2021 Annual Conference of England LMC representatives
25 November from 2pm and 26 November 2021
To be held virtually

27,000 GPs and falling....
Conference of England LMC Representatives

Agenda

To be held on

Thursday 25 November at 14.00 and Friday 26 November 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 Shaba Nabi (Avon)
Deputy Chair Elliott Singer (London)

Conference Agenda Committee
Shaba Nabi (Chair of Conference)
Elliott Singer (Deputy Chair of Conference)

Paul Evans (Gateshead and South Tyneside)
Matthew Mayer (Buckinghamshire)
Simon Minkoff (Manchester)
Zoe Norris (Yorkshire)
Roger Scott (Liverpool)
NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 9 September 2021. Although 9 September 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 emailed to the secretariat via the LMC conference inbox which is info.lmccconference@bma.org.uk by 9am on Monday 22 November.

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

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

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

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

While the Agenda Committee has done the best job it can of prioritising motions for debate in the normal way, avoiding where possible existing policy, we know that some of the motions not prioritised for debate are also important to you, and you can use the chosen motions ballot form to nominate motions from Part 2 of the Agenda which you would like to see debated at the appropriate time during the conference. The online system will also be used to allow representatives to vote for their three preferences in advance. Further details will be sent to representatives nearer to the conference. The ballot for chosen motions is open and will close at 9am Monday 22 November – please click here.
CONFERENCE OF ENGLAND LMCs ELECTIONS

The following elections will be held on Thursday 25 and Friday 26 November 2021.

Chair of conference
Chair of conference for the session 2021-2022 (see standing order 63) - nominations will be open at noon on Thursday 18 November and closes at 3pm on Thursday 25 November 2021.

Deputy chair of conference
Deputy chair of conference for the session 2021-2022 (see standing order 64) - nominations will be open at noon on Thursday 18 November and closes at 5pm on Thursday 25 November 2021.

Five members of LMC England conference agenda committee
Five members of the England conference agenda committee for the session 2021-2022 (see standing order 65) - nominations will be open at noon on Thursday 18 November and closes at 10am on Friday 26 November 2021.

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

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

Voting opens for all positions: 2pm Friday 26 November
Voting closes for all positions: 2pm Monday 29 November
Results announced soon after voting closes.

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

It is strongly recommended that representatives obtain a BMA website account in advance of conference to ensure there are no complications
# Schedule of business
## Thursday 25 November 2021

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening business</td>
<td>14.00</td>
</tr>
<tr>
<td>Chair of GPC England’s report</td>
<td>14.20</td>
</tr>
<tr>
<td>Interface</td>
<td>14.40</td>
</tr>
<tr>
<td>Advice and Guidance</td>
<td>15.00</td>
</tr>
<tr>
<td>Consultants in general practice</td>
<td>15.20</td>
</tr>
<tr>
<td>Break</td>
<td>15.30</td>
</tr>
<tr>
<td>Integrated Care Systems (ICS)</td>
<td>15.40</td>
</tr>
<tr>
<td>Conference format</td>
<td>16.00</td>
</tr>
<tr>
<td>NHS 111</td>
<td>16.20</td>
</tr>
<tr>
<td>Environment</td>
<td>16.40</td>
</tr>
<tr>
<td>Close</td>
<td>17.00</td>
</tr>
</tbody>
</table>
**Friday 26 November 2021**

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening business</td>
<td>09.00</td>
</tr>
<tr>
<td>Online consultations</td>
<td>09.10</td>
</tr>
<tr>
<td>Chosen motions</td>
<td>09.30</td>
</tr>
<tr>
<td>Contract reform</td>
<td>09.50</td>
</tr>
<tr>
<td>Break</td>
<td>10.30</td>
</tr>
<tr>
<td>Covid-19 vaccination programme</td>
<td>10.50</td>
</tr>
<tr>
<td>Wellbeing themed debate</td>
<td>11.00</td>
</tr>
<tr>
<td>Lunch</td>
<td>12.30</td>
</tr>
</tbody>
</table>

**Closed section of the Agenda**

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPC England transparency</td>
<td>13.30</td>
</tr>
<tr>
<td>Questions to GPC England</td>
<td>14.00</td>
</tr>
<tr>
<td>PCN DES</td>
<td>14.50</td>
</tr>
<tr>
<td>Break</td>
<td>15.30</td>
</tr>
<tr>
<td>New business – to be detailed in the supplementary agenda</td>
<td>15.40</td>
</tr>
<tr>
<td>Chair of GPC England closing remarks</td>
<td>16.40</td>
</tr>
<tr>
<td>Closing business</td>
<td>16.50</td>
</tr>
<tr>
<td>Close</td>
<td>17.00</td>
</tr>
</tbody>
</table>
Thursday 25 November

OPENING BUSINESS 14.00

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

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

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

CHAIR OF GPC ENGLAND’S REPORT 14.20

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

INTERFACE 14.40

* 5 SHEFFIELD: That conference recognises the negative impact that inappropriate transfer of workload from secondary care to primary care is having on GP morale and recruitment and calls on GPC England to negotiate with NHSEI for a nationally funded hospital discharge review system that will:
   (i) prevent contractually inappropriate requests
   (ii) help develop new discharge pathways appropriate to care in the community
   (iii) include an educational element for all clinicians
   (iv) create more clinical dialogue between primary and secondary care.

5a LINCOLNSHIRE: That conference recognises that patients discharged from hospital frequently present to their GP practice due to poor discharge planning, this creates distress for the patient and work for the GP practices. Conference thus calls for:
   (i) GPC England to engage with consultants committee to enforce the importance of better discharge planning
   (ii) NHSEI to add a clause to the Standard NHS Contract which mandates that trusts have all discharges reviewed by a pharmacist who will ensure adequate medication supply and patient education regarding medication
   (iii) GPC England to negotiate global sum increase, to fund practices to be able to make contact with all recently discharged patients to review their hospital discharge and support post-discharge care.

5b BATH AND NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference demands that secondary care use modern communications technology like email and SMS as a routine when corresponding with patients to ensure appointments are received, DNAs are reduced and precious NHS appointments are not wasted.

5c SURREY: That conference are concerned about the lack of progress in the introduction of secondary care electronic prescribing and the consequent effect on GP workload and asks that GPC England negotiate the swift implementation of an electronic prescribing service that allows secondary care to issue medications to community pharmacy.

5d WEST SUSSEX: That conference worries that outpatient transformation plans are being used as ways of shifting workload into a community setting that is already working at (or beyond) capacity, and ask GPC England to:
   (i) remind commissioners that general practice does not have infinite capacity
   (ii) ask NHSEI to instruct commissioners to ensure that the workload and workforce implications of all such plans are properly assessed and published before enacting them
(iii) ask NHSEI to instruct commissioners to write proper business cases for such projects, including how such additional workload will be funded in the community and where the extra workforce capacity will be found
(iv) NHSEI to instruct commissioners to work with training hubs to develop such capacity prior to the workload shift taking place.

5e HERTFORDSHIRE: That conference demands that before hospitals, CCGs, Integrated Care Boards or other bodies consider transferring any work to primary care or requesting any new work from primary care, a full formal patient safety assessment must first be carried out, which includes an assessment of whether the GP has the necessary skills, knowledge, resources and capacity to undertake the specific tasks.

5f NORTHAMPTONSHIRE: That conference demands that secondary care must stop off-loading their responsibilities on primary care or be directly charged by primary care when services are provided.

5g LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands a nationally agreed activity based enhanced service that recognises the unresourced transfer of work from secondary care.

5h HEREFORDSHIRE: That conference believes there is enormous pressure to move work into general practice and that our stance should be, if it’s not in our contract, we’ll consider doing it if you fund it and we have the manpower.

5i DEVON: That conference demands that funding be negotiated for the unresourced work that is transferred from secondary care into general practice. This will both relieve pressure on secondary care and allow general practice to recruit appropriately.

5j NORTH YORKSHIRE: That conference agrees improved primary and secondary care relationships have the potential to deliver significant benefits, but is concerned that the majority of suggestions for collaboration currently involve flow of work into practices and demands:
(i) appropriate resource to support this shift of work
(ii) additional support for practices and PCNs to enable adequate time to take part in such local discussions
(iii) work is done to support trusts to understand the unique nature and risks associated with the independent contractor model.

5k HERTFORDSHIRE: That conference notes the continued unfunded transfer of work from secondary care to primary care and demands that GPC negotiates for the establishment of a system to enable GPs to charge hospitals where they undertake work on their behalf.

5l SURREY: That conference recognises that much of the increased workload is being driven by problems in secondary care, and asks GPC England to ask:
(i) commissioners to hold hospitals to their contractual obligations
(ii) NHSEI to instruct commissioners to collect data on hospital contract breaches, by instituting a robust and convenient general practice reporting system
(iii) NHSEI to instruct commissioners to act on them appropriately by instituting a system of fines for hospitals that repeatedly breach their contract
(iv) NHSEI to reinvest said funds in the community.

5m DEVON: That conference demands that NHSEI enforce the NHS standard contract to ensure that secondary care fulfils all of its contractual obligations.

5n CAMBRIDGESHIRE: That conference is appalled by the ongoing shift of clinical work and risk from secondary care to general practice and asks GPC England to address the situation with NHSEI as a matter of urgency to insist that hospitals abide by their contract and immediately halt workload transfer, particularly with regards to:
(i) clinical examination when a hospital service has assessed remotely
(ii) ordering of investigations that are part of secondary care work up
(iii) fit notes
(iv) onward referrals.
SUTTON: That conference calls upon GPC England to:
(i) once and for all make it clear that secondary care and other healthcare providers need to check the results of their own investigations and request their own investigations for follow up
(ii) request secondary care to refer patients to community NHS services if required and not send this as an administrative task in correspondence for general practice to complete
(iii) ensure that whilst ‘patient choice’ is respected, that this is not abused and inappropriately used by secondary care and other health care providers to request general practice to complete work which is within their remit
(iv) ensure community NHS services which do not require e-referrals are also able to self-refer to each other if required instead of adding to general practice workload to complete these referrals on their recommendation
(v) ensure the response to advice and guidance is reasonable ask of general practice instead of investigations and medications that cannot be requested or prescribed by general practice leading to more time and effort to resolve the problem.

BEDFORDSHIRE: That conference:
(i) believes that the obvious conflict between primary and secondary care is clearly not in the best interests of the patients they exist to treat, and
(ii) instructs GPC to emphasise the need to facilitate seamless interaction between primary and secondary care.

BEDFORDSHIRE: That conference:
(i) believes that doctors would rather work together to care for their patients than be divided by the dictates of the market, and
(ii) calls on GPC England to negotiate for a more integrated primary and secondary care system.

EALING, HAMMERSMITH AND HOUNSLOW: That conference believes that in the interests of patient care, there should be a formal obligation for secondary care trusts to have regular primary and secondary care liaison meetings facilitated by LMCs to resolve any difficulties in local care pathways.

NOTTINGHAMSHIRE: That conference is very concerned by the increasing volume of unresourced shifting of work from secondary care into general practice. This lack of adherence by acute trusts to the standard NHS hospital contract is severely hurting general practice and so we ask for:
(i) collaborative working between professional branches to support and invest into the creation of educational materials for use in induction for junior doctors on the primary/secondary care interface
(ii) clear action from GPC England in discussions with NHSEI to implement contractual levers and contract management to disincentivise and punish breaches of the standard hospital contract.

GLOUCESTERSHIRE: That conference calls on NHSEI to require all providers of surgery or other medical procedures to provide patients with clearly signposted direct access, for a specified time after said procedures, to manage and advise on all complications arising.

LEEDS: That conference believes it is unacceptable in 2021 that secondary care clinicians cannot yet use electronic prescribing systems to enable medication to be dispensed in local community pharmacies dispensing practices and calls on government and NHSEI to take urgent steps to address this in order to reduce inappropriate shifted work to general practice and to improve services to patients.

BEDFORDSHIRE: That conference:
(i) believes it is necessary to resurrect the issue of electronic prescribing and investigation request in secondary care, after the failure to meet the ARM policy targets from 2015 for all secondary care providers to employ these by 2020, and
(ii) believes that a secondary care consultant requesting a test should order it themselves and should have the same access to digital technology to be able to do this as a GP has, and
(iii) instructs that GPC England negotiate with the government that the relevant technology and training is made available for secondary care doctors to be able to undertake electronic prescribing, request tests via the local digital system (such as ICE), and issue Fit Notes digitally.
BUCKINGHAMSHIRE: That conference believes that the current, commonly used approach of prescribing recommendations made by secondary care being forwarded to primary care for actioning, is unsafe, adds unnecessary delays and increases primary care workload inappropriately. Conference instructs GPC England to negotiate for:

(i) solutions whereby prescribing recommendations are to be actioned by the service making the recommendation, by issuing a prescription directly to the patient that can be used by a hospital or community pharmacy, with a record of this to go into the clinical records held in primary care

(ii) a full adoption of electronic prescribing in secondary care, and primary care clinical software which automatically includes any secondary care prescribing in the coded “medication” section.

ADVICE AND GUIDANCE 15.00

AGENDA COMMITTEE TO BE PROPOSED BY NOTTINGHAMSHIRE: That conference is concerned about a lack of cohesion between general practice and secondary care and calls on GPC England to ensure that:

(i) GPs cannot be mandated to use advice and guidance by commissioners or providers
(ii) GPs should be free to refer to a secondary care colleague when thought to be clinically necessary, without pre-referral interference
(iii) if advice and guidance is used, then it is be the role of secondary care, not general practice, to dispense the advice to patients and prescribe where appropriate.

NOTTINGHAMSHIRE: That conference is concerned about a lack of cohesion between general practice and secondary care and requests that:

(i) our secondary care colleagues are trained to enable consultant-to-consultant referral to run smoothly thus preventing the “referred back to GP” letter request ongoing referral
(ii) a review is required of referral between the private and NHS sectors, making it completely transparent who has responsibility for the patient care and the costs thereof.

NOTTINGHAMSHIRE: That conference recognises that referral to our secondary care colleagues is, in some area becoming more bureaucratic and calls on GPC England to ensure that commissioners recognise that:

(i) GPs should be free to refer to a secondary colleague when thought to be clinically necessary without pre-referral interference
(ii) a complete block on further referral template development should be sought unless subject to national agreement with GPC England.

KENT: That conference believes that advice and guidance significantly increases workload in general practice and demands that any transfer of activity receives an appropriate transfer of resource.

Motion by HERTFORDSHIRE: That conference is concerned that the escalating use of advice and guidance (A&G) which is being mandated by some CCGs is increasing GP workload by transferring the responsibility for prescribing, management and follow up, that would previously have been the role of secondary care, onto GPs and calls on GPC England to ensure that:

(i) GPs retain their ability to refer to secondary care when appropriate without being forced to use advice and guidance pathways
(ii) if A&G is used, then it should be the role of secondary care, not general practice, to dispense the advice to patients and prescribe where appropriate
(iii) general practice should only enter into advice and guidance patient care if resources are transferred into general practice.

CONSULTANTS IN GENERAL PRACTICE 15.20

CAMBRIDGESHIRE: That conference sees Integrated Care Systems as having the potential to support the general practice workload crisis so calls on GPC England to explore with NHSEI changes to the performers’ list regulations to allow consultant staff to deliver care within general practice.

BREAK 15.30
AGENDA COMMITTEE TO BE PROPOSED BY WORCESTERSHIRE: That conference recognises that GP representation in the new Integrated Care Systems is unclear and variable and demands that GPC England negotiate with NHSEI that:

(i) all Integrated Care Systems should outline how they will enable LMCs to carry out their statutory role
(ii) there should be no mandated limit on the number of general practice representatives on both NHS and Place Boards and general practice alone should decide who represents them within an ICS
(iii) national funding for GPs roles in system and place leadership be made available
(iv) funding must be ring fenced for enhanced services that are currently commissioned from general practice through locally commissioned services
(v) where collaboration and streamlining of pathways involves work transferring to general practice from secondary care, funding and resource follows from funding previously aligned to secondary care budgets.

WORCESTERSHIRE: That conference is concerned by the lack of a clearly defined role for local medical committees within Integrated Care Systems and believes that:

(i) LMCs and PCN clinical directors should be recognised within integrated care systems for their different but complementary roles
(ii) there should be no mandated limit on the number of general practice representatives on both NHS and Place Boards and general practice alone should decide who represents them within an ICS
(iii) all Integrated Care Systems should outline how they will enable LMCs to carry out their statutory role.

HEREFORDSHIRE: That conference asks GPC to negotiate national funding for GPs role in system and place leadership, in order that general practice can play a full role in developing and enabling changes.

WORCESTERSHIRE: That conference believes that Integrated Care Systems must recognise general practices as independent businesses that cannot absorb financial risk in the way that larger organisations can and demands that:

(i) LMCs must be permitted to protect the commercial interests of practices within an ICS
(ii) funding is ring fenced for enhanced services that are currently commissioned from general practice through locally commissioned services
(iii) where collaboration and streamlining of pathways involves work transferring to general practice from secondary care, funding and resource follows from funding previously aligned to secondary care budgets.

NOTTINGHAMSHIRE: That conference believes that although the formation of ICSs may to some extent reduce bureaucracy, it will also decrease the involvement of general practice care in core NHS planning, and asks for statutory representation by GPs through the LMC in all aspects of general practice development planning.

SURREY: That conference recognises that GP representation in the new ICSs is unclear and variable, and currently lacks clarity over accountability and funding, and asks GPC England to:

(i) ask NHSEI to issue central guidelines to ICSs on the statutory role of the LMC
(ii) ask NHSEI to work with commissioners to ensure that the interests of general practice are properly represented at all levels of the ICS
(iii) ask NHSEI to work with commissioners to ensure GP representation (and the attendant governance) is properly funded
(iv) work with the BMA to develop advice on representation, accountability, and most importantly conflicts of interest.

DEVON: That conference demands that the balance of input into local care partnerships is appropriate and not weighted so that primary care is disadvantaged.
AVON: That conference calls for NHSEI 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.

DEVON: That conference requests the negotiation of funding for general practice to be represented at ICS and LCP levels allowing full engagement of primary care in health care discussions.

LEEDS: That conference believes general practice must be enabled to take a leading role in ICS and ICP arrangements and insists that this work must be fully funded to allow GPs and team members to take an effective part.

DEVON: That conference calls for an equality of decision making and distribution regarding the Better Care Fund in all areas.

GREENWICH: That conference is concerned that ICSs have failed to recognise the pivotal role of general practice in delivering population health outcomes and demands that general practice has a voice on ICSs in recognition of the unique holistic role of GPs which makes them ideally placed to identify areas of health gains at the strategic level.

HEREFORDSHIRE: That conference requires GPC to negotiate a defined process to establish a funding floor for locally commissioned services, so that the creation of integrated care systems does not destabilise practices.

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.

NORTH STAFFORDSHIRE: That conference believes ICSs are making decisions about primary care without involving primary care, and that GPC England should negotiate the reinstatement the key role of LMCs as the voice of general practice and that conference demands

(i) that the GPC England executive should work with NHSEI to make sure clinical leadership of primary care at ICS level should be appointed with involvement with LMCs, and this should be made mandatory

(ii) that conference is concerned that it is not clear from the health and social care bill how the commissioning units will look like in the ICSs and urges GPC England Executive to negotiate LMC input into the setting up of these.

KENT: That conference believes that the introduction of Integrated Care Systems presents a risk to general practice funding and stability, and demands that GPC England defines mechanisms for integration between general practice and other stakeholders that:

(i) safeguard the independent contractor model

(ii) ensure funding is allocated fairly between system partners

(iii) ensure general practice has parity with other providers when allocating contracts.

NORFOLK AND WAVENEY: That conference asks GPC to ensure general practice funding is ring-fenced within local ICS funding. Otherwise the development of ICSs could potentially adversely affect direct and indirect funding that currently supports general practice service provision.

AVON: That conference demands that GPC England, in negotiations with NHSEI, insists that funding is not removed from primary care budgets as a result of the new NHS reforms.

KENT: That conference demands PCN clinical directors are funded appropriately for their participation in Integrated Care System meetings.
CONFERENCE FORMAT 16.00

* 9 DEVON: That conference proposes that we should bravely lead the way and update the tired, 1970s styled, binary motion format we follow by empowering the next Agenda Committee to completely rewrite the conference standing orders with the aim of having:
(i) fewer motions, more debate
(ii) motions written by the Agenda Committee responding to subjects proposed by LMCs
(iii) motions debated in camera that do not form policy but revisit controversial subjects as these often produce the most informative debate
(iv) more experimentation and exploration of the value of break-out discussion groups.

9a SOMERSET: That conference admires and thanks the agenda committee for its stalwart work but:
(i) believes that the grave, volatile circumstances affecting primary care make submitting motions in September for a November conference even more potentially irrelevant than usual and
(ii) urges the agenda committee to find a way to bring the deadline for submission nearer to the date of the conference.

9b HAMPSHIRE AND ISLE OF WIGHT: That conference acknowledges that the expertise in local medical committees extends beyond the elected GP members with many having appointees from other staff groups, including practice managers. We therefore request an amendment to standing orders such that any lay person, who is a co-optee or invitee under the constitution of their LMC, may request to speak to all business of the conference at the request of their LMC.

NHS 111 16.20

* 10 AGENDA COMMITTEE TO BE PROPOSED BY DERBYSHIRE: That conference, with respect to NHS 111:
(i) believes that general practice is not an emergency service and cannot safely receive one / two hour dispositions from NHS 111 services and demands that these stop
(ii) recognises that it has become a conduit for patient flow, causing delays to ambulance services, A&E departments and NHS general practice for non-urgent issues
(iii) calls for its wholesale review so that protocols, staffing, and funding are fit for purpose
(iv) demands that all direct NHS 111 bookings into NHS general practice are suspended where an OPEL4 / Red alert (or equivalent) has been declared by the practice.

10a DERBYSHIRE: That conference understands Direct 111 booking into practices of frequently inappropriate appointments is unsustainable at a time of national general practice crisis. Therefore, direct NHS 111 booking must be suspended when a practice area is declaring OPEL 4 / Red alert rating.

10b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that 111 is not fit for purpose, indicating that patients need to book an appointment with general practice in an hour is both unrealistic and unreasonable. General practice is not ED, so if a patient is required to be seen with such urgency an appropriate service should be devised and resourced.

