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2022 Special Conference of England LMC representatives

Friday 25 November 2022

2024 Vision: Crossroads for General Practice



Special Conference of England LMC Representatives

Agenda

To be held on

Friday 25 November 2022 at 9.00am

[Friends House, 173-177 Euston Road, London NW1 2BJ](#)

Chair Shaba Nabi (Avon)

Deputy Chair Elliott Singer (Waltham Forest)

Conference Agenda Committee

Shaba Nabi (Chair of Conference)

Elliott Singer (Deputy Chair of Conference)

Paul Evans (Gateshead and South Tyneside)

Matthew Mayer (Buckinghamshire)

Simon Minkoff (Manchester)

Zoe Norris (Yorkshire)

Roger Scott (Liverpool)

Members of the England LMC Conference Agenda Committee 2022

Dr. Shaba Nabi



Chair of the Agenda Committee

Dr. Elliott Singer



Deputy Chair of the Agenda Committee

Dr. Paul Evans



Member of the Agenda Committee

Dr. Matt Mayer



Member of the Agenda Committee

Dr. Simon Minkoff



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Notes about Special Conference

A Special Conference of England LMCs is being held according to Standing Order 2, following a motion passed at the England GP Committee on 19 May 2022.

The special conference on 25 November 2022 will be a closed session, which means it will only be attended by members of conference and lay executives registered to the conference. It will not be broadcast to the public and will not be open to the media.

The purpose of this special conference is to discuss a vision for English General Practice with which to negotiate a new GP contract in 2024. The format will consist of group discussions in four break-out rooms, which will be facilitated by a member of the Agenda Committee, alongside a member of the GPC Executive, who will be responding to the discussions at the end of the day. Members of conference have been randomly selected for each break-out room to enable representation across all LMCs.

Please aim to arrive at your scheduled break-out room in time, to minimise any disruption to a workshop in progress. Your name badge will be colour coded to enable you to identify the order of break-out rooms.

Schedule of business

Friday 25 November 2022

Item	Time
Opening business	09.00
Movement time	09.30
Break-out group 1	09.40
Break	10.40
Break-out group 2	11.00
Lunch	12.00
Break-out group 3	13.00
Movement time	14.00
Break-out group 4	14.10
Break	15.10
Plenary	15.30
Final business	16.20
Close	16.30

Order of break-out rotation

	FACILITATOR	09.40	11.00	13.00	14.10
New Contract	Zoe Norris				
Best Alternative to Current PCN DES	Roger Scott / Paul Evans				
Supplementary non-NHS Options	Matt Mayer				
Alternative Action	Simon Minkoff				

NEW CONTRACT BREAK-OUT ROOM

Current policy for a new GP contract

- Workload caps
- Moving away from targets and incentivising continuity
- Changing from a block contract to a fee for service contract
- A review of the funding formula with additional funding for practices serving deprived communities, ensuring no practice is less well off
- Removal of home visits from the core contract
- Introduce limited liability for partnerships and reimbursement for redundancy costs
- Increased core funding with at least above inflation annual rises
- **Desired workshop outputs:**
 - **Enable GPC England to understand a model with which to negotiate a new contract**

BEST ALTERNATIVE TO CURRENT PCN DES BREAK-OUT ROOM

Current Policy for PCN DES

- Move all PCN funding to core contract
- A ballot of the profession before any extension of PCN DES
- ARRS roles to expand to include GPs, practice nurses, support staff
- Unspent ARRS funds to be retained by PCN to be spent on other services
- Annual uplifts to core PCN funding payment
- Reject PCN responsibility for out of hours provision
- IIF moved to practice level

The Agenda Committee is aware of the strong desire from the profession to move all PCN funding into the core contract. The purpose of this workshop is not to reiterate this desire, but to consider best alternatives to the current PCN DES, if this aim is not achieved. The leverage to achieve this aim can be discussed in workshops 3 and 4.

- **Desired workshop outputs:**
 - **Allow GPC England to negotiate a model for working at scale which is acceptable to the profession, in the event that none of the PCN funding moves into the core contract**

SUPPLEMENTARY NON-NHS OPTIONS BREAK-OUT ROOM

Current Policy for Non-NHS options

- Offer private services alongside NHS services when services not commissioned to be provided by general practice
- GPDF to commission/fund an options paper to explore how a GMS contract could offer both NHS and non-NHS services
- Survival of the profession should take precedence over survival of the NHS

This workshop will not be discussing any radical changes to healthcare modelling, as this is not in the gift of GPC England or NHS England. Instead, it will focus more on the desire and implementation of a mixed model, whereby NHS and non-NHS options may feature within the core contract.

Current guidance for this is as follows:

[BMA guidance on private practice and GP contracts](#)

[BMA: what services practices can and cannot charge for](#)

- **Desired workshop outputs:**
 - **Enable GPC England to understand the appetite for both service and access based non-NHS options in any future negotiations and how these may be achieved**

ALTERNATIVE ACTION BREAK-OUT ROOM

Current Policy for Alternative Action

- Arrange a ballot to organise opposition to any imposition of contract

This workshop is to consider options of last resort when negotiations have failed. There are regulatory and legal considerations which will be shared within the group, in addition to the following resources:

[GMC position on Industrial Action](#)

[Gov.UK advice on Industrial Action](#)

[BMA safe working in general practice](#)

- **Desired outputs**
 - **Enable GPC England to identify most powerful alternative action available from membership**
 - **Enable GPC England to identify the barriers that would need to be overcome to maximise the participation in any alternative action**

References for break out groups

NEW CONTRACT BREAK-OUT ROOM

Policy group: General practitioners UK, 2022

(Source: Conference)

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.

Policy group: General practitioners UK, 2022

(Source: Conference)

That conference demands that we move away from a target-based GP contract and be rewarded for prioritising continuity.

Policy group: General practitioners UK, 2022

(Source: Conference)

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.

Policy group: General Practitioners England, 2021

(Source: Conference)

That conference believes that GPC England is at risk of presiding and prevaricating over the slow death throes of GMS, and:

- (i) believes that the current GMS block contract of funding for general practice is outdated and inadequate for the current healthcare environment
- (ii) believes that the model of unrestricted workload for a fixed fee is a major disadvantage to general practice within the new ICS landscape
- (iii) calls on GPC England to negotiate a fee for service contract, including item of service payments for core general practice work, rather than the current block contract
- (iv) tasks GPC England with negotiating a contract that allows practices to offer private services alongside NHS services, where such services are not commissioned by the NHS for delivery in a general practice setting
- (v) tasks GPC England with exploring alternative contractual models for general practice in a post-NHS world.

Policy group: General practitioners UK, 2021

(Source: Conference)

That conference believes that additional funding should be made available to meet the extra needs of deprived communities and that:

- (i) the Carr Hill formula is no longer fit for purpose
- (ii) the impact of the Carr Hill formula on weighted capitation disadvantages practices serving the areas with the highest levels of deprivation
- (iii) seeks additional funding to specifically mitigate against the increased healthcare risks demands and needs of deprived communities.

Policy group: General Practitioners England, 2020

(Source: Conference)

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

- (i) urgently calls for NHSEI to review the GP funding formula
- (ii) ensures that any future formula provides fair and full remuneration which recognises GP workload
- (iii) ensures that a revised funding formula appropriately and proportionately accounts for differences in patient demographics, deprivation and health-seeking behaviour at individual practice level
- (iv) ensures that any revision does not result in practices losing out.

Policy group: General Practitioners England, 2019

(Source: Conference)

That conference believes that GPs no longer have the capacity to offer home visits and instructs the GPC England to:

- (i) remove the anachronism of home visits from core contract work
- (ii) negotiate a separate acute service for urgent visits
- (iii) demand any change in service is widely advertised to patients.

Policy group: General Practitioners England, 2018

(Source: Conference)

That conference calls on GPC England to reduce the inherent risks in the current partnership model that are alienating GPs and pushing experienced GPs into early retirement by negotiating with the government to:

- (i) introduce a form of Limited Liability into the partnership model for contract holders
- (ii) recognise the financial burden of taking on a partnership by seeking full reimbursement of necessary costs incurred in providing NHS premises
- (iii) require NHS England to cover staff redundancy costs in the case of list dispersal.
- (iv) ensure NHS England is obligated to take over the lease of a collapsed practice and act as a tenant of last resort
- (v) introduce a statutory cap to the liability which can befall a contractor who finds themselves in the position of being "last partner standing".

Policy group: General Practitioners England, 2018

(Source: Conference)

That conference believes core funding for general practice has been eroded to the point that it is now unsustainable and unsafe, and

- (i) that annually negotiated adjustments to the GMS contract is a method of negotiation which is failing to address the crisis in general practice
- (ii) mandates GPC England to negotiate a recurrent global sum uplift at least over and above inflation
- (iii) proposes that payments for enhanced services are index linked.

BEST ALTERNATIVE TO CURRENT PCN DES BREAK-OUT ROOM

Policy group: General Practitioners England, 2021

(Source: Conference)

That conference believes that PCNs are a Trojan Horse and a failed project which was mis-sold to the profession and:

- (i) believes PCNs pose an existential threat to the independent contractor model
- (ii) that the workload, staffing, estate, supervision and HR issues outweigh any benefit derived from ARRS
- (iii) instructs GPC England to refuse to negotiate new work, funding for PCNs or an extension of the PCN contract beyond its 2023 end date
- (iv) instructs GPC England to negotiate that PCN funding be moved into the core contract
- (v) instructs GPC England to ensure practices are able to easily withdraw from the DES in a straightforward way that will not destabilise the practice withdrawing, other local practices or the provision of patient services.

Policy group: General Practitioners England, 2020

(Source: Conference)

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

Policy group: General Practitioners England, 2020

(Source: Conference)

That conference instructs GPC England to negotiate for the Additional Roles Reimbursement Scheme element of the Network Contract to allow funding for:

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

Policy group: General Practitioners England, 2020

(Source: Conference)

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

- (i) believes this is woefully inadequate to fund all the schemes it has been allocated to cover and additional workforce it is anticipated to employ and manage
- (ii) insists that this payment must be uplifted annually to reflect the expanding workforce and responsibility, as a minimum in line with core GMS contract uplifts
- (iii) demands that this payment is renegotiated for 2021 / 2022, to accurately reflect the workload that it is supposed to support.

Policy group: General Practitioners England, 2020

(Source: Conference)

That conference demands that any future proposal to give PCNs responsibility to deliver out of hours care is a redline for GPC England negotiators.

Policy group: General Practitioners England, 2020

(Source: Conference)

That conference, in respect of future contract negotiations, mandates that:

- (i) there must be a genuine financially viable option to enable practices to decline to sign up to future versions of the PCN DES
- (ii) PCN involvement must always remain a DES, not to be moved to core GMS services
- (iii) the priority area for investment must be the core contract, not the PCN DES
- (iv) there remains a clear demarcation between core GMS services and enhanced services including the PCN DES
- (v) any changes to the PCN DES must not impact negatively on core GMS funding.

Policy group: General Practitioners England, 2020

(Source: Conference)

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

Policy group: General Practitioners England, 2020

(Source: Conference)

That conference, in respect of the Investment and Impact Fund:

- (i) believes that the 2020 / 21 targets would be better assessed at practice level, rather than at PCN level
- (ii) is concerned that the performance management of practices by other practices within a PCN introduces a new layer of regulation
- (iii) believes this scheme to be discriminatory to practices who choose not to participate in the PCN DES
- (iv) rejects the 2020 / 21 iteration of this fund
- (v) mandates that the funding within this scheme is moved into a practice level scheme immediately.

Policy group: General Practitioners England, 2020

(Source: Conference)

That conference believes that current rules regarding ARRS must be modified to specifically state that:

- (i) any underspend cannot be moved into CCG baselines
- (ii) all funds allocated to a PCN for workforce should remain for that PCN to use
- (iii) London weighting should be applied to ARRS reimbursement.

