

Conference of Representatives of Local Medical Committees

Agenda

FOUR NATIONS: ONE VOICE



Tuesday 10 and Wednesday 11 May 2022
York, Barbican Centre

Conference of Representatives of Local Medical Committees

Agenda

To be held on

Tuesday 10 May 2022 at 10.30 and Wednesday 11 May 2022 at 09.00

To take place in York at the Barbican Centre, Paragon Street YO10 4AH

Chair Katie Bramall-Stainer (Cambridgeshire)

Deputy Chair Matthew Mayer (Buckinghamshire)

Conference Agenda Committee

Katie Bramall-Stainer (Chair of Conference)

Matthew Mayer (Deputy Chair of Conference)

Ursula Brennan (Eastern, Northern Ireland)

Paul Evans (Gateshead and South Tyneside)

Rachel McMahon (Cleveland)

Shaba Nabi (Avon)

Bethan Roberts (Bro Taf)

Elliott Singer (Waltham Forest)

Alastair Taylor (Glasgow)

NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 2 March 2022. Although 2 March 2022 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent to the conference staff lead – Dominic Norcliffe-Brown (dnorcliffe-brown@bma.org.uk) prior to the conference.

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

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

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

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

Deadlines for this year's Annual Conference of Representatives of LMCs

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

Item	Deadline for submission
Chosen motions (see note below)	12noon on Friday 6 May
Notification of rider	12noon on Friday 6 May
Notification of amendment	12noon on Friday 6 May
Emergency motions	12noon on Friday 6 May

While the Agenda Committee has done the best job it can of prioritising motions for debate in the normal way, avoiding where possible existing policy, we know that some of the motions not prioritised for debate are also important to you, and you can use the [chosen motions ballot](#) process to nominate motions from Part 2 of the Agenda, which you would like to see debated during conference.

Elections at LMC UK conference

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

1. Chair of LMC UK conference 2023
2. Deputy chair of LMC UK conference for 2023
3. Seven members of the LMC UK conference agenda committee 2023
 - a. *At least one of whom shall represent each of the four UK nations and not more than one of whom shall be a sitting member of the GPC UK*
4. Seven members of the UK General Practitioners Committee 2022-2023
5. One 'early career' GP to be co-opted to the UK General Practitioners Committee 2022-2023
6. Forty-six members* to attend the Annual Representative Meeting (ARM) of the BMA in Brighton, 27-29 June 2022

*the Chair and Deputy Chair of LMC UK Conference and the GPC UK Chair have automatic seats to the ARM

Eligibility to vote in the elections

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

Election schedule

Nominations

Nominations opened for representatives to GPC UK 2022-23 – **12pm Tuesday 5 April 2022**

Nominations close for representative to GPC UK 2022-23 – **12pm Tuesday 3 May 2022**

Nominations open for representatives to ARM 2022 – **12pm Thursday 14 April 2022**

Nominations close for representatives to ARM 2022 – **12pm Thursday 21 April 2022**

Nominations open for all other positions – **10am Monday 9 May 2022**

Nominations close for all other positions – **11am Wednesday 11 May 2022** (day 2 of conference)

Voting

Voting opens for representatives to ARM 2022 – **12pm Friday 22 April 2022**

Voting closes for representatives to ARM 2022 – **12pm Friday 29 April 2022**

Voting opens for representatives to GPC UK 2022-23 – **5pm Tuesday 10 May 2022** (day 1 of conference)

Voting opens for all other positions – **12pm Wednesday 11 May 2022** (day 2 of conference)

Voting closes for *all* positions – **3:30pm Wednesday 11 May 2022** (day 2 of conference)

Results will be announced soon after the conclusion of voting.

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

Schedule of business

Tuesday 10 May 2022

Item	Time
Opening business	10.30
Annual report from the Chair of GPC UK	10.50
Solutions to workload	11.00
Patient empowerment	11.10
Safe workload limits	11.30
Core hours	11.50
Solutions for the workforce	12.20
The practice team	12.30
Professional wellbeing	12.40
Lunch	13.00
Themed debate – Unresourced workload	14.00
Working across interfaces	15.00
GPDF	15.10
UK report from Chair of Sessional GPs	15.20
Sessional GPs and portfolio practice	15.30
Regulation and UK professional issues	15.40
Partnership and contracts	16.00
Soapbox	16.30
UK report from GPDF	17.00
Questions to GPDF	17.10
Close	17.30

Wednesday 11 May 2022

Item	Time
UK report from Chair of GP trainees	09.00
GP trainees and GP training	09.10
MRCGP	09.20
Continuity of care and health promotion	09.40
Health inequalities	10.00
Digital, technology and data governance	10.10
Charities (Cameron Fund and Claire Wand Fund)	10.30
Themed debate – National Association of LMCs	10.50
Clinical, prescribing and dispensing	11.50
Environment and premises	12.00
Four nations	12.10
Lunch	12.30
Medico-legal and indemnity	13.30
Conferences of LMCs	13.40
Social media	14.00
Non doctor representatives	14.20
GPC	14.40
Fit notes	15.00
Chosen motions	15.10
New business / supplementary motions	15.30
Closing business	15.50
Conference close	16.00

OPENING BUSINESS

10.30

RETURN OF REPRESENTATIVES

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

STANDING ORDERS

- 2 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the standing orders (appended), be adopted as the standing orders of the meeting.
- 3 AGENDA COMMITTEE TO BE PROPOSED BY THE DEPUTY CHAIR: That conference accepts the proposed changes to the Standing Orders, as recommended by the Agenda Committee and as outlined in Appendix 1 regarding:
 - (i) Membership
 - (ii) Observers
 - (iii) Voting
 - (iv) Elections
 - (v) Rules of debate.

REPORT OF THE AGENDA COMMITTEE

- 4 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the report of the agenda committee be approved with permission to again include an election for an 'early career' GP to GPC UK for the 2022-2023 session.

ANNUAL REPORT FROM THE CHAIR OF GPC UK

10.50

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

SOLUTIONS TO WORKLOAD

11.00

- * 6 KENSINGTON, CHELSEA AND WESTMINSTER: That conference instructs GPC UK to conduct a comparison review across the four nations of the impact of the outcomes of their contractual negotiations on the stability and sustainability of GP practices, including GP: patient ratios, retention of GPs and PNs, real investment in essential services, and patients' satisfaction with GP services.
- 6a SANDWELL: That conference requires that GPC convene a working party that will analyse the workload of general practice and do a time and motion study as a basis for UK general practice development and resourcing for the 21st Century.
- 6b LEEDS: That conference notes both the frequent changes and complexity of GP contracts in each nation which can lead to practices and practitioners being uncertain what is required of them and therefore directs the four GPCs to produce a summary of all contractual requirements (that are in addition to essential services) each year for GPs and practices in their country to use as a reference guide.
- 6c OXFORDSHIRE: That conference directs national negotiators to request that UK government carry out a root and branch analysis of GP workloads, and work with system partners to revolutionise the way in which

healthcare is delivered, with a focus on whole systems capacity, ie what can realistically be delivered, rather than access, ie what we could deliver if whole systems capacity was unlimited.

PATIENT EMPOWERMENT

11.10

- * 7 AGENDA COMMITTEE TO BE PROPOSED BY AYRSHIRE AND ARRAN: That conference has observed that the public are emerging from the pandemic with additional and unrealistic expectations of general practice, and:
 - (i) believes that the continued political and media pressure for general practice to meet demand over need in a chronically underfunded health service is unacceptable
 - (ii) believes that more support is needed for patients to make informed choices for their personalised care that avoids duplication, is truly necessary and free from harm, and prevents or reduces medical intervention
 - (iii) believes that requesting written evidence of support from a GP for non-medical issues is inappropriate
 - (iv) demands an education campaign for patients to encourage the use of self-care
 - (v) demands an education campaign for patients to appropriately utilise pharmacy, optometry and dental services.
- 7a AYRSHIRE AND ARRAN: That conference has observed that the public are emerging from the pandemic with additional and unrealistic expectations of general practice, expecting the immediacy of remote clinician contact and access to face to face contact in equal measures and whilst we strive to return to our pre-pandemic service, we demand that the government promotes a public campaign:
 - (i) to encourage the use of self-care
 - (ii) to appropriately utilise pharmacy, optician and dental services.
- 7b ISLINGTON: That conference calls upon GPC / BMA to work with the RCGP in promoting a wider engagement with Rethinking Medicine, and support patients to make informed choices for their personalised care that avoids duplication, is truly necessary and free from harm and prevents or reduces medical intervention whilst remaining consistent with patient values.
- 7c CAMBRIDGESHIRE: That conference believes that the continued political and media pressure for general practice to meet demand over need in a chronically underfunded health service is not only unacceptable, but is also directly responsible for the demise of general practice, and:
 - (i) calls on the Secretary of State and DHSC to cease using the media to desecrate general practice, and to be honest with patients about what services can be offered through the NHS
 - (ii) calls on GPC UK to further develop, publicise and strongly advocate worked-up plans to introduce safe workload limits for general practice that does not constitute a breach of contract.
- 7d DERBYSHIRE: That conference, noting the ever changing government attitudes and demands with regards to availability of online / remote general practitioner consultations versus face-to-face consultations reminds both government and the public that the prime difficulty in accessing general practitioner services of any type is capacity constraints which are the product of years of under investment in general practice (as opposed to primary care) and that to correct this mandates GPCs and the BMA to mount a sustained negotiating campaign with governments and an education campaign for patients.
- 7e LEEDS: That conference is appalled at the failure of governments to ensure a comprehensive NHS dental service, with the result that growing numbers of patients are requesting help from general practice for common and preventable dental problems and calls on GPC UK to liaise with the British Dental Association to highlight this failure and lobby governments and NHS national bodies to resolve it.
- 7f SUTTON: That conference acknowledges the positive changes implemented within primary care, during the pandemic and recommends that the NHS in each of the four nations promotes greater use of pharmacies and optometrists, for the initial management of minor ailments, thus reducing inappropriate GP workload.

- 7g 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 the GPC to work with the administrations of the UK to agree a system of rationing to enable the fair and equitable use of limited and finite general practice resource.
- 7h MERTON: This conference believes that there should a charter specifying the services offered by GP practices and:
- (i) recommends that the GPC negotiates the explicit clarification of the responsibilities of general practice, to safeguard the sustainability of the profession
 - (ii) calls upon the NHS of the four nations to recognise that GP time is limited and needs to be prioritised to care for patients with the most need.
- 7i OXFORDSHIRE: That conference requests that BMA negotiate with HM Government, to effect nationwide change in attitudes and to address unrealistic expectations that the health service can provide solutions to issues that lie outside the medical model, making it clear that requesting written evidence of support from a GP for non-medical issues is inappropriate, and to reaffirm that GPs' remit is medicine, not oversight of all aspects of healthcare, social care, and population health management.

SAFE WORKLOAD LIMITS

11.30

- * 8 **AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND:** That conference, with regards to current workload within general practice:
- (i) believes that patient safety is paramount
 - (ii) recognises that reducing the number of patient contacts will have an impact on access
 - (iii) calls on GPC UK to coordinate the creation of credible agreed workload measures that are acceptable to the profession and to the wider NHS
 - (iv) calls on GPC UK to further develop, publicise and strongly advocate worked-up plans to introduce safe workload limits for general practice that do not constitute a breach of contract
 - (v) calls on the GPCs to use data on safe workload to renegotiate the GMS contracts with workload limits in order to protect all general practice staff and patients.
- 8a CLEVELAND: That conference, with regards to current workload within general practice:
- (i) believes that patient safety is paramount
 - (ii) believes that significant numbers of clinicians are working at an intensity which is potentially unsafe
 - (iii) recognises that reducing the number patient contacts will have an impact on access
 - (iv) empowers GPs to reduce their workload to a safe level
 - (v) mandates the GPDF to fund a patient facing campaign to support a culture shift from prioritising patient access to safe working within general practice.
- 8b CAMBRIDGESHIRE: That conference acknowledges "enough is enough" with regard to GP burnout and workforce attrition, and that workload as a driver needs to be addressed as a matter of urgency, with GPC UK instructed to:
- (i) work with GPDF to commission and fund research into how the current, unlimited workload is impacting upon burnout and workforce attrition
 - (ii) follow-up as planned in the GPC publication "Workload Control in General Practice" strategy (2018), by releasing guidance on qualitative and quantitative limits to individual safe practice for GPs and implementation of safe practice across scenarios
 - (iii) use data on safe workload to update the salaried GP contract with workload limits, including, but not limited to, daily appointment numbers, appointment duration and time spent completing administration
 - (iv) use data on safe workload to renegotiate the GP contract with workload limits in order to protect all general practice staff and patients.
- 8c LANCASHIRE COASTAL: That conference believes that the unsustainable pressures on general practice are a direct result of the failure to agree any credible measures of pressure and calls on GPC to coordinate the creation of agreed measures that are acceptable to the profession and to the wider NHS.

- 8d NORFOLK AND WAVENEY: That conference supports the Royal College of General Practitioners call for 15 minutes appointments for face to face contacts for primary care professionals, recognising that this is impossible to achieve without a growth in the primary care workforce.
- 8e DERBYSHIRE: That conference is extremely concerned at the current psychological health and wellbeing of GPs (and their staff) many of whom have sustained moral injury and mandates GPC UK to negotiate a “right to be disconnected” giving GPs and their staff downtime to recover and recuperate.
- 8f DERBYSHIRE: That conference insists that to accurately inform post Covid recovery and future negotiations that a new and robust GP workload survey is required urgently and that GPCs negotiate accordingly.
- 8g AVON: That conference believes that the unlimited workload within general practice is causing many GPs to burnout and leave the profession and demands that a daily workload cap is introduced for each GP, which follows the BMA principles of safe working.
- 8h AYRSHIRE AND ARRAN: That conference believes general practice is being crippled by increasing routes of access to general practitioners and demands that the BMA urgently work with RCGP to:
- (i) define a reasonable maximum daily clinical workload
 - (ii) change the contract to allow practitioners to say we are full for the day without being in breach of contract
 - (iii) review the means of access to general practitioners with a view to defining what tools can be used.
- 8i CENTRAL LANCASHIRE: That conference believes that GPs working patterns are dictated purely in response to demand, without any recognition of the complexity and intensity of the decisions they are required to make on a minute by minute basis and insists that a realistic job plan is introduced on a national basis to allow breathing space and respite during the working day.
- 8j NORFOLK AND WAVENEY: That conference asks GPC to seek a limit of patient contacts per day for reasons of clinical effectiveness and health and wellbeing of clinical professionals.
- 8k MORECAMBE BAY: That conference believes that a plethora of wellbeing initiatives is merely a sticking plaster to justify GPs being pressurised to accept impossible workloads, when the only responsible wellbeing initiative is to reduce GP workload.
- 8l CLEVELAND: That conference, with regards to demand measurement systems such as OPEL or GPAS:
- (i) believes that these are essential to allow general practice to articulate pressure in real time
 - (ii) insists that supportive resource must flow automatically when it is needed.
- 8m DERBYSHIRE: That conference in connection with measuring general practice workloads:
- (i) notes that currently there is no single recognised agreed set of tools or systems for generating such metrics
 - (ii) notes that much GP workload is currently unquantifiable except in time terms
 - (iii) insists that any system can also identify and quantify work shift and uncontracted work
 - (iv) any system be able to capture work without special action by clinicians and record work undertaken away from the surgery or desktop without the need for data entry afterwards
 - (v) insists that absence of evidence of workload is not evidence of absence of workload and instructs the GPCs to negotiate as a matter of urgency a system of such metrics to inform the profession, the governments, and negotiations.

CORE HOURS

11.50

- * 9 AVON: That conference believes urgent action should be taken to manage the workload / workforce mismatch within general practice and demands that the core GP contract is reduced to the hours of 09.00 to 17.00.

- * 10 AGENDA COMMITTEE TO BE PROPOSED BY GP TRAINEES COMMITTEE: That conference celebrates and values the contribution of international medical graduates to our workforce and calls on the UK government to:
 - (i) support the option of relocation of the close family of NHS workers to the UK
 - (ii) facilitate tier 2 sponsorship / skilled worker status funding for all practices across the country
 - (iii) mandate a five year minimum visa award to doctors entering UK GP training programmes
 - (iv) extend the duration of any existing tier 2 visa (or health and social care visa) before the planned CCT date without trainees having to secure employment for visa sponsorship
 - (v) lobby the DVLA to prioritise IMG GP trainees who do not hold a UK driving license for driving tests.
- 10a GP TRAINEES COMMITTEE: That conference condemns the short-sighted length of contract linked visa durations given to doctors entering into UK GP training programmes. Therefore, we call on the BMA to lobby relevant bodies to:
 - (i) mandate a five year minimum visa award to doctors entering UK GP training programmes
 - (ii) extend the duration of any existing tier 2 visa (or health and social care visa) before the planned CCT date without having trainees to secure employment for visa sponsorship.
- 10b MORGANNWG: That conference calls for a solution for skilled worker / tier 2 visa applications for international medical graduates.
- 10c CLEVELAND: That conference:
 - (i) celebrates and values the contribution of international medical graduates to our workforce
 - (ii) acknowledges the additional strain that the pandemic has brought when close family members are living overseas
 - (iii) mandates the BMA to work with governments to support the option of relocation of the close family of NHS workers to the UK.
- 10d DERBYSHIRE: That conference recognises that as GP numbers fall and practices struggle with recruitment conference calls upon GPC to negotiate tier 2 sponsorship / skilled worker status funding for all practices across the country.
- 10e NORTHERN IRELAND WESTERN: That conference calls on the UK government to urgently review the system of skilled worker visa (formerly tier 2) , which is a barrier to recruitment of international medical graduates, including GPs, in Northern Ireland as well as the rest of the UK.
- 10f BRO TAF: That conference demands that GPC UK seek urgent agreement from the Home Office for international medical graduate trainees to be granted automatic visas to remain and take up employment in the UK following their medical training.
- 10g GP TRAINEES COMMITTEE: That conference notes the increasing proportion of international medical graduates (IMGs) successfully gaining GP training places, who are unable to gain timely access to UK driving tests, to allow them both travel to work, and undertake home visits as part of GP training. We call on GPC UK to lobby the DVLA to prioritise IMG GP trainees who do not hold a UK driving license for driving tests.
- 10h LOTHIAN: That conference calls on the governments of all four nations to commit to an increase in WTE of general practitioners and to detailed workforce plans to show how this will be delivered.
- 10i HULL AND EAST YORKSHIRE: That conference recognises the crisis in GP training practice places and demands:
 - (i) urgent support and funding to training practices to support estates development
 - (ii) an improved funding package for trainers and practices
 - (iii) facilitation of innovative training posts across the UK for all areas
 - (iv) additional, tailored support for international medical graduates joining GP training.