10c SOUTH STAFFORDSHIRE: That conference insists that urgent care needs to be integrated with the whole NHS and care systems so that trusts and companies providing out of hours care have to provide a local service that supports in hours primary and secondary care, rather than ‘fire-fighting’ and passing out of hours problems into emergency secondary care or back into in hours primary care. 111 protocols and staffing must be strengthened to support this.’

10d NOTTINGHAMSHIRE: That conference deplores the continuing disproportionate funding of 111 in its current state, recognising it as a conduit for patient flow to both A&E departments and to general practice for issues that are often not urgent at all. We call for a review of 111 in its present state, with the aim that monies can be better spent elsewhere in both the Health and Social Care budgets.

10e NORTH YORKSHIRE: That conference demands that NHSEI recognise that primary care is not an emergency service and GPC England negotiate that 111 must stop the ‘GP respond within one or two hour’ dispositions.
WEST PENNINE: That conference demands national ambulance waiting times are met universally and triaging 111 calls should not be part of ambulance trusts’ requirements and recognises that the 111 algorithm is a major cause of AED and ambulance delays.

NORFOLK AND WAVENEY: That conference asks GPC to negotiate a formal method whereby general practice, comparable with all other areas of the NHS, can declare to its population and the wider health and social care system that it is under maximum pressure and in order to safely continue to operate and needs to make short term adjustments to its working patterns.

ENVIRONMENT

AGENDA COMMITTEE TO BE PROPOSED BY KERNOW: That conference, recognising our responsibilities to achieve carbon neutrality by 2030, calls for:

(i) a primary care clinical lead on every ICS sustainability board with a commitment to greater prioritisation of primary care in ICS Green Plans
(ii) an evaluation of the environmental impact and clinical suitability of personal protective equipment procurement
(iii) a review of the return, reuse and recycling of medicines, medical devices, and equipment to reduce un-necessary waste generation by the NHS including general practice
(iv) GPC England to negotiate with NHSEI to provide sustainability funding to ensure all NHS GP surgeries are net carbon neutral by 2030
(v) the Department of Health and NHSEI to require a carbon neutral footprint of pharmaceutical products by 2030, preferentially procuring with providers who can demonstrate this to purchasers, prescribers and patients.

KERNOW: That conference requests GPC England to negotiate with the government to ensure that general practice is either included in the public sector decarbonisation fund or that government creates a separate fund for general practice to accelerate investment in larger infrastructure projects and retrofitting buildings to reduce the carbon footprint of the buildings in primary care.
(Supported by Gloucestershire LMC)

KERNOW: That conference, given the shocking IPCC report on the climate crisis, calls on the GPC to negotiate with NHSEI to ensure that the ICSs prioritise sustainability and carbon neutrality. We ask that:
(i) each ICS employs a primary care clinician as a sustainability lead
(ii) each ICS includes a detailed plan for primary care in its green plan, has a sustainability action plan and that primary care is included in that plan
(iii) any work coming to practices as a result of the plan is resourced fully and exchanged for other work which doesn’t have such immediate priority and being mindful that much work may just need to be done once e.g. inhaler switches, waste management alterations etc.

KERNOW: That conference welcomes the Greener NHS ambition to reach net zero carbon by 2040 but demands that practices receive urgent practical and financial resources to make the necessary changes, by
(i) GPC England negotiation with NHSEI for sustainability funding for practices
(ii) GPC England dissemination of success in primary care decarbonisation through widely promoting the resources of RCGP Green Impact for Health toolkit and the Greener Practice website
(iii) inclusion of a primary care clinical lead on every ICS sustainability board and significantly greater prioritisation of primary care in ICS Green Plans.
(Supported by Gloucestershire LMC)

KERNOW: That conference notes NHSEI’s net zero targets for carbon emissions but is concerned with the paucity of reference to primary care in its report “Delivering a Net Zero Health Service”. The conference therefore asks GPC England to lobby NHSEI for practical and financial support for primary care decarbonisation by:
(i) providing funding for case studies of carbon reduction for each of the regions in primary care and support for all GP practices to implement them
(ii) providing the necessary education and support to promote a significant shift from metered dose, to dry powder inhaler prescription in general practice
(iii) developing a balanced, and potentially less carbon-intensive infection control policy appropriate to the lower risks found in primary care compared to other healthcare settings.

(Supported by Sheffield LMC)

11e GLOUCESTERSHIRE: That conference is concerned about the carbon footprint of pharmaceutical companies and urgently calls on them to reduce the carbon footprint of their products and deliver useful carbon costing information to prescribers and patients.

11f GLOUCESTERSHIRE: That conference calls on the government to prioritise contracting with only the pharmaceutical companies that have an audited demonstration of working towards a carbon neutral goal by 2030.

11g GLOUCESTERSHIRE: That conference is concerned that waste streams are not reviewed and evaluated and we need rapid access to appropriate alternatives and waste streams:
(i) PPE use is evaluated for its environmental impact and alternatives (such as funding reusable Type IIR approved masks) are evaluated and funded
(ii) waste stream funding is negotiated to ensure that practices are incentivised to recycle and dispose of waste appropriately
(iii) recycling schemes for inhalers are made locally available to all community pharmacists with ease of use for patients the priority.

11h GLOUCESTERSHIRE: That conference notes NHSEI’s net zero targets for carbon emissions but is concerned with the paucity of reference to primary care in its report “Delivering a Net Zero Health Service”. The conference therefore asks GPC to lobby NHSEI for practical and financial support for primary care decarbonisation by:
(i) providing funding for case studies of carbon reduction for each of the regions in primary care and support for all GP practices is evaluated to implement them
(ii) providing the necessary education and support to promote a significant shift from metered dose, to dry powder inhaler prescription in general practice
(iii) developing a balanced, and potentially less carbon intensive infection control policy appropriate to the lower risks found in primary care compared to other healthcare settings.

11i GLOUCESTERSHIRE: That conference, given the shocking IPCC report on the climate crisis, calls on the GPC to negotiate with NHSEI to ensure that the ICSs prioritise sustainability and carbon neutrality. We ask that:
(i) each ICS employs a primary care clinician as a sustainability lead
(ii) each ICS has a sustainability action plan and that primary care is included in that plan
(iii) any work coming to practices as a result of the plan is resourced fully and exchanged for other work which doesn’t have such immediate priority and being mindful that much work may just need to be done once eg inhaler switches, waste management alterations etc.

11j AVON: That conference, given the shocking IPCC report on the climate crisis, calls on the GPC to negotiate with NHSEI to ensure that the ICSs prioritise sustainability and carbon neutrality. We ask that:
(i) each ICS employs a primary care clinician as a sustainability lead
(ii) each ICS includes a detailed plan for primary care in its green plan, has a sustainability action plan and that primary care is included in that plan
(iii) any work coming to practices as a result of the plan is resourced fully and exchanged for other work which doesn’t have such immediate priority.

11k AVON: That conference is concerned about the carbon footprint of pharmaceutical companies and urgently calls for GPC to lobby Greener NHS to make them reduce the carbon footprint of their products and deliver useful carbon costing information to prescribers and patients.

11l AVON: That conference calls on NHS England to prioritise contracting with only the pharmaceutical companies that have an audited demonstration of working towards a carbon neutral goal by 2030.

11m AVON: That conference is concerned that waste streams are not reviewed and evaluated and we need rapid access to appropriate alternatives and waste streams. The conference calls for GPC to negotiate with NHS England to ensure that:
PPE use is evaluated for its environmental impact and alternatives (such as funding, reusable Type IIR approved masks) are evaluated and funded.

Waste stream funding is negotiated to ensure that practices in England are incentivised to recycle and dispose of waste appropriately.

Recycling schemes for inhalers are made locally available in England to all community pharmacists with ease of use for patients the prior.

HAMPSHIRE AND ISLE OF WIGHT: That conference has already supported addressing the climate and ecological emergency. The upcoming agenda is an opportunity to progress action on this. Also to more strongly recognise the importance and health impacts of doing so. We need a net zero plan for primary care. Conference calls on the GPC to negotiate with NHSEI to:

(i) make sure that each ICS has employed a funded clinician as a sustainability lead
(ii) that each ICS has a sustainability action plan and that primary care is included in the plan, and
(iii) that any work coming to practices as a result of the plan is fully resourced.

WALTHAM FOREST: That conference recognises the role we all have in addressing the current ecological crisis and that to support general practice to become ‘greener’ requires:

(i) every borough to have a general practice sustainability lead
(ii) a change to infection control policies that support and encourage the safe use of re-usable medical equipment
(iii) GPC England to publicly lobby government to introduce legislation that enables medication return and recycling.

CAMDEN: That conference requests GPC England to negotiate with the government to ensure that general practice is included in the public sector decarbonisation fund or that government creates a separate fund for general practice to accelerate investment in larger infrastructure projects and retrofitting buildings to reduce the carbon footprint of the buildings in primary care.

LIVERPOOL: That conference believes that, given the Intergovernmental Panel on Climate Change report on the climate crisis, GPC England must negotiate with NHSEI to ensure that the ICSs prioritise sustainability and carbon neutrality, such that:

(i) each ICS employs a clinician as a sustainability lead
(ii) each ICS has a sustainability action plan and that primary care is included in that plan
(iii) any work coming to practices as a result of the plan is resourced fully and exchanged for other work which doesn’t have such immediate priority, being mindful that much work may just need to be done once, for example inhaler switches and waste management alterations.

LIVERPOOL: That conference believes that the greener NHS ambition to reach net zero carbon by 2040 should be welcomed, but demands that practices receive urgent practical and financial resources to make the necessary changes, by:

(i) GPC England negotiating with NHSEI for sustainability funding for practices
(ii) GPC England dissemination of success in primary care decarbonisation through widely promoting the resources of RCGP Green Impact for Health toolkit and the Greener Practice website
(iii) inclusion of a primary care clinical lead on every ICS sustainability board and significantly greater prioritisation of primary care in ICS Green Plans
(iv) GPC England negotiating with NHSEI for funding to install charging points, at GP practices, for electric vehicles.

BARNET: That conference is concerned about the carbon footprint of pharmaceutical companies and calls on the Department for Health together with NHSEI to urgently require a reduction in the carbon footprint of their products and ensure that:

(i) contracting with pharmaceutical companies that have an audited demonstration of working towards a carbon neutral goal by 2030 is prioritised
(ii) products deliver useful carbon costing information prescribers and patients.

ISLINGTON: That conference, given the shocking IPCC report on the climate crisis, calls on the GPC England to negotiate with NHSEI to ensure that the ICSs prioritise sustainability and carbon neutrality and ensure that:
(i) each ICS employs a clinician as a sustainability lead
(ii) each ICS has a sustainability action plan in place that includes primary care as part of that plan
(iii) any work coming to practices as a result of the plan, given the potential workload and organisational impact upon practices, is fully supported and resourced.

(Supported by Tower Hamlets LMC)

11u ISLINGTON: That conference notes NHSEI’s net zero targets for carbon emissions but is concerned with the paucity of reference to primary care in its report “Delivering a Net Zero Health Service”. Conference therefore asks GPC England to lobby NHSEI for practical and financial support for primary care decarbonisation by:
(i) providing funding for regional pilots for carbon reduction in primary care and support for all GP practices to implement them
(ii) providing support for the necessary education to promote the shift from metered dose to dry powder inhaler prescription in general practice
(iii) developing a balanced, and potentially less carbon intensive infection control policy appropriate to the lower risks found in primary care compared to other healthcare settings.

11v HARINGEY: That conference is concerned that waste streams are not reviewed and evaluated and calls upon GPC England to lobby the Department of Health and NHSEI to ensure that:
(i) PPE use is evaluated for its environmental impact and alternatives (such as funding reusable Type IIR approved masks) are fully evaluated and funded
(ii) waste stream funding is provided to ensure that practices are incentivised to recycle and dispose of waste appropriately
(iii) working with community pharmacy colleagues, prioritise the provision of recycling schemes for inhalers that are easily accessible for patients use locally.

11w LIVERPOOL: That conference believes that general practice should be supported in its continued use of virtual and telephone consultations as a first point of contact option in acknowledgement of the benefit this has on carbon emissions in primary care and for access to primary care (respecting the digital divide issues).

11x CLEVELAND: That conference wishes to see further investment in the digitalisation of general practice, to enhance workplace efficiency and to support the roadmap to carbon neutrality.
**OPENING BUSINESS**

**ONLINE CONSULTATIONS**

* 12 AGENDA COMMITTEE TO BE PROPOSED BY WIRRAL: That conference believes that GP practices should decide how they can provide the best service to their patients; the introduction of online consulting was inadequately planned and resourced, and:

(i) insists on proper evaluation of the workload, safety, cost and impact on health inequalities of these before any further roll out is implemented

(ii) directs GPC England to negotiate regulations that enshrine the rights of practices to choose which systems they use for their population

(iii) believes that online consulting should not be a part of the GMS contract

(iv) calls for the removal of all mandates and incentives regarding online consultations

(v) is concerned that the 21/22 PCN DES includes a target for number of e-consultations per practice and calls for this target should be scrapped.

12a WIRRAL: That conference believes that the introduction of electronic consulting:

(i) was inadequately planned and resourced

(ii) it is putting an excessive strain on primary care

(iii) compromising service delivery and patient care

(iv) exacerbating existing inequalities in access to healthcare

(v) should therefore not become a contractual.

12b DEVON: That conference calls for the removal of all NHSEI mandates and incentives regarding electronic consultations as GP practices should decide how they can provide the best service to their patients.

12c GLOUCESTERSHIRE: That conference questions the value of current electronic consultation access to practices and insists on proper evaluation of the workload, safety and cost of these before any further roll out is implemented.

12d KENT: That conference believes that online consultations increase the total number of patients contacts therefore reduces the efficiency of general practice and demands that the GPC England negotiates sufficient resource to reflect the additional workload.

12e DERBYSHIRE: That conference understands the non-negotiated 21/22 PCN DES Update, includes a target for the number of e-consultations per practice. We are concerned that this opens the door to a 24 hour consultation culture that is neither safe nor sustainable and directly increases health inequalities. Practices within a PCN must be allowed to determine how best to consult their patients and this target should be scrapped.

12f NORFOLK AND WAVENYEY: That conference believes that the use of information technology should be focused towards helping clinicians managing the increasing demand on the health service rather than focusing on ease of access for the patient which is driving unprecedented demand. This has had an effect on widening health inequalities as the most vulnerable in society have the least access to this technology.

12g EAST SUSSEX: That conference recognises that NHSEI’s aspirations for a digital service have cause significant problems for practices, and asks GPC England to negotiate:

(i) a moratorium on implementation until the workload and access implications are better understood

(ii) new funding to explicitly support the extra workload created by the increased access created by a digital service
CHOSEN MOTIONS

CONTRACT REFORM

* 13 AGENDA COMMITTEE TO BE PROPOSED BY EAST SUSSEX: That conference believes that GPC England is at risk of presiding and prevaricating over the slow death throes of GMS, and:
   (i) believes that the current GMS block contract of funding for general practice is outdated and inadequate for the current healthcare environment
   (ii) believes that the model of unrestricted workload for a fixed fee is a major disadvantage to general practice within the new ICS landscape
   (iii) calls on GPC England to negotiate a fee for service contract, including item of service payments for core general practice work, rather than the current block contract
   (iv) tasks GPC England with negotiating a contract that allows practices to offer private services alongside NHS services, where such services are not commissioned by the NHS for delivery in a general practice setting
   (v) tasks GPC England with exploring alternative contractual models for general practice in a post-NHS world.

13a EAST SUSSEX: That conference notes that the profession and LMCs both predate the NHS, and will probably outlive it; but given the current relationship between NHSEI and GPC England, and the parlous state of both the NHS and social care, it tasks GPC England with:
   (i) exploring alternative contractual models for general practice in a post-NHS world
   (ii) negotiating a contract that allows us to offer private services alongside NHS services, where such services are not commissioned by the NHS for delivery in a general practice setting, in order to fill service gaps and bring investment into general practice.

13b CLEVELAND: That conference, in respect of the current GMS contract:
   (i) believes that the model of unrestricted workload for a fixed fee is a major disadvantage to general practice within the new ICS landscape
   (ii) believes that it is no longer fit for purpose
   (iii) mandates GPC England to formally commence negotiations on a new GMS contract.

13c CAMBRIDGESHIRE: That conference believes that GPC England is at risk of presiding and prevaricating over the slow death throes of GMS and calls on the committee to urgently rethink its strategy and focus on protecting GMS and total practice income above all other metrics and contractual mechanisms.

13d BERKSHIRE: That conference believes that the current GMS block contract of funding for general practice is outdated and inadequate for the current healthcare environment, and:
   (i) does not sufficiently fund either the quantity or the quality of primary care now delivered by general practice
   (ii) has led to an exodus of GPs from partnership, and a crisis in workforce recruitment and retention
   (iii) calls on GPC England to negotiate a fee for service contract, including item of service payments for core general practice work, rather than the current block contract
   (iv) demands a simplification of additional funding streams for primary care, rather than current target based funding formats which increase administrative burden and reduce the time GPs have available to care for their patients.

13e CLEVELAND: That conference mandates GPC England to negotiate an amendment to the clause within the GMS contract which prevents GPs from undertaking non-NHS work within their NHS premises such that this is permissible:
   (i) for services that are not commissioned from the NHS anywhere within the ICP/ICs area
(ii) for services that are not included within the GMS contract or any LES/LIS
(iii) outside of core contracted hours
(iv) for non-registered patients
(v) without any restrictions.

13f KENT: That conference demands that general practice funding streams are simplified and added to the global sum.

13g KENT: That conference believes that funding growth for general practice does not cover increased running costs and demands the GPC lobbies NHSEI to rectify this.

13h WEST SUSSEX: That conference believes that the current GMS funding is not sufficient for the service we are being asked to deliver, and that current increases are not keeping pace with rising costs, and asks GPC England to:
(i) ensure that recommended or obligatory increases in staff pay, pensions, and national insurance contributions are factored in to all negotiations
(ii) negotiate an agreed minimum capitation value to avoid practices being adversely penalised by the Carr-Hill formula
(iii) negotiate increases in GMS funding that at least match those in secondary care.

13i MID MERSEY: That conference believes that general practice cannot survive on a fixed income that takes no account of escalating activity.

13j MID MERSEY: That conference considers that funding calculations must account for this increased activity and the hours of clinician and staff time required to deliver it, including adjustments for inherent additional costs such as overtime and sickness.

13k WEST SUSSEX: That conference recognises that since the last major contract agreement in 2004 the workload and output of general practice has increased significantly whilst both real-term and proportional funding has decreased, and asks GPC England to:
(i) urgently negotiate a new contract which explicitly links workload and funding
(ii) negotiate a contract that directs 11% of NHS funding into general practice.

13l BEDFORDSHIRE: That conference calls upon GPDF to commission and fund research into the creation of an options paper for GPC England that will investigate:
(i) the benefits / risks options and costs associated with the provision of general practice in England outside of the GMS / PMS / APMS contract model
(ii) 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
(iii) how the future of a separately negotiated model around NHS and non NHS provision of general medical services could be facilitated.

13m GLOUCESTERSHIRE: That conference holds that demand is at an unsustainable level, and that all measures need to be taken to reduce this including a small patient charge refundable as appropriate as successfully happens in many Western European countries with better health outcomes and a healthier workforce.

13n BERKSHIRE: That conference notes the recent failure to account for a 3% increase in salary costs for salaried GPs (after the relevant recommendation of the DDRB) with any associated uplift in global sum funding for general practice, and:
(i) calls for any such recommendations to be considered a negotiating baseline, not a ceiling, in future contract negotiations
(ii) believes that primary care requires an uplift to core funding far in excess of this, in order to ensure the stability of practices and ensure good quality care.

13o CAMBRIDGESHIRE: That conference is disappointed that GPC England has failed to negotiate any review of the GP funding formula despite previous conference motions mandating it to do so, and reaffirms that the current funding formula remains flawed, outdated and unfit for purpose; contributes to the widening of health inequalities affecting populations; has a direct deleterious effect on workforce numbers in areas of
lower funding and calls on GPC England to produce a briefing paper on funding formulae to be brought back to England Conference of LMCs in 2022.

13p CLEVELAND: That conference believes that successive governments have failed to properly invest in general practice to meet the needs of the population, and therefore mandates that GPC England takes action to control demand by:

(i) issuing contractual guidance on workload control with a focus on registered list size
(ii) issuing contractual guidance on workload control with a focus on safe practice staffing
(iii) seeking to renegotiate GMS essential services, to numerically define the contractual requirements within this clause.

13q AVON: That conference finds due to whole system pressures, the workload of general practice is unsustainable. Conference is asked to instruct the GPC to make representations to NHSEI to recognise that GPs cannot continue to guarantee that patient care will not be compromised if GPs are required to ensure that practices:

(i) are sustainable
(ii) cope with an increasing workload
(iii) continue to support clinically the rest of the health care system.

13r LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference demands that GPC renegotiates the GMS contract to recognise the increasing demands placed on general practice by:

(i) financially recognising consultation rates
(ii) defining the "reasonable needs of patients"
(iii) placing a ceiling on individual GP consultations per day.

13s NORTH STAFFORDSHIRE: That conference believes that the volume of work has increased considerably for general practices in the last year and urges GPC Executive to negotiate with NHSEI a workable solution to support general practices, rather than spending all new resources on PCNs.

13t SANDWELL: That conference asks GPC England to clarify what is a reasonable and sustainable workload for a GP partner. If GPC England cannot so do, they shall indicate who can.

13u MID MERSEY: That conference considers that funding must also take account of the demand that is currently unmet and enable practices to bridge the gap between current capacity and unmet expectations.

13v NORFOLK AND WAVENEY: That conference believes that the recent BMA publication 'Workload Control in General Practice' does not provide the answers to the problem. That 'Overflow hubs' be unsuitable for non-urban areas, and they will result in loss of continuity of care, efficiency, final responsibility and as a result, job satisfaction for GPs.

13w HERTFORDSHIRE: That conference believes the time has come to separate acute and chronic work in general practice and calls on GPC to push for the full funding for general practices or PCNs to establish these as soon as possible.

13x AVON: That conference requests that GPC England provide an update to conference on the work on safe consulting limits which was previously discussed.

