all GPCs to:
- (i) negotiate reasonable adjustments be made to the appraisal and revalidation process across all four devolved nations
  - (ii) demands that the onus should rest on the regulatory bodies to proactively offer an assessment for reasonable adjustments to all GPs with these conditions in accordance with the Equality Act 2010.

## CREATING AND MAINTAINING A WORKFORCE FIT FOR THE FUTURE

### GP Partnerships

- A 47 NORTHAMPTONSHIRE: That conference believes that GP partnerships should be made more attractive to account for the stress and effort that is put into running a successful business.

- A 48 NORFOLK AND WAVENEY: That conference requests that more is done to promote and support GP partnerships to all GPs and trainees, noting the background rising hostility against GPs in the media due to disinformation.
- A 49 SOUTH STAFFORDSHIRE: That conference believes it is unacceptable to push through changes in the structure of the NHS in the midst of a pandemic and that in all of these changes the independent voice of primary care and the successful partnership model must be maintained.
- GP training - differential attainment**
- A 50 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.
- A 51 SCOTTISH CONFERENCE OF LMCs: That conference is concerned that there are reports from GPs and practice staff of increasingly rude and uncivil behaviour from patients which puts additional pressure on GP practices and:
- (i) wishes to send a public message that this is not acceptable
  - (ii) supports a zero-tolerance policy in GP practices
  - (iii) is worried that unrealistic expectations are partly fueled by political messages.
- A 52 GLASGOW: That conference is concerned that there are reports from GPs and practice staff of increasingly rude and uncivil behaviour from patients which puts addition pressure on GP practices and:
- (i) wishes to send a public message that this is not acceptable
  - (ii) supports a zero tolerance policy in practices
  - (iii) is worried that unrealistic expectations is partly fueled by political messages.
- A 53 GLASGOW: That conference congratulates the BMA on reaching agreement with the Scottish Government on Death in Service benefit which addresses the inequity faced by GP locums.
- A 54 AYRSHIRE AND ARRAN: That conference believes that primary care leadership positions should be fully recognised and contractually supported inclusive of leadership and clinical work, and with adequate protection for leadership training and skill development.
- A 55 AYRSHIRE AND ARRAN: That conference champions the importance of NHS staff wellbeing and demands:
- (i) exemplary health and well-being practices and culture throughout the NHS
  - (ii) that these practices are demonstrated from the top of the organisation down to lead by example.
- A 56 LOTHIAN: That conference calls upon the BMA to lobby all four nations foundations schools to ensure that all two year foundation programmes contain one hospital based medical post and one community based general practice post.
- A 57 WANDSWORTH: That conference welcomes the work that the BMA has done over recent years to support sessional and locum GPs by producing model contracts and terms and conditions and calls upon the GPC to build upon this work by continuing to highlight the need for fair contractual conditions to be adopted consistently.

- A 58 GLOUCESTERSHIRE: That conference believes that further help is needed for international medical graduates qualifying as GPs by the NHS, in relation to:
- (i) early identification and support for such individuals that require tier 2 sponsorship to work in the UK as a GP
  - (ii) supporting practices fully to become sponsoring practices thereby aiding recruitment and retention of GPs at a time when we cannot afford to lose valuable colleagues.

## GDPR AND DIGITAL SERVICES

- A 59 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires that all documents as listed below (or their equivalents) can be created electronically from all UK GP clinical systems and transferred electronically regardless of the UK country of origin or receipt:
- (i) Med3 (Statement of Fitness for Work)
  - (ii) cremation forms
  - (iii) medical certificate of cause of death
  - (iv) UC113
  - (v) DS1500.
- A 60 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that the UK Governments specify that Subject Access Requests are limited only to be used for the singular purpose as defined by Recital 63 of the preamble of the General Data Protection Regulations, that they are “in order to be aware of, and verify, the lawfulness of the processing” and that access for any other reason is chargeable.
- A 61 BEDFORDSHIRE: That conference calls on GPC to negotiate an item of service fee for each Subject Access Request rather than this being a single amount bundled into Global Sum.
- A 62 DEVON: That conference notes that in a year of unprecedented strains on an already overburdened GP workforce there is concern with the increasing workload created by requests for ‘Subject Access Requests’. This practice is becoming increasingly common as a tactic made by legal professionals to avoid paying for medical reports. The unreasonable time frames, the burden of processing the request on administrative staff and the clinical input needed to check and redact reports is significant, without an option to politely decline the work nor to receive remuneration for it in times of workload crisis. Conference acknowledges the important role GPs play in supporting their patients who may be struggling with legal issues but feel as a sector overall primary care is disproportionately affected by SARs under GDPR legislation and request that a central solution be found.

## REGULATION AND UK PROFESSIONAL ISSUES

- A 63 CAMBRIDGESHIRE: That conference calls for GPC UK to push for parity with other health and care partners across the UK in working with governments and other LNCs to commission an occupational health service for general practitioners, their practice teams, and other primary care partners.
- A 64 NORTHAMPTONSHIRE: That conference insists that the regulations should always make provision for GP representation through the elected LMC of their choice.
- A 65 WELSH CONFERENCE OF LMCs: That conference calls for commitment and significant investment from Welsh Government to promote placement of medical students in primary care with sufficient remuneration to practices to ensure that there is a succession plan for the future of care in community.

## PREMISES

- A 66 LEEDS: That conference believes that the requirement to invest in and improve GP premises should be a national priority and calls on the UK Government to commit significant additional and recurrent funding for GP premises development in the next spending review.

- A 67 NORFOLK AND WAVENEY: That conference urges GPC to enable premises and facilities expansion to accommodate new clinical roles within practice networks as the current situation is leading to inequity of provision and access between practices.
- A 68 HERTFORDSHIRE: That conference believes that the pandemic has highlighted a need for premises to be upgraded to meet higher infection control measures and calls on GPC to ensure that funding is available to do this that in a way that does not put undue financial, time and bureaucratic pressures on GP partners.
- A 69 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.

## GENERAL PRACTICE PAY AND CONDITIONS

- A 70 MANCHESTER: That conference notes that the DWP (or its agents) have stopped including fees claim forms with requests for PIP Factual Reports to the financial detriment of general practice. We request that the:
- (i) GPC publicises widely that a fee is payable for this work and it should be claimed, and
  - (ii) DWP ensures that payment is made for each PIP Factual Report completed and invoiced.
- A 71 LANCASHIRE COASTAL: That conference believes that any reorganisation of the NHS must ensure, as a basic principle, that primary care funding is ring fenced.

## MANAGING FUTURE DEMAND

- A 72 BUCKINGHAMSHIRE: That conference notes the lack of robust clinical systems in place to provide care for transgender patients and:
- (i) believes it is inappropriate and unsafe for specialist tertiary centres to demand GPs take on prescribing and monitoring responsibilities outside their sphere of expertise
  - (ii) notes the unfair position patients are placed in by lack of any such robust systems
  - (iii) calls on GPC to urgently work with all stakeholders to put systems in place which ensure clinical responsibility lies with the specialist and not with the GP
  - (iv) calls for properly resourced specialist services to be commissioned to provide the appropriate standard of care that this important group of patients' needs.
- A 73 HERTFORDSHIRE: That conference notes that good medical practice places a duty on doctors to take action where patients are at risk because of inadequate resources, policies or systems. The lack of appropriate services for patients with gender incongruence is deplorable and calls on GPC to demand that commissioners:
- (i) recognise this gap in commissioning
  - (ii) accept their responsibility to commission services
  - (iii) commission appropriate services
  - (iv) support GPs not to undertake work where they feel unsafe and unsupported.
- A 74 NORTHAMPTONSHIRE: That conference believes that general practice should not have to offer specialist services like gender reassignment due to the lack of local secondary services.
- A 75 WELSH CONFERENCE OF LMCs: That conference recognises that there is an unacceptable shortage of medicines in the UK and urges the government to enable community pharmacists to be able to provide an equivalent alternative so as to reduce its impact on the workload in primary care.
- A 76 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference deplores the unnecessary and increasing amounts of detrimental bureaucracy facing GPs which are not in the interests of the patient or the doctor and urges for immediate action to eliminate this.
- A 77 NOTTINGHAMSHIRE: That conference realises that Brexit and logistics issues have led to many drugs being in short supply, requiring GPs to urgently substitute drugs on numerous occasions. We wish for



it to be adopted as policy that pharmacists to be enabled to substitute medications when shortages occur lifting another unnecessary burden from general practice.

- A**      **78**      HERTFORDSHIRE: That conference calls on GPC to take appropriate steps to ensure that secondary care colleagues are required to start using electronic prescribing rather than passing on their work to GPs.
- A**      **79**      HERTFORDSHIRE: That conference calls on GPC to ensure minimum standards are set for hospital clinical information systems which must include a requirement to:
- (i)          be able to integrate with primary care
  - (ii)        enable the use of electronic prescribing.
- AR**      **80**      CAMBRIDGESHIRE: That conference acknowledges the pressures that our ambulance trust colleagues are working under, but notes with concern both the fact that patients in the company of a GP will not be prioritised, and the unsafe conditions for GPs finding themselves waiting until an ambulance arrives, and calls upon GPC UK to work with governments to address these issues and to cease mandating the use of the NEWS2 triaging tool on emergency patients based in primary care environment.

