

**Conference of  
Representatives  
of Local Medical  
Committees**

**Agenda**

Hanging on by a thread

**Thursday 18 and  
Friday 19 May 2023**  
The Light: Friends House, London

# Conference of Representatives of Local Medical Committees

## Agenda

To be held on

**Thursday 18 May 2023 at 10.00 and Friday 19 May 2023 at 09.00**

To take place at The Light, Friends House, 173-177 Euston Road, London NW1 2BJ

**Chair** Katie Bramall-Stainer (Cambridgeshire)

**Deputy Chair** Matthew Mayer (Buckinghamshire)

### **Conference Agenda Committee**

Katie Bramall-Stainer (Chair of Conference)

Matthew Mayer (Deputy Chair of Conference)

Ursula Brennan (Eastern, Northern Ireland)

Paul Evans (Gateshead and South Tyneside)

Rachel McMahon (Cleveland)

Shaba Nabi (Avon)

Bethan Roberts (Bro Taf)

Euan Strachan-Orr (Liverpool)

Alastair Taylor (Glasgow)

## Members of the UK LMC Conference Agenda Committee 2023

**Dr. Katie Bramall-Stainer**



*Chair of the Agenda Committee*

Katie Bramall-Stainer is your elected chair of the Annual Conference of Representatives of LMCs. A salaried GP in Hoddesdon, Katie's primary role is Chief Executive of Cambridgeshire LMC. Katie also sits as an *ex officio* member of GPC U.K. and GPC England and is an elected member of BMA Council representing the Eastern region.

**Dr. Matt Mayer**



*Deputy Chair of the Agenda Committee*

Matt Mayer is Deputy Chair of the Annual Conference of Representatives of LMCs. A portfolio GP from Buckinghamshire, Matt works as a locum and out-of-hours GP. Aside from his clinical roles, Matt works as Co-Chief Executive Officer of Berkshire, Buckinghamshire & Oxfordshire (BBO) LMCs. He sits *ex officio* on GPC UK and GPC England, and also serves on the Agenda Committee of the England Conference of LMCs.

**Dr. Ursula Brennan**



*Member of the Agenda Committee*

Ursula Brennan is the Northern Ireland representative of UK LMC Agenda Committee. She is a GP Portfolio Partner working in Belfast. She works 6 clinical sessions in addition to her representative roles Chair of the Eastern Local Medical Committee, member of the Northern Ireland GP Committee and member of the South Belfast GP Federation Board since it's inception

**Dr. Paul Evans**



*Member of the Agenda Committee*

Paul has now been a civilian GP for nearly a decade and is attempting to learn to play nicely with normal people, sometimes even those on the other side of the commissioning divide. He likes LMCs (particularly Gateshead and South Tyneside and NE regional, which he chairs), clinical work (including OOH), independent contractor status, dogs and running. He dislikes unfunded work, renegeing on contracts and integrity failures. He also really likes Conference.

**Dr. Rachel McMahon**



*Member of the Agenda Committee*

Rachel is the matriarch of the agenda committee. She loves variety, working as a GP locum, GP appraiser and Interim CEO of Cleveland LMC. She is also an elected member of the Sessional GPs Committee. Her main passion in life is running, usually up hills over the North Yorkshire Moors for most of the day.

**Dr. Shaba Nabi**



*Member of the Agenda Committee*

Shaba is an Essex girl who has relocated to Brizzle. She is the current Chair of the England Conference of LMCs. Her passions include: dance music, medical politics and education - in that order. What winds her up is a lack of democracy and transparency.

**Dr. Bethan Roberts**



*Member of the Agenda Committee*

Bethan is a salaried GP in Caerdydd/Cardiff, mainly found behind bars. She is a member of Bro Taf LMC and co-chair of the BMA's sessional GP committee.

This is Bethan's second year flying the flag for Cymru on the agenda committee.

**Dr. Euan Strachan-Orr**



*Member of the Agenda Committee*

Euan Strachan-Orr is a locum GP working across Merseyside in a variety of in and out of hours roles, primarily in the Liverpool area. This is his first year as an elected Agenda Committee member of the Annual Conference of Representatives of LMCs. Euan previously chaired the BMA GP Trainees committee, alongside sitting on GPC UK and England, and remains an *ex-officio* GP Trainees committee member as immediate past chair. He is a member of Liverpool LMC.

**Dr. Alastair Taylor**



*Member of the Agenda Committee*

Alastair Taylor is the Scottish representative on the UK LMC Agenda Committee. He is a 5 session GP Partner in addition to his representative roles which include: Treasurer of Glasgow Local Medical Committee, member of the Scottish GP Committee and Chair of Scottish LMC Conference.



## NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 28 February 2023. Although 28 February 2023 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent [via the link](#) by 12noon Tuesday 16 May.

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

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

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

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

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

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

Item	Deadline for submission
<a href="#">Chosen motions</a> (see note below)	12noon on Tuesday 16 May
<a href="#">Notification of rider</a>	12noon on Tuesday 16 May
<a href="#">Notification of amendment</a>	12noon on Tuesday 16 May
<a href="#">Emergency motions</a>	12noon on Tuesday 16 May

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

## Elections at LMC UK conference

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

1. Chair of LMC UK conference 2024
2. Deputy chair of LMC UK conference for 2024
3. Seven members of the LMC UK conference agenda committee 2024  
*At least one of whom shall represent each of the four UK nations and not more than one of whom shall be a sitting member of the GPC UK*
4. Seven members of the UK general practitioners committee 2023-2024
5. One 'early career' GP to be co-opted to the UK general practitioners committee 2023-2024
6. Forty-seven members\* to attend the Annual Representative Meeting (ARM) of the BMA in Liverpool, 3-5 July 2023

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

### Eligibility—to vote in BMA elections

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

Only LMC representatives are eligible to vote in the election to GPC UK.

### Election schedule

#### Nominations

Nominations open for representatives to GPC UK 2023-24 – **12pm Thursday 13 April 2023**

Nominations close for representatives to GPC UK 2023-24 – **12pm Thursday 11 May 2023**

Nominations open for representatives to the ARM 2023 – **12pm Thursday 20 April 2023**

Nominations close for representatives to the ARM 2023 – **12pm Monday 1 May 2023**

Nominations open for all other positions – **10am Wednesday 17 May 2023**

Nominations close for all other positions – **11am Friday 19 May 2023 (2<sup>nd</sup> day of conference)**

#### Voting

Voting opens for representatives to the ARM 2023 – **12pm Tuesday 2 May 2023**

Voting closes for representatives to the ARM 2023 – **12pm Tuesday 9 May 2023**

Voting opens for representatives to GPC UK 2023-24 – **5pm Thursday 18 May 2023** (1<sup>st</sup> day of conference)

Voting opens for all other positions – **12pm Friday 19 May 2023** (2<sup>nd</sup> day of conference)

Voting closes for *all* positions – **3:30pm Friday 19 May 2023** (2<sup>nd</sup> day of conference)

Results will be published shortly after voting closes apart from the Agenda Committee election which will be announced after the ARM.

For more information, please see the attached guidance (appendix 1) or email the Elections team at [elections@bma.org.uk](mailto:elections@bma.org.uk).

## Schedule of business

Thursday 18 May 2023

Item	Time
Opening business	10.00
Guest speaker	10.20
Survival of general practice	10.40
GMC	11.00
Cost of living crisis	11.10
Collapse of the NHS	11.20
UK Chairs: Sessional GPs report	11.50
GP working schedules	12.00
UK salaried model contract	12.20
Lunch	12.40
The Cameron Fund	13.50
The role of the expert generalist	14.00
Primary care	14.10
Primary care doctors – Major Issue Debate	
Introduction	14.20
Major issue debate	14.30
UK Chair: GP trainee report	15.20
Future of GP training	15.30
GP recruitment and retention	15.50
MRCGP	16.20
GP trainees conference	16.30
LMC support network briefing	16.50
Close	17.00

## Friday 19 May 2023

<b>Item</b>	<b>Time</b>
UK Chairs: GPC UK report	09.00
GPC UK	09.10
GPDF: Chair's report	09.20
Plenary session – Governance of LMCs	09.30
Plenary feedback and questions	10.00
LMC governance	10.10
Professional standards	10.20
Public health	10.30
Death certification	10.40
Soapbox	11.00
Formats for conference workshops	11.40
Lunch	12.20
Claire Wand Fund	13.40
Future formats for conference	13.50
The independent contractor	14.00
Firearms	14.20
Private practice	14.40
Pay restoration	15.00
Chosen motions	15.20
New business	15.30
Closing business	15.50
Conference close	16.00



## OPENING BUSINESS

10.00

## RETURN OF REPRESENTATIVES

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

## STANDING ORDERS

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

## REPORT OF THE AGENDA COMMITTEE

- 3 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the report of the agenda committee be approved with permission to again include an election for an 'early career' GP to GPC UK for the 2023-2024 session.

## GUEST SPEAKER

10.20

## SURVIVAL OF GENERAL PRACTICE

10.40

To submit a speaker slip for Motion 4 – [please click here](#)

- \* 4 CAMBRIDGESHIRE: That conference requests that the BMA supports GPC UK by undertaking a series of FOI requests to:
- (i) determine the number of practices which have been dispersed; merged; novated; or reprocured via APMS across the UK
  - (ii) determine the total cost of NHS-funded management consultancies across the UK since the contracts were devolved to single nations
  - (iii) extrapolate how many patients are now 'without' a GP assuming recommended ratio of 1 whole-time equivalence to registered list size
  - (iv) then publicise the real crisis around a depletion of patient choice, and fractured continuity of care by the destruction of general practice.
- 4a NORTHERN IRELAND EASTERN: That conference deplores the unrelenting toxic media stories about primary care and condemns the repeated attack, insult and scapegoating of general practice across the media and instructs GPC UK to publicly support and defend dedicated GPs and primary care staff against the onslaught of misinformation and abuse promoted by the media.

- 4b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that to support the development of general practices in all UK nations that the GPC UK produces or commissions a report on the arrangements for general practices across all western countries to include a description of scope of work, remuneration, training and a description of the pros and cons of each system.
- 4c KENSINGTON, CHELSEA AND WESTMINSTER: That conference has concerns that the role and value of general practice are not always understood, to the detriment of our patients and our profession. Conference calls on all four nations of GPC to work with RCGP to produce:
- (i) an agreed concise definition of the role and value of general practice and the GP practice
  - (ii) and implement a plan for dissemination to all stakeholders.
- 4d LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes that the constant vilification of general practice in the news and by politicians is adversely affecting the mental health and job satisfaction of GPs, and the doctor-patient relationship. The GPC UK supported by the GPDF must undertake an ongoing press campaign including funding adverts to promote general practice and reverse the negative perceptions.
- 4e LEEDS: That conference is seriously concerned that no nation within the UK is adequately funding general practice to provide a safe service for patients, believes this is therefore a national emergency and calls on the Treasury to take immediate actions to address this or accept that they are responsible for patient harm.
- 4f LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference rejects that there is a problem with access to general practice, but that there is a problem with an imbalance between demand and capacity across the whole of the UK which can only be resolved by politicians.
- 4g GLOUCESTERSHIRE: That conference notes that demand to see a GP is greater in the UK than most comparable nations and asks GPC UK to carefully consider the reasons and adopt policies to reduce demand.
- 4h CLEVELAND: That conference:
- (i) believes that demand on general practice is unsustainable and unsafe
  - (ii) believes that some patients have unrealistic expectations of general practice
  - (iii) insists that clinically appropriate over the counter medications are made directly available to patients at the same cost as their prescription items
  - (iv) mandates UK governments to launch a public facing campaign educating patients about the safe and appropriate use of GP services.
- 4i TOWER HAMLETS: That conference recognises the efforts of our secondary care colleagues in trying to reduce the out-patient and treatment waiting lists brought about by the Covid pandemic and:
- (i) notes that unlike general practice, secondary care is not being publicly judged on the basis of the proportion of face to face to telephone consultation it is offering in trying to address the backlog
  - (ii) recognises that general practice is supporting attempts to reduce waiting lists by engaging with advice and guidance and in doing so is providing more complex care to patients
  - (iii) requires GPC UK to work with other branches of practice in publicising the work being done by general practice in trying to reduce waiting lists
  - (iv) requires GPC UK to negotiate with the 4 national NHS systems that all appointment data is reported on the basis of 'per WTE GP' not just as 'per 1,000 patients'.

- 4j NORTH ESSEX: That conference asserts that the current focus on access alone not only ignores capacity and hence clinical safety but reduces general practice to a same-day minor illness service. This neglects the multigenerational care with excellent continuity that has been the greatest contribution that the NHS has made to the health of the nation for decades. Conference mandates GPC UK to protect continuity and complex general practice across the UK by:
- (i) supporting devolved national GPCs to reject any access targets in forthcoming contract negotiations
  - (ii) promoting and developing methods of workload capping to allow a better balance between capacity and complexity
  - (iii) working with the BMA and GPDF to develop strong public messaging regarding the need for continuity above access.

## GMC

11.00

To submit a speaker slip for Motion 5 – [please click here](#)

- \* 5 GATESHEAD AND SOUTH TYNESIDE: That conference thanks the GMC for confirming they will not act against junior doctors taking industrial action and demands that the same pledge be extended to GPs, should they also invoke their legal right to take industrial / coordinated action.

## COST OF LIVING CRISIS

11.10

To submit a speaker slip for Motion 6 – [please click here](#)

- \* 6 NORTHERN IRELAND CONFERENCE OF LMCs: That conference notes with dismay the destabilising effect of rapidly increasing expenses and energy costs which are being absorbed by GP practices and instructs GPC UK to negotiate an urgent package of support measures for all practices.
- 6a CONFERENCE OF ENGLAND LMCs: That conference believes that the rise in energy prices is having a catastrophic impact on the financial viability of GP practices and calls for in-year intervention to address these inflationary pressures, which were unforeseen at the introduction of the current GP core contract.
- 6b NORTHERN IRELAND CONFERENCE OF LMCs: That conference notes with dismay the destabilising effect of rapidly increasing expenses and energy costs which are being absorbed by GP practices and instructs GPC UK to negotiate an urgent package of support measures for all practices. AND RUTLAND: That conference is concerned that failure to recognise the current significant cost of living pressures including for energy and staff costs across the UK will destabilise general practices, cause more independent contractor GPs to leave, and have a negative effect on health care for patients. We therefore demand that no GPC in the UK accepts any negotiated deal for 2023 / 24 unless these cost pressures are fully recognised.
- 6c AVON: That conference knows that the rising cost of living has had an adverse effect on the viability of practices. The government needs to uplift the GP contract to cover the increasing costs including the cost of water, gas and electricity. GPC is mandated to negotiate with government a cost-of-living increase in the GP contract.
- 6d MERTON: That conference calls upon government to recognise the existential threat to the viability of general practices of unprecedented increases in energy expenses and to provide financial support for those affected.

- 6e CLEVELAND: That conference expresses grave concern about the hidden crisis in the cost of running a GP practice and calls for urgent action from each of the UK governments to ensure practices remain financially viable.
- 6f LOTHIAN: That conference is dismayed that enhanced service payments have not kept up with costs and that this needs to be addressed urgently to help maintain high quality patient care.
- 6g OXFORDSHIRE: That conference demands that the total funding to an NHS general practice must be increased annually in line with nationally recognised pay body awards.
- 6h HERTFORDSHIRE: That conference calls on GPC to negotiate the re-introduction of a practice expenses reimbursement scheme to manage the increasing costs of utility bills and expenses, and to support the provision of an appropriate clinical environment to provide high quality patient care.
- 6i AVON: That conference considers the rise in the national minimum wage and inflationary wage rises affecting major business. Conference asks GPC to negotiate inflation linked funding for staffing costs to enable all practices to pay all staff a living wage, since practices are unable to pass these costs on to the "customer".
- 6j LAMBETH: That conference believes all contracts should be priced so that all staff can be paid at least the real living wage and calls on both GPC and local negotiators to make this a criterion in negotiations.
- 6k DEVON: That conference has serious concerns with regards with the lack of satisfactory funding increases in all UK Nations to reflect the cost-of-living crisis that staff and patients are experiencing. The private sector is now financially more attractive and staff at all levels are haemorrhaging out of general practice which must be halted.
- 6l NOTTINGHAMSHIRE: That conference deplores the unmitigated rising costs of running a practice due to a combination of living wage rises, energy bill rises, cost of living and urges GPC to negotiate emergency funding to help to offset the costs.
- 6m HULL AND EAST YORKSHIRE: That conference demands equality between acute trusts who are able to operate in financial deficit, and general practice and calls for:
- (i) each government to offer a financial hardship package of support for practices facing insolvency
  - (ii) practices not to be penalised or threatened with remedial notices if they declare themselves in financial distress
  - (iii) public recognition from government that the financial instability of practices will lead to healthcare worker redundancies and a direct negative impact on patient care.
- 6n MERTON: That conference recommends the GPC should negotiate full funding for primary care of pay rises that are nationally mandated for salaried staff.
- 6o NORTH AND NORTH EAST LINCOLNSHIRE: That conference condemns the commitment by governments to increase the wages of employees of general practice without any mechanism to increase core funding in a commensurate uplift.
- 6p KENT: That conference demands the GPC negotiate a mechanism for ensuring that contractual annual uplifts precisely reflect changes to practice expenses.
- 6q GATESHEAD AND SOUTH TYNESIDE: That conference recognises the burden of energy costs upon both practices and patients, and calls for the rapid, large-scale investment in low / zero-carbon energy required to enable better health delivery for GPs and health outcomes for their patients.