13y EAST SUSSEX: That conference recognises that the hugely increased workload in general practice has brought the service to breaking-point, and asks GPC England to:

(i) urgently negotiate with NHSEI the provision of extra resources to allow practices to cope in the short and medium term
(ii) work with the BMA to set maximum safe levels of acceptable workload.

13z NORFOLK AND WAVENEY: That conference believes in a time of significantly increased demand in primary care, it is not currently possible or sustainable to continue to offer both unrestricted online access, and face to face / telephone access to our patients in a safe form due to limited NHS resources of clinical and administrative staff.
13aa NORTH YORKSHIRE: That conference believes QOF is time expired and that GPC England should negotiate this funding being reinvested into practices to support emerging work on local population health priorities and inequalities.

13bb WALTHAM FOREST: That conference acknowledges GPC policy that the Carr Hill formula is no longer fit for purpose but will not continue to accept the lack of progress in enacting this policy and insists that:
(i) as an interim measure any new or change to existing capitation based contracts is based on raw list size and not weighted populations
(ii) prior to GPC England entering into any new negotiations with NHSEI, a public statement from NHSEI is required stating that the GP funding formula will be reviewed, this must include a deadline as to when the review will be completed.

13cc BEDFORDSHIRE: Because the GMS contract has no caps on it in terms of patient appointments, conference asks GPC England to:
(i) negotiate a "National GP Traffic Light System" for daily patient/GP contacts to ensure there is a maximum number of such contact to safeguard patient and the mental and physical health of the GP, or
(ii) prior to GPC England entering into any new negotiations with NHSEI, a public statement from NHSEI is required stating that the GP funding formula will be reviewed, this must include a deadline as to when the review will be completed.

13dd GLOUCESTERSHIRE: 'That conference holds that a maximum list size of around 1000 patients per WTE should be a target for GPC to deliver to achieve a safer general practice for patients and staff.

BREAK

COVID-19 VACCINATION PROGRAMME

14 GATESHEAD AND SOUTH TYNESIDE: That conference recognises the efforts made by practices across the nation to deliver a world-leading vaccination programme, saving lives and helping the country recover from the pandemic and:
(i) applauds the fact that many GPs are prepared to deliver the booster programme in the face of an unprecedented workload burden
(ii) questions the preferential terms given for delivery of small batches to pharmacies
(iii) is concerned that the PCN model of delivery places an undue burden on practices and limits access for patients
(iv) demands that practices be given the freedom to deliver at practice level in order to increase freedom of delivery and vaccine uptake whilst reducing their administrative burden.

14a LEEDS: That conference applauds the lifesaving work by GPs and their teams by vaccinating millions of people with both Covid-19 boosters and influenza vaccine, following the hugely successful phase 1 and 2 of the Covid-19 vaccination programme earlier this year, and encourages any remaining eligible people to take up the offer to be vaccinated as soon as possible.

14b LIVERPOOL: That conference believes that not enabling Covid-19 vaccinations to easily take place at GP practices potentially risks the lives of the most hard to reach patients, including many of the most vulnerable in society, and calls upon GPC England to negotiate practice level delivery, in the same way that smaller pharmacies have been enabled to deliver Covid-19 vaccinations.

14c NOTTINGHAMSHIRE: That conference believes that there has been lack of foresight and collaboration with general practice when designing the Covid-19 vaccination 3rd dose enhanced service to dovetail with flu vaccination roll out and requests:
(i) timely, proactive and inclusive consultation and information dissemination from policy makers to aid clarity about major strategic decisions which impact on general practice and patient safety
(ii) policy makers incorporate flexibility, uplifted investment in-built into the tariffs and mitigations which allow for increased creative local implementation

(iii) an uplift of the flu tariff in general practice to sustain and support the profession to take into consideration that uptake may be limited this year due to diverting finite practice resources into delivering the Covid-19 3rd dose vaccine roll out.

14d NORTH YORKSHIRE: That conference insists national bureaucracy associated with the vaccine programme ceases now, and regions and GPs / pharmacists are enabled to innovate and simply get on with delivering it.

WELLBEING – THEMED DEBATE 11.00

In 2021, the agenda committee knew that there would be many reflections on how hard the last 18 months had been for general practice. We were, however, overwhelmed both by the number of motions submitted, and the deep hurt and damage to the profession that they articulated. We all know friends and colleagues who have not survived the pandemic - either sacrificing their lives, their mental health or their career. The term "wellbeing" cannot possibly encompass all the challenges that those who work in general practice have to face. But it is a place to start.

This themed debate seeks to provide a platform and a voice for those working and representing general practice. Some things you may wish to share:

- What does it feel like to be a GP at the moment?
- What one message do you want your patients to hear?
- What does abuse from patients feel like?
- How has abuse affected you and your team?
- Have you suffered from burnout or work-related depression?

Please take part by:

- Submitting a pre-recorded speech (instruction on how to do this are attached)
- Emailing (info.lmccconference@bma.org.uk) your experience to be read out by a member of the agenda committee (this can be done anonymously)
- Entering a speaker slip from the opening of conference.

The decision to include this debate in the open section of the agenda, and to extend invitations to as wide a press and public presence as possible is deliberate. We want your voices to be heard. The Wellbeing Themed Debate will be conducted under standing order 50. The motions submitted by LMCs that the Agenda Committee considers are best covered by this themed debate are included in the agenda here and are numbered TD1 to TD34. All members of conference may take part in this debate in the ways outlined above, with time limit of one minute per speaker.

Please send your pre-recorded videos to info.lmccconference@bma.org.uk by 12 noon on Wednesday 17 November 2021.

Statements that are to be voted on:

- That conference supports our patients whose care is being compromised by insufficient resources to meet their needs.
- That conference believes the abuse of primary care staff directly affects patient care and puts patient safety at risk.
- That conference believes when government and NHSEI choose not to support NHS staff, they directly affect patient safety and knowingly put lives at risk.
• That conference empowers our representatives to prioritise the safety and wellbeing of general practice doctors in all discussions and negotiations with the government and NHSEI.

• That conference demands healthcare policy is decided based on high quality evidence on population health, and not the whims of a handful of vitriolic media.

TD1 LINCOLNSHIRE: That conference is disgusted by recent increases in abuse and aggression directed towards general practice teams and calls on NHSEI to:
(i) run a sustained and vociferous media campaign which endorses the good work that general practices are doing
(ii) amend the Special Allocation Scheme to allow patients to be included who have displayed any form of aggression in person, on telephone, or online.

TD2 LIVERPOOL: That conference believes that it is imperative for NHSEI to work with the GPC England to openly, publicly and effectively refute the ideology, which is rapidly gaining traction in the media that “general practice is closed”, as this is leading to abuse and aggression towards GP practices and its staff.

TD3 TOWER HAMLETS: The conference is concerned about the safety and the negative impact on front facing staff in primary care from increasing hostility and aggression due to delays in accessing treatment following the Covid-19 pandemic and that conference:
(i) acknowledges that the pandemic has put pressure on NHS resources
(ii) calls on GPC England to demand that NHSEI make it clear to the public that general practice is not to blame for treatment delays
(iii) calls on GPC England to demand that general practice staff are entitled to expect the same level of security as our secondary care colleagues and for meaningful discussions as to how this can be affected.

TD4 NORTH YORKSHIRE: That conference finds it deeply upsetting and damaging to moral that NHSEI and DHSC stay silent whilst inaccurate negative news articles about general practice are continually published and demands a formal apology and letter published in support of general practice.

TD5 DEVON: That conference believes that inaccurate media reporting is causing severe damage to the reputation of general practice. This must be countered by an effective, swiftly implemented media campaign.

TD6 NORFOLK AND WAVENEY: That conference is concerned that the ongoing false messages portrayed in the tabloid and social media that general practice has not been open for business should be more robustly refuted by HMG, NHSEI and others in authority as there is an increasing detrimental effect on the mental well-being of all staff in general practice and will contribute to further problems in workforce retention.

TD7 EALING, HAMMERSMITH AND HOUNSLOW: That conference condemns NHSEI’s failure to adequately publicly promote GPs contribution to the pandemic response and calls upon GPC England to insist that NHSEI stand up for GPs and clearly acknowledge their vital contribution to vaccinating the nation at a time of despair in nearly every other outcome related to Covid-19.

TD8 CENTRAL LANCASHIRE: That conference agrees that the level of abuse towards primary care staff has reached unacceptable levels and calls upon GPC England to urgently work with the government to come up with a plan to address this that involves a robust public facing campaign.

TD9 BEDFORDSHIRE: That conference calls on GPC England to make clear both to GPs and the public at large that:
(i) despite negative comments in the press, GPs are working hard to deal with backlogs created by Covid-19
(ii) the workload of Covid-19 and its aftermath is having a serious impact on the physical and mental health of GPs
(iii) GPs will not improve their patients’ health by sacrificing their own.

TD10 WORCESTERSHIRE: That conference believes that NHSEI are increasingly distanced from the realities of general practice and we insist that:
(i) the tone of communications sent directly to GPs by NHSEI is addressed urgently as this has served only to demoralise the workforce and further encourage colleagues to leave the profession

(ii) delays to income protection when circumstances are beyond our control is unacceptable and NHSEI must reassure the profession that they will act promptly to put this in place in such scenarios in future. Uncertainty results in unnecessary additional workload and stress for practices.

TD11 OXFORDSHIRE: That conference calls on the BMA to make a positive case for NHS general practice in the media rather than merely reacting to negative press.

TD12 LAMBETH: That conference is concerned about the increasing levels of abuse of practice teams and calls for a review of NHS zero tolerance policies and that:
   (i) it is made clear to the public that all types of abusive behaviour is inappropriate and will not be tolerated
   (ii) the legislation to remove a patient from a practice list is simplified so as not to require multiple warning or police involvement
   (iii) patients removed from a practice list for abusive or violent behaviour are assigned to the special allocation scheme.

TD13 SHROPSHIRE: That conference supports a policy of zero tolerance to abuse of GP practice or those working in them and calls upon NHSEI to create a fast-track mechanism for GP practices to remove patients from their lists who publicly make abusive statements about primary care doctors or their staff.

TD14 COVENTRY: That conference believes that the benefits of remote consulting are being severely undermined by a media onslaught based on patient want rather than need. In light of this, conference calls upon NHSEI to support practices in:
   (i) delivering care to patients in the most clinically appropriate manner as determined by GPs
   (ii) in launching a patient education initiative explaining to the public and media that in many cases remote consulting is of significant benefit to patient care and wellbeing
   (iii) highlighting that drivers behind the surge in remote consulting are infection control, workforce pressures and the significant increase in demand that general practice has seen since March 2020.

(Supported by Warwickshire LMC)

TD15 GREENWICH: That conference deplores the lack of support and positive messaging from NHSEI to help patients adjust to the new remote and digital ways of working which had left many practices in the firing line for Healthwatch and the media and calls upon NHSEI to:
   (i) have an extensive nationwide media campaign supporting practices
   (ii) allow local primary care teams to have local media campaigns.

TD16 SOMERSET: That conference, noting news media outrage claiming GPs do not offer enough face-to-face appointments followed NHSEI announcing an Impact and Investment Fund indicator target for online consultations, urges GPCE to insist that NHSEI:
   (i) has "hung general practice out to dry" by not defending it publicly
   (ii) is honest about its requirement for primary care to deliver more remote consultations to 'enhance productivity and value for money.'

TD17 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that in order to maintain patient safety, and protect general practice staff from burnout, general practice needs to be able to control workload created by online services. This includes each practice having the ability to turn the service on and off at their will and being able to limit the number of contacts including both clinical and administrative.

TD18 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference goes above and beyond to protect and defend its front line GPs who have worked tirelessly throughout the pandemic only to be made the fools carrying the can for the systems flaws.

TD19 MERTON: That conference would like to recognise the outstanding contribution made by GPs and their teams through the painful, difficult and extremely demanding past 18 months. The cost to individuals and practices has been immeasurable with many colleagues providing care that has been exceptional.
MERTON: That conference laments the ignorance shown by the public in their interactions with our practices with many instances of abuse, aggression and on occasions violence. We call on the NHS leadership to provide visible and public support for all our GP practices and staff through a national campaign including clarification information explicitly stating that the vast majority of interactions provided by the NHS are being undertaken in the community.

BEDFORDSHIRE: That conference believes that:
(i) general practice has for decades been a profession where the immense rewards of a fulfilling vocation barely outweigh the pressure of a huge workload, over-regulation, excessive bureaucratic box-ticking, and an NHS management structure where bullying and intimidation is seen as the way to get the best out of GPs, but
(ii) that the cumulative effects of growing pressures on GPs over the years, and the final straw of Covid-19, are causing GPs to regard their vocation as worthless and their reward as simply not worth the effort.

CLEVELAND: That conference is proud that general practice teams continue to try to do their best for patients every day with limited resources and limitless demand but is appalled and dispirited by undermining and disinformation by the media and believes this will only serve to increase the exodus of exhausted GPs from the profession, worsening services to patients.

SHROPSHIRE: That conference believes that high profile attacks upon general practices in the media are symptomatic of a governmental and NHSEI’s disregard for GPs and their contribution to health care during the Covid-19 pandemic.

CAMBRIDGESHIRE: That conference calls upon NHSEI and the Department of Health to work with the BMA in delivering a public facing communications campaign, to convey with honesty to patients the challenges facing general practice this Autumn, including the ongoing dangerous workforce crisis; the volume of demand around access; the importance of maintaining triage given the paucity of investment in general practice estate; the impact of the Becton Dickinson blood sampling shortages; and delays to the UK accessing influenza vaccines in a timely manner.

NORTH STAFFORDSHIRE: That conference believes more action needs to be taken to reduce abusive behaviour towards general practice staff and GPC Executive should campaign for improved legal safeguards against offenders and a NHSEI media campaign to make clear the essential role general practice has in supporting the NHS system, despite secondary care delays.

DEVON: That conference requests that support is given for a more proactive media campaign, spearheaded by our colleagues in the BMA and RCGP to tackle the media propaganda against general practice.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference has been appalled by increasing and orchestrated false and derogatory media articles which undermine general practice and public confidence. This has resulted in increased complaints and abuse, and to improve the situation, demands:
(i) NHSEI to publicly condemn such articles
(ii) DHSC to publicly condemn such articles
(iii) that the GPC should report all journalists who make false accusations to the Independent Press Standards Organisation
(iv) that the GPC should respond to each article in a timely manner
(v) that the GPC should provide infographics, and information to all practices that they can share with patients.

GATESHEAD AND SOUTH TYNESIDE: That conference thanks GPC England for their recent attempts to combat the relentlessly negative press coverage, much appearing to have the tacit endorsement of NHSEI and HMG and reassures GPC England that they have a firm mandate to robustly defend the reputation of the profession and requires that a pro-active communications strategy be developed in anticipation of further reputational slurs.
TD29 WEST SUSSEX: That conference deplores the current wave of GP-bashing in the media, and also recognises the conspicuous lack of public support from NHSEI, and tasks GPC and BMA with:
(i) appointing a PR firm to manage the reputation of the profession and rebut the false allegations of uninformed media commentators
(ii) writing to colleagues who make similarly ignorant statements in the media, and reminding them of their GMC duties to the profession
(iii) exploring legal avenues of redress for such defamation.

TD30 NOTTINGHAMSHIRE: That conference congratulates general practitioners who have continued to maintain patient services throughout the Covid-19 crisis, and insists that:
(i) this is formally recognised in parliament
(ii) the allegations made in the press about GP access are refuted formally
(iii) NHSEI makes clear to the public that GPs must be allowed to offer appointments to patients in the manner they deem fit, whether that be by ‘phone; video; patient surgery consultation or home visiting services.

TD31 NOTTINGHAMSHIRE: That conference recognises that general practitioners have spent most of the past 18 months feeling overworked and undervalued, not only by NHSEI but also by many in society in general. We ask for public recognition in parliament, and by NHSEI, and by the ICS of the work we have done for our patients, the NHS; our country.

TD32 CLEVELAND: That conference is appalled by the repeated focus from central government on hospital waiting lists in respect of Covid-19 recovery funding and believes that this demonstrates a fundamental lack of understanding of the pressures faced by general practice, and our critical role in supporting the rest of the NHS.

TD33 MERTON: That conference deplores the concerted effort of NHSEI to blame and castigate GPs for being closed when all practices are providing extraordinary care in the face of rising demand, diminishing resources and often difficult connections/interactions with our specialist colleagues.

TD34 MORECAMBE BAY: That conference condemns NHSEI on the recent blood bottle shortage:
(i) on allowing the situation to arise and not having any contingency plans in place.
(ii) along with politicians who remained quiet at the outset and took no responsibility.
(iii) and notes the abuse and anger directed at GPs and their staff and asks politicians to recognise this.
(iv) and calls on the Department of Health and NHSEI to undertake a critical event review and share their learning of this review with the BMA.

LUNCH 12.30
CLOSED SECTION OF THE AGENDA

The Agenda Committee has listened to your feedback and the need to express yourselves freely to develop GPC England policy. As such, this closed section of conference will not be open to the media or observers and will not be broadcast. This will allow business to be debated without the constraints of a media spotlight.

We would like to remind you of the need for respect and professionalism throughout this section of the agenda and any breach of this principle will be addressed by the Chair.

GPC ENGLAND TRANSPARENCY

13.30

15 AGENDA COMMITTEE TO BE PROPOSED BY GATESHEAD AND SOUTH TYNESIDE: That conference is concerned about an apparent loss of connection between grassroots GPs and their elected representatives on GPC England and:
   (i) requires that brief minutes be made available to constituents of GPC England meetings
   (ii) calls for a standing item on the conference agenda where GPC England reports successes and failures of negotiation and seeks conference’s views on a way forward
   (iii) demands that the voting records of GPC England members from this point onwards be made available to constituents to enhance transparency
   (iv) requires a review of the function of GPC England, with a recommendation that, if needs be, professional negotiators are engaged for future negotiations, paid for by GPDF.

15a GATESHEAD AND SOUTH TYNESIDE: That conference is concerned about an apparent loss of connection between grassroots GPs and their elected representatives on GPC England and:
   (i) notes that a greater degree of transparency has been mandated by the conference of UK LMCs for GPC UK and suggests that this be replicated for GPC England
   (ii) appreciates the sensitivity of much discussion and requires that brief minutes be made available to constituents, with transcripts remaining confidential to permit full, frank discussion of difficult subjects
   (iii) believes that a GPC England that is more visible and engaged with its constituents is more likely to have their support and backing should concerted action ever be needed
   (iv) suggests that increased engagement is likely to lead to better representation from the full spectrum of GPs working in English general practice
   (v) demands that the voting records of GPC England members from this point onwards be made available to constituents in order to enhance transparency and enable constituents to make informed decisions about their elected representatives.

15b CLEVELAND: That conference is dismayed by the lack of meaningful progress on implementing the majority of motions carried at previous conferences, and therefore mandates a formal review, led by the LMCs of the structure and function of:
   (i) our negotiating relationships with external bodies
   (ii) the Conference of England LMC Representatives
   (iii) GPC England.

15c BEDFORDSHIRE: That conference calls for a standing item on the conference agenda where GPC reports failures of negotiation and seeks conference’s views on a way forward.

15d BEDFORDSHIRE: That conference:
   (i) believes it is crucial that the GPC England negotiating team put emphasis on the views and needs of all members of GPC and their constituents, regardless of their background, needs or working environments, and
(ii) insists that current failings in this regard should be addressed.

15e SOMERSET: That conference, thanking the GPC England negotiators for their efforts over the years in dealing with their less principled opposite numbers at NHSEI and DHSC, believes that the:
  (i) time is long overdue for professional negotiators to be engaged to help, and
  (ii) costs of professional negotiators should be defrayed by the GPDF.

15f BEDFORDSHIRE: We call on conference to instruct GPC England to work more closely with GPDF to ensure that both representation in addition to leadership and negotiation are funded sufficiently well.

15g CLEVELAND: That conference is gravely concerned that a lack of a clear and open account on the reasons for poor progress on previous conference motions is having a significant negative impact on our constituent members, and requests that a greater level of detail be provided by the GPC England leadership.

15h BEDFORDSHIRE: That conference calls on GPC England to adopt a new format for negotiation possibly following the approach of other trades unions in adding professional negotiators to the team to ensure excellent negotiation with the employers with regard to all aspects of the contract.

QUESTIONS TO GPC ENGLAND 14.00

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

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

This section will be held under standing order 55.

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

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

All members of conference and lay executives of LMCs are invited to submit questions for consideration. These should be submitted by email to Karen Day (kday@bma.org.uk) by 9am on Monday 22 November 2021.

PCN DES 14.50

* 16 AGENDA COMMITTEE TO BE PROPOSED BY SOUTH STAFFORDSHIRE: That conference believes that PCNs are a Trojan Horse and a failed project which was mis-sold to the profession and:
  (i) believes PCNs pose an existential threat to the independent contractor model
  (ii) that the workload, staffing, estate, supervision and HR issues outweigh any benefit derived from ARRS
  (iii) instructs GPC England to refuse to negotiate new work, funding for PCNs or an extension of the PCN contract beyond its 2023 end date
(iv) instructs GPC England to negotiate that PCN funding be moved into the core contract
(v) instructs GPC England to ensure practices are able to easily withdraw from the DES in a straightforward way that will not destabilise the practice withdrawing, other local practices or the provision of patient services.

16a SOUTH STAFFORDSHIRE: That conference believes that PCNs are a Trojan Horse and a failed project which was mis-sold to the profession and although has benefitted some areas, is an overall net burden on the profession, done more damage to the morale of the profession than benefit and that:
(i) PCNs pose an existential threat to the independent contractor model which is evident with the long term plan of the NHS, and what was sold to us as investment in general practice is not essentially into core GMS but wider system agenda including micro management of practices
(ii) recognise the workload, staffing, estate, supervision, HR issues supersede any benefit derived from ARRS
(iii) recognise that the profession has not benefitted to the tune of £12 - £15 per head and practices are still struggling to perform the core GMS function and PCNs have made the recruitment of GPs and core practice staff more difficult, and ARRS have had minimal effect on it
(iv) GPC England must urgently negotiate to move at least 50% investment from PCNs including ARRS and IIF funding to core GMS/practice led DES
(v) GPC England to urgently negotiate no further funding into PCNs from April 2022 and move all future funding into core GMS/practice led DES/LES
(vi) GPC England to acknowledge and negotiate with NHSEI to name general practice as the primary care cornerstone, rather than PCNs.