- * 11 **AGENDA COMMITTEE TO BE PROPOSED BY MORGANNWG:** That conference requests an overhaul of processes for the modern general practice to account for services provided by the extended general practice team and demands:
 - (i) a public-facing campaign to introduce patients to the skills and expertise of the extended general practice team
 - (ii) that the NHS develop patient pathways and guidance to facilitate online booking into the correct allied health professional clinic
 - (iii) that Allied Health Professionals should be able to refer directly, without involving a GP, to other services
 - (iv) reimbursements for cover to be extended to all clinical staff employed in primary medical services.
- 11a MORGANNWG: That conference calls for a multilateral approach to referral and prescribing rights of Allied Health Professionals to effectively and efficiently use these qualified and supervised individuals.
- 11b BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference acknowledges that the clinical team has diversified in response to the workforce crisis created by a lack of GPs and that current parental and sickness leave reimbursement schemes are now unfairly restrictive and outdated and therefore calls for:
 - (i) reimbursements for cover to be extended to all clinical staff employed in primary care and
 - (ii) reimbursements for cover extend for the full length of any maternity, paternity or shared parental leave or adoption leave
 - (iii) reimbursements cover both sick leave and any subsequent phased return to work
 - (iv) where like-for-like locum cover is not available, primary care organisations may receive reimbursement for cover using a different suitable professional group.
- 11d NEWHAM: That conference believes that existing online booking processes do not acknowledge the breadth of clinicians currently working in general practice and:
 - (i) recommends that the NHS in each of the four nations develop a patient education programme informing patients about limitations in GP capacity and their evolving roles in managing complex or undifferentiated illness, as well as supervising allied health professionals within the practice
 - (ii) recommends that the NHS devise a public-facing campaign to introduce patients to the skills and expertise of the extended general practice team
 - (iii) recommends that the NHS develop patient pathways and guidance to facilitate online booking into the correct allied health professional clinic.
- 11e AVON: That conference requests an overhaul of referral processes for the modern general practice to account for services that other primary care staff including ARRS roles, should be able to refer directly to, without involving a medic, such as weight loss services, rehabilitation equipment, lifestyle interventions and first contact mental health services.
- 11f BEDFORDSHIRE: That conference calls on GPC to inform the governments of the UK that, if general practice is to survive, it will need a massive education and communication program to explain how and why the multi-disciplinary approach is the best way to develop a targeted and effective primary care system.
- 11g KENT: That conference believes that referrals should be recognised and accepted from allied primary care professionals by all parts of the health care system. We request that the GPC negotiate this should be formalised in the NHS standard contract.
- 11h BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference calls on GPC to acknowledge the crucial role that practice managers have to the operational integrity of practices and calls for the parental and sick leave reimbursements cover to be extended to them.
- 11i BEDFORDSHIRE: That conference believes that:
 - (i) "just because we've always done it this way" doesn't mean there aren't better ways of doing things

- (ii) both doctors and patients need to understand that a GP is not always the best person to see someone for a particular type of problem
- (iii) by filtering people to other members of the multi-disciplinary team, GPs are able to concentrate on complex problems which need their particular expertise
- (iv) while face to face consultations are often essential, text and email can be effective and safe in many situations, and
- (v) new ways of working actually help people whose problems are more social than medical to access help and information they need.

PROFESSIONAL WELLBEING

12.40

- * 12 **AGENDA COMMITTEE TO BE PROPOSED BY NORTHERN IRELAND CONFERENCE OF LMCs: That conference applauds the efforts of health and care workers during the pandemic, and:**
 - (i) praises general practice for continuing to deliver safe and effective healthcare throughout, including face to face consultations where appropriate, alongside the vaccination programme
 - (ii) calls upon GPC UK to work alongside Northern Ireland GPC, GPC Wales, GPC Scotland and GPC England in proactively ensuring that the public know that their practices are, and have been, open
 - (iii) condemns the ill-informed and unwarranted negativity and hostility by the press and on social media towards general practice
 - (iv) calls for changes to the GMS (General Medical Services) regulations to allow for the immediate removal of an individual from the practice list for any form of abuse
 - (v) calls on the BMA to lobby for increased sentencing for those abusing general practice staff.
- 12a **NORTHERN IRELAND CONFERENCE OF LMCs: That conference notes with dismay the repeated defamation of the primary care workforce in sections of the popular press and on social media, and media and:**
 - (i) instructs GPC UK / BMA to continue to engage with other bodies to ensure that the reputation of primary care is restored
 - (ii) calls upon all public representatives to consider the impact on health and care staff when commenting on the many problems in the health service, while acknowledging that many local politicians have been engaging positively with general practice.
- 12b **SCOTTISH CONFERENCE OF LMCs: That conference applauds the efforts of health and care workers during the pandemic, and:**
 - (i) praises general practice for continuing to deliver safe and effective healthcare throughout, including face to face consultations where appropriate, alongside the vaccination programme
 - (ii) condemns the ill-informed and unwarranted negativity and hostility by the press and on social media towards general practice
 - (iii) demands more action from government to prevent the abuse of GPs and their staff.
- 12c **LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is angered by the constant referral to a general practice access problem which infers GPs are to blame, rather than to the more accurate description of a general practice capacity problem which infers the system is to blame, and insists that all documents, press releases, and all other communications produced by all GPCs and LMCs no longer refer to a problem with access.**
- 12d **NORTH YORKSHIRE: That conference is very concerned by ongoing rhetoric from government about primary care access which has a direct negative impact on abuse that practice staff receive on a daily basis and demands that there is:**
 - (i) a national campaign led by government to demonstrate the true worth of practices
 - (ii) national recognition that current demand outstrips supply and further work done on highlighting alternative options for patients to empower them to self-care
 - (iii) an honest conversation with the public about what the NHS can afford currently and in the future.
- 12e **SCOTTISH CONFERENCE OF LMCs: That conference deplores the abuse from the public that GPs and practice staff have endured during the pandemic with the risk of the staff sustaining moral injury and harm and calls:**
 - (i) for changes to the GMS (general medical services) regulations to allow for immediate removal of an individual from the practice list for any form of abuse

- (ii) on the BMA to lobby for increased sentencing for those abusing general practice staff.
- 12f GLASGOW: That conference deplores the abuse from the public that GPs and practice staff have endured during the pandemic and:
 - (i) calls for a zero tolerance policy for any verbal, physical or online abuse
 - (ii) supports changes to the GMS Regulations for immediate removal from the practice list for any form of abuse.
- 12g AVON: That conference demands urgent action on abuse and violence directed towards GPs and their staff.
- 12h GLASGOW: That conference wishes to thank and applaud our GPs and practice staff colleagues across the UK who have continued to provide general medical services to patients overcoming the multiple challenges of the Covid pandemic, rising workload and staffing challenges.
- 12i GRAMPIAN: That conference feels the abuse received in general practice is now intolerable and to prevent staff sustaining moral injury and harm resulting in leaving the profession instructs GPC to work with government to clearly explain the capacity challenges facing general practice to MPs and the public.
- 12j GRAMPIAN: That conference feels the abuse received in general practice is now intolerable and instructs GPC to work with police to agree support for practices, to work with relevant agencies to increase police sentencing for those abusing general practice staff and to offer national training programme for zero tolerance training to be offered for general practice staff.
- 12k KENSINGTON, CHELSEA AND WESTMINSTER: That conference believes that the patient feedback from revalidation should be reviewed as it adds to the moral injury inflicted on GPs who are increasingly unable to provide the quality of care for which they trained, as a result of the mismatches between capacity, demand, and unrealistic expectations.
- 12l NORTHERN IRELAND EASTERN: That conference condemns the unwarranted toxic media campaign against general practitioners by the UK press and directs GPC UK to rebuff the narrative and the negative impact it is having on colleagues in all four nations.
- 12m AYRSHIRE AND ARRAN: That conference acknowledges the increased public frustration with NHS service provision exacerbated by the Covid-19 pandemic and:
 - (i) believes there is a related increase in violence and aggression experienced by NHS staff, including in general practice
 - (ii) calls on a stricter UK wide minimal punishment for proven violence and aggression against NHS staff to help deter this type of behaviour.
- 12n WIRRAL: That conference believe that the combination of negative and hostile press against general practice and abusive and sometimes violent attacks on GPs and their staff confirm how under-valued GPs are, and demands that:
 - (i) government take specific and direct measure to protect GPs and their staff
 - (ii) GPC and BMA improve on its communication apparatus to help in promoting general practice better
 - (iii) GPs continue to maintain their pride and confidence in the excellent service the profession provides and demonstrate and declare such at every opportunity.
- 12o AYRSHIRE AND ARRAN: That conference believes general practice has been significantly impacted by the pandemic and further damaged by recent negative media rhetoric and:
 - (i) believes that this negative rhetoric is damaging morale and leading to poor patient satisfaction, negativity and frustration
 - (ii) demands an end to the negative media designed to undermine general practice
 - (iii) demands a balanced public campaign of the merits and benefits of general practice.
- 12p NOTTINGHAMSHIRE: That conference believes that most healthcare professionals feels demeaned and undervalued when health news announcements appear in newspapers and the BBC before professional

communications evidenced recently in the 'living with Covid strategy' and requests that GPC urges DHSC to reconsider how they release important communications in the future in the spirit of 'no decision about me, without me'.

- 12q WORCESTERSHIRE: That conference believes that the use of the media to further political agendas in regard to healthcare is unethical and damaging to both patients and those working in general practice and insists that changes in government policy are communicated professionally and through appropriate channels with those affected by any change informed in advance of the media.
- 12r GLASGOW: That conference is appalled at the negativity and untruths coming from politicians and the media about general practice and face to face consultations and
- (i) demands an immediate stop to this
 - (ii) calls on the four governments to work on public information campaigns to inform the public about the realities of GP services.
- 12s BEDFORDSHIRE: That conference believes that the state of general practice is no joke but in the prevailing climate maybe we need a comedian to get the message across.
- 12t NORTHERN IRELAND CONFERENCE OF LMCs: That conference:
- (i) congratulates all the staff of general practice across the four nations within the UK for their phenomenal efforts in response to the pandemic, in providing the great majority of patients contacts during the crisis
 - (ii) strongly condemns and refutes the allegation that practices have been "closed", and
 - (iii) calls upon the GPC UK to work alongside Northern Ireland GPC, GPC Wales, GPC Scotland and GPC England in proactively ensuring that the public know that their practices are, and have been, open.
- 12u NORTHERN IRELAND NORTHERN: That conference condemns the perception that general practices have been closed to patients and highlights the extraordinary efforts that practices and all of their staff have made over the past two years in providing the vast majority of clinical contacts during the Covid-19 pandemic.
- 12v NORTHERN IRELAND EASTERN: That conference acknowledges the dedication all the staff of general practice across the UK for their phenomenal efforts in response to the pandemic and strongly condemns and refutes the allegation that practices have been "closed".
- 12w AVON: That conference would like to congratulate the entire GP profession and its leadership for the extraordinary achievement seen across all four nations, with both the Covid-19 response and the Covid vaccination programme.

LUNCH

13.00

THEMED DEBATE – UNRESOURCED WORKLOAD

14.00

The Unresourced Workload Themed Debate will be conducted under standing order 53. The motions submitted by LMCs that the Agenda Committee considers best covered by this themed debate are included in the agenda here and are numbered TD1 to TD26.

All members of Conference may take part in this debate by speaking from the microphones in the hall, rather than the podium, when called by the Chair, with a speaker time limit of one minute per speaker (SO 53.5).

It was clear from the number and breadth of motions received, that a universal pressure facing the profession across all four nations is the transfer of unresourced workload. The Agenda Committee wants the

voice of the LMC representative to take centre stage this year, and this is the first of our two themed debates. Here, we set some conference time aside to allow representatives an opportunity to showcase solutions to their problems; and to highlight to attending members of Conference, their priorities to focus on in the year ahead.

The Agenda Committee will endeavour through the Themed Debate, to capture a set of principles which we will ask Representatives to prioritise on an online interactive platform such as Slido.

- TD1 CENTRAL LANCASHIRE: That conference believes that it is a fundamental principal that all new referral forms are agreed with general practice, and this should be incorporated in the standard NHS contract.
- TD2 CONFERENCE OF ENGLAND LMCs: 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.
- TD3 GATESHEAD AND SOUTH TYNESIDE: That conference, referring to both the contractual duties of secondary care and previous conference motions, remains concerned about the amount of secondary care work transferred without agreement or funding into general practice, and requires that:
- (i) any changes to wider systems be required to have high-level general practice representative involvement in order to anticipate and prevent this
 - (ii) all secondary care providers be required to forfeit a proportion of their income for every time they attempt to pass work, unfunded and unagreed, into general practice
 - (iii) all secondary care providers be required to make easily available to general practice a single-point-of-access email to enable attempted workload transfer to be pushed back rapidly and effectively, said email to be secure and monitored by staff of sufficient seniority to enforce action.
- TD4 NORTH YORKSHIRE: That conference is concerned by ongoing workload shifts into primary care without adequate resource following and instructs GPC to negotiate:
- (i) any work previously done in hospitals must only be passed to primary care if primary care agrees to this shift, and the shift is accompanied by appropriate resource (workforce or funding)
 - (ii) any new work asked of primary care is suitably resourced
 - (iii) agrees that just because work can be done in the community doesn't mean that it should, and local decisions need to be taken based on circumstances
 - (iv) no one part of the system should make a change involving workload shift without due consideration of the impact on another part, or which risks destabilising another part.
- TD5 LINCOLNSHIRE: That conference believes the backlog in hospitals and move to remote consulting in hospitals has increased general practice workload and calls upon governments to provide support for general practices to deal with this workload.
- TD6 BEXLEY: That conference is concerned by the impact of the increase in inappropriate workload transfer from secondary care to general practice since the pandemic and, as a matter of urgency recommends that the GPC:
- (i) urgently investigates and quantifies the adverse impact of this issue on general practice

- (ii) negotiates with the NHS in each of the four nations, to ensure that secondary care providers meet all their contractual obligations relating to care at the interface with general practice.
- TD7 CITY AND HACKNEY: That conference recognises that general practice administrative staff are being increasingly burdened by requests from patients to chase hospital investigations which were ordered by outpatient clinics and recommends that:
- (i) hospital clinics give patients clear advice on waiting times for investigation results
 - (ii) hospital clinics provide patients with a direct point of contact to chase overdue investigation results if needed
 - (iii) patients should be empowered to have oversight of their own care, where appropriate.
- TD8 AVON: That conference for the establishment of national call centres for patients who are on surgical and out-patient waiting list to contact with questions regarding delays to their care, rather than contacting GP surgeries.
- TD9 LEWISHAM: That conference calls for all NHS hospital trusts to publish the direct dial telephone numbers and/or email address of consultant secretaries, listed against their named consultants by specialty, on their respective websites, so that patients can contact them directly for matters relating to follow up of test results.
- TD10 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference asserts that the GMS contract allows for patients to be seen in general practice who are ill or believe themselves to be ill. A pathway requiring the review of patients initiated by others, or at a specific point in time, would need to be commissioned and resourced.
- TD11 LINCOLNSHIRE: That conference calls on governments to rapidly develop systems whereby hospitals can generate and transmit electronic prescriptions to pharmacies so that patients do not have to get prescriptions from their already overworked GPs.
- TD12 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference asserts that, under the GMS contract, GPs have the contractual right to refer patients, whom in their judgment, require referral to secondary care services. Where information or tests are required, that are not required by the referrer need to be commissioned and resourced.
- TD13 HERTFORDSHIRE: That conference:
- (i) believes that there is an unfair and unnecessary transfer of work from secondary care to primary care, and
 - (ii) demands the roles and responsibilities of primary and secondary care to be drawn clearly in respective contracts to provide seamless, safe care for the patients. Currently it varies so greatly that degrades our profession and puts enormous burden on primary care.
- TD14 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 in discussions with the NHS to implement contractual levers and contract management to disincentivise and punish breaches of the standard hospital contract.
- TD15 NORFOLK AND WAVENEY: That conference recognises the pressures that the pandemic both primary care and secondary care have sustained and continuing pressures and calls for less criticising or deriding but we should show compassion and work together for the betterment of our patients.
- TD16 WORCESTERSHIRE: That conference believes that Advice and Guidance has increased workload and medico-legal risk for general practice and insists that:
- (i) funding is transferred from secondary care budgets to primary care budgets in recognition of the additional work and ability to manage patients in the community rather than in hospital

- (ii) if specialist diagnostics and imaging are required as a result of an advice and guidance request, these are ordered, interpreted and actioned by secondary care colleagues
 - (iii) that there is a standardised approach and training for all specialities to enable timely and appropriate responses
 - (iv) that any requests for conversion to a referral are respected and implemented by consultants without question.
- TD17 SOMERSET: That conference believes that NHS hospital contract enforcement must be equivalent to that applied to GP contracts across the UK.
- TD18 CLEVELAND: That conference acknowledges the strain within secondary care with regards to managing growing waiting lists, and requests that the same acknowledgement is expressed to general practice by the wider healthcare system.
- TD19 LOTHIAN: That conference insists that where a procedure is performed in the private sector and the patient then chooses to re-join the NHS, if the follow up is normally under specialist supervision, local specialist services should provide this follow up and not general practice.
- TD20 WALTHAM FOREST: That conference, with regards to advice and guidance as the only route to refer for specialist opinion:
- (i) believes that it adversely impacts general practice by transferring workload from secondary care to primary care
 - (ii) requires GPC to investigate the impact of advice and guidance on the general practice workload
 - (iii) maintains that it is unsafe if community services such as imaging are not made more available
 - (iv) insists that this is not adopted as a cost saving exercise
 - (v) requires GPC to negotiate a tariff with the devolved nations' department of health which funds this work to an equivalent amount to a first hospital outpatient appointment.
- TD21 LANCASHIRE PENNINE: That conference believes that it is a fundamental right of a GP to refer a patient to the service that best meets the patient's needs but believes that new referral forms from providers are being used to limit that choice and to effect a change in the role of the GP to do more and more of the initial investigations and insists that no new referral forms are accepted without agreement with general practice.
- TD22 WEST SUSSEX: That conference calls for more effective sanctions to ensure the clauses within the acute trust national contract are complied with.
- TD23 HULL AND EAST YORKSHIRE: That conference believes the roll out of diagnostic centres in the community is too slow to have any real impact on patient care and condemns the failure of the UK health ministers to work innovatively to expedite these within a meaningful time frame.
- TD24 LANCASHIRE PENNINE: That conference believes that general practice is at a crossroads between being primary care physicians or intermediate care physicians and urgently requires a strategy to be agreed by GPC to address this fundamental issue.
- TD25 CAMBRIDGESHIRE: That conference recognises the challenges at the primary-secondary care interface across the four nations of the UK, and the impact this has on workload, fatigue, declining professional status, and recruitment/retention, and calls upon GPDF to work with GPC UK to publish research into the various ways in which this interface is broken, to better enable GPC UK to negotiate solutions to this problem.
- TD26 HERTFORDSHIRE: That conference:
- (i) believes that secondary care consultants are still undertaking a large proportion of consultations remotely, resulting in additional work for GPs
 - (ii) calls on GPC to negotiate with the consultants' branch of practice that consultants should return to working primarily face to face, with similar targets and monitoring as GPs.