## **PENSIONS**

- A**      **81**      AYRSHIRE AND ARRAN: That conference, in relation to pensions:
- (i)          recognises that annual and lifetime allowances are not appropriate to GP earnings
  - (ii)        demands a change to the current annual allowance and lifetime allowance of pension provisions as they currently discriminate against more senior and full-time GPs.

## **Agenda: Part II**

### **(Motions not prioritised for debate)**

#### **THE COVID-19 PANDEMIC - EXPERIENCES GAINED AND LESSONS LEARNT**

- 82 SOMERSET: That conference considering the Coronavirus Act 2020 provisions on issuing a Medical Certificate of Cause of Death, urges that:
- (i) 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) 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.
- 83 HERTFORDSHIRE: That conference welcomes the changes that were introduced during the pandemic to facilitate the processes for death certification and cremation forms and calls on GPC to make sure these changes are made permanent.
- 84 DERBYSHIRE: That conference insists that proper emergency preparedness requires regular and proper exercising of plans rather than a simple tick box table top exercise lasting barely half a day and that LMCs must be fully involved in such exercises.
- 85 OXFORDSHIRE: That conference believes that it is unrealistic to expect that general practice will be able to operate as normal from April and calls on GPC to ensure that income protection for QOF should continue into the 2021 / 2022 financial year in order to enable practices to continue support the COVID-19 vaccination programme and continue to operate safely given ongoing pandemic restrictions.
- 86 LIVERPOOL: That conference believes that GPC must call for an enquiry as to why government failed to follow its own advice regarding preparing for a pandemic and therefore was woefully ill prepared for the pandemic to the extent that GP practices were supplied with, for example, inadequate, out of date PPE.
- 87 SCOTTISH CONFERENCE OF LMCs: That conference considers that the shielding workload that GPs were given at the start of the pandemic was:
- (i) immensely challenging
  - (ii) unfunded
  - (iii) in addition to GP workload that was heavy at the time
  - (iv) made more difficult because of constant rule changes.
- (Supported by Glasgow)
- 88 LIVERPOOL: That conference believes that there were systemic failings in the way in which the pandemic was handled and believes that GPC should have done more, earlier, to support general practice in meeting the needs of patients rather than the UK governments.
- 89 LIVERPOOL: That conference believes that the way in which the NHS has communicated with GPs and practices has been poor and insists that GPs should be advised of changes directly and not via reports appearing in the media first.
- 90 DERBYSHIRE: That the suite of general practice and primary care business continuity documents developed jointly by the GPC / RCGP / Departments of Health for pandemics in 2009 be updated urgently in the light of the lessons learned from COVID-19 and also devolution and that the GPCs initiate discussions to this end.
- 91 LEEDS: That conference is seriously concerned about the economic consequences of the COVID-19 pandemic, the impact of unemployment and on low paid workers, the need for benefit support and the

- widening of health inequalities and calls for UK Government funding to enable Citizens Advice or similar organisations to be linked to all practices in order to provide direct support to patients who need this.
- 92 NORFOLK AND WAVENEY: That conference believes that post-pandemic period will place greater challenges and dangers to society and the healthcare system through burn-out and challenges of health resources, patient and government expectations and staff retention than the effect of coronavirus during the pandemic. There therefore must be sufficient service and financial support to enable the NHS to manage this appropriately.
  - 93 NORFOLK AND WAVENEY: That conference recognises that the COVID-19 pandemic will have lasting consequences both on the mental health and treating and managing Long Covid syndrome and requests that GPC negotiates adequate resources for general practice to look after these particular sequelae of the pandemic.
  - 94 MANCHESTER: That conference agrees that governments and their health departments should ensure that every household is equipped with the means to measure body temperature and understands that a hand is not reliable for the purpose of confirming presence of fever.
  - 95 LIVERPOOL: That conference believes that whilst the move to a 'control and command' situation may have been necessary at the beginning of the pandemic, devolving planning to local systems has to be the more effective means of managing health care in successive waves of the pandemic.
  - 96 SOMERSET: That conference, in the light of recent events, disagrees with the dictum that "scientists should be on tap, but not on top" when it comes to making political decisions on public health.
  - 97 DORSET: That conference believes that all NHS workers should receive a form of official recognition from government for their efforts in responding to the COVID-19 pandemic, eg along the lines of military personal getting specific awards for active service and mindful that troops are usually rotated so that they have a defined period within active theatre before withdrawal for R&R.
  - 98 GLOUCESTERSHIRE: That conference believes that the COVID-19 pandemic has exposed that the UK is too small and the population too similar to justify four different health systems working in slightly different ways and requests a return to one CMO and one United Kingdom healthcare system for the UK.
  - 99 NORTHERN IRELAND SOUTHERN: That conference instructs UK government to ensure that access to healthcare and to medications remains equitable in all four nations post Brexit. The health of our citizens is more important than a politically driven protocol and it is incumbent on our politicians to deliver and to guarantee this.
  - 100 AYRSHIRE AND ARRAN: That conference believes that the inability to agree a UK approach to the long-term funding of social care in the face of huge demographic challenges is a failure of governmental policy and calls for this to be addressed urgently.
  - 101 NEWCASTLE AND NORTH TYNESIDE: That conference notes with suspicion the UK government's claims for the future reducing of outsourcing within the NHS are undermined by the large shifts of taxpayers' money to the private sector during the COVID-19 pandemic.
  - 102 NORFOLK AND WAVENEY: That conference believes that GPs should be recognised as expert generalists involved in the whole care of their patients in comparison with hospital colleagues who are increasing expert sub-speciality specialists. This recognition, however, requires government to invest adequately in wide-spread and accessible diagnostic services which will reduce involvement of secondary care in the longer term.
  - 103 DERBYSHIRE: Patients with no right to NHS provision of care still need seeing in primary care. We ask the GPC to seek a national position on this that is not simply, 'make them a temporary resident'.
  - 104 DERBYSHIRE: That a comprehensive recovery and normalisation support package for GP practices and their staff be developed to include:

- (i) financial support
  - (ii) wellbeing support
  - (iii) workload support
  - (iv) reduced administrative, bureaucratic and regulatory burdens and that GPCs negotiate accordingly.
- 105 DERBYSHIRE: That
- (i) to defend GPs from criticism and complaints from patients with conditions awaiting elective interventions
  - (ii) to preserve the principle of treatment in order of CLINICAL priority the GPCs together with the Royal Colleges develop re-triage guidelines for patients who face very prolonged waiting list times.
- 106 DERBYSHIRE: That conference maintains that the UK response to COVID-19 has been hampered by the 30 year old policies of:
- (i) an empty bed is an idle bed wasting resources and must therefore be closed
  - (ii) sweating NHS assets including its most precious asset – its staff
  - (iii) inadequate minimalist specification GP practice premises and that future government policy must recognise that spare beds, a degree of overstaffing and GP premises designed for one way patient flows are the capacity which allows a healthcare system to meet the natural peaks and troughs of infectious and other disease incidence.
- 107 SOMERSET: That conference believes that the phrase an “all you can eat buffet” is as unrealistic, as disingenuous and as unhealthy as a metaphor for what the public can expect from the NHS as it is in real life.
- 108 SOMERSET: That conference believes that healthcare professionals in general practice have a greater responsibility to the patient in front of them than to the wider community when it comes to the rationing of NHS services.
- 109 DERBYSHIRE: That conference notes that during the pandemic without the burdens of:
- (i) CQC interference and inspections
  - (ii) overbearing micro-management
  - (iii) administrative returns of dubious value
  - (iv) bureaucratic appraisal systems that high levels of clinical service have been delivered with professionalism and competence by GPs and conference rejects any substantial return of such burdens instructing the GPCs to negotiate accordingly.
- 110 DERBYSHIRE: That in respect of infectious disease pandemics and control, whilst respecting home nation autonomy of healthcare delivery, infectious disease policy, doctrine, strategy and tactics must be UK based and UK led to both maximise swift success and to gain public support and avoid confusion.
- 111 SUTTON: That conference is concerned that what was set out as an engagement document with the deadline on January 8 for responses, despite being in the midst of the COVID-19 pandemic and vaccine roll out underway at speed across the UK, has had no feedback on concerns raised. The conference asks GPC to ensure that:
- (i) the voice of GP is not diluted and that it is mandatory to have GP provider representation within the ICS structure
  - (ii) the partnership model of GP and independent contractor status is protected
  - (iii) any organisational model is operated by NHS and accountable bodies free from competition and privatisation
  - (iv) primary care service commissioning should not be delegated or transferred to ICS bodies
  - (v) steps in the transition process are discussed with GP representatives and in a timely manner to enable robust discussion.
- 112 WANDSWORTH: That conference deplores the national announcements made by the government during the COVID-19 pandemic about initiatives to be supported by GPs without GPs having been informed prior to the announcements being made.