To submit a speaker slip for Motion 7 – [please click here](#)

- \* 7 AGENDA COMMITTEE TO BE PROPOSED BY FORTH VALLEY: That conference acknowledges patients are increasingly seeking healthcare privately, including travelling abroad for surgery. We call on the GPCs to work with appropriate authorities and stakeholders to:
  - (i) ensure patients are not required to seek approval from their NHS GP prior to accessing private healthcare
  - (ii) obligate private providers to inform patients of the total cost of recommended investigations, treatments and follow-up, highlighting these may not be provided by their NHS GP
  - (iii) obligate private providers to act upon investigations undertaken, and not simply pass results or further management suggestions onto NHS GPs to action
  - (iv) ensure that those who cannot access required follow up are not left without adequate specialist care
  - (v) ensure any involvement in a patient's care by an NHS GP as requested by a private healthcare or insurance provider is remunerated appropriately.
  
- 7a FORTH VALLEY: That conference acknowledges that there are increasing demands from private health care providers to GP practices and asks that all the GPCs negotiate with their respective bodies so that guidance is formed for private health care providers to ensure:
  - (i) private providers must be up-front to patients what the cost of a whole episode of care is and not just the initial consultation
  - (ii) private providers must tell patients before embarking on an episode of care that follow up monitoring and prescriptions may not be provided by the NHS and that they should check with their practice if this is possible before deciding if they wish to continue privately
  - (iii) care that would be delivered by specialist services in the NHS is not passed on to GPs by private providers with expectation that general practice will be able to do this.
  
- 7b NORTH AND NORTH EAST LINCOLNSHIRE: That conference believes patients should be able to self-refer to private providers without involvement from their NHS GP.
  
- 7c GLASGOW: That conference notes the increasing demands being made on GP practices following patients having undergone surgery in the private sector, both in the UK and abroad, and:
  - (i) notes that specialist follow up is not the work of general practice
  - (ii) deplores the lack of specialist follow up care that is being provided to those patients
  - (iii) calls on the relevant bodies to develop pathways for accessing specialist services to ensure that those who cannot access private specialist follow up are not left without adequate care.
  
- 7d BUCKINGHAMSHIRE: That conference believes that:
  - (i) requirements to seek NHS GP approval prior to allowing a patient to see a private healthcare provider operate as a triage tool of the insurance industry to reduce its costs without appropriately reimbursing the NHS or NHS GP surgeries for the time and workload such requests generate
  - (ii) patients should not be required to seek approval from their NHS GP prior to being referred to a private healthcare provider
  - (iii) patients who wish to be referred to a private healthcare provider should be able to have this approved directly through their insurance provider's internal processes without the need to seek any form of unfunded approval from the NHS GP
  - (iv) any involvement of the NHS GP by a patient's private insurance provider should be remunerated appropriately.

- 7e LOTHIAN: That conference calls on the GPCs to work with appropriate authorities to ensure that private healthcare providers have an obligation to arrange and act upon any investigations which they feel appropriate following a consultation, rather than simply write to GPs with lists of suggested investigations.
- 7f OXFORDSHIRE: That conference:
- (i) believes the NHS principle of separation is being eroded, as patients access private care and then seek to exercise their right to return to NHS services
  - (ii) believes that long waiting lists for NHS secondary care are driving patients to access private secondary care, including some patients who cannot afford comprehensive care in the private sector
  - (iii) believes that patients returning to NHS services from a private episode of care should have their needs reassessed by a competent clinician within the NHS system
  - (iv) believes that NHS GP time and resource should not be used to deliver formal “shared care” arrangements with private providers
  - (v) calls for BMA to provide national guidance on the interface between NHS and private sector care, similar to existing BMA guidance on the primary and secondary care interface.
- 7g CENTRAL LANCASHIRE: That conference believes patients are increasingly choosing to seek investigations and treatment outside of the NHS due to lengthy NHS waiting lists and local commissioning gaps and where this is the case, subsequent requests for GPs to undertake aftercare via blood tests and monitoring:
- (i) are unsafe
  - (ii) are unethical
  - (iii) are unresourced
  - (iv) should be challenged unless commissioned appropriately.
- 7h AVON: That conference implores the health departments of all four nations to ensure that patients who undergo specialist surgical procedures abroad are able to access appropriate specialist follow up in the UK rather than this responsibility falling to GPs without the competence or resource to take on this work.
- 7i HERTFORDSHIRE: That conference calls on GPC to make it clear that private providers asking GPs to do tests and administration they require is unfair and an inappropriate abuse of strained NHS resources.11.50
- 7j CAMBRIDGESHIRE: That conference calls upon:
- (i) the national GPCs to petition the Treasury to act with immediate effect to provide ongoing recurrent additional funds for ‘deep end practices’ given the deterioration in the inverse care law
  - (ii) the RCGP to do similarly, given that fewer than a third of UK deep end practices are thought to be training practices thereby further impacting recruitment.
- 7k BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE: That conference believes that current shortage of GPs, both due to the attrition rate and inadequate workforce planning, is not only extremely alarming but also threatening patient safety. We note the worsening workforce situation is likely to be worsening GP recruitment and retention initiatives. We therefore call on those responsible in all four nations to:
- (i) adequately assess numbers of those entering UK medical schools and plan adequately sufficient numbers taking into account all factors such as likely working patterns of future graduates
  - (ii) report accurately and truthfully the actual numbers of fully qualified GPs working in the NHS from workforce data
  - (iii) take a balanced rather than media led approach to workforce planning and attitude towards general practice.



- 7l BUCKINGHAMSHIRE: That conference believes that:
  - (i) the NHS is broken
  - (ii) the NHS is broken beyond repair.
- 7m CAMBRIDGESHIRE: That conference:
  - (i) reiterates 2018 policy that the future of the profession should take precedence over the future of the NHS
  - (ii) maintains that general practice is not broken, the problem is that it is being destroyed, leading to a shortage of GPs and a lack of funding
  - (iii) determines that the hospital model is broken, in spite of the significant uplift in both the number of consultants and funding
  - (iv) resolves that any NHS transformation needs to begin with doubling investment of out-of-hospital care, starting with general practice and social care, as evidenced by the Dartmouth Center Research.

## UK CHAIRS: SESSIONAL GPs REPORT

11.50

## GP WORKING SCHEDULES

12.00

To submit a speaker slip for Motion 8 – [please click here](#)

- \* 8 CONFERENCE OF ENGLAND LMCs: That conference:
  - (i) believes referring to GPs as “full time”, “part time”, or “full time equivalent” in terms of numbers of “sessions” worked fails to capture the real hours worked by many GPs
  - (ii) demands that any new BMA model contract or new GMS contracts define GP working schedules in terms of hours rather than sessions
  - (iii) demands that any workforce data collection (eg for NHS workforce planning) be done on the basis of hours worked, not contracted sessions.
- 8a GLOUCESTERSHIRE: That conference calls for GP working time to be calculated in actual worked hours, rather than outdated sessional time, which grossly under represents the work of GPs. In doing so workloads can be accurately demonstrated, helping public perception, accurate workforce planning can be undertaken and fair discussions around remuneration can be held.
- 8b DERBYSHIRE: That conference notes from experience that six patient facing sessions in general practice together with the associated clinical administrative and liaison burden takes at least 37.5 hours a week to complete and from henceforth six patient facing sessions will be considered “FULL TIME” and that GPCs negotiators must adopt this policy.
- 8c AVON: That conference asks that the public reporting of GPs working week is referred to in typical hours worked and no longer in sessions or days in order to convey to the public that most GPs work compressed hours not 'part time'.
- 8d DORSET: That conference acknowledges that clinical sessions represent only a fraction of true GP workload and calls for introduction of:
  - (i) consultant style PA sessions with protected time to undertake admin, CPD, service improvement and leadership roles
  - (ii) workforce planning that acknowledges and addresses this
  - (iii) media comms to dispel the myth that all GPs are working part time.

- 8e DORSET: That conference is extremely concerned about the continuing decline in the GP workforce with many colleagues choosing to leave in mid-career. It calls on the Health Improvement Organisations in each of the four nations, such as NHSEI in England and Healthcare Improvement Scotland to undertake an urgent GP workforce review to:
- (i) better understand true GP workforce numbers
  - (ii) understand how many hours GPs are working each week (clinical and non-clinical)
  - (iii) conduct exit interviews for all GPs leaving or reducing sessions to understand why
  - (iv) commission independent modelling to accurately assess what current and future GP numbers are required to deliver safe, effective general practice under the current or any future contract.
- 8f DERBYSHIRE: That conference recognises that clinical administration is a necessary part of safe patient care, and the GP contract must be revised to explicitly reflect the clinical administrative burden that follows each patient facing session of clinical activity akin to administration programmed activities found in the hospital consultant contract. It instructs GPCs to negotiate accordingly.
- 8g NORTH YORKSHIRE: That conference demands the narrative around workload and demand in general practice needs to change and insists GPC lobby NHSE to report metrics from data captured of the demand in general practice alongside secondary care data.
- 8h SOMERSET: That conference is dismayed by the HMG's apparent disbelief in the scale of the crisis in general practice and demands that:
- (i) any new core contract should encourage the collection and sharing of high-quality data around practice work and pressure
  - (ii) this data should be considered by all system partners before changes are made which may impact upon general practice workload
  - (iii) data collection and analysis should be adequately resourced.

## UK SALARIED MODEL CONTRACT

12.20

To submit a speaker slip for Motion 9 – [please click here](#)

- \* 9 **AGENDA COMMITTEE TO BE PROPOSED BY GP TRAINEES COMMITTEE:** That conference believes that the model contract for salaried GPs must be strengthened, with improved advised rates of pay, and calls on GPC UK and the Sessional GP Committee to:
- (i) rapidly arrange mechanisms to renegotiate the model contract, with ongoing review reinstated
  - (ii) ensure that salary rates are increased to reflect pay restoration, with a view to protecting the profession in a time of crisis
  - (iii) amend the model salaried GP contract to be consistent, by including the BMA safe working limits of 25 patient contacts per day.
- 9a GP TRAINEES COMMITTEE: That conference believes that the model contract for salaried GPs must be strengthened, with improved advised rates of pay in line with progression from BMA published junior pay rate card as a minimum. We call on GPC UK and its component committees to:
- (i) rapidly arrange mechanisms to renegotiate the model contract, with ongoing review reinstated
  - (ii) ensure that salary rates are increased to reflect pay restoration, with a view to protecting the profession in a time of crisis.
- 9b AVON: That conference believes that core general practice funding will never be restored to the levels required for a thriving partnership, and we need to take steps to protect the salaried GP contract in preparation for a fully salaried service.

- 9c CAMBRIDGESHIRE: That conference recognises poor morale and worsening GP retention may be directly attributable to excessive workload and:
- (i) is concerned by poor workplace cultures where staff burnout may be ignored, thereby damaging employed GPs who do not have the authority to implement BMA recommended safe workload limits
  - (ii) recommends all LMCs publicise how practices may limit their workload to 25 patients a day as recommended by the BMA
  - (iii) recommends the BMA amends the model salaried GP contract to be consistent, by including the BMA safe working limits of 25 patient contacts per day
  - (iv) requests GPC UK create promotional material around the tangible benefits of improving workplace culture, guided by the BMA safe working recommendations.
- 9d CAMBRIDGESHIRE: That conference recognises the increasing number of salaried GPs who, unlike their trust-employed consultant equivalents, do not benefit from standardised pay scales commensurate with experience and responsibility, and asks that the GPC UK research the impact of a fully government funded progressive pay scale on employment and retention (including the pros and cons for areas of deprivation); gender pay-gap; and the future-proofing of wage suppression.
- 9e GLOUCESTERSHIRE: That conference calls for the development of a national GP consultants' contract for consideration.
- 9f WAKEFIELD: That conference believes there needs to be an established general practice pay scale as this would ensure fairness and reduce turnover.
- 9g CAMBRIDGESHIRE: That conference is disappointed by the failure of many practices to include DDRB annual increments in their salaried GP contracts, despite this being a fundamental part of the BMA model GP contract, and recommends GPC UK works with LMCs to produce resources to raise awareness not to accept a contract that omits this clause.

## LUNCH

**12.40**

## THE CAMERON FUND

**13.50**

To submit a speaker slip for Motion 10 – [please click here](#)

- \* 10 AGENDA COMMITTEE TO BE PROPOSED BY GRAMPIAN: That conference recognises that GPs have a key role in primary care with providing continuity, dealing with complex physical and psychosocial presentations whilst leading the MDT team and:
  - (i) agrees that GPs are expert medical generalists whose training allows them to deal with complexities in patient presentations that no other members of the primary care team can
  - (ii) recognises the importance of RCGP exam and CCT to ensure GPs have been trained to a high standard to enable them to deal with the complexities involved in being a GP in 2023
  - (iii) demands the GMC immediately merge the specialist register with the GP register and recognise the profession as specialists in primary care
  - (iv) calls on UK government to appreciate this key role GPs play by rebranding GPs as consultants in family medicine
  - (v) calls on governments to include leadership of MDT as a contractual requirement with appropriate funding and time for this role.
- 10a GRAMPIAN: That conference recognises that GPs have a key role in primary care with providing continuity, dealing with complex physical and psychosocial presentations whilst leading the MDT team and calls on UK government to appreciate this key role GPs play by rebranding GPs as consultants in family medicine.
- 10b LOTHIAN: That conference believes that any introduction of non-GP trained doctors into non-training roles in general practice can only work with the introduction of a consultant in primary care role for trained and qualified GPs.
- 10c BRADFORD AND AIREDALE: That conference demands the GMC immediately merge the specialist register with the GP register and recognise the profession as specialists in primary care.
- 10d HIGHLAND: That conference demands progress in the legal recognition of GPs as specialists, acknowledging the rigorous and lengthy process that GPs have to go through to practice, and calls on GPCs and BMA to work with governments to progress changes to the Medical Act and have a single advanced medical register for senior doctors
- 10e GRAMPIAN: That conference agrees that GPs are expert medical generalists whose training allows them to deal with complexities in patient presentations that no other members of the primary care team can.
- 10f GRAMPIAN: That conference recognises the importance of RCGP exam and CCT to ensure GPs have been trained to a high standard to enable them to deal with the complexities involved in being a GP in 2023.
- 10g GRAMPIAN: That conference recognises that the extended MDT, ANPs, physiotherapists, paramedic practitioners, and mental health workers can only function with the GP being the leader of the team and calls on government to acknowledge this and include leadership of MDT as a contractual requirement with appropriate funding and time for this role.
- 10h GATESHEAD AND SOUTH TYNESIDE: That conference is concerned that, with a population simultaneously larger, sicker and older, there is a move towards de-skilling the primary care workforce and calls for:
  - (i) the evaluation of costs / benefits of non-doctor staff in general practice
  - (ii) medico-legal liability for all non-doctor staff to lie with the individual, rather than any GP
  - (iii) the termination and reversal of a move towards GPs supervising ever greater numbers of staff unable to work independently, from first principles, or both.

- 10i NORFOLK AND WAVENEY: That conference asks GPC to address the shortage of general practitioners and to oppose the government strategy of trying to fill the gaps with alternative staff roles. Alternative staffing roles cannot and will not replace a trained GP.
- 10j LIVERPOOL: That conference believes that the fragmentation of roles within general practice is harming patient care and continuity of care and calls upon GPC to reaffirm the key role of GPs as the expert generalists.
- 10k KENSINGTON, CHELSEA AND WESTMINSTER: That conference notes differences in mortality and morbidity for those with LTCs across the UK and believes that there should be a fully funded defined minimum offer to all people with long term conditions, wherever they live, that:
  - (i) acknowledges the significant upskilling of, and responsibility falling to, GPs over the past 20 years in meeting the increasingly complex needs of patients with long term conditions, which has not been matched by appropriate resourcing and workforce
  - (ii) is based on modelling of current and future patient need
  - (iii) is supported by appropriate and available workforce, training and resource.
- 10l HIGHLAND: That conference is concerned about the multiple challenges to providing healthcare in rural areas and calls on GPCs to lobby governments to ensure there is action to support older populations, where there are larger distances to cover, and poor connectivity.
- 10m KENSINGTON, CHELSEA AND WESTMINSTER: That conference believes that GPs and allied healthcare professionals should never feel compelled to act outside the remit of their training and expertise. Conference demands:
  - (i) monitoring and reporting of the timeliness and quality of advice from specialists for both urgent and non-urgent care, in addition to OP waiting times
  - (ii) health inequalities assessments and clinical safety reviews of referrals from GPs that are rejected
  - (iii) a means of national escalation of commissioning gaps / pathways that result in GPs feeling compelled to act outside their expertise
  - (iv) that the responsibilities and accountability falling to allied healthcare professionals who work in general practice are clearly defined, including the limits of responsibility and accountability
  - (v) that the role and remit of GP supervision to our practice allied healthcare colleagues is clarified.
- 10n LIVERPOOL: That conference rejects the idea that GPs are consultants in primary care. General medical practitioners are expert generalists.