WORKING ACROSS INTERFACES

15.00

- * 13 **AGENDA COMMITTEE TO BE PROPOSED BY LEEDS:** That conference is seriously concerned by the impact of waiting times for secondary care NHS treatment, both on patients who are waiting unacceptably long times for appointments and on practice workload, and:
 - (i) believes current government initiatives to reduce waiting times have been wholly inadequate
 - (ii) demands that governments provide additional funding for practices to support the additional workload they are dealing with
 - (iii) calls on the four governments to provide clear plans for reducing lengthy waiting times so that appropriate care can be provided at the right time
 - (iv) believes that the widespread rejection of primary care referrals by secondary care could lead to patient harm and significant missed diagnoses
 - (v) insists that if a referral from general practice is declined for whatever reason, then this should be communicated by a named, accountable individual.
- 13a LEEDS: That conference is seriously concerned by the impact waiting times for secondary care NHS treatment are having both on patients who are waiting unacceptably long times for appointments, and on practice workload and:
 - (i) believes current government initiatives to reduce waiting times have been wholly inadequate
 - (ii) demands that governments provide additional funding for practices to support the additional workload they are dealing with.
- 13b GLASGOW: That conference remains deeply concerned about the impact of lengthy waiting times for hospital clinics and investigations on patients and the impact on the population's health and wellbeing and calls on the four governments to provide clear plans for improvement.
- 13c BRO TAF: That conference demands urgent action to tackle the backlog of patients on hospital waiting lists and to provide appropriate care at the right time.
- 13d HAMMERSMITH AND FULHAM: That conference notes the widespread rejection of primary care referrals by secondary care could lead to patient harm and significant missed diagnoses. Primary care never declines to see a patient that is transferred back to the GP from secondary care, so the same should apply the other way round.
- 13e LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that communication between providers and general practice should be from a named individual. As an example , if a referral from general practice is declined for whatever reason, then this should not be communicated by 'the team', but should have a named, accountable individual.

GPDF

15.10

- * 14 **AGENDA COMMITTEE TO BE PROPOSED BY GPDF:** That conference accepts the proposed amendments made by GPDF to the standing orders as appended (appendix 2) for 2023 regarding:
 - (i) Membership
 - (ii) Agenda
 - (iii) The black box.

UK REPORT FROM CHAIR OF SESSIONAL GPs

15.20

SESSIONAL GPs AND PORTFOLIO PRACTICE

15.30

- * 15 **AGENDA COMMITTEE TO BE PROPOSED BY CITY AND HACKNEY:** That conference recognises that the increasing patient demand for appointments and the escalating challenges of managing more complex patients all lead to greater workload pressures and:
 - (i) supports the BMA model contract for salaried GPs
 - (ii) recommends that the BMA salaried GP model contract is urgently reviewed
 - (iii) recommends that the BMA gives clearer guidance on how GP sessions may be divided up into specific working periods, by mutual agreement of the sessional GP and the practice
 - (iv) advises that the GPC determines and disseminates the average sessional rate for GPs across the UK, across the four nations and at borough level, to facilitate practice-level negotiations and place-based discussions.
- 15a **CITY AND HACKNEY:** That conference recognises that the increasing patient demand for appointments and the escalating challenges of managing more complex patients all lead to greater workload pressures and:
 - (i) recommends that the BMA salaried GP model contract is urgently reviewed
 - (ii) recommends that the BMA gives clearer guidance on how GP sessions may be divided up into specific working periods, by mutual agreement of the sessional GP and the practice
 - (iii) advises that the GPC determines and disseminates the average sessional rate for GPs across the UK, across the four nations and at borough level, to facilitate practice-level negotiations and place-based discussions.
- 15b **AVON:** That conference welcomes the standard BMA salaried GP contract but feels it is time for a review of terms and conditions and demands that we move away from a sessional rate and move towards an hourly rate for salaried GPs.
- 15c **SURREY:** That conference supports the BMA model contract for salaried GPs and encourages GP practices to support the terms and conditions within it.

REGULATION AND UK PROFESSIONAL ISSUES

15.40

- * 16 **AGENDA COMMITTEE TO BE PROPOSED BY OXFORDSHIRE:** That conference is concerned that the profession (even before the pandemic) is under constant strain and that this is having an impact of the health and wellbeing of the profession and:
 - (i) is concerned that GPs either as individuals or as a profession, do not receive the equivalent supervision or support that other professional bodies receive as part of their continuing professional development
 - (ii) seeks GPC, BMA and UK governmental support to make professional supervision and support a statutory requirement during GP training and ongoing GP registration
 - (iii) recognises that it is becoming increasingly difficult to maintain knowledge in a working day and calls for an increase in protected education time with adequate backfill for essential training as part of core GP funding.
- 16a **OXFORDSHIRE:** That conference:
 - (i) is concerned that the profession (even before the pandemic) was under constant strain and that this has had an impact of the health and wellbeing of the profession
 - (ii) notes that other professional bodies have supervision and support integrated into their training and post-qualification delivery models and as part of their continuing professional development
 - (iii) is concerned that equivalent support for GPs (via appraisal and revalidation) does not adequately support individuals or the profession
 - (iv) seeks GPC, BMA and UK governmental support to make professional supervision and support a statutory requirement during GP training and ongoing GP registration, to effect a reform of existing appraisal and revalidation processes to ensure these are fit for purpose and truly supportive.
- 16b **WAKEFIELD:** That conference supports a continuation and expansion of the measures introduced during the Covid pandemic to reduce the unnecessary administrative burden on practices.

- 16c NOTTINGHAMSHIRE: That conference recognises that it is becoming increasingly difficult to maintain knowledge in a working day which has become increasingly pressured. We call for an increase in protected education time and adequate backfill for essential training as part of core GP funding.

PARTNERSHIP AND CONTRACTS

16.00

- * 17 AGENDA COMMITTEE TO BE PROPOSED BY NORTH STAFFORDSHIRE: That conference believes that a “nationalised general practice service” is not in the best interest of patients or doctors and:
- (i) believes there is an abject failure of governments to recognise the value of the independent contractor model for delivery of primary care
 - (ii) believes vertical integration is an existential threat to the independent contractor model and the role of the GP partner
 - (iii) calls for clear modelling of the impact of a fully employed GP service in all UK countries to be undertaken by GPC UK
 - (iv) calls on GPCs to take all necessary action to defend and promote the partnership model and independent contractor status of general practice in the UK
 - (v) instructs the GPC to form a separate GP contract holders subcommittee to represent and discuss GP partnership contract issues.
- 17a NORTH STAFFORDSHIRE: That conference believes that the partnership model is the only way to sustain UK general practice and agrees that:
- (i) the model emphasises place, continuity, quality and clinical ownership of patient care
 - (ii) other models diminish these key qualities and increase risk for clinicians and patients
 - (iii) vertical integration is an existential threat to the model and the role of the GP partner.
- 17b HULL AND EAST YORKSHIRE: That conference believes:
- (i) there is an abject failure of UK governments to recognise the value of the independent contractor model for delivery of primary care
 - (ii) clear modelling of the impact of a fully employed GP service in all UK countries should be undertaken by GPC UK
 - (iii) resources must be provided by GPC UK to LMCs to help them communicate the threats of such a model to their local systems.
- 17c KENT: That conference believes that “nationalised general practice service” is not in the best interest of patients or doctors and requires the GPC to reject the concept at every opportunity.
- 17m NORTH STAFFORDSHIRE: That conference instructs the GPC to form a separate GP contract holders subcommittee, to represent and discuss GP partnership contract issues and that:
- (i) the partnership model needs clear and transparent priority support
 - (ii) maintenance of the partnership model is a GPC red line
 - (iii) the partnership model needs sustainable investment before future PCN expansion.
- 17d LEEDS: That conference:
- (i) reaffirms its belief that the partnership model and independent contractor status should remain the basis for general practice delivery in the UK
 - (ii) calls on GPCs to take all necessary action to defend and promote the partnership model and independent contractor status of general practice in the UK
- 17e WEST PENNINE: That conference accepts that, if the government’s olive branch of support through primary care networks is rejected by conference, then we reject independent contractors status along with that and a vertically integrated model of foundation trusts providing a national salaried GP service will follow from 1 April 2024.
- 17f WORCESTERSHIRE: Conference notes that the Secretary of State for Health is considering a review of general practice that may lead to privatisation and vertical integration and instructs GPC to robustly resist this and continue to prioritise the independent contractor, partnership-based model as the preferred vehicle for the delivery of general practice in the United Kingdom.

- 17g WIRRAL: That conference note with keen interest the current wholesale review of general practice and:
- (i) reject in totality any plan to nationalise general practice
 - (ii) demand that the views of grassroots general practitioners must be specifically sought and considered
 - (iii) ask GPC to ensure that future of GP independent contractors status is safeguarded.
- 18h LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the vertical integration proposal is eroding the independent contractor model and we must do everything we can to preserve the heart of primary care and the NHS. How can this help an already failing NHS, when secondary care is already on its knees with backlogs which will take over two years to get into a manageable position.
- 18i CAMBRIDGESHIRE: That conference is appalled by the Health Secretary's consideration, as reported by The Times, of radical changes to the NHS including the "nationalisation" of general practice, which clearly demonstrates a singular lack of understanding of the role and benefits of general practice, in direct contrast to recent research proving the measurable reductions in morbidity and mortality of the principles of UK-style general practice, and calls on GPC UK to be the strong, vocal, united advocate in defence of our role, our profession and the interests of our patients.
- 18j WORCESTERSHIRE: That conference believes that no new work should be taken on by general practice until sufficient funding is negotiated by GPC to go directly into core GMS. Conference believes this is necessary to support the independent contractor model, retention of staff, achievement of existing priorities and management of workload and to ensure sustainable general practice for the future.
- 18k WAKEFIELD: That conference believes that the partnership model is still the best model for doctors and patients and that GPC UK negotiates measures to support this model and support continuity of care within this model.
- 18l AVON: That conference instructs the GPC to work with NHSE to ensure that the GP independent contractor model of care continues.
- 18n DEVON: That conference requests that NHS leaders within the UK are open and transparent with their plans of the roadmap for general practice for the next five years with GPC UK leadership.
- 18o WEST SUSSEX: That conference requires the BMA to ballot their GP membership on the future of general practice.

SOAPBOX

16.30

UK REPORT FROM GPDF

17.00

QUESTIONS TO GPDF

17.10

CLOSE

17.30

GP TRAINEES AND GP TRAINING

09.10

- * 19 NORFOLK AND WAVENEY: That conference asks GPC UK to work with relevant bodies across the UK to ensure that all secondary care speciality training should include a mandatory three-month placement within general practice.
- 19a HERTFORDSHIRE: That conference calls for GPC to negotiate with the relevant branch of practice within the BMA that all secondary care training should have at least four months in primary care.

MRCGP

09.20

- * 20 AGENDA COMMITTEE TO BE PROPOSED BY GP TRAINEES COMMITTEE: That conference, with regards to the MRCGP examination process:
 - (i) calls on GPC UK to lobby the RCGP to provide improved individualised, disability specific, evidence-based reasonable adjustments for all trainees with disabilities for MRCGP exams
 - (ii) notes with dismay the repeated problems with the application process to take the MRCGP applied knowledge test
 - (iii) calls on GPC UK to lobby the RCGP to consider if the applied knowledge test assessment is still fit for purpose 15 years after introduction
 - (iv) mandates GPC UK to liaise with the RCGP to ensure an immediate return to the clinical skills assessment.
- 20a GP TRAINEES COMMITTEE: That conference notes that the requirements for reasonable adjustments for MRCGP exams, specifically the recorded consultation assessment (or previously clinical skills assessment) are unreasonably restrictive and calls on GPC UK to lobby the RCGP to provide improved individualised, disability specific, evidence-based reasonable adjustments for all trainees with disabilities for MRCGP exams in line with reasonable adjustments recommended in appropriate reports and in the workplace.
- 20b GP TRAINEES COMMITTEE: That conference notes plans to review and replace the RCA and CSA with a new assessment, but no such plans in place to review the applied knowledge test (AKT). We call on GPC UK to lobby RCGP to undertake a similar process with the AKT, to consider if the assessment is still fit for purpose 15 years after introduction, all alternative forms of assessment that are fit for the future and have a continued focus on reducing differential attainment in MRCGP examinations.
- 20c GP TRAINEES COMMITTEE: That conference notes with dismay the repeated problems with application to take the MRCGP applied knowledge test (AKT), resulting in candidates being unable to access timely reasonable adjustments, being required to travel hundreds of miles to take the exam, or simply being unable to book despite being eligible. We call on GPC to demand RCGP:
 - (i) report fully on the problems, and provide detailed solutions to resolving the problems with booking for future booking periods
 - (ii) offer a prioritised booking window in advance of the next booking window for candidates who have been unable to access an appropriate AKT sitting
 - (iii) move away from the typical scheduling of AKT only during the traditional academic year, to facilitate more sittings throughout the year, to allow more flexibility in training progression.
- 20d CAMBRIDGESHIRE: That conference acknowledges the difficulties faced by GP trainees during the Covid-19 pandemic and congratulates them on their perseverance, but also recognises that the training is not adequate in preparing trainees for practice and asks GPC UK to:
 - (i) liaise with the RCGP to ensure an immediate return to the clinical skills assessment

- (ii) seek to formalise a compulsory period of post-MRCGP, during which all GPs would benefit from additional mentoring and training in essential non-clinical management skills, whilst gaining confidence in managing the 'real' workload.

CONTINUITY OF CARE AND HEALTH PROMOTION

09.40

- * 21 **AVON: That conference demands that we move away from a target-based GP contract and be rewarded for prioritising continuity.**
- 21a AYRSHIRE AND ARRAN: That conference calls on the BMA and governments in all four nations to recognise the published research emphasising the benefits of GP continuity of care and demands contractual support and respect for the important role in relationship based care provided by general practitioners.
- 21b CAMBRIDGESHIRE: That conference welcomes the clear evidence to back up our lived experience that continuity of care between a doctor and patient reduces unplanned care; hospital attendance; and overall mortality, and therefore calls on GPC UK to run a visible campaign to keep this lifesaving principle at the heart of general practice policy across the UK, and to demand that GPC UK challenge those system changes which threaten continuity of care.
- 21c CAMBRIDGESHIRE: That conference notes that evidence supported by recent published studies demonstrates that continuity of care confers better health outcomes and quality of life for patients, as well as the most cost-effective way of providing care and:
 - (i) demands that all new initiatives are assessed objectively by the national GPC committees to ask if continuity is going to be disrupted and patient care damaged as a result
 - (ii) demands prioritisation of commissioning continuity of care of patients with chronic conditions, such as dementia, in national contracts to better ensure care is provided by a team of clinicians who know the patient, family and vice versa
 - (iii) demands that investment of both funding and time is prioritised in national contracts for the teams providing continuity of care in both secondary and primary care and where they interface
 - (iv) demands that the national committees work with the DHSC to ensure up-to-date patient / carer held records are available and can be accessed at all times for patients with chronic conditions in order to maintain continuity.
- 21d TOWER HAMLETS: That conference understands the need for general practice to embrace new technologies to improve the care we can offer patients and recognises that some patients prefer remote access but:
 - (i) is concerned that remote consultations risk care becoming a transactional process
 - (ii) insists that continuity of care is maintained regardless of the method of consultation
 - (iii) insists that our offer to patients does not prioritise convenience over access for those with greater need
 - (iv) will not agree to accept any technology without an impact assessment on how it will affect continuity of care.
- 21e LINCOLNSHIRE: That conference recognises that continuity of care provided by GPs keeps patients healthy and reduces health costs and believes that integrating general practices into NHS trusts will reduce this continuity and be bad for patients.
- 21f WARWICKSHIRE: That conference believes that the insidious erosion of core funding into general practice over many years has to be exposed, stopped and reversed as an absolute priority, otherwise:
 - (i) practices will continue to be destabilised and risk collapsing
 - (ii) it will become increasingly hard for practices to recruit and retain staff
 - (iii) patient continuity of care will be irrevocably adversely affected resulting in poorer health outcomes, higher hospital admission rates and a large increase in health care costs for the Country
 - (iv) dedicated, experienced and mutually supportive practice teams will be dispersed and years of experience and resilience will be wasted and broken.
- 21g COVENTRY: That conference believes that the insidious erosion of core funding into general practice over many years has to be exposed, stopped and reversed as an absolute priority, otherwise:

- (i) practices will continue to be destabilised and risk collapsing
 - (ii) it will become increasingly hard for Practices to recruit and retain staff
 - (iii) patient continuity of care will be irrevocably adversely affected resulting in poorer health outcomes, higher hospital admission rates and a large increase in health care costs for the Country
 - (iv) dedicated, experienced and mutually supportive practice teams will be dispersed and years of experience and resilience will be wasted and broken.
- 21h KENT: That conference requires that the GPC puts continuity of care at the centre of future NHS GMS negotiations by:
- (i) rewarding GPs for their commitment to a practice
 - (ii) reducing fragmentation of services
 - (iii) reducing unnecessary bureaucracy.

HEALTH INEQUALITIES

10.00

- * 22 **AGENDA COMMITTEE TO BE PROPOSED BY WESTMINSTER:** That conference is deeply concerned by the rise in health inequalities in our communities and calls upon GPC to:
 - (i) conduct a review into the impact of current national and local general practice funding models including funding formulae and outcomes payments
 - (ii) negotiate enhanced funding for GP practices serving areas of significant deprivation to resource addressing the additional workload
 - (iii) negotiate a requirement for a health impact analysis to be carried out by commissioners when any new housing or care homes are located in these areas of deprivation
 - (iv) negotiates for fairer funding of vaccinations which does not financially discriminate against practices with low vaccine uptake.
- 22a WESTMINSTER: That conference is deeply concerned by the rise in health inequalities in our communities and calls upon GPC to conduct a review into the impact of current national and local general practice funding models including funding formulae and outcomes payments.
- 22b NORFOLK AND WAVENEY: That conference asks GPC to negotiate a more pragmatic view to chronic disease management next year and reduced the amount of chronic disease management outcomes but focusing heavily on immediate necessary targets such as blood pressure control and diabetic checks and putting slightly less emphasis on more wide-ranging long-term outcomes acknowledging the pressures that practices are under with secondary care delays.
- 22c CLEVELAND: That conference, in respect of long-term condition management within general practice:
 - (i) recognises that the capacity to optimally support all patients does not exist at present
 - (ii) recognises that the inverse care law has impacted care provision for many years
 - (iii) believes that outcomes have worsened due to the pandemic, with a larger impact on those who have the greatest need
 - (iv) welcomes guidance on tailoring management based on clinical need, rather than a one size fits all approach
 - (v) demands the suspension of all contractual targets until at least April 2024.
- 22d GATESHEAD AND SOUTH TYNESIDE: That conference notes with dismay the evidence of widening health inequalities throughout the pandemic, and requests of GPC UK that:
 - (i) a full review of funding for general practice be conducted, including but not limited to Carr-Hill
 - (ii) general practice funding increases be matched, as a minimum, to inflation
 - (iii) the support of GPC UK be given to the principle of practices being free to recruit and spend according to local need, with core GMS remaining the absolute priority.
- 22e KENT: That conference requires the GPC to negotiate an incentive scheme to boost recruitment of GPs to the most under-doctored areas in the UK.
- 22f AVON: That conference roundly rejects any proposals of national vaccination services for fear that these centres would widen health inequalities and vaccine uptake.