- 113 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.
- 114 SOUTH STAFFORDSHIRE: That conference believes that CQC should follow the trend set by the recalibration of appraisal by becoming more supportive and empathetic in order to relieve the burden on hard-pressed GPs thus improving recruitment and retention.
- 115 DEVON: That conference abhors the postcode lottery created during the pandemic by some local councils and CCGs agreeing to protect funding for practices while others were not so forthcoming, and welcomes the opportunities gained by the nationally negotiated financial protections to reconsider how we negotiate and safeguard our profession in future. Conference asks that GPC and the BMA work jointly to help all LMCs draft national emergency" clauses to be added to all locally negotiated enhanced services in future such that no community will be left trying to justify the need to continue to fund practices while dealing with an emergency like the pandemic.
- 116 SEFTON: That conference calls upon the Secretary of State to pause the implementation of the intended re-organisation of the NHS in England in recognition that:
- (i) health professionals in hospitals and general practice are entirely focussed on the exigencies of fighting the COVID-19 pandemic and will not be able to contend with such organisational change for the foreseeable future
  - (ii) the catch up needed in treatment and care delayed because of the pandemic must be the priority for the NHS in the period following it.
- 117 AVON: That conference instructs GPC to ensure that NHSE reviews the best options for strengthening primary care as ICP success will depend greatly on primary care delivery and greater engagement with community care.
- 118 AVON: That conference instructs GPC to make representations to the government setting out the fact that the proposed new NHS reforms have not been introduced in a democratic and proper way. The government has announced major NHS reforms during the English lockdown. The consultation period was brief and again occurred during lockdown when the NHS and GPs were working to provide core medical services during the COVID-19 pandemic together with GP practices being involved in the mass vaccination programme.
- 119 AVON: That conference understands that the new NHS reforms involve an extension of the role of integrated care systems and involve the devolution of a greater share of primary care funding with increased resourcing to integrated care systems. Specifically mentioned are:
- (i) primary care providers working with a wide variety of other services with delegated budgets
  - (ii) finances to be increasingly organised at integrated care systems level
  - (iii) combining current CCG budgets, primary care budgets, specialised commissioning spends, central support or sustainability funding and nationally held transformation funding
  - (iv) current CCG functions being incorporated into integrated care systems.
- 120 TOWER HAMLETS: That conference:
- (i) notes the disintegration and fragmentation of care in the NHS
  - (ii) believes that merging of CCGs, underfunding, shortage of staff and COVID-19 have added intolerable pressure to a system already under strain
  - (iii) does not believe that integrated care systems will improve patient care
  - (iv) calls on the GPC to demand a National health service not one broken into small parts.
- 121 WIGAN: That conference recognises that one of the important lessons to be learned from the new ways of working occasioned by the pandemic is that the burden of CQC inspection can be substantially reduced

without loss of rigour in maintaining standards. It calls upon GPC to secure with the CQC the permanent adoption of a remote triage approach.

## **GENERAL PRACTICE IN A POST-COVID-19 WORLD - LESSONS LEARNT FROM PANDEMIC AND VACCINATIONS**

- 122 BRO TAF: That conference deplores the four UK governments' handling of the Pfizer COVID-19 vaccination programme by changing the schedule without any published data beyond six weeks and ask GPC to strongly support the BMA stance in challenging the adoption of the JCVI guidance on vaccine spacing.
- 123 SOUTH STAFFORDSHIRE: That conference believes that the current lower uptake of the COVID-19 vaccination amongst certain population groups, like the BAME population for example, requires a pro-active approach with financial incentives, better communication and a national drive to improve.
- 124 EALING, HAMMERSMITH AND HOUNSLOW: That conference regrets that by prioritising patients by age, the COVID-19 vaccination programme may have exacerbated the inverse care law and calls upon government to ensure that renewed efforts are taken to address the wider determinants of health and health inequalities across society.  
(Supported by Kensington, Chelsea and Westminster, Brent, Harrow and Hillingdon)
- 125 HULL AND EAST YORKSHIRE: 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.
- 126 NORTH STAFFORDSHIRE: That conference asks the GPC Executive to make the COVID-19 vaccination compulsory for all healthcare workers (when not contraindicated), for their own safety and that of other staff and for the safety of patients. There is a conflict between personal autonomy and wider safety that is unbalanced and unjustified. This should be a professional probity issue.
- 127 DORSET: That conference is saddened that the UK has lost its WHO 'measles-free' status and calls for immediate action to counteract the false news spread by anti-vaxxers and re-establish levels sufficient to provide herd immunity.
- 128 NOTTINGHAMSHIRE: That conference prepares itself for potential future vaccination campaigns either for new strains/booster campaigns and requests that all prison and secure environment workers get greater priority in future mass vaccination campaigns.
- 129 LAMBETH: That conference demands:
- (i) COVID-19 vaccine should be available without needing an NHS number
  - (ii) public facing workers who have the highest rates of death from COVID-19 should be prioritised for vaccination
  - (iii) GPC Executive lobby government to ensure that COVID-19 vaccine is available to the global poor as well as to the global rich.
- 130 TOWER HAMLETS: That conference believes that to mount effective resistance to COVID-19 that access to COVID-19 vaccine must be equitable. Conference demands:
- (i) COVID-19 vaccine should be available without needing an NHS number
  - (ii) public facing workers who have the highest rates of death from COVID-19 should be prioritised for vaccination
  - (iii) GPC Executive lobby government to ensure that COVID-19 vaccine is available to the global poor as well as to the global rich.
- 131 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that GPC has once again let us down by not negotiating the terms of delivery and funding for COVID-19 vaccination programme:
- (i) GPC undervalued primary care time and again whether its flu programme or CVP
  - (ii) primary care is bullied into agreeing term of politicians
  - (iii) always end up being scape goat for any failures

- 132 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that GPC should negotiate or influence NHS England to move from Push to Pull model for COVID-19 vaccination programme.
- 133 LIVERPOOL: That conference believes that now is the time to review the process for ordering flu vaccine from individual practice ordering to a central procurement method and instructs GPC to evaluate the benefits of changing the process.
- 134 KENT: That conference notes the present Covid Vaccinations Enhanced Service and:
- (i) demands an amendment that allows individual practices to receive only the AstraZeneca vaccine
  - (ii) condemns the discrimination between GP surgeries and other providers that prioritised them for the AstraZeneca vaccine and visibility on the National Booking System
  - (iii) condemns it for setting up GPs to fail.
- 135 KENT: That conference notes the supplement paid for vaccinating housebound patients under the COVID-19 vaccination programme and demands that the GPC negotiate the same level of funding to support vaccination of housebound flu patients within the seasonal influenza and pneumococcal DES.
- 136 SOMERSET: That conference believes the annual ritual of practices being pressurised to gamble on ordering influenza vaccine supplies, often before a decision has been taken on brand reimbursement:
- (i) is inefficient and outdated
  - (ii) that a central supply system where the government purchases vaccines and reimburses practices for administration should be introduced and,
  - (iii) the item of service fee should be raised to account for the loss of practice income that this change would incur.
- 137 OXFORDSHIRE: That conference condemns the inequitable deal that general practice has been given regarding the COVID-19 vaccination programme and believes that mass vaccination centres, pharmacy vaccination centres and other vaccination providers should have the same contractual obligations and total funding envelope as GP vaccination sites when it comes to delivering COVID-19 vaccines.
- 138 NORTH STAFFORDSHIRE: That conference recommends that:
- (i) the GPC Executive negotiates to ensure that COVID-19 vaccination work by other providers should not be cherry picked or manipulated and
  - (ii) that the 20% extra work involved in providing the Pfizer vaccine (largely delegated to PCNs and practices due to its complexity) compared to the AstraZeneca vaccine is recognised in fair payments.
- 139 NOTTINGHAMSHIRE: That conference recognises that the offer of the COVID-19 vaccination has polarised views in parts of society. Despite changing the V&I QOF we will still be penalised by vaccine refusers and we ask for these patients to be removed from the denominator for payment purposes, so we are not penalised for their refusal.
- 140 LAMBETH: That conference:
- (i) deplores the attempts by NHSE and CCGs to micro manage the roll out of the coronavirus vaccinations
  - (ii) insists that GPC in future negotiate specifications which give GPs more freedom.
- 141 LEWISHAM: That conference notes that the pandemic and the vaccination programme has highlighted health inequality in the BAME population and calls upon all STPs to work with communities to develop deliverable strategies to eliminate health inequality.
- 142 LEWISHAM: That conference:
- (i) agrees that the last year has demonstrated the ability of general practice to rapidly and safely develop to meet a new and challenging scenario at both practice level and across a population and the successful roll out of the vaccine programme demonstrates its ability to work effectively at scale
  - (ii) agrees that in order for an ICS to effectively deliver change all partner need to be appropriately represented, and

- (iii) insists that ICSs do not determine that representation but ask general practice across the ICS footprint to determine how best it is represented.
- 143 EALING, HAMMERSMITH AND HOUNSLOW: That conference acknowledges that the successful roll out of the COVID-19 vaccination programme could not have been achieved without the hard work and personal sacrifices of GPs and their practice staff, and calls upon the GPC to ensure that the value of general practice is reflected in the outcomes of forthcoming NHS reform.  
(Supported by Kensington, Chelsea & Westminster, Brent, Harrow, Hillingdon)
- 144 NORTHUMBERLAND: Involvement of community pharmacy in the COVID-19 vaccination programme has been significantly hindered by red tape and inflexible criteria imposed centrally. Conference calls for the promised 'easing of bureaucracy', and a pragmatic approach to allow PCNs and pharmacies to work together effectively.