Policy group: General Practitioners England, 2020

(Source: Conference)

That conference believes the support and information available to PCNs and clinical directors regarding tax, VAT and PAYE has been confusing and inadequate, and:

- (i) the lack of good advice has placed practices at risk
- (ii) it is not acceptable that PCNs are having to fund this advice themselves
- (iii) conference demands to know, as soon as possible, what negotiations, consultations and discussions were had with HMRC by the BMA prior to approval of the PCN DES
- (iv) calls for fit for purpose tax advice to be provided to PCNs funded by NHSEI.

Policy group: General Practitioners England, 2020

(Source: Conference)

That conference believes that PCN DES is a Trojan horse to transfer work from secondary care to primary care and that:

- (i) this strategy poses an existential threat to the independent contractor model
- (ii) there should be immediate cessation of LES and DES transfers from practice responsibility to that of PCNs
- (iii) GPC England is mandated to urgently survey the profession to get feedback on whether they intend to sign the new PCN DES
- (iv) GPC England must urgently negotiate investment directly into the core contract as the only way to resolve the crisis in general practice is by trusting GP partners with realistic investment
- (v) the profession should reject the PCN DES as currently written.

Policy group: General Practitioners England, 2019

(Source: Conference)

That conference, with regard to PCNs:

- (i) has no faith that they will result in a reduction in GP workload
- (ii) is concerned that they do not actually address the issue of the dwindling GP workforce
- (iii) has not seen any evidence that they will assist practices in supporting increasing numbers of patients with increasingly complex health need.

Policy group: General Practitioners England, 2019

(Source: Conference)

That conference recognises the workload of the clinical director of the new PCNs and:

- (i) they must be empowered and supported to resist the unrealistic expectation of all organisations that seem to believe PCNs will solve the problem within NHS primary care
- (ii) rejects any attempt by commissioners to use clinical directors for the performance management of PCNs and constituent practices
- (iii) instructs GPC England to negotiate for clinical directors to be paid for the role they undertake independent of network size
- (iv) calls upon GPC England to negotiate with NHS England in ensuring parental and sickness leave reimbursements, in line with practice reimbursements, are available for PCN clinical directors.

Policy group: General Practitioners England, 2019

(Source: Conference)

That conference, with regard to the Additional Roles Reimbursement Scheme:

- (i) believes that it disproportionately disadvantages innovative practices who hired workforce ahead of the scheme
- (ii) believes it is unrealistic to expect PCNs to be able to appoint to the designated additional roles from day 1 of each DES Year and calls for the protection of the inevitable underspends for each PCN
- (iii) demands that there is allowance for alternative appropriate roles
- (iv) requires that PCNs who are unable to recruit into additional roles are allowed to retain the funding for other projects or staff
- (v) asks the GPC England to negotiate a per capita sum that a network can allocate to the workforce needed and available as it sees fit.

SUPPLEMENTARY NON-NHS OPTIONS BREAK-OUT ROOM

Policy group: General Practitioners England, 2021

(Source: Conference)

That conference believes that GPC England is at risk of presiding and prevaricating over the slow death throes of GMS, and:

- (i) believes that the current GMS block contract of funding for general practice is outdated and inadequate for the current healthcare environment
- (ii) believes that the model of unrestricted workload for a fixed fee is a major disadvantage to general practice within the new ICS landscape
- (iii) calls on GPC England to negotiate a fee for service contract, including item of service payments for core general practice work, rather than the current block contract
- (iv) tasks GPC England with negotiating a contract that allows practices to offer private services alongside NHS services, where such services are not commissioned by the NHS for delivery in a general practice setting
- (v) tasks GPC England with exploring alternative contractual models for general practice in a post-NHS world.

Policy group: General practitioners UK, 2021

(Source: Conference)

That conference calls upon GPDF to commission and fund research into the creation of an options paper for GPC UK to review prior to April 2022 that will investigate how the future of a separately negotiated model around NHS and non-NHS provision of general medical services could be facilitated.

Policy group: General practitioners, 2018

(Source: Conference)

That conference believes that the survival of the profession should take precedence over the survival of the NHS.

ALTERNATIVE ACTION BREAK-OUT ROOM

Policy group: Annual Representative Meeting, 2022

(Source: ARM)

That this meeting supports GPs fighting to defend the GMS contract and NHS independent contractor status. The long-term GP patient relationship and the right for GPs to control their workload in a safe way, is essential for the future of general practice. We applaud the South Staffordshire motion passed at the 2021 LMC conference which called for GPCE to negotiate the end of the Primary Care Networks (PCNs) from 2023 as they 'pose an existential threat to independent contractor status' and this meeting:-

- (i) calls on GPCE and the BMA to organise the withdrawal of GP practices from the PCNs by 2023
- (ii) calls for PCN funding to be moved into the core contract
- (iii) instructs GPC England to act upon the GP ballot of 2021 and to organise opposition to the imposition of the new contract including industrial action if necessary.

NEW CONTRACT BREAK-OUT ROOM

- 1.1 HERTFORDSHIRE: That conference calls on GPC England to ensure that there are break clauses / breaks for exceptionalities negotiated into any future multi-year deals.
- 1.2 NORTHUMBERLAND: Continuity of care has been shown to improve outcomes and increases clinician satisfaction. Conference demands that this is enshrined in all future policy applicable to primary care.
- 1.3 LAMBETH: That conference instructs GPC England to negotiate GP contracts which reward continuity of care.
- 1.4 SHEFFIELD: That conference notes that the five year GP contract reform changes announced in 2019 are due to come to an end soon and there is significant concern about the lack of clarity of what the future arrangements will be for general practice. The conference therefore requests an urgent update from GPC England in relation to:
 - (i) how the PCN funding streams will be incorporated into the global sum
 - (ii) plans to secure additional funding exclusively for premises improvements and developments for the next decade
 - (iii) how the practices that are struggling to recruit staff via the ARRS scheme due to shortage of premises will be mitigated for in any future arrangements.
- 1.5 GATESHEAD AND SOUTH TYNESIDE: That conference believes the GMS model provides excellent value for the taxpayer but:
 - (i) believes that this comes at the expense of the GP partners delivering it at significant personal cost, with tolls exacted upon mental and physical health
 - (ii) recognises that the English public and the nature of medicine have changed since the days of five minute surgeries and a 50-page BNF
 - (iii) does not see this model as sustainable unless significant investment is made into general practice
 - (iv) requests that the contract be renegotiated to fund general practice by item of service means, in order to reward work done.
- 1.6 LIVERPOOL: That conference believes that continuity of care is the secret ingredient that makes general practice so effective and expects GPC England to negotiate a contract that recognises and rewards continuity as a priority.
- 1.7 BARNET: That conference recognises that GP contracts and associated funding streams are unnecessarily complex and calls upon GPC England to go back to NHSEI and negotiate a 'simplified' contract, more easily managed and which ensures increased investment into core.

- 1.8 BUCKINGHAMSHIRE: That conference notes the expiration of the five year contract in 2024 and demands that current workforce funding is guaranteed for at least another five years in any further contracts, in order to allow GPs to recruit and retain staff beyond 2024.
- 1.9 OXFORDSHIRE: That conference believes general practice has been overlooked for far too long, and now urgently requires:
- (i) stability and fortification of the NHS contract
 - (ii) financial stability with guaranteed income of salaried GPs and GP partners
 - (iii) removal of block contract work and replacement with a "fee for service" model in order to free up GP time to focus on such necessary patient outcomes as are determined by the GP and patient, rather than by NHS England.
- 1.10 SOMERSET: That conference calls for simplifying the content and length of documents and contracts relevant to commissioning general practice.
- 1.11 LAMBETH: That conference believes that with regard to general practice funding:
- (i) it should be simplified and included in the GMS contract
 - (ii) that additional GP funding for temporary schemes should be added to the core contract rather than the current inefficient complexity of having multiple small funding pots to bid for / claim.
- 1.12 NORFOLK AND WAVENEY: That conference asks GPC England to ensure patient continuity of care is the bedrock of the GP contract whether using personal lists or other systems.
- 1.13 SOMERSET: That conference instructs GPC England to negotiate incentivisation of the primary prevention agenda through the core contract.
- 1.14 BUCKINGHAMSHIRE: That conference:
- (i) believes that GPs are best placed to decide how to design their appointment systems
 - (ii) demands that existing contractual mandates, which require practices to offer a set minimum number of "appointments per practice list size" to be available for direct booking online by patients, be removed from future contracts
 - (iii) demands that existing contractual mandates, which require practices to offer a set minimum number of "appointments per practice list size" to be available for direct booking by NHS111, be removed from future contracts.
- 1.15 CAMBRIDGESHIRE: That conference notes the changes to England's economic landscape over the past twelve months and with an eye to the year ahead determines that in contract negotiations, GPC England should:
- (i) retain the flexibilities afforded by GMS
 - (ii) seek AfC parity for primary medical services staff via ring-fenced funding
 - (iii) determine the national cost of organisational development across the 42 ICSs over the past three years as leverage

- (iv) seek capital and revenue funding for explicit primary medical services premises and estates separate to ICS budget.
- 1.16 LIVERPOOL: That conference believes that the funding provided to practices is increasingly inadequate to provide the services requested and requires GPC England to negotiate:
- (i) a minimum initial uplift of £50 to the global sum
 - (ii) an uplift of at least CPI annually on an ongoing basis
 - (iii) that all DDRB mandated pay awards must be fully funded, including on costs, via the global sum.
- 1.17 LEEDS: That conference insists that the following principles must apply to any new GP contract. It must:
- (i) enhance the independent contractor model
 - (ii) be high trust low bureaucracy
 - (iii) not include performance management targets
 - (iv) be supported predominately by capitation payments with a significant increase in funding compared with the current global sum
 - (v) be underpinned by a workload related funding formula
 - (vi) be properly priced item of service fees for services all practices have a first option to provide.
- 1.18 CAMBRIDGESHIRE: That conference demands GPDF jointly fund with GPC England, an analysis of market valuations of GP workload across England with a third-party specialist consultancy firm ahead of any new contract negotiations to appropriately value the cost of providing:
- (i) same day urgent care including triage, consultation models, treatments, and visits
 - (ii) preventative and population health outcomes
 - (iii) long term conditions – including proactive patient contact, reviews, tests, consultations, and management.
- 1.19 GATESHEAD AND SOUTH TYNESIDE: That conference recognises the benefits of the partnership model for GPs, patients and secondary care and demands:
- (i) the unequivocal support of GPC England for the partnership model
 - (ii) all new resource to be directed to practice-level
 - (iii) the restoration of ties between GP and community services, permitting greater continuity and variety that will help retain GPs with special interests
 - (iv) the development of part-time GPwSI posts in secondary care, to enable better retention and skill transfer.
- 1.20 LEEDS: That conference insists that the following principles must apply to any new GP contract. It must:
- (i) enhance the independent contractor model
 - (ii) be high trust low bureaucracy

- (iii) not include performance management targets
 - (iv) be supported predominately by capitation payments with a significant increase in funding compared with the current global sum
 - (v) be underpinned by a workload related funding formula
 - (vi) be properly priced item of service fees for services all practices have a first option to provide.
- 1.21 LEEDS: That conference believes that a future contract should not include an out of hours funding deduction and that any practice choosing to deliver any aspect of out-of-hours service should be paid separately for this.
- 1.22 LEEDS: That conference insists that a future GMS contract:
- (i) must not include a pay for performance quality scheme such as QOF
 - (ii) should include a small number of professionally led, developed and agreed indicators of quality clinical care that enable peer review but are not linked to funding
 - (iii) will require computer system clinical prompts that are implemented at the time and no later than any indicator is introduced.
- 1.23 HOUNSLOW AND HAMMERSMITH: That conference recognises that the GP partnership model is currently under severe strain and:
- (i) with the demographic time-bomb of GP retirements in the next five years , this will severely worsen
 - (ii) believes that the widespread employment of GPs by hospitals is not the answer and will end the independence of general practice
 - (iii) an urgent 'plan B' for the future model of employment for GPs needs urgent discussion , debate and formulation
 - (iv) consideration needs to be given to general practitioners becoming a 'new category' of NHS employee, represented by the LMCs and BMA, with GPC England as their negotiating body.
- 1.24 BEDFORDSHIRE: That conference believes that, for the allocation to general practice, the system needs to look into new ways of funding deprived areas, taking account of the broad Marmot principles if it is serious about addressing health inequalities and levelling up and believes that new ways of funding must take account of:
- (i) multi morbidity, irrespective of age
 - (ii) GP consultations happening on a daily basis in languages other than English without interpreters
 - (iii) number of GP contacts for issues other than medical problems, such as social prescribing issues.
- 1.25 MID MERSEY: That conference demands a new fair contract for general practice that recognises the falling numbers of GPs, increased workload and increasingly complex patients.
- 1.26 KENT: That conference believes the current formulation of the GMS contract based on centrally defined performance measures has standardised outcomes for patients and demands GPC England to negotiate a

new contract that trusts GPs to exercise professional judgement and innovation to improve outcomes for the communities they serve.