- 22g LEEDS: That conference is alarmed at the fall in the number of children receiving MMR and other childhood vaccinations and:
- (i) calls on governments to do far more to promote childhood vaccination
 - (ii) calls on GPCs to negotiate funding and target arrangements for vaccination which recognise health inequalities.
- 22h LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that it the addition of vaccinations to be added to the Quality and Outcome Framework was a mistake which must be avoided for all four nations, and insists that the following lessons are learned:
- (i) vaccinations should never be part of any quality scheme
 - (ii) no new areas are added to any quality scheme where ability to achieve is related to demographics and can increase health inequalities by reducing income of practices in deprived areas
 - (iii) the amount of funding in quality schemes is reduced with that amount being transferred to core funding for general practices
- 22i WORCESTERSHIRE: That conference is concerned that the inability to exemption report children in the Quality and Outcomes Framework whose parents decline immunisations is unfair and risks widening health inequalities. Conference insists that no practice should lose income where attempts to engage local populations can be evidenced.
- 22j LEWISHAM: That conference recognises both the imperativeness of vaccination programmes and the key part played by general practice in their roll-out, and recommends that GPC negotiates with the NHS in each of the four nations to:
- (i) ensure that general practice in inner city areas, is not financially penalised for failing to meet immunisation targets, as, with the current resources available, vaccine hesitancy is a deep-seated issue beyond the control of local GPs
 - (ii) increase vaccine payments per inoculation, to better reflect the GP practice resource required to undertake the work.
- 22k GREENWICH: That conference recognises that additional work is required by general practice, to meet targets in deprived populations; and recommends that the GPC negotiates with the NHS in each of the four nations to:
- (i) reduce the currently unachievable childhood immunisation targets
 - (ii) increase the general practice funding linked to immunisation in areas of deprivation.
- (Supported by Bromley]
- 22l LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the current funding structure for vaccination can significantly penalise practices that have certain demographic profiles . This can make achieving the set targets all but impossible and could be perceived to be a culturally insensitive approach to achieving high vaccination rates.
- 22m LOTHIAN: That conference believes there is an urgent need to address health and social inequalities, and:
- (i) considers deprivation to be the key determinant of health inequalities
 - (ii) recognises the additional workload that deprivation brings to GP practices
 - (iii) has grave concerns about the likelihood of unmet health care need in deprived communities
 - (iv) calls for enhanced funding for GP practices serving areas of significant deprivation.
- 22n NORTH AND NORTH EAST LINCOLNSHIRE: That conference recognises the significant health inequalities experienced by patients in rural and coastal areas and calls for:
- (i) specific strategies from all commissioning organisations to identify and address these inequalities
 - (ii) adjustment of any performance related indicators to ensure practices in those areas are not unfairly disadvantaged
 - (iii) fully funded transport solutions to support both patients and primary care
 - (iv) impact analyses to be carried out by commissioners when any new housing or care homes are located in these areas
 - (v) recognition that dispensing practices provide essential services in these communities and must be protected from punitive healthcare policies.

- 22o LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the variation of provision of services across county, or local authority borders should not be allowed to disadvantage patients. This can be particularly apparent for practices whose boundaries are not directly aligned to local authority borders and can lead to an inequity of provision of community services which are often now under the remit of public health and therefore controlled by local authorities rather than the health community.
- 22p AVON: That conference wishes to acknowledge the importance of the NHS Race and Health Observatory report that found widespread ethnic inequalities leading to poor outcomes. All representatives commit, on behalf of the constituencies that they represent, to tackle all instances of poor quality or discriminatory treatment due to ethnicity.
- 22q GREENWICH: That conference is concerned by the increasing inequalities in health care provision arising from both the Covid pandemic and the resulting backlog of care and recommends that the UK Government urgently addresses the funding shortfalls in general practice, particularly in practices working with deprived populations.
- 22r AVON: That conference calls for the Departments of Health and Commissioners to create policies and have policies that make it clear that post-pandemic the NHS and general practice will be focusing on reducing health inequalities and those patients that need healthcare the most and are most likely to benefit.
- 22s BRADFORD AND AIREDALE: That conference recognises vaccination uptake is dropping across the population and:
- (i) calls on the government to take rigorous public action to counter the misleading information on vaccines abounding on social media; and
 - (ii) negotiates for fairer funding of vaccinations which does not financially discriminate against practices with low vaccine uptake.
- 22t SHROPSHIRE: That conference recognises that refugees from war-torn countries should be welcomed into the UK and should be offered healthcare according to their need but does not believe that GPs should be penalised for offering it. Specifically, the move of childhood vaccination into QOF in England has left practices unable to receive payment for the majority of immunisation being successfully delivered, due to the arrival onto the patient list of children already outside the window to achieve vaccination within the time limit, such as refugees from Afghanistan and elsewhere.
- 22u NOTTINGHAMSHIRE: That conference recognises that the pandemic has put health inequalities in sharp focus and moves to push for reappraisal of the Carr-Hill formula as well as dedicated budgets outside of core GMS for closing the gap in equality for patients.

DIGITAL, TECHNOLOGY AND DATA GOVERNANCE

10.10

- * 23 NEWHAM: That conference believes that recent digital innovations have increased health inequalities for our most vulnerable patients and:
- (i) instructs GPC to insist in all negotiations that individual practices have the right to determine the most appropriate form of consultation to best serve their patient's needs
 - (ii) calls on the UK government to investigate the impact of recent digital innovations on health inequalities.
- 23a SCOTTISH CONFERENCE OF LMCs: That conference concerned that digital-first approaches to primary care increase general practice workload unless stringent conditions are met, and believes that:
- (i) justification for these approaches should be based on evidence about the benefits in relation to the costs, rather than assumptions about reductions in workload, and that
 - (ii) given the potential increase in workload, which in due course could worsen problems of access, these initiatives should be implemented in a staged way alongside careful evaluation.

- 23b SESSIONAL GPs COMMITTEE: That conference takes the opportunity provided by the government's Levelling Up white paper to encourage our health boards and new integrated care systems to become "Marmot Communities".
(Supported by Dorset)

CHARITIES (CAMERON FUND AND CLAIRE WAND FUND) 10.30

THEMED DEBATE - NATIONAL ASSOCIATION OF LMCs 10.50

The National Association of LMCs Themed Debate will be conducted under standing order 53. The motions submitted by LMCs that the Agenda Committee considers best covered by this themed debate are included in the agenda here and are numbered TD26 to TD36.

All members of Conference may take part in this debate by speaking from the microphones in the hall, rather than the podium, when called by the Chair, with a speaker time limit of one minute per speaker (SO 53.5).

There remains a lack of clarity around this issue which has developed over recent conferences. The Agenda Committee are keen to put this debate in the hands of LMC representatives to tease out principles to build upon. What is a National Association of LMCs? What is the current proposal for such a model? What is the alternative? What degree of support is there among wider representatives? This Themed Debate provides an opportunity given the scope, to clarify what is being proposed; what its remit should be; what its remit should not be; and if it should exist at all. Is this a solution to a four-nation problem, or a single-nation issue of such importance that it requires four-nation support?

The Agenda Committee will endeavour through the Themed Debate, to capture a set of principles which we will ask Representatives to prioritise on an online interactive platform such as Slido.

- TD27 BERKSHIRE: That conference notes the establishment of a National Association of LMCs, is encouraged by the progress made on this issue, and calls on GPDF to ensure that such an organisation must:
- (i) support LMCs in providing the best services to their constituents
 - (ii) focus on the preservation of the independent partnership model and the businesses of constituent GPs
 - (iii) provide robust and accountable representation for general practice
 - (iv) be involved in national policy and contract negotiations.
- TD28 CAMBRIDGESHIRE: That conference supports the ongoing consultation on the development of a UK-wide National Association of LMCs which aims to establish what functions a NALMCs could provide and the options around its governance and calls upon GPDF to produce an options appraisal and a special conference of UK LMC secretaries and chairs to decide this in due course.
- TD29 OXFORDSHIRE: That conference believes the creation of the National Association of LMCs will repair the relationship between LMCs and health policy makers which has felt lacking and unilateral for such a long time, and calls:
- (i) on the GPDF to keep firm focus on its creation
 - (ii) for LMCs to be consulted on its structures
 - (iii) calls for the GPDF to oversee its elections.
- TD30 CUMBRIA: That conference believes that the development of peer support and networking opportunities for LMCs needs to be led by LMCs, for LMCs and be an integral part of the local, regional and national infrastructure that harmonises with the functions of GPC.

- TD31 NORTH STAFFORDSHIRE: That conference believes the current form of national representation of GPs requires review, and calls on GPDF to:
- (i) review the record of the GPC in representing the GP partnership model in annual negotiations
 - (ii) evaluate how LMCs and GMS partnerships can best be represented at national level in the interests of sustaining the partnership model
 - (iii) ensure any National Association of LMCs has an independent partner voice to advocate for GP partnerships
 - (iv) review the future funding of GPC by GPDF through LMC voluntary levy contributions.
- TD32 AVON: That conference believes that the GP committee of the BMA is not serving the partnership model of general practice and demands that a separate union is developed, through LMCs, to primarily represent GP partners.
- TD33 WEST SUSSEX: That conference believes GPC UK is not demonstrating that it is a functional, representative body of GPs, and calls for:
- (i) GPDF to not extend its deed of grant beyond the 2023 end date
 - (ii) GPDF to fund a National Association of LMCs
 - (iii) GPDF to divert the GPDF ['voluntary'] levy that currently funds GPC activity to a National Association of LMCs, to fulfil the role of a new national representative body of GPs
 - (iv) any National Association of LMCs board should which ex officio contains the democratically elected chair, deputy chair, and representatives of the Agenda Committee of the Conference of Representatives of LMCs.
- TD34 CAMBRIDGESHIRE: That conference recognises that the Meldrum Review has directly led to a decline in effectiveness of some GPC committees, and directly led to changes in the BMA / GPC relationship which further endanger the future of general practice, and:
- (i) recognises that the current level of secretariat support provided by the BMA, is insufficient to support general practice in effective negotiation
 - (ii) believes that the BMA is irreversibly conflicted and thus unable to adequately support both sessional and contractor GPs under one organisation
 - (iii) calls on the GPDF to urgently prioritise investigating what other avenues of possibility there are to negotiate future national contracts outside of the BMA.
- TD35 CLEVELAND: That conference is concerned about the use of the GPDF quota to provide support to general practice via the BMA, and requests that the GPDF:
- (i) ensures that the specific needs of LMCs are being met
 - (ii) provides a copy of the Deed of Grant to any LMC who requests this
 - (iii) increases its monitoring of the BMA's compliance with the Deed of Grant
 - (iv) increases the overall funding within the Deed of Grant.
- TD36 TOWER HAMLETS: That conference:
- (i) notes that GPDF is funded from voluntary levies and that many who contribute to this are not BMA members
 - (ii) demands that honoraria and expenses are paid to all elected GPC representatives whether they are members of the BMA or not.

CLINICAL, PRESCRIBING AND DISPENSING

11.50

- * 24 AGENDA COMMITTEE TO BE PROPOSED BY CAMBRIDGESHIRE: That conference calls on GPC UK to renegotiate the dispensing doctor fee envelope to:
- (i) avoid mid-year fluctuations in dispensing payments
 - (ii) allow cost neutral changes to dispensing doctor drug reimbursement pursuant to the 2021 DHSC review
 - (iii) allow dispensing to compete with pharmacists on a level playing field.

- 24a CAMBRIDGESHIRE: That conference calls on GPC UK to renegotiate the dispensing doctor fee envelope to:
 - (i) avoid mid-year fluctuations in dispensing payments
 - (ii) negotiate cost neutral changes to dispensing doctor drug reimbursement pursuant to the 2021 DHSC review.
- 24b SUFFOLK: That conference calls on GPC to renegotiate the dispensing doctor fee envelope to avoid mid-year fluctuations in payments.
- 24c SUFFOLK: That conference calls on GPC to negotiate equitable changes to dispensing doctor drug reimbursement pursuant to the 2021 DHSC review.
- 24d DERBYSHIRE: That conference recognises the reduction in the dispensing fee because GPs “over dispensed” is effectively the government seeking to have necessary work performed at no cost to the taxpayer and at the personal expense of the GP and mandates the GPCs to review this as soon as possible.
- 24c BEDFORDSHIRE: That conference:
 - (i) believes that dispensing practices should not lose dispensing rights simply because a pharmacy opens in the area, and
 - (ii) calls on GPC to negotiate that practices should be given the opportunity to continue to dispense and to compete with pharmacists on a level playing field.

ENVIRONMENT AND PREMISES

12.00

- * 25 SUTTON: This conference recognises that health care delivery in general practice is adversely impacted by the shortcomings of existing GP estates, including insufficient consultation rooms and meeting rooms and:
 - (i) calls on the NHS in each of the four nations to investigate the impact of current GP estate limitations on the effective safe delivery of care and the recruitment of both clinical and non-clinical GP staff
 - (ii) calls on the NHS in each of the four nations to investigate the impact of the limited number of disability adapted GP consultation rooms, on the clinical care of disabled patients
 - (iii) instructs GPC to negotiate with the NHS in each of the four nations, to urgently provide much needed new funding to develop GP estates.
- 25a CLEVELAND: That conference is exasperated by the lack of physical space within many GP practices and demands properly funded premises support to enable:
 - (i) the uptake of an expanded GP and Foundation Training programme
 - (ii) physical integration of the multi-disciplinary team
 - (iii) genuine care closer to home delivered by secondary care colleagues.
- 25b 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. We call on GPC 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 team 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.
- 25c LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference asserts that modern, quality general practice cannot be delivered from old, cramped premises that are no longer fit for purpose, and demands that the GPC negotiates an ongoing requirement for the NHS to:

- (i) provide additional ring fenced funding on a yearly basis for developing general practice premises
 - (ii) fund development of premises based on the requirement to provide contracted services, without requirement to provide additional unfunded services or to a specification above that contracted.
- 25d NOTTINGHAMSHIRE: That conference believes that there should be a massive and immediate injection of funds to enable practice to consult safely; to enable flexible use of premises for other healthcare providers and encourage partnership working,
- 25e 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.

FOUR NATIONS

12.10

- * 26 **AGENDA COMMITTEE TO BE PROPOSED BY REDBRIDGE:** That conference believes that all additional services delivered by general practice should be adequately remunerated and:
 - (i) calls for the end of the postcode lottery of LES contracts and requests a centrally negotiated menu of appropriately funded additional services
 - (ii) that the GPC negotiates with the four nations' NHS, to ensure that general practice participation in locally negotiated contracts is not dependent on sign up to the voluntary component of national contracts.
 - (iii) requires agreement by the NHS in each of the devolved nations that all calculations for projected costs of service delivery should be transparent and available for scrutiny and comment by GPC or LMCs (depending on whether a national or local service is involved)
 - (iv) funding calculations should allow for GP remuneration at a commensurate rate to the cost of locum GPs
 - (v) requires GPC to develop a cost calculator, agreed with the four devolved nations' departments of health, defining the unit cost for general practice which should then be used in all local negotiations.
- 26a REDBRIDGE: That conference believes that all additional services delivered by general practice should be adequately remunerated and:
 - (i) requires agreement by the NHS in each of the devolved nations that all calculations for projected costs of service delivery should be transparent and available for scrutiny and comment by GPC or LMCs (depending on whether a national or local service is involved)
 - (ii) funding calculations should allow for GP remuneration at a commensurate rate to the cost of locum GPs
 - (iii) requires GPC to develop a cost calculator, agreed with the devolved nation's department of health, defining the unit cost for general practice which should then be used in all local negotiations.
- 26b NEWHAM: That conference recommends that the GPC negotiates with the four nations' NHS, to ensure that general practice participation in locally negotiated contracts is not dependent on sign up to the voluntary component of national contracts.
- 26c SCOTTISH CONFERENCE OF LMCs: That conference believes that enhanced services still have a role to play, not for simple service delivery for areas which move elsewhere under the GMS contract, but to ensure local flexibility for particular settings and should remain a contractual option going forward.
- 26d 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.

LUNCH

12.30

MEDICO-LEGAL AND INDEMNITY

13.30

- * 27 CAMBRIDGESHIRE: That conference notes the recent 'folic acid' legal case in the media, and supports GPC UK researching the benefits of a no-fault medical compensation scheme to replace the current tort-based system, with the intention of providing this data to the government to add weight to their patient-centered reviews, particularly assessing whether a no-fault scheme would:
 - (i) reduce GPs' anxiety associated with possible litigation and therefore reduce defensive medicine
 - (ii) improve doctors' and patients' experiences of resolving a claim, particularly with regard to mental health impact
 - (iii) improve patient safety by enabling doctors to more freely admit to adverse events and share learning from these episodes.

CONFERENCES OF LMCs

13.40

- * 28 BEDFORDSHIRE: That conference calls for Conference of LMCs to be more frequent than annually, with some conferences held virtually so that they can address UK-wide issues in the morning and then split into the four nations for the afternoon.
- 28a BEDFORDSHIRE: That conference calls for there to be two one day Conferences of UK LMC annually to allow issues to be picked up more frequently than once a year.

SOCIAL MEDIA

14.00

- * 29 LIVERPOOL: That conference believes that GPC should have more of a social media presence to be able to engage with and respond to grassroots GPs.
- 29a LIVERPOOL: That conference believes that GPC should be actively engaging with groups such as GP survival and resilient GP to ensure that the needs of all GPs are fully understood.

NON DOCTOR REPRESENTATIVES

14.20

- * 30 DEVON: That conference agrees that non clinicians who are partners in general practices with a signed partnership agreement and are LMC representatives are fully able to enjoy the same rights of voting and proposing at conference as GPs are.

GPC

14.40

- * 31 WEST SUSSEX: That conference reminds GPC UK that conference exists to formulate policy which GPC UK should endeavour to implement, and calls for GPC UK to publish:
 - (i) an annual business plan, incorporating conference policy
 - (ii) a formal biannual report against the business plan, published on the BMA website, and made available to LMCs at least one month prior to the closing date of motion submissions to conference
 - (iii) a quarterly report against the business plan to LMCs.

- * 32 AGENDA COMMITTEE TO BE PROPOSED BY GLASGOW: That conference with regard to fit notes, observes that most GPs do not have occupational health qualifications and:
- (i) believes that it is a huge drain on GP resources to do a fit note in the first four weeks of illness
 - (ii) congratulates the UK government on the decision to temporarily extend the period for which people can self-certify absence from work to 28 days
 - (iii) believes that self-certification for social security and work purposes should be extended from the current seven days to 28 days as a permanent change
 - (iv) believes that general practice is neither the best placed, nor GPs the most appropriate professional, to assess fitness to work
 - (v) believes that for illness more than four weeks long, an independent occupational health service should be set up that would assess any patient for these matters, removing that workload completely from general practice.
- 32a GLASGOW: That conference with regard to fit notes, notes that most GPs do not have occupational health qualifications and:
- (i) believes that it is a huge drain on GP resources to do a fit note in the first four weeks of illness
 - (ii) commends the efforts to help GPs by the temporary measure removing the need for fit notes for periods of fewer than 28 days
 - (iii) calls on the UK government to permanently increase the number of days covered to at least 14 days
 - (iv) believes that general practice is neither the best place nor the most appropriate professionals
 - (v) believes that for illness more than four weeks long an independent occupational health service should be set up that would assess any patient for these matters taking that workload completely out of general practice.
- 32b CLEVELAND: That conference notes the ease with which the self-certification fit note period was extended to 28 days and calls for this to be re-instated as a permanent change.
- 32c LOTHIAN: That conference congratulates the UK government on the decision to temporarily extend the period for which people could self-certify absence from work and feels that:
- (i) it showed that people could be trusted to manage short term illness absence
 - (ii) it did reduce demands on GPs to provide fit notes for short term illness
 - (iii) it is now time for the governments to use the learning from this short-term change to trust the public, reduce unnecessary demand on general practice and extend the period of self-certification beyond the current seven days.
- 32d BEXLEY: That conference is concerned by the considerable GP time required to prepare fit notes and recommends that the:
- (i) UK government urgently removes the responsibility for writing fit notes from general practitioners' workload
 - (ii) issuing of fit notes become solely the responsibility of the patient's occupational health services and / or the DWP.
- 32e OXFORDSHIRE: That conference:
- (i) notes that the involvement of GPs in the assessment and certification of fitness to work is inappropriate, and can compromise the doctor-patient relationship
 - (ii) believes that GPs are not resourced or trained to offer such large-scale occupational health or benefits administration services, and their inclusion in GPs' standard contracts is anachronistic and no longer fit for purpose
 - (iii) believes that UK employers and benefits agencies are best placed to commission their own occupational health and disability assessments
 - (iv) mandates GPC UK to negotiate for the removal of work related sickness certification from standard GP contracts, and for relief from the growing strain of GP involvement in the bureaucratic processes of benefits administration.