16b GATESHEAD AND SOUTH TYNE AND WEAR: That conference is concerned that it is becoming increasingly difficult for practices to exist without the PCN DES, which was initially presented to practices as a beneficial, optional extra, and:
(i) requires that GPC England, noting the outcomes of the special conference of March 2020, commits to prioritising core funding over DES
(ii) requests a public commitment from GPC England and NHSEI to ensuring that independent contractor status remains viable outwith the DES
(iii) calls for an indefinite pause to any new DES requirements until both evidence of benefit and sufficient, funded staff exist to deliver them without impact upon core work
(iv) suggests that if the above are not agreed, practices be supported should they choose to withdraw from the DES en masse.

16c WEST SUSSEX: That conference believes that, whilst collaborative working between practices is both desirable and effective, PCNs are not an enhancement of general practice but are being developed as its replacement, and asks GPC England to:
(i) state publicly that it does not support the model as representing the future of general practice
(ii) state publicly that it continues to support the local independent contractor model as being the most effective and efficient way to deliver care to patients, as wells as to defend the independence and autonomy of the profession
(iii) refuse to negotiate new work or funding for PCNs
(iv) refuse to negotiate an extension of the PCN contract beyond its 2023 end date
(v) negotiate that PCN funding be moved into the core contract
(vi) publicly treat investment into general practice and investment into PCNs as entirely separate and distinct for reasons of clarity.

16d LIVERPOOL: That conference believes that the PCN DES has failed to achieve a reduction in workload for GPs and instructs GPC England to renegotiate the PCN funding into GP practices to enable them to better control the use of the investment in the workforce and improve services and quality of care for patients.

16e LIVERPOOL: That conference believes that the ideology behind the Primary Care Network is flawed and:
(i) that those employed under the Additional Roles Reimbursement Scheme are actually dealing with previously unmet need, rather than reducing workload for GPs and the wider primary care workforce
(ii) calls upon GPC England to undertake a robust rapid evaluation of the impact of PCNs upon GP workload and the quality of care and access for vulnerable and hard to reach patients.
KENT: That conference demands that GPC England admits PCNs are a Trojan horse for the destruction of the GMS contract and abandon the PCN DES immediately.

EALING, HAMMERSMITH AND HOUSNOW: That conference requires GPC England to urgently produce a clear national strategy for negotiating future GP contract developments and that this must include:
(i) that any further investment into the PCN DES must be matched by equal investment into core funding to support safe delivery of essential services
(ii) that GPC England will publicise the strategy of insisting on equal investment into core funding to the profession and beyond so that all GPs understand and can unite behind this approach.

HERTFORDSHIRE: That conference believes that the promotion of the Additional Roles Reimbursement Scheme is enabling CCGs, NHS England and the government to deflect attention from the increasing workforce crisis within general practice and calls on GPC England to abandon its support of this scheme.

TOWER HAMLETS: That conference is furious at the misrepresentation of general practice by prominent journalists and the almost complete silence from government and NHSEI on this matter and that:
(i) this confirms the belief that government and NHSEI do not value general practice
(ii) in response there should be a withdrawal from the PCN DES.

EALING, HAMMERSMITH AND HOUSNOW: That conference does not believe that the PCN DES has delivered on the essential objectives of decreasing GP workload and increasing practice level funding and instructs GPC England to undertake a national review to quantify the real effect the PCN DES has had on these two objectives.

WORCESTERSHIRE: That conference believes that Additional Roles Reimbursement Scheme (ARRS) is not the solution to the problem to the primary care workforce crisis and that further extension of this scheme be halted. Further investment must be aimed at increasing the numbers of general practitioners.

GLOUCESTERSHIRE: That conference holds that the primary care network funding is failing to save general practice and insists that the ARRS funding be devolved to practices, its use extended to fund any health care worker including GPs and practice nurses.

SURREY: That conference recognises that there is a recruitment crisis in general practice, and ask GPC England to:
(i) negotiate to allow ARRS money to be redirected from PCNs to practices, to be spent on the core staff we need
(ii) negotiate to allow ARRS money to be spent flexibly on the staff roles that we need to deliver the service.

COVENTRY: That conference believes real and additional funding is required to maintain stability in general practice. Further, that the promised ARRS funding will be spent only in part due to the unavailability of professionals in the key roles required and that any residual funding should be given back to practices as part of global sum and must not be lost back to the centre.

NORTH STAFFORDSHIRE: That conference asks GPC Executive to negotiate that PCNs - ARRS funds which are not being used are made available to PCNs in that area to use them to help general practice for recruiting any staff that will make practices sustainable.

WARWICKSHIRE: That conference believes real and additional funding is required to maintain stability in general practice. Further, that the promised ARRS funding will be spent only in part due to the unavailability of professionals in the key roles required and that any residual funding should be given back to practices as part of global sum and must not be lost back to the centre.

KENT: That conference demands that ARRS funding:
(i) which is unspent remains in general practice
(ii) can be used to employ any staff that supports delivery of general practice services.
HERTFORDSHIRE: That conference notes the original premise of PCNs as supporting and sustaining general practice has been ignored by NHSEI resulting in a DES which has created a huge volume of additional, non-evidenced work for general practice whilst turning PCNs into tools for performance managing practices, and calls for GPC England to ensure this is mitigated by insisting that:
(i) ARRS are expanded to allow for the funding of GPs, nurses and ANPs
(ii) funding is provided for training of ARRS staff
(iii) performance management targets are immediately removed from the DES
(iv) practices are able to easily withdraw from the DES in a straightforward way that will not destabilise the practice withdrawing, other local practices or the provision of patient services.

WIRRAL: That conference observes that Primary Care Network (PCN) DES as it is currently run:
(i) is neither cost effective nor relieving pressure on general practice
(ii) should not be made to become representation of general practice
(iii) be urgently renegotiated to reflect the reality of general practice need.

HERTFORDSHIRE: That conference believes that the requirements for training and supervision for people in ARRS roles:
(i) are increasing demands on GP time
(ii) are leading to an increase in GP workload rather than a reduction
(iii) are often disproportionate and excessive
(iv) should be fully funded in addition to the reimbursements within the PCN DES.

SUFFOLK: That conference deplores the drift of PCN resources and staff towards solving crises in other parts of the NHS and instructs GPC to negotiate a renewed and exclusive focus on solving primary care pressures.

DEVON: That conference recognises that the workload associated with the PCN DES is leading to some practices wishing to withdraw from the DES and asks that GPC England negotiators:
(i) seek to spread this workload over a longer time frame
(ii) seek to redesign the DES so that PCNs (or individual practices within them) can opt out of any parts where they can demonstrate there is little clinical benefit for their population
(iii) demand a significant reduction in the ever increasing bureaucracy associated with the DES
(iv) agree an aid package for practices who choose to withdraw that contains guidance and support via LMCs as well as significant funding from NHSEI ie a parachute clause.

NORTH YORKSHIRE: That conference recognises some benefits to PCNs but believes the PCN DES in its current format is not fit for purpose and represents only a tiny fraction of the work PCNs are now expected to be involved with and asks GPC England to:
(i) acknowledge that the DES has thus far failed to deliver its main aim (stability to practices)
(ii) negotiate an increase to the £1.50 to support PCN development and management support for the CD
(iii) insist on reduced bureaucracy and fewer ‘assurance’ returns.

KENT: That conference demands the GPC England negotiations should prioritise increasing funding for the GMS contract over the PCN DES.

DERBYSHIRE: That conference understands ARRS is not fit for purpose. Practices are required to recruit into roles that fail to meet the needs of their patient population, nor in anyway mitigate the exodus of experienced general practitioners. We call upon GPC England to:
(i) publish the national underspend for ARRS to demonstrate the lack of true investment in general practice
(ii) extend the ARRS scheme to cover reimbursement for additional GPs
(iii) ensure that the necessary funding for estates, IT and training is provided and is in addition to the ARRS funds.

SOMERSET: That conference, recognises the efforts of GPC to negotiate the Primary Care Network DES and its success in some areas, nevertheless demands that NHSEI should make public its contingency plans for dealing with the wide-spread collapse of general practice and failure of PCNs in some areas.
OXFORDSHIRE: That conference believes the uncertainty of what lays ahead after the five year PCN DES jeopardises staff employment and viability for practices, and mandates GPC England to:
(i) negotiate reassurances that practices are not at risk if their PCN continues to grow and employ
(ii) consult GPs in 2022 with options of what they would prefer after the outlined five year DES.

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>BREAK</td>
<td>15.30</td>
</tr>
<tr>
<td>NEW BUSINESS</td>
<td>15.40</td>
</tr>
<tr>
<td>To be detailed in the supplementary agenda</td>
<td></td>
</tr>
<tr>
<td>CHAIR OF GPC ENGLAND CLOSING REMARKS</td>
<td>16.40</td>
</tr>
<tr>
<td>CLOSING BUSINESS</td>
<td>16.50</td>
</tr>
<tr>
<td>CLOSE</td>
<td>17.00</td>
</tr>
</tbody>
</table>
Conference of England LMC Representatives

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

A and AR Motions

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

INTERFACE

AR 17 LINCOLNSHIRE: That conference believes that when patients move from area to area it should be the responsibility of specialists to facilitate transfer of care to a specialist in the patient’s new location without involving the patient’s GP.

CONSULTATIONS

A 18 BARKING AND HAVERING: That conference believes that how a patient is seen in a practice should be a clinical decision and practices should not be pressurised by the CCG to see every patient face to face.

A 19 WEST PENNINE: That conference believes GP practices should continue to triage before offering face to face consultation to protect patients and staff members.

DIGITAL

A 20 CLEVELAND: That conference welcomes the increased provision of laptops to support safe remote working, and:
   (i) considers these to be an essential part of the centralised NHS IT offer to general practice
   (ii) mandates an increase in the centralised NHS IT budget to provide appropriate maintenance.

A 21 DEVON: That conference demands that GPC England work urgently with NHS Digital and NHS 111 to review and improve the poor and unsafe quality of information sent to general practice.

AR 22 CLEVELAND: That conference believes that the post-COVID environment has highlighted the need to invest in telephony infrastructure within practices, and mandates that new funding is released to support this.

AR 23 LAMBETH: That conference demands that the chronic under investment in the necessary IT infrastructure and support is reversed, practices should be provided with state of the art equipment, and not have to continue to work with out of date PCs and out of date software eg outlook 2010.

WELLBEING
| A24 | GLOUCESTERSHIRE: That conference insists in light of the health repercussions from the Covid-19 pandemic the government restarts the funded occupational health service for all general practice staff immediately. |
| A25 | NOTTINGHAMSHIRE: That conference deplores the continuing lack of a fully funded professional occupational health service for general practice and calls for immediate access to this to prevent further loss of staff through ill health; retraining and leaving the profession, or suicide because of work induced health issues. |

**PCN DES**

| A26 | NORTH STAFFORDSHIRE: That conference believes sessional GPs are not encouraged to be PCN CDs and the GPC executive must negotiate an equal level playing field in CD selection for all GPs. |
| A27 | NORTHAMPTONSHIRE: That conference believes that PCNs should be given greater autonomy and flexibility to employ a wider range of health care professionals to support primary care. |
| AR28 | HAMPSHIRE AND ISLE OF WIGHT: That conference believes whilst a welcome addition to the practice team, current permitted ARRS staff don’t appear to have significantly addressed the workload crisis facing GP practices. Conference calls for Primary Care Network Additional Role Reimbursement Scheme funding eligibility to be widened to include GPs and practice nurses employed at a PCN level and mandates GPC England to negotiate this with NHSEI as a priority. |

**CONTRACTS**

| A29 | AVON: That conference instructs GPC England to work with NHSEI to ensure that the GP independent contractor model of care continues. |
| A30 | GATESHEAD AND SOUTH TYNESIDE: That conference is deeply concerned about the imposed requirement to declare GP incomes of £150,000 or greater, and seeks the immediate removal of this requirement, noting that: (i) this remains substantially lower than the average, inflation adjusted pay of GPs 15 years ago (ii) current GPs are increasingly burdened with debts that previous generations did not leave medical school with (iii) such incomes are in the minority and generally obtained only by those working the equivalent of two full-time (37.5hr) jobs; this declaration therefore penalising those who take on the highest-risk areas of practice such as out-of-hours and hot services (iv) it is likely that penalising, even reputationally, those working in out-of-hours/hot services, will result in material harm to patients if GPs reduce their working hours (v) the special conference of March 2020 voted overwhelmingly against this requirement, mandating GPC England to seek removal of it from the contract as something that serves to fuel hatred and detracts from the provision of healthcare. |
| A31 | LEEDS: That conference condemns the government plan to compel GPs to publicly declare earning above £150,000 and believes this will lead to: (i) hardworking GPs being publicly named and shamed (ii) GPs being abused and potentially subject to violent attack (iii) a reduction in GPs will do additional sessions, including in out of hours and urgent care, resulting in increased attendance at emergency departments (iv) worsening of the GP recruitment and retention crisis. |
NOTTINGHAMSHIRE: That conference believes that the DHSC regulations requiring GPs and their staff to publish NHS earnings of £150,000 and over in 2019/20 should be immediately repealed.

KENT: That conference demands the abolition of salary disclosure of all general practitioners as it will undoubtedly bring the profession into further unnecessary scrutiny, disrepute and abuse from our patient population.

LAMBETH: That conference demands that primary care receive a global sum uplift of 3% to enable it to fund the 3% final agreed pay award to NHS staff.

MERTON: That conference calls upon government to provide assurance to general practice that pay rises awarded to employed personnel on the basis of DDRB or government mandate are automatically and fully compensated.

OXFORDSHIRE: That conference calls on the BMA to negotiate for GP partnerships to receive an uplift to core funding that, at minimum, matches any recommended pay uplift for employed NHS staff each year, for example the Agenda for Change framework, and any recommendations made by the DDRB, so that GP partners may pass on this uplift to their employed staff without any associated real-terms pay cut to the partners themselves.

CITY AND HACKNEY: That conference is concerned that the recent shortage of blood testing bottles will not be the only occasion where issues outside of general practice control will have a significant impact on general practice funding and requires GPC England to negotiate a standard clause in all NHSE general practice contracts that guarantee full practice funding in the event of a national incident that prevents practices achieving the contract outcomes.

CLEVELAND: That conference, in light of the exceptional challenges faced by practices in recent months, demands the suspension of all QOF targets by 2021 / 2022, with full funding protection.

BUCKINGHAMSHIRE: That conference believes the Quality Outcomes Framework 2021-22 needs to be paused with income protection, as it will be impossible for surgeries to catch up on meeting the QOF targets during the very busy autumn and winter months following the efforts to deliver the Covid-19 vaccination campaign and the reduced national availability of blood testing tubes.

NOTTINGHAMSHIRE: That conference believes that the pandemic crisis has shone a spotlight on the problems our current contract can cause when some aspects are impractical or extraneous and calls on NHSE to suspend QOF once again to prevent potential financial collapse through no fault of the practice.

HERTFORDSHIRE: That conference demands that where circumstances outside of the control of general practice prevent practices from working on QOF, such as the restrictions on blood tests, arrangements are put in place to ensure practices are not penalized either financially or by being forced to condense one year’s work into a shorter period of time.

CAMBRIDGESHIRE: That conference recognises the heroic work of general practice teams during this Covid-19 pandemic both in surgeries and in the hundreds of GP-led vaccination centres. Conference recognises that this workload burden has not waned and with national shortages of blood bottles as well as the potential for the busiest winter on record, GPC England need to negotiate a suspension of QOF with protected payments for 21/22.

SOMERSET: That conference, because the unprecedented Covid-19 related pressure on general practice shows no signs of abating, mandates the GPC to demand that the Quality and Outcomes Framework be suspended in 2021 / 22 with protection of income to maintain services to patients.
LIVERPOOL: That conference believes that GP practices should not be financially penalised by the lack of availability of blood tubes and instructs GPC England to negotiate changes to QOF in the current financial year, 2021 / 22, to take account of the disruption in work that had been planned by GP practices, to deliver QOF.

LINCOLNSHIRE: That conference believes that when calculating NHS income for publication this must exclude pension contributions and dispensing income.

CONFERENCE FORMAT

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes that the BMA Jewitt report concluded that sexism is still common in general practice, mirroring the persisting sexism in the BMA as per the Romney Report. This conference condemns all and any form of sexism and advises that all LMCs should consider what actions they can take to help assign this to the history books.

NOTTINGHAMSHIRE: That conference recognises the importance of LMCs and calls for increased support from GPC England and GPDF in training LMC officers and members in their respective roles, recognising that LMCs and not other organisations are the local representatives of general practice.

REGULATION

GLOUCESTERSHIRE: That conference notes with dismay that in many areas allied health professionals within general practice are still unable to request x-rays and urges GPC to negotiate for them to request radiographs within their skill set as soon as possible.

HERTFORDSHIRE: That conference notes that general practice in England survived without CQC’s interference during the last 18 months and that Wales, Scotland and Northern Ireland have managed well without it for years and calls on GPC England to campaign for its demise.

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

NOTTINGHAMSHIRE: That conference recognises that both CQC and appraisals were suspended during the pandemic and that they are both resurfacing as bureaucratic systems causing unnecessary and unwanted burdens on GPs and practices. We ask for a light touch appraisal to be maintained and CQC’s activity to be reduced to only the most urgent cases.

PREMISES

NORFOLK AND WAVENY: That conference asks GPC to make renewed efforts to ensure that primary care estates has sufficient resources and physical capacity to house clinicians employed in ARRS roles.

NOTTINGHAMSHIRE: That conference recognises that GP premises development has been woefully neglected over the past decade and more and calls for an immediate and substantial injection of funds to future proof GP premises into the 21st century.

SUTTON: The conference calls upon GPC England to:
(i) urgently review practice premises and estates with a view to establishing the dire need of some practices struggling to provide clinical care due to the lack of room
availability being a limiting factor and stretching an already stretched out
workforce to deliver care
(ii) ensure there is adequate funding for estates development and practice premises
especially where this is affecting workload on current practice staff
(iii) condemn 'working from home' as the norm in practices who only do this due to
the limitation of the practice premises and not through personal choice.

**WORKFORCE**

A  55  NOTTINGHAMSHIRE: That conference has already recognised the problems with
recruitment and retention, and now calls on GPC England to urgently address the problem
of the “last man standing”, whereby the lack of a GP partner may lead to the practice

closing.

AR  56  CUMBRIA: That conference asks that given the incentive schemes for new doctors, GPC
England and NHSEI need to work together to encourage and support doctors who are
thinking of leaving the profession and / or who are nearing retirement, so that more
experienced doctors can carry on and remain in work where they are desperately needed.

**COVID-19 HEALTH POLICY**

A  57  CLEVELAND: That conference welcomes the changes to death certification following the
Coronavirus Act 2020 and believes that these should remain in place permanently.

A  58  NORFOLK AND WAVENEY: That conference believes that the Covid-19 pandemic has
increased health inequalities and that current general practice funding underestimates the
needs associated with deprivation. GPC England is asked to review the current funding and
ensure it recognises the increased need of those in socioeconomically deprived areas, to
support addressing health inequities.

**WORKLOAD**

AR  59  HARINGEY: That conference recognises the plight of Afghan Refugees who have been given
sanctuary here and welcomes the measures put in place to support them in their time of
crisis. However, conference expresses dismay that it has taken this crisis to bring into focus
the lack of service provision for other refugees impacting on their health and well-being.
Conference calls on GPC England to ensure that NHSEI accepts this is a national problem
and to put in place a negotiated and adequately resourced contract for GP services as a
start to address the significant and complex needs of our refugees.
(Supported by Camden and Islington LMCs)

**CLINICAL (PRESCRIBING, DISPENSING AND PHARMACY)**

A  60  KENT: That conference demands GPC England lobbies the GMC to remove its contradictory
guidance on GPs bridging prescriptions for patients seeking gender reassignment on the
grounds of it contradicting their guidance for safe responsible prescribing.

AR  61  NOTTINGHAMSHIRE: That conference affirms the crucial importance of a primary care led
influenza vaccine campaign and calls upon the government to guarantee timely delivery in
future campaigns with extensive contingency planning.

**PRIMARY CARE SUPPORT ENGLAND (PCSE)**

A  62  HERTFORDSHIRE: That conference deplores the continuing shambles that is PCSE and
demands that NHS England:
compensates practices for lost income, stress and time spent trying to resolve problems
(ii) compensates GPs for any problems caused by PCSE’s handling of pension information
(iii) commissions a more responsive and effective support and help line for practices and GPs to be able to access easily
(iv) holds PCSE and Capita to the same level of scrutiny with regards to how they handle complaints as it does general practice
(v) recognises that PCSE is not fit for purpose and starts a process for recommissioning these services in a better way.

LIVERPOOL: That conference believes that PCSE has failed to meet deadlines and targets to support practices adequately and expects GPC England to negotiate compensation for the aggravation and additional work caused by PCSE incompetence and inefficiency.

WANDSWORTH: That conference demands a better, more efficient PCSE pensions handling system in order to mitigate the hours spent by practices correcting errors.

CAMBRIDGESHIRE: That conference demands that GPC England:
(i) negotiates urgent action from PCSE with regard to their management of the GP pension contributions they manage
(ii) ensures that all GPs have accurate and accessible pension records
(iii) seeks financial redress from PCSE on behalf of those GPs who face delays in accessing their pension payments.

KENSINGTON, CHELSEA AND WESTMINSTER: That conference instructs GPC to demand the cancellation of Capita (PCSEs) contract in relation to GP pensions and removal from any involvement with GP pensions and for the transfer of all management of NHS pensions to NHS BSA.

DERBYSHIRE: As anticipated the move to PCSE administering pensions has been a disaster. That conference agrees:
(i) PCSE is not fit for purpose
(ii) GPC urgently take steps to compel NHSEI to performance manage PCSE and, if those standards are not met, seek alternative provision.
Agenda: Part II  
(Motions relevant to UK LMC Conference)

This section of the part 2 agenda contains motions that the England Agenda Committee felt pertained to UK-wide issues and would therefore benefit from debate at the UK LMC Conference. If your LMC has a motion in this section, it is strongly recommended that you re-submit your motions to the UK LMC Conference. The deadline for submission of motions is noon Wednesday 2 March 2022.