- 1.27 EALING: That conference has grave concern and unequivocally opposes postulated future models for mainstream general practice, in which GPs are either employed by hospitals or by large scale profit driven commercial healthcare providers.
- 1.28 BERKSHIRE: That conference demands that:
- (i) any new contract to replace current GMS move to a “fee-for-service” model rather than block payment or capitation
 - (ii) any new contract to replace current GMS allow practices to offer private services to all of their registered patients, in a manner to be determined by the practice in agreement with the patient
 - (iii) current contracts that result in GP practices chasing multiple small sources of funding be consolidated into core funding.
- 1.29 BRADFORD AND AIREDALE: That conference recognises the independent contractor model has proven itself to be the most efficient form of general practice, we demand GPC England negotiate a new contract from 2024:
- (i) which supports the independent contractor model by increased investment in core funding
 - (ii) that allows improved continuity and by this improved quality of care in general practice
 - (iii) provides flexibility allowing individual practices to deliver care in the most appropriate way for their individual patient population.
- 1.30 HERTFORDSHIRE: That conference calls on GPC England to negotiate a GP contract which:
- (i) acknowledges the professionalism of GPs, with a focus on patient care
 - (ii) abolishes QOF, IIF and other target-driven initiatives
 - (iii) allows population health management (PHM) measures to tailor initiatives with local input and in negotiation with general practice.
- 1.31 WEST SUSSEX: That conference is disappointed by the lack of progress on implementing a plan for Industrial Action since the Indicative Ballot of GPs in November 2021, and calls on GPC England to negotiate with NHSEI / DHSC:
- (i) a tariff based primary medical services contract commencing in April 2024
 - (ii) all funding for the PCN DES to be incorporated into core [primary medical service contract global sum] commencing in April 2024
 - (iii) that the current restrictions on general practice private practice are removed from any new primary medical services contract commencing in April 2024.
- 1.32 GATESHEAD AND SOUTH TYNESIDE: That conference recognises the failure of GPC England to progress previous conference policy on home visiting and:

- (i) believes that with an ageing, impoverished population, continuation of the status quo will increase workload and prove unsustainable for practices
 - (ii) is concerned that an increase in preventable admissions will have wider system implications affecting patients and GPs alike
 - (iii) calls for additional resource to be allocated to practices with significant need for home visits
 - (iv) stipulates that home visit provision may be provided by whoever is deemed clinically suitable, rather than the GP as default
 - (v) affirms the right of all GPs to visit only the housebound and reject all other requests.
- 1.33 HULL AND EAST YORKSHIRE: That conference believes the only viable model for a new GP contract must limit either the number of patients that each whole time equivalent GP is responsible for to no more than 1500 or provide an increase in core funding sufficient to provide adequate services for the patient population.
- 1.34 NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes any new funding model must be based on a minimum number of staff required to safely and effectively provide care to a defined patient population. For any increase in patient numbers due to patient registrations or loss of clinicians, care cannot be provided until the required staff are in place to do so safely.
- 1.35 OXFORDSHIRE: That conference demands that in the upcoming contract negotiations:
- (i) the core GMS contract be maintained, as a viable contract for general practice in England, in its own right
 - (ii) the Network Contract DES remains a separate, optional contract which practices may freely decide to opt in or opt out of
 - (iii) commissioners, who are currently required to ensure total population coverage for the Network Contract DES specification, be required to assist practices with any staff liability arising from a practice decision to opt out of the Network Contract DES.
- 1.36 LIVERPOOL: That conference believes that the LMC would want to support the partnership model of care and would want to see APMS contracts revert to GMS or be capable of reverting to GMS contracts. The LMC would not support vertical integration with hospital trusts as this will destroy the essence of general practice.
- 1.37 DEVON:
- Defined workload limits with an overspill mechanism such as urgent care centres.
 - Secondary care and community providers should be held to contract to stop unauthorised workload transfer.
 - Funding should be entirely through GMS with PCN allocations clearly nominated.
 - Net remuneration should go up at the very least in line with inflation.
 - Consider a complete fee for service model with no practice lists - ie the patient goes to whichever practice they want for a given problem, his would stop us being the providers of last resort.

1.38 BEDFORDSHIRE: What does your LMC think is needed regarding GP Contractual Models?

- Retain independent contractor status
- Financially viable to deliver core contractual services without being reliant on other funding pots (eg QOF, LES, DES)
- Consistency in contract funding – level playing field (i.e. not having APMS contracts paid at GMS + 20%)
- GMS contract index linked to protect against inflation and other economic changes (not tied into multi-year financial constraints)
- Promotes the ability to provide continuity of care
- Contains a mechanism to limit workload – the open-ended nature of the current contract is not sustainable – a new contract needs to protect the profession
- Reduced bureaucracy.

(Supported by Hertfordshire)

1.39 NORTH STAFFORDSHIRE: This requires the thorough assessment of unfunded workload transfer from delayed and virtual secondary care out-patients and from the supervision and mentoring of ARRS roles within PCNs. This then needs core GMS investment (ring-fenced if required) to maintain the viability of the partnership model.

1.40 AVON: Avon LMC considers that there should be a single GP contract negotiated nationally for GPs and not varied locally. It is essential to ensure that the independent contractor status model for GPs is maintained.

1.41 HEREFORDSHIRE: The toxic effects of rising workload and reducing workforce are placing intolerable pressures on individual GPs. Any new contract must stipulate a workload cap for individual GPs, to protect the workforce, and place the responsibility for workload surges on the wider health system.

1.42 HILLINGDON: More funding needs to come through core or practice based contracts. Having ever more funding going through PCNs will be an eventual threat to the independent contractor model. A change as the current GP contractual models with the eligible maximum pay against the 70% (or 100%) reimbursement will apply. These percentages will neither taper nor increase from today over the next five years despite the cost of living rise, inflation and other factors. This makes a small practice not viable within a PCN.

1.43 BRENT: Recognition and support for increased consultation rates per patient. There has been funding for numbers of appointments for direct booking access from 111 and Urgent Care. Can this be extended within the contractual models?

1.44 MORECAMBE BAY: The current core contract is broad in its description of what is required of general practice. In theory it leaves it to the professional judgement of GPs to decide how they are to deliver the contract to meet the needs of their patients. On balance we think this is the right approach, although it leaves general practice open to challenge.

Any temptation to tie the contract down with detail and metrics will fail and lead to micro management. This is already much the case with enhanced services where there is low trust, over prescriptive requirements, and a host of bureaucracy.

- 1.45 BRADFORD AND AIREDALE: The current workload is unsustainable, any new model needs to have a clear connection between funding and workload, and to continue the Independent Contractor model, funding needs to go into Global Sum. This will maintain autonomy, promote innovation, and be more cost effective for the NHS. A salaried model would need to be based on the consultant contract with allocated Pas for non-patient facing work. PCNs do not promote continuity of care, the priority should be LTCs and less financial risk to retain the workforce. GPs should not be at risk of bankruptcy at the behest of the DHSC.
- 1.46 NORTH YORKSHIRE: We need a clearer definition of what is and isn't expected of general practice - LES schemes should be standardised over the country, urgent and emergency care demands should be removed from the model and the focus passed to long term conditions and preventative care. ARRS roles need to increase flexibility, on funding, responsibility and to include patient facing clinical staff such as nursing and GP colleagues. Workload remains unsustainable – any future model needs to define a realistic workload with a remuneration that makes the job of a GP sustainable long term and attractive to younger doctors.
- 1.47 LINCOLNSHIRE: Genuine support of the independent contractor GP partnership model as current alternative options do not seem to provide the same levels of commitment and efficiency of the independent contractor model.

Safe working limits need to be agreed contractually and made visible to the public to understand there cannot be an endless capacity and that this will ultimately support safe working and create the capacity and continuity for when they need us for their complex care.

While PCNs have created collaboration and a more diverse team within general practice, the long-term benefits are yet to be seen. They were sold as a mechanism to support sustainable general practice, but the ever-increasing demands of the DES with faltering recruitment and expanding ARRS staff pay expectations within a finite reimbursement envelope have, in some cases, served to add more pressure to already struggling practices. The new contract needs to review the inflexible nature of the PCN DES such as the ARRS recruitment and deployment of services such as enhanced access to truly allow local application and efficient and appropriate deployment of the DES to improve conditions for practices and make the service sustainable to allow them to provide and further develop outstanding services for their patients. If the PCN DES is to continue, then future aspects need to avoid the loss of core GMS services and an assumption that delivery on a PCN footprint is better than on a practice footprint.

- 1.48 DORSET: What does your LMC think is needed regarding GP Contractual models?
- Difficult to be certain on the best model for delivering general practice without knowing what we are being asked to deliver.
 - A general feeling that the partnership / independent contractor model has worked well and offers agility, innovation and a sense of ownership. It is still fit for purpose if we have a reasonable workload, adequate workforce, less top down micro management and move away from target driven healthcare in any new contract.
 - One single model for GP for the future may well not be a realistic ask nationally
 - Any model will require investment in staff and infrastructure and also has to be an attractive proposition to work in for existing and future staff

- An honest discussion is needed with the public and other providers as to what general practice can realistically be asked to deliver
 - The recent Kings fund paper *Levers for change in primary care: a review of the literature* (kingsfund.org.uk) should provide an evidence base to inform contract negotiations.
- 1.49 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: What does your LMC think is needed regarding GP Contractual models?
- Increase in core funding, particularly given inflation.
 - Move to safe working levels with limits on number of patients that can be seen in a day. Protected 15-minute appointments.
 - Preservation of partnership Model.
- 1.50 HARROW: Recognition of the additional workload and responsibility of being a GP partner with appropriate remuneration, whilst also ensuring adequate resources to fairly pay salaried GPs and locums. Greater clarity regarding core and non-core work. Contractual safeguards to prevent unfunded and inappropriate workload transfer from secondary care at community care services.
- 1.51 HAMPSHIRE AND ISLE OF WIGHT: What does your LMC think is needed regarding GP Contractual models?
- Our LMC committee members have fed back that a priority is being in control of workload.
 - They voiced support of the partnership model.
 - There simply isn't enough workforce to fulfil current contractual demands. Needs clear limits to what GPs are asked to do.
 - Time and resource allocation needs to recognise and reflect both true clinical patient demands but also the growing but hidden administrative and management demands on GPs.
 - Estates are vital to the future of general practice as well.
- 1.52 NORFOLK AND WAVENEY: The partnership model should remain at the core of any future contract as a full salaried service will be detrimental to the valued and proven benefits of continuity of care. Partnership should be incentivised with a reduction of financial risk, this will bring long-term stability to general practice. The New to Partnership scheme has been a success and should be built upon.
- 1.53 EALING: The Partnership mode is the best model for GPs to deliver care to patients; however, it requires sufficient government investment to be sustainable. The concept of a fully salaried GP service won't work, as it will be run by secondary care who have no understanding of what GPs do day to day.
- 1.54 SHEFFIELD: There is strong support for the partnership as long as investment matches workload and expansion of services. It allows local pragmatic decision making, responding to patient needs at place. Current government is undermining this with no appreciation of the level of goodwill and 'extra' given to the system by partners. Difficulties in recruitment, alongside the addition of ARRS staff, has led to an increasingly supervisory role. This must be built into negotiations - GPs require supervision time and longer appointments to deal with complexity. Support should include addressing pension taxation, recognition of seniority and investment in those taking on partnership.