- 32f OXFORDSHIRE: That conference mandates GPC UK to negotiate for the removal of work related sickness certification from standard GP contracts, and for relief from the growing strain of GP involvement in the bureaucratic processes of benefits administration.
- 32g DERBYSHIRE: That conference insists that in order to increase access to general practice it is necessary to reduce unnecessary GP consultations and to that end with regard to sickness certification:
- (i) that self-certification for social security and work purposes should be extended from the current seven days to 28 days
 - (ii) that secondary care and community based outreach clinics be provisioned with and be required to issue relevant certificates thus obviating needless wastage of a GP appointment purely for the issue of a certificate
 - (iii) that steps be taken to ensure acceptance of either “wet” or electronic signatures on sick notes and either physical or electronic transmission
 - (iv) that the government ensures that both patients and employers be updated with relevant information concerning sickness certification/ control of workplace absence rules and requirements and that the BMA / GPC negotiate accordingly.

CHOSEN MOTIONS

15.10

NEW BUSINESS / SUPPLEMENTARY MOTIONS

15.30

CLOSING BUSINESS

15.50

CONFERENCE CLOSE

16.00

Conference of Representatives of Local Medical Committees

Agenda: Part II (Motions not prioritised for debate)

Agenda: Part II

(Motions not prioritised for debate)

A and AR Motions

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

SOLUTIONS TO WORKLOAD

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| AR | 33. | NORTH YORKSHIRE: That conference recognises that time and time again general practice has demonstrated how agile and dynamic it can be during Covid-19, and it demands government recognise this and empowers the profession to support our communities with adequate funding and lifting of bureaucracy. |
| AR | 34. | AVON: That conference requests an overhaul of referral processes for the modern general practice to account for services that patients care directly self-refer to, such as physiotherapy, occupational therapy, and community nurses. |
| A | 35. | NORTH YORKSHIRE: That conference recognises the immense pressure practice managers are under and instructs GPC to negotiate rapid reductions in unnecessary bureaucracy for practice teams. |
| A | 36. | MERTON: That conference calls upon government to provide adequate resources to support core general practice to safely meet the increasing complexity of patient need. |

SOLUTIONS FOR THE WORKFORCE

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| A | 37. | AYRSHIRE AND ARRAN: That conference believes that general practice is on its knees as a result of increasing multi morbidity, increasing polypharmacy, increasing patient contacts, increasing time until end point intervention as a result of expanding waiting lists, increasing resignations, increasing burnout and calls on the government to primarily support the well-being of GPs to retain an expert workforce. |
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THE PRACTICE TEAM

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| AR | 38. | NOTTINGHAMSHIRE: That conference acknowledges that there is evidence of racism and discrimination within our profession and champions: <ul style="list-style-type: none">(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. |
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PROFESSIONAL WELLBEING

- | | | |
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| A | 39. | 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 |
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further loss of staff through ill health; retraining and leaving the profession, or suicide because of work induced health issues.

- A 40. AYRSHIRE AND ARRAN: That conference believes that there is a burgeoning mental health crisis within primary care staff and calls on GPC UK to ensure that the well-being of frontline staff is prioritised urgently to help retain the expert workforce.

REGULATION AND UK PROFESSIONAL ISSUES

- A 41. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the current yearly less burdensome appraisal to remain the same in the coming years. The Covid pandemic has shown that the current appraisal system is working well. The onerous year on year appraisal would affect staff retention and increase unnecessary work load.
- A 42. NORTH YORKSHIRE: That conference recognises the benefit of the reduced 'light touch' appraisal model used during Covid and demands that such a model is continued.
- A 43. BERKSHIRE: That conference believes that, following the adoption of the new 2020 appraisal to reflect the changing needs of the profession with the pandemic:
- (i) GPC has a mandate to work with the GMC to adopt this updated appraisal as the new template going forward
 - (ii) appraisal should continue to focus on support rather than counting CPD
 - (iii) appraisal should continue to be properly funded
 - (iv) appraisal should continue to focus on pastoral support.
- A 44. MORGANNWG: That conference calls for all four home nations to recognise UK-wide Medical Performers Lists, geographical boundaries should no longer be a barrier and a mechanism is required to aid virtual and F2F service delivery.
- A 45. EALING: That conference calls upon the GPC and the BMA to rectify, with the utmost urgency the iniquitous and unjust situation where some local authorities pay GP practices for safeguarding medical reports and attendances at child protection conferences but the others do not.
- A 46. AVON: That conference asks that the cervical screening services of the four nations work together to agree unified screening intervals to prevent confusion and impact on uptake when patients move between countries.

PARTNERSHIP AND CONTRACTS

- A 47. NOTTINGHAMSHIRE: That conference has already recognised the problems with recruitment and retention, and now calls on GPC to urgently address the problem of the “last man standing”, whereby the lack of a GP partner may lead to the practice closing.

GP TRAINEES AND GP TRAINING

- A 48. NORFOLK AND WAVENEY: That conference believes that general practice should be at the heart of undergraduate training and asks GPC to negotiate that all practices should be supported to train both undergraduates and postgraduates students with appropriate funding and infrastructure to accommodate this and believes more efforts are needed to support retention of GPs in areas where they undertake their training.
- A 49. HERTFORDSHIRE: That conference:
- (i) believes that the burden on trainers in terms of bureaucracy and deadlines is a barrier to trainer recruitment and retention, and
 - (ii) calls for a review and overhaul of the training system to reduce the bureaucracy for GP trainers.

DIGITAL, TECH AND DATA GOVERNANCE

- A 50. LEEDS: That conference notes the benefit that electronic prescribing has been for many patients to be able to receive their prescription when temporarily away from home, but also that it is still not possible to send prescriptions from practices in England to pharmacies elsewhere in the UK, and therefore calls on all four nations to enable electronic prescribing throughout the UK.
- A 51. LINCOLNSHIRE: That conference believes that patients from rural and remote practices are disadvantaged by EPS being unavailable to dispensing practices and calls on governments to rectify this situation immediately.
- A 52. NORTH YORKSHIRE: That conference is very concerned about proposals to allow patients full access to medical records without suitable redaction software being available and demands that any such proposals be paused until such a time as suitable software is available or there is sufficient capacity in the GP workforce to perform such checks manually.

MEDICO-LEGAL AND INDEMNITY

- A 53. NORTHERN IRELAND EASTERN: That conference insists that all GPs in the UK are treated fairly and equitably in terms of the risks they face and the costs they incur and calls on UK government to step in and provide an indemnity solution for Northern Ireland if the NI executive are incapable of doing so.

CONFERENCE AND LMCs

- A 54. NOTTINGHAMSHIRE: That conference recognises that LMCs have continued to support GP practice throughout the pandemic and have remained by GPs side from before the inception of the NHS. We ask that the LMCs are now recognised formally as THE representative for general practice and MUST be the professional organisation referred to, and consulted with by systems, trusts and commissioners in all issues affecting patient care in the community.

GPC UK

- AR 55. GATESHEAD AND SOUTH TYNESIDE: That conference believes that regular, weekly communications from the GPC are valued by the majority of LMCs and calls on the GPC to reinstate weekly bulletins.
- A 56. LIVERPOOL: That conference believes that GPC should now move quickly to the introduction of multi-member seat constituencies, for its regional representatives, as has previously been discussed by conference, as a means of improving GP representation on GPC UK.

PENSIONS AND FINANCE

- AR 57. AYRSHIRE AND ARRAN: That conference believes that the current pensions taxation system is severely affecting the ability of GPs to work and:
- (i) is forcing GPs to reduce working hours or retire early to avoid financial penalty
 - (ii) is exacerbating a crisis in recruitment and retention
 - (iii) believes annual allowance taxation is perverse in such a scheme
 - (iv) demands an urgent change such as that implemented for judges.
- A 58. LEEDS: That conference believes all GPs should be sent an annual NHS pension benefit statement and annual allowance statement every year without needing to request this and calls on GPC UK to ensure NHS pensions does this.
- A 59. MORGANNWG: That conference calls for a solution for pension annual allowance breaches and lifetime allowance breaches.

- A 60. 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.
- A 61. WEST SUSSEX: That conference believes the current annual allowance tax taper is a significant disincentive to NHS retention.
- A 62. LOTHIAN: That conference insists that there must be full reimbursement for GP practices of the upcoming rise in employers National Insurance contributions, to avoid GP partners becoming the only part of the medical workforce hit by this additional cost.
- A 63. BRADFORD AND AIREDALE: That conference calls on the GPC to negotiate increased funding for general practice now that we have morphed from a National Health Service into an Individual Health Service, and the extra demands that this has introduced.
- A 64. SHROPSHIRE: That conference regrets the failure of government to address current perverse and punitive pension and taxation regulations which actively encourage doctors to limit their workload, and believes, not least because of the massive pressures facing the NHS, that this requires urgent review.
- A 65. NORTHERN IRELAND WESTERN: That conference believes that the current pension contribution system for Sessional GPs is unfair. Sessional GPs currently have their earnings annualised prior to employee contributions being made. The employee contribution rate should be based on actual days worked not the annualised figure.
- A 66. LOTHIAN: That conference implores the governments of all four nations to ensure that GPs have parity with hospital colleagues with regards to Covid sick leave reimbursement.

REBUILD AND RESCUE POST COVID

- A 67. WELSH CONFERENCE OF LMCs: That conference asks that PPE provided to primary care is supplied on the basis of need.
- A 68. KENT: That conference requests the GPC to negotiate additional resources to support general practice to tackle the backlog of care that has arisen during the pandemic.

UNSCHEDULED CARE AND OUT OF HOURS

- A 69. BRO TAF: That conference demands that the ambulance services be fully resourced to meet targets and ensure adequate emergency care for patients.
- A 70. SESSIONAL GPs COMMITTEE: That conference recognises the vital role of out of hours GPs in looking after our patients and asks that:
- (i) it is recognised as a subspecialty of general practice
 - (ii) GPC UK encourages the RCGP to reclassify OOH work as a mandatory training for the VTS
 - (iii) GPC UK considers how OOH cover is provided and funded when negotiating GP contracts. (Supported by Dorset)

WANTS V NEED: ACCESS AND DEMAND

- AR 71. NORTHERN IRELAND EASTERN: That conference insists that no patient in any part of the UK should be harmed in the access to medicines as a result of UK government decisions and negotiations.
- A 72. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that there should be primary care access to a nationally funded occupational health service, accessible to all members of the primary care team, whether they are clinical or non-clinical staff.

Agenda: Part II

(Motions not prioritised for debate)

SOLUTIONS TO WORKLOAD

73. HERTFORDSHIRE: That conference calls on GPC to negotiate additional funding to cover childcare provision for GPs and practice staff to enable those with childcare responsibilities to continue to contribute to the practice workforce.
74. NORFOLK AND WAVENEY: That conference requests GPC to negotiate an extension to the New to Partnership Scheme both in length and to include practice managers as it believes this is fundamental to the survival of general practice.
75. LOTHIAN: That conference recommends that all appraisal platforms undertake annual development plans which include reducing unnecessary GP workload and stress for GPs.
76. CITY AND HACKNEY: That conference is concerned by the unnecessary stress caused to general practice teams by the tight deadlines issued by NHSE to sign up for contractual changes and the provision of new services and:
 - (i) recommends that the GPC highlights that adequate time is required by both practices and PCNs for consultation, to determine the feasibility and sustainability of potential contract changes or the delivery of new services
 - (ii) recommends that the GPC negotiates a minimum of a six week lead-in period, before sign-up for any contract changes or for the delivery of any new services
 - (iii) requires that the GPC negotiates a minimum of a six week gap prior to implementation of any new service, following general practice sign up.
77. REDBRIDGE: That conference recognises the work that has been done by GPC in trying to define safe workload for general practice and believes that this work must continue and that:
 - (i) it is detrimental to patient safety to create a system in which all new funding requires additional tasks to be undertaken by the practice
 - (ii) it is the responsibility of government to ensure that there is sufficient general practice workforce to allow safe delivery of all general practice based contracts
 - (iii) all contract changes must include specific details stating the workforce capacity that will be required for delivery
 - (iv) GPC, when negotiating further contract changes, must insist on reverting to the premise of the 2004 agreement of no new work without new funding.
78. BERKSHIRE: That conference calls for all contractual obligations to deliver online consultations to be removed in order to allow general practitioners to decide for themselves how best to deliver their services.
79. DERBYSHIRE: That conference believes that GP partners are increasingly stretched as they try to run both their own practices and run the system at multiple levels (PCN, ICS). Therefore, we demand that there is additional:
 - (i) funding for the management roles to run practices
 - (ii) funding for the management roles to run the system
 - (iii) training for these roles funded centrally.
80. KENT: That conference believes that the funding for GPs to engage with Advice and Guidance in the Investment and Impact Fund is derisory and requires the GPC to negotiate funding that reflects the additional workload and risk involved.

SOLUTIONS FOR THE WORKFORCE

81. GATESHEAD AND SOUTH TYNESIDE: That conference is concerned that, despite previous motions and resulting promises, experienced GPs continue to leave and calls for:
 - (i) a recognition of the many potential years of service lost, costed in terms of appointments that will never take place
 - (ii) a survey of recently retired GPs to elicit whether there are common themes that have led to retirement, with action to be taken on any such themes
 - (iii) a widening of GP retainer schemes, with other appropriate support as needed
 - (iv) a promise that burdens cited by many as prompts to retirement, such as appraisal, revalidation and CQC, are not permitted to return in their previous petty, bureaucratic, heavy-handed, incarnations
 - (v) a working culture in the NHS that asks 'what can we do to help you stay?' rather than simply deactivating a GP's Smartcard when they serve notice to retire.
82. GP TRAINEES COMMITTEE: That conference notes the rising numbers of GP registrars over the past five years but that despite these increase in training places, numbers of GP partners and full time equivalent GPs has fallen over the same time period. We call on GPC to carry out an annual survey of general practitioners who have joined the GP register in the past 12 months, to determine their career commitments to the NHS and the rationale for these career choices.
83. BEDFORDSHIRE: That conference:
 - (i) believes that, due to the current severe pressures on general practice made worse by the inadequate numbers of GPs, GPs and practice nurses should be exempt from being called for jury service
 - (ii) calls on GPC to negotiate with the relevant authorities, the exemption from jury service for GPs and practice nurses.
84. HERTFORDSHIRE: That conference:
 - (i) believes that, due to the current severe pressures on general practice made worse by the inadequate numbers of GPs, GPs and practice nurses should be exempt from being called for jury service, and
 - (ii) calls on GPC to negotiate with the relevant authorities, the exemption from jury service for GPs and practice nurses.
85. DERBYSHIRE: That conference reminds government that healthcare is delivered by a highly trained, experienced and intelligent human workforce, each of whom has individual limits and capacities. The Covid-19 crisis has highlighted those human limitations and the failed governmental approach to NHS GP workforce planning over the past 20 years. The GPC(s) together with the BMA develop a costed and time lined GP workforce plan ready to present to governments by December 2022.
86. DERBYSHIRE: That conference recognises the latest data on falling general practitioner numbers and demands GPC England set out a coherent strategy for general practice staff retention including negotiating the funding for this.
87. WARWICKSHIRE: That conference, whilst acknowledging the reality of a more pluralistic workforce in general practice, believes that this model increases the pressures to supervise other professionals and the risk to which GPs are exposed. It takes our most skilled GPs away from the front-line care for which they trained. As such, we must continue to press for a substantial increase to GP numbers.
88. COVENTRY: That conference, whilst acknowledging the reality of a more pluralistic workforce in general practice, believes that this model increases the pressures to supervise other professionals and the risk to which GPs are exposed. It takes our most skilled GPs away from the front-line care for which they trained. As such, we must continue to press for a substantial increase to GP numbers.
89. MORGANNWG: That conference calls for a recruitment and training strategy that considers the UK and global context to tackle workforce shortages.

90. LINCOLNSHIRE: That conference recognises the workforce shortage in general practice and asks governments to address this long term issue by:
 - (i) further increasing total medical school places
 - (ii) further increasing GP training places
 - (iii) making general practice a mandatory placement in all medical, nursing, and allied health professional training.
91. DORSET: That conference recognises the sterling work the care sector has undertaken both during the pandemic and historically, without which primary care would be unable to function. We therefore call for GPC UK to show our support and lobby the government to:
 - (i) ensure care workers are valued as key workers, provided with a fair wage and benefits for all the services they provide
 - (ii) increase the informal carers allowance.
92. BERKSHIRE: That conference calls for physician associate training programmes to include greater exposure to general practice than is currently the case, to ensure that these clinicians have a proper understanding and preparation for work in general practice.
93. SUTTON: This conference recognises the adverse impact both on chronic disease management and population mental health caused by the pandemic and recommends that:
 - (i) the GPC negotiates with the NHS in each of the four nations to reflect the additional workload required to meet current population needs
 - (ii) the NHS in each of the four nations introduces urgent and ongoing measures to safeguard the mental health and wellbeing of general practice staff.
94. CAMBRIDGESHIRE: That conference calls for national committees with work with their governments, and the BMA to work with DHSC to secure ring fenced discrete funds for practice clinical staff to access Agenda for Change to improve recruitment, retention and decrease attrition.
95. WARWICKSHIRE: That conference, whilst it welcomes the winter access fund, recognises that this reactive approach falls short of investing in addressing the long-term sustainability of the general practice. We must call upon NHSE to support general practice with clear plans to address recruitment and retention of the work force to meet the ever-worsening demand and capacity issue.
96. COVENTRY: That conference, whilst it welcomes the winter access fund, recognises that this reactive approach falls short of investing in addressing the long-term sustainability of the general practice. We must call upon NHSE to support general practice with clear plans to address recruitment and retention of the work force to meet the ever-worsening demand and capacity issue.
97. REDBRIDGE: That conference recognises the workforce crisis affecting general practice throughout the UK and:
 - (i) acknowledges the different ways that each of the four nations are trying to address this, such as the ARRS
 - (ii) believes it is unhelpful for schemes to limit the type of healthcare professional who can be employed
 - (iii) requires the funding to be made at practice level, as this is where the patient care is being delivered
 - (iv) calls on GPC to negotiate less bureaucratic and more flexible schemes
 - (v) requires NHSE to confirm that any funding for staff will continue for the life of the current GMS contract and not be withdrawn at the end of the current five year agreement.

THE PRACTICE TEAM

98. GRAMPIAN: That conference recognises the shortfall in workforce amongst GPs and professional MDT members such as primary care physiotherapists, mental health workers, pharmacists, visiting practitioners and calls on GPC to negotiate with relevant agencies a national increase in funded training places for these staff and recruitment drives.

99. DERBYSHIRE: That conference recognises the pivotal role of practice managers and admin teams in modern general practice and notes promised inclusion of PMs in the New to Partnership Scheme have not been forthcoming. We therefore demand investment into local PM and admin training programmes.
100. WEST SUSSEX: That conference believes the funding associated with the ARRS roles would more effectively support patient care if diverted to funding the core contract.
101. DERBYSHIRE: That conference acknowledges the dire state of staffing within the general practice workforce and that frequently neither practices nor PCNs can compete with the T+Cs of secondary care. It calls upon GPC to negotiate:
 - (i) an increase in core funding to cover annual cost of living rise
 - (ii) an additional funding to practices so that agenda for change T+C including uplifts and continuation can be applied
 - (iii) a fully funded occupational health service for ALL members of the general practice team.