**CONTRACTS**

68 CLEVELAND: That conference is concerned at the suggested expectations of GPs in new firearms licensing guidance, and:
   (i) acknowledges that the GP record is an importance source of relevant health information
   (ii) insists that any requirements for GP input attract an appropriate fee
   (iii) believes that any new health assessments are work that GPs do not have the time or training to do and must be commissioned elsewhere.

69 KENT: That conference insists that GPs are not involved in the process of firearms licensing and insist in all negotiations that such work is conducted by another appropriately trained medical professional.

70 KENT: That conference is horrified by the recent tragedy in Plymouth and demands the GPC England immediately secures strengthened gun licensing by:
   (i) removing GPs entirely from the gun licensing process
   (ii) mandating that all medical assessments for licensing are performed by a police surgeon with access to the patient record
   (iii) ensuring all police surgeons are adequately trained and resourced to provide risk assessments for firearms licensing
   (iv) requiring every firearms risk assessment to include an assessment of household contacts and any other relevant persons.

71 CAMBRIDGESHIRE: That conference notes the successes made by BBO LMCs followed by a number of home counties LMCs, in managing to negotiate a firearms licensing pathway with local constabularies and calls for the BMA to promote this solution nationally as a priority.

72 CAMBRIDGESHIRE: That conference recognises the out of date fee structure for private work relating to DVLA and DWP assessments and calls on GPC to negotiate increased fees for this work is in line with inflation.

73 WIGAN: That conference declares that the intended level of increased funding for the NHS and Social Care which will be produced by the recently announces increase in employment taxes will be inadequate to meet the needs of both.

74 HERTFORDSHIRE: That conference notes that no other country in the world has followed the NHS model of free at the point of delivery and calls on GPC England to work with NHSEI to agree a system of rationing to enable the fair and equitable use of limited and finite general practice resource.

75 NOTTINGHAMSHIRE: That conference is concerned that the recent announcements in parliament of a rise in National Insurance contributions will represent another pay cut for GP partners not to mention the impact on employees. We implore GPC England to prevent this extra cut in negotiations with NHSEI to offset the extra costs through an increase in core funding.
BATH AND NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference notes that GPs have yet again been unable to effectively defend themselves against recent national criticism. Currently there does not exist a dedicated national representative body to speak for all of us in UK general practice. LMCs are currently very effective but are generally only locally representative bodies for all GPs. We move that LMCs should form a UK National Association of LMCs to support LMCs and give all GPs a single dedicated voice: a voice that is empowered to address the nation on our behalf.

NEWCASTLE AND NORTH TYNESIDE: That conference believes the BMA's 2020 document "Sustainable and environmentally friendly general practice" is a positive move to highlight changes needed in England but:
(i) laments the lack of real progress with it and requests that GPC England shows leadership and takes action to implement this report urgently
(ii) should stop seeing the response to the Climate Emergency as someone else's problem and one that can be deferred and increase the work it is doing in this area to a level that reflects the predicted dangers set out in the IPCC Sixth Assessment Report.

KENT: That conference demands the GPC lobbies the GMC to maintain the five year limit for patient complaints to the GMC.

KENT: That conference demands anonymous multisource feedback and patient feedback are removed from the appraisal process due to a lack of evidence regarding their validity.

SANDWELL: In view of the new appraisal approach being acknowledged and endorsed by all involved, conference deplores the waste of NHS resources on the last 15 years of the old method of appraisal.

CENTRAL LANCASHIRE: That conference believes the role of the Medical Examiner in primary care needs to be very carefully developed with an understanding of the potential impact on the ongoing relationship with the families of the deceased and the practicalities of the working practices of daily primary care.

NOTTINGHAMSHIRE: That conference condemns examples of regulatory inequality in treatment of GPs from ethnic minority backgrounds and calls for an ethical and moral overhaul of the regulatory system by requesting:
(i) a comprehensive external independent inquiry of the GMC’s regulatory decision-making processes which is followed by a subsequent commitment to implement its findings
(ii) implementation of external safeguards to ensure fairness and transparency in its handling of any disciplinary referrals.

GATESHEAD AND SOUTH TYNESIDE: That conference is concerned at the concept of 'doctor apprentices' mooted this year and:
(i) has particular concerns that these would be largely aimed at general practice, with both obvious reputational and safety issues arising from this
(ii) requires that this idea be repudiated fully and suggests that a better mechanism for increasing access to medicine be the full funding of medical school places and bursaries for able students of limited means.

EALING, HAMMERSMITH AND HOUNSLOW: That conference believes the HEE proposal for a doctor apprenticeship scheme primarily geared towards primary care risks creating a two tiered system which
threatens the professional standards and status of GPs as a profession and calls upon GPC England to fully oppose its introduction.

NOTTINGHAMSHIRE: That conference acknowledges that there is evidence of racism and discrimination within our profession and champions:
(i) strong senior leadership comprising of representative numbers from different ethnic/cultural backgrounds
(ii) improving education about equality and diversity and
(iii) allyship as the light which we all need to shine to help challenge individual bias and institutional racism to create a brighter future of equality, diversity and inclusion.

PENSIONS

DEVON: That conference requests HM treasury to revisit GP NHS Pensions as a priority to:
(i) halt the exodus of experienced GPs from the profession
(ii) allow GPs with capacity to work more without financial penalty
(iii) consider a more realistic lifetime allowance.
Agenda: Part II
(Motions not prioritised for debate)

INTERFACE

87 COVENTRY: That conference believes that all specialist training schemes should include time in general practice so consultant colleagues have experienced the complexity and diversity of general practice work as well as the workload pressures faced. This will make them aware of the need to minimise the transfer of work to general practice.

88 CAMBRIDGESHIRE: That conference demands standardisation of shared care agreements across England, with a single list of shared care medication to be formulated and a single shared care agreement for each, in the expectation that GPC England will support each LMC to negotiate an appropriately compensated LES for such work, to mitigate against specialist medication being prescribed in the primary care setting outwith this agreement.

89 NORFOLK AND WAVENEY: That conference requests GPC to negotiate:
(i) removing ever-increasing and unnecessary admin
(ii) stopping the rejection of referrals
(iii) resisting the dumping of secondary care contractual responsibilities onto primary care.

90 BRADFORD AND AIREDALE: That conference believes that direct access for patients needs to be encouraged for community based services and Allied Health Professionals and that it should be a condition of funding for any new or re-commissioned services. Not all of these services need to be accessed through the GP Gatekeeper role.

91 SUFFOLK: That conference instructs GPC England to open discussions with NHSEI on the need for the proper provision of automated interval testing not involving GPs, perhaps based on the model of cervical screening, where patients have been deemed by secondary care to need a regular follow-up test, eg PSA, MGUS, but secondary care chooses not to take responsibility for driving those tests.

92 SANDWELL: That conference ask that the GPC England does not condone the partial commissioning of secondary care services. Where commissioning gaps occur, GPC England confirm that practices and PCNs are at liberty to treat the non-commissioned elements as non–GMS and have every right to offer to supply those services.

93 OXFORDSHIRE: That conference is concerned by the growing burden of targeted recall and individualised management plans being delegated to primary care, for delivery without adequate resource (for example follow-up imaging and echocardiography, or prostate specific antigen or monoclonal gammopathy monitoring), and:
(i) rejects any implication that the GP’s role is to deliver management plans recommended by specialists, without the GP’s explicit agreement to this
(ii) believes that individual targeted recall requires a robust national approach, with adequate IT databases which continue to deliver effective call / recall reminders even in the event of a patient moving GP surgery
(iii) calls on GPC England to negotiate on GPs behalf to ensure that delivery of these personalised management plans is not delegated to GPs in the absence of robust call/recall systems being in place, and
(iv) calls on the BMA to promote collaborative working in this area, respecting the pressures and limitations of general practice, so that GPs and specialists retain clinical responsibility for the management plans they recommend to their patients.
CITY AND HACKNEY: That conference recognises how the Covid-19 pandemic has amplified the inequalities between primary and secondary care and requires GPC England to negotiate with NHSEI that:

(i) the recovery programme considers the NHS as a whole system and does not differentiate between primary and secondary care
(ii) there is a clearly defined funding resource for general practice to assist with the recovery programme
(iii) there is a recognition that practices are best placed to determine how any additional resourcing is best used to support the Covid-19 recovery programme and as such practices will be given the autonomy to use these resources to meet our local community needs
(iv) any funding for the recovery programme is for direct resourcing to practices as an addition to the global sum payment.

CONSULTATIONS

KENT: That conference calls for a vote of no confidence in NHS England following its disastrous briefing to the media instructing GPs to resume face to face consultations which had never stopped.

EAST SUSSEX: That conference believes that, whilst digital and remote services can play a role in delivering care, that the gold standard for care remains face-to-face access, and asks GPC England to negotiate a contract that ensures that digital and remote access remains an option for those patients that want it, but that there is no contractual requirement to implement obligatory Digital First and digital triage options.

LAMBETH: That conference demands that patients should not have the right to see their GP F2F purely based on choice and that:

(i) all patients should be required to engage and follow practice processes to assess their needs at a request for help (over phone or online)
(ii) practices need to be able to direct patients at the point of request for help to the right capacity (which might be outside the practice) based on the patient’s health need.

DIGITAL

TOWER HAMLETS: Conference notes the uneasiness across many sections of society regarding the robustness of data security with respect to GDPR. Conference demands that before any data is shared that the demands set out in the Open Letter to the Government sent by Solihull, Gateshead and South Tyneside, North Central London and Tower Hamlets https://drbhatti.com/2021/07/06/an-open-letter-to-the-government-regarding-gdpr/ must be met at minimum.

KENT: That conference demands that GPC England insists on a formal investigation into the loss of essential IT services that occurred on 29 August 2021.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that, GP clinical IT systems should have clinical information and patient safety as the main prompt and not have the main focus as a tool for business continuity and commissioning.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is appalled at the mishandled implementation of the General Practice Data for Planning and Research (GPDPR) extraction service, and believes that:

(i) there is a need for data extracted from general practice to support NHS heath service planning and research
(ii) a single centralised service to extract data from general practice IT systems for NHS services with appropriately safeguard is in the best interests of general practices and the public
(iii) members of the public must be fully informed of how their data extracted via GPDPR will be used, and must have the ability to opt out of all or any GPDPR extraction and at any time
(iv) the Independent Group Advising on the Release of Data (IGARD) must include at least two practicing general practitioners, including at least one nominated by GPC England
(v) NHS Digital must consult the Joint GP IT Committee prior to agreement to each and every extraction using GPDPR
(vi) no data extracted via GPDPR should ever be used by or sold to any body outside of an NHS contract.

MERTON: That conference, following the recent Data-sharing debacle, calls upon the government to provide assurance that any moves to acquire or share patient data are fully and openly consulted in a meaningful way with all relevant parties with sufficient time to ensure that the end proposals are safe for all concerned.

NHS 111

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.

BERKSHIRE: That conference notes that the standard GMS contract now includes a requirement to provide a certain number of appointments for NHS 111 providers to book directly onto GP clinical systems, that the numbers of appointments required to be made available in this way was increased six-fold early in the Covid-19 pandemic, and that this reduces the ability for practices to determine their own models of delivery for their services. Conference calls for GPC England to negotiate for:
(i) further unilateral extensions to the increased numbers of appointments, under the existing contractual terms
(ii) removal of the contractual clause that allows the increased provision to be dictated unilaterally by NHSEI
(iii) removal of the contractual clause that allows NHS 111 providers to make any direct bookings onto the GP clinical system.

NOTTINGHAMSHIRE: That conference acknowledges that the NHS 111 CCAS scheme is primarily designed to help ease pressure on pre-hospital services and A&E departments without due consideration for the system pressures that general practice faces and demands that this scheme is abolished post-haste.

COVID-19 VACCINATION PROGRAMME

CITY AND HACKNEY: That conference requires NHSEI to recognise, rather than penalise, the efforts of practices that have populations who are vaccine hesitant by awarding IIF vaccination funding for the work undertaken in engaging with these communities rather than just for the actual vaccine uptake.

WELLBEING

WAKEFIELD: That conference recognises the exceptional pressure that general practice has been under due to the pandemic workload, supporting the vaccination campaign and dealing with the backlog of work due to Covid-19 and will negotiate to make sure general practice does not suffer financially and through workload burnout because of this as GPs attempt to attain currently unrealistic targets.

GLOUCESTERSHIRE: That conference believes general practice faces separate crises of unmanageable demand and of GP retention, whilst delivering a vaccination programme unprecedented in scale. As a result, GPs are exhausted, burnt-out and primary care itself is in danger of collapse. Conference calls on NHSEI to urgently reduce the burden of contracted services whilst protecting practice income, and to make stabilisation of the existing workforce a top priority. Non-essential clinical activities must be deprioritised, to enable practices to cope with the day-to-day demand, and staff to recover from the stress of the pandemic.
GPC ENGLAND / LMCs

109 EALING, HAMMERSMITH AND HOUNSLOW: That conference, in the light of the GPC England vote on Thursday 2 September 2021, demands to be told immediately, and that LMCs be told, by the Chair of GPC England, on which criteria the GPC England Executive judged that sufficient confidence had been restored in NHSEI (senior executives) to enable the motion presented to the committee to be debated without the proposal of a prior motion to establish that sufficient confidence had indeed been restored. (Supported by Berkshire, Buckinghamshire and Oxfordshire LMCs)

110 TOWER HAMLETS: That conference, believes the Covid-19 pandemic has underscored the contempt with which government and NHSEI hold general practice and that:
   (i) the GPC England pause in negotiations with NHSEI did not improve the situation on the ground
   (ii) the profession needs to force government and NHSEI to listen and act on our concerns
   (iii) the GPC England executive must survey the profession asking what GPs would be prepared to do in protest at our treatment by government and NHSEI, up to and including industrial action
   (iv) if the profession provides GPC England with a clear steer from a survey, this will be followed by a formal ballot of the profession.

111 NORTHAMPTONSHIRE: That conference states that if there are any further misspeaks / errors of communication from NHS England regarding general practice, the BMA will call for an immediate apology directly from Dr Nikki Kanani as she has ultimate responsibility in her role as Medical Director for Primary Care for NHS England and NHS Improvement. Failure to respond will escalate to a call for her to resign.

112 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is appalled that the NHSEI continues to fail to promote, protect and generally stand up for general practice. GMC must not resume business as usual until such time that NHSEI publicly condemns inaccurate media articles and false accusations about general practice.

113 WORCESTERSHIRE: That conference agrees that general practitioners were deeply dismayed by letter BO497 from NHS England. Despite objections raised by GPC, NHS England have continued to ignore the enormous pressure on general practice and NHSEI’s persisting lack of insight into the state of general practice as the Covid-19 pandemic escalates again confirms that they are not fit for purpose. This conference now recommends the GPC re-engage with NHSEI in the most robust way so that NHSEI listens to the GPC rather than the press and instruct NHSEI to retract the concept that patient want and preference determines consultation mode ahead of clinical need.

PCN DES

114 LIVERPOOL: That conference believes that the reimbursement for PCN clinical directors is woefully inadequate for the work and responsibility covered by the clinical director role and insists that the GPC England negotiates a rate equivalent to one full time equivalent for the clinical director role of the average PCN.

115 GATESHEAD AND SOUTH TYNE AND WEAR: That conference supports the principle that evidence-based healthcare work should attract payment for the time and effort taken to deliver and demands that IIF monies earned through the provision of high-quality healthcare be free for practices who have met the requisite targets to disburse as they see fit, without restriction.

116 SOMERSET: That conference, deplores the attempts of Health Education England to unilaterally impose its own standards on the training and supervision of Additional Role Reimbursement Scheme staff and believes that:
   (i) HEE threatens to reduce ARRS staff usefulness across PCNs and
   (ii) PCN teams themselves know best what standards are required in local circumstances.
KENT: That conference demands that all value added taxation liabilities are removed from all GP contracted services including those pertaining to the PCN DES for purposes of safeguarding patient care and the ongoing stability and resilience of general practice.

DORSET: That conference recognises that the current ARR scheme has not had the desired effect in reducing the workload on general practitioners and calls on GPC England to negotiate:
(i) reimbursement to PCNs of the full costs of employing new staff
(ii) the employment by PCNs of nurses specialising in the management of long term conditions
(iii) a mechanism for PCNs to directly employ staff that allows payment of superannuation and automatic recognition by the CQC.

NORTH YORKSHIRE: That conference believes that district nurses should be employed by PCNs to serve networks rather than hospital trusts.

LIVERPOOL: That conference believes that NHSEI needs to be more realistic about what it expects from PCNs and calls upon GPC England to negotiate:
(i) the delivery of routine general practice appointments in a flexible way to improve access, not simply outside of normal working hours, to support recovery from the pandemic and catch-up on the backlog of work.

AVON: That conference asks for GPC England to reject the new IIF indicators for 22/23 that relate to appointment waiting time. Several of the IIF indicators are blurring the lines between practice core business and the PCN. The profession views this interference as unacceptable. If NHSEI view this as an essential measurable then this should be in QoF, not the IIF.

LAMBETH: That conference, notes that the requirements of the Investment and Impact Fund (IIF) are very complicated but unlike QOF we have no good way of monitoring our achievements and requires GPC England to negotiate a suspension of requirements until the IIF dashboard is functioning effectively that does not financially penalise practices or PCNs.

NORFOLK AND WAVENEY: That conference is concerned with the increasing employment to ARRS, the increased role of GPs in supervision, education, support and risk management should be recognised so that their absence from front line work whilst fulfilling these duties can be reflected within workforce calculations.

LIVERPOOL: That conference believes that PCNs, where there has been a relationship breakdown with a particular GP practice, should not be expected to incorporate that GP practice back within their PCN and calls upon GPC England to renegotiate the terms of a PCN contract such that a PCN can ultimately have the final decision on whether such a GP practice should be incorporated within its PCN.

SURREY: That conference recognises that PCNs are a contract and not entities, and that the contract can be given at any point to any number of other providers of which general practice is only one, and asks GPC England to negotiate:
(i) a new contract that states that PCN contracts can only be held by collaborations of local GP practices, or legal entities owned by local practices
(ii) with NHSEI to pay for legal and accountancy costs for those collaborations of GP partnerships who wish to form a legal entity to deliver the PCN contract
(iii) that such entities should remain wholly owned by the practices.

CONTRACTS

GLOUCESTERSHIRE: That conference fears that the wider general practice profession does not have sufficient understanding of the process and implications of ‘handing back’ GMS / PMS contracts, even where this course of action may be the least bad option facing a practice and it may therefore be in their best interests and calls upon the GPC to prepare and promote informational resources on the subject so that GPs can be made aware of their options.
CAMBRIDGESHIRE: That conference believes in light of ongoing patient demand; the unprecedented length of waiting lists for secondary services; and delays to blood testing; the Covid booster programme and the influenza vaccine deliveries; practices cannot realistically deliver their contractual targets for 2021/22 and calls upon GPCE to work with NHSEI to instead provide a guarantee of funding security for practices until 31.03.2022. Conference requires GPC England to produce, by 31 January 2022:

(i) a practice and PCN facing campaign to outline to practices how they can facilitate their PCN serving their needs as a priority, and not the local Integrated Care System

(ii) clear guidance around how to mitigate attempts to subvert GMS/PMS/APMS into vertically aligned systems and ICPs

(iii) a reinvigorated review of the outstanding promises from NHSEI at the beginning of the PCN DES and the original partnership review, holding NHSEI’s words against their own failed promises.

CAMBRIDGESHIRE: That conference reaffirms the case that under Section 88 of the Road Traffic Act 1988 (RTA 1988) it is not within GPs’ scope of practice to advise patients whether or not they are fit to drive, but that the role of the GP is to provide factual information to the DVLA so that their expert medical advisers can decide upon fitness and calls upon the BMA to press the DVLA for urgent solutions and to allow family doctors to prioritise NHS care.

SOMERSET: That conference, to make being a GP in England an attractive career for life, rather than changing an outdated funding model using endless piecemeal initiatives, instructs GPC to negotiate with NHSEI:

(i) a GP specialist employed contract, and

(ii) for NHSEI to take on full responsibility for all primary care estate with compensation for existing owners.

SUFFOLK: That conference reminds the GPC Executive that the impending changes to the National Insurance Rates may have an adverse effect on GP partnerships and PCNs as employers and notwithstanding any consideration of ‘fixed five year pay settlements’ requests that additional funding is secured for practices in order that these losses be fully mitigated.

GATESHEAD AND SOUTH TYNESIDE: That conference fails to understand the rationale for the deliberate exclusion of practice managers, without whom general practice would fail, from the new partner incentive scheme and requires the inclusion of practice managers in the new partner incentive scheme, in order to incentivise those wishing to take a stake in the future of their surgeries.

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

HERTFORDSHIRE: That conference is dismayed that despite a motion from GPC UK Conference being passed in May 2021 stating that any DDRB recommendations for an uplift had to be matched by an appropriate increase in Total Practice income, this appears to have been totally ignored by this year’s DDRB recommendations.

NORTH YORKSHIRE: That conference is deeply concerned that the profession is in crisis and more wellbeing or resilience initiatives won’t stop us reaching the cliff edge unless accompanied by immediate sustained changes in working conditions and asks GPC England and NHSEI to recognise this and agree to:

(i) income protect QOF for this year with a view to winding it down from 2022

(ii) support extended access funding being diverted into primary care winter pressures initiatives for adults and children during working hours

(iii) fund and incentivise joint working with other aspects of the urgent and emergency care network to collectively better manage same day demand.

NORTHAMPTONSHIRE: That conference states that the BMA will negotiate further contracts emphasising the importance of prioritising GP income through GMS rather than just PCN contractual work to stop the risk to financial viability of small practices.
MID MERSEY: That conference wishes to remind practices that there are no fees set or agreed for the completion of commercial medical reports, and that practices should charge a professional rate for completion of these.

WIGAN: That conference believes that the promulgation of the seasonal flu vacc programme 2021 as an open 'enhanced service' is an unwelcome step and should not be repeated:
(i) it marks the serious weakening of the preference for GP provision of primary care and undermines direct investment in general practice which threatens the financial stability of practices as going concerns
(ii) it discloses a strategy of increasing general practices subordinate dependence on heretofore locally centralised sources of key funding – PCN/ICP.

AVON: That conference deeply regrets the lack of standardised healthcare provision for babies who are resident in a mother and baby unit and directs GPC England to negotiate a new national enhanced service specification to ensure equality of access for these children that promotes good practice in safeguarding.