- 1.55 WIRRAL: Several surveys and reviews have been conducted on the appropriate contractual model for general practice; and each time Independent Contractors (Partnership) model has always been favoured. Our LMC is calling on GPC England to ensure that this model is respected, preserved, promoted, and adequately resourced within the developing PCNs, (and without compromising the autonomy of individual practices), and this should be implicit within the GP contract.
- 1.56 SANDWELL: The very least we would expect is that the representatives of the profession would not have to ask this question seven (7) years after the Prime Minister acknowledged that the profession was in crisis. The requirement of last year's conference, that GPC England prepare to negotiate a fee per service contract (motion no.13, overwhelmingly passed) has resulted in no action. We do not expect a new model contract will emerge from a loose break-out session. It is the task of our elected representatives to develop a vision strategy. We require that this happens as a matter of absolute priority.
- 1.57 GREENWICH: Overall the current contractual models remain robust and valid, setting out clear responsibilities and expectation for commissioners and providers. Moreover, the test of time has shown it offers significant protection for general practice funding. We should be wary of any changes to the current contractual models.
- 1.58 LEWISHAM: We believe that the GP contract should reflect and support the continuation of the partnership model. This should be financially robust and designed to help partner retention and recruitment and help to create a working environment that encourages newly trained doctors to enter general practice.
- 1.59 CLEVELAND: We fully support a move to an item of service contract, with realistic funding and expectations around workload (time taken to undertake each clinical task or contact). Every new piece of future work within this contract must attract additional realistic funding, and every part of the contract must be uplifted in perpetuity with inflation. Safe working limits must be embedded.
- 1.60 SUTTON: Independent contractor models allow greater continuity of care and positively impact on patient outcome, job satisfaction and efficiency. A model with a fixed fee regardless of the number of consultations / patient contacts means finite income and potentially infinite outgoings causing primary care to stretch beyond safe limits. A defined limit to the number of daily appointments with additional funding to provide more if necessary is needed. Additional work from activities such as Advice and Guidance / Refer to be factored in as should additional time taken to provide services for the homeless, those in refuges and non-English speaking communities. Adequate funding for deprivation.
- 1.61 WANDSWORTH: Recognition that the partnership model is required to retain general practice. It has been a successful model and encourages retention, continuity of care, and activity has improved care provision via QOF / LES / DES. Current recruitment challenges to partnerships is not because of lack of motivation or career aspiration but because partners' earnings are now equivalent to salaried GPs so there is no financial benefit to being a partner. If primary care was funded correctly there would be less recruitment challenges. Early discussion and negotiation is needed for planning for GP contract review with strong negotiation by BMA / GPC England.
- 1.62 MERTON: An emphasis on retaining the independent contractor model and promoting its value in recognition that continuity of care is critical and cost effective. Improved ways of managing workload to keep patients safe and prevent further loss of skilled professionals such as moving to a model of paying for work done or something which effectively prevents other parts of health and social care shifting working into primary care. Capping activity and ensuring safe limits of care are built into the contract specifying

limits on responsibility in a primary care charter to ensure adherence. Flexibility and an even playing field for all.

1.63 LAMBETH: We would like to see the end of APMS and have only one sort of contract (preferably GMS). It must pay enough for practices to be financially viable. It needs to focus on healthcare (not trying to remedy the gaps in social care and other services), with simplified targets and rewards for continuity of care. Extraneous requirements, SOPs etc should be removed to allow practices more autonomy about the ways in which services are delivered to suit their patients.

1.64 ENFIELD: More investment into core contract, rather than just splitting funding, or for example, putting money into PCNs.

1.65 BERKSHIRE: Regarding contractual models, we need:

- A move to fee for service / abandon “en bloc” contracting,
- To eliminate micro management on how practices spend funds
- To end schemes where multiple small pockets of money are allocated to practices via “tick box exercise funding”.

It is also worth reviewing the old Red Book which had a guaranteed income for providing care with an element of capitation and item of service fees for all the extra non-core work. The issue then is that defining core work can tie us into providing care which not all practices consider to be the basic care they provide to patients which is why it has not been feasible to complete this exercise in the past. Any suggestions on how to achieve this, learning from the past, would help towards a new contract formula.

1.66 BARNET: There needs to be a conversation about what an alternative to the partnership model could look like. If the partnership model is no longer working for GPs or their patients, we need to think of what model we would like. It doesn't have to be a salaried model run by Acute Trusts. The BMA salaried model contract is not followed by GMS or PMS practices eg time for CPD. In my Facebook group, many practices don't give their salaried GPs CPD time, and a PMS practice not offering maternity leave, (my practice is one of these).

1.67 BUCKINGHAMSHIRE: Regarding contractual models, we need:

- Proper resource to primary care infrastructure, at least on a par with the “40 new hospitals”.
- Focus on GP workforce, not non-GP workforce “ARRS”.
- End to new monies with new pointless “targets”.
- Automatic annual inflationary correction of funding.
- Pay based on per consultation / fee for service rather than Carr-Hill / Global Sum.
- To remove childhood immunisations from QOF, and potentially remove all targets - QOF, PCN DES , Quality Incentive Schemes, and allow us to care for our patients.
- Every contact must count and be paid for – whether directly with the patient (online, video, telephone, face to face) or indirectly (relatives, care homes, third party non-NHS organisations).
- A safe workload level/maximum number of interactions per session must be defined.

- GPs to be able to offer and charge for private services to their NHS patients (like pharmacists and dentists)
- 1.68 CROYDON: Colleagues believe the partnership model should be the core continuing option for general practice, being clinically effective, resource efficient, supporting continuity of patient care, and creating a professionally rewarding and sustainable environment for general practitioners. Collaborative working is supported, but the PCN DES and IIF are seen as micro management. All this funding should be negotiated into the core contract, giving partnerships the resources and flexibility to deliver care. Without increased core funding and a built-in allowance for unavoidable expenses, NHS general practice is in inevitable decline. Given appropriate funding and a workforce autonomously recruited by general practitioners, it could flourish.
- (Supported by East Sussex, West Sussex, Surrey and Kingston and Richmond)
- 1.69 BARNET: The BMA salaried model contract is not followed by GMS or PMS practices eg time for CPD. In my Facebook group, many practices don't give their salaried GPs CPD time, and a PMS practice not offering maternity leave, (my practice is one of these).
- 1.70 SEFTON: In view of the recently proposed radical but destructive revision of the current GMS and independent contractor model by certain policy think tanks - a reassertion of the value of a national contract framework based on independent GP contractors is needed. This properly supported by a manpower planning/education strategy and with health and safety workload limits.
- 1.71 KENT: We support a fully funded GMS contract provided by independent contractors. We believe targets should be reduced and then capped. The current model is complex and requires a lot of planning and management taking up valuable clinical time of GP partners. The contract must contain workload control clauses with reference to BMA guidance on safe working. Although a significant proportion of our GP workforce are working in a salaried capacity, we see no evidence of a wish to move to a fully salaried service.
- 1.72 OXFORDSHIRE: Regarding contractual models:
- Maintain core GP as a viable contract, so that the PCN DES remains a genuinely optional "extra".
 - Maintain GP autonomy to deliver services for those who are ill or believe themselves to be ill, in a manner to be determined between the doctor and the patient.
 - Need to promote the benefits of the individuality and diversity of GP practices and defend GP autonomy; that this is a strength and the key to efficiency and responsiveness that NHSEI should want
 - Core GMS funding should fund the delivery of core work – seeing patients who ill or believe themselves to be ill. Delivering this should be viable without any need to participate in additional contracts or "enhanced services".
 - The national agreed contract should be the baseline for financial viability and nothing else.
 - The level of core funding should be revised according to workload data provided by primary care
 - Redefine the ARRS staffing as being to support delivery of CORE work, not just the PCN DES, and therefore open up access to all practices not just PCN DES signatory practices
 - Safe workload caps in line with BMA guidance

- No option for NHSEI to make unilateral contract changes without proper negotiation or after a mere “consultation period”
 - All Enhanced Services should be locally negotiated according to local priorities (we believe the “one size fits all” approach of the PCN DES leads to poor use of resources)
 - We need fewer targets across whole contractual landscape.
 - Complex and extensive targets create an additional administrative burden, taking front line staff away from delivering care.
 - Targets should only be set for very clear evidence based interventions (e.g. BP treatment targets vs “refer x number of patients to a link worker or social prescriber”).
 - Targets should be based on outcomes of clinical merit, and not “activity”.
 - Targets should be set for long term – eg 3-5 years. Not be re-designed every 6-12 months.
- 1.73 WIGAN: In view of the recently proposed radical but destructive revision of the current GMS and independent contractor model by certain policy think tanks- a reassertion of the value of a national contract framework based on independent GP contractors is needed. This properly supported by a manpower planning/education strategy and with health and safety workload limits.
- 1.74 REDBRIDGE: The current model is overly bureaucratic, micro-managed and based on aspirational targets of limited clinical value, from which there is need to move to realistic targets. The finite capacity of general practice and the high value of clinical time requires recognition, with reduction in activity that removes clinicians from direct patient care, unless the activity significantly reduces patient morbidity or mortality. To reduce the effects of the inverse care law, there is urgent need for a fair funding model that includes a basic practice allowance and weighted payments based on the major patient factors that affect workload, in particular deprivation.
- (Supported by City and Hackney, Newham, Tower Hamlets and Waltham Forest)
- 1.75 GLOUCESTERSHIRE: General practice is failing due to lack of funding from successive governments. Even with significant increases in funding we must seek a different model outside of NHS control or the same situation is inevitable in the future. Contracting models need to have an increased degree of privately funded work. All work shifted from hospitals should be fully charged and funded, a flaw in the current open-ended system. Less bureaucracy, box ticking; referral management. More support, supervision and training for early career GPs to operate their business. Close monitoring on numbers of patient contacts, with safe limits or funding increased proportionately.
- 1.76 NOTTINGHAMSHIRE: The capitation based contractual model is at odds with the activity based one and causes unresourced shift of work as it introduces unhealthy counter-productive competition within the same system in a race to the bottom and patients suffer as a result. Capitative models also encourage an ‘all you can eat’ abuse and devaluation of a highly skilled and thinly spread workforce. Contractual models need to be aligned to maximise efficiency.
- 1.77 WORCESTERSHIRE: What does your LMC think is needed regarding GP Contractual Models?
- A core contract that recognises numbers of patient contacts, additional work undertaken and which takes account of real time practice expenses and running costs. It should recognise the value of continuity of care and allow practices the autonomy and flexibility needed to meet the needs of the local population without top-down micro management. Benefits of the PCN DES including collaborative working and integration

should be bought back into the core contract. There must be recognition that general practice cannot be all things to all people. Individual practices should retain responsibility for how they meet their patients' reasonable needs. Bureaucracy and target setting must be reduced, have real value to patient care and be deliverable by GPs within sensible working hours, retaining the workforce and encouraging recruitment.

- 1.78 CHESHIRE: Negotiation team (GPC England) to have a strong steer from LMCs to deliver a national contract spec.

BEST ALTERNATIVE TO CURRENT PCN DES BREAK-OUT ROOM

- 2.1 DEVON: That conference needs to instruct the GPC England to recognise PCNs are evidently here to stay as a pivotal building block within the new NHS structures and; as such they are a strong negotiating tool that needs to be utilised quickly.
- 2.2 DEVON: That conference believes continuity of care is the bedrock of the sustainable delivery of excellent primary care provision but the concept that this can be done at scale with 7-day access is clinical nonsense.
- 2.3 DEVON: That conference is not representative as it has voted on numerous occasions to oppose the concept of enhanced access but the vast majority of PCNs have chosen to deliver it.
- 2.4 DEVON: That conference makes NHSEI aware that the exponential rise in duplication of data requested from that PCNs needs to stop and they need to recognise the dangers for the NHS in:
- (i) the paradox of attempting to micromanage general practice at scale
 - (ii) falsely naming assessment questionnaires as surveys with short deadline turn arounds
 - (iii) asking PCNs to complete regular national workforce data when this is all clearly visible to them via ARRS claiming systems
 - (iv) allowing NHS Digital to continue without a proper detailed published audit of their activities.
- 2.5 BEDFORDSHIRE: That conference urges that existing conference policy to widen the scope of the Additional Roles Reimbursement Scheme to include GPs, nurses and ANPs should be pushed urgently in any forthcoming negotiations.
- 2.6 BEDFORDSHIRE: That conference calls on GPC England to:
- (i) acknowledge that the expansion of the general practice workforce through the additional PCN roles is welcome, but
 - (ii) emphasise that there have been decades of government neglect and failure to invest in GP premises, with the result that GP premises are totally inadequate for the larger, multi-disciplinary teams that are crucial to managing the complexities of modern practice, and to
 - (iii) negotiate for funding for premises expansion or to rent additional spaces where needed for additional roles staff.
- 2.7 AVON: GPC England needs to ensure that the government understands that promoting the collective working of practices in PCNs / localities whilst beneficial can also be to the detriment of practices, continuity of care, and the efficiency of patient care.
- 2.8 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that PCN Enhanced Access will result in destabilising core services, increasing services which are unsafe, decrease patient satisfaction, increase health inequalities, and be a further reason for practices to close. GPC England must negotiate for this ill-conceived project to be abandoned.