## PRIMARY CARE

14.10

To submit a speaker slip for Motion 11 – [please click here](#)

- \* 11 **AGENDA COMMITTEE TO BE PROPOSED BY LIVERPOOL: That conference believes that the terms primary care and general practice are neither synonymous nor interchangeable and believes that:**
  - (i) **general practice is part of primary care**
  - (ii) **primary care funding is being used to obfuscate a lack of funding in general practice**
  - (iii) **appropriate recognition be given to the specialism of general practice in all arenas.**
- 11a LIVERPOOL: That conference believes that the terms primary care and general practice are neither synonymous nor interchangeable and reaffirms our belief that:
  - (i) general practice is part of primary care
  - (ii) speaking about primary care funding is being used to obfuscate a lack of funding in general practice.

- 11b BRADFORD AND AIREDALE: That conference demands the blurring of primary care and general practice be stopped and appropriate recognition be given to the specialism of general practice in all arenas.

## PRIMARY CARE DOCTORS - MAJOR ISSUE DEBATE

### INTRODUCTION

14.20

**Dr Ujjwala Anand Mohite**

- Associate Specialist in Histopathology at Dudley Group NHS Foundation Trust
- Chair, BMA's Staff and Associate Specialist Committee

and

**Dr Sarah Matthews**

- GPC UK Representative for Coventry and Warwickshire
- Policy Lead for Education, Training and Workforce, GPC England

Please refer to the GPC UK paper (appendix 2), shared in your agenda pack.

### MAJOR ISSUE DEBATE

14.30

There will follow an invitation for speakers from the floor to contribute to the debate with regard to all of the motions and brackets below, with speeches no longer than **one minute each** from the microphones.

Speakers may wish to consider the following questions:

- *Could SAS (Specialist and Associate Specialist) doctors assist with GP workload in the surgery, in their areas of expertise?*
- *Could 'Primary Care Doctors' assist with GP workload in the surgery seeing an undifferentiated presentation of cases supervised by a GP?*
- *Would 'Primary Care Doctors' add to the supervision burden for GP partners?*
- *Would 'Primary Care Doctors' create a two-tier service?*
- *Should pilots / legislative changes progress outside of BMA input, how can the profession positively influence changes?*
- *What are the potential benefits to consider?*
- *What are the potential areas of concern to mitigate?*



Following the conclusion of the Themed Debate there shall follow a straight vote on 12. If 12 passes, then we shall not debate 13 or 14 which automatically fall. If 12 falls, we shall progress to take a straight vote on 13. If 13 falls, we shall progress to take a straight vote on 14. If 14 falls, conference shall fail to create policy.

- \* **12** **NORFOLK AND WAVENEY: That conference asks GPC to reject the GMC’s proposed changes to the Performers’ List to enable non-CCT holders to work within general practice as primary care doctors.**
- 12a GATESHEAD AND SOUTH TYNESIDE: That conference rejects, on grounds of patient safety and potential exploitation, any and all proposals to permit non-GP (staff-grade) doctors to work in general practice.
- 12b GLASGOW: That conference recognises the quality service that GPs give in their role as expert medical generalists and:
  - (i) insists that all doctors working in general practice (unless in a training programme) continue to require to be on the GMC GP Register
  - (ii) believe it is time GPs on the GMC GP Register are rebranded as consultants in primary care.
- 12c LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that non-GP qualified doctors working in general practice is inappropriate and requires GPC UK to resist the proposal, as it will:
  - (i) undermine general practice as a speciality
  - (ii) conflate specialists in other specialities working in the community in their own speciality with working in general practice
  - (iii) lead to a two-tier service and create a lower paid group of doctors
  - (iv) create more work for the remaining partners supervising and taking responsibility of this group of doctors.
- 12d TAYSIDE: That conference, with reference to the proposals from GMC to enable doctors without CCT to work in general practice:
  - (i) views such proposals with concern as this is potentially a threat to the role and status of the general practitioner
  - (ii) should not detract from all efforts to increase the number of fully trained GPs
  - (iii) should be a time limited appointment with a view to gaining a CCT in general practice.
- \* **13** **AVON: That conference believes that medically qualified doctors who are not on the GP Performer's List could provide valuable workforce capacity within general practice, if undertaking work within their scope, or under supervision.**

- \* 14 OXFORDSHIRE: That conference respects the significant contributions of sessional and staff grade (SASG) doctors to the health system both in primary and secondary care, and:
  - (i) notes that (non-training grade) doctors delivering primary medical services are currently required to be on the GMC's GP register and also to be on a performers list
  - (ii) notes that sessional and staff grade (SASG) doctors working in secondary care settings do not have to be on either a performers list, or the GMC GP or specialist registers
  - (iii) demands that any move to employ non training grade doctors, who are also not on the GP register, in GP settings must only occur in a strictly controlled pilot programme, set up to assess outcomes for those doctors and for general practice
  - (iv) recommends that BMA explore the potential to recognise both "GPs" and "non training grade doctors working in general practice", similar to the system of employing consultants and SASG doctors in secondary care.
- 14a CAMBRIDGESHIRE: That conference notes the GMC's plans to permit non-CCT holding non-training grade doctors to work in the GP setting as 'primary care doctors' and calls on GPC UK together with sessional GPC to work with the RCGP to create a summative assessment qualification and training programme for such doctors.
- 14b OXFORDSHIRE: That conference notes suggestions that the GMC's GP and specialist registers be merged, and:
  - (i) believes merging the GMC's GP and specialist registers would be a positive step
  - (ii) recommends that BMA advocate for "consultant equivalent status" and parity of esteem for GPs, even if the GP and specialist registers are not merged
  - (iii) recommends that a GP "consultant equivalent status" is developed for those GPs that meet three requirements, namely being; on the GMC GP register, on a performer's list, and responsible for a named patient list
  - (iv) recommends that a GP "sessional and staff grade equivalent status" is developed for GPs that do not meet three requirements, namely being; on the GMC GP register, on a performer's list, and responsible for a named patient list.

## UK CHAIR: GP TRAINEES REPORT

15.20

## FUTURE OF GP TRAINING

15.30

To submit a speaker slip for Motion 15 – [please click here](#)

- \* 15 GP TRAINEES COMMITTEE: That conference notes the value of GP trainees maximising their experience of general practice during their training. We call on the BMA to lobby the relevant bodies to ensure that the entirety of general practice speciality training is spent in a primary care setting.

To submit a speaker slip for Motion 16 – [please click here](#)

- \* 16 **AGENDA COMMITTEE TO BE PROPOSED BY WIGAN:** That conference believes that more strident efforts should be taken to induce medical students and newly qualified doctors to choose general practice as their medical career path, and calls upon governments to provide financial incentives:
  - (i) that provide an MOD-style sponsorship for GP VTS
  - (ii) that include a medical student debt cancellation scheme
  - (iii) with eligibility based on a prescribed number of years' service as a salaried or principal GP.
  
- 16a WIGAN: That conference believes that more strident efforts should be taken to induce medical students and newly qualified doctors to choose general practice as their medical career path, It calls upon governments and devolved NHS administrations to incentives this choice with a 'bounty' equivalent to 50% of student debt plus all examination costs paid upon reaching a prescribed number of years' service as a GP - salaried or principal.
  
- 16b GATESHEAD AND SOUTH TYNESIDE: That conference calls for an MOD-style sponsorship for GP VTS, with an optional bursary, repayable upon emigration within five years of CCT, being offered to GP trainees.
  
- 16c NORTH YORKSHIRE: That conference demands that given you cannot fill a bucket full of holes, all workforce plans should focus first on retention at every stage of a GP career, rather than fanciful claims about recruitment for a decade in the future.
  
- 16d DORSET: That conference applauds NHS Kent and Medway for announcing their own financial scheme to attract new GPs into the area and into substantive salaried positions. Conference now requests that:
  - (i) GPC UK negotiate with the appropriate NHS commissioning organisations in each of the four nations to ensure that such a scheme is supported financially and nationally to all practices at risk of failure through under-recruitment
  - (ii) in the event of any underspend from such a scheme, the money is reinvested directly into primary care at a local level in those areas and not reabsorbed to fund other projects
  - (iii) GPC seeks to clarify any underspend in the partnership incentivisation scheme and lobby for use as a potential funding source for this project.
  
- 16e LOTHIAN: That conference believes that creating a scheme of debt cancellation for medical students, contingent on them remaining in the NHS post qualification, would help to address the current workforce crisis across the NHS.

To submit a speaker slip for Motion 17 – [please click here](#)

- \* 17 **WAKEFIELD:** That conference is aware that in some areas 86% of GP trainees are NHS naïve at the point of entry to training. These require much more assistance than those with NHS knowledge. A fully funded NHS induction course is needed for this group of trainees as is extra reimbursement, to recognise the extra workload for their trainers.

- 17a DORSET: That conference believes that with the proportion of non-UK medical graduates entering into general practice being greater than ever before training for international medical graduates needs to be supportive in helping individuals transition into UK general practice. Current training schemes do not have flexibility to allow time for cultural transition. We call for an increase in supportive measures to allow international medical graduates the best training experience to meet their needs, these include:
- (i) extra national funding to be made available to allow longer training schemes for international medical graduates if wished to help with cultural transition
  - (ii) a funded UK cultural integration period for non-UK graduates moving to the UK for GP training
  - (iii) a digital support hub to support GP trainees moving to the UK with relevant resources and support offers.
- 17b CLEVELAND: That conference is particularly concerned for the wellbeing of doctors in training who are new to the UK and:
- (i) reiterates the need for urgent actions on Skilled Workers Visas in relation to the cliff edge that many trainees face at the point of CCT
  - (ii) mandates the GP Trainees Committee to ensure that all trainees are aware of potential visa issues
  - (iii) mandates GPC UK to ensure that all practices and other employers of GPs are aware of the advantages of being a sponsor for the Skilled Worker Visa programme
  - (iv) believes that the cost of becoming a sponsor within the Skilled Worker Visa programme should be cost neutral to GP practices
  - (v) encourages GP training schemes to provide bespoke social support to promote integration into UK society.
- 17c COVENTRY: That conference believes that:
- (i) there needs to be increased support and effort in retaining GPs who are foreign medical graduates trained in the UK
  - (ii) increased transfer of workload, frustration with the current state of health systems, demoralising public and media opinion along with better visa programs for families, better quality of work-life balance, financial incentives are making GPs who are foreign medical graduates move to other countries
  - (iii) if appropriate measures are not taken, we will risk becoming a training-only destination for foreign medical graduates who want to work elsewhere.
- (Supported by WARWICKSHIRE)
- 17d NORFOLK AND WAVENEY: That conference asks GPC to negotiate:
- (i) an uplifted allowance to support the increased demand of training new GPs and the additional work required to fully support the needs presented by International Medical Students into the Vocational Training Schemes
  - (ii) increase GP training opportunities for International Medical Graduate Doctors, addressing the limitations currently in place which prevent increasing the timescales allowed for learning and training opportunities where required for these individuals.
- 17e AYRSHIRE AND ARRAN: That conference believes that GP training grants need reviewed and would propose that:
- (i) there is a strong correlation to scoring within the selection process for GP training and outcomes of training
  - (ii) there should be a tiered structure to GP training grants to ensure adequate support from the outset of training.

- 17f BEDFORDSHIRE: That conference celebrates and values the contribution of international and former-EU medical graduates (IMG) to our workforce and calls on the UK government to:
- (i) reduce the number of exams that these GPs need to sit to work in the UK to the minimum consistent with clinical safety – and to allow as many of these exams as possible to be sat in the person’s country of origin
  - (ii) create a coordinator or buddy scheme to help IMGs while they are getting inducted and starting in the NHS, including making IMGs aware of LMCs and the support they can offer to IMGs
  - (iii) make the on boarding process more efficient both by reducing the time when IMGs are unable to work because they are waiting for exams and by reducing the number of interviews before starting with the scheme
  - (iv) support IMGs with indemnity costs for their first year working for the NHS.

## MRCGP

16.20

To submit a speaker slip for Motion 18 – [please click here](#)

- \* 18 **AGENDA COMMITTEE TO BE PROPOSED BY NORTH WALES:** That conference, in respect of the MRCGP examination:
- (i) asks GPC UK and its component committees to lobby and work with RCGP and other stakeholders to ensure no GP trainee is forced to extend their training due to lack of availability of examination sittings
  - (ii) calls on all GPCs to work with the RCGP towards a system that will offer GP trainees who score under 480 on selection four- or five-year training at the outset rather than waiting for them to “fail” their examinations
  - (iii) believes that single sitting, "big bang" RCGP exams such as AKT are no longer an appropriate assessment and calls for them to be replaced by an educationally evidence-based assessment
  - (iv) notes the significant financial impact MRCGP examination and mandatory RCGP membership fees have on GP trainees and calls upon GPC UK and its component committees to lobby governments and education bodies to fund the first attempt at MRCGP examinations.
- 18a NORTH WALES: Applicants to GP training who score under 480 on selection are very likely to need extensions to training after failing elements of the MRCGP. Conference:
- (i) acknowledges the avoidable negative effects on the individuals of labelling these doctors as “failing”
  - (ii) acknowledges the stress that short notice extensions have on the programme directors when they are having to find additional placements
  - (iii) calls on all GPCs to work with the RCGP towards a system that will offer this cohort four- or five-year training at the outset rather than waiting for them to “fail”.
- 18b LIVERPOOL: That conference notes the recent decision by RCGP to cap exam place numbers for GP trainees sitting the Recorded Consultation Assessment at short notice, and the undue stress and concern this has brought onto trainees. We ask GPC UK and its component committees to lobby and work with RCGP and other stakeholders to:
- (i) future proof future exam cycles by improving planning to prevent short notice restrictions on MRCGP examination places, including the new Simulated Consultation Assessment
  - (ii) ensure no GP trainee is forced to extend their training due to lack of availability of examination sittings
  - (iii) provide additional MRCGP examination sittings throughout the year to provide flexibility in training
  - (iv) recruit and train more examiners to meet the demand.

- 18c GP TRAINEES COMMITTEE: That conference believes that single sitting, "big bang" RCGP exams such as AKT are no longer an appropriate assessment of the knowledge or skills needed to work independently as a GP and calls for them to be abolished and replaced by educationally evidence-based assessment.
- 18d LIVERPOOL: That conference notes the significant financial impact MRCGP examination, and mandatory RCGP membership fees have on GP trainees, and in the context of a cost-of-living crisis and real terms pay cuts, that this impact has become more acute. We therefore call upon GPC UK and its component committees to:
  - (i) lobby RCGP to provide a clear breakdown of the use of fees to provide justification for the cost of RCGP AiT membership and MRCGP examinations
  - (ii) lobby governments and education bodies across the United Kingdom to support GP training and recruitment by funding the first attempt at MRCGP examinations.
- 18e GLOUCESTERSHIRE: That conference is appalled at the proposed rise in costs of the replacement to the RCA and insists on a value for money and cost analysis of the suggested rise.
- 18f AVON: That conference, in light of the proposed Simulated Consultation Assessment (SCA) of the MRCGP exam, calls upon GPC UK to demand an equality impact evaluation of this new exam to minimise the existing differential attainment amongst GP trainees.
- 18g AYRSHIRE AND ARRAN: That conference recognises that general practice training has become increasingly onerous and complex and urges GPC UK to work with the RCGP to:
  - (i) simplify the curriculum with more weight added to WPBA
  - (ii) increase training time to four years with two years in general practice at ST3.

## GP TRAINEES CONFERENCE

**16.30**

To submit a speaker slip for Motion 19 – [please click here](#)

- \* 19 GP TRAINEES COMMITTEE: That conference notes the significant value GP trainees derive from attending LMC conferences across the UK. We call on:
  - (i) GP trainees committee to organise an annual UK GP trainees conference
  - (ii) GPDF to fund an annual UK GP trainees conference.