GLOUCESTERSHIRE: That conference insists that children in prison mother and baby units receive their medical care from properly commissioned appropriate medical staff and not simply be allocated to GPs in the vicinity.

NORTHAMPTONSHIRE: That conference states that it is the responsibility of the Department of Health to run a publicity campaign explaining the impact of the blood bottle crisis, and it should not be the responsibility of the BMA and individual GP surgeries to explain this nationwide problem.

LIVERPOOL: That conference believes that as the country moves into a post-pandemic phase, NHSEI needs to be more realistic about what it expects from GPs and their teams and calls upon GPC England to negotiate a modified QOF and enhanced services package to reflect what needs to be done to most cost-effectively manage the enormous backlog of work built up since March 2020.

GLOUCESTERSHIRE: That conference insists that the blood bottle and reagent shortages represent a disaster for general practice and means that the relevant QOF targets are unrealistic. We ask that GPC negotiate compensation for the significant additional work caused by poor planning and supply.

DERBYSHIRE: That conference understands general practice is on its knees with a huge increase in consultation numbers, the backlog of working resulting from the pandemic. Added to this perfect storm we had a blood bottle shortage and yet still NHSEI were unmoved to act. We call upon GPC England to ensure that any national event/s impacting practices ability to deliver QOF targets automatically results in QOF being protected for that financial year.

AVON: That conference deeply regrets the recent national shortage of blood sample bottles which led to wide-spread cancellation of many routine clinics in surgeries including chronic disease management and requests that GPC England:
(i) obtain written assurances from named individuals at NHS England that lessons have been learnt from this significant event and that mitigating actions will be put in place to reduce further similar supply chain shortages
(ii) negotiate with NHSEI that there will be income protection for 1/12 of QOF income for the financial year 21-22.

MERTON: That conference, in view of the sudden and unexpected problems caused by the national shortage of blood test bottles and the challenges posed by the ongoing Covid-19 pandemic complicated by new import/export requirements following Brexit, calls upon government to ensure that critical supply lines are diversified in such a way as to prevent the risk of persistent disruption.

KENT: That conference lobbies to ensure that GPs are not held responsible for any issues arising from factors outside of their control such as the recent blood bottle shortage.
NORTH STAFFORDSHIRE: That conference believes GP partnerships with GMS contracts be allowed the protection that is afforded by being a LLP or limited company, rather than an unlimited partnership. This may remove some of the risk associated with being a partner and make the role more attractive to newer GPs.

**Integrated Care System (ICS)**

AVON: That conference notes that Avon LMC notes that there is no statutory representation for GPs in the Health and Care Bill 2021. Conference is asked to instruct the GPC to demand of NHSEI that this deficiency be rectified either in statutory instruments or in guidance to Integrated Care Boards.

NORFOLK AND WAVENEY: That conference calls upon GPC to negotiate with NHSEI to ensure that the latest round of reorganisation to ICSs does not waste public funds in redundancies of staff, later to be re-employed elsewhere in the system as has happened before and to ensure that the reorganisation does not adversely affect the already overstretched health services; in particular it must not drain resource from general practice at a time when it is propping up the whole system due to the volume of work being passed to it from secondary care at the same time as delivering the largest part of the vaccination program.

AVON: That conference mandates the GPC England 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.

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.

SURREY: That conference believes that the current major re-organisation of NHS management structures offers nothing new or helpful, but instead weakens the NHS by significantly reducing clinical influence and also public oversight and accountability and asks GPC England and BMA to make a public statement to that effect.

WEST SUSSEX: That conference believes that CCGs, and the commissioning of care overseen by groups of GPs, were a good idea that was sabotaged from the very beginning by NHSEI and senior managers.

**CONFERENCE FORMAT**

DERBYSHIRE: The recent suspension of negotiations by GPC England with NHSEI, which was necessary for a provision under siege, had the unanticipated consequence of leaving LMCs unsupported and exposed as a barrage of un-negotiated, unfit specifications have been released to a broken general practice. Therefore any further decision to step away from contract negotiations must include contingency planning to ensure GPC England still provides a service for LMCs and by doing so, their constituents.

SEFTON: That conference condemns the inaccurate and partisan campaign manifested by certain national newspapers in:

(i) misreporting - access to and the workloads of general practice and GPs
(ii) accusing - GPs of purposely deferring face to face appointments owing to the ‘high level’ of their earnings and an innate idleness
(iii) Fomenting - mistrust between patients and their GPs in the pursuit of a destructive populist agenda.
It calls upon the GPC/BMA press department to redouble its efforts in rebutting each and every misleading statement and claim and providing LMCs with copy which can be used to counter local press emulation of the same.

156 BEDFORDSHIRE: That conference calls on GPC England to review the impact of the Meldrum report, with particular attention to the unexpected consequences of Covid-19 – that fewer meetings increase the isolation of reps and, with remote meetings, the cost saving is not an issue.

157 SOMERSET: That conference, after noting opinion pieces in media outlets close to the Conservative party claiming that general practice is an easy, overpaid job, instructs GPC England to demand that NHSEi explains:
(i) why GP partner numbers are actually in decline, and
(ii) there is shortage of new doctors willing to replace them?

158 MERTON: That conference calls upon the new SOS for health and social care and the new head of NHSEi to underline their understanding of the importance of engaging with general practice as the bedrock of the NHS by accepting an invitation to attend the Conference of England LMCs.

159 LEEDS: That conference believes that to improve GPC England representation and diversity all members should be elected in the same way using:
(i) regional constituencies
(ii) multi-member constituencies
(iii) gender constraints
(iv) contractual constraints.

160 DERBYSHIRE: That conference understands over the past 18 months the situation in general practice has become more complex and difficult to navigate than ever. LMCs require national support which includes signposting and information. With the transition to ICSs LMC need national backing to support our local practices. Despite this over time the current provision for LMC support via the LMC-L and /or info, GPC England has shown a notable lack of response to queries. We ask GPC England with the support of GPDF to finance a responsive platform for supporting LMCs in fielding queries on national and local issues in order to support their constituents.

161 HAMPSHIRE AND ISLE OF WIGHT: That conference deplores the apparent inability of the GPC to hold HM Government publicly to account for the consequences of their policies and once again calls for the public promulgation of a charter for general practice requiring inter alia no new work streams without proving adequate doctor numbers and no new work without a clear public identification by commissioners of what work will therefore cease.

ENVIRONMENT

162 ENFIELD: That conference, with the support of Health Education England and the Vocational Training Schemes, develops and implements formal training on the health impacts of the climate crisis and what can be done in practice to address it.

REGULATION

163 LEEDS: That conference does not believe that practices should be expected to give an opinion whether patients are of “unsound mind” when local systems are determining a person’s mental capacity as part of a deprivation of liberties (or its successor) assessment and calls for fully funded arrangements for mental capacity assessments which do not require the involvement of practices.

164 BRADFORD AND AIRDALE: That conference believes that the time and resource taken up by GPs doing Med 3 “fit notes” could be better utilised caring for patients and calls for:
(i) an audit is done to establish the workload cost of sickness certification in general practice
(ii) the self-certification period to be extended to 14 days
(iii) employers to use their own occupational health services to certify staff absences
165 OXFORDSHIRE: That conference notes the question posed in CQC’s Mythbusters 46, “How do you make sure that all test results requested have been returned to the practice?” condemns the lack of progress towards robust GP IT systems capable of reconciling all laboratory investigations sent from primary care, with all results received, and:
   (i) rejects any paternalistic interpretation, that GPs should implement systems to pursue every patient who does not attend for a blood test or other investigation recommended by the GP
   (ii) recognises the significant clinical benefits of systems that reconcile all blood tests and other investigations actually sampled, with results received back to the practice, and flags up samples sent where no result is received with a locally agreed time frame
   (iii) calls on GPC England IT leads and GP IT software systems providers to negotiate the development of such systems urgently.

166 CLEVELAND: That conference wishes to see GPC England working in collaboration with CQC to develop a process that is mutually supportive, educational, and genuinely provides a benefit to practices and to patient care.

167 SOUTH STAFFORDSHIRE: That conference requests that to help the ‘perfect storm’ of crises of recruitment and retention, recovery from the pandemic, the CQC helps by becoming more supportive towards primary care, and that where problems are found, the practice is helped to improve, including targeting increased resources and that personnel concerned are not targeted and publicly humiliated.

PREMISES

168 LEEDS: That conference believes many practices and other premises GPs work in have cramped public and office spaces, with poor ventilation, leaving patients and the workforce at risk of transmission of infection and:
   (i) believes government is liable for this and must take full responsibility if patients or staff contract Covid-19 or other serious infection when inside a building GPs work in
   (ii) calls on the government to take urgent action to fund GP premises improvement and expansion.

169 SOMERSET: That conference urges GPC to recognise and publicise the threat posed by the secondary care initiated Cavell Centres to traditional general practice provision.

170 CLEVELAND: That conference mandates that all needs assessments in relation to premises are carried out at the practice level, not based on a PCN footprint.

171 CLEVELAND: That conference welcomes NHS England’s bureaucracy review and insists that the processes and funding relating to premises, IT and all other associated infrastructure are prioritised, to support practice expansion and development.

172 NOTTINGHAMSHIRE: That conference calls for increased proportionate investment into general practice estates to help support the ARRS multi-disciplinary team; this should be enabled working with a fair, intuitive and paper-light process to access such funding.

173 BEDFORDSHIRE: That conference calls on GPC England to:
   (i) acknowledge that the expansion of the general practice workforce through the additional PCN roles is welcome, but
   (ii) emphasise that there have been decades of government neglect and failure to invest in GP premises, with the result that GP premises are totally inadequate for the larger, multi-disciplinary teams that are crucial to managing the complexities of modern practice, and to
   (iii) negotiate for funding for premises expansion or to rent additional space where needed for additional roles staff.

174 GP TRAINEES COMMITTEE: That conference notes the chronic under investment across the primary care estate, and the impact of Covid-19 has had on the use of space in GP practices. Conference also notes the
increasing number of GP trainees being recruited, and the increased time these GP trainees will spend in
general practice, as well as the increasing numbers of staff in primary care being funded via primary care
networks. We call on GPC England to lobby relevant stakeholders to ensure GP premises receive the
necessary funding to allow:
(i) general practice to adapt to the long-term space and premises demands that Covid-19 has
dictated to be made to ensure patient and staff safety, such as but not limited to ventilation,
social distancing and isolation rooms
(ii) GP trainees have adequate space to practice and work in, as a fully integrated member of the
practice team, at the standard a fully qualified GP would expect
(iii) the wider general practice and PCN workforce access to an appropriate space to practice and
work in, appropriate to their role
(iv) the development of rooms and workspaces that are suitable for face to face consulting as
standard for GPs and GP trainees.

175 CAMBRIDGESHIRE: That conference supports the proposals for Cavell centres as a central pillar of the
NHSEI estates strategy for general practice and believes the time has come for GP partners to move away
from a model of property ownership.

176 NORFOLK AND WAVENEY: That conference negotiates changes to the funding stream linked to any future
Premises Cost Directions properly funded estates/expansion in general practice to accommodate the
ever-expanding workforce and that this funding be ring-fenced to primary care. The arrival of the ARRS
roles highlights the limitations that many practices have in terms of accommodating additional staff and
working efficiently.

177 DERBYSHIRE: That conference calls on GPC England to increase investment in GP practice premises and
remove the burdensome administration and that CCGs are held to account over how they prioritise and
plan schemes of work with scrutiny by local medical committees to ensure fairness and transparency.

178 KENT: That conference believes arrangements for premises developments are not fit for purpose, and
demands the GPC England negotiates that NHS England and Improvement:
(i) always takes on the responsibility of last person standing
(ii) provides 100% funding for premises developments that improve patient care.

179 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.

WORKFORCE

180 BEDFORDSHIRE: That conference believes that the only hope of saving general practice is for the
government to acknowledge the current dire position and to take immediate action on several fronts,
namely:
(i) to address recruitment at the start, middle and end of GP careers by incentivising young doctors
to the profession, retaining and re-recruiting those who take career breaks or emigrate, and
incentivizing retired GPs in their 50s and early 60s to return
(ii) to make appraisal and revalidation a supportive, joyous and uplifting process, and immediately
suspend present appraisal and revalidation requirements until the necessary redesign of the
system is achieved
(iii) to reduce the plethora of regulatory bodies who have jurisdiction in general practice to no more
than one
(iv) to relieve GPs of the risks and responsibility of financing their own premises, as equipping all
practices with suitable premises at no expense or risk to the doctors who work there should be
a matter of course
(v) to relieve GPs of the many pointless admin task that are currently statutory
(vi) to replace the current gargantuan complaint system with one that is fair, efficient, reaches
decisions promptly, and does not blame doctors for the failings of a dysfunctional system.
DORSET: That conference recognises the burden falling on declining numbers of partners in general practices and calls upon GPC England to negotiate a package of measures to encourage experienced partners to stay in practice including:

(i) a financial award for every three years in practice after 20 years in one practice
(ii) a partially funded sabbatical every five years after 10 years in one practice
(iii) a reduction in the frequency of revalidation to every seven years after 20 years in practice.

NORFOLK AND WAVENEY: That conference acknowledges the need to attract a new generation of GPs at both partnership and salaried levels, as well as the implementation of an up to date and accurate workforce survey with a detailed questionnaire to all over 55 year old GPs, enquiring of their retirement plans, so that forthcoming crisis is more evident.

WALTHAM FOREST: That conference notes despite government aims, the year-on-year reduction in whole time equivalent GPs and that:

(i) a key reason for this is subsequent government policies which have resulted in poor retention of experienced GPs
(ii) to help encourage retention seniority payments need to be reintroduced.

NOTTINGHAMSHIRE: That conference believes that general practice always has been, and still remains the key access point for patients and vital gateway to the wider health and social care system, and calls upon GPC England to lobby the government to:

(i) recognise the key role of general practice in parliament
(ii) differentially increase funding to general practice to compensate for the relative lack of funding over the past decade and more
(iii) to work with all interested parties to address the problems of recruitment and retention, not only to save our noble profession but the entire NHS.

WORCESTERSHIRE: That conference is appalled by the lack of accurate data to demonstrate the current workforce crisis and recognises the significant levels of burnout and exhaustion amongst GPs as GPs leave or reduce their hours. We call on government to:

(i) ensure that there is a renewed commitment to creating the conditions for the healthcare workforce to find joy and meaning in their work and in doing so, improve the experience of providing care
(ii) ensure that methodology used by NHS Digital is accurate and fit for purpose
(iii) communicate honestly with the public about the extent of pressures on healthcare systems, with regarding to hospital waiting lists and levels of demand facing general practice in order to reset public expectations over the next year.

NORTH STAFFORDSHIRE: That conference believes that there is no new or ongoing support for the GP partner role, that the £20K offer failed to improve GP partnerships intake and urges GPC Executive to negotiate better proposals to increase GP partnership recruitment and retention.

SOMERSET: That conference, believing there must be a reduction in the wide “pay relative to workload” gap that currently exists between GP partners, salaried GPs and locums, calls for changes in GP training to:

(i) reflect more of the workload that can reasonably be expected in daily practice and
(ii) stop working to unrealistic ideals that contribute to some young GPs to become disillusioned about their chosen career.

LEEDS: That conference is seriously concerned at the continued fall in the number of GP partners in England and calls on government and NHSEI to:

(i) increase the funding of the partnership premium
(ii) reduce the premises risk for GP partners
(iii) resolve pension lifetime and annual allowance issues to support workforce retention
(iv) reduce GP workload pressures
(v) make the improvement of GP morale a key national target.
HEARTFORDSHIRE: That conference believes that, despite all the promises and programmes, workforce shortages across the whole of the NHS are still at crisis level and calls on government and NHS England to publicly recognise this as a national emergency.

GP TRAINEES COMMITTEE: That conference notes the rising numbers of GP registrars in England over the past five years but that despite these increase in training places, numbers of GP partners and other GMPs has fallen over the same time period. We call on GPC England to carry out an annual survey of general practitioners who have attained their Certificate of Completion of Training in the past 12 months, to determine their career commitments to the NHS and the rationale for these career choices.

GP TRAINEES COMMITTEE: That conference notes the growing demands by GP trainees for more flexible working conditions. We call on GPC England to review the rules around timetable planning for GP registrars, with a mind to offering more flexibility to GP trainees.

GP TRAINEES COMMITTEE: That conference notes with dismay the repeated problems with application to take the AKT, resulting in candidates being unable to access reasonable adjustment, being required to travel hundreds of miles to take the exam, or simply being unable to book despite being eligible. We demand the RCGP:
(i) report fully on the problems, and provide detailed solutions to resolving the problems with booking for future booking periods and
(ii) offer a prioritised booking window in advance of the next booking window for candidates who have been unable to access appropriate AKT sitting.

NORFOLK AND WAVENEY: That conference believes that general practice still needs to be more represented at undergraduate training level, both in terms of placement but also at a managerial / dean level.

NORFOLK AND WAVENEY: That conference calls on GPC to renegotiate as it believes that current GP training grants are woefully inadequate for the supervision required particularly with reference to the desire for an expansion of the GP training schemes.

NORFOLK AND WAVENEY: That conference believes as a speciality general practice has as a more complex role and the current time spent in practice of 18 months is inadequate and as such GP training should be aligned to specialist hospital training and extended to five years with at least three years in general practice.

NORFOLK AND WAVENEY: That conference believes that all GP practices should be provided with increased support and funding, similar to secondary care, to enable them to be training practices in order to adequately train the numbers of GPs needed in the future and address the increased numbers graduating from medical school.

GLOUCESTERSHIRE: That conference demands that NHSEI provide better support for GPs experiencing leave of absence due to illness or parental leave and allows practices the flexibility to ‘backfill’ GPs with other clinician roles (such as ANPs) where a like-for-like locum replacement cannot be found.

GLOUCESTERSHIRE: That conference calls on NHSEI to better support practices with absent GPs due to leave (sickness, maternity and parental) by allowing commensurate reimbursement for backfill, towards appropriate senior clinical roles when locum GP cover cannot be sourced for the full duration of an absence.

SHEFFIELD: That conference notes with dismay the inadequate and inconsistent level of funding provided to GP educators for educational supervision of GP trainees and demands that there is:
(i) a nationally agreed tariff for GP educators for providing educational supervision
(ii) an adequate financial recompense for the time and expertise that is required for the role of educational supervision.
CLEVELAND: That conference recognises the importance of GPs finding the right practice for them, and therefore requests that the New to Partnership Payment Scheme is renegotiated to include those who have only experienced partnership during a period of mutual assessment in the past.

MERTON: That conference calls upon government to recognise that general practices constitute the bedrock of the delivery of general medical services and that there is urgent need to invest in general practice personnel, both clinical and non-clinical, as well as in general practice estate and IT infrastructure to make it fit for the 21st century.

WEST SUSSEX: That conference notes the lack of understanding of general practice amongst NHS managers at every level and asks that managerial training in the NHS be revamped to ensure that every manager is appropriately trained so as to understand the value, scope and scale of general practice.

MID MERSEY: That conference considers that practice nurses and advanced nurse practitioners are integral members of general practice teams, is concerned that unlike GPs there is no reimbursement for sickness absence payable for these colleagues and asks for sickness absence reimbursement to be negotiated for them going forwards.

MID MERSEY: That conference is concerned about the viability of general practice partnerships and of ‘last man standing’ practices and asks for a minimum income guarantee to be negotiated for partners and sole traders to provide some protection and support in desperate circumstances.

NOTTINGHAMSHIRE: That conference recognises the importance of general practice to the education of all medical students regardless of their intended area of specialisation and calls on GPC England to work with colleagues for an increase in student exposure to the profession.

NORTHUMBERLAND: That conference calls on GPC England to insist that NHSEI extend the reimbursement for maternity and sick pay to include not just the medical workforce of general practice but also those other health professionals that are now filling front line primary care roles. This includes but is not limited to pharmacists, physiotherapists, mental health workers and paramedics. In addition to permit the money to be spent on health care professional other than GPs.

SHROPSHIRE: That conference calls upon the English Government to acknowledge the remarkable contribution of those working in the NHS and Social Care sectors by exempting them from paying the new Health and Social Care Levy.

KENT: That conference demands that Fellowships should also be offered on a less than full time basis to avoid discrimination and attract candidates from across the profession.

DORSET: That conference recognises the invaluable impact of the GP retainer scheme in supporting GP numbers, increasing gender diversity, and enabling individual careers to continue and develop. As such we ask the GPC England to negotiate an extension to this scheme beyond the current permitted five years.

COVID-19 HEALTH POLICY

NOTTINGHAMSHIRE: That conference reminds NHSEI that the pandemic crisis has further exposed the problems around the Health and Social Care interface and calls for an urgent review of social care funding, particular at its interface with health care to prevent such problems again for those which are amongst the most vulnerable in our society.

LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes with dismay the number of patients seeking legal and/or financial redress against practices enforcing the requirement of wearing masks in line with national guidance, and requires the GPC England to support affected practices including:

(i) a letter of first response for practices to send
(ii) to fund appropriate legal action on behalf of a practice to set precedent
to complain to the Solicitors Regulation Authority about any solicitor misusing Equality Regulations or other legislation to spuriously support such a claim.

KENT: That conference demands that GPC England ensures that practicing privileges for procedures, including minor surgery and LARC, are not lost due to reduced activity during the pandemic.

SEFTON: That conference believes that the Secretary of State’s approach in connection with the Covid-19 vaccination of all NHS Staff – "get vaccinated or sacked" represents a signal failure of policy and health education and also contravenes human rights.

WORKLOAD

OXFORDSHIRE: That conference believes that general practice forms the bedrock of the NHS, recognises NHSEI’s tendency towards micromanagement as an existential threat to the independent contractor model of general practice, and:

(i) condemns the apparent imbalance in NHSEI’s easing of contract management and support for Hospital medicine during the pandemic, compared with the “command and control” approach taken towards primary care
(ii) calls for urgent renewal of BMA guidance around what constitutes safe working in primary care, and
(iii) calls for opening up of funding currently allocated to the Additional Roles Reimbursement scheme staff, for use by practices however they feel most appropriate, including the employment of doctors.

SANDWELL: Most of the profession feel unsafe and yet the workload continues to rise. Conference would like to indicate to GPC England who they feel should be responsible for determining safe levels of work for a practice partner:

(i) DoHSC
(ii) RCGP
(iii) GPC / BMA
(iv) somebody else
(v) nobody.