- 2.9 MID MERSEY: That conference demands the funding for ARRS should be directed to core funding in general practice rather than PCNs to sustain general practice.
- 2.10 MID MERSEY: That conference notes that it is time to reinvent the wheel again! and that the time of PCNs has to come to a much-awaited end and demands that PCN funding is shifted into general practice.
- 2.11 FULHAM: That conference notes that in relation to non-GP clinical supervision of staff, urgent attention is needed to recognise the role and address both funding and training of that role.
- 2.12 KENT: That conference recognises the limitations of the very prescriptive Additional Roles Reimbursement Scheme (ARRS), and requires the GPC England negotiates that PCNs have the freedom to recruit into roles that meet the needs of their patients.
- 2.13 KENT: That conference demands that GPC England negotiates greater freedom for PCNs to determine how to deliver Enhanced Access for their populations.
- 2.15 KENT: That conference requests that GPC England 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 the significant management costs incurred in employing and managing ARRS roles.
- 2.16 KENT: That conference demands that GPC England works with NHSEI to produce a standardised coding system for PCN payments to enable practices to easily identify PCN funding streams.
- 2.17 SOMERSET: That conference believes that any practice or PCN that can demonstrate an inability to recruit to unfilled clinical vacancies should not be penalised for the inability to comply with contract changes requiring additional clinical work.
- 2.18 BRADFORD AND AIREDALE: That conference supports the BMA resolution that PCNs are an existential threat to Independent Contractor Status. Conference also believes that the PCN DES is a threat to:
- (i) continuity of care, in that the suggestion that personal care planning is best achieved by practices grouping together is clearly ludicrous
 - (ii) patients having their own surgery, as PCNs progress and care is dispersed patients will not only no longer have their own GP they will no longer have a surgery to call their own
 - (iii) doctor led general practice, due to the only new funding streams for general practice are clearly designed to replace GPs with other health professionals
 - (iv) financial viability of practices, as the absence of any increase in the cap on funding for individual ARRS roles is just the beginning.
- 2.19 BRADFORD AND AIREDALE: That conference believes that Extended Access is an expensive way of providing additional capacity with a clinician with whom the patient is unfamiliar, at a location and time that are inconvenient to the patient and this funding should be transferred to Global Sum to increase capacity there.

- 2.20 NORTH YORKSHIRE: That conference rescinds the policy to withdraw from the PCN Des in April 2023 and supports those practices and PCNs that choose to continue to provide the DES.
- 2.21 NORTH YORKSHIRE: That conference agrees that the PCN DES in its current form is restrictive and asks GPC England to ensure that the renegotiated DES allows for flexibility, innovation and for PCNs to determine how best to utilise funding to meet their own service and population needs.
- 2.22 HAMPSHIRE AND ISLE OF WIGHT: That conference acknowledges that primary care networks if utilised appropriately can have benefits for both patients and general practice. Conference also acknowledges one of the great strengths of English general practice is the entrepreneurial nature that allows flexibility and autonomy to react to local population needs. With this in mind conference calls on GPC England to increase flexibility of PCN ARRS roles by negotiating additional:
- (i) GP sessions become an ARRS role
 - (ii) advanced nurse practitioner sessions become an ARRS role
 - (iii) practice nurse sessions become an ARRS role.
- 2.23 NORFOLK AND WAVENEY: That conference asks that the rules for ARRS funding are changed so that hard to filled posts can be backfilled by other disciplines and providers.
- 2.24 NORFOLK AND WAVENEY: That conference asks GPC England to negotiate to end the PCN DES and have the funding reallocated into core GMS payments to practices as PCNs are an ineffective way of improving workforce resilience and dealing with demand in general practice and the attached staff work mainly to fulfil the requirements of the PCN DES.
- 2.25 NOTTINGHAMSHIRE: That conference calls for increased proportionate investment into general practice estates to help support the ARRS MDT working in a way that is fair, intuitive and free from bureaucracy.
- 2.26 HERTFORDSHIRE: That conference calls on GPC England to negotiate that the PCN DES includes a new, additional funding stream to cover the employment of a PCN manager.
- 2.27 WORCESTERSHIRE: That conference insists that performance indicators beyond the control of general practice are removed from IIF indicators with immediate effect and that contractors should not be financially penalised where IT systems are not in place to support contractual requirements such as in the enhanced access aspects of the Primary Care Network Directed Enhanced Service.
- 2.28 SUFFOLK: That conference recognises that many practices are already heavily invested in PCN workforce. Conference asks GPC England to consider that as a result, PCN contract withdrawal may not be a viable mechanism for potential industrial action.
- 2.29 NOTTINGHAMSHIRE: That conference is concerned about the growing requirements on practices through the PCN DES and requests that GPC England negotiates with NHS England to ensure that a significant proportion of funding is ring-fenced out of PCN budgets for practices individually to decide how to use on joint working.
- 2.30 LIVERPOOL: That conference believes that networks have the potential to facilitate locality based care planning and address local health inequalities. In order to do this networks must:

- (i) be adequately funded to recruit and employ a clinical leadership team and the associated administrative support
 - (ii) not be funded as an alternative to a fully funded GMS contract
 - (iii) be sufficiently autonomous to be able to make local decisions for local issues.
- 2.31 BEDFORDSHIRE: That conference believes that although some PCNs are like relationships made in heaven, many more were formed like a shotgun wedding and are in no way functional institutions. It therefore calls on GPC England to explain to NHSEI that if PCNs are to be successful they need:
- (i) more freedom to decide on local priorities
 - (ii) fewer dashboards / targets
 - (iii) more flexibility in the staff they can employ and the skill mixes to meet local needs or fill gaps where other ARRS staff can't be recruited, in particular nurses, ANPs and GPs.
- 2.32 SEFTON: That conference demands that NHSEI and GPC England agree to suspend primary care network performance indicators, allowing practices to use these staff to support patient access rather than chase targets.
- 2.33 HERTFORDSHIRE: That conference appreciates the wider additional primary workforce available through the ARRS scheme but notes that their introduction has come at a cost to general practice and believes that there is now an urgent requirement for:
- (i) an overview of all ARRS salaries
 - (ii) an in-built salary increment scheme
 - (iii) funding for GP supervision and training of ARRS staff.
- 2.34 CITY AND HACKNEY: That conference recognises that a diverse set of health care professionals have been recruited into general practice through the PCN DES and recommends that:
- (i) GPC England negotiates with NHSEI England to guarantee full funding for the continued employment of ARRS staff beyond the current contract period, regardless of whether the PCN DES continues, and that funding arrangements are confirmed by 1 April 2023
 - (ii) GPC England negotiates with NHS England that any future ARRS funding makes allowance for annual wage increases in line with inflation.
- 2.35 GLOUCESTERSHIRE: That conference is very disappointed at the overall ability of allowable ARRS staff to take workload off practice nurses and GPs and insists that all posts including GPs and nurses should be available under the ARRS scheme forthwith.
- 2.36 GLOUCESTERSHIRE: That conference recognises the significant responsibility that practices, and in turn GPs have for supervising ARRS staff and asks the BMA to call for:
- (i) increased guidance on support and oversight models for all ARRS roles
 - (ii) specific funding to be allocated to practices to provide support and oversight for ARRS roles
 - (iii) clarification of the responsibilities that practices have in employing these staff within their roles.

- 2.37 KENSINGTON AND CHELSEA That conference believes that the ARRS scheme should be evaluated including:
- (i) quantifying any proportion of the fund not invested in practices
 - (ii) the impact of the new roles in addressing the mismatch between demand and GP workforce capacity.
- 2.38 SUTTON: That conference notes that there is a phenomenal amount of work involved for PCNs to deliver the PCN DES and demands that:
- (i) responsibility shouldered on PCN CDs should be in line with their contractual duties as they are at risk of potential burnout adding to further workforce issues
 - (ii) the ARRS workforce needs training after recruitment and a period of settling into general practice as many may work across a number of practices
 - (iii) having created an internal market for ARRS roles funding needs to be realistic to recruit into these roles.
- 2.39 GATESHEAD AND SOUTH TYNESIDE: That conference believes the IIF to have been an unmitigated disaster and:
- (i) has concerns about the ethics of medicines being included in a performance / funding measure without health outcomes to back this up
 - (ii) is dismayed that the box-ticking nature of IIF work detracts from both patient care and the constructive use of practice managers' time
 - (iii) believes that the harm done to inter-practice relationships by forcing them to performance manage each other will set back attempts to collaborate in the future
 - (iv) requires that any new contract keep payment-by-performance at practice level
 - (v) demands that all current IIF monies be distributed to practices on a weighted, pro-rate basis for use as they see fit to meet patient need.
- 2.40 WEST SUSSEX: That conference believes that funding of the PCN DES poses an existential threat to the independent contractor status of general practice and patient care by diverting such funds from the Primary Medical Services Core Contract.
- 2.41 GATESHEAD AND SOUTH TYNESIDE: That conference condemns the expensive failure of PCNs to either relieve workload or improve retention and calls for the:
- (i) recognition that PCNs were ill-conceived, poorly executed and have proven popular with neither patients nor GPs
 - (ii) repatriation of ARRS funds into GMS, to be increased in line with inflation
 - (iii) freedom for practices to spend said funds on the members of staff both available and useful to them, without limitation.
- 2.42 SEFTON: That conference calls upon NHSEI and the GPC England to agree moving primary care network funding into core contracts, allowing practices to recruit and retain more GPs by making the job doable again.

- 2.43 CITY AND HACKNEY: That conference acknowledges the controversial nature of the PCN DES and the variability in satisfaction with the DES across general practice in England, and:
- (i) insists that GPC England actively engages with all GP practices in England, in advance of any contract negotiations regarding the potential continuation of the PCN DES
 - (ii) requires NHSEI to undertake and share a comprehensive analysis of the impact of the PCN DES from 2019-2023, including but not limited to clinical outcomes, in parallel with the workload required to meet the obligations of the service specifications and IIF.
- 2.44 CLEVELAND: That conference reminds secondary care colleagues, NHS England, Integrated Care Boards and the government that the GP practice is the core unit for service delivery, not the PCN.
- 2.45 MANCHESTER: That conference notes general practice in England needs stability and opportunity to plan instead of the repeated need to respond to last minute announcements. We call on GPC England and NHSEI to provide at least six months' notice for their proposals for the future or replacement of the PCN DES.
- 2.46 CITY AND HACKNEY: That conference:
- (i) strongly believes that it is imperative for the PCN DES to remain within the 2024 GP contract
 - (ii) advises that GPC England prioritises the PCN DES for discussion with NHS England
 - (iii) recommends that GPC England confirms with NHS England by 1 April 2023, whether the PCN DES will remain within the 2024 GP contract
 - (iv) recommends that GPC England confirms with NHS England by 1 July 2023, the complete details of the PCN DES, including all service specifications
 - (v) suggests that GPC England negotiates that from 1 January 2023 onwards, there should be no deadline for withdrawing from the PCN DES and any practice wishing to withdraw from the PCN DES should be able to do so at any time.