## LMC SUPPORT NETWORK BRIEFING

**16.50**

## CLOSE

**17.00**



To submit a speaker slip for Motion 20 – [please click here](#)

- \* 20 LIVERPOOL: That conference, with respect to GPC UK:
- (i) expects the committee to represent the interests of all GPC committees and focus on addressing pan-UK issues affecting all components GPC committees, including sessional and GP trainee committees
  - (ii) demands clarity on the composition of GPC UK
  - (iii) expects any changes to the composition of GPC UK to allow it to function as intended, focusing on pan-UK issues, without any one component committee dominating the membership of the committee.
- 20a WEST SUSSEX: That conference notes with dismay that GPC UK has only met once since May 2022 and has not published an action plan incorporating conference policy or quarterly reports. Conference therefore has no confidence that GPC UK can deliver the will of conference.
- 20b CAMBRIDGESHIRE: That conference is concerned by how proposed changes to the structure of GPC UK affect conference itself, and:
- (i) seeks assurance that there will be zero diminution to diversity of representation by constraining seats for GPs of all contractual status alongside protected characteristics
  - (ii) believes GPC UK gains much from the grass root representation elected annually by conference, including the ‘seventh seat’ and ‘early years’ members and does not seek to reduce this
  - (iii) calls for an impact assessment to be undertaken to understand the implications of the BMA having removed resource from both trainee and sessional representatives to be able to attend conference.
- 20c NORTHERN IRELAND CONFERENCE OF LMCs: That conference calls for a streamlining of GPC UK so that it truly represents the interests of all four nations and instructs NIGPC, SGPC, GPC Wales and GPC England to restructure this committee and redefine its shared purpose.
- 20d WEST PENNINE: That conference believes that the GPC reforms from 2016 have demonstrably failed to improve representation of general practice across the UK, and:
- (i) believes the implementation of these reforms has widened representative inequalities between the devolved nations of the UK
  - (ii) calls on GPDF to ensure that in funding negotiations with the BMA, devolved nations receive equity of representation
  - (iii) demands that GPDF take back oversight, responsibility, and control of all costs of GPC honoraria, expenses, and executive contracts
  - (iv) believes the implementation of these reforms has negatively impacted representation at conference.
- 20e LIVERPOOL: That conference believes that a unified GP voice is vital to ensure general practice is positively represented in the public eye as the core component of an all-population focused, effective and efficient NHS, and calls on GPC UK to work closely with the RCGP to facilitate this.

## GPDF: CHAIR'S REPORT

09.20

## PLENARY SESSION – GOVERNANCE OF LMCs

09.30

*Good Governance for LMCs – Sharing Best Practice in being Accountable to constituent GPs  
Dr Richard Wood – Oxfordshire LMC, Co-chief executive BBO LMCs*

## PLENARY FEEDBACK AND QUESTIONS

10.00

## LMC GOVERNANCE

10.10

To submit a speaker slip for Motion 21 – [please click here](#)

- \* 21 AVON: That conference has concerns about the overarching governance of LMCs and requests that GPDF and NI GPDF investigate how they may support accountability and consistency across LMCs.
- 21a LEEDS: That conference believes the BMA should provide increased support for LMCs through the provision of:
  - (i) negotiation training
  - (ii) media and communication training
  - (iii) contract and regulation training
  - (iv) chairing skills training.

## PROFESSIONAL STANDARDS

10.20

To submit a speaker slip for Motion 22 – [please click here](#)

- \* 22 AGENDA COMMITTEE TO BE PROPOSED BY LOTHIAN: That conference recognises the incredible strain that GPs and other doctors across the UK are working under, and:
  - (i) calls on regulators to be cognisant of these pressures when investigating and responding to complaints related to stresses upon the system
  - (ii) applauds the move to a light touch, supportive, wellbeing focused appraisal process adopted in Scotland during the pandemic and supports the maintenance of this approach to appraisal going forward in all four nations
  - (iii) rejects any assertion that GPs must use commercial packages for the presentation of appraisal evidence, insists that appraisal evidence can always be presented without cost to the appraisee, and instructs GPC UK to negotiate to this end.
- 22a LOTHIAN: That conference calls on the GMC to recognise the incredible strain that GPs and other doctors across the UK are working under at the moment and to:
  - (i) reform appraisal to take account of this, and
  - (ii) be cognisant of these pressures when investigating and responding to complaints related to stresses upon the system.

- 22b OXFORDSHIRE: That conference believes that appraisals are taking an unreasonable amount of GP sessions away from the day job, and:
- (i) demands that GPs be given the choice about whether to return to more substantial formal appraisals (as was the case prior to the COVID-19 pandemic), or continue with the “light touch” model that started due to the pandemic
  - (ii) demands that GPs be given the choice between a traditional face to face appraisal (if this is practical and compatible with infection control practices at the time), and a virtual online process
  - (iii) demands a that appraisal and revalidation requirements be reviewed, including a review of the existing “5-year revalidation cycle”.
- 22c CLEVELAND: That conference rejects any assertion that GPs must use commercial packages for the presentation of appraisal evidence, insists that appraisal evidence can always be presented without cost to the appraisee, and instructs GPC UK to negotiate to this end.
- 22d GLASGOW: That conference applauds the move to a light touch, supportive, wellbeing focused appraisal process adopted in Scotland during the pandemic and supports the maintenance of this approach to appraisal going forward in all four nations.
- 22e TAYSIDE: That conference believes that GP appraisal, in its current form, is not fit for purpose.
- 22f BERKSHIRE: That conference demands that BMA:
- (i) develop and ensure that all relevant minimum mandatory training, as specified by regulatory bodies for inclusion on the GP performers lists, are freely available to all GPs as e-learning resources and clearly labelled as being necessary for inclusion
  - (ii) conduct an evaluation of the effectiveness and evidence-basis of national mandatory learning, including additional training that employers impose, and consider what if anything is achieved by asking GPs to repeat these at regular intervals
  - (iii) conduct an impact assessment of mandatory training requirements on workload in primary care, including but not limited to costing staff time and remuneration and number of appointments that could be offered to patients.
- 22g DEVON: That conference is confused as to why GPs in England have to pay to be appraised as the MAG form no longer works properly and NHSE are advising the use of commercial appraisal systems whereas this is not the case in the other nations.
- 22h NORTHERN IRELAND EASTERN: That conference calls on GPC UK to work with NIGPC, SGPC, GPC Wales and GPC England to centrally and locally lobby where more appropriate to develop the retention of GPs of all ages within the general practice workforce through the following measures:
- (i) appraisal frequency to be extended to two or three years
  - (ii) removal of the disincentive to work through the stealth taxes of AA / LTA.

To submit a speaker slip for Motion 23 – [please click here](#)

- \* 23 **AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS:** That conference notes how the effects of the Strep A campaign in December 2022 caused widespread panic and unprecedented demand that could not be met by a system under pressure and:
  - (i) calls on governments and public health bodies to take into consideration the wider system effects of sending public health messages around single diseases
  - (ii) calls on governments and public health bodies to perform a comprehensive significant event analysis of the effects of national communications surrounding the Group A Streptococcal outbreak in December 2022
  - (iii) believes that GPs are not responsible for the management of communicable disease outbreaks as this is the role of public health
  - (iv) believes that general practice is not responsible for the management of asymptomatic communicable disease contacts, as it is the role of public health protection teams to arrange chemoprophylaxis
  - (v) calls on the relevant national agencies to ensure mechanisms are put in place to commission the prescribing of any necessary and timely treatments.
- 23a **TOWER HAMLETS:** That conference calls on the government and public health bodies to take into consideration the wider system effects of sending public health messages around single diseases. The effects of the strep A campaign in December caused widespread panic and unprecedented demand that could not be met by a system under pressure.
- 23b **LEEDS:** That Conference believes the national communication of the rise in cases of Group A Streptococcus infection in November and December 2022 was seriously flawed and caused harm by creating damaging levels of anxiety, increased workload in general practice and the wider NHS to dangerous levels and led to an unprecedented unavailability of essential antibiotics, and therefore calls on the UK Government and the UK Health Security Agency, with full involvement of GPCUK, to complete and publish a comprehensive significant event analysis.
- 23c **HAMPSHIRE AND ISLE OF WIGHT:** That conference believes that GPs are not responsible for management of communicable disease outbreaks as this is the role of public health. We call on UKHSA to ensure mechanisms are in place to prescribe necessary and timely treatments via UKHSA teams, and not to delegate this to general practice.
- 23d **AVON:** That conference submits that general practice should not be expected to prescribe Chemoprophylaxis for those asymptomatic individuals which UKHSA has assessed as being close contacts of streptococcal A disease, meningitis, or any other infectious disease. This is another example of increased, but un-resourced, workload in general practice. Conference insists that it is for the HPSA to prescribe the appropriate treatment. If general practice is to prescribe antibiotics to such individuals, then this work requires appropriate resourcing being provided by UKHSA or government.

To submit a speaker slip for Motion 24 – [please click here](#)

- \* 24 **NORTH YORKSHIRE:** That conference demands that regulations should be modernised around death certification and expanded to include other qualified health care professionals completing certification if they have been involved in a patients care.

- 24a BRADFORD AND AIREDALE: That conference recognises that as primary health care teams diversify, it is now timely to permit other healthcare professionals to complete death certificates.
- 24b WIRRAL: That conference notes that only medical doctors registered with the GMC are legally allowed to issue a MCCD. Meanwhile, the nature of general practice workforce has changed considerably in line with NHSE policy and PCN DES such that other healthcare professionals like ANPs, Paramedics are now providing end of life care to frail and elderly patients, especially in care home settings. It therefore asks that GPs should no longer be the only health care practitioners to issue a MCCD in situations of deaths in the community.

## SOAPBOX

**11.00**

## UK CONFERENCE 2024 AND BEYOND - WORKSHOPS

**11.40**

We invite representatives and observers to join their allocated workshop, in its allocated room from 11.40am. Each room will have facilitators to allow participants an opportunity to discuss, debate, and develop potential formats for the UK Conference from 2024 for the Agenda Committee to consider.

Following the conclusion of the workshops at 12:20pm, attendees will be invited to break for lunch, returning to The Light for 13:40 and the commencement of the final session.

## LUNCH

**12.20**

## CLAIRE WAND FUND

**13.40**

## FUTURE FORMATS FOR CONFERENCE

**13.50**

To submit a speaker slip for Motion 25 – [please click here](#)

- \* 25 HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the current format of the UK conference of LMCs is no longer as relevant compared to nation specific conferences due to the divergence of contracts across the four UK nations (and the consequent limited number of UK issues for debate). Conference therefore requests a wholesale review of the current format of the UK Conference of LMCs, and such a review to report back in advance of the 2024 UK conference of LMCs and to include reflections on:
  - (i) relevance to all four UK nations and subject matter for debate
  - (ii) timing and length of conference
  - (iii) cost of conference including costs for individual LMCs
  - (iv) method of attendance including virtual and hybrid options
  - (v) recommendations for future formats.

- 25a SESSIONAL GPS COMMITTEE: That conference:
- (i) is concerned about the inequity of funding arrangements for different representatives attending UK LMC conference
  - (ii) believes that the lack of funding for GPC UK members' (and all its constituent committee members') attendance has made conference less representative
  - (iii) demands that funding to attend conference for GPC UK members (and all its constituent committee members) be reinstated in the upcoming Deed of Grant negotiations.
- 25b GLASGOW: That conference applauds the work being done to reform GPC UK and calls for a similar reform to the membership of the UK Conference to better reflect its role in informing UK GPC policy.
- 25c GLASGOW: That conference recognises the importance of the UK LMC Conference in uniting GPs from all four nations but realises that we have now have four separate GP contracts and:
- (i) calls on UK agenda conference to consider all nation specific motions submitted as incompetent
  - (ii) where the passing of a motion prioritised for debate might cause contractual issues for one nation, calls for the chair of that GPC to be allowed to ask, prior to conference, for the motion if passed not to apply in that nation.
- 25d GP TRAINEES COMMITTEE: That conference recognises the value for members of fully collaborative working and consistent, clear communication across representative committees and calls for:
- (i) devolved nation General Practice Trainee Committee (GPTC) and Sessional Committee representatives to have regular meetings with the relevant GPC executives
  - (ii) devolved nation GPTC representatives receiving either non-voting or voting seats on their respective devolved nation JDCs
  - (iii) devolved nation GPTC representatives to have a minimum of a non-voting seat on their respective devolved nation JDC executive subcommittees
  - (iv) GPTC and Sessional Committee representatives from a particular nation to be invited to attend the relevant national LMC conference as voting members
  - (v) devolved nation GPTC and Sessional Committee representatives to be involved in LMC conference planning to ensure the conference meets the needs of these groups.
- (Supported by the SESSIONAL GPs COMMITTEE)
- 25e GRAMPIAN: That conference appreciates there is concern regarding GPC UK and GPC England's performance and supports that the UK LMC Conference moves to every two years to allow funding to be redirected from attendance at conference to support GPC UK and GPC England's reorganisation.
- 25f GRAMPIAN: That conference recognises although the UK conference is a four-nation conference it is only natural that debate at times gravitates towards single nation issues and in an attempt to combat this supports rotation of conference chairperson between the four nations to allow for a fairer UK-wide representation of general practice.
- 25g NORTHERN IRELAND EASTERN: That conference calls on the UK AC to ensure that there is restoration of the regional rotation of the UK LMC conference venue.
- 25h LOTHIAN: That conference feels that GPC UK should be put in abeyance, with regular meetings of negotiating teams and the UK LMC conference replacing it as the main way of sharing information and learning across the UK.
- 25i LOTHIAN: That conference believes that the UK conference of LMCs should only set policy on UK matters, but that it should continue to debate matters of importance from across the UK, referring these on to national conferences for policy decisions where appropriate.



- 25j LOTHIAN: That conference believes that the UK conferences of LMCs should move to every two years given that most matters are now considered on a nation-by-nation basis.
- 25k GATESHEAD AND SOUTH TYNESIDE: That conference believes, that given the divergence of the provision of healthcare across the four nations there should be more emphasis on the individual national conferences, and consideration should be given to reducing the UK conference to a one-day event and increasing the role of the four national conferences.
- 25l DEVON: That conference should recognise that the role of the UK conference has diminished due to the vast differences between current GP contracts in the separate nations and conference needs to seriously debate its form and function.
- 25m DEVON: That conference has a section where each home nation can have a separate session as an interim update between their own national conferences.
- 25n ENFIELD: That, with reference to Conference Standing Orders 4 and 5, all local medical committees are entitled to appoint a representative to the conference. The Agenda Committee will then allocate any remaining seats for representatives amongst LMCs, and with the aim to ensure fair representation, this is done according to the number of GPs they represent. The unintended consequence of this method of allocation is to disenfranchise those LMCs in under-doctored areas, and rather than maintain the allocation of seats according to numbers of GPs in any given LMC area, Conference is asked to approve a change in Standing Order 5 so that the allocation of seats to conference reflects the patient population covered within that LMC area.
- 25o SUFFOLK: That conference notes the increasing divergence between the GP contractual arrangements of the four constituent nations of the UK. Conference suggests therefore that this be reflected in the gravitas accorded to the LMC conferences of those nations. Conference requests therefore that GPC UK give consideration to devolving more time, investment and authority to those conferences including the transfer of GPC elections from the UK conferences to the devolved ones, recognising that the growth of those local conferences may be at the expense of the diminution of the UK conference.
- 25p FORTH VALLEY: That conference supports the annual UK conference of LMC representatives moving to a two-yearly format as health systems are now so different in the four nations that there is not enough UK wide issues to justify an annual conference.
- 25q BRADFORD AND AIREDALE: That conference recognises the climate crisis continues unabated despite the BMA goal of carbon net zero and demands:
- (i) the principle of carbon net zero should immediately be part of all future conference planning
  - (ii) climate crisis and sustainability should be integral to future policy debate and decisions
  - (iii) resources be provided by NHSE to assess each practice carbon footprint
  - (iv) all resources be provided to facilitate carbon saving changes to general practice from mapped footprints.

To submit a speaker slip for Motion 26 – [please click here](#)

- \* 26 **WARWICKSHIRE:** That conference supports protection of the independent contractor model of GP partnership and believes that:
  - (i) the GP partnership model is deliberately portrayed as inefficient and unsustainable in order to facilitate abolishment of the partnership model and a transition to a salaried service
  - (ii) the current model has the ability to thrive, if provided with adequate primary care funding alongside greater GP involvement and autonomy in key decision making.