PROFESSIONAL WELLBEING

102. BEDFORDSHIRE: That conference fears that the state of the NHS and general practice in particular may be beyond satire but hopes a sharp wit might be persuaded to take our plight to the nation.
103. HERTFORDSHIRE: That conference calls on GPC to negotiate the urgent commissioning of a GP FOR GPs consultation service to allow GPs to access prompt quality confidential care from colleagues not known to them professionally, given the increasing collaboration amongst practices.
104. CAMBRIDGESHIRE: That conference notes the increasing number of GPs being unwell and unable to work as a result of stress and burnout, the personal impact on these GPs, coupled with the impact on capacity and workforce on primary care, is an escalating emergency for all UK general practice with practices unable to nurture and support colleagues in difficulty and to address this:
 - (i) suggests GPC UK advocates for the paid provision of a designated staff member "advocate" in all practices to whom GPs can turn for support when experiencing symptoms of stress and signpost to resources such as PHP
 - (ii) works with the RCGP to embed essential training for all GPs both before and after CCT to ensure awareness of signs of burnout in themselves and colleagues
 - (iii) works with national committees and governments to push for a "no blame" process enabling GPs to take time out promptly before burnout is established and receive the necessary time off and work modifications as soon as possible.

WORKING ACROSS INTERFACES

105. NORFOLK AND WAVENEY: That conference asks GPC to enforce the hospital standard contract to ensure that discharge letters from secondary / tertiary care reach primary care in an electronic form within 24 hours of patient discharge.
106. CITY AND HACKNEY: That conference recognises the adverse impact of poor-quality hospital correspondence on patient care and GP workload and requires GPC to negotiate amendment to the NHS standard contract to include:
 - (i) mandatory use of a standard proforma for all clinic letters, with a minimum obligation to provide certain clearly defined information
 - (ii) the need for all hospital clinic letters to contain the following: all diagnoses, new diagnoses made following this appointment, all current medications, medication changes following this appointment, new investigation results since last clinic appointment, further investigations requested, any onward referrals made, any actions for GP, and a direct email for GP to use if any queries
 - (iii) the ability for GPs to reject unclear hospital patient correspondence, with a mandate that the hospital will provide clear correspondence to the GP within 72 working hours of the GP rejection.

107. DORSET: That conference is appalled with the increasing delays in ambulance response time and calls on GPC to ensure that risk and responsibility for patient care lie with the ambulance service when an ambulance has been requested by anyone for conveyance of patients to hospital.
108. HERTFORDSHIRE: That conference:
 - (i) believes that mental health services are failing patients, and
 - (ii) calls on GPC to add its support to fair and adequate funding for mental health services.
109. SESSIONAL GPs COMMITTEE: That conference recognises the sterling work the care sector has undertaken both during the pandemic and historically, without which primary care would be unable to function. We therefore call for GPC UK to show our support and lobby the government to:
 - (i) ensure care workers are valued as key workers, provided with a fair wage and benefits for all the services they provide
 - (ii) increase the informal carers allowance.
110. HIGHLAND: That conference believes that doctors can provide a critical insight into destabilising events and enhance planning for disaster risk reduction and humanitarian response, as such medical students should be encouraged to undertake relevant intercalated degrees.
111. LANCASHIRE COASTAL: That conference believes that the profession needs to unite around a cohesive and credible strategy for the future of general practice as we emerge from the Covid pandemic and fundamental changes to the models of NHS provision are emerging.

REGULATION AND UK PROFESSIONAL ISSUES

112. SANDWELL: Given that GPC England is mandated to seek a fee-per item contract at next renewal, there will be no global sum containing educational allowance (PGEA) or appraisal reimbursement. Conference suggests that now would be an appropriate time to introduce an hourly, fee-per-item based educational and appraisal allowance throughout the United Kingdom.
113. NOTTINGHAMSHIRE: That conference recognises that GPs are still very much on the front-line of fighting the pandemic and that we are now in what will be a considerable recovery phase. To this end we request that appraisals-lite are deferred until April 2023 at the earliest.
114. AVON: That conference instructs GPC to make representations to the government setting out the fact that the proposed new NHS reforms have not been introduced in a democratic and proper way.
115. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is concerned that the contract to write Version 5 of the Good Practice Guidelines has been provided to NECS, cutting the preceding ties of editing and authorship from the RCGP and GPC. Conference therefore demands that unless this is reversed, any and all reference to the Good Practice Guidelines in Regulation 67 of the NHS (GMS Contracts) Regulations 2015 and elsewhere affecting any of the four nations in any other relevant regulation or contract are removed.
116. 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.
117. SOMERSET: That conference, appalled by the hardship caused when a GP partner, suspended from a national medical performers list during an investigation is forced to leave their partnership, insists that if suspension is truly "a neutral act" then:
 - (i) NHS reimbursement of lost income must continue until a definitive decision is made and
 - (ii) directs the BMA to negotiate to correct this injustice in all four nations.

118. DERBYSHIRE: That conference supports a multi professional team working across general practice. However, ARRS funding is a false promise of investment. We call upon GPC to publish the national and regional ARRS underspends to highlight the inadequacies of the ARRS approach and demand this underspend is used to cover salary support for any member of the general practice team subject to local need.
119. DERBYSHIRE: That conference recognises it is already coming to light that in an ICS the representation of primary care is seen as an insignificant minority partner. Conference demands the GPC negotiate that primary care must be the cornerstone of an ICS, which all other services are built upon.
120. DERBYSHIRE: That conference recognises trusts make up the majority of influence and votes in an ICS. Conference demands the GPC negotiate a change in the system where primary care have the veto on trusts setting their own agendas despite general practice.
121. NORTHERN IRELAND SOUTHERN: That conference instructs the four GPCs and GPC UK to work with relevant bodies, both regionally and nationally, to develop a solution for efficient transfer of GPs across performer's lists within the UK.
122. KENT: That conference rejects the imposition of 'network standard hours' and:
 - (i) is concerned that this further undermines independent contractor status
 - (ii) demands individual practices are given the freedom to plan services to meet their patients' needs.
123. SOUTH STAFFORDSHIRE: That conference believes that the Covid-19 pandemic has brought to light the excellent work done by general practice as a profession. It has highlighted how redundant and unnecessary the CQC inspection process is and general practice can provide excellent patient care without being subjected to pointless punitive inspections and instructs GPC that:
 - (i) CQC inspections are an unnecessary burden on the majority of practices causing a significant amount of stress, time involvement and leading to a reduction in the recruitment and retention of GPs and practice managers, thereby contributing to the decline of workforce and thereby threatening the future of general practice
 - (ii) routine CQC inspections should be stopped as soon as possible and permanently
 - (iii) the ICS should have local systems and measures in place to locally support struggling practices, and only refer them to CQC if significant concerns persist
 - (iv) LMCs should play a larger role along with the ICSs to support struggling practices to provide a supportive rather than punitive approach
 - (v) this motion does not condone poor practice but firmly believes practices should not be subject to tormenting CQC inspections and punitive actions arising mostly due to historical and current opaque and disadvantageous investment decisions and policy.
124. TAYSIDE: That conference believes that it is inappropriate for GP surgeries to be listed as a source for providing proof of address by other bodies including financial and insurance companies and directs GPC UK to work with appropriate representative and regulatory bodies to end this current practice.
125. NORTHERN IRELAND EASTERN: That conference believes that the administrative burden of gaining entitlement to NHS services as a whole for new entrants should no longer fall to general practices and should be through a separate body. GPs should provide immediately necessary care or register the patient for GP services once the individual has been provided with an appropriate medical card.

SESSIONAL GPs AND PORTFOLIO PRACTICE

126. SCOTTISH CONFERENCE OF LMCs: That conference welcomes the development of improved quality improvement and leadership elements of GP training, however:
 - (i) recognises that availability of leadership and quality improvement training are inadequate in primary care for the majority of GPs following qualification
 - (ii) recognises that these skills are vital to the successful development of 'expert medical generalists'
 - (iii) calls for better accessibility of training opportunities, adequate funding and time to promote and support development of these skills.

127. CLEVELAND: That conference regrets that many locum GPs continue to feel excluded and calls for:
- (i) equitable access and funding with regards to training opportunities
 - (ii) equitable access to IT solutions to support safe and flexible working
 - (iii) meaningful engagement on relevant workforce initiatives
 - (iv) LMCs to review their internal processes to ensure that there are no unintended barriers to locum GP engagement.

PARTNERSHIP AND CONTRACTS

128. LIVERPOOL: That conference believes that NHS England's decision to apply contract terms and conditions without a negotiated agreement with GPCE creates an existential threat to all GPs across all four nations of the UK and calls on all GPCs to formally seek the views of the profession regarding industrial action in light of such belligerence from NHSE.
129. NORTHERN IRELAND SOUTHERN: That conference insists that UK practices retain autonomy in deciding how best to deliver services for their patients in the aftermath of the pandemic.
130. GLASGOW: That conference is concerned that the ongoing pressures on GP practices may lead GP contractors resigning their contracts.
131. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that all nations should learn from the disastrous implementation of Primary Care Networks in England and demand that no significant change is negotiated for general practice in any national unless pilots demonstrate:
- (i) they reduce bureaucracy and workload for general practices and in particular the scarce remaining partners
 - (ii) that it does not increase expectations and requirements
 - (iii) it does not divert funding away from core general practice services
 - (iv) it supports improved funding and / or other resources for core services and not just fueling transfer of additional work into general practice
 - (v) it does not undermine a holistic general practice providing continuity of care
 - (vi) that the change will also include additional funding for any expansion or alteration in premises that is needed to deliver.
132. GRAMPIAN: That conference recognises there is a risk to NHS general practice with contracts being offered to private care providers on an ad hoc basis and requests transparency and national discussion on this direction.
133. HAMPSHIRE AND ISLE OF WIGHT: 'That conference is perennially disappointed at the imposition of contracts across the UK, for example the recent contract variation in England. For too long across the four nations contracts require services be moved into different parts of the system, often into general practice, almost universally with no data forthcoming pertaining to the nature of that work. Furthermore requests to access that data are often met with obstruction. It is impossible to plan robust new services whilst maintaining existing ones without good data in regard to the work that is coming with new contracts. It's a risk to workforce, patient safety, finance just to name a few. Conference demands that any new contractual work is accompanied by an open and transparent approach from higher NHS bodies in providing data about who currently does that work, how much of it there is, and what the current standards and outcome measures are.

GP TRAINEES AND GP TRAINING

134. GP TRAINEES COMMITTEE: That conference feels that the majority of the national and regional RCGP Trainee of the Year awards across England, Northern Ireland, Scotland and Wales are outdated with regards to the criteria used for judging excellence and furthermore introduce inequalities within the award system. It calls upon GPC UK to:
- (i) lobby the RCGP in England, Northern Ireland, Scotland and Wales to review criteria for all RCGP trainee awards including an Equalities Impact Assessment

- (ii) alter award criteria to ensure that standards used are more inclusive and reflective of current understandings of perceived excellence and ideal attributes for a future GP
 - (iii) that the review process takes place by a diverse group including equality, diversity and inclusivity experts and trainees.
135. HIGHLAND: That conference believes that the emergency planning and management of major incidents should be embedded within the specialty training of GPs and asks the BMA to petition the RCGP in pursuit of this.
136. GP TRAINEES COMMITTEE: That conference calls for GP trainees who are also new to the UK to have their first training placement in a GP practice based setting, where the trainers and education supervisor have received appropriate training, resources and support to provide the best possible introduction to UK healthcare.
137. BEDFORDSHIRE: That conference believes that experienced GPs approaching retirement might be encouraged to take a more active role in passing on the experience they have acquired over the years if there was a less exhaustive (and exhausting) route to being acknowledged as a qualified teacher rather than a trainer as is currently required.
138. GP TRAINEES COMMITTEE: That conference notes the growing demands by GP trainees for more flexible working conditions. We call on GPC to review the rules around work planning for GP registrars, with a mind to offering more flexibility to GP trainees.
139. BEDFORDSHIRE: That conference:
- (i) believes the burden on trainees and trainers in terms of deadlines, submissions and exams makes both roles unattractive and less rewarding than in the past, and
 - (ii) calls for a review and overhaul of the training system.
140. AYRSHIRE AND ARRAN: That conference believes that leadership capabilities are a requirement for the future of primary care and:
- (i) recognises the challenges of accessing quality leadership training
 - (ii) recognises the inequity of leadership training across the NHS
 - (iii) demands that more leadership training is made available and accessible to independent contractors.

CONTINUITY OF CARE AND HEALTH PROMOTION

141. DEVON: That conference recognises the links between public health nursing and general practice have been almost completely severed in some parts of the UK and calls for:
- (i) this to be officially recognised as a problem that affects the health and safeguarding of children
 - (ii) the approaches to this problem in different nations to be shared
 - (iii) a strong, unified, properly funded solution is implemented as soon as possible.
142. NORFOLK AND WAVENEY: That conference requests GPC to acknowledge the often unspoken pandemic of domestic violence and abuse and the huge damage it has on the mental and physical health of our most vulnerable patients, their families and society, and recognising the unique and privileged position general practice holds with these families and communities, negotiates clear funding directly into general practice to enable it to seize this opportunity and play its full part in helping tackle the problem comprehensively.
143. LANCASHIRE PENNINE: That conference believes that GPC should renegotiate the childhood vaccination and immunisation domain of QOF, which ostensibly encouraging a high uptake of the vaccine programmes, but in fact result in the opposite, as practices pursue a course of diminishing returns to get the last few babies / children immunised and realise it isn't worth the effort.
144. CAMBRIDGESHIRE: That conference notes that the seven year period of phasing out correction factor payments to practices has now come to an end, and that many LMCs may be aware of practices who, dependent on factors such as a lack of dispensing; adverse effects of the Carr-Hill formula; atypical and

deprived populations, highlights a number of practices struggling to remain solvent, and calls upon the national committees to work with the DHSC and their governments in creating a new MPIG to guarantee a baseline of core funding to maintain access, continuity of care and provision of primary medical services to these populations.

DIGITAL, TECHNOLOGY AND DATA GOVERNANCE

145. CLEVELAND: That conference welcomes the digitalisation agenda in general practice and:
 - (i) insists that all required hardware and software is provided at no cost to practices
 - (ii) mandates fully funded IT support for all approved digital products to all staff within NHS general practice
 - (iii) emphasises that it is for practices alone to determine implementation, to meet the needs of their specific registered list.
146. AVON: That conference demands a significant improvement in general practice clinical systems to improve safety and to reflect the shifting environment in general practice. Specifically, we need unified clinical templates, robust recall systems and safety processes.
147. SUFFOLK: That conference recognises that in this era of increasing records integration it is no longer appropriate to expect GP practices to be the primary data controller for the patient's digital health records. Conference mandates GPC to work with the various stakeholders to agree a solution that:
 - (i) removes the responsibility for practices to be solely responsible for managing Subject Access Requests
 - (ii) shares the responsibility for the maintenance of accurate data management with the other users of the record
 - (iii) removes the requirement for general practice to be responsible for decisions surrounding data sharing
 - (iv) ensures that ongoing work to improve the integration of data does not produce a further burden for a general practice service already in crisis.
148. TOWER HAMLETS: That conference:
 - (i) believes that Subject Access Requests are a drain on our over-stretched administrative staff, are time-consuming, require significant training and add almost nothing to improving patient care
 - (ii) demands that the GPC negotiates an adequate fee for this work.
149. DEVON: That conference notes that in a year of unprecedented strains on an already overburdened GP workforce there is concern with the increasing unfunded workload created by Subject Access Requests and:
 - (i) the unreasonable time frames, burden of processing the request on administrative staff and the clinical input needed to check and redact reports is significant without an option to politely decline the work, nor to receive remuneration for it
 - (ii) that conference acknowledges the important role GPs play in supporting their patients who may be struggling with legal issues but feel as a sector overall primary care is disproportionately affected by SARs under GDPR legislation and request that a central solution be found.
150. CLEVELAND: That conference, with regards to patients having full access to their medical record:
 - (i) supports the principle
 - (ii) believes that more training is required across primary and secondary care to ensure that records can be meaningfully understood by patients
 - (iii) emphasises that the primary function of the record is inter professional communication.
151. WEST PENNINE: That conference is appalled by the lack of adequate publicity underpinning the development of integrated electronic health and social care records.
152. LANCASHIRE PENNINE: That conference believes that one of the fundamental causes of patient distress and frustration is the inability to get through to their practice on the telephone in a timely manner and asks GPC to negotiate a far higher level of support, financially and technically, to enable practices to have systems that are fit for purpose as the NHS embraces the digital world.

153. BEDFORDSHIRE: That conference deplores the fact that despite years of talking about it, the NHS is still virtually "spineless" and calls for a properly integrated IT infrastructure to unite all areas of the NHS.

CLINICAL, PRESCRIBING AND DISPENSING

154. NORFOLK AND WAVENEY: That conference calls upon the BMA to protest that the recent imposed introduction of a new cholesterol lowering medication (inclisiran) is an inappropriate use of NHS resources and GP appointments for a drug that:
- (i) has a black triangle status
 - (ii) has no data on whether it has any long-term benefit in preventing vascular disease
 - (iii) has been priced that means practically will only be possible for it to be issued in primary care with a commercial agreement only lasting two years with significant potential future cost increases
 - (iv) has not been piloted in any form for use in a primary care format
 - (v) essentially bypasses usual local arrangements for the managed introductions with no good explanation.
155. TOWER HAMLETS: That conference:
- (i) believes it is the job of government to address society's health inequalities and that it is not the job of the GP to prescribe food
 - (ii) rejects the proposal for GPs to participate in a trial to prescribe fruit and vegetables as part of the levelling up agenda
 - (iii) puts the responsibility for ensuring people can have sufficient fruit and vegetables on the government and not as an addition role for general practice.
156. KENT: That conference is dismayed by the lack of adequate gender dysphoria services and believes it is imperative the GPC ensures NHSEI:
- (i) formally acknowledge that it is not appropriate for general practice to prescribe this medication without specialist initiation
 - (ii) ensure appropriate services are commissioned at a local level that provide ongoing prescribing and support for patients with gender dysphoria
 - (iii) ensure that any shared care arrangements are appropriately resourced with mechanisms in place if a GP chooses to decline to accept shared care.
157. KENT: That conference demands a Covid vaccination enhanced service that allows individual surgeries to receive and administer vaccinations for their own patients.

ENVIRONMENT AND PREMISES

158. GLASGOW: That conference is concerned by the IPCC report on the climate crisis and calls on UK GPC to negotiate with the four governments to ensure that sustainability and carbon neutrality are recognised priorities within primary care and that any workload or resource implications are fully supported in order that they meet the 2045 net zero law demands.
159. GLASGOW: That conference asks that governments in collaboration with RCGP develop, offer and resource formal training on the health impacts of the climate crisis and what can be done in general practice to address it.
160. GLASGOW: That conference requests UK GPC to negotiate with the governments to ensure that general practice is either included in the public sector decarbonisation fund or that a separate fund for general practice to accelerate investment in larger infrastructure projects and retrofitting buildings to reduce the carbon footprint of primary care premises, and the provision of electric vehicle charging points, and safe cycle storage.
161. MORGANNWG: That conference calls for a support programme, including carbon literacy training, to enable practices to assist with the UK wide commitment to decarbonise.