## GP APPRAISAL AND REVALIDATION

- 145 SANDWELL: That conference mandates that the GPC commission an independent review of the appraisal system for general practitioners to determine if it has brought any objective or measurable benefit to general practice in the last 15 years.
- 146 LIVERPOOL: That conference believes that with the recent need to vary arrangements for appraisal on account of the COVID-19 pandemic, GPC must:
  - (i) call for a suspension of appraisals
  - (ii) undertake a full evaluation of the appraisal system to determine whether it should be continued or replaced with a system that is more fit for purpose.
- 147 KERNOW: That conference is asked to support a change in emphasis for GP appraisal away from being summative and regulatory. Conference demands that the NHS starts to look after its GP workforce and funds an obligatory annual physical and mental health review through a stand-alone service that is entirely supportive and confidential.

## CREATING AND MAINTAINING A WORKFORCE FIT FOR THE FUTURE

### GP partnerships

- 148 NORTH STAFFORDSHIRE: That conference instructs the GPC to explore the best future contractual options to safeguard partners from open ended current partnership obligations. These include open liabilities, last man standing and lease requirements. This may take some of the form of LLPs or LLCs.
- 149 NOTTINGHAMSHIRE: That conference continues to lead the conversations with the government on commissioning reforms in the integrated agenda recognising the partnership model as the bedrock of general practice. The pace of change needed to enable the COVID-19 vaccination programme is arguably greatly helped by an independent contractor workforce leading the efforts.
- 150 GRAMPIAN: That conference recognises the additional workload for GP practices from post Brexit sponsorship of non UK graduates for their skilled worker visa (previously tier 2 visa) and calls on relevant agencies to lobby the government to make sponsorship of these doctors a health board responsibility.
- 151 BEDFORDSHIRE: That conference calls on GPC to ask that the governments of the UK 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.
- 152 SOMERSET: That conference, holding that employing practices know best what training is needed by their Allied Health Professional employees, and that although guidelines, aspirational roadmaps etc from other



- agencies are useful and well-intentioned, demands that they should never supersede locally agreed requirements.
- 153 DORSET: That conference is appalled at attempts to corral locum GPs into “flexible pools”, thus imposing terms and conditions, pay and a loss of autonomy. We ask for GPC to ensure that this is a collaborative process, with sessional GPs recognised and protected as independent contractors.  
(Supported by Sessional GPs Committee)
- 154 AYRSHIRE AND ARRAN: That conference:
- (i) recognises the significant adaptation in the role of primary care over the last decade
  - (ii) recognises the risk of deskilling of the primary care medical workforce with the expansion of the primary care team
  - (iii) demands ongoing protected training time for established GPs to develop and maintain the skills needed for their new role.
- 155 HERTFORDSHIRE: That conference instructs GPC 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.
- 156 BEDFORDSHIRE: That conference calls on GPC to work with the governments of the UK to see how general practice can be helped to increase education capacity in primary care in order to improve UK self-sufficiency.
- 157 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.
- 158 WORCESTERSHIRE: That conference is concerned by the apparent lack of vacancies for newly qualified GPs whose roles seem to have been replaced by ARRS staff and retired GPs returning to work to support the pandemic effort and believes that initiatives to support their employment must be urgently put in place.
- 159 WORCESTERSHIRE: That conference believes that practices who have GPs taking part in the GP Fellowship scheme must have full backfilled funding to allow them to be released for training in order for the scheme to achieve its objectives.
- 160 DERBYSHIRE: General practice is facing an existential crisis and an exodus of staff following the COVID-19 pandemic. Conference calls upon GPC to address this by negotiating and agreeing the following with NHSE:
- (i) a five year commitment to invest in GP resilience and retention
  - (ii) ensure no reintroduction of the red tape that we have been freed from
  - (iii) keep appraisal high trust low evidence
  - (iv) enable flex in the GP contract to allow ARRS money to be used to fund GPs
  - (v) cull extended hours and recycle the funding into the core contract.
- 161 DORSET: That conference acknowledges the economic and professional impact COVID-19 has had on locum GPs and calls for GPC to work with NHSE to:
- (i) prioritise locums for work
  - (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.
- 162 SANDWELL: Conference requests that the GPC negotiate with NHSE to establish a recruitment and training program for general practice nurses with sufficient resources and places to address the chronic shortage of GPNs.
- 163 HIGHLAND: That conference welcomes the NHS Highland Healing Process and:
- (i) offers its sincere thanks to the Cabinet Secretary for Health and Sport for the personal interest she took in supporting the victims of bullying

- (ii) is pleased that affected GPs and other NHS workers now have a route to a personalised apology, psychological therapy and an independent review panel
  - (iii) is deeply concerned that NHS Highland's 2020 survey of staff in Argyll & Bute, recommended by John Sturrock QC, has identified further bullying
  - (iv) seeks ongoing assistance from government to support vital cultural change.
- 164 LAMBETH: That conference recognises that ARRS budgets to London PCNs have effectively been cut by 20% and additional funding should be made available to fund the high cost of living supplement in order to make the funding equitable.
- 165 CITY AND HACKNEY: That conference welcomes the change in ARRS funding to enable payment of high cost of living supplement but requires further negotiation to provide additional funding to enable this in the long term without reducing the workforce available to high cost areas compared to other parts of England.
- 166 NEWHAM: That conference, with regard to additional roles reimbursement scheme:
- (i) believes they have so far done little to reduce primary care workload
  - (ii) recognise the recruitment, necessary training and supervision has actually increased workload
  - (iii) asks for a nationally recognised, standardised, minimum training pathway for all clinical roles.
- 167 WIGAN: That conference is aware from authoritative sources that numbers of general practice staff are increasing save for GPs the successful increase in GP numbers must involve staunching the rate of outflow of GPs to premature retirement. It calls on the GPC to explore with the NHSE&I and treasury a substantial financial 'commitment' award scheme which is exempt from the annual and lifetime allowance calculation and the counterproductive taxation arrangements which apply to both.

## DIGITAL TECHNOLOGY AND DATA

- 168 NORFOLK AND WAVENEY: That conference believes that increased use of technology should be employed to reduce the current workload rather than creating more demand.
- 169 DERBYSHIRE: That conference seeks to establish new mechanisms for LMCs to both communicate clearly with GPC and receive timely responses rather than relying on a list server which is not fit for purpose.
- 170 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 their best redress for concerns is a direct approach via a complaints procedure rather than the morale sapping negative Facebook or google review
- 171 MID MERSEY: That conference notes that some online services offer a review facility allowing the public to provide star ratings and reviews of GP practices, recognises that some reviews may be defamatory and cause significant reputational damage, and calls on GPC to take appropriate steps to hold such services to account for defamatory posts posted on their sites.

## GDPR AND DIGITAL SERVICES

- 172 BUCKINGHAMSHIRE: That conference asks GPC to investigate whether insurance companies and other private organisations are subverting the GDPR rules by instructing patients to raise Subject Access Requests as a means of obtaining patient information without charge and share any such evidence with the ICO.
- 173 DERBYSHIRE: That conference is incensed that in respect of NHS GP computer systems for spurious reasons attributed to 'IT Security':
- (i) minor IT glitches can no longer be addressed by GP staff resulting in serious detriment to patient services when they occur

- (ii) reasonable and normal routine internet access has been withdrawn hampering ordinary legitimate practice operation both administratively and clinically
  - (iii) GPs and their staff are being treated as untrustworthy by censorious IT managers acting in isolation and without an agreed mandate
- and that GPCs must negotiate to reverse these changes to provide a better working environment for staff and service to patients.
- 174 DERBYSHIRE: That the recently withdrawn administrator IT privileges afforded to practice staff be restored without delay in order to prevent serious dislocation of patient services occasioned by minor IT glitches and that the GPCs negotiate accordingly.
- 175 WORCESTERSHIRE: That conference believes that as access to patient records and data sharing spreads over an increasingly wide footprint general practice faces unprecedented risk and liability which is unsustainable for independent contractors.
- 176 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that following Brexit there must be no reduction in the protection of data as defined in the European General Data Protection Regulations and the Data Protection Act 2018.
- 177 LIVERPOOL: That conference believes that the rationalisation of GP computer systems to a limited number of accredited systems has resulted in GPs receiving a poor service from suppliers and insists that either current suppliers improve their services or GPC takes action to allow more accredited systems of choice.
- 178 HIGHLAND: That conference supports the use of open platforms for our digital health systems, including electronic health records, especially where this prevents the lock-in of data.
- 179 BEDFORDSHIRE: That conference:
- (i) believes that once a patient has died then the GP should no longer be the data controller for those notes and
  - (ii) calls on GPC to negotiate that any request for access to the notes of a dead patient should be passed to another appropriate person, eg the relevant Secretary of State or the provider of primary care support services.
- 180 WEST PENNINE: That conference believes that there are significant risks in sharing patient data under the COPI notice, as it is unlikely that the data will be returned or deleted when the COPI Notice expires. We do not know what errors there are and it is important for patients and / or their carers to also be able to responsibly see and understand their data as we live with and beyond COVID-19.
- 181 BEDFORDSHIRE: That conference calls on GPC to negotiate an item of service fee for the provision of online access for patients to their complete medical record rather than this being part of Global Sum.