(Supported by COVENTRY)
- 26a **BRO TAF:** That conference insists all current UK governments issue a statement strongly disagreeing with the recent suggestion by the shadow UK Minister of health the direction of travel should be towards a totally salaried service with the phasing out of independent contractor status general practice, and would expect all political parties to distance themselves from this remark.
- 26b **AVON:** That conference is concerned that the Shadow Health Secretary, Mr Wes Streeting, has indicated that Labour may overhaul general practice. There is a suggestion of phasing out the independent contractor model and replacing it with a salaried service. This would be a disaster for the provision of health care in this country and the GPC is instructed to open negotiations with the Shadow Health Secretary to arrive at an acceptable model of general practice health care provision.
- 26c **NORTH STAFFORDSHIRE:** That conference recognises that:
  - (i) both the Conservative and Labour parties currently deliberately offer no hope for the future of GP partners
  - (ii) this is already causing morale sapping erosion of the GP partnership model
  - (iii) this, in addition to the punitive pension tax disaster, is causing an unprecedented loss of workforce of GPs at all stages of their careers
  - (iv) replacement of GPs by practitioners and therapists causes a dilution of clinical skills and an increasingly intolerable burden of supervision and risk on the shrinking, residual GPs, which will be unsafe for patients
  - (v) this existential crisis for the GP partnership model, for short- and medium-term patient safety, now requires the strongest forms of all viable work sanctions.
- 26d **LEEDS:** That conference is alarmed by the comments made by the UK Labour leadership that if they were elected the GP partnership model would be replaced by NHS employment and:
  - (i) believes this would make care for patients worse rather than better
  - (ii) would lead to practices closing and communities losing their current GP service
  - (iii) demands that GPC UK vigorously oppose these proposals
  - (iv) demands that GPC UK immediately leads a significant campaign to defend, promote and highlight the benefits of the GP independent contractor status and partnership model.
- 26e **WORCESTERSHIRE:** That conference believes that the independent contractor model if properly resourced remains the best model for the delivery of primary medical services and insists that GPC robustly challenge proposed universal salaried models and vertical integration.
- 26f **LEICESTER, LEICESTERSHIRE AND RUTLAND:** That conference affirms that general practice delivered by a partnership model provides the most cost effective, efficient, and nimble service and requests all UK GPCs not to enter into any negotiation into a partial or complete salaried based general practice service.

- 26g LOTHIAN: That conference believes that the population we serve is best served by GP practices which are owned and managed by GPs who work in them and calls for a halt in any further moves towards private companies holding contracts for GP services.
- 26h NORTH STAFFORDSHIRE: That conference urges GPC executive to start an urgent campaign to support and sustain GP independent contractor model.
- 26i NORFOLK AND WAVENEY: That conference asks GPC to challenge the view to abolish the GP partnership model in the strongest possible manner and publicise the potential harm to patient care that would likely come from a loss in continuity of care due to a fragmented service provision.
- 26j CAMBRIDGESHIRE: That conference:
- (i) reaffirms its support for the 2018 policy that the partnership model is the most efficient and cost-effective way of delivering general practice, and that we must do everything possible to support and sustain this model
  - (ii) would support all GPs being allocated a named GP mentor in their main practice of work for a minimum of 24 months following CCT
  - (iii) believes that continuity of care is not only lifesaving for patients, but career-fulfilling for GPs
  - (iv) recommends that GPs do not locum for the first 24 months following the award of their CCT.
- 26k WEST PENNINE: That conference believes the GP partnership model continues to provide the most cost-effective care in Britain and we deplore any steps to undermine this keystone of the NHS.
- 26l GATESHEAD AND SOUTH TYNESIDE: That conference notes various proposals for a salaried GP service in several devolved nations and:
- (i) notes the current working conditions, and apparent unhappiness, of our consultant colleagues
  - (ii) believes that this would remove the 'name on the door' responsibility and therefore link between GPs and their patients
  - (iii) believes that this would result in worse health outcomes for patients, in light of evidence for continuity on morbidity and mortality
  - (iv) believes that this would result in increased expense, greater risk or both
  - (v) rejects this proposal utterly, when and wherever it next emerges.
- 26m KENT: That conference believes that partnerships have been hugely important to the foundation of the NHS and requests the GPC to strongly rebut any proposals from the nations' governments to move to a wholly salaried service.
- 26n AVON: That conference is saddened that government does not appear to appreciate the work which general practice provides on behalf of patients. The practice model is financially the golden egg in the NHS and any action by government to remove the independent contractor status model will be the termination of general practice. The GPC must be resolute in its determination to fight the government's efforts to remove independent contractor status.

## FIREARMS

14.20

To submit a speaker slip for Motion 27 – [please click here](#)

- \* 27 BERKSHIRE: That conference notes the tragic loss of life in Plymouth in August 2021 and the subsequent renewed media attention on firearms licensing. Conference:
  - (i) believes that assessment of eligibility to possess firearms is a matter for police forces, not GPs
  - (ii) believes that the role of GPs in the licensing process is to provide medical facts, not provide an opinion on eligibility
  - (iii) demands that BMA work with representatives of police forces and government to agree processes whereby relevant factual information can pass from the GP data controller to the police directly, reducing the possibility of an applicant tampering with the information provided
  - (iv) demands that the work involved in delivering firearms licensing be properly resourced, for example through a fee paid by the applicant
  - (v) believes that current electronic flagging systems or “firearms markers” on GP medical records are unlikely to improve public safety and should be removed.
  
- 27a GLOUCESTERSHIRE: That conference is alarmed at the jeopardy that new procedures on firearms licencing have on GPs who have been enlisted unwittingly into patrolling patients with firearms and:
  - (i) demands that the current process be stopped forthwith until evidence of any benefits and risks are fully assessed
  - (ii) calls on the implementation of firearms licencing processes followed across most of Europe to be adopted in the UK.

## PRIVATE PRACTICE

14.40

To submit a speaker slip for Motion 28 – [please click here](#)

- \* 28 AGENDA COMMITTEE TO BE PROPOSED BY BUCKINGHAMSHIRE: That conference notes that unlike dentists and pharmacists, GPs cannot currently 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) GPs can be trusted to manage potential conflicts of interests arising from offering paid-for services to their NHS patients
  - (iv) the BMA should state that the wellbeing of its members is a higher priority than the delivery of NHS services.

- 28a BUCKINGHAMSHIRE: That conference notes that unlike dentists and pharmacists, GPs cannot currently 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) commissioners 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.
- 28b WEST SUSSEX: That conference asks GPC UK and the BMA to negotiate and recommend alternatives to the GMS Contract for GP practices, that promote a hybrid NHS and private service, and the BMA:
- (i) states the wellbeing of its members is a higher priority than delivering NHS services
  - (ii) continues to publicise the intransigence of government in negotiations on NHS GP issues
  - (iii) publicly declares its intention to support the delivery of non-NHS services by GPs as an alternative to the current GMS / PMS contracts.
- 28c AVON: That conference calls upon GPC UK to negotiate regulatory changes allowing non-core private services for a GPs registered list.
- 28d SOUTH STAFFORDSHIRE: That conference believes a new fit for purpose contract needs to be negotiated that primarily funds practices for providing patient access and allows GPs to use their skills in order to provide patients services on a private basis, especially if the NHS is no longer normally providing these.
- 28e BUCKINGHAMSHIRE: That conference believes that public access to primary care will be enhanced by removing constraints on private practice in NHS contracts held by the UK's GPs.
- 28f NORTH YORKSHIRE: That conference believes without a significant change in approach by UK governments private general practice is the only viable option to maintain the future of the profession.
- 28g WAKEFIELD: That conference believes that the only way to deal with a limitless demand safely, by an underfunded and under-doctored general practice service, is for patients to have a charge levied to see a GP.
- 28h CAMBRIDGESHIRE: That conference:
- (i) believes the impact of the cost-of-living crisis is threatening the financial viability of general practice
  - (ii) reaffirms its belief in 2018 policy that the survival of the profession should take precedence over the survival of the NHS
  - (iii) requests the GPDF commission informative preparatory work into options beyond the NHS for GP partnerships
  - (iv) believes that the political obsession with 'access' in general practice continues to fuel demand directly leading to workforce burnout, practice closure, and poorer population health outcomes
  - (v) calls on the BMA to present a coherent, costed alternative to GPs as the single most efficient part of the NHS to counter the misleading trope of emphasising numbers of appointments as the critical metric.

- 28i DORSET: That conference notes the current system where treatments not available on the NHS are only available from private providers. Some of these treatments could be available at lower cost with better continuity of care from their own GP practice. We therefore suggest that:
  - (i) where GPs have the relevant qualifications and skills, they are able to charge a reasonable rate to their own registered patients
  - (ii) such monies paid by patients are then used to reinvest in general practice.
- 28j KENSINGTON, CHELSEA AND WESTMINSTER: That conference deplores the current attrition rate of highly trained and skilled GPs from the profession because working in the NHS has become increasingly unsafe and untenable. Conference calls on GPC to explore ways of retaining GPs in the profession, outside the toxic NHS environment, in ways that do not increase social injustice and health inequalities.
- 28k TAYSIDE: That conference believes that GPs working in the private sector, where patients are eligible for NHS treatment, should be able to refer directly for NHS investigations and treatments without referring the patient back to their NHS GP.

## PAY RESTORATION

15.00

To submit a speaker slip for Motion 29 – [please click here](#)

- \* 29 **BERKSHIRE: That conference fully supports the junior doctors in their strike action and drive for pay restoration, demands a similar approach to be taken by the four nations to drive for full pay restoration for general practice, and believes GPs must consider industrial action if required to achieve this.**
- 29a GP TRAINEES COMMITTEE: That conference notes that GP trainees and junior doctors across the UK have been impacted by the effects of chronic pay erosion on real-terms wages:
  - (i) we offer a public display of solidarity for GP trainees and junior doctors, across the UK, who are taking action to tackle real terms pay erosion and seek pay restoration
  - (ii) we call on all BMA GP committees to support GP trainees and junior doctors, across the UK, who are taking action to tackle real terms pay erosion, in line with the work GPCE have undertaken to support GP trainees and junior doctors in England.
- 29b AVON: That conference applauds the organisation and courage of the Junior Doctors Committee in all four nations and hopes that GPC UK can learn how to effectively engage with GPs of all contractual status.
- 29c NORFOLK AND WAVENEY: That conference asks GPC to address the significant lack of funding to general practice. General practice funding must be uplifted to reflect the real costs being faced to enable current service provision to be maintained.
- 29d MERTON: That conference calls upon government to increase direct investment in the general practice core contract, guaranteeing increments matching the rate of inflation as well as reflecting any nationally agreed salary increases for salaried staff, in order to support current stabilisation and future sustainability of general practice.
- 29e BERKSHIRE: That conference demands that GP contracts move away from performance-based schemes and instead move to reinvest such money into the Global Sum.
- 29f DERBYSHIRE: That conference recognises that the core GP contract funding by capitation is fundamentally flawed. Practices that deliver more doctor or nurse time for patients results in lower remuneration for partners. Hence this meeting directs GPCs to negotiate new contracts which are time sensitive.

- 29g WORCESTERSHIRE: That conference believes that future contract negotiations must focus on investment in core GMS, delivery of continuity of care and safe working with bureaucracy and unrealistic targets minimised in order to meet patient demand and prevent further workforce attrition.
- 29h SANDWELL: That conference advises the GPC that there is a very real danger the profession will not accept a contract, either agreed or imposed, that does not make a substantial and immediate improvement to the dangerous workload in general practice. Without substantial and immediate measures improvement general practice will disappear and with it, the NHS.
- 29i LEWISHAM: That conference calls upon government to value, reward and develop existing frontline staff rather than continuing to invest in wasteful funding initiatives that effectively defund general practice.
- 29j BRADFORD AND AIREDALE: That conference recognises and welcomes the contribution of a wider team in general practice but notes the refusal of all governments to invest in and support the skill set and contribution of the GP workforce.
- 29k NORTH STAFFORDSHIRE: That conference recognises that:
- (i) the implied net pay decrease from the impact of unfunded higher DDRB awards versus the five-year rolling 2.1% award for core GMS needs a netting off focus and widespread publicity
  - (ii) core GMS has had a near flat line of investment which puts GP partners in an impossible position in attempting to offset rising costs, address inflation and retain their loyal staff
  - (iii) for lower earning practices, this makes being a GP partner role personally non-viable
  - (iv) the critical tipping point for this non-viability (now Covid has stabilised) needs priority researching, modelling and highlighting for colleagues and the system, before the GP system collapses.
- 29l DERBYSHIRE: That conference insists that re-instatement of an EXPLICIT practice expenses reimbursement mechanism for general practice
- (i) is essential to the survival of the independent contractor provision of GP services
  - (ii) prevents government from financially abusing GPs through painting gross increases in primary care resourcing as GP “pay”
  - (iii) as such a system served both the taxpayer and the profession well over 38 years including at times of high inflation until 2004
  - (iv) permits proper financial planning of services at times of rampant inflation
- and instructs GPCs to negotiate accordingly.

## CHOSEN MOTIONS

15.20

To submit a speaker slip for Chosen Motions - [please click here](#)

## NEW BUSINESS

15.30

To submit a speaker slip for New Business Motions - [please click here](#)

## CLOSING BUSINESS

15.50

## CLOSE

16.00

# Conference of Representatives of Local Medical Committees

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



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

### **A and AR Motions**

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

#### **CLINICAL, PRESCRIBING AND DISPENSING**

- A** 30. LIVERPOOL: That conference believes that clinical hours are wasted on account of medicines being out of stock in community pharmacies. We ask GPC and its component committees to lobby for a change in the medicines serious shortage protocol to allow a broader definition to enable community pharmacies to more readily substitute medicines without the need to go back to a prescriber.
- AR** 31. CONFERENCE OF ENGLAND LMCs: That conference is dismayed by the lack of adequate gender dysphoria services and believes it is imperative that GPC ensures the NHS:
- (i) formally acknowledge that it is not appropriate for general practice to prescribe medication without specialist initiation and only then when supported by a shared care agreement and if a GP believed they are competent to prescribe
  - (ii) ensure appropriate services are commissioned at a local level that provide ongoing prescribing and support for patients with gender dysphoria
  - (iii) ensure that any shared care arrangements are appropriately resourced with mechanisms in place if a GP chooses to decline to accept shared care.
- AR** 32. HERTFORDSHIRE: That conference:
- (i) recognises that adequate services for transgender patients are lacking, and
  - (ii) calls on GPC to engage with national commissioners to negotiate the commissioning of effective services for our transgender populations.
- AR** 33. BEXLEY: That conference following legislative changes in July 2022, asks that government provide continuing support to eligible healthcare professionals to ensure they have the required expertise and knowledge to be able to certify and issue fit notes; and that any problems arising from this arrangement, do not fall back on GPs to rectify.

#### **PORTFOLIO AND SESSIONAL GPs**

- A** 34. SURREY: That conference demands that salaried GPs employed by non-GMS / PMS contractors should be entitled to the BMA model contract.

#### **GP TRAINEES AND GP TRAINING**

- A** 35. GP TRAINEES COMMITTEE: That conference notes the declining numbers of GP trainees choosing a career as a GP partner post-CCT. We call on GPC UK to lobby the relevant health education bodies to ensure that:
- (i) relevant business skills are taught as a mandatory part of general practice speciality training

- (ii) appropriate time is allocated in all GP trainee rotas (including those working LTFT) to allow trainees to gain experience of the business side of running a GP practice.
- A** 36. LOTHIAN: That conference reaffirms the importance of postgraduate education and calls on all UK governments to work with our negotiating teams to ensure that time to access this vital resource becomes a contractual right for all GPs.
- A** 37. LOTHIAN: That conference calls for all FY2s to spend at least four months in general practice, believing this is essential experience for all doctors who will be working in the NHS and will improve understanding across primary and secondary care.
- A** 38. HULL AND EAST YORKSHIRE: That conference calls on the GPC to support and promote practices to deliver work experience opportunities in general practice, maximising local uptake and promoting primary care to those from deprived backgrounds.
- A** 39. LIVERPOOL: That conference believes that if the NHS genuinely wants more GPs, the NHS will have to invest more on GP trainers and estates, to facilitate the training of more GPs for the future, GP teachers for medical schools, and GP clinical academic workforce for teaching and research in General Practice, Primary and Integrated Care.
- A** 40. GP TRAINEES COMMITTEE: That conference notes that general practice has the widest gender pay gap (GPG) of any branch of medicine and calls for all component committees of GPC UK to:
- (i) make reducing this pay gap a priority
  - (ii) incorporate ongoing review of the impact on the GPG of all strands of work, but especially on any contract negotiations.
- AR** 41. GRAMPIAN: That conference recognises the role of the GP is changing with an ageing population, pressures on secondary care, increase in defensive medicine and working in a chronically underfunded service and calls on appropriate bodies to be involved in providing a post graduate education programme which includes backfill and a regular commitment to educational development to ensure GPs are fit for the role.
- AR** 42. NOTTINGHAMSHIRE: That conference is concerned that GPs leaving training are not prepared for working in practices, particularly partnerships. This leads to GPs choosing not to enter partnerships thus threatening the independent contractor model. We ask for:
- (i) a UK-wide offer of training equivalent to a ST4 year to prepare GPs for the business of general practice
  - (ii) funding to be negotiated to assist new partners to undertake personal development activities to help them to contribute to the running of practices
  - (iii) business basics and negotiation skills to form part of the ST3 curriculum.

## DIGITAL AND DATA

- A** 43. GLASGOW: That conference supports a change to GDPR rules regarding Subject Access Requests to charge a reasonable fee for such work to match the significant impact it is having on GP practice workload.
- A** 44. LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that there is interoperability between GP IT systems across all four UK nations and that:
- (i) records should be transferable electronically between all practices
  - (ii) prescriptions should be able to be electronically issued in any home nation and able to be dispensed in any pharmacy in any home nation.
- A** 45. NORFOLK AND WAVENEY: That conference asks GPC to ensure focus on enhancing the use of technology to increase patient access is coupled with appropriate resource into general practice to meet this subsequent increase in activity.