SUPPLEMENTARY NON-NHS OPTIONS BREAK-OUT ROOM

- 3.1 BUCKINGHAMSHIRE: That conference believes that:
- (i) the NHS is broken
 - (ii) the NHS is broken beyond repair.
- 3.2 GATESHEAD AND SOUTH TYNESIDE: That conference is concerned that the ending of the free-at-the-point-of-use model in England is approaching and:
- (i) is concerned that this will be disastrous for many of our more deprived patients in terms of late presentations and early mortality
 - (ii) notes the increasing number of patients who present with preventable dental disorders as a result of being unable to afford routine dental treatment
 - (iii) requires that, with BMA assistance if needed, GPC England model and present publicly the likely consequences of insurance based or pay-as-you-go models of general practice upon English patients, both at national and regional levels
 - (iv) demands that any such findings be actively promoted, in order that GPs and the English public be aware of the likely implications to both health and finances of any changes to the model of healthcare funding.
- 3.3 GLOUCESTERSHIRE: That conference believes regrettably NHS general practice is unsustainable in its current format now and in the future unless significant changes are made urgently that support general practice therefore GPC England need to make alternative plans for general practice within England as a matter of urgency.
- 3.4 SANDWELL: That conference has grave concerns that all previous efforts by GPC England to alert NHSEI to the parlous state of general practice have been fruitless. The stated intention of NHSEI is that, absent a new agreement, they intend to roll over the existing contract. Conference indicates:
- (i) this is unacceptable to providers
 - (ii) in the event that a new sustainable contract is not agreed, mandate that GPC England prepare a contingency plan for members to protect them from further economic, professional and psychological detriment.
- 3.5 LIVERPOOL: That conference believes that In any discussion on future funding, the LMC would not support any move towards co-payments or insurance based funding. Any change to the funding mechanism would inevitable affect the poorer more deprived members of society, widening health inequalities. We would vehemently oppose any suggestion of charging patients for attending (or not attending) a GP appointment as this will lead to an end to NHS general practice as has occurred with NHS dentistry.
- 3.6 GLOUCESTERSHIRE: That conference believes there has been a persistent and ongoing failure of successive governments to adequately resource NHS primary care. We call on the BMA to commission a study on the feasibility of general practices transitioning to a privatised, "dental" model of GP and publish guidance and a roadmap for practices who wish to explore this route.

- 3.7 BUCKINGHAMSHIRE: That conference notes that unlike dentists and pharmacists, GPs cannot under existing contracts offer many private services to their NHS patients, and believes that:
- (i) GP surgeries should at their discretion be allowed to offer their NHS patients paid-for services if these services are not routinely offered by the NHS
 - (ii) GP surgeries should at their discretion be allowed to offer their NHS patients paid-for services if these services are routinely offered by the NHS but are not accessible in a time frame that the patient deems reasonable
 - (iii) ICS have a role in defining which services are not routinely offered by the NHS
 - (iv) GPs can be trusted to manage potential conflicts of interests arising from offering paid-for services to their NHS patients.
- 3.8 ENFIELD: That conference calls upon GPC England to strongly reject the proposal for a £10 charge to see a GP, as this would further widen health inequalities, increase administrative burden for practices and distance GPs from their patients.
- 3.9 BERKSHIRE: That conference believes the private healthcare sector in England has the potential to destabilise NHS general practice by expecting that the GP will pick up the pieces arising from fragmented, non comprehensive private healthcare models, and:
- (i) demands that the BMA make an assessment of the true costs to GPs of facilitating patients' movements in and out of the NHS
 - (ii) insists that any new contract allows GPs to bill for the time taken to facilitate patients moving into the private sector for an episode of care or returning to the NHS after an episode of care, these costs to be borne by the insurers where the patient's policy allows, or the patient themselves where it does not.
- 3.10 SANDWELL: That conference has previously mandated GPC England to prepare a fee per service contract to replace the unrestricted and unrestrictable block contract currently destroying GMS services and providers. Conference is:
- (i) dismayed that no such proposal appears to have been prepared or presented to the membership
 - (ii) insist that GPC England urgently bring all resources to bear to realise that vision
 - (iii) bring a fully worked alternative to special conference prior to any further negotiation with NHSEI.
- 3.11 SUFFOLK: That conference recognises the perilous financial position of many general practices and demands of GPC England to negotiate a mechanism whereby non-NHS private clinical services (such as minor cosmetic procedures or ear micro suction) can be offered to registered patients.
- 3.12 CUMBRIA: That conference believes:
- (i) the current state of general practice runs a very serious risk of GP practices seceding from their contracts and instead contracting directly with their patients
 - (ii) such a secession from contract may be attractive to GPs financially and in terms of workload but would be detrimental to population health and would radically change the NHS in a potentially fatal way.

- 3.13 DERBYSHIRE: That conference believes that practices should be able to charge their registered patients for private services where it can be demonstrated this improves access for NHS provision of care and where the patient is happy to pay.
- 3.14 GLOUCESTERSHIRE: That conference notes that consultation rates in England are double that of most comparable countries and agrees:
- (i) that a small charge per consultation with appropriate reimbursement for deprivation would reduce demand and free up time to see more patients in general practice
 - (ii) calls for the GPDF to vigorously promote implementation of this policy as fast as possible.
- 3.15 NORFOLK AND WAVENEY: That conference asks GPC England to oppose any political plan to charge patients who fail to attend their GP appointment, because it is unworkable, unnecessary, and wrong.
- 3.16 LIVERPOOL: That conference believes that in light of the growing concern over the cost of living crisis:
- (i) a move to co-pay or a private model of GP provision would be potentially detrimental to the health and well-being of the most vulnerable members of society
 - (ii) the most equitable system for primary care is an adequately funded, free at the point of use service.
- 3.17 DEVON: We need a fully worked up and viable plan B for a National swap over to private general practice. This would include a system whereby those with lower incomes could have state funding in order for them to be able to appropriately access primary care.
- 3.18 BEDFORDSHIRE: What does your LMC think is needed regarding non-NHS options/Plan B
- A properly researched investigation into other possible models and how a transition from the current model to a future model would work, not ideas based on anecdote and personal vitriol.
 - A realistic plan B – There is no appetite amongst our constituents for bringing the NHS to its knees in order to force a change (radically stopping NHS work is not possible) - therefore any plan needs to offer a pathway to a better future not an overnight revolution, eg practice being able to undertake non-NHS work for their own patients, in incremental stages (as has been done with the acute trusts?)
- (Supported by Hertfordshire)
- 3.19 NORTH STAFFORDSHIRE: As seen with the dentists, the NHS is willing to let a core primary service completely collapse and go private. This is de facto beginning to happen with general practice, with the acceptance of very low quality models with no GP partner ownership of quality. There does need to be on the shelf an alternative GP partnership model if and when the current system collapses or when waves of contracts are handed back.
- 3.20 AVON: Avon LMC considers this to be the nuclear option which may cause more irreparable damage to the root and branches of general practice and play into the government's hands. This option would involve the mass handing back of NHS contracts to NHSEI by practices and the LMC does not consider that this is a practical option.

- 3.21 HEREFORDSHIRE: Our LMC believes that restrictions on private services should be lifted, where appropriate and we should be allowed the flexibility allowed by other groups of providers such as dentists.
- 3.22 LEEDS: We do not believe a non-NHS GP service is viable if patients have to pay the full cost of prescriptions.
- 3.23 HILLINGDON: Options may have to be explored for a part state funded part insurance based model as a plan B if all other avenues are closed on us (hopefully not needed!). The privatisation of primary care in the NHS by other providers might be inevitable and GPs are demoralised and undervalued as a profession.
- 3.24 CUMBRIA: General practice is the bedrock of the NHS and needs to remain as a major force for change in the NHS. If practices were to leave the NHS, then the equity of access and provision, based on need, would be lost and continuity of care would be jeopardised. It would lead to significant financial risk and vulnerability for practices and open up the floodgates to private competition. There is no Plan B but general practice needs to take control of its own destiny to work within safe and realistic limits and be supported in doing so by GPC.
- 3.25 BRADFORD AND AIREDALE: Without major investment, general practice will continue to lose its current workforce. We are rapidly reaching the point where “plan B” related to private practice, similar to dentists will be the only economic option open to those with decades left to work. This used to be “unthinkable” now it is almost a preferred choice. Patients are voting with their feet already. The duty of a GP is to provide good medical care to their patients, not save the NHS, this is not a new debate, should we contract with patients directly to discover our true worth?
- 3.26 NORTH YORKSHIRE: Patients are increasing their use of private services to avoid delays. Our contract prevents us from benefitting from this market in the way consultants can. With good regulation, why should general practice not join the services currently available privately? This could be an option to facilitate practices continuing in the NHS and providing services if they could work privately in evenings and weekends. Plan B needs to be worked up, costed and presented as a step by step pathway by the BMA. The BMA needs to divorce itself from advocating the NHS – NHSEI and DHSC have utilised that mantra to abuse and break too many good GPs and the world-leading service previously provided.
- 3.27 LINCOLNSHIRE: We don't think this is a realistic prospect. While the information on how this could work will help inform colleagues, it feels like things would have to be even worse for this to be considered due to the concerns over long term impact on patient care and relationship.
- 3.28 DORSET: What does your LMC think is needed regarding non-NHS options/Plan B?
- To be avoided unless working within the NHS does not improve
- 3.29 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: What does your LMC think is needed regarding non-NHS options/Plan B ?
- Recognise the NHS is in crisis. Be mindful that Babylon Health has just handed back its contract - indicative of how financially unviable the current model of care is
 - Prefer to remain engaged with NHS options.

- 3.30 HAMPSHIRE AND ISLE OF WIGHT: What does your LMC think is needed regarding non-NHS options/Plan B?
- Variety of views. Concerns for the consequences for the NHS and patients if general practice left the NHS.
 - In particular concern private general practice would not be good for patients and would increase health inequalities.
 - However feeling it's getting closer to a critical mass of exit - either something is organised or there will be nothing left to save.
 - We may have reached the time for general practice to leave the NHS and to have contractual conversations with private healthcare providers/ large employers and consider a private pay per use system.
 - Options should be worked through so GPs can make an informed choice.
- 3.31 EALING: The danger is that the government seek to force GPs into a situation similar to NHS dentistry, where increasing numbers of patients feel they have to go private. This threat needs to be highlighted to the general public.
- 3.32 WIRRAL: We are not entirely certain what this is about but presumed this is about GPs opting for private health care provision instead of NHS services. Our LMC believes that this option should be pursued only as a last resort if the government (and the press) continue to treat GPs and their staff with disdain. It will require extensive consultation and planning to make it successful.
- 3.33 SANDWELL: There is manifestly no existing plan B, C, D or E. There is only plan A, (see above) or plan Z available to the profession at this point. Plan Z needs to outline the orderly dissolution and disbandment of NHS primary care in England. It needs to be co-ordinated in such a way that the extraordinary (but broken) practitioners you represent suffer no further economic, psychological, professional or other detriment.
- 3.34 GREENWICH: It is noted that in terms of private work many practices provide this already, eg private taxi medicals may be an important income stream.
- 3.35 LEWISHAM: Unfortunately we have not time to develop a workable Plan B.
- 3.36 CLEVELAND: Private practice is not accessible to the majority when there is a high level of social deprivation. There must always be a solution that protects the most vulnerable, both patients and practices. A non-NHS option is not supported.
- 3.37 SUTTON: More patients are considering private healthcare. Practices should have an opportunity to offer private GP services to help offset additional costs using a straightforward process. Considering options provided in other countries where patients pay a reimbursable fee could ensure appropriate use of general practice and NHS services. Sadly, the NHS being free at point of contact is becoming its own worst enemy. Practices being taken over by private providers should be looked upon as a failure of the healthcare system; failing both GPs and patients using the services appropriately with no changes currently being made to address the underlying issues.
- 3.38 WANDSWORTH: More open discussions with the population regarding the current state and challenges of the NHS including what can be done to alleviate this by looking at learning from private sector models/options. Currently the private sector is creaming off profits for making diagnoses and leaning on

NHS for service delivery, investigation, and ongoing care, this is a drain of public finance to private individuals whose business model is not sustainable without NHS GP backstop. This needs to be stopped. Where will the workforce come from - if one system cannot be staffed how will there be potential to staff 2 systems

3.39 MERTON: Costed options to provide a basic population based care service. This could be useful if the public could be made aware of what the alternative cost to them in primary care failed might be. Undated signed resignations from PMS / GMS contract holders. A primary care charter setting out specific and 'closed' limits of responsibility.