## THE ROLE OF GPC AND LMCs

### The GPC

- 182 WELSH CONFERENCE OF LMCs: That conference does not see the purpose of a separately elected GPC UK in a country with four devolved health services and that pan-UK issues should be discussed and managed by representatives of the four national GPCs coming together not a separate and expensive body.
- 183 SURREY: That conference believes the interests of the profession would be better served by engaging a professional negotiating team, working with a remit set by GPC, than the current arrangements.

### The role of LMCs

- 184 SCOTTISH CONFERENCE OF LMCs: That conference believes that, in relation to LMC and GP subcommittee office bearers, the title 'medical secretary' is no longer fit for purpose and calls on SGPC, working with GPC UK as required, to agree an alternative title for this role.

- 185 WORCESTERSHIRE: That conference demands that NHSE include LMCs in its distribution lists and ensures that formal communication with general practice is not by means of WhatsApp messaging.
- 186 WORCESTERSHIRE: That conference insists that LMCs are recognised in formal documentation relating to Integrated Care Systems and demands that it be mandatory for LMCs to be represented on ICS boards in all areas.
- 187 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires the GPC to negotiate to ensure that LMCs are formally represented on ICS boards.
- 188 KENT: That conference notes the development of Integrated Care Systems and demands that:
- (i) LMCs must have a seat at board level
  - (ii) LMCs must be acknowledged as the only representatives of grass roots general practice.
- 189 LAMBETH: That conference requires GPC to:
- (i) negotiate mandatory representation of LMC to ICS and to place-based boards
  - (ii) reinforce the autonomy of the partnership, registered list model of GP through a ring-fence budget
  - (iii) place a statutory duty on ICS to manage conflicts of interest
  - (iv) establish a funding structure which enables the transfer of funding out of hospital to community care
  - (v) ensure that there are clear lines of governance and accountability in ICS including transparency in how contracts are awarded and monitored.

#### **The Annual Conference of LMCs**

- 190 NORTHUMBERLAND: The pace of change is now so great that today's concerns are frequently resolved and replaced by others within a few days. Submitting motions nearly 3 months in advance of the conference, albeit with limited flexibility through emergency motions, restricts conferences' ability to consider important current issues. This mode of debate is no longer fit for purpose and an urgent review standing orders is necessary.
- 191 MERTON: That conference, in recognition that UK LMCs have represented the voice of general practice in a statutory capacity for over a century, calls upon the government to recognise British general practice's fundamental role within the National Health Service by requiring the Secretary of State for Health to attend the annual UK Conference of LMCs, to make a presentation to the delegates and respond to questions.

## **GP CONTRACT NEGOTIATIONS**

- 192 WORCESTERSHIRE: That conference ensures that no future contracts are negotiated and agreed to by GPC that can be unilaterally varied.
- 193 KENT: That conference notes that individual practices are the fundamental building blocks of primary care and that this is prioritised in all contract negotiations.
- 194 SUTTON: That conference is concerned that senior NHS management and ministers are communicating via the media to GPs about changes to general practice services. The conference asks GPC to not condone this and formally inform senior NHS management that:
- (i) it is not acceptable to use the media to inform the profession about changes to service delivery in this manner
  - (ii) changes to service delivery should be communicated to GPs via the appropriate channels
  - (iii) social media should not be used to share such information
  - (iv) direct criticisms made about general practice via the media are wholly inappropriate and destroy any trust that GPs have with the NHS and DHSC leadership.
- 195 NEWCASTLE AND NORTH TYNESIDE: That conference believes that all governments included those of the devolved nations should show their commitment to the NHS by prioritising an increase in NHS funding (including a boost for primary care) and the workforce crisis.

- 196 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes primary care should be proportionally represented based on patient contacts in decision making bodies at neighbourhood, place and system levels.
- 197 NORFOLK AND WAVENEY: That conference asks GPC to negotiate the statutory meaningful representation of general practice on care systems in order to protect general practice and protect the independent contractor model.
- 198 KENT: That conference demands that the awarding of lead provider status affecting the provision of community and primary care services should:
- (i) not occur without LMC agreement
  - (ii) prioritise general practice before other providers.
- 199 BUCKINGHAMSHIRE: That conference notes a pattern of increasingly underhand techniques used by NHS bodies when negotiating with GPC. Conference demands an end to such practices and calls on GPC to stop rewarding such bad behaviour, and calls on GPC to:
- (i) (re)negotiate a code of behaviour with all NHS bodies to inform future major contractual negotiations
  - (ii) refuse on principle to agree to any contract that gives NHS bodies the right to make wholesale changes without GPC agreement
  - (iii) refuse to accept inferior contractual terms when there is recent evidence of better terms for similar projects being offered to private contractors.
- 200 SANDWELL: That conference wishes to inform the GPC that the profession does not feel that the crisis in general practice has been abated to any significant degree. Virtually none of the elements of “urgent prescription for general practice” have been implemented. Consequently, motion 20, passed at the special conference of Jan 2016, still mandates the GPC to act.
- 201 AVON: That conference mandates the GPC to express its opposition to these changes and to seek to amend them to give GPs a greater say in the new system. The system will move from one where:
- (i) GPs have a leading role, to one where GPs will be just one voice among many with the consequence of a significantly reduced role and influence
  - (ii) the funding for primary care will no longer be separate from the single pot which the leadership of the integrated care system will disburse as it sees fit.
- 202 CHESHIRE: That conference requests that the GPC negotiate to ensure that any growth of PCN manpower and resource is not at the expense of a practice based funding.
- 203 KENT: That conference notes the that the wording used in the January PCN ballot was not reflective of the motion passed and was a breach of conference good will, and demands:
- (i) the GPC acknowledges this
  - (ii) the GPC desists from its apparent bias towards the PCN model
  - (iii) a future ballot of the PCN DES will only allow GPs to vote.
- 204 KENT: That conference acknowledges the failure of the present GMS contract to sustain the profession and:
- (i) demands the negotiation of a co-payment model
  - (ii) believes the PCN DES has had a negative effect on workload.
- 205 KENT: That conference believes that the PCN DES should be abolished and demands that:
- (i) practices should be able to exit the PCN DES at any point and not suffer any financial penalties
  - (ii) GPC negotiates an exemption for VAT costs incurred under the PCN DES
  - (iii) PCN funding is diverted into the core contract.
- 206 NORTH STAFFORDSHIRE: That conference seeks the GPC executive to make NHSE/I agree for it to be mandatory to have LMC representation on the emerging ICS boards.
- 207 NORTH STAFFORDSHIRE: That conference asks the GPC Executive to negotiate the protection of all delegated and non-delegated budgets for general practice going forwards into ICSs and ICPs post 1.4.22.

- 208 AVON: That conference instructs the GPC to work with NHSE to ensure that the GP independent contractor model of care continues.
- 209 AVON: That conference calls for NHSE to work with the GPC 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.
- 210 WANDSWORTH: That conference:
- (i) commends the way general practice has played a crucial role as part of the system response to the pandemic
  - (ii) is concerned that despite its vital role in the response to the pandemic general practice has no formal representative role in the proposed new Integrated Care Systems.
- 211 AVON: That conference instructs the GPC to seek the necessary reassurance that as the new NHS reforms develop, the position of PCNs in the ICP structure is maintained and strengthened. PCNs are the cornerstone of general practice, which the DES supports.
- 212 CITY AND HACKNEY: That conference is concerned that the PCN DES results in a considerable amount of extra work and additional cost to practices without a significant reduction in clinicians workload and requires GPC to ensure that practices and their PCN are not held responsible for the delivery of service specification for which they have insufficient resourcing.
- 213 CITY AND HACKNEY: That conference, with regard to the implementation of new PCN DES service specification seeks assurance from NHSE that they will be introduced at a realistic and achievable pace.
- 214 TOWER HAMLETS: That conference notes that APMS contracts are being used as a vehicle to sell general practice to global multinationals and:
- (i) believes that this sounds the death knell of holistic, community based family medicine and continuity of care
  - (ii) demands that GPC Exec make clear to government that GPs will not tolerate this attack
  - (iii) demands that the GPC run a high-profile publicity campaign explaining to the public what is happening
  - (iv) demands that the profession is balloted for action up to and including industrial action to defend the traditional model of general practice
- 215 WALTHAM FOREST: That conference, in light of 38 CCGs merging into 9 as of 1 April 2021 and the DHSC White paper (February 2021), is concerned regarding the future of the GMS / PMS contract and needs urgent clarification from SoS HSC that:
- (i) there will be a continuation of the current local community based, partnership model of general practice based on the GMS contract
  - (ii) the GMS contract will be commissioned by NHSE primary care teams and not delegated to ICS boards
  - (iii) the development of general practice services with appropriate resourcing will be a key requirement of all ICS.
- 216 MID MERSEY: That conference notes that the Additional Roles Reimbursement Scheme for primary care networks specifically excludes advanced nurse practitioners, while supporting the recruitment of dietitians, occupational therapists, paramedics, physician associates, nurse associates, mental health practitioners, clinical pharmacists, care coordinators and social prescribing link workers – and calls on GPC to ensure that future regulations support the recruitment of advanced nurse practitioners working in network roles.
- 217 MID MERSEY: That conference believes that limiting each primary care network to recruitment of a single mental health practitioner for 2021-2022, and just two such practitioners for 2022-2023, is grossly insufficient to improve the provision of mental health care for patients in primary care, and calls on GPC to urgently ensure that the regulations enable networks to use their available ARRS funding to recruit mental health practitioners according to need.