- A** 46. LAMBETH: That conference believes the NHS must find a way to support the safe implementation of useful algorithms, such as QRISK, in GP electronic patient record systems.
- A** 47. HIGHLAND: That conference is awake to the prospect of future cyber-attacks and threats of disruption to the clinical systems we use in general practice, and asks for a proportionate response from our GPCs in seeking improved cyber resilience for general practice and out of hours services, that might include support around business continuity and cyber security training for the workforce.
- A** 48. HIGHLAND: That conference calls on governments to collect and publish whole time equivalent (WTE) data on the fully qualified GP workforce, not relying on headcount, and demands clarity where any workforce figures have included GP trainees.
- AR** 49. WAKEFIELD: That conference demands that in order to meet the requirements of the long-term plan, GP use of technology is fully funded including all aspects of IT systems and SMS messaging.
- AR** 50. WAKEFIELD: That conference is aware of continuing developments in telephony systems to improve patient access and that these need to be fully funded to allow general practice to make use of them.
- AR** 51. LEWISHAM: That conference support the urgent need for greater investment in general practice to ensure IT infrastructure remains fit for purpose: to enable practices to function efficiently, share information more effectively with local authorities; help manage enhanced access; and meet patient expectations for appointments.

## **GPC / LMCs / LMC CONFERENCE / BMA**

- A** 52. WEST SUSSEX: That conference notes that the Deed of Grant between the BMA and GPDF expires in June 2023 and recommends GPDF ensures any future Deed of Grant agreement represents value for money for LMCs who pay the GPDF levy and includes a framework for monitoring BMA usage of this funding.
- AR** 53. NORTHERN IRELAND EASTERN: That conference calls on GPC UK to work with NIGPC, SGPC, GPC Wales and GPC England to centrally and locally lobby where more appropriate for an expansion of GP training places numbers to support sustainable general practice across the UK.

## **THE WIDER SURGERY TEAM**

- A** 54. HIGHLAND: That conference wants a systematic approach to supporting protected learning time (PLT), enabling practice teams to regularly have opportunities to meet and improve together within office hours.
- A** 55. NOTTINGHAMSHIRE: That conference deplores the continuing lack of a fully funded professional occupational health service for general practice and calls for immediate access to this to prevent further loss of staff through ill health; retraining and leaving the profession, or suicide because of work induced health issues.
- A** 56. HERTFORDSHIRE: That conference calls on GPC to:
- (i) investigate the reasons for the diminishing numbers of GPs and then propose solutions to address this, and
  - (ii) lobby the government and opposition parties in all nations to commit to increasing GP numbers in future in line with what GPC has determined is necessary.
- A** 57. MERTON: That conference asks the GPC to highlight the difficulties in general practice staff retention and to negotiate for a UK-wide safe limit to be placed on workload.
- AR** 58. DORSET: That conference recognises the damaging effect that the current working environment is having on GP mental and physical health and calls for specific additional funding to enable all GPs to have protected time in their work plan for self-care, supervision, coaching and mentoring.

- AR** 59. BUCKINGHAMSHIRE: That conference decries the loss of knowledge and experience from the workforce when a GP retires and recommends that new posts (for example an “end career clinical fellowship”) are created, in order to capture this knowledge and experience and pass it on to a new generation of GPs.

## **COST OF LIVING CRISIS**

- A** 60. HIGHLAND: That conference endorses the need for progress to be made in respect of reducing the carbon footprint of general practice and:
- (i) calls on the GPCs to work with governments to improve the opportunities around this
  - (ii) asks the GPCs to explore arrangements that will allow improvements and retrofitting of GP premises to be made possible regardless of ownership.
- A** 61. HIGHLAND: That conference believes that more can be done to reduce the volume of material waste generated in general practice, improve how it is separated and processed to become more sustainable, and calls on GPCs to push for practices to be provided with assistance in pursuit of this.
- A** 62. KENT: That conference demands GPC UK secures more funding to support the green transition in general practice.

## **POLITICAL DEMANDS VS PATIENT NEEDS**

- A** 63. BEDFORDSHIRE: That conference calls on GPC to press the national governments for a media campaign to explain what does and doesn’t need a GP, and what alternatives there are.
- A** 64. LIVERPOOL: That conference believes that it is unreasonable for health systems to expect practices to bid for funding, for short term projects with tight deadlines of only a few weeks and asks GPC UK and its component committees to discuss with the NHS, the problems caused by the inability to plan appropriately for hastily released resources.
- AR** 65. BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE: That conference recognises the GPDF had not engaged with defending the profession sufficiently during this time of crisis, and that the recent change in leadership is an opportunity to utilise the available funds to defend general practice by:
- (i) requisitioning a UK-wide media campaign engaging the public about their relationship with primary care, which focuses on identifying what service the population wish general practice to provide
  - (ii) publishing the mismatch between what the public wish for GPs to provide and the current and falling capacity to highlight to the public the level of the current crisis
  - (iii) using a media campaign focused on the mismatch between demand and supply to provide a basis for national GP contract negotiations and help repair the misaligned expectations between the population and primary care.
- AR** 66. CONFERENCE OF ENGLAND LMCs: That conference believes the relentless denigration of general practice continues to drive a crisis of recruitment and retention and that GPC:
- (i) must respond in a robust and timely manner to news reports which unfairly target general practice
  - (ii) needs a dedicated PR budget to provide a robust and timely defence of general practice.
- AR** 67. CONFERENCE OF ENGLAND LMCs: That conference believes general practice is unsafe due to a shortage of doctors and a lack of investment; that this problem must be owned by government, and:
- (i) believes that focusing on patient safety is more appropriate than trying to meet high patient demand and therefore calls for GPC to use “safe capacity” and avoid “access” in communications and negotiations
  - (ii) deems the scapegoating, moral injury and lack of psychological safety faced by GPs, in the context of whole NHS system failure, to be entirely unacceptable

- (iii) calls for an effective mechanism for LMCs to escalate issues that impact on patient safety in general practice that are outside the gift of practices to address and have failed to be addressed locally
- (iv) believes it is time that a workload sensitive contract for GPs was introduced without further delay which includes a proactive system of monitoring and wellbeing safeguards.

**AR** 68. NOTTINGHAMSHIRE: That conference is concerned that patients are still subject to misinformation about why they may be finding it harder to get appointments, much of what they hear is an inaccurate and harmful narrative. We urge GPC to work with national media outlets to mount a sustained public-facing campaign explaining the challenges on the profession and supporting safe working in practices.

## THE INDEPENDENT CONTRACTOR

**A** 69. SUFFOLK: That conference continues to be appalled at the personal liability held by GP contractors on behalf of a failing system and calls for GPC to:

- (i) negotiate, as a matter of urgency, changes in the statutory regulation to permit novation for all practices without jeopardy whilst explicitly safeguarding existing dispensing rights
- (ii) highlight the deleterious effect on partner numbers and practice stability
- (ii) lead the profession to a place of limited liability without further delay.

## PENSIONS

- A** 70. GLASGOW: That conference calls on the Chancellor to heed his own words and sort the pension taxation chaos which is devastating the input into the NHS from senior doctors at patients' expense.
- A** 71. AVON: The on-going failure to address the NHS Pension factors that are penalising GPs and driving doctors from the profession is a source of frustration and disappointment. Conference asks the government to address these issues with an urgency to support the GP workforce and patient care
- A** 72. DORSET: That conference calls for a radical overhaul of the current NHS pension system for salaried GPs and locums which is overly bureaucratic, complex and time consuming.
- A** 73. WELSH CONFERENCE OF LMCs: That conference call for locum GPs who are a member of the NHS Pension Scheme to receive the same death in service benefit as other types of GPs should they die on a day when they are not due to be in work.
- AR** 74. NORFOLK AND WAVENEY: That conference asks GPC to negotiate the removal of the maximum amount or increase the personal allowance in NHS pensions to allow senior doctors to continue to work without having to pay additional tax on their pensions.

## PREMISES

- A** 75. BEDFORDSHIRE: That conference asks GPC to negotiate a pot of new money for general practices, which is specifically ring-fenced for new premises and estates funding.
- A** 76. AVON: That conference calls for urgent investment in the general practice estate in all four nations as the current condition of general practice buildings is unacceptable and a barrier to improving patient care.
- A** 77. BEDFORDSHIRE: That conference asks GPC in each of the four nations to negotiate that service charges be included in reimbursable costs for practices.
- AR** 78. LEEDS: That conference believes many practice premises are full to bursting and have no spare capacity, which is adversely effecting patient access and quality of care, limiting training opportunities for the current and future, and limiting community service provision, and calls on Treasury to provide the necessary capital and revenue investment to enable all UK nations to address this.

- AR** 79. NORFOLK AND WAVENEY: That conference calls on GPC to enable more funding for premises, technology and facilities expansion to accommodate new clinical roles as the current situation is preventing GP practices from recruiting this much needed additional resource.
- AR** 80. BEDFORDSHIRE: That conference asks GPC to press for legislation or regulations to require local authorities and developers to liaise with local health commissioning organisations about any requirements for healthcare premises before the building of new developments, on the principle of “no doctor, no building development”.

## PRIMARY / SECONDARY INTERFACE

- A** 81. NORTHERN IRELAND CONFERENCE OF LMCs: That conference instructs GPC UK to demand there is transparency for the public around the status of waiting list arrangements for patients for referral, awaiting investigation and for review. This information should be publicly accessible, and queries need to be managed by service providers not by GPs.
- A** 82. NORTH YORKSHIRE: That conference demands shared care should mean just that, where secondary and primary care accept equal responsibility for patient care, not a hierarchical relationship of instructions from one service to another.
- A** 83. BRADFORD AND AIREDALE: That conference demands greater clarity on the primary secondary care workload transfer, with financial penalties for those that breach them.
- A** 84. CLEVELAND: That conference, with regards to recent pressures in emergency departments and other acute hospital settings:
- (i) express concern for patient safety
  - (ii) stands in support of all colleagues working on the frontline in secondary care
  - (iii) notes the impact of these on general practice workload
  - (iv) believes that these were entirely predictable and that these will be repeated next winter without focused meaningful action by all UK governments
  - (v) insists that general practice contracts never contain requirements to compensate for secondary care pressures.
- A** 85. HERTFORDSHIRE: That conference:
- (i) recognises that there are excessive waiting times for mental health services, and
  - (ii) calls on GPC to engage with national commissioners to negotiate sufficient funding for a complete mental health service.
- A** 86. GLASGOW: That conference acknowledges the need for good whole system working and:
- (i) recognises the importance of developing effective primary secondary care interface groups, working collaboratively to develop new patient pathways
  - (ii) demands a cease to inappropriate back to referrer outcomes
  - (iii) calls for investment in and prioritisation of fit for purpose IT solutions to facilitate communication between primary and secondary care clinicians.
- AR** 87. CONFERENCE OF ENGLAND LMCs: That conference notes the increase in attempted shifting of work from secondary to primary care since the introduction of block contracts for trusts and calls for:
- (i) all trust-employed staff to request prescriptions, investigations and referrals from within their team, and to promote this by the creation of educational materials for use in their induction of new staff
  - (ii) LMC approved audits to be conducted to demonstrate that trusts' annual action plans result in improvements
  - (iii) all trusts to have a standardised 'work-dump' email for use by practices, to be monitored and actioned daily
  - (iv) all trusts to have a dedicated telephone and online portal to deal with patients who are experiencing delays in secondary care treatment, without recourse to their general practitioner.

- AR** 88. WORCESTERSHIRE: That conference believes that the role of the GP as an expert generalist has been undermined and insists that:
- (i) advice and guidance is not used to block or delay referrals
  - (ii) GPs are not asked to order and interpret specialist tests
  - (iii) shared care agreements are in place for specialist drugs prescribed within any enhanced service
  - (iv) secondary care work is not passed to the GP without additional resource and agreement
  - (v) government manages public expectation of what can safely be provided by general practice at this time.
- AR** 89. CONFERENCE OF ENGLAND LMCs: That conference, whilst recognising their staffing crisis, is concerned about the diminishing access to mental health services and:
- (i) does not accept the near automatic rejection of GP referrals or insistence on completion of lengthy proforma before acceptance
  - (ii) does not accept referral responses which simply consist of a list of websites that the patient can consult
  - (iii) abhors the almost complete absence of CAMHS services for those who need such services but have not (yet) attempted suicide
  - (iv) calls on GPC to look at ways of ensuring that the current service inadequacies do not fall to general practice.
- AR** 90. DEVON: That conference asks the GPC to seek clarification over the recording of a patient's individual decision regarding advance directives and work to ensure that the onus for this transfer of information is shared by both primary and secondary care.
- AR** 91. AVON: That conference asks the BMA to lobby the ambulance services to utilise their own clinical desk for rapid advice on patients rather than spending long periods waiting for a GP who may be otherwise engaged with patients.
- AR** 92. AVON: That conference demands that any expansion of acute care at home by means of virtual wards does not lead to an increased burden of work for GPs and that governance for these patients sits with the secondary care team unless there is appropriate additional funding and resources available for GPs to provide the service.

## UK GOVERNMENT

- A** 93. CLEVELAND: That conference notes the current crisis in GP workload and insists that this is a failure of governments to properly commission primary care services.
- A** 94. LAMBETH: That conference laments the lack of a coherent workforce strategy for the NHS that matches training places to those leaving / retiring in each staff group.
- A** 95. HIGHLAND: That conference wishes for our next GP contracts to have vision, aspiration and a clear direction of travel, but insists that this must be backed up with detailed service specifications and a level of financial planning commensurate with this.
- A** 96. LIVERPOOL: That conference believes that the DDRB pay increase for salaried GPs must be appropriately funded through the GP contract and expects GPCs to ensure that this is negotiated in future contract negotiations.
- A** 97. LIVERPOOL: That conference believes that the DDRB recommended pay rises for GPs must be fully funded within core general practice remuneration.

## COMMISSIONING

- A** 98. WELSH CONFERENCE OF LMCs: That conference believes that improved continuity of relationship-based care should be encouraged in preference to access targets.

- A** 99. LEEDS: That conference believes that continuity of care is fundamental to good quality general practice, as recognised by the UK parliament's Health and Social Care select committee and calls on the four national governments to acknowledge the importance of this and support practices to deliver it by reducing the burden of other contractual requirements.
- A** 100. LAMBETH: That conference calls on GPC to negotiate contracts in all four nations which reward continuity of care.



## **Agenda: Part II**

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

#### **CLINICAL, PRESCRIBING AND DISPENSING**

101. GLOUCESTERSHIRE: That conference believes that in light of evidence supporting home blood pressure monitoring, blood pressure machines should be available on prescription.
102. LOTHIAN: That conference believes that blood pressure monitors should be available on prescription to enable equitable access to home monitoring regardless of an individual's financial resources.
103. SUFFOLK: That conference noting the flawed NHSE publications pertaining to Inclisiran, conference instructs GPC to:
  - (i) publicly enquire why, for over a year, NHSE have not yet publicly acknowledged or corrected VAT errors (the net effect of which is to significantly reduce reimbursement) whilst simultaneously incorporating the drug within IIF metrics and encouraging local systems to attempt implementation
  - (ii) seek recompense for practices who have been billed the incorrect 'hospital' charge of around £2000 per injection and indemnity against all future cases
  - (iii) engender national solidarity by publishing fresh guidance to practices encompassing clinical and financial concerns (noting inadequate remuneration for practice nurse administration in particular).
104. GATESHEAD AND SOUTH TYNESIDE: That conference deplores the lack of moral courage of devolved nation health ministers and calls for the black listing (with NICE involvement) of medications deemed to be of negligible clinical value, rather than simultaneously encouraging patient demand whilst encouraging GPs to restrict prescribing.
105. WEST PENNINE: That conference is concerned that NICE guidance is now so specialist directed that it fails to support primary care and the generalist approach.
106. TAYSIDE: That conference believes that the current legislation surrounding controlled drugs serves neither patients nor the profession well and requires urgent revision.
107. AVON: That conference with increasing numbers of patients with multiple long-term conditions being cared for in the community, either in care homes or in their own homes, conference seeks additional funds and resources to support the provision of a consistent high-quality offer to patients in care homes.
108. BARNET: That conference recognises the need:
  - (i) for increased awareness of the safety implications and risks involved in prescribing steroid medication, including topical steroid addiction (TSA) and topical steroid withdrawal (TSW)
  - (ii) to provide appropriate training for all GPs, including for GP trainees, within the GP training curriculum".
109. NORFOLK AND WAVENEY: That conference calls upon the BMA to protest imposed introduction of new drugs, for example Inclisiran, until they are appropriately evaluated to ensure they provide:
  - (i) clear clinical evidence of cost-effectiveness
  - (ii) assurance that they have not been priced so that is only possible for them to be issued in primary care
  - (iii) appropriate commercial agreements lasting longer than two years and without significant potential future cost increases
  - (iv) effective and transparent pilot studies to inform whether it is appropriate for general practice to prescribe
  - (v) evidence against the undermining of local arrangements for managed introductions without valid reason.