162. LEEDS: That conference ,noting the goals set in motion 16 "Green General Practice" at the 2021 Annual Conference of Representatives of LMCs, the outcome of COP 26, and the urgency of the climate emergency, requires GPC UK to produce an annual Green General Practice report outlining work done by the BMA, and progress made on negotiations with NHS bodies and governments, to support general practice to play a role in reducing carbon emissions to net zero.
163. BRADFORD AND AIREDALE: That conference is committed to the BMA's goal of carbon net zero, and argues for resourcing to:
- (i) measure each practice's carbon footprint; and
 - (ii) action the carbon saving changes to be made from this mapping.
164. GP TRAINEES COMMITTEE: That conference supports a sustainable approach to infection control policies in primary care and calls on all general practice providers to:
- (i) perform a carbon impact assessment of all infection control policies in primary care
 - (ii) review all infection control policies to take into account the lower risk environment of primary care, compared to secondary care.
165. SCOTTISH CONFERENCE OF LMCs: That conference accepts the imminent threat of climate breakdown outlined in the 2021 IPCC (Intergovernmental Panel on Climate Change) report, and:
- (i) is proud that the COP26 talks were hosted in Glasgow
 - (ii) recognises the significant contribution of the NHS to the nation's carbon footprint
 - (iii) believes the NHS has not been ambitious enough in setting carbon neutral targets
 - (iv) demands a more comprehensive environmental strategy for public bodies, with targets for the NHS and support for achieving these, including for independent contractors.
166. NORTH AND NORTH EAST LINCOLNSHIRE: That conference calls upon the UK ministers for health to support general practice in reducing its most significant carbon footprint by:
- (i) providing funding and staff to support a move from the prescribing of metered dose inhalers (MDI) to dry powder inhalers (DPI)
 - (ii) delivering a patient facing communication campaign to raise awareness of the impact of MDIs on the environment
 - (iii) incentivising pharmaceutical companies to produce carbon neutral inhalers.
167. GLASGOW: That conference is concerned that clinical and PPE waste streams are not reviewed, evaluated and appropriate alternatives promoted and calls for waste stream funding to be negotiated at a national level to ensure that practices are incentivised to recycle and dispose of all waste appropriately. Furthermore, we call for medical supplies and instruments to have reduced packaging and increased recycling options.
168. GLASGOW: That conference supports the introduction of recycling schemes for inhalers to be made locally available to all community pharmacists with ease of use for patients the priority.
169. HIGHLAND: That conference acknowledges that disasters are inevitable:
- (i) and recognises the importance of preparation by the many organisations that have a role to play
 - (ii) and that climate breakdown and growing socioeconomic inequality both contribute to the likelihood of crises
 - (iii) and is horrified at the UK failing to meet the UN target of spending 0.7% of Gross National Income on Official Development Assistance
 - (iv) demands that the BMA lobby the UK government to immediately increase contributions to meet their responsibilities around aid and humanitarian programmes.
170. SOMERSET: That conference calls on the BMA to put environmental sustainability at the heart of general practice and calls on the BMA to lobby relevant stakeholders to:
- (i) commence a review of pharmaceutical companies' medicines recycling schemes to include inhalers, ensuring these schemes are widespread, accessible and visible to patients
 - (ii) commit pharmaceutical companies carbon neutrality by 2030 and to preferentially work with providers who can demonstrate this

- (iii) appoint a primary care sustainability lead to each ICS in England (and closest equivalent in devolved nations)
 - (iv) provide funding for each practice to ensure they can achieve carbon net zero by 2030
 - (v) provide funding to support nature based interventions in healthcare.
171. GP TRAINEES COMMITTEE: That conference calls on the BMA to put environmental sustainability at the heart of general practice. We call on the BMA to lobby relevant stakeholders to:
- (i) commence a review of pharmaceutical companies' medicines recycling schemes to include inhalers, ensuring these schemes are widespread, accessible, and visible to patients
 - (ii) commit pharmaceutical companies carbon neutrality by 2030 and to preferentially work with providers who can demonstrate this
 - (iii) appoint a primary care sustainability lead to each ICS in England (and closest equivalent in devolved nations)
 - (iv) provide funding for each practice to ensure they can achieve carbon net zero by 2030
 - (v) provide funding to support nature based interventions in healthcare.
172. CONFERENCE OF ENGLAND LMCs: 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 unnecessary 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.
173. NORFOLK AND WAVENEY: That conference requests that GPC undertakes negotiations with NHSE and government to ensure that in all Local Authority Areas health is prioritised in accessing Section 106 and CIL monies for new housing developments, and that they are easier for primary care to access to support local primary care estates improvements. Also that S106 and CIL contributions are taken into account within the new Premises Costs Directions so that this developer contribution can be used flexibly to reduce the practice contribution to a project first, before the NHS contribution, and does not need to be subject to abatement.
174. DERBYSHIRE: That conference, noting the lessons regarding GP premises highlighted by the pandemic instructs the GPCs to reconsider and review our premises policy with regards to:
- (i) ownership policy
 - (ii) building specification
 - (iii) funding policy
 - (iv) changing GP demographics and attitudes to risk
- taking into account any lessons learned in each of the four countries and to present the report to the next GPC UK conference.
175. GATESHEAD AND SOUTH TYNESIDE: That conference condemns the ongoing 'hygiene theatre' that appears responsible for much current PPE use and demands that:
- (i) there be acknowledgment that early failures by NHSE and others to step up PPE in general practice when Covid struck do not justify current PPE use
 - (ii) whilst practices be supported in their use of appropriate masks, for patients and staff, to prevent respiratory transmission, they be supported where they choose to cease use of unnecessary PPE
 - (iii) that in all future pandemics PPE use will be stepped up and down according to internationally recognised evidence, not supply constraints or the vested interests of well-connected individuals
 - (iv) that planning begin for recyclable, re-usable and / or compostable PPE to enable ongoing and future PPE needs to involve less needless damage to the world we inhabit.

MEDICO-LEGAL AND INDEMNITY

176. NOTTINGHAMSHIRE: That conference recognises that certification has changed during the pandemic. We ask that the role of the medical examiner and the potential workload for general practice be closely examined and adequate remuneration planned for the increased workload generated.
177. NOTTINGHAMSHIRE: That conference acknowledges that the GP / coroner interface can be confusing. We request that the rules around MCCDs and cremation certificates be clarified with all relevant professional groups including the coroner's office, to end the continuing confusion around what is and isn't legal so all groups work to the same national framework.
178. KENT: That conference requires GPC to demand NHS Resolution:
- (i) ceases to coerce GPs to abandon legal privilege and protections when seeking support with civil litigation requests
 - (ii) accords GPs full confidentiality when dealing with negligence claims
 - (iii) is forbidden from reporting GPs that have acted in good faith to NHS England and any other regulatory bodies when they are seeking assistance in negligence claims.
179. CAMBRIDGESHIRE: That conference is concerned that the move to state backed indemnity for general practice in England and Wales, alongside reliance on the DHSC's NHS Resolution, has reduced the quality of the indemnity cover for individuals and demands that GPC UK opens an enquiry into this, to be brought back to UK Conference 2023.

CONFERENCE AND LMCs

180. NORTH STAFFORDSHIRE: That conference believes that the local voice of core GMS remains in the form of LMCs and that this should be recognised by:
- (i) local ICS / ICB / PBP systems and levels
 - (ii) any interface negotiations with core GMS
 - (iii) out of hours contract tendering processes, despite conflict of interest issues
 - (iv) pathway changes that impact on core GMS.
181. DERBYSHIRE: That conference demands that the GPC must ensure that:
- (i) in every ICS the LMC is recognised as the representative body for general practice.
 - (ii) that the LMC has a mandated place at the board to represent general practice.
182. WAKEFIELD: That conference will launch a campaign to promote awareness of the role of LMCs to GP trainees, GPs, practice managers and the ICS, as many people are unaware of the LMC's role or the support they can provide.
183. GRAMPIAN: That conference recognises that the term LMC "medical secretary" is outdated and calls on conference to support the change of term as we have done in Scotland to LMC Medical Director.
184. WEST PENNINE: That conference accepts that the time has come for it to prove its democratic legitimacy by mapping the output of conference's determinations with a survey of all GPs at a practice level.
185. SOUTH STAFFORDSHIRE: That conference recognises that the current GPC Executive and members have willingly ignored the conference will of reducing funding into PCNs, and moving into core as evident by their lobbying of NHSE for versatility for PCNs to employ staff based on local need rather than being bound by rigid, prescriptive job roles and mandates the GPC to:
- (i) acknowledge that their negotiations have failed due to going against the profession's view thus trying to negotiate from a position of weakness rather than strength
 - (ii) make it completely transparent whether their views align with the LMCs' views, if so to provide monthly updates on agendas approved by LMCs on how they are implementing them
 - (iii) mandate the GPC Chair and executive to acknowledge and publicly explain the risks and threat of PCNs to the independent contractor model

- (iv) ask the GPC Chair and exec to work with all the LMCs to engage with all grassroots GPs to help the profession opt out of PCNs within the next six months, thereby paving the way for moving funding into core GMS, which has been a diabolical failure this year
- (v) urgently set out a road map for all practices to be able to opt out of PCNs without destabilising them.

FIT NOTES

186. BRO TAF: That conference demands that DWP application forms like PIP applications should clearly state that “applicants (patients) should not go to their GP to get letters for evidence”. This is completely unnecessary and a waste of time for both GPs and patients and increases workload for primary care.

GPC UK

187. SESSIONAL GPs COMMITTEE: That conference is appalled at the recent resignation of a GPC representative who felt they had no choice after feeling “ignored, undervalued and patronised”. We therefore call for:
- (i) a further review of how GPC UK and the LMCs have implemented the recommendations of the Romney Report, with the findings shared with all members
 - (ii) an assessment of whether the current training to ensure inclusion and engagement for all committee members is working and what changes may need to be made
 - (iii) better support for members who raise concerns over their ability to be heard and represent their constituent's views
 - (iv) an exit interview to be undertaken with anyone resigning from their elected position to see what learning can be made and changes implemented.
- (Supported by Dorset)
188. SESSIONAL GPs COMMITTEE: As we endeavour to operate with openness, honesty and integrity, that conference calls for an end to the use of non-disclosure agreements within both GPC UK and LMCs.
(Supported by Dorset)
189. SOMERSET: That conference believes that:
- (i) the NHS is no longer the “envy of the world”
 - (ii) that underfunding is no longer the main reason for overall NHS underperformance
 - (iii) it is time for alternative methods of commissioning and delivery of health care to be considered in the UK
 - (iv) models in the EU nations such as Germany and in Australia and New Zealand could be taken as exemplars
 - (v) a Royal Commission should be established to get a wide range of expert views.
190. SOMERSET: That conference deplores the announcement of NHS policy changes through social and mainstream news media as being both unprofessional and inequitable and insists that formal channels be used at all times.
191. SANDWELL: Given the welcome election of Dr Farah Jameel as Chair of GPC, conference advises the GPC to pause, for three to six months, pursuit of proposed actions. This is to allow the new Chair to develop a strategy and message that will reassert the professional, sustainable service that general practice should be for a 21st century Britain.
192. DEVON: That conference demands that communication with regards to NHS policy changes relevant to general practice is through the profession and not through social media or newspapers.
193. DEVON: That conference believes that UK general practice is in the most vulnerable, demoralised and disenfranchised state that it has ever been in, and:
- (i) there is no best alternative to a negotiated agreement in contract negotiations across the four nations

- (ii) GPC UK should rapidly and thoroughly produce and publish a plan for an alternative non-NHS operating framework applicable to all of UK general practice.

PENSIONS AND FINANCE

- 194. HULL AND EAST YORKSHIRE: That conference warns the failure to resolve NHS pension issues is directly impacting patient care by adversely affecting retention of staff, and urges all UK governments to:
 - (i) immediately work to resolve outstanding pension issues for the general practice workforce
 - (ii) implement solutions to annual allowance penalties that do not penalise doctors who wish to continue working to care for their patients
 - (iii) enforce contractual tools to ensure pension providers allocate more resources to resolving queries from NHS pension scheme members working in primary care.
- 195. SCOTTISH CONFERENCE OF LMCs: That conference believes that, where undertaking additional but necessary work, GPs should not be penalised by additional taxes on pension income and should be able to opt such earnings out of NHS pensionable income.
- 196. DERBYSHIRE: That conference, noting the consequences for patient access and the remaining GP workload arising from the haemorrhage of experienced GPs into early retirement because of currently punitive personal pension taxation rules instructs GPC UK:
 - (i) to have estimated the net gain or loss to society of the tax take versus the lost GP productivity and patient access of such early retirements
 - (ii) seek through the BMA, solutions which encourage GPs (and other healthcare staff) to stay for a full career.
- 197. AYRSHIRE AND ARRAN: That conference recognises the impact of the pandemic on all parts of the NHS, is concerned about the ability of the current system to recover and:
 - (i) believes that the current pension arrangements further exacerbate the crisis
 - (ii) believes that inflationary increases discriminate against older practitioners relative to those earlier in their careers
 - (iii) demands an end to punitive lifetime allowance and annual allowance limits.
- 198. NORTHERN IRELAND WESTERN: That conference believes that the current AA growth figure of £40000:
 - (i) is detrimental to the development of the current (limited) primary care workforce and stops us taking on extra roles
 - (ii) leads to false assumptions among the public that we are lazy or are letting services down.
- 199. LIVERPOOL: That conference believes that the payment to practices to cover maternity and adoption leave is woefully inadequate and does not realistically cover practice costs in engaging a locum and instructs GPC to negotiate a reimbursement that actually compensates for the cost of maternity locum cover.
- 200. NORTH YORKSHIRE: That conference is concerned by the escalating workforce crisis including for reception / admin staff and demands that contract updates truly reflect the cost of living crisis and the increasing difficulties of these roles and enable practices to take account of this with adequate pay awards.
- 201. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that any attempt to claw back historic seniority payments which were paid and received in good faith at the time and has been reported in the medical press should be strongly resisted. The value of any such miscalculation made by the NHS is a tiny fraction of the value of payments made to fund poorly managed contracts during the Covid 19 pandemic.
- 202. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference requires GPC to renegotiate the GMS contract such the patient consultations are funded on an item of service basis.
- 203. LINCOLNSHIRE: That conference was reassured by the governments' assurances that general practices would not be financially penalised for providing care during the Covid-19 pandemic, and therefore calls for
 - (i) dispensing fee reduction to be reversed

- (ii) all prescription charge claims to be reimbursed whether or not the prescription was signed by patients
 - (iii) all vaccination and immunisation claims to be paid whether or not they were made late due to pandemic challenges.
204. DEVON: That conference abhors the postcode lottery created during the pandemic by some local authorities and commissioners agreeing to protect funding for practices while others were not so forthcoming and:
- (i) welcomes the opportunities gained by the nationally negotiated financial protections to reconsider how we negotiate and safeguard our profession in future
 - (ii) asks that GPC UK and the BMA work jointly to help all LMCs draft "national emergency" clauses to be added to all locally negotiated general practice contracts in future
 - (iii) demands that no community will be left trying to justify the need to continue to fund practices while dealing with an emergency such as a pandemic.
205. DEVON: That conference is aware that general practice is becoming a political football with news and ideas made public destabilising the profession. Conference demands that practice ceases to safeguard the profession.
206. AVON: That conference demands that GPC, in negotiations with NHSE, insists that funding is not removed from primary care budgets as a result of the new NHS reforms.
207. 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.
208. GATESHEAD AND SOUTH TYNESIDE: That conference is delighted, albeit unsurprised, that general practice not only delivered the majority of the Covid vaccination programme, but did so more cost-effectively than other providers and demands that:
- (i) GPC UK seek public acknowledgment from Her Majesty's Government of the role played by general practice in enabling greater freedoms
 - (ii) all communications that led to other providers becoming involved in the vaccination programme be made public in order for the public to have awareness of how their money was spent, and who gained
 - (iii) accounting be made of how other providers proved more expensive per vaccination delivered, despite general practice dealing with the most elderly, housebound and vaccine hesitant populations
 - (iv) all current and future vaccination programmes be kept in general practice and adequately funded, as per the evidence of cost-efficiency and better reach into more deprived populations.
209. KENT: That conference requests the GPC negotiate:
- (i) for practices to be able to exit the PCN DES at any point without financial penalties
 - (ii) reimbursement for VAT costs incurred from being part of a PCN
 - (iii) reimbursement for management costs incurred employing all ARRS roles.
210. KENT: That conference demands that GPC England works with NHSEI to produce a standardised coding system for PCN payments to enable practices to identify PCN funding streams easily.
211. OXFORDSHIRE: That conference:
- (i) is concerned that the model of paying for GP services in the UK is no longer fit for purpose, with true activity levels and patient need not taken into account in the funding formulas or various contractual mechanisms

- (ii) seeks root and branch review of GP funding across the UK, to bring it in line with twenty-first-century and pandemic related realities, with activity paid for in full.