- 218 BEDFORDSHIRE: That conference calls on GPC to negotiate an item of service fee for each registration of a temporary resident, rather than this being part of Global Sum.
- 219 SURREY: That conference expresses its concern that the latest White Paper on NHSE reorganisation paves the way for the abolition of CCGs, and the consequent loss of any meaningful GP representation as part of local NHS bodies.
- 220 WEST SUSSEX: That conference believes the requirement for general practitioners to publish income information on their website should be waived unless all primary care contractor groups have the same contractual requirement, or, if that is not the case, withdrawn entirely as it inappropriately targets general practitioners in the eyes of both NHSE and the public.

## REGULATION AND UK PROFESSIONAL ISSUES

- 221 KENT: That conference demands that an independent judicial review be conducted into deaths of GPs occurring while they undergo performance processes.
- 222 NOTTINGHAMSHIRE: That conference recognises that primary care teams need to have a wide skill mix but given the workload issues cannot run on GPs alone, particularly with falling WTE numbers. Present regulations mean that a GP must be named on a GMS contract, and although that has been the tractional model, we ask that this could be changed to enable practice evolution.
- 223 GRAMPIAN: That conference instructs the BMA to expedite the publication of the professional fee engine which has been developed by the Professional Fees Committee.
- 224 NOTTINGHAMSHIRE: That conference recognises that there is a mismatch between coronial regulations and crematoria regulations throughout the UK leading to body viewing still being necessary at times even if the coroner is satisfied that events can proceed. We ask for urgent clarification, and hopefully unity throughout the UK to enable bereaved families to proceed with their affairs without the complication and delay that can occur when referees need urgent GP clarification.
- 225 KENT: That conference demands that the specification for the Child Health Surveillance additional service in the GMS contract should state that:
- (i) the responsibility for weighing and measuring babies remains with the health visiting service
  - (ii) GPs should perform physical checks to screen for congenital anomalies
  - (iii) commissioners should encourage the establishment of joint clinics where GP and health visitors work together.
- 226 MORGANNWG: That conference calls for all four home nations to recognise UK-wide Medical Performers Lists, geographical boundaries should no longer be a barrier and a mechanism is required to aid both the short and long term movement of virtual and F2F service delivery.
- 227 DERBYSHIRE: General practice is not an emergency service which should be commissioned elsewhere.
- 228 KENT: That conference believes that the professional regulatory processes discriminate against BAME doctors and demands a major review of the system.
- 229 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 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.
- 230 WAKEFIELD: That conference welcomes the settlement the negotiators have reached for the first part of 2021 but want the income protection we have had around QOF to be extended at least until June, in line with the COVID-19 uncertainty that is still ongoing and the continuation of the mass vaccination programme.

- 231 NORFOLK AND WAVENEY: That conference calls on GPC to negotiate better standardised financial and specialist support for practices rated Inadequate or Requires Improvement by a Regulatory Authority to make the required improvements.
- 232 NORFOLK AND WAVENEY: That conference recognises and requests GPC to insist that LMCs represent practice networks through their GPs and constituent practices and not self-imposed organisations such as NHS Confederation.
- 233 NORFOLK AND WAVENEY: That conference calls on GPC to negotiate better financial protection and terms to GP partners securing a bank loan if they have been rated Inadequate or Requires Improvements by a Regulatory Authority.
- 234 DERBYSHIRE: That conference asks GPC, in their negotiations with NHSE, to ensure that LMCs, as the independent representatives of general practice, are compulsorily included alongside PCNs in the proposed ICS structure as published in the recent white paper.
- 235 LIVERPOOL: That conference believes that the level of GP representation on Integrated Care Systems where GPs will cease to exist is egregiously and despicably low and calls on GPC to actively support increased GP representation on ICS Boards.
- 236 KENT: That conference notes NHSEI's commitment to reduce bureaucracy in general practice in the General Practice Forward View and demands:
- (i) no additional data collection or proforma may be sanctioned without the agreement of the LMC
  - (ii) all providers and organisations requiring non-contractual proforma should be required to pay a fee for each completed
  - (iii) NHSEI and CCGs should conduct an annual audit on the burden of bureaucracy on general practice, discussing their findings with their LMC and demonstrate year on year improvements.
- 237 KENT: The conference demands that:
- (i) CQC collects data on ethnicity and diversity of its inspectors and teams, as well as the people/practice teams it inspects
  - (ii) CQC is held accountable for ensuring that it treats practices and GPs fairly and without any discrimination.
- 238 SOUTH STAFFORDSHIRE: That conference believes that the move towards the ICS model threatens the distinct and hard-earned discipline of general practice and calls for regulation to ensure a depth and breadth of GP opinion is incorporated into such schemes over and above token primary care representation.
- 239 DEVON: That conference notes that CQC mandates practices to provide evidence of equality, diversity, and inclusion training in practice staff but does not provide publicly available evidence that its teams have undergone the same training nor that it is seeking to improve its representation of the profession it inspects. As anecdotal evidence of disproportionate adverse outcomes from CQC inspections arise from practices with BAME CQC leads is increasing, conference requests that GPC negotiate for:
- (i) publication of diversity data including protected characteristics of CQC inspectors
  - (ii) publication of CQC inspection outcomes stratified by the protected characteristics of practice CQC leads including ethnicity and gender
  - (iii) CQC's plan to improve its representation of the population should its data demonstrate a diversity gap.
- 240 SEFTON: That conference debates candidly the future organisation and purpose of general practice as a distinct and autonomous unit of health care delivery within the developing context of PCNs, their incorporation and the direction of primary care funding streams to PCNs and ICSs.
- 241 AVON: That conference notes that the NHS reform paper indicates that there is a fundamental change to the way primary care is organised and in the way that the funding will be allotted. The system will move from one where:



- (i) GPs have a leading role, to one where GPs will be just one voice among many with the consequence of a significantly reduced role and influence
  - (ii) the funding for primary care will no longer be separate from the single pot which the leadership of the integrated care system will disburse as it sees fit.
- 242 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 core business by their own CCG.
- 243 AVON: That conference demands that GPC, in negotiations with NHSE, insists that funding is not removed from primary care budgets as a result of the new NHS reforms.
- 244 CENTRAL LANCASHIRE: That conference believes that the fragmentation of primary care commissioning in the 2012 reorganisation should not be repeated in the 21 / 22 reorganisation.
- 245 MORECAMBE BAY: That conference believes that the impact of a remote and less accountable ICS to member practices will have a detrimental impact on general practice.
- 246 MID MERSEY: That conference calls on GPC to work with NHSE/I to provide conference with an annual report on NHSE/I's performance management processes and procedures in primary care, focusing not only on outcomes but also on the proportion of cases where early resolution has been reached, any steps taken to achieve a fair and consistent approach across different regions, and any data relating to the treatment of GPs with protected characteristics.
- 247 NORTHAMPTONSHIRE: That conference believes that there should be an incentive in the GMS contract for small practices to merge their contract to form five or more GP practices to manage the increase of bureaucracy, GDPR, CQC and data collection.

## CLINICAL, PRESCRIBING AND DISPENSING

- 248 REDBRIDGE: That conference welcomes the community pharmacy services but is concerned that it needs to be developed further to enable integration with the wider primary care offer including:
- (i) enabling direct booking by general practice into the service
  - (ii) referral by the pharmacist for any patient they believe needs to be reviewed by a GP
  - (iii) the ability for patients to self-refer to the service
  - (iv) a requirement for a record of the consultation including all the relevant medical information to be sent to the patient's GP.
- 249 NOTTINGHAMSHIRE: That conference notes that anticoagulation services are funded through a variety of mechanisms throughout the UK, warfarin being recognised as drug needing careful monitoring. More patients are now treated with Noval Oral Anticoagulants (NOACS) but these are not monitoring free drugs, and we ask for an enhanced service to be introduced in recognition of this.
- 250 SHROPSHIRE: That conference:
- (i) recognises that appropriate use of dosette boxing of medication can be beneficial to patients and carers
  - (ii) notes that dispensing practices and pharmacies are not reimbursed for providing this service despite the additional costs involved
  - (iii) understands there is a move away from monitored dose systems but believes their use will continue for the foreseeable future
  - (iv) requests introduction of an enhanced dispensing fee, for dispensing practices and pharmacies, to reflect the additional costs incurred when dosette boxing is used, and
  - (v) believes payment of this fee should be contingent on monthly prescribing.

## PUBLIC HEALTH

- 251 HIGHLAND: That conference believes that the coronavirus pandemic has demonstrated the importance of baseline population health on the resilience and wellbeing of citizens and asks GPC to explore with government how to improve the funding of the activities in public health and primary care that lead to improved population health outcomes.
- 252 NOTTINGHAMSHIRE: That conference recognises public health interventions achievable at scale and so lobbies for fluoridisation of water to all households in the UK.

## **PREMISES**

- 253 NOTTINGHAMSHIRE: That conference recognises that practice change needs space and the ability to react to changing circumstances. We ask the GPC to negotiate with the DHSC so that primary care can enjoy the bounty of capital funding that secondary care has had over the past few years.
- 254 KERNOW: That conference is asked to support the following:
- (i) a commitment from NHSE/I 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 NHSE/I 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.