3.40 LAMBETH: Our LMC does not have Plan B. If not working for the NHS some would retire, some would seek to emigrate, and others would leave healthcare altogether.

3.41 BERKSHIRE: Regarding non-NHS options or "Plan B", we would suggest contracts be amended to allow practices to offer both NHS and private services to their patient lists.

GPC England need to be prepared to walk away from negotiations if progress not made on delivering outcomes of conference.

3.42 ENFIELD: I am not sure what this means, but I think it is about co-payments/ charging for GP appointments or a mix of payment options available within the NHS. I would be against this. It would be a dilution of NHS principles and the beginning of the end of NHS system. More investment through general taxation is required, not top ups of funding of those who can afford to pay.

3.43 CROYDON: Colleagues believe that the NHS should commission comprehensive NHS general practice services; without these, health inequalities will widen and patients risk receiving fragmented and inefficient care. Colleagues also believe GPs should be entitled to deliver private services, and current contractual restrictions should be removed. This would allow private provision as a choice although colleagues believe this would result in cross-subsidy to enhance NHS services, given colleagues commitment to these. Colleagues believe general practitioners are increasingly opting for non-NHS work. GPC England needs to support private general practice on an equal footing with NHS services, as the BMA does for consultant colleagues.

3.44 EAST SUSSEX: Colleagues believe that the NHS should commission comprehensive NHS general practice services; without these, health inequalities will widen and patients risk receiving fragmented and inefficient care. Colleagues also believe GPs should be entitled to deliver private services, and current contractual restrictions should be removed. This would allow private provision as a choice although colleagues believe this would result in cross-subsidy to enhance NHS services, given colleagues commitment to these. Colleagues believe general practitioners are increasingly opting for non-NHS work. GPC England needs to support private general practice on an equal footing with NHS services, as the BMA does for consultant colleagues.

3.45 KINGSTON AND RICHMOND: Colleagues believe that the NHS should commission comprehensive NHS general practice services; without these, health inequalities will widen and patients risk receiving fragmented and inefficient care. Colleagues also believe GPs should be entitled to deliver private services, and current contractual restrictions should be removed. This would allow private provision as a choice although colleagues believe this would result in cross-subsidy to enhance NHS services, given colleagues commitment to these. Colleagues believe general practitioners are increasingly opting for non-NHS work.

GPC needs to support private general practice on an equal footing with NHS services, as the BMA does for consultant colleagues.

(Supported by Surrey and West Sussex)

3.46 BUCKINGHAMSHIRE: Regarding Non-NHS options / “Plan B”, we need:

GPC to come up with a credible plan on how to manage the mass exodus of NHS GPs and estate in to private service provision if a contract that is acceptable to the profession cannot be negotiated.

This must include discussions with other providers like BUPA, AXA etc to look into new funding streams outside the NHS to allow patients to pay for GP services directly and indirectly through private insurance policies.

A credible Plan B and exit strategy stops the NHS from trying to call a possible bluff and makes successful NHS contract negotiations more likely and impositions less likely.

3.47 KENT: We believe (in a similar fashion to consultants) there needs to be a hybrid model allowing GPs to work in private practice alongside NHS work, to allow more flexible working to better attract newly qualified GPs and encourage retention in experienced GPs. This should not negate the need for a fully funded GMS contract.

3.48 SEFTON: Not much – that these are an ill-conceived and a self engineered threat to the NHS.

3.49 OXFORDSHIRE: Regarding non-NHS options / “Plan B” –

We note that in relation to primary care estates – NHSEI either needs to fully underwrite leases/financial risk of GP practice estates or allow the use of buildings for private work (with notional rent scaling according to how much is used for private work. It is invidious to prevent GPs from doing private work from their premises, if the NHS does not take on the financial risk associated with those premises.

We note the position of Dentists within the NHS with interest.

3.50 NEWHAM: Consider the key components of the crisis: workforce, funding and demand. GP Independence needs to be enhanced – the NHS commissions specific services but these can also be offered directly to individuals and employers. Any alternative plan needs to distinguish between same day and planned care. Funding would be based on true cost and capacity determined by the workforce available, not the current situation of a demand led service regardless of funding and safe capacity. Working conditions and staff wellbeing need to be recognised within any alternative plan to improve recruitment/retention which is currently one of the drivers for the crisis.

(Supported by City and Hackney, Redbridge, Tower Hamlets and Waltham Forest)

3.51 WIGAN: Not much – that these are an ill-conceived and a self engineered threat to the NHS.

3.52 GLOUCESTERSHIRE: Plan B is the only option, we are locked into an NHS that thinks it has a monopoly on GPs. NHSEI needs to understand that this is not the case The only model for 20 years has been relentlessly unacceptable working practices with micromanagement; too many targets; too many patient contacts per GP. The majority of Western Europe have a charge per patient contact with appropriate rebates for deprivation and a reduced consultation rate. Crucially, this largely leads to improved morbidity and

mortality rates. This could have the potential to save general practice by halving our workload effortlessly and rapidly.

3.53 NOTTINGHAMSHIRE: Whilst we support that the essence that a tax based, rationed system which is free at the point of access is the gold standard model of provision; the limited resources due to the chronic underfunding may necessitate other models being used to supplement it. The danger, however, is that over time, demand will continue to further outstrip capacity and the alternative models may end up gradually replacing the original one without anyone even noticing.

3.54 WORCESTERSHIRE: What does your LMC think is needed regarding non-NHS options/Plan B

There are too many stipulations in the contract regarding private services that could be offered from GP surgeries within core hours. This potential additional source of income could help to protect the independent contractor model without a move to a fully privatised service. Charging patients to attend an appointment would not be appropriate but wider public health measures such as initiatives to educate the public on when to attend the practice along with alternative sources of support could have an impact. Not enough is being done to tackle issues such as obesity through policy change or public health initiatives. A focus on prevention is key. Patients should be empowered to look after themselves. A well negotiated core GMS contract should not require a Plan B. If a salaried service were the only remaining option, we would not support vertical integration and would seek to find local solutions from within general practice.

3.55 SHEFFIELD: There is a strong feeling to stay within the NHS and for energies to be focused on this. There is no real desire to consider alternatives at present.

It is felt this could be facilitated and supported by a fairer system of taxation, discussions regarding expectations of a free at the point of contact service, and genuinely addressing the wider determinants of health. If there was a winding down of the partnership model the questions raised include:

- Where would primary care ownership move to?
- What would the negotiating path look like?
- Who would fund such a transfer?

3.56 CHESHIRE: Not sure this would address long term workforce problem or reduce the asks of practices. Let's get plan A correct.

ALTERNATIVE ACTION BREAK-OUT ROOM

4.1 BERKSHIRE: That conference:

- (i) demands that GPC England look at all available options for Industrial Action in the case that an agreement cannot be reached on a new contract
- (ii) expects that if full industrial action is considered not to be an option for the profession, GPC England will advise England's GPs to work within BMA safe working guidance until such time as agreement can be reached on a contract. This would necessarily include a recommendation that GPs have at least 15 minutes per appointment, and provide no more than three hours consulting per session, leaving 1 hour 10 mins for all other clinical administration per 4 hour 10 minute session
- (iii) recommends that clinical administration time should be ringfenced and not be used to increase capacity for direct patient contact activities.

4.2 TOWER HAMLETS: That conference believes that the current crisis in general practice is unprecedented and:

- (i) calls on GPC England to provide clear guidance to practice on how they close their practice list on the grounds of patient safety
- (ii) requires GPDF to fund legal support to any practice who receives a breach notice or other contractual action in relation to closing their practice list on the grounds of patient safety
- (iii) requires GPC England to negotiate that any practice whose list is closed on the basis of patient safety is still eligible to undertake and receive funding for any enhanced services
- (iv) calls on the unions to ballot the profession for willingness to collectively close their practice lists on the grounds of patient safety.

4.3 DEVON:

- Without breaching contract action which inconveniences commissioners / NHSEI not patients.
- Work to contract only.

4.4 BEDFORDSHIRE: What does your LMC think is needed regarding collective action/industrial action options?

At present there seems to be little appetite from our local GPs to undertake any sort of CA / IA. In order for this to change GPs would require:

- (i) clear information on what is meant by collective action / industrial action
- (ii) clarity on what they are taking action against / asking for – to date this has been far too vague and generic (ie we want NHS/the government to treat general practice better)
- (iii) what options are being proposed?
- (iv) what does success look like? How will GPC England measure if the desired outcome is achieved?

(Supported by Hertfordshire)

- 4.5 NORTH STAFFORDSHIRE: This needs to address unfunded workload and rigorous rebounding of inappropriate transfers of work. It also needs to be based on safety with consultation number caps and transfer of overflows of demand. Demand now is want driven and way above historical levels and is unsustainable. This is then destroying the current workforce, to which we have a higher duty of care.
- 4.6 AVON: Avon LMC as a Board is not supportive of industrial action but believes in strong and robust negotiation with government. During these difficult times it is essential that general practice does not alienate patients whose support is crucial. Using the non-NHS option is likely to be more powerful.
- 4.7 LEEDS: Local practices are not calling for industrial action and GP partners would not be willing to take the risk of doing this without trade union protection that is provided to employees.
- 4.8 HILLINGDON: There is not enough appetite amongst the profession for an all out strike/industrial action due to risk of patient harm. However there is backing for collective action. This could entail:
- (i) providing urgent care only/emergency appts only
 - (ii) pulling out of PCN DES
 - (iii) refer everything.
- Something needs to be done to save the independent contract model and stop GPs leaving the profession.
- 4.9 BRENT: The increase in practice appointments has not been formally recognised discussed or solutions proposed. Rather the converse with negative focus on GP access and schemes related to urgent access being developed. An example of this is the inclusion of this in ICS priorities.
- 4.10 LANCASHIRE COASTAL: Industrial action is not an option for GP practices. It is always difficult to coordinate any form of consistent action across all practices and the culture of general practice will always put patient needs first. Any form of action will alienate our patients and we need them on side. General practice is haemorrhaging experience and talent - there are many qualified GPs out there carrying a much reduced or no clinical load. We need to devise a model of general practice that meets reasonable needs of patients but within safe levels of working to reverse this trend.
- 4.11 BRADFORD AND AIREDALE: Industrial Action is a worst case scenario – no one will win, it is unlikely to achieve real change. A range of options is needed, with a clear understanding of the consequences of each option. How would we manage this – should it be co-ordinated with other BOPs? The ambition should be to break the “red line” of no new funding into global sum, the continuation of which makes PCNs a clear “existential threat” to the Independent Contractor model, as the PCN DES becomes financially obligatory for survival. Pay restoration should be a goal.
- 4.12 NORTH YORKSHIRE: We have already lost the battle with the public, who lack the appreciation and awareness of what is happening in the NHS / general practice. IA will not gain public support. There needs to be more investment into achieving collective action – to reject and resist workload shift, handing back non-profitable LESSs, or continue if a national negotiation of reasonable funding to include on-cost and surplus for development / income. Additional services are unlikely to gain support unless the financial modelling continues to deteriorate – eg childhood immunisations in QOF. If vaccinations were removed, many more GPs would support aggressive action. Choose carefully what we wish to withdraw!