GLOUCESTERSHIRE: That conference believes general practice is in crisis and on a ‘war footing’ and calls on NHSEI to alter services to reflect this. All non-essential activity should cease to enable practices to cope with current demand, whilst income is protected.

GLOUCESTERSHIRE: That conference that for years businesses have sought to pass liability for products and services on to practices by including disclaimers such as ‘please consult your GP prior to use’ in a manner which increases workload and wastes NHS time and calls for the GPC to negotiate the creation of a license similar to music licensing regulation, which would require a subscription payment in order to use such disclaimers, with funds coming back to general practice

COVENTRY: That conference believes that practices are being subjected to a barrage of FOIA requests. Many of these are sent by unidentified individuals to a large number of practices and involve considerable time, effort and workforce to respond to. GPC should look to exempt general practice from these demands or insist that NHSEI provide a central facility to deal with them on behalf of practices.

WARWICKSHIRE: That conference believes that all specialist training schemes should include time in general practice so consultant colleagues have experienced the complexity and diversity of general practice work as well as the workload pressures faced. This will make them aware of the need to minimise the transfer of work to general practice.

WARWICKSHIRE: That conference believes that practices are being subjected to a barrage of FOIA requests. Many of these are sent by unidentified individuals to a large number of practices and involve considerable time, effort and workforce to respond to. GPC should look to exempt general practice from these demands or insist that NHSEI provide a central facility to deal with them on behalf of practices.
LINCOLNSHIRE: That conference calls upon GPDF to fund a national system for measuring and quantifying GP workload.

CLINICAL (PRESCRIBING, DISPENSING AND PHARMACY)

LEEDS: That conference condemns NHSEI’s failure to commission adequate NHS services for the diagnosis and treatment of children and adults with ADHD, leading to many seeking private services as an alternative and calls for:
(i) investment in to mental health services to rapidly reduce NHS waiting lists to access these services
(ii) fully funded enhanced services when LMCs agree shared care arrangements
(iii) local NHS mental health services to take responsibility for long term care and support for patients given a diagnosis of ADHD by online and private psychiatric services.

SOMERSET: That conference notes that primary care networks – plans for 21 / 22 and 22 / 23 state that PCNs must improve the identification of those at risk of atrial fibrillation in line with NICE guideline CG180, and urges GPC England to demand that NHSEI explains why it has:
(i) used outdated guidance
(ii) recommended a practice not in line with the replacement guidance NG196
(iii) introduced a screening initiative which is not currently recommended by the National Screening Committee?

KENT: That conference demands immediate action by NHS England to produce a safe and functional NHS transgender care pathway by:
(i) mandating all Integrated Care Systems to provide an interim gender dysphoria clinic with consultant endocrinologist and psychologist input by March 2022, with a permanent clinic formally commissioned in each ICS by 30 September 2022
(ii) ensuring all clinicians providing prescriptions for the treatment of gender dysphoria hold a diploma in GIHP as a minimum qualification, in line with the RCGP position statement on transgender care
(iii) requiring national screening programmes and recall systems are suitable for and offered to all applicable patients regardless of gender identity.

CAMBRIDGESHIRE: That conference mandates GPC England to negotiate with NHSEI to create standardised 2WW referral pathways across the country, that are as succinct as possible in order to reduce national inequality of timely access to 2WW pathways.

CROYDON: That conference recognises that NHSEI’s aspirations for population health lack definition, and ask GPC England to ask NHSEI to:
(i) define its public health goals
(ii) define its goals for proactive care
(iii) set out a fully-costed five year plan for both of these areas.

BEDFORDSHIRE: That conference instructs GPC England to:
(i) negotiate that an established dispensing practice should be allowed to continue to dispense to its established dispensing patients even if a new pharmacy opens in the practice area; or
(ii) negotiate a staged financial compensation over a number of years, where the opening of a new pharmacy means that a dispensing practice loses some of its dispensing patients
(iii) oppose the protectionism and restriction of trade embodied in the current dispensing regulations, so that GPs who wish to offer a dispensing service are allowed to do so without restriction on which patients they may dispense to.

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

BEDFORDSHIRE: That conference:
(i) believes that dispensing is a task that can be done by any qualified person, and
calls on GPC England to negotiate that the rules about dispensing should be deregulated to allow competition between pharmacy and any general practice and to allow patient choice.

230  **BEDFORDSHIRE:** That conference:

(i) notes that more and more patients are seeking private opinions, because of backlogs, resulting in requests for GPs to undertake a number of investigations or make onward referral into the NHS, and placing additional pressure on GPs and on NHS resources

(ii) asks GPC England to clarify if GPs have a right to decline to make a request for which they cannot see a clinical need, even if the procedure is available on the NHS, and

(iii) asks GPC England to advise patients that requests from private practitioners cannot automatically be dealt with ahead of NHS requests, despite the fact that patients often expect requests from private practitioners to be fast tracked.

### PENSIONS

231  **GATESHEAD AND SOUTH TYNESIDE:** That conference finds the repeated errors made by PCSE which make it impossible to calculate the contributions and projected benefits wholly unacceptable and:

(i) is baffled by the fact that despite this issue being ongoing for years, PCSE’s performance has seemingly not improved

(ii) laments the fact that NHSEI have not seen fit to either remediate performance nor remove the contract from the current provider

(iii) demands that a legal opinion be sought as to whether such incompetence, with obvious financial implications for many staff, borders upon the criminal.

232  **WIRRAL:** That conference believes that the recent change to GP payment and introduction of PCSE GP pay and pensions portal is a mistake, fraught with a lot of difficulties and errors. It should therefore be fixed immediately or scrapped completely.

233  **TOWER HAMLETS:** That conference demands that NHSEI contracts PCSE to:

(i) provide LMCs with regular data updates (including contact details) on all changes to the National Medical Performers list, including Locum GPs, and the number of GPs per LMC area who have declined to share their details with the LMC

(ii) include a message (wording provided by the LMCs) in the application process for joining the National Medical Performers List which explains the role of the LMC as a representative body and why the applicants would benefit from sharing their details with the LMC.

234  **DERBYSHIRE:** The Motion Number 25 passed at the LMC 2020 conference is resolved due to further ongoing problems with Capita

**PRIMARY CARE SUPPORT ENGLAND (PCSE) (25)**

That conference believes that the way Capita Primary Care Support England has mismanaged the GP pension scheme is unacceptable, falling well below expected professional standards and calls:-

(i) for Capita to be stripped of its PCSE contract immediately

(ii) on the GPC to issue a formal complaint regarding Capita PCSE to the Pensions Ombudsman

(iii) on GPC to demand that any workload or time commitment required on the part of GPs and practices to correct these errors will be financially compensated for.

235  **WEST SUSSEX:** That conference believes the pension crisis is getting worse and asks the GPC England to:

(i) acknowledge the complexities of the NHS pension system for clinical staff and asks the GPC England to negotiate a simpler system

(ii) acknowledge that the difficulties created by the pension payment system that is putting undue stress and work pressure on practice managers and all GPs, and is another factor in causing their burnout and resignation

(iii) we ask GPC England to request a full independent review of the performance of Capita, and encourage the government to change the provider or add meaningful changes to their contract so they provide a good service for the profession
(iv) change the payment system for pension contributions so all practices receive an invoice 30 days before any money is taken, and a challenge system is put in place that allows this payment to be clarified, corrected or paused before collection.

(v) change the collection of the contributions for salaried doctors so practices are not responsible for payments years later when the tier changes and they may have left their employment. The pension agency should endeavour to contact the GP directly for any top ups or refunds when tier rates change.

(vi) simplify the Annual and Lifetime allowance rules so GPs can easily understand the payments and they can contribute what they like, which may help GPs return to full time work or stay within the profession for a few more years.
# STANDING ORDERS

## Index

<table>
<thead>
<tr>
<th>Standing order</th>
<th>Standing order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda</td>
<td>17-28</td>
</tr>
<tr>
<td>Allocation of conference time</td>
<td>51-55</td>
</tr>
<tr>
<td>Chair’s discretion</td>
<td>71</td>
</tr>
<tr>
<td>Conferences</td>
<td></td>
</tr>
<tr>
<td>Annual</td>
<td>1</td>
</tr>
<tr>
<td>Special</td>
<td>2</td>
</tr>
<tr>
<td>Rules of debates</td>
<td>34-50.8</td>
</tr>
<tr>
<td>Time limit of speeches</td>
<td>58-59</td>
</tr>
<tr>
<td>Major issues</td>
<td>27</td>
</tr>
<tr>
<td>Distribution of papers and announcements</td>
<td>68-69</td>
</tr>
<tr>
<td>Elections</td>
<td></td>
</tr>
<tr>
<td>Chair</td>
<td>63</td>
</tr>
<tr>
<td>Deputy Chair</td>
<td>64</td>
</tr>
<tr>
<td>Conference Agenda Committee</td>
<td>65</td>
</tr>
<tr>
<td>Interpretations</td>
<td>10-14</td>
</tr>
<tr>
<td>Membership</td>
<td>3</td>
</tr>
<tr>
<td>Minutes</td>
<td>72</td>
</tr>
<tr>
<td>Mobile phones</td>
<td>69</td>
</tr>
<tr>
<td>Motions</td>
<td></td>
</tr>
<tr>
<td>A and AR</td>
<td>24-25</td>
</tr>
<tr>
<td>C</td>
<td>26</td>
</tr>
<tr>
<td>Composite</td>
<td>21</td>
</tr>
<tr>
<td>Grouped</td>
<td>20</td>
</tr>
<tr>
<td>Not debated</td>
<td>67</td>
</tr>
<tr>
<td>Not included in the agenda</td>
<td>56</td>
</tr>
<tr>
<td>Rescinding</td>
<td>23</td>
</tr>
<tr>
<td>With subsections</td>
<td>22</td>
</tr>
<tr>
<td>Observers</td>
<td>9</td>
</tr>
<tr>
<td>Press</td>
<td>70</td>
</tr>
<tr>
<td>Procedures</td>
<td></td>
</tr>
<tr>
<td>Amendments</td>
<td>29</td>
</tr>
<tr>
<td>Rider</td>
<td>30</td>
</tr>
<tr>
<td>Quorum</td>
<td>57</td>
</tr>
<tr>
<td>Representatives</td>
<td>4-8</td>
</tr>
<tr>
<td>Returning officer</td>
<td>66</td>
</tr>
<tr>
<td>Standing orders</td>
<td></td>
</tr>
<tr>
<td>Motions to amend</td>
<td>15</td>
</tr>
<tr>
<td>Suspension of</td>
<td>16</td>
</tr>
<tr>
<td>Voting</td>
<td>60</td>
</tr>
<tr>
<td>Majorities</td>
<td>61-62</td>
</tr>
</tbody>
</table>
STANDING ORDERS

CONFERENCES

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

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

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

Representatives
4. All local medical committees in England are entitled to appoint a representative to the conference.

5. The agenda committee shall each year allocate any remaining seats for representatives amongst LMCs. Allocation of additional seats shall be done in such a manner that ensures fair representation of LMCs according to the number of GPs they represent. Each year the agenda committee shall publish a list showing the number of representatives each LMC is entitled to appoint and the method of allocating the additional seats.

6. Local medical committees may appoint a deputy for each representative, who may attend and act at the conference if the representative is absent.

7. Representatives shall be registered medical practitioners appointed at the absolute discretion of the appropriate local medical committee.

8. The representatives appointed to act at the annual conference shall continue to hold office until the following annual conference, unless the GPC is notified by the relevant local medical committee of any change.

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

Interpretations
10. A local medical committee is a committee recognised by a PCO or PCOs as representative of medical practitioners under the NHS Act 2006.

11. ‘Members of the conference’ means those persons described in standing order 3.
12. ‘Representative’ or ‘representatives’ means those persons appointed under standing orders 4 to 8, and shall include the deputy of any person who is absent.

13. ‘The conference’, unless otherwise specified, means either an annual or a special conference.

14. ‘As a reference’ means that any motion so accepted does not constitute conference policy, but is referred to the GPC England to consider how best to procure its sentiments.

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

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

Agenda
17. The agenda shall include:
   17.1 motions, amendments and riders submitted by the GPC England, and any local medical committee. These shall fall within the remit of the GPC England, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and any Acts or Orders amending or consolidating the same
   17.2 motions submitted by the agenda committee in respect of organisational issues only.

18. When a special conference has been convened, the GPC England shall determine the time limit for submitting motions.

The agenda shall be prepared by the agenda committee as follows:
19. In two parts; the first part ‘Part I’ being those motions which the agenda committee believe should be debated within the time available; the second part ‘Part II’ being those motions covered by 24 and 25 below and those motions submitted for which the agenda committee believe there will be insufficient time for debate or are incompetent by virtue of structure or wording.

20. ‘Grouped motions’: Motions or amendments which cover substantially the same ground shall be grouped and the motion for debate shall be asterisked. If any local medical committee submitting a motion so grouped in writing before the day of conference, the removal of the motion from the group shall be decided by the conference.

21. ‘Composite motions’: If the agenda committee considers that no motion or amendment adequately covers a subject, it shall draft a composite motion or an amendment, which shall be the motion for debate. The agenda committee shall be allowed to alter the wording in the original motion for such composite motions.

22. ‘Motions with subsections’:  
   22.1 motions with subsections shall deal with only one point of principle, the agenda committee being permitted to divide motions covering more than one point of principle  
   22.2 subsections shall not be mutually contradictory  
   22.3 such motions shall not have more than five subsections except in subject debates.

23. ‘Rescinding motions’: Motions which the agenda committee consider to be rescinding existing conference policy shall be prefixed with the letters ‘RM’.

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

25. ‘AR’ motions: Motions which the chair of the GPC England is prepared to accept without debate as a reference to the GPC England shall be prefixed with the letters ‘AR’.
26. *‘C’ motions*: A ballot of representatives shall be conducted to enable them to choose motions, amendments or riders for debate. Using only the prescribed form, which must be received by the GPC England secretariat by a time to be agreed and advertised by the agenda committee, each representative may choose up to three motions, amendments or riders to be given priority in debate. The three motions, amendments or riders receiving the most votes shall be given priority.

27. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 42, 43, 44, and 45 shall not apply and the debate shall be held in accordance with standing order 50.

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

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

**Procedures**

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

30. A rider shall – add words as an extra to a seemingly complete statement, provided that the rider is relevant and appropriate to the motion on which it is moved.

31. No amendment or rider which has not been included in the printed agenda shall be considered unless a written copy of it has been handed to the agenda committee. The names of the proposer and seconder of the amendment or rider, and their constituencies, shall be included on the written notice. Notice must be given before the end of the session preceding that in which the motion is due to be moved, except at the chair’s discretion. For the first session, amendments or riders must be handed in before the session begins.

32. No seconder shall be required for any motion, amendment or rider submitted to the conference by the GPC England, a local medical committee, or the joint agenda committee, or for any composite motion or amendment produced by the agenda committee under standing order 21. All other motions, amendments or riders, after being proposed, must be seconded.

33. No amendments or riders will be permitted to motions debated under standing order 27.

**Rules of debate**

34. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.

35. Every member of the conference should be seated except the one addressing the conference.

36. A member of conference shall address conference through the chair.

37. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.

38. Members of the GPC England, who also attend the conference as representatives, should identify in which capacity they are speaking to motions.

39. The chair shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.

40. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.
41. The chair shall take any necessary steps to prevent tedious repetition.

42. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.

43. Amendments shall be debated and voted upon before returning to the original motion.

44. Riders shall be debated and voted upon after the original motion has been carried.

45. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 42, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.

46. If it is proposed and seconded or proposed by the chair that the conference adjourns, or that the debate be adjourned, or ‘that the question be put now’, such motion shall be put to the vote immediately, and without discussion, except as to the time of adjournment. The chair can decline to put the motion, ‘that the question be put now’. If a motion, ‘that the question be put now’, is carried by a two thirds majority, the chair of the GPC England or their representative and the mover of the original motion shall have the right to reply to the debate before the question is put. The chair of GPC England or their representative shall limit their reply to the content of the debate, relevant policy work and the feasibility of enacting the motion under debate. They shall not express any personal opinions.

47. If there be a call by acclamation to move to next business it shall be the chair’s discretion whether the call is heard. If it is heard then the proposer of the original motion can choose to:
   (i) accept the call to move to next business for the whole motion
   (ii) accept the call to move to next business for one or more subsections of the motion
   (iii) have one minute to oppose the call to move to next business.

Conference will then vote on the motion to move to next business and a 2/3 majority is required for it to succeed.

48. All motions expressed in several parts and designated by the numbers (i), (ii), (iii), etc shall automatically be voted on separately. But, in order to expedite business, the chair may ask conference (by a simple majority) to waive this requirement.

49. If by the time for a motion to be presented to conference no proposer has been notified to the agenda committee, the chair shall have the discretion to rule, without putting it to the vote, that conference move to the next item of business.

50. In a major issue debate the following procedures shall apply:
   50.1 the agenda committee shall indicate in the agenda the topic for a major debate
   50.2 the debate shall be conducted in the manner clearly set out in the published agenda
   50.3 the debate may be introduced by one or more speakers appointed by the agenda committee who may not necessarily be members of conference
   50.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
   50.5 subsequent speakers will be selected by the chair from those who have indicated a wish to speak. Subsequent speeches shall last no longer than one minute.
   50.6 the Chair of GPC England or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
   50.7 at the conclusion of the debate the introductory speakers may speak for no longer than two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
   50.8 the response of members of conference to any major debate shall be measured in a manner determined by the agenda committee and published in the agenda.

Allocation of conference time

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

52.1 A period may be reserved for a ‘soapbox’ session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.

52.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.

52.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.

52.4 GPC England members shall not be permitted to speak in the soapbox session.

53. Motions which cannot be debated in the time allocated to that block shall, if possible, be debated in any unused time allocated to another block. The chair shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.

54. Motions prefixed with a letter ‘A’, (defined in standing orders 24 and 25) shall be formally moved by the chair of conference as a block to be accepted without debate during the debate on the report of the agenda committee in the first session of the conference.

55. Other periods of time may be allocated by the Agenda Committee for other purposes as indicated in the Agenda.

Motions not published in the agenda

56. Motions not included in the agenda shall not be considered by the conference except those:

56.1 covered by standing orders relating to time limit of speeches, motions for adjournment or “that the question be put now” motions that conference “move to the next business” or the suspension of standing orders

56.2 relating to votes of thanks, messages of congratulations or of condolence

56.3 relating to the withdrawal of strangers, namely those who are not members of the conference or the staff of the British Medical Association

56.4 which replace two or more motions already on the agenda (composite motions) and agreed by representatives of the local medical committees concerned

56.5 prepared by the agenda committee to correct drafting errors or ambiguities.

56.6 that are considered by the agenda committee to cover new business which has arisen since the last day for the receipt of motions

56.7 that may arise from a major issue debate; such motions must be received by the agenda committee by the time laid down in the major issue debate timetable published under standing order 50.

Quorum

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

Time limit of speeches

58. A member of the conference, including the chair of the GPC England, moving a motion, shall be allowed to speak for three minutes; no other speech shall exceed two minutes. However, the chair may extend these limits.

59. The conference may, at any period, reduce the time to be allowed to speakers, whether in moving resolutions or otherwise, and that such a reduction shall be effective if it is agreed by the chair.

Voting

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

Majorities

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

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

Elections
63. Chair
63.1 At each conference, a chair shall be elected by the members of the conference to hold office from the termination of the conference. All members of the conference shall be eligible for nomination.
63.2 Nominations must be handed in on the prescribed form before 10am on the day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

64. Deputy chair
64.1 At each annual conference, a deputy chair shall be elected by the members of the conference to hold office from the termination of the conference. All members of the conference shall be eligible for nomination.
64.2 Nominations must be handed in on the prescribed form before 12 noon on the day of the conference. Nominees may enter on the form an election statement of no more than 50 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

65. Five members of the conference agenda committee
65.1 The agenda committee shall consist of the chair and deputy chair of the conference, the chair of GPC England and five members of the conference, not more than one of whom may be a sitting member of GPC England at the time of their election. In the event of there being an insufficient number of candidates to fill the five seats on the agenda committee, the chair shall be empowered to fill any vacancy by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected and shall continue in office until the end of the following annual conference.
65.2 The chair of conference, or if necessary the deputy chair, shall be chair of the agenda committee.
65.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by 1.00pm on the day of the conference. Any member of the conference may be nominated for the agenda committee. All members of the conference are entitled to vote. Nominees may enter on the form an election statement of no more than 50 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.

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

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

Distribution of papers and announcements
68. In the conference hall, or in the precincts thereof, no papers or literature shall be distributed, or announcements made, or notices displayed, unless approved by the chair.
69. Mobile phones may only be used for conversation in the precincts of, but not in, the conference hall.
The press
70. Representatives of the press may be admitted to the conference but they shall not report on any matters which the conference regards as private.