## REGULATIONS

110. DEVON: That conference, whilst recognising safeguarding training is important conference asks the GPC to recognise that the guidelines for hours of training expected are:
- (i) burdensome and excessive
  - (ii) should not be mandated
  - (iii) recognised as an area for discussion at annual appraisal but not allotted annual targets.
111. BERKSHIRE: That conference demands that BMA:
- (i) explore the scale of complaints received by GPs and the extent to which some of these may be considered “vexatious”, and consider possible mechanisms to tackle this
  - (ii) commission or provide a service to support individual GPs and practices who are subject to such complaints
  - (iii) conduct an analysis on the workload each complaint produces, and survey general practice to understand disparities in which GPs and practices receive complaints
  - (iv) lobby regulatory bodies to simplify and streamline complaints handling.
112. SUFFOLK: That conference, noting the increasing disparity between the letters of support from NHSE, GMC, RCGP, etc and that of statute pertaining to the responsibilities of a registered medical practitioner, instructs GPC to:
- (i) open a national dialogue around whether UK law in this area is fit for purpose and adequately reflects the operating environment within our modern-day NHS
  - (ii) publicly illustrate that the considerable resource allocated to NHS Resolution (and medico-legal expenditure in general) would be better deployed under a ‘no fault’ compensation scheme with the resulting savings reinvested into reversing the vicious cycle of diminishing frontline capacity and rising indemnity costs.
  - (iii) evaluate and publish the likely impact of such changes (a true “no blame culture”) on the health and wellbeing of the workforce
  - (iv) highlight the patient centric benefits of reducing ‘defensive medicine’.
113. KENSINGTON, CHELSEA AND WESTMINSTER: That conference deems the scapegoating, moral injury and lack of psychological safety faced by GPs, in the context of whole NHS system failure, to be entirely unacceptable and calls for:
- (i) GPC to work with GMC on greater transparency regarding how the demand: workforce capacity context will be taken into consideration in investigations
  - (ii) GPC to work with CQC to ensure the demand: workforce capacity context is taken into consideration to avoid the self-fulfilling impact on recruitment and retention
  - (iii) a review of the patient satisfaction questionnaire required as part of GPs’ revalidation so that GPs are not held responsible for system failings and pressures.
114. WEST PENNINE: That conference deplores the unrealistic gold level standards still expected of us by CQC and NHSE.
115. NORTH YORKSHIRE: That conference demands the performers list should be abolished because it:
- (i) has no benefits for doctors or patients over and above the other regulatory systems governing all doctors
  - (ii) introduces an inequity with other specialist clinical groups
  - (iii) acts as a barrier to workforce expansion from other medically qualified professionals and SAS doctors
  - (iv) is used in performance management to create a “double jeopardy” of PAG and GMC for simultaneous investigation of GPs related to a single issue.

## PORTFOLIO AND SESSIONAL GPs

116. KINGSTON AND RICHMOND: That conference believes any new GP contract should offer a sessional payment based on the consultant model, with sessions for clinical care, teaching, CPD, and research, with a fixed number of patient appointments provided within each clinical session.

117. GLASGOW: That conference notes with concern the difficulties in obtaining locum GPs being experienced by practices, and:
- (i) believes that this presents a challenge for GPs being able to take annual leave, which is of huge importance to their welfare
  - (ii) calls on the four governments to work with the GPCs and RCGP to implement solutions.
118. WAKEFIELD: That conference is concerned that the “free for all” of locum rates continually escalating needs to be stopped and capped payments implemented as this will benefit the whole system.
119. GP TRAINEES COMMITTEE: That conference notes the significant gender pay gap in GP salaries. We call on the BMA address this by:
- (i) GPC UK lobbying the relevant health education bodies to ensure negotiation training, centered around job interviews, is taught as a mandatory part of general practice speciality training
  - (ii) delivering negotiation training skills to any BMA member (specifically GPs) around how to achieve the best pay and conditions when commencing new employment.

## THE EXPERT GENERALIST

120. NORTHERN IRELAND SOUTHERN: That conference deplores the difficulty that fully licensed and appraised GPs have in moving throughout the UK and instructs GPC UK to work with the GMC and the respective deaneries to develop a centralised performers list to ensure more freedom of movement.
121. CLEVELAND: That conference advocates for a single Medical Performers List across the UK.

## GP TRAINEES AND GP TRAINING

122. NORFOLK AND WAVENEY: That conference believes that general practice should be at the heart of undergraduate training and asks GPC to negotiate for:
- (i) all practices to be supported to train both undergraduate and postgraduate students through appropriate funding and infrastructure to accommodate this
  - (ii) enable GP trainers to mentor non-training practices to widen the training resources
  - (iii) more incentives being made available to support retention of GPs in areas where they undertake their training
  - (iv) increased promotion and support in GP partnership roles to all GPs and trainees, through increased training opportunities in the role of a partner and financial incentives.
123. HERTFORDSHIRE: That conference calls on GPC to negotiate that funding should be provided for LMCs hosting GP trainees in the same manner as funding is available to trusts and GP practices hosting GP trainees.
124. GP TRAINEES COMMITTEE: That conference notes the pressure on governments to expand GP training numbers across the UK, to keep pace with rising demand. We call on the BMA to:
- (i) lobby relevant bodies to disclose plans on how resources (trainers, facilities, infrastructure, etc) have been allocated to provide any planned expansion to GP training numbers
  - (ii) oppose any planned expansion of GP training numbers in circumstances where the BMA cannot ensure that adequate additional resources will be delivered to support such expansions.
125. GP TRAINEES COMMITTEE: That conference notes that the BMA and COGPED co-produced “Guide to a session for GP trainees and trainers” document, which forms the basis of GP trainee rotas across the UK, was last updated in 2012. We call on:
- (i) GPC UK to lobby COGPED to work with GP trainees committee to update this document
  - (ii) GP trainees committee to identify parts of this document which can be modernised.
126. GP TRAINEES COMMITTEE: That conference notes that GP trainees are the future of the profession and is appalled that GP trainees are not being appropriately represented within the RCGP. We call on GPC UK to lobby RCGP to:
- (i) restore the AiT (Associate in Training) committee within the RCGP and ensure this is appropriately resourced and empowered to represent AiTs within the RCGP

- (ii) overhaul the allocation of seats within the RCGP council, to ensure AiTs are appropriately represented on RCGP council, in line with their proportional representation within the RCGP membership.
127. AYRSHIRE AND ARRAN: That conference believes that UK general practice must adapt to changing preferences of doctors completing their foundation training and:
- (i) recognises not all doctors wish to commit to a run through training programme immediately
  - (ii) is aware of clinical development fellowship posts in other areas of the system
  - (iii) urges GPC UK to work with the RCGP to develop similar posts in primary care.
128. NORTHERN IRELAND SOUTHERN: That conference deplores the attitude that the junior medical workforce is only required for provision of service in secondary care settings and instructs GPC UK to work with the devolved governments and relevant colleges to ensure a fairer distribution of the medical workforce across the whole health service.
129. NORFOLK AND WAVENEY: That conference acknowledges the negative stigma associated with GP training in the press and in hospitals, and the subsequent lack of retention of trainees by:
- (i) formally educating hospital specialists to provide a positive image of general practice
  - (ii) providing the public with an accurate portrayal of the division of labour and difficulties of "front-door" service.
130. AVON: That conference is concerned about the suggestion of doctor apprenticeships and directs GPC to obtain appropriate remuneration on a rate-card and funding for any training that GPs will be asked to provide.
131. GLOUCESTERSHIRE: That conference is concerned at the inflexibility of GP training scheme placements within deaneries and insists on more placements near to doctors' residence or preferred place of working.
132. BEDFORDSHIRE: That conference asks GPC to work with the relevant bodies to review how long a senior GP can continue as a GP educator after ceasing revalidation, so that the senior GP's store of knowledge and experience can continue to be available to GP trainees for as long as possible.
133. NORTH AND NORTH EAST LINCOLNSHIRE: That conference demands any increase in medical student training numbers must:
- (i) only take place after full engagement with GPC UK representatives
  - (ii) include an impact assessment on local NHS services of any such increase
  - (iii) not be agreed without approval by the LMC(s) covering those practices within each medical school's local area.
134. KENT: That conference believes that tackling the crisis in GP numbers requires the simplification and streamlining of the bureaucracy required to become an education supervisor and demands that the GPC:
- (i) negotiate a standardised educational supervisor accreditation process
  - (ii) a national passporting mechanism that enables educational supervisors to move from one deanery to another.
135. GP TRAINEES COMMITTEE: That conference recognises that experiences during GP training have significant influence on the retention of newly qualified GPs post CCT and ensuring positive experiences during training is vital to curb the exodus of newly qualified GPs to countries where they feel their expertise would be more valued. We call on GPC UK and its component committees to:
- (i) lobby statutory education bodies across the United Kingdom to review and remove any ineligibility criteria that prevents study leave for AKT preparation for attempts subsequent to the first sitting
  - (ii) negotiate that breaks are clearly defined in the terms and conditions of service for GP trainees and any GP practice-based contracts that exist across the United Kingdom
  - (iii) lobby the Home Office and other relevant stakeholders to increase the duration of validity of tier 2 visas, to help GP trainees stay in the UK post training avoiding issues around visas
  - (iv) lobby RCGP to increase the booking window length for MRCGP examinations.

136. GP TRAINEES COMMITTEE: That conference recognises that the future of general practice will be impacted by the experiences of GP trainees during their time in general practice. We, therefore:
- (i) recognise the increasing difficulties in providing a positive trainee experience due to a lack of adequate facilities, increase in other staff members working in GP, and a reduction in the number of trainers relative to the increasing number of trainees
  - (ii) note the calls within the NHS and government to double the number of medical students in the coming years, and the inevitable impact that this will have on general practice
  - (iii) call on GPC UK to lobby governments and NHS education bodies in each of the four nations to provide adequate resources to recruit and retain GP trainers to be able to facilitate a positive training experience for GP trainees
  - (iv) call on GPC UK to lobby governments and providers of GP estates in each of the four nations to ensure appropriate funding is provided to facilitate upgrading of physical infrastructure of the GP estate to allow appropriate workspace for the increasing number of GP trainees.
137. LIVERPOOL: That conference believes that the answer to the GP workforce crisis will not be resolved by trying to train GPs through the apprentice route.
138. WAKEFIELD: That conference believes that the interface issues across primary and secondary care would be eased if secondary care doctors had a better understanding of primary care and to that end propose a mandatory six-month placement in general practice for all hospital specialty trainees.
139. DORSET: That conference believes that overseas students who have completed all or part of their undergraduate medical training in the UK should have any inhibiting or punitive barriers that currently prevent or discourage them from entering foundation training removed, in particular by:
- (i) introducing a timely visa application process which does not delay foundation training
  - (ii) setting the date of PLAB exams to better coincide with commencement of foundation training, so that students are able to apply at the same time as UK students.

## DIGITAL AND DATA

140. EALING, HOUNSLOW AND HAMMERSMITH AND FULHAM: That conference believes that GP practices - across the UK - should have NHS funded practice websites, especially in the digital age we now live in.
141. NORTHERN IRELAND CONFERENCE OF LMCs: That conference deplores the delays in the patient registration process and demands a centrally managed system available in all of the four areas of the UK which respects patient choice and ensures that the burden of gathering the required documentation is removed from primary care administrative teams.
142. AVON: That conference is dismayed that the Qrisk calculator is to be withdrawn from the EMIS clinical system from the end of March 23. This will cause a significant increase in workload for GPs and pose a clinical risk. This position is unacceptable, and an urgent resolution should be sought with the input of all stakeholders.
143. LAMBETH: That conference believes that central GP IT Futures Systems Funding should include text messaging and video conferencing and calls on GPC to negotiate this in all four nations.
144. HIGHLAND: That conference hopes that data collection relating to the general practice multi-disciplinary team can:
- (i) provide intelligence around what rewarding careers look like for GP pharmacists and first contact physiotherapists, and
  - (ii) show that there are career progression opportunities for these individuals while retaining them within the primary care workforce.
145. LEWISHAM: That conference calls for improved data sharing between primary, secondary sectors, and local authorities to support integration of patient services and care.

## GPC / LMCs / LMC CONFERENCE / BMA

146. CENTRAL LANCASHIRE: That conference believes that it is an impossibility to achieve a GP contract settlement that will fully address the plight of the general practice if both the profession and the government cannot define an adequate solution to the current crisis but implores GPC to remain resolute in representing our howl of abused anguish.
147. MID MERSEY: That conference considers that the current system of adjusted GP capitation payments has failed to account for rising demand and activity per patient over recent years and asks GPC to work to introduce a data-based method founded on an accurate measurement of clinical and administrative workload at system and / or practice level.
148. KENT: That conference demands the GPC to negotiate contractual workload limits for all GPs with central provision of urgent care for demand that exceeds these limits.
149. SURREY: That conference requires GPC England to publish, at least six weeks prior to the LMC England Conference date:
- (i) a detailed report describing progress in relation to LMC England Conference motions from the previous year
  - (ii) a detailed explanation of why no or partial progress has been made, if this is the case
  - (iii) that a dedicated session at each conference is made available to discuss this report with the GPC England Executive Team.
150. GP TRAINEES COMMITTEE: That conference notes the hostile environment towards GPs created by the Daily Mail, Mail on Sunday and MailOnline We call on:
- (i) GPC UK to highlight the physical and mental damage that the editors of the Daily Mail, Mail on Sunday and MailOnline cause to GPs across the UK
  - (ii) the BMA to highlight the damage to patients caused sensationalist reporting of health issues in the Daily Mail, Mail on Sunday and MailOnline
  - (iii) the BMA to highlight to the public the promotion of private health services in both articles and advertisements in the Daily Mail, Mail on Sunday and MailOnline
  - (iv) the BMA to lobby relevant NHS bodies across the UK to ban sales of the Daily Mail and Mail on Sunday on NHS premises.
151. WIRRAL: That conference observes that despite numerous complaints from grassroots GPs about Primary Care Support England (PCSE), the services delivered by PCSE are still woefully suboptimal and in some cases damaging to general practice. It therefore proposes that:
- (i) all the current services of PCSE delivered by Capita on behalf of NHSE be stopped immediately
  - (ii) all such services be commissioned using local arrangements as it was the case before the formation of PCSE
  - (iii) GPC and LMCs must be allowed to have adequate input into such local arrangements.
152. HAMPSHIRE AND ISLE OF WIGHT: That conference believes that there is purpose and strength of unity in the meeting of LMC representatives across the UK. Conference believes that despite the devolved nations diverging there is merit in coming together in a joint forum. We believe the UK conference should be in a format to add weight to GPC UK to effect national public and governmental support for:
- (i) the professional integrity of being a GP which is still being eroded by politicians, the media and health systems that don't understand the true 'value' of GPs
  - (ii) the most effective intervention we have which is continuity of care
  - (iii) general practice across the four nations to be funded appropriately to allow continuity of care to be given
  - (iv) the value of 'generalists' as opposed to 'specialists' in managing health complexity particularly mindful of our aging population
  - (v) the establishment of realistic expectations for service users that are proportionate to funding levels
  - (vi) the acceptance that general practice can only deliver to its full potential with resolution of the current workforce and retention crisis.

153. SESSIONAL GPS COMMITTEE: That conference directs the BMA to explore option towards becoming a White Ribbon accredited organisation.

## THE WIDER SURGERY TEAM

154. NORFOLK AND WAVENEY: That conference believes effective use of resources is better achieved by enhancing the medicine management within primary care teams with improved core funding rather than directed to stand-alone commercial community pharmacies which are not integrated with primary care systems, nor have the capacity to deal with this increased workload in a meaningful way.
155. LIVERPOOL: That conference believes that whilst physicians associates, nursing associates and pharmacy technicians might be increasing the primary care workforce, they are not replacing GPs and are not the answer to the workforce crisis in general practice.
156. DEVON: That conference seeks uniformity across the UK as to the role the community nursing teams are contracted to take in the medical care of housebound patients with long term medical conditions.
157. CHESHIRE: That conference believes that to help with retention of GPs in the workforce, the national GP contract should reflect the need to improve long-term sickness management and return to work provision in general practice and thus supports:
- (i) standardised and regulated employment and long-term sickness procedures in general practice
  - (ii) occupational health input that can be accessed in a structured and timely manner
  - (iii) provision to practices to allow the GP role if needed to be adapted to one where reasonable adjustments of appointment length, rest breaks, work environment, flexible working and caseload are a real possibility and are seen in a positive light
  - (iv) GPs who are no longer able to offer the full complement of requirements needed to fulfil the grassroots job demands of them, are still able to be accommodated in an inclusive workplace, where they can continue to provide a meaningful contribution to both the NHS and its patients.
158. DERBYSHIRE: That conference notes that personnel in new roles coming into general practice (such as for example those in the ARRS) require a significant amount of training, supervision, and support from existing general practitioners and:
- (i) such activities must be appropriately resourced both financially and in dedicated professional time
  - (ii) general practitioners can only be responsible for staff whom they directly employ
- and instructs GPCs to negotiate accordingly.
159. DERBYSHIRE: That conference whilst recognising the value of working in multi-disciplinary teams with clearly defined and easily identifiable roles notes the development of “PAs” – physician associates and demands that in order that the public not be misled or deceived by such healthcare workers they:
- (i) shall be renamed physician assistants, never be called “doctor” in a healthcare setting even if they have a PhD, nor have grading structures which could permit confusion as to whether they hold a medically registerable qualification in the traditional sense
  - (ii) must hold their registration through the Health Professions Council and NOT through the General Medical Council
  - (iii) must only be appointed to work to a named responsible registered medical practitioner (or a named deputies), one of whom who is immediately available, appropriately indemnified AND specifically consents in writing to supervise a physician ASSISTANT
  - (iv) must take personal responsibility for their own professional actions
- and instructs the GPCs to work with the BMA to achieve these aims.