- 4.13 LINCOLNSHIRE: There is some feeling that waiting lists in GP for different conditions may happen. Prioritising in such ways and the ICB / NHSEI and government seeing the outcry from patients would certainly send a strong message but again impact patient relationships and exposes colleagues to potentially more abuse. We do see, however, that significant resources are deployed to acute trusts when they have large backlogs and there is no good reason why this should not be the case in general practice.
- The alternative would be agreed safe working limits (without a cut in GMS funding) with additional demand being diverted elsewhere with the responsibility on ICS's responsible for this excess (This may be commissioned back into general practice with funding to allow additional workforce recruitment if possible).
- Both options cost money, neither address patient education on appropriate use of services or immediately help to resolve our workforce shortfall.
- All practices could create protected time in contracted hours for learning and wellbeing, again leaving ICBs to decide how to manage patient care in those times. Safe and sustainable practice and innovative general practice needs dedicated time to flourish.
- The age-old issue in any action is getting all colleagues on board. Patient safety and relationship concerns prevent many colleagues supporting any action. Finding the sweet spot is the million dollar question.
- 4.14 DORSET: What does your LMC think is needed regarding collective action/industrial action options?
- Mixed views on industrial action (Which is different to previously where there was pretty much consensus that IA was not an option)
 - A feeling that 'something must be done'. We can't continue as we are.
 - Perhaps collective action more realistic.
- 4.15 BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: What does your LMC think is needed regarding collective action/industrial action options?
- We had mixed views here. Some supported industrial action toward pay restoration and significant improvement in Terms and Conditions. Others did not support industrial action.
- 4.16 HAMPSHIRE AND ISLE OF WIGHT: What does your LMC think is needed regarding collective action/industrial action options?
- Some appetite - concern not enough though.
 - Suggestion need to stand up for ourselves - needs to be balanced against our role in society.
 - Acknowledgement we are better paid than many. Before action a clear outline of the ask, a full impact assessment on patient care, staffing and finance.
 - Concern over current lack of unified purpose and cohesion. Only do this as last resort.
 - Prefer - Better understanding from public and secondary care about what we can actually manage in general practice.
 - Our main purpose is not to help secondary care manage their waiting lists.
 - Across system work together cohesively.

- 4.17 NORFOLK AND WAVENEY: General practice is constrained by legal status from taking collective industrial action unlike our hospital colleagues. It may be more effective to support the junior doctors in their demands which ultimately is likely to have a beneficial effect on the workforce. The constant media and political bad-mouthing of GPs will always mean we are on the backfoot. The political pressure will mount when there is an escalation of practices collapsing this winter. Industrial action should be avoided especially at a time of hardship for many of our patients as it will not find public support.
- 4.18 HARROW: Given that GPs are not protected as partners from trade union rules, it would be better to have collective action regarding working strictly to our contract, and with support in collectively ceasing non contractual work.
- 4.19 EALING: If GPs leave PCNs or minimise their engagement with PCNs in a form of 'work to rule' this will undermine the government's NHS reforms. With a general election only around two years away, now may be the time to seek to pressure the government to address the crisis facing primary care and GPs.
- 4.20 SHEFFIELD: There is an overriding concern that collective action will impact patient care and will have little to no public support. Any action must be safe and considered, with minimal direct patient impact for these reasons.
- Options submitted to Sheffield LMC by constituents include:
- Declining all inappropriate workload requests out with core contract obligations.
 - Declining use of advice and guidance systems.
 - Declining all secondary care generated phlebotomy.
 - Declining all private work such as medical reports/medicals.
 - Switching all longer term stable medications where safe to 3 monthly issues.
- 4.21 WIRRAL: Opinions on this are divided in our LMC. Some people believe it is the only way government's attention could be adequately drawn to understand the various issues leading to the sorry state of general practice today (especially poor state of funding of general practice), and possibly secure a better deal for the profession. However, some believe industrial actions would undermine and damage the profession's reputation and lead to loss of support of our allies (the patients). Meanwhile, everyone agreed that it is a subject we should have grown-up debates on.
- 4.22 SANDWELL: It is incomprehensible to our LMC that the executive could contemplate anything less than an entirely new model of general practice, ready to offer the profession, and the country, at the next contractual juncture. The profession is made up of self-employed partners aka providers. No "strike" can achieve the level of charge required. The legislative hurdles make action almost impossible. The potential for adverse publicity for the profession would be overwhelming. The leaders of the profession should be able to manage the current crisis in a manner such that the true responsibility for the crisis and its mismanagement will become apparent.
- 4.23 GREENWICH: Taking that collective / industrial action is the very last resort when all negotiations have stalled.
- 4.24 LEWISHAM: We are anxious about the impact of remedial action on the relationship with our patients; however, we would consider 'red lines' which would include not doing work passed from secondary care to

primary care; and also supporting further development of moving services from the acute to the community, until there is real change to support general practice resilience and stability.

- 4.25 SUTTON: Whilst acknowledging general practice needs a stronger voice and the argument for industrial action, this is ethically and practically not a pragmatic option. Where will patients go? Is there a breach of contractual responsibility? Who will be responsible in a partnership? When will there be time for missed consultations to be delivered? Collective action to continue with a more uniform approach to resist unrealistic, non-deliverable contract changes, and refusing unresourced work bounced from hospital. Primary care cannot continue to be the default for delivery of all new initiatives and nationally declining/defaulting on inadequately funded DESs not serving general practice interests.
- 4.26 CLEVELAND: We should be “working to rule”, applying strict workload caps on our day, with overspill going elsewhere. We do not support full strikes, or withdrawal from any optional parts of the contract (DESs, QOF, etc) as this will have a negative impact on practice finances. Currently, we do not have the support of the public, who still believe that we are “hiding” due to Covid.
- 4.27 WANDSWORTH: With no public voice and engagement industrial action is likely to be misunderstood and may turn public opinion further against us. Need united front with NHS management, secondary and primary care.
- 4.28 MERTON: For industrial action to take place and be effective there would need to be a far greater degree of robust, clear and united messaging from the GPC England / BMA. This would require greater engagement with all members and significant and effective outreach from the leadership at a time when many GPs are too tired and burnt out to consider significant action. Possible actions include limiting hours of availability, declining all non-core NHS work and work which is not properly funded, limiting working hours for staff to a safe number of hours per day/week; resigning from the PCN DES en-masse.
- 4.29 LAMBETH: We think the press are not sympathetic to GPs, but public attitudes towards industrial action are shifting and collective action with other healthcare workers might be effective eg with junior doctors and nurses. If practices are no longer financially viable, we should tender mass contract resignation. Every GP and medical spokesperson must challenge every time the words "GP access problem" are uttered - it is not an access problem: it is a capacity problem.
- 4.30 BERKSHIRE: Regarding collective action or IA, we expect GPC England to explore all options for industrial action, should negotiations fail to achieve an acceptable outcome for the profession. Industrial must involve one or some of the following:
- (i) practices seeing a maximum of 25 patients per day as per BMA safety guidance and "working to rule". These patients will be face to face appointments only, and brought down to sit in the waiting room
 - (ii) stopping all shared care work
 - (iii) rejecting work delegated without agreement by secondary care
 - (iv) closure of patient lists
 - (v) LMCs to gather unsigned resignations from the constituent practices and holding them in case required
 - (vi) full, walk out strike.

- 4.31 HARINGEY: GPC England needs to open a discussion about ways in which GP partners can take industrial action in a way likely to be acceptable to most GPs. Ideas may include prescribing of all branded meds, non-compliance with script-switch and other medicines management directives, strict adherence to BMA recommended number of contacts per day (deferring to ED / WIC when we are full) or a lowered threshold for referrals. But conference expects that the GPC England will be able to come up with many more similar ways in which partners can take industrial action.
- 4.32 BARNET: Disillusioned that practices will not take any action that would affect change. The polio vaccine is an example-most practices have signed up as there is some money involved, despite the unfair ask. It is bad but practices still seem to be managing, and it needs to get worse before practices will agree to any action.
- 4.33 ENFIELD: I think industrial action needs to be done properly or not at all. Previous half-hearted industrial actions have not worked. I don't think there is the appetite for full on industrial action.
- 4.34 CROYDON: Colleagues believe this should be a pre-considered suite of available options. A minority believe this should be a visible threat – especially should other branches of practice pursue this option. Colleagues are very reluctant to pursue any action that directly effects the provision of patient care, believing this unprofessional and risks irretrievable reputational damage. Action that would ‘disrupt the system’ is warranted as general practice is being taken for granted. Salaried colleagues wouldn’t enter a dispute with partnerships over a national issue. Partners would need the explicit assurance of Union support given the risk of NHS England responding with contract sanctions.

(Supported by East Sussex, West Sussex, Surrey and Kingston and Richmond)

- 4.35 BUCKINGHAMSHIRE: Regarding collective action / IA, we need to consider:
- refusing non-core services
 - refusing travel immunizations,
 - refusing to provide private letters, for example completing private insurance letters, and DVLA “fitness to continue to drive” statements.
- 4.36 KENT: There is no appetite for industrial action among our membership and we are concerned about the message this would send to our communities and would inevitably lead to a surge of work the following day. We would support collective action that means GPs and practice teams working to a safe workload limit. We support limiting the relentless and unlimited push for increasing access to general practice at the cost of staff wellbeing and continuity of care. We believe the numbers of GPs retiring early, reducing clinical sessions, or choosing to leave is in itself a form of action.
- 4.37 SEFTON: The recent experience of bungled and woefully unsupported call for GPs to take boycott forms of action demonstrates that this MO is not viable in the context of GPs.
- Better is the alternative strategy of action, which involves an “over participation” in the system - by both GPs and their representative organisation on an agenda of demands - which it cannot refuse.
- 4.38 OXFORDSHIRE: Regarding Collective Action / IA options –
- We note that GP partners in particular do not seem to have the ability to go “on strike”.

- 4.39 DERBYSHIRE: Industrial Action is unlikely to be successful and will not be popular with the public. Collective action short of industrial action has a place and should be considered.
- 4.40 REDBRIDGE: CA/IA does not work unless there is followership; there is little value in trying to implement CA unless there is sufficient local support. There will not be one single unifying CA covering all practices in England. Local engagement between the GPC England regional representatives and their practices needs to occur to determine what local action practices are prepared to undertake. The role of the BMA / GPC England will be to support and back up the different local actions so that in total there is national action. Our focus must be on the impact the current trajectory of general practice will have on patient safety.

(Supported by City and Hackney, Newham, Tower Hamlets and Waltham Forest)
- 4.41 WIGAN: The recent experience of bungled and woefully unsupported call for GPs to take boycott forms of action demonstrates that this MO is not viable in the context of GPs. Better is the alternative strategy of action which involves an 'over participation 'in the system - by both GPs and their representative organisation on an agenda of demands - which it cannot refuse.
[notes:///ClientBookmark?OpenWorkspace&id=13](https://ClientBookmark?OpenWorkspace&id=13) Databases
- 4.42 GLOUCESTERSHIRE: Any action requires a clear goal, supportable by the whole profession; clarity on delivery plus support from GPDF / GPC England; extensive communications/social media investment. This will provide confidence for all practices to join and declare their agreement. Emphasis on maintaining patient safety throughout, whilst making it clear that patient safety is an inevitable casualty if the destruction of general practice continues. LMCs require full support; straightforward instructions both practically and legally to enable them to lead and assist practices; media training for key GPs leading to confidence to speak and engage; co-ordinating actions from the BMA and GPC England.
- 4.43 NOTTINGHAMSHIRE: Whilst we acknowledge that patients may be placed at risk of harm as a result of industrial action; what is certain is that they are being placed at harm as a result of the government not listening to the voice of the profession. No one thinks that striking is in anyone's best interests. Industrial action is reserved an action of last resort but we feel it is justified as all other reasonable options have been repeatedly exhausted and the unilateral will of the government is being forced on us to the detriment of the safety of patients and GPs.
- 4.44 WORCESTERSHIRE: What does your LMC think is needed regarding collective action / industrial action options?

We think this ship has sailed. Practices are struggling to manage soaring demand and both retention and recruitment are difficult with many colleagues burning out under excessive workloads. The only type of collective action we would want to see now is something practical that would reduce our workload immediately. For example, uniting behind not accepting transferred work from secondary care would unite the profession, reduce the workload and have long lasting effects. Increasing appointment lengths is desirable but the demand will remain the same unless more is done to address it and patient expectations. We must focus more of our attention on informing the public of the reality we are facing and try to bring them along with us. Our goals are fundamentally the same ie Continuity of care, local services tailored to local need, time with the GP when they need it. Taking action without public support would be foolish and detrimental to the profession.
- 4.45 CHESHIRE: The mood has not changed yet with regards to CA / IA. It's not clear what it would achieve. There would be other ways of influencing the system if/when required.