REBUILD AND RESCUE POST COVID

- 212. NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes GPs with extended interests are a key part of the NHS Covid recovery plan and that:
 - (i) development of such roles should be supported with adequate funding for both the individual practitioner and their usual place of work
 - (ii) the lack of a national framework for such extended interest roles should not be a barrier to their development
 - (iii) acute, community and mental health providers must be mandated to support such roles with necessary educational opportunities
 - (iv) local workforce initiatives and strategies should include GPs with extended interests as a distinct group.
- 213. WELSH CONFERENCE OF LMCs: That conference recognises the overwhelming evidence that Covid is an airborne pathogen and that the failure to provide enhanced face mask protection to those on the frontline (including in general practice) has unnecessarily left staff at risk of harm and must be reversed urgently.
- 214. LOTHIAN: That conference laments the lack of appropriate PPE for primary care staff during the recent pandemic and regrets that staff did not have access to FFP2 masks as a minimum.
- 215. TOWER HAMLETS: That conference notes that Covid-19 is widely accepted to be an airborne disease and:
 - (i) condemns government policy to end the legal requirement for those who test positive for Covid-19 to isolate
 - (ii) demands that GPC negotiates with each devolved nation's Department of Health to provide respiratory protective equipment for all general practice staff and that the cost of this is borne by government.
- 216. AYRSHIRE AND ARRAN: That conference recognises the changes to Covid testing and isolation rules and:
 - (i) remains frustrated by the inconsistent messaging from governments
 - (ii) demands that there is an immediate public campaign explaining why there remains differences in healthcare settings
 - (iii) demands that the government urgently reviews the guidance in primary care with a pathway to allow general practice to return to more normal IPC guidance.
- 217. LAMBETH: The Department of Health reports that the UK government spent around £9 billion on PPE which was over-priced, substandard, defective or past its use by date. Conference recognises that PPE should have been purchased more diligently and efficiently, and:
 - (i) recommends that all UK government procurement processes for NHS equipment should be transparent, robust and represent value for money, regardless of pandemic status
 - (ii) insists that there should be no nepotism and no use of "VIP lanes" during NHS procurement processes.
- 218. DERBYSHIRE: That conference in recognising the need for a new post Covid start for NHS general practice insists that both the governments and the profession must start from a "can-do" position seeking solutions and not from a prejudged "we cannot" attitude and that seeking to settle old scores (by either side) in the process is totally inappropriate. Underlying this fundamental negotiating position must be subscription by both sides to deliver changes which in each and every case satisfy all the principles of:
 - (i) an NHS free at the point of use open equally to all patients
 - (ii) the essential need for a reasonable work-life balance for anyone taking part in NHS general practice delivery by whatever contractual route
 - (iii) fair personal rewards for work reflecting individual professional skills and experience, individual operational responsibility and individual personal financial liability

- (iv) a realistic approach to paying the expenses of delivery of service (including consideration of a return to a “cost-plus” contract) which must obviate any personal financial subsidy by GPs collectively or individually towards the costs of delivery of care
 - (v) firmly defined limits as to the operational responsibilities, professional obligations and personal liabilities of general practitioners particularly at the secondary care/social care/general practice interfaces and mandates the GPCs to negotiate new post Covid contracts on this basis.
219. NORFOLK AND WAVENEY: That conference calls on the GPC to organise a positive media campaign that has the aim of attracting funding, personnel and public understanding to bolster the primary care workforce and reverse the decade long undermining of this jewel in the NHS. During the Covid pandemic, government and media have correctly focused on the extraordinary pressures in secondary care. The recovery will require an enormous effort from a largely exhausted and often demoralised primary care system.
220. HIGHLAND: That conference acknowledges the suffering endured during the Covid pandemic by people who live in care homes and:
- (i) is appalled at the extent of transfers of patients from hospitals into care homes without adequate testing for SARS-CoV-2
 - (ii) condemns the delay in the vaccination of care home residents that occurred in some health authority areas
 - (iii) offers its heartfelt condolences to the relatives and friends of those who suffered or died with Covid in care homes, who were either unvaccinated or inadequately vaccinated
 - (iv) calls on the BMA to demand that governments review whether the JCVI prioritisation of vaccination of people in care homes was followed by health authorities, and report on the health impacts of any delayed vaccinations.
221. LOTHIAN: That conference insists that the percentage of additional post-Covid money given to primary care in order to establish recovery should at least match the proportion given to secondary care.
222. AYRSHIRE AND ARRAN: That conference believes we are now in the midst of a mental health crisis in the UK, escalated significantly by 2 years of living through a pandemic and urges the UK government to:
- (i) take immediate steps to better resource and finance mental health services within the community
 - (ii) vastly increase training opportunities for those seeking to work within mental health services
 - (iii) allow mental health services to be accessed by patients in the first line without the need for GP referral.
223. LIVERPOOL: That conference believes that free Covid-19 testing is essential for monitoring Covid-19 infection rates and guiding public health measures and:
- (i) would encourage the UK government to continue to offer funded Covid-19 testing for all UK nations
 - (ii) would strongly resist the use of general practice as a gatekeeper to free LFD Covid-19 testing on the NHS.
224. CLEVELAND: That conference, with regards to Covid testing:
- (i) supports the removal of free universal population testing
 - (ii) supports free NHS testing based on clinical grounds, which must include at the request of the GP
 - (iii) believes that open access to testing has devalued to the public the diagnostic skills of the GP
 - (iv) mandates that referral pathways recognise a clinical diagnosis by the GP as an acceptable alternative to lab based tests.
225. HIGHLAND: That conference believes that emergency planning arrangements within the NHS are inadequate, and that health authorities should:
- (i) provide credible and competent leadership that is perceived as such
 - (ii) set appropriate anticipatory guidance and expectations
 - (iii) provide adequate training to continue with realistic service provision even in the event of terrorist, biochemical or nuclear incidents.

226. HIGHLAND: That conference is confident that, in the event of a national emergency, if GPs are to serve their patients to the best of their ability, governments will need:
- (i) to prepare and equip practices prior to the event and then provide them with a reliable supply of consumables to protect their staff and patients throughout the emergency
 - (ii) to provide clear, practical, and authoritative guidance to practices, regarding medical and administrative management, and any suspensions of normal contracting arrangements
 - (iii) to provide clear, practical, and authoritative guidance to patients
 - (iv) to ensure protection from consequential loss of practice income.
227. MERTON: In light of the devastating impact of the Covid pandemic on our patients, professional colleagues and health and social services in general, conference calls upon government to ensure that adequate and well-advertised preparations are made to face future threats, be those infectious or other in nature.
228. MERTON: Covid remains a significant widespread threat to our patients, even if more endemic rather than pandemic in nature; conference calls upon government to continue with simple messaging that safety measures such as mask-wearing and vaccination remain the most effective methods of helping prevent the resurgence of Covid or other infectious diseases such as flu.

WANTS V NEED: ACCESS AND DEMAND

229. DEVON: That conference recognises the enormous growth in the presentation of autistic spectrum disorders in both children and adults over the last few years and calls for:
- (i) recognition that the complexity of assessing these patients means the option of a patient self-referral process is a more appropriate method than a GP referral route
 - (ii) a national shared care agreement that both NHS and private organisations prescribing medication for these conditions will recognise and adhere to
 - (iii) schools throughout the UK to have adequate resource and support so that children who they identify as requiring assessment can get this without parents needing to involve their GP.
230. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that NHS 111 and NHS 24 should not be allowed direct access to GP appointment booking systems, and that pressure for this to occur from the NHS should be resisted:
- (i) this will increase the pressures already in place on appointment systems by using appointments for inappropriate concerns which do not need urgent attention
 - (ii) in addition it removes the ability of experienced clinicians to triage and signpost to more appropriate sources of advice
 - (iii) it runs the risk of setting a precedent that allows the NHS increasingly direct control of systems within practices and reduces the flexibility of the partners who own the practices to control what occurs within them.
231. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference opposes NHSE demand on practices to offer more face to face appointments despite no contractual requirement. The discretion should be at the practice. This is due to unprecedented demand for appointments within a volatile working environment.
232. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference raises the attention of the perpetual issue of 111 failures being picked up in primary care. Primary care is not an emergency service, and the 1–4-hour dispositions aren't fit for purpose and need to be relooked at and sent elsewhere.
233. NORFOLK AND WAVENEY: That conference believes that the decisions on how best to manage a patient and what form of contact is appropriate should be left for the clinician involved in the patient's care to decide and additionally requests that politicians cease interfering in clinical decision making over mode of contact and immediately stop the witch hunt against hard working GPs in order to allow them to best manage the care of all their patients according to clinical need.
234. BEXLEY: That conference believes that the continuing increase in direct NHS 111 bookings places unacceptable demands upon general practice, at a time when resources could be better used to manage the backlog of care arising from the Covid pandemic; and

- (i) recommends that the GPC instruct the NHS in each of the four nations to stop any further increments in the number of directly bookable NHS111 appointments
 - (ii) recommends that the NHS in each of the four nations assess the effectiveness of direct NHS 111 bookings to ensure the best value from GP appointments in meeting patient need.
235. DERBYSHIRE: That conference insists that GPs have consistently, diligently and flexibly managed their appointment systems to maximise availability to patients taking into account local circumstance, patient safety and actual staff and consultation facility availability on a day-to-day basis. Giving external agencies the right of direct or indirect access to appointment systems, threatens the safety of the system, its ability to cope and simply allows queue-jumping. Conference mandates the GPCs to negotiate to end such third-party booking arrangement systems.
236. SOMERSET: That conference instructs the GPC to negotiate that services in primary care that prioritise convenience over need to be outside the core contract, provided with a specific budget via a DES and optional for core contract holders who can concentrate on core services.

STANDING ORDERS

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STANDING ORDERS

CONFERENCES

Annual conference

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

Special conference

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

Membership

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

Representatives

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

Observers

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

Interpretations

10. A local medical committee is a committee recognised by a PCO or PCOs as representative of medical practitioners under the NHS Act 2006 as amended or by equivalent provisions in Scotland, Wales, and Northern Ireland.
11. 'Members of the conference' means those persons described in standing order 3.
12. 'Representative' or 'representatives' means those persons appointed under standing orders 4 to 8 and shall include the deputy of any person who is absent.
13. 'The conference', unless otherwise specified, means either an annual or a special conference.
14. 'As a reference' means that any motion so accepted does not constitute conference policy but is referred to the GPC UK to consider how best to procure its sentiments.

Motions to amend standing orders

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

Suspension of standing orders

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

Agenda

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

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

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

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

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

Other duties of the agenda committee include:

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

Procedures

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

Rules of debate

36. Members of the conference have an overriding duty to those they represent. If a speaker has a pecuniary or personal interest, beyond his capacity as a member of the conference, in any question which the conference is to debate, this interest shall be declared at the start of any contribution to the debate.
37. A member of conference shall address the chair and shall, unless prevented by physical infirmity, stand when speaking.
38. A member of the conference shall not address the conference more than once on any motion or amendment, but the mover of the motion or amendment may reply, and when replying, shall strictly confine themselves to answering previous speakers. They shall not introduce any new matter into the debate.

39. Members of the GPC UK who also attend the conference as representatives, should identify in which capacity they are speaking to motions.
40. The chair shall endeavour to ensure that those called to address the conference are predominantly representatives of LMCs.
41. Lay executives of LMCs may request to speak to all business of the conference at the request of their LMC.
42. The chair shall take any necessary steps to prevent tedious repetition.
43. Whenever an amendment or a rider to an original motion has been moved and seconded, no subsequent amendment or rider shall be moved until the first amendment or rider has been disposed of.
44. Amendments shall be debated and voted upon before returning to the original motion.
45. Riders shall be debated and voted upon after the original motion has been carried.
46. If any amendment or rider is rejected, other amendments or riders may, subject to the provisions of standing order 44, be moved to the original motion. If an amendment or rider is carried, the motion as amended or extended, shall replace the original motion, and shall be the question upon which any further amendment or rider may be moved.
47. If it is proposed and seconded or proposed by the chair that the conference adjourns, or that the debate be adjourned, or 'that the question be put now', such motion shall be put to the vote immediately, and without discussion, except as to the time of adjournment. The chair can decline to put the motion, 'that the question be put now'. If a motion, 'that the question be put now', is carried by a two thirds majority, the chair of the GPC UK and the mover of the original motion shall have the right to reply to the debate before the question is put.
48. If there be a call by acclamation to move to next business it shall be the chair's discretion whether the call is heard. If it is heard then the proposer of the original motion can choose to:
 - (i) accept the call to move to next business for the whole motion
 - (ii) accept the call to move to next business for one or more subsections of the motion
 - (iii) have one minute to oppose the call to move to next business. Conference will then vote on the motion to move to next business and a 2/3 majority is required for it to succeed.
49. Proposers of motions shall be given prior notice if the GPC intends to present an expert opinion by a person who is not a member of the conference.
50. All motions expressed in several parts and designated by the numbers (i), (ii), (iii), etc shall automatically be voted on separately. But, in order to expedite business, the chair may ask conference (by a simple majority) to waive this requirement.
51. Any motion, amendment or rider referred to the conference by the joint agenda committee shall be introduced by a representative or member of the body proposing it. That representative or member may not otherwise be entitled to attend and speak at the conference, neither shall he/she take any further part in the proceedings at the conclusion of the debate upon the said item, nor shall he/she be permitted to vote. In the absence of the authorised mover, any other member of the conference deputed by the authorised mover may act on their behalf, and if there is no deputy the item shall be moved formally by the chair.
52. If by the time for a motion to be presented to conference no proposer has been notified to the agenda committee, the chair shall have the discretion to rule, without putting it to the vote, that conference move to the next item of business.
53. In a major issue debate the following procedures shall apply:
 - 53.1 the agenda committee shall indicate in the agenda the topic for a major debate
 - 53.2 the debate shall be conducted in the manner clearly set out in the published agenda
 - 53.3 the debate may be introduced by one or more speakers appointed by the agenda committee

- who may not necessarily be members of conference
- 53.4 introductory speakers may produce a briefing paper of no more than one side A4 paper
- 53.5 subsequent speakers will be selected by the chair from those who have indicated a wish to speak. Subsequent speeches shall last no longer than one minute.
- 53.6 the Chair of GPC UK or his/her representative shall be invited to contribute to the debate prior to the reply from the introductory speaker(s)
- 53.7 at the conclusion of the debate the introductory speakers may speak for no longer two minutes in reply to matters raised in the debate. No new matters may be introduced at this time.
- 53.8 The response of members of conference to any major debate shall be measured in a manner determined by the agenda committee and published in the agenda.

Allocation of conference time

- 54. The agenda committee shall, as far as possible, divide the agenda into blocks according to the general subject of the motions, and allocate a specific period of time to each block.
- 55. Motions will not be taken earlier than the times indicated in the schedule of business included in the agenda committee's report.
- 56. 'Soapbox session':
 - 56.1 A period shall be reserved for a 'soapbox' session in which representatives shall be given up to one minute to present to conference an issue which is not covered in Part I of the agenda.
 - 56.2 Other representatives shall be able to respond to the issues raised during the soapbox session, or afterwards via means to be determined by the agenda committee.
 - 56.3 Representatives wishing to present an issue in the soapbox should complete the form provided and hand to a member of the agenda committee at the time of the debate.
 - 56.4 GPC (UK) members shall not be permitted to speak in the soapbox session.
- 57. Motions which cannot be debated in the time allocated to that block shall, if possible, be debated in any unused time allocated to another block. The chair shall, at the start of each session, announce which previously unfinished block will be returned to in the event of time being available.
- 58. Motions prefixed with a letter 'A', (defined in standing orders 25 and 26) shall be formally moved by the chair of conference as a block to be accepted without debate during the debate on the report of the agenda committee in the first session of the conference.
- 59. One period, not exceeding one hour, may be reserved for representatives of LMCs to ask questions of the GPC executive teams.

Motions not published in the agenda

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

Quorum

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

Time limit of speeches

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

Voting

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

Majorities

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

Elections

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

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

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

Returning officer

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

Claire Wand award

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

Motions not debated

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

Distribution of papers and announcements

77. In the conference hall, or in the precincts thereof, no papers or literature shall be distributed, or announcements made, or notices displayed, unless approved by the chair.

Mobile phones

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

The press

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

No smoking

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

Chair's discretion

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

Minutes

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

Amendments to standing orders

STANDING ORDERS

- 1 AGENDA COMMITTEE TO BE PROPOSED BY THE DEPUTY CHAIR: That conference accepts the following amendments to the standing orders as below:

Standing order 3 to be amended to read:

3. The members of conference shall be:
 - 3.1 the chair and deputy chair of the conference
 - 3.2 365 representatives of local medical committees
 - 3.3 the **voting** members of the GPC UK
 - 3.4 9 members appointed by the Scottish GPC
 - 3.5 3 members appointed by the Welsh GPC
 - 3.6 2 members appointed by the GPC (Northern Ireland)
 - 3.7 2 members appointed by GPC England
 - 3.8 the seven elected members of the conference agenda committee (agenda committee)
 - 3.9 the regionally elected representatives of the GP Trainees ~~sub~~Committee, together with its immediate past chair
 - 3.10 the elected members of the sessional GPs ~~sub~~Committee of the GPC
 - 3.11 the Chairs and Deputy Chairs of the England, Northern Ireland, Scotland and Wales national LMC conferences**

- 2 Standing order 9 be amended to read:

Local Medical Committees may nominate personnel from their organisations to attend conference as observers, subject to ~~the~~ Chair of Conference's discretion. **The non-voting members of GPC UK will be invited as observers.** In addition, the Chair of Conference may invite any person who has a relevant interest in conference business to attend as an observer. **Invitations shall be extended to the Chief Officers of the BMA; the non-voting members of GPC UK; the Chair and Board of GPDF Ltd, where those individuals are not already in attendance.**

- 3 Standing order 41 be amended to read:

Lay executives of LMCs; **non-voting members of GPC UK; and the Chair of the GPDF** may request to speak to all business of the conference ~~at the request of their LMC~~ **at the discretion of the Chair.**

- 4 Standing order 64 be amended to read:

Except as provided for in standing orders ~~67 72~~ (election of Chair of Conference), ~~68 73~~ (election of Deputy Chair of Conference), ~~75 70~~ (election of seven members of the Agenda Committee) and ~~76 71~~ (election of ARM representatives), only representatives of local medical committees may vote.

- 5 Standing order 69 be amended to read:

Seven members of the General Practitioners Committee UK

~~Nominations may be made only by representatives, and a representative may make not more than one nomination.~~

For six of the seats, any registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, whether a member of the conference or not, is eligible for nomination providing that such a level of commitment has been

maintained for at least the period of the six months immediately prior to the election, allowing for any ~~maternity~~ **parental**, sickness or study leave absence. All GPs on the NHS Retention Scheme, and medically qualified LMC secretaries, are eligible for nomination regardless of their level of commitment to providing or performing NHS primary medical services. For the seventh seat, only an LMC representative at conference may be nominated, and that LMC representative must never have previously sat on the GPC UK. This LMC representative must also be a registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any ~~maternity~~ **parental**, sickness or study leave absence. The members elected will serve on the GPC from the conclusion of the following ARM until the conclusion of the ARM one year thereafter.

6 Standing orders 67.2, 68.2, 69.4, 70.3 and 72.2:

Election statement word limit of 50 words to be changed to an election statement word limit of 100 words.

Amendments to standing orders by GPDF

GPDF

- 1 AGENDA COMMITTEE TO BE PROPOSED BY GPDF: That conference accepts the proposed amendments made by GPDF to the standing orders below.
- 2 Standing order 3 to be amended to read:
 3. The members of conference shall be:
 - 3.1 the chair and deputy chair of the conference
 - 3.2 365 representatives of local medical committees
 - 3.3 the voting members of the GPC UK
 - 3.4 9 members appointed by the Scottish GPC
 - 3.5 3 members appointed by the Welsh GPC
 - 3.6 2 members appointed by the GPC (Northern Ireland)
 - 3.7 2 members appointed by GPC England
 - 3.8 the seven elected members of the conference agenda committee (agenda committee)
 - 3.9 the regionally elected representatives of the GP Trainees Committee, together with its immediate past chair
 - 3.10 the elected members of the sessional GPs Committee of the GPC
 - 3.11 the Chairs and Deputy Chairs of the England, Northern Ireland, Scotland and Wales national LMC conferences

***3.11/12 the Chair of GPDF, or their nominated deputy, who must be a registered medical practitioners.**

**depending on outcome of other proposed amendments to membership of LMC UK conference.*
- 3 Standing order 17 to read:
 17. The agenda shall include:
 - 17.1 motions, amendments and riders submitted by the GPC UK, and any local medical committee. These shall fall within the remit of the GPC, which is to deal with all matters affecting medical practitioners providing and/or performing primary medical services under the National Health Service Act 1977 and/or the National Health Service (Scotland) Act 1978 and/or the Health and Personal Social Services (Northern Ireland) Order 1972 and any Acts or Orders amending or consolidating the same and as from time to time extended to all or any part of the United Kingdom
 - 17.2 motions, amendments and riders connected with NHS general practice from constituencies of the British Medical Association's representative body, or one of the other craft conferences convened by a standing committee of the BMA, referred by the BMA's joint agenda committee
 - 17.3 motions passed at national LMC conferences and submitted by their chairmen
 - 17.4 motions relating to the Cameron fund, Claire Wand fund and the Dain fund
 - 17.5 motions submitted by the agenda committee in respect of organisational issues only
 - 17.6 **motions relating to GPDF.**
- 4 To delete SO 29 and re number accordingly:

~~29: Identifying, by enclosing within a 'black box', motions received from those local medical committees which have failed to meet their quotas to the General Practitioners Defence Fund Ltd. Before effecting this, one year's grace must be given to such local medical committees, who must have received warning that, unless the deficit is made up by 1 May after the following year, they would become subject to the 'black box' procedure.~~