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

Minutes
72. Minutes shall be taken of the conference proceedings and the chair shall be empowered to approve and confirm them.
## Resolution Updates Conference 2020

<table>
<thead>
<tr>
<th>Motion</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COVID-19</strong>&lt;br&gt;5&lt;br&gt;AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference, in respect of the response of general practice to the COVID-19 pandemic, commends practices for stepping up to the unique challenges, and:&lt;br&gt;(i) congratulates GPs and clinicians for developing and using alternative consulting methods during the pandemic&lt;br&gt;(ii) believes that finding our way through the COVID-19 pandemic has been and continues to be a driver for modernisation and positive developments&lt;br&gt;(iii) believes general practice has demonstrated that the GP partnership model works and expects the government to remain committed to this model of primary care&lt;br&gt;(iv) instructs GPC England to inform the government that GPs will not accept the return to the previous conditions of micro-management and central control once the pandemic is over&lt;br&gt;(v) mandates GPC England to use this to insist on investment in the core contract rather than the flawed PCN model. Carried</td>
<td>GPC has engaged extensively with NHSX,D E&amp;I over alternative methods of consultation and changes made to the delivery of healthcare in general practice including by securing hardware and software in the early stages of the pandemic and scrutinising new platforms and programmes before they are rolled out nationally throughout the pandemic. Where programmes stood up during the pandemic, particularly around data sharing, are poised to become permanent, we have taken steps to ensure that they are fully scrutinised – as would have been the case at any other time and can be implemented with minimal burden to GPs.&lt;br&gt;General practice has continued to support the pandemic effort, and GPC England has provided support to GPs and practices throughout. Our COVID toolkit for GPs and practices has been well received and one of the most visited parts of the BMA website throughout the pandemic. GPC England also negotiated the COVID vaccination programme for practices to deliver – the largest and fastest vaccination programme the health service has seen and which was admired worldwide.&lt;br&gt;The rapid change and response though the pandemic demonstrated the strength of the partnership model.&lt;br&gt;GPCE has lobbied NHSEI and government to move away from a micromanagement approach but they instead re-instated QOF in April 2021 and have refused to suspend it as part of their access and support plan.&lt;br&gt;Additional investment, £150m and then £120m, was secured between November 2020 and September 2021 for workforce expansion and in most CCGs paid directly to practices. The NHSEI access plan includes £260m to be used between October 2021-March 2022 and which could be used in practices but GPCE has serious concerns about the limitations and allocation of this resource.</td>
</tr>
<tr>
<td><strong>6</strong>&lt;br&gt;AGENDA COMMITTEE TO BE PROPOSED BY OXFORDSHIRE: That conference believes the government has failed to provide sufficient funding or resources to general practice in a timely manner to fight the COVID-19 pandemic, and:</td>
<td>GPC England has continued to call for additional support for general practice and a reduction or delay to other workload, throughout the pandemic.</td>
</tr>
</tbody>
</table>
### Motion

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

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

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

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

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

Carried (Unanimous)

### Update

As highlighted above, additional funding for practice was secured and in addition PCN service specifications were reduced in scope or delayed until April 2022. Access scheme changes have also been delayed until 2022. NHSEI and government have refused to continue the suspension of QOF or other enhanced services since April 2021.

GPC England, and the profession, has responded in the strongest terms possible – with a call for industrial action.

### Primary Secondary care interface

<table>
<thead>
<tr>
<th>7</th>
<th>AGENDA COMMITTEE TO BE PROPOSED BY HILLINGDON: That conference is concerned about the unfunded transfer of workload and responsibility from secondary care to GP during COVID-19, and calls on GPC England to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i)</td>
<td>ensure all secondary care clinicians undergo an annual educational activity covering their duties and responsibilities under the NHS Standard Contract</td>
</tr>
<tr>
<td>(ii)</td>
<td>urgently negotiate that NHSEI mandates that all investigations initiated in secondary care are followed up in secondary care</td>
</tr>
<tr>
<td>(iii)</td>
<td>ensure that GPs are not held responsible if their patient’s clinical medical condition deteriorates whilst on unacceptably long waiting lists</td>
</tr>
<tr>
<td>(iv)</td>
<td>insist that NHSEI formally engage with CCGs to provide clear guidance on how to define unacceptable workload shifts</td>
</tr>
<tr>
<td>(v)</td>
<td>agree financial sanctions against providers who do not reduce this transfer, with resulting funds being paid directly to affected practices</td>
</tr>
</tbody>
</table>

(i), (ii), (iii) (v) carried

(iv) carried as a reference

NHSE/I have indicated that they are planning to work with clinicians and other key stakeholders together to review and redesign outpatient pathways across primary, secondary and community care. The BMA will take part in that work to enable local systems to transform their services, enabling seamless integration, truly patient-centred pathways and more convenient access to necessary treatment and care for patients. Commissioning structures are now changing, and it is vital that clinicians from across primary, community and secondary care are able to have a voice in new planning structures. The BMA has heard reports from members of positive work to improve interface working at CCG level being lost due to STPs (sustainability and transformation partnerships) and ICSs (integrated care systems) not seeing them as a priority. It is vital that as the NHS moves to larger scale system-level commissioning and planning, local relationships and initiatives are given the backing they need to succeed. The response to Covid-19 showed the value of harnessing clinical input into system change. ([Supporting effective collaboration between primary, secondary and community care in England in the wake of Covid-19](https://www.bma.org.uk/))

Letter to practices on supporting appropriate workload
<table>
<thead>
<tr>
<th>Motion</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chosen motions</strong></td>
<td></td>
</tr>
<tr>
<td>124</td>
<td><strong>KENT:</strong> That conference demands that all referrals to secondary care must: (i) be assessed by an appropriate clinician in secondary care (ii) not be rejected without a clinical explanation to the referrer that is copied to the patient (iii) not be downgraded to advice and guidance when a full assessment is requested (iv) transfer the medico-legal responsibility to the secondary care clinician. (i), (ii), (iii) carried (iv) carried as a reference</td>
</tr>
<tr>
<td>243</td>
<td><strong>SHROPSHIRE:</strong> That conference views as unacceptable, in light of additional work undertaken in the COVID19 pandemic, the contract clause about a balancing mechanism which will adjust between the global sum and workforce reimbursement sum in the Network Contract DES depending on real terms partner pay levels and calls on GPC England to demand that any additional funding for additional work is not subsequently clawed back from the practices’ core income. Carried</td>
</tr>
<tr>
<td><strong>Role of NHSEI in supporting general practice</strong></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><strong>GATESHEAD AND SOUTH TYNE SIDE:</strong> That conference finds abhorrent and insulting much of NHSEI’s communications with the profession, the press and the public and: (i) demands that NHSEI apologise and retract all communications that have implied general practitioners have not been fully involved in patient care throughout the pandemic, staining our reputation and inciting complaints (ii) deplores the habit that appears to have developed of NHSEI briefing journalists, particularly those hostile to general practice, before communicating with the profession and its representatives (iii) demands that general practice's contribution to the management of both the pandemic, and continuation of service whilst other parts of the healthcare system have stepped back from face-to-face work, be recognised, particularly given the general practitioners who have died in the course of their duties to the public. Carried</td>
</tr>
<tr>
<td>Motion</td>
<td>Update</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Digital first</strong></td>
<td>GPC England continues to express opposition to this policy, particularly the creation of new practices in areas that currently have no patients registered in this way and believes that CCGs should not be forced to accept such new practices. As a result these plans have not been progressed by NHSEI.</td>
</tr>
<tr>
<td>9 AGENDA COMMITTEE TO BE PROPOSED BY LINCOLNSHIRE: That conference notes with deep concern the proposal of NHSEI to commission extended (eg 20 year) APMS contracts from providers to enable digital health provision in under-doctored or deprived areas and calls upon GPC England to: (i) oppose the proposal to award longer term APMS contracts (ii) seek a legal challenge around the impact on the provision and stability of GMS services in these areas (iii) make this a ‘red line’ in any future contract negotiations. Carried</td>
<td>GPC England believes these new practices will not address health inequalities in under-doctored areas, but potentially make them worse, as such organisations will use the new practice base not as a vehicle to primarily provide services to the local population but as a way to register the young and more affluent elsewhere in the area. This will then take resources away from the CCG that could otherwise be better invested in local practices and services. GPC England has continued to lobby NHSEI to not implement this policy as it will be detrimental to existing general practice and patients.</td>
</tr>
<tr>
<td><strong>Core funding</strong></td>
<td>GPC England has called on NHSEI to review the funding formula, however NHSEI has been clear that they have no plans to do this within the remaining 2 years of the 5 year contract agreement and there would be no additional funding so there would be winners and losers in any changes. GPC England is not able to agree to this as there would be a detrimental impact on existing practices. GPC England has called on NHSEI and Government to negotiate a new contract for general practice; this would include negotiation over funding, its purpose, and its allocation.</td>
</tr>
<tr>
<td>10 WALTHAM FOREST: That conference strongly believes that the current GP funding formula is both seriously flawed and outdated and demands that GPC England: (i) urgently calls for NHSEI to review the GP funding formula (ii) ensures that any future formula provides fair and full remuneration which recognises GP workload (iii) ensures that a revised funding formula appropriately and proportionately accounts for differences in patient demographics, deprivation and health-seeking behaviour at individual practice level (iv) ensures that any revision does not result in practices losing out. Carried</td>
<td></td>
</tr>
<tr>
<td><strong>NHS 111</strong></td>
<td>As from 1st October 2021, NHSEI has stood down the need for a combination of NHS 111 and CCAS appointments at a rate of 1:500 and reverted back to 1:3000 for NHS 111 only.</td>
</tr>
<tr>
<td>11 CITY AND HACKNEY: That conference is concerned by recent moves to increase the number of GP appointments available to NHS 111 for direct booking and demands that GPC England ensures that the number of directly bookable GP appointments allocated to NHS 111 are not increased beyond what was agreed in the 2019 / 2020 GMS Contract. Carried</td>
<td>Statement from Simon Walsh</td>
</tr>
<tr>
<td><strong>GP consultation</strong></td>
<td></td>
</tr>
<tr>
<td>12 BEDFORDSHIRE: That conference:</td>
<td></td>
</tr>
<tr>
<td>Motion</td>
<td>Update</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>(i) deplores the action of NHSEI in failing to support GPs in</td>
<td>GPC England has continued to support practices to deliver services to</td>
</tr>
<tr>
<td>the use of their professional judgement in deciding when and if a</td>
<td>their patients, in the most appropriate way throughout the pandemic</td>
</tr>
<tr>
<td>patient needs a face-to-face appointment</td>
<td>and in line with IPC guidance from the Government. This has meant a</td>
</tr>
<tr>
<td>(ii) calls for a national campaign to explain why a face-to-face GP</td>
<td>change to the traditional face to face delivery of care and has been</td>
</tr>
<tr>
<td>appointment is not always necessary or safe</td>
<td>welcomed by many patients.</td>
</tr>
<tr>
<td>(iii) following the words of the Secretary of State for Health and</td>
<td>GPC England has been clear that moving forward, there will need to be</td>
</tr>
<tr>
<td>Social Care, agrees that the “new normal” will mean that more</td>
<td>a hybrid model of service delivery (face to face, telephone and</td>
</tr>
<tr>
<td>consultations will be done by telephone or video consultation rather</td>
<td>digital) – NHSEI and the Government has agreed but is concerned that</td>
</tr>
<tr>
<td>than face-to-face</td>
<td>the balance is not appropriate at present. GPC England is clear that</td>
</tr>
<tr>
<td>(iv) emphasises that if a doctor feels a patient needs to be</td>
<td>the balance is to be determined by the practice acting in the interests</td>
</tr>
<tr>
<td>seen face-to-face such an appointment will be arranged.</td>
<td>of their patients rather on the wishes (as opposed to needs) of</td>
</tr>
<tr>
<td>Carried</td>
<td>patients or on the wishes of NHSEI or Government. This has been one of</td>
</tr>
<tr>
<td></td>
<td>the major components of our opposition to the Government’s recent plan</td>
</tr>
<tr>
<td></td>
<td>to improve access.</td>
</tr>
<tr>
<td></td>
<td>In August 2021 we launched the Support Your Surgery campaign with the</td>
</tr>
<tr>
<td></td>
<td>aim of explaining the reasons why face-to-face appointments have been</td>
</tr>
<tr>
<td></td>
<td>limited throughout the COVID-19 pandemic but at the same time available</td>
</tr>
<tr>
<td></td>
<td>to patients based on clinical need. To do this we provided GP practices</td>
</tr>
<tr>
<td></td>
<td>with the tools they need to manage expectations with patients and</td>
</tr>
<tr>
<td></td>
<td>explain why face-to-face is not always appropriate.</td>
</tr>
<tr>
<td></td>
<td>We have sent to more than 5,800 practices in England posters to display</td>
</tr>
<tr>
<td></td>
<td>in their practices as well as a range of online materials to use in</td>
</tr>
<tr>
<td></td>
<td>waiting rooms, on practice websites or across social media including</td>
</tr>
<tr>
<td></td>
<td>infographics, template letters to MPs, FAQ documents, social media</td>
</tr>
<tr>
<td></td>
<td>banners and patient information notices on COVID-19 restrictions.</td>
</tr>
<tr>
<td></td>
<td>To support this the BMA has employed a digital marketing agency to</td>
</tr>
<tr>
<td></td>
<td>develop an online advertising strategy. We are also working with GPDF</td>
</tr>
<tr>
<td></td>
<td>on a substantial media campaign.</td>
</tr>
<tr>
<td></td>
<td>The issues facing GPs have also been central to events run by the BMA</td>
</tr>
<tr>
<td></td>
<td>in partnership with the RCGP at both the Labour and Conservative Party</td>
</tr>
<tr>
<td></td>
<td>conferences.</td>
</tr>
<tr>
<td></td>
<td>In the media, the BMA has continued to make this case strongly through</td>
</tr>
<tr>
<td></td>
<td>a large number of interviews, both nationally and locally, and</td>
</tr>
<tr>
<td>Motion</td>
<td>Update</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>respond to articles, opinion pieces and letters criticizing GPs.</td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference, considering the massive shift to remote consulting demonstrated during the pandemic, mandates GPC England to: (i) lobby educational bodies and other stakeholders to recognise the need for GP training to reflect this (ii) state that a digital consultation with a GP still takes up at least as much GP time as a face-to-face consultation (iii) work with stakeholders to find sensible ways to limit and manage the workload from e-consultations (iv) ensure that there is sufficient equipment to enable at least 50% of the workforce to work remotely (v) ensure that IT support is available 24 hours a day nationally to all GP working environments. (i), (ii), (iii) (v) carried (iv) carried as a reference</td>
</tr>
<tr>
<td></td>
<td>This will be taken forward in this session by the GP Trainees Committee and the Education, Training &amp; Workforce policy group. The issue was raised with the RCGP at their Specialty Training Board in September.</td>
</tr>
<tr>
<td><strong>14</strong></td>
<td>AGENDA COMMITTEE TO BE PROPOSED BY LINCOLNSHIRE: That conference believes any contract deal where public sector employees can receive a pay rise with no additional funding for their employer is a failure and: (i) believes that 2.8% does not reflect the increase in workload experienced by GPs of all types (ii) regrets the pay rise for independent contractor GPs and their administrative staff amounted to only 1.8% (iii) that this is a pay cut for independent contractors who have funded a pay increase to 2.8% for salaried GPs (iv) calls upon GPC England to negotiate an increase to at least the DDRB recommended raise of 2.8%, for all GPs, backdated to April 2020. Carried</td>
</tr>
<tr>
<td></td>
<td>GPC England has attempted to negotiate an increase to align with the DDRB recommendation for all GPs, however NHSEI and Government have refused to provide any additional funding, nor willing to utilise existing funding from elsewhere, to allow for this. However the most recent earnings and expenses report for 2019/20 reported that GP partner earnings had increased by 3.8%, significantly more than the DDRB recommendation for that year.</td>
</tr>
<tr>
<td><strong>258</strong></td>
<td>HARINGEY: That conference, despite a number of previous motions regarding unsustainable GP workload that have been previously carried by conference: (i) believes that it is no coincidence that GP workload continues to increase, and the numbers of GP continues to fall (ii) calls on government to stop producing patronising panaceas for the workload crisis that we are in and works with LMCs and GPC England to provide solutions to unsustainable workload that help us now Carried</td>
</tr>
</tbody>
</table>
|        | GPC England has called on NHSEI and Government to negotiate a new contract for general practice which would account for the workload and workforce constraints – NHSEI and Government are yet to respond. In the meantime, GPC England has provided advice to practices on how to manage their workload through measure they can take:  
  - offer patients consultations that are 15 minutes or more  
  - apply to close their list in order to focus on the needs of existing patients  
  - stop all non-GMS work to give priority to GMS care |

Chosen motions
<table>
<thead>
<tr>
<th><strong>Motion</strong></th>
<th><strong>Update</strong></th>
</tr>
</thead>
</table>
| Motion Update | - reject all shifted work from secondary care that has not been formally commissioned  
- not accept additional NHS 111 referrals above the contractual 1 per 3000 patients  
- stop unnecessary cost-based prescribing audits and focus on quality care  
- decline to do additional extended access sessions beyond routine patterns of working to focus on the core work of the practice and to maintain personal wellbeing  
| **PCN ballot** | A ballot on the PCN DES was run in January 2021, prior to continued negotiations on changes to the DES for 2020/21. The ballot showed 80% of respondents agreed to give GPC England a mandate for the PCN DES ahead of any negotiations, extensions or changes.  
Following the vote, GPC England negotiated minimal changes to the PCN DES while the pandemic was ongoing and some service specifications delayed until 2022.  
| 15 | DEVON: That conference notes that the GPC England has never secured a robust democratic mandate for the PCN DES and so again asks the GPC England to secure a firm mandate from the entire profession by means of ballot before negotiating any extension or changes to the PCN DES for the year 2021 / 2022.  
Carried  
| **Sessional GPs** | The GPCE Exec lead for workforce, GPC UK lead for education, training and workforce and the GPC Sessional GP Committee chair used the monthly workforce meetings with NHS England to push these priorities. The meetings were then of course paused following the GPCE vote to withdraw from discussions. NHSE-I did introduce the Primary Care Flexible Staff Pools Scheme earlier in 2021.  
On (i), there were a mixture of locums and retired returners in CCAS before it was dissolved. Again, we have not received statistics on what has happened to those retired doctors as meetings were paused, but we’ve not heard of concerns from locums. We expect this means the job market has returned to some form of normality and locums have work they can access again.  
We have not been made aware of any problems in relation to (ii) and (iii).  
| 16 | DORSET: That conference acknowledges the economic and professional impact COVID-19 has had on locum GPs and calls for NHSE-I to:  
(i) prioritise locums for work over those GPs returning to practice from retirement  
(ii) enable locums to work safely  
(iii) ensure locums are equipped and trained for new ways of working  
(iv) ensure locums are included in future discussions over primary care’s response to and recovery from the crisis.  
Carried  

<table>
<thead>
<tr>
<th>Motion</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARRS</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 17 AGENDA COMMITTEE TO BE PROPOSED BY HERTFORDSHIRE: That conference instructs GPC England to negotiate for the Additional Roles Reimbursement Scheme element of the Network Contract to allow funding for: | As part of the 20/21 settlement, GPC England secured an increase in ARRS funding from £430m to £746m.  
While GPC England secured the addition of Nursing Associates and trainee Nursing Associates to the list of eligible roles, NHSEI has remained firm that GPs and Nurses will not be eligible.  
We have however secured an additional £43m for the rest of 2021/22 for PCN leadership and management, with PCN CDs deciding how their allocation can be spent. Future IIF funding could be used to pay for more GPs and nurses in practices. |
| (i) additional GPs including locums                                    |                                                                        |
| (ii) practice nurses                                                   |                                                                        |
| (iii) advanced nurse practitioners                                     |                                                                        |
| (iv) non-clinical staff / supportive staff outside the prescribed national roles. |                                                                        |
| Carried                                                               |                                                                        |
| **PCN funding**                                                       |                                                                        |
| 18 CLEVELAND: That conference, in respect of the Core PCN Funding Payment (£1.50 / registered patient / year): | As part of the 20/21 settlement, practices received an uplift to the contract of £253m, an increase of 3%. Although the core PCN funding payment did not increase there were increases to ARRS and IIF as well as a new care home premium. Clinical Director payments increased throughout t General practice has also received significant financial support (£270m additional funding and income protection) throughout the pandemic to assist with managing workload.  
GPC England will continue to push for increased funding for PCNs in coming year |
<p>| (i) believes this is woefully inadequate to fund all the schemes it has been allocated to cover and additional workforce it is anticipated to employ and manage |                                                                        |
| (ii) insists that this payment must be uplifted annually to reflect the expanding workforce and responsibility, as a minimum in line with core GMS contract uplifts |                                                                        |
| (iii) demands that this payment is renegotiated for 2021 / 2022, to accurately reflect the workload that it is supposed to support. |                                                                        |
| Carried                                                               |                                                                        |</p>
<table>
<thead>
<tr>
<th>Motion</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccination programme</strong></td>
<td><strong>Motion</strong></td>
</tr>
</tbody>
</table>
| 19 | AGENDA COMMITTEE TO BE PROPOSED BY LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference, in respect of the 2020 / 2021 annual flu vaccination campaign:  
(i) is disappointed that staff have not been universally offered from the wider healthcare system to support practices  
(ii) believes that a higher payment should have been negotiated for this year’s DES in light of COVID-19  
(iii) mandates GPC England to negotiate an appropriate uplift in the DES payment for all future years that are impacted by COVID-19 or a similar situation that results in additional costs outwith the control of general practice  
(iv) would particularly highlight for early examination the differences in requirements in the flu vaccine delivery contracts offered to GMS / PMS and pharmacy providers  
(v) believes that announcing flu vaccination for 50-64 year olds without a plan for the supply or delivery of this programme was either simple incompetence or a cynical political ploy. | GPC England regularly pushes for increases to V&I payments, regardless of other circumstances. As a result practices are now eligible to claim and item of service fee for giving flu vaccination to their staff. Additional funding for the programme was provided with reasonable additional costs caused by COVID19 eligible for reimbursement, as well as additional funding provided under the PCN IIF. Requirements for both the general practice and pharmacy programmes are publicly available; the differing contracts and operations of general practice and pharmacy makes a direct comparison difficult. NHSEI recognised that the delay in announcement caused significant uncertainty for practices during last year’s programme, and as a result they have been included from the onset of the programme for 2021/22 |
| 295 | AGENDA COMMITTEE TO BE PROPOSED BY CAMBRIDGE: That conference deplores the pace and pressure put upon GPC England and its Executive team in the negotiation of the COVID-19 vaccination programme enhanced service, and  
(i) calls on GPC England to make it clear to patients and the public that faults in the COVID-19 vaccination programme lie with Government not with GPs  
(ii) rejects the mandated 8am-8pm seven days a week proposals and demands that GPs are best placed to decide when and how to conduct their business to ensure maximal population coverage with minimal wastage  
(iii) rejects the suggestion of single PCN designated sites and mandates the GPCE Executive to push for vaccine choice allowing general practice to deliver what it can at a practice level  
(iv) demands an immediate renegotiation of funding and flexibility attached to the proposed enhanced service, now that timelines and possibilities are better understood | The GP-led Covid 19 vaccination programme was a great success and delivered the large majority of initial Covid vaccinations within England and as a result received worldwide praise. As the programme has developed and the range of vaccines and restriction on their handling and transport have decreased, some restrictions on the delivery model have been eased, with many more practices being able to be used separately to the designated site. GPC England continued to push for further liberalisation of delivery to enable greater practice based delivery, especially given the potential for co-administration with flu vaccines for the coming year. This has been to a large extent enabled. |