## **MEDICO-LEGAL AND INDEMNITY**

- 255 KENT: That conference notes the concerns expressed by indemnity providers that the goodwill shown to clinicians in the pandemic will be lost under a deluge of litigations and demands the GPC seeks:
- (i) full immunity for all doctors from clinical negligence claims during the COVID-19 pandemic
  - (ii) a Repeal of S2(4) of the Law Reform (Personal Injuries) Act 1948
  - (iii) the establishment of an independent body to define the NHS health and social care package which can give an appropriate standard of care for all patients irrespective of the cause of the patient's care requirements
  - (iv) seeks to limit compensation claims to the costs of additional care required
  - (v) that we move to a New Zealand no fault compensation scheme.
- 256 BEDFORDSHIRE: That conference calls on GPC to work with the governments of the UK to make any necessary changes to the law to protect doctors from retrospective manslaughter charges relating to decisions made during the pandemic.
- 257 KENT: That conference applauds the duty of confidentiality which exists as an obligation under both common law and data protection legislation and demands that the GPC ensures that NHS resolution protects the confidentiality of GPs who seek advice and representation in negligence cases.
- 258 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 that have acted in good faith to NHS England and any other regulatory bodies when they are seeking assistance in negligence claims.

## **GENERAL PRACTICE PAY AND CONDITIONS**

- 259 NORTHAMPTONSHIRE: That conference insists that GPs should be reimbursed for taking time out of practice to support the ICS and should not be penalised financially.
- 260 CONFERENCE OF ENGLAND LMCs: That conference strongly believes that the current GP funding formula is both seriously flawed and outdated and demands that GPC:

- (i) urgently calls for a review of 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.
- 261 BUCKINGHAMSHIRE: That conference believes that GP workload has increased in both volume and complexity to unmanageable levels, and:
- (i) older patients, complex patients and patients with long-term conditions require more interactions with their GP service than their younger or healthier counterparts
  - (ii) online consultations increase the number of interactions between patients and GP services
  - (iii) NHS general practice needs to move from an annual block payment model for healthcare provision to an interaction based funding model and conference therefore mandates GPC to negotiate contract changes to that effect.
- 262 WANDSWORTH: That conference agrees that the current system of paying practices on weighted list sizes is outdated and payments should be based on raw list sizes to truly reflect the workload.
- 263 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.

## MANAGING FUTURE DEMAND

- 264 MANCHESTER: That conference agrees NHS England must commission a specialist service inclusive of prescribing to ensure adult transgender patients receive an equitable service to that of other patients who require specialist services and which does not transfer this workload to general practice.
- 265 NORTH STAFFORDSHIRE: That conference calls upon the GPC to challenge NHSE/I about the service gaps in the care of people with gender dysphoria and to negotiate funding gender identity clinics to continue prescribing and monitoring their patient hormonal preparations.
- 266 WELSH CONFERENCE OF LMCs: That conference believes that End of Life care forms (including DNAR and treatment escalation plans) should be completed and signed off by the clinician most involved with the patient, in partnership with the patient as appropriate. Requiring a senior doctor to countersign such forms is a nonsense in an era of multidisciplinary working and needs to stop.
- 267 DERBYSHIRE: The increasing availability of private investigations that can be accessed without any referral, results of which then arrive unheralded in primary care, create additional work as well as the assumption of responsibility. Conference asks GPC to seek a judicial review on where the responsibility of dealing with the incidentalomas that are found should sit.
- 268 DERBYSHIRE: That the increasing tendency of clinical organisations to use email as the primary communication method especially for matters of a clinically urgent nature be outlawed as such practice:
- (i) is dangerous
  - (ii) results in a patient's care becoming disconnected
  - (iii) promotes uncontracted work dumping onto general practitioners
  - (iv) results in unscheduled unwarranted extensions to the GP working day and the general practitioner committees must develop and negotiate appropriate policies and contractual terms as a matter of urgency.
- 269 DORSET: That conference calls for GPC to negotiate with secondary care to completely overhaul the process for GPs to admit patients to hospital. We call for:

- (i) an end to the belief that anyone other than the GP can make the clinical decision as to whether further input into their patient's care is required
- (ii) a fast, electronic process to input details
- (iii) the passing over of responsibility to the secondary care clinician for the patient
- (iv) GPs to specifically document the reason for admission.

## **PENSIONS**

- 270 SCOTTISH CONFERENCE OF LMCs: That conference demands that GPs should have the option to receive all of the 20.9% employer superannuation contribution if they leave the NHS pension scheme as taxable income so they can most efficiently determine their future planning.
- 271 BRADFORD AND AIREDALE: That conference believes that the handling of the NHS pension scheme by PCSE is incompetent due to irregular and inaccurate withholdings that lead to financial instability in general practice due to delays in challenging and reimbursing incorrect assessments.

## **PRIVATE GENERAL PRACTICE**

- 272 KENT: That conference demands that the GPC negotiates a reduction in restrictions on private practice in general practice.
- 273 WEST SUSSEX: That conference believes the current restrictions on NHS general practitioners to see and treat private patients should be removed.

## **LMC GOVERNANCE**

### **The Annual Conference of LMCs**

- 272 NORTHERN IRELAND SOUTHERN: We call on conference to change standing orders so that elections will ensure that the Chair and Deputy Chair of conference are not from the same nation.

# STANDING ORDERS

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# STANDING ORDERS

## CONFERENCES

### Annual conference

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

### Special conference

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

### Membership

3. The members of conference shall be:
  - 3.1 the chair and deputy chair of the conference
  - 3.2 365 representatives of local medical committees
  - 3.3 the members of the GPC UK
  - 3.4 9 members appointed by the Scottish GPC
  - 3.5 3 members appointed by the Welsh GPC
  - 3.6 2 members appointed by the GPC (Northern Ireland)
  - 3.7 2 members appointed by GPC England
  - 3.8 the seven elected members of the conference agenda committee (agenda committee)
  - 3.9 the regionally elected representatives of the GP trainees subcommittee, together with its immediate past chair
  - 3.10 the elected members of the sessional GPs subcommittee of the GPC.

### Representatives

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

## **Observers**

9. Local medical committees may nominate personnel from their organisations to attend conference as observers, subject to 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 as amended or by equivalent provisions in Scotland, Wales, and Northern Ireland.
11. 'Members of the conference' means those persons described in standing order 3.
12. 'Representative' or 'representatives' means those persons appointed under standing orders 4 to 8 and shall include the deputy of any person who is absent.
13. 'The conference', unless otherwise specified, means either an annual or a special conference.
14. 'As a reference' means that any motion so accepted does not constitute conference policy but is referred to the GPC UK to consider how best to procure its sentiments.

## **Motions to amend standing orders**

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

## **Suspension of standing orders**

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

## **Agenda**

17. The agenda shall include:
  - 17.1 motions, amendments and riders submitted by the GPC UK, and any local medical committee. These shall fall within the remit of the GPC, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and/or the National Health Service (Scotland) Act 1978 and/or the Health and Personal Social Services (Northern Ireland) Order 1972 and any Acts or Orders amending or consolidating the same and as from time to time extended to all or any part of the United Kingdom
  - 17.2 motions, amendments and riders connected with NHS general practice from constituencies of the British Medical Association's representative body, or one of the other craft conferences convened by a standing committee of the BMA, referred by the BMA's joint agenda committee
  - 17.3 motions passed at national LMC conferences and submitted by their chairmen
  - 17.4 motions relating to the Cameron fund, Claire Wand fund and the Dain fund
  - 17.5 motions submitted by the agenda committee in respect of organisational issues only.

18. Any motion which has not been received by the GPC UK within the time limit set by the BMA's joint agenda committee shall not be included in the agenda. This time limit does not apply to motions transferred to the conference by the BMA's joint agenda committee. The right of any local medical committee, or member of the conference, to propose an amendment or rider to any motion in the agenda, is not affected by this standing order.
19. When a special conference has been convened, the GPC UK shall determine the time limit for submitting motions.

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

20. In two parts; the first part 'Part I' being those motions which the agenda committee believe should be debated within the time available; the second part 'Part II' being those motions covered by 25 and 26 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording. If any local medical committee submitting a motion included in Part II of the agenda objects in writing before the deadline for items to be considered for the supplementary agenda, the transfer of the motion to Part I of the agenda shall be decided by the conference during the debate on the report of the agenda committee.
21. 'Grouped motions': Motions or amendments which cover substantially the same ground shall be grouped and the motion for debate shall be asterisked. If any local medical committee submitting a motion so grouped objects in writing before deadline for items to be considered for the supplementary agenda, the removal of the motion from the group shall be decided by the agenda committee.
22. 'Composite motions': If the agenda committee considers that no motion or amendment adequately covers a subject, it shall draft a composite motion or an amendment, which shall be the motion for debate. The agenda committee shall be allowed to alter the wording in the original motion for such composite motions.
23. 'Motions with subsections':
  - 23.1 motions with subsections shall deal with only one point of principle, the agenda committee being permitted to divide motions covering more than one point of principle
  - 23.2 subsections shall not be mutually contradictory
  - 23.3 such motions shall not have more than five subsections except in subject debates.
24. 'Rescinding motions': Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters 'RM'.
25. 'A' motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chair of the GPC UK as being noncontroversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A'.
26. 'AR' motions: Motions which the chair of the GPC UK is prepared to accept without debate as a reference to the GPC UK shall be prefixed with the letters 'AR'.
27. 'C' motions: Prior to the conference, a ballot of representatives shall be conducted to enable them to choose motions, ('C' motions), amendments or riders for debate. Using only the prescribed form, which must be signed and received by the GPC secretariat by the time notified for the receipt of items for the supplementary agenda, each representative may choose up to three motions, amendments or riders to be given priority in debate. Chosen motions must receive the vote of at least ten representatives. The first three motions, amendments or riders chosen, plus any others receiving the vote of at least twenty representatives, shall be given priority.



28. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 44, 45, 46, 47 and 52 shall not apply and the debate shall be held in accordance with standing order 54.
29. Identifying, by enclosing within a 'black box', motions received from those local medical committees which have failed to meet their quotas to the General Practitioners Defence Fund Ltd. Before effecting this, one year's grace must be given to such local medical committees, who must have received warning that, unless the deficit is made up by 1 May after the following year, they would become subject to the 'black box' procedure.

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

30. Recommending to the conference the order of the agenda; allocating motions to blocks; allocating time to blocks; setting aside reserved periods, as provided for in standing orders 59 and 61, and overseeing the conduct of the conference.

**Procedures**

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

**Rules of debate**

36. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.
37. A member of conference shall address the chair and shall, unless prevented by physical infirmity, stand when speaking.
38. 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.

39. Members of the GPC UK who also attend the conference as representatives, should identify in which capacity they are speaking to motions.
40. The chair shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.
41. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.
42. The chair shall take any necessary steps to prevent tedious repetition.
43. 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.
44. Amendments shall be debated and voted upon before returning to the original motion.
45. Riders shall be debated and voted upon after the original motion has been carried.
46. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 44, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.
47. 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 UK and the mover of the original motion shall have the right to reply to the debate before the question is put.
48. 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.
49. Proposers of motions shall be given prior notice if the GPC intends to present an expert opinion by a person who is not a member of the conference.
50. 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.
51. Any motion, amendment or rider referred to the conference by the joint agenda committee shall be introduced by a representative or member of the body proposing it. That representative or member may not otherwise be entitled to attend and speak at the conference, neither shall he/she take any further part in the proceedings at the conclusion of the debate upon the said item, nor shall he/she be permitted to vote. In the absence of the authorised mover, any other member of the conference deputed by the authorised mover may act on their behalf, and if there is no deputy the item shall be moved formally by the chair.
52. 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.
53. In a major issue debate the following procedures shall apply:
  - 53.1 the agenda committee shall indicate in the agenda the topic for a major debate
  - 53.2 the debate shall be conducted in the manner clearly set out in the published agenda
  - 53.3 the debate may be introduced by one or more speakers appointed by the agenda committee

- who may not necessarily be members of conference
- 53.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
- 53.5 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.
- 53.6 the Chair of GPC UK or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
- 53.7 at the conclusion of the debate the introductory speakers may speak for no longer two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
- 53.8 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**

- 54. 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.
- 55. Motions will not be taken earlier than the times indicated in the schedule of business included in the agenda committee's report.
- 56. 'Soapbox session':
  - 56.1 A period shall be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
  - 56.2 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.
  - 56.3 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.
  - 56.4 GPC (UK) members shall not be permitted to speak in the soapbox session.
- 57. 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.
- 58. Motions prefixed with a letter 'A', (defined in standing orders 25 and 26) 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.
- 59. One period, not exceeding one hour, may be reserved for representatives of LMCs to ask questions of the GPC executive teams.

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

60. Motions not included in the agenda shall not be considered by the conference except those:
- 60.1 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
  - 60.2 relating to votes of thanks, messages of congratulations or of condolence
  - 60.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association
  - 60.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned
  - 60.5 prepared by the agenda committee to correct drafting errors or ambiguities.
  - 60.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions
  - 60.7 that may arise from a major issue debate; such motions must be received by the agenda committee by the time laid down in the major issue debate timetable published under standing order 54.

### **Quorum**

61. 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**

62. A member of the conference, including the chair of the GPC, 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.
63. 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**

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

### **Majorities**

65. Except as provided for in standing order 48 and 49 (procedural motions), decisions of the conference shall be determined by simple majorities of those present and voting, except that the following will also require a two-thirds majority of those present and voting:
- 65.1 any change of conference policy relating to the constitution and/or organisation of the LMC/conference/GPC structure, or
  - 65.2 a decision which could materially affect the GPDF Ltd funds.
66. 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

67. Chair
- 67.1 At each conference, a chair shall be elected by the members of the conference to hold office from the termination of the BMA's annual representative meeting (ARM) until the end of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
- 67.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda of the conference with any election to be completed by the time indicated in the Agenda. 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.
68. Deputy chair
- 68.1 At each conference, a deputy chair shall be elected by the members of the conference to hold office from the termination of the ARM until the termination of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
- 68.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda with any election to be completed by the time indicated in the Agenda. 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.
69. Seven members of the General Practitioners Committee UK
- 69.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. For six of the seats any registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, whether a member of the conference or not, is eligible for nomination providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. All GPs on the retention scheme, and medically qualified LMC secretaries, are eligible for nomination regardless of their level of commitment to providing or performing NHS primary medical services. For the seventh seat, only an LMC representative at conference may be nominated, and that LMC representative must never have previously sat on the GPC UK. This LMC representative must also be a registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any maternity, sickness or study leave absence. The members elected will serve on the GPC from the conclusion of the following ARM until the conclusion of the ARM one year thereafter.
- 69.2 Only representatives shall be entitled to vote.
- 69.3 Nominations, election statements and photographs must be received by the GPC office seven working days before the start of the conference.
- 69.4 Nominees may submit an election statement of no more than 50 words, excluding numbers and dates in numerical format, in a manner and format which will be specified by the Agenda Committee (that format being specified one calendar month before the start of conference). Recognised abbreviations count as one word.
- 69.5 Nominees may also submit a photograph in a format specified by the Agenda Committee (that format being specified one calendar month before the start of conference).

- 69.6 All nominees shall have the opportunity to take part in any hustings arranged by the agenda committee.
  - 69.7 All lists of candidates, in whatever format, shall be in random order.
  - 69.8 Elections, if any, will take place at conference and be completed by the time indicated in the Agenda.
  - 69.9 The GPC UK shall be empowered to fill casual vacancies occurring among the elected members.
70. Seven members of the conference agenda committee
- 70.1 The agenda committee shall consist of the chair and deputy chair of the conference, the chair of the GPC UK and seven members of the conference, at least one of whom, subject to appropriate nominations being received, shall represent each of the four UK nations and not more one of whom shall be a sitting member of the GPC UK. In the event of there being an insufficient number of candidates to fill the seven seats on the agenda committee, the chair shall be empowered to fill the vacancy, or vacancies, by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected and shall continue in office until the end of the following annual conference.
  - 70.2 The chair of conference, or if necessary, the deputy chair, shall be chair of the agenda committee.
  - 70.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by the time indicated in the Agenda. Elections, if any, will take place at conference and be completed by the time indicated in the Agenda. 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.
  - 70.4 The result of the election to the agenda committee shall be published after the result of the ARM election of GPC UK members is known.
  - 70.5 The two members of the agenda committee to be appointed to the joint agenda committee in accordance with article 53 of the BMA's Articles of Association shall be the chair of the conference and the chair of the GPC UK.
71. The representatives allocated to represent general practice at the BMA Annual Representative Meeting shall be members of the BMA both at the time of their annual appointment/election and throughout their term of office and shall comprise:
- 71.1 the chair and deputy chair of conference, if eligible
  - 71.2 the chair of the GPC UK, if eligible
  - 71.3 sufficient members of conference to fill the allocation of seats, elected on a regional basis in advance of conference by those members of the conference who are members of the BMA
  - 71.4 should there be vacancies after the regional elections these shall be filled by the GPC UK from the unsuccessful candidates standing in those elections.
72. Three trustees of the Claire Wand fund
- 72.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. Any registered medical practitioner who is, or has been, actively engaged in practice as a general medical practitioner under the National Health Service Acts, whether a member of the conference or not, is eligible for nomination.
  - 72.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda. Elections, if any, will take place at conference and be completed by the time indicated in the Agenda. Only representatives in attendance at the conference may vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers.
  - 72.3 Trustees will be elected on a triennial basis for a period of three years, to run from the termination of the next ARM.

73. Dinner committee
- 73.1 At each conference there shall be appointed a conference dinner committee, formed of the chair and deputy chair of the conference and the chair of the GPC, to take all necessary steps to arrange for a dinner to be held at the time of the following annual conference, to which the members of the GPC, amongst others, shall be invited as guests of the conference.

#### **Returning officer**

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

#### **Claire Wand award**

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

#### **Motions not debated**

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

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

77. 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.

#### **Mobile phones**

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

#### **The press**

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

#### **No smoking**

80. Smoking or vaping is not permitted within the building during the conference.

#### **Chair's discretion**

81. 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**

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