160. DERBYSHIRE: That conference:
- (i) recognises changes to the role of a practice manager
  - (ii) agrees supporting accreditation to a governing body through the Institute of General Practice Managers
  - (iii) increases funding to support the wider practice management team
  - (iv) introduces support for practice managers to be included as partners
- and instructs GPCs to negotiate accordingly.
161. LEEDS: That conference believes that more support is needed for those working in general practice who are neurodivergent and calls on GPC UK to produce a public report that highlights these issues, their impact and what governments need to do to address them.
162. TOWER HAMLETS: That conference believes that practice nurses should be on Agenda for Change.
163. WARWICKSHIRE: That conference calls for NHS England to commit to a statement that:
- (i) confirms that the original core purpose of funding the ARRS roles in PCNs was in recognition that the GP workforce had become chronically depleted and recruitment and retention were not keeping pace with the decline
  - (ii) the ARRS staff are to support the core work in the practices to offer a wider service to the practice patients and to relieve the work pressures on GPs and practice nurses
  - (iii) makes it clear to ICBs that the PCN DES staff and resources cannot be viewed as wider system monies and must not be appropriated for wider system work without the agreement of the practices working together within a PCN
  - (iv) where a PCN decides to use its ARRS staff and estates to participate in joint pathway working with secondary care and other agencies, then this should attract funding in recognition of the work transferred into primary care.
- (Supported by COVENTRY)
164. NORTH STAFFORDSHIRE: That conference recommends that:
- (i) practices cease childhood vaccinations, given the non-viable funding model
  - (ii) practices adopt capped safe levels of activity for all clinicians
  - (iii) practices charge PCNs within ARRS role costs for clinical supervision
  - (iv) GPC define safe supervision ratios and time requirements
  - (v) GP registrars have more clearly defined support procedures, systems and standardised progression expectations.
165. SURREY: That conference urges GPC England to provide detailed resources enabling GPs to reject non-contractual workload transfer.
166. WELSH CONFERENCE OF LMCs: That conference calls for the development of a nationally agreed process for physician associates to be able to request radiographic imaging which does not involve ionising radiation.
167. HIGHLAND: That conference endorses the important role that community hospitals play in the delivery of local health care and calls on GPCs to work with governments to sustain these services through:
- (i) proactive development by boards that allows for community hospitals that are modern, locally sustainable and responsive to local community needs
  - (ii) provision of resources that are commensurate with allowing them to fulfil such a function while operating within a modern health and social care setting
  - (iii) recognising that the role that GPs can fulfil as expert medical generalists is also well suited to the provision of medical input to community hospitals
  - (iv) the promotion of community hospitals as having the potential to be hubs from which a range of intermediate care services can be delivered, strengthened by the ability of GPs to act in the role of expert medical generalists.



168. NOTTINGHAMSHIRE: That conference sees the role of practice manager as crucial to the effective working of practices and recognises that practice management has no consistency in offer or support. We urge GPC / GPDF to help to implement the following at national level:
- (i) funded or subsidised practice manager basic training
  - (ii) practice manager appraisal templates and support
  - (iii) training to help managers to convert to practice management from outside of general practice.
169. GLASGOW: That conference calls on the four governments to work to strengthen and support community based schemes to help patients with diet, exercise, sleep, harmful substances and social groups; and calls for these to be easily accessible for patients.

## COST OF LIVING CRISIS

170. KENT: That conference demands general practice should have equal access to patient transport services to enable more effective use of clinical resources.
171. LIVERPOOL: That conference believes that no GPC should enter into a multi-year pay deal without an explicit clause which will take account of the annual rate of inflation, as defined by the Consumer Prices Index (CPI), to fund the salaries of GPs, practice staff and other practice expenses.
172. COVENTRY: That conference believes NHS England should take action commensurate to the scale of the climate and ecological crisis by:
- (i) recognising sustainability and carbon emission reduction as priorities in all primary care contractual targets / arrangements / negotiations
  - (ii) accelerate the decarbonisation of the GP estate by granting access to the public sector decarbonisation fund, giving parity with secondary care healthcare bodies
  - (iii) invest in system wide schemes to safely reuse medical equipment, reducing our reliance on single use plastics
  - (iv) invest in system wide schemes to improve/promote access to recycling facilities, including medicinal waste.
173. HULL AND EAST YORKSHIRE: That conference believes the failure to adequately invest in NHS dentistry amounts to negligence by successive governments and:
- (i) penalises the most vulnerable patients across the United Kingdom
  - (ii) causes a direct increase in GP workload when patients are unable to access basic dental care
  - (iii) calls on all UK governments to deliver supervised brushing programmes to under 5s
  - (iv) believes failure to fluoridate drinking water in the most deprived parts of the UK is indefensible.
174. LOTHIAN: That conference believes that, with general practice becoming ever more stretched and climate change recognised as a global emergency, having patients out with practice boundaries makes care less efficient and increases travelling times for both GPs and patients, and calls for GPs:
- (i) not to be assigned patients out with their practice boundary, and
  - (ii) to be able to remove patients out with their boundary where there is agreement for another practice to take them on.
175. LIVERPOOL: That conference believes that any future contract negotiations must include a clause requiring minimum inflationary rises year on year, as defined by the Consumer Prices Index (CPI).
176. GRAMPIAN: That conference believes the introduction of co-payments will affect deprived and vulnerable patients most, attack the core principles of the NHS being “free at the point of use” and result in increased morbidity and mortality for our patients.
177. GATESHEAD AND SOUTH TYNESIDE: That conference notes the natural experiment generated by devolved nation prescribing and calls for an objective, pan-UK, review of the net costs and benefits of prescription charging, in order to empower all nations to make decisions based on evidence rather than their political slant.

178. SEFTON: That conference is seriously concerned about the impact on the health and well-being of many patients of the inordinate rise in the rate of food price inflation. This has reached 17% in the past months. Many low income individuals and families are now at increased risk of malnutrition as maintaining an adequate diet is push further out of financial reach. It calls upon government to provide improved levels of social security and safeguards against malnutrition in order to avert the damage to health it causes and the future costs of dealing with it.

## POLITICAL DEMANDS VS PATIENT NEEDS

179. NORTH YORKSHIRE: That conference demands an immediate public communications campaign from DHSC explaining the difference between needs and wants and what the NHS can provide.
180. NOTTINGHAMSHIRE: That conference recognises that to discern patient need from demand there needs to be consistency and intelligent triage of issues to ensure that patients get what it appropriate for them. We request that GPC / GPDF works to provide:
- (i) a national training package to help practices to triage effectively
  - (ii) clear guidance on how at-scale general practice can work eg acute hubs can work to deal with same-day demand
  - (iii) a national helpline for patients to call to navigate through their DEMANDS and link them up with their practices where they meet the criteria and demonstrate NEED.
181. NORTHERN IRELAND EASTERN: That conference instructs GPC UK to demand that the UK government and devolved nations health commissioning accept that there is a complete mismatch in the demand and current general practice capacity, and to look for mechanisms to rebalance such as:
- (i) enabling of AHP self-referrals
  - (ii) overhaul and / or re-examination of prescription charges in all four nations.
182. LEEDS: That conference believes that access to GP appointments will be a central part of the next General Election and:
- (i) is significantly concerned that this will be damaging for general practice and the morale of our workforce
  - (ii) calls for GPC UK to proactively prepare resources for GPCs and LMCs to rapidly counter misinformation
  - (iii) calls on GPC UK to develop a counter-narrative that clearly outlines to the public the benefit of UK general practice and the need to support it.
183. WORCESTERSHIRE: That conference believes that allowing patients to make direct referrals to secondary care would increase the financial and workload burden on all sectors of the NHS whilst widening health inequalities and worsening access for those who need it most.
184. BERKSHIRE: That conference calls on the BMA to:
- (i) carry out a comprehensive analysis of GP workload that includes inappropriate transfers of care into general practice; hours worked per GP; and non-direct-patient care duties such as but not exclusive to: administration, supervision, teaching, research, business management, quality improvement and audit
  - (ii) develop a coherent media strategy and campaign that highlights the disproportionate workload of general practice, in the context of the workforce and financial resource it has available.
185. HIGHLAND: That conference agrees that the wellbeing of workers and safety of patients should be at the heart of public holiday arrangements and:
- (i) demands that adequate notice is given when these are proposed in order to enable practices to close and out of hours to operate safely
  - (ii) acknowledges the confusion and distress that is incurred where inadequate notice has meant that some practices cannot close
  - (iii) is supportive of those practices, such as those struggling to balance the books, who may not be able to grant additional paid leave to staff
  - (iv) calls on GPCs to explore with governments if there are any measures that could bring harmony.
186. HIGHLAND: That conference recognises the significant additional costs incurred by practices through two additional public holidays appearing during an exceptional year, demands recognition of the impact of this on GP practices, and seeks financial support for practices to mitigate these costs.

187. HERTFORDSHIRE: That conference on GPC / BMA to:
- (i) provide clear guidelines on what practices can and can't do when using the BMA's safe working document, and
  - (ii) provide clear guidelines on daily appointment limits and to share these with national governments and the media.
188. NORFOLK AND WAVENEY: That conference asks GPC to oppose the publication of earnings for GPs as it will only drive a wedge between clinicians and their patients.
189. KENT: That conference demands all targets in general practice are suspended until the GP numbers exceed the extra 5,000 target set in 2017.
190. LINCOLNSHIRE: That conference believes that the Conservative government in Westminster has actively undermined the NHS so that it can be broken up and be sold to corporate bodies, and thus recommends that GPC advises GPs to lobby their patients to vote for another party at the next election.
191. WEST SUSSEX: That conference confirms that a fundamental element of general practice is the consultation and believes that counting the number of consultations, rather than considering the quality of their content and patient benefit, demonstrates that NHS England is interested in the numbers but not the value.
192. GRAMPIAN: That conference is proud of the principles of the NHS but not the service that is currently being provided and calls on government to appropriately fund general practice rather than consider privatisation which will disadvantage the already disadvantaged more vulnerable population.
193. GRAMPIAN: That conference feels safeguards are required against privatisation which this conference feels the government aims to do by chronically underfunding general practice.
194. LANCASHIRE PENNINE: That conference believe the importance of childhood immunisation is being undermined by a lack of recognition of the difficulties achieving targets, particularly for practices with disproportionate levels of deprivation for example, and that lower thresholds or other measures such as exception reporting should apply to allow for practices to be funded appropriately for their efforts.
195. KENSINGTON, CHELSEA AND WESTMINSTER: That conference acknowledges that commissioners operate with considerable financial constraint but believes that patient safety is paramount. Conference demands that:
- (i) commissioners have a responsibility to offer contracts that are clinically safe and resourced appropriately
  - (ii) commissioners are held to account for unsafe or irresponsible commissioning decisions
  - (iii) there is a mechanism for escalating safety concerns that result from commissioning decisions in all nations
  - (iv) there is robust clinical governance, with clinical input, oversight and accountability, for all commissioning decisions
  - (v) there are robust governance arrangements in place to ensure that responsibilities and accountabilities are clear when contracts are subcontracted.
196. GRAMPIAN: That conference calls on the relevant organisations to lobby and call for the NHS to be removed from the political agenda and be managed cross party as it is felt the only "realistic" way to save the NHS from further demise.

## THE INDEPENDENT CONTRACTOR

197. BRADFORD AND AIREDALE: That conference calls on a UK Plan B to be worked up to be instigated on 1/4/24, with a notice of intention to resign being issued 1/10/23 unless there is a full commitment that UK GP is funded adequately.
198. WEST PENNINE: That conference has serious concerns on government proposals to abolish the GP contract and partnership model in favour of a national salaried service:
- (i) failure to acknowledge the additional unpaid work conducted by partners beyond 9-5 working hours

- (ii) failure to foresee a likely reduction of in-hours workload and daily capacity as a result of a fixed contract hours and employee status
  - (iii) failure to foresee diversion of overspill demand to out of hours services and emergency departments
  - (iv) failure to recognise shifting of demand to the above services is less cost effective than value provided by partnership contracts
  - (v) failure to note that a partnership model provides resource management, and a deep understanding of local population needs in comparison to regional management
  - (vi) failure to foresee the impact on GP recruitment and the number of colleagues leaving the profession for other opportunities, worsening the workload crises and adding to the unprecedented demand seen in general practice.
199. WEST PENNINE: That conference has serious concerns on future recruitment of GPs into partnership roles:
- (i) little education provided to trainees regarding partnership models, business skills and the benefits of becoming a partner during training
  - (ii) negativity associated with the role from direct clinical observation on workload demands and commitments both within and beyond working hours
  - (iii) perception of clear superior alternatives in a portfolio or locum role, offering a stark difference in stress, flexibility, commitment, emotional and finance reward
  - (iv) the haemorrhaging of newly qualified GPs leading to an increase in the workload crises often to lucrative opportunities abroad in contrast to a lack of opportunities for partnership roles available.
200. NOTTINGHAMSHIRE: That conference is concerned that there is often no succession plan for practices getting into difficulty with GP contracts move out of local ownership and bids to run practices given to those with greater skills in writing compelling bids. We need to help general practice to help itself and request that the GPC / GPDF provides:
- (i) bid-writing support for when GP contract procurement is in play
  - (ii) workshops around options for succession
  - (iii) an offer for practices that are at risk of handing back their contract to access expert support in assessing their situations and helping general practice locally to explore options for succession.
201. AVON: That conference seeks assurances that the PCN DES will obtain additional funding to cover the full cost of ARRS staff, including:
- (i) costed backfill time for supervision and training
  - (ii) costed backfill time for administrative input from practices regarding PCN logistics
  - (iii) costed resource for physical space and development
  - (iv) costs for overheads that will accompany the rise in space, including utilities and insurance.
202. OXFORDSHIRE: That conference demands that BMA negotiate the removal of any contractual requirement that GP practices declare or publish their earnings or average earnings.
203. SEFTON: That conference calls upon all UK NHS administrations to explicitly endorse the recommendation of the Parliamentary Select Committee for Health and Social Care contained in its report 'The Future of General Practice'.
204. DERBYSHIRE: That conference recognises that the NHS will continue with winter pressures in future years and directs GPC to negotiate a QoF year-end be moved from 31 March to 30 June.

## PENSIONS

205. CLEVELAND: That conference insists that the planned October 2023 changes to the NHS Pension Scheme include the complete removal of Annual Allowance and Lifetime Allowance tax charges.
206. WAKEFIELD: That conference is committed to the reform of punitive NHS pension rules, beyond the current recent changes, in particular tackling the annual allowance charge and lifetime allowance and extending death in service benefit to those who have opted out of the scheme whilst they are still working for the NHS.

207. CAMBRIDGESHIRE: That conference:
- (i) notes with grave concern the inflationary impact upon GP pensions which will contribute dramatically to the already critical issue of retention in general practice
  - (ii) calls on the BMA to survey UK GPs aged between 40 - 55 to ascertain the likelihood of attrition from the workforce due to the financial impact and uncertainty of the pension growth impact on AA tax charges
  - (iii) demands that GPC UK then urgently raise the issue with the Chancellor of the Exchequer to seek immediate alteration of the Finance Act Section 235.
208. GLASGOW: That conference is seriously concerned about the current complex superannuation scheme for GPs and:
- (i) the failure to reform pension contribution rates
  - (ii) the impact of the annual allowance
  - (iii) the lack of flexibility to vary the proportion of NHS income which is superannuated
  - (iv) the effect current pension arrangements are having on the retention of GPs and the number of sessions that GPs are undertaking.
  - (v) calls for an immediate reform of the punitive, discriminatory, disincentivising, and destabilising NHS pension scheme.
209. DEVON: That conference understands that GP pensions are a UK wide issue but due to the gravity of the situation for GPs in England we:
- (i) deplore the arcane pension regulations that act as an incentive against long term retention of GPs
  - (ii) demand that an immediate review is conducted concerning GP pensions as part of the NHS Scheme. Specific attention should be paid to issues which give rise to perverse incentives causing GPs to leave the profession early or pay huge tax bills for benefits that they have not received.
210. SANDWELL: That conference advises the GPC that the issue of general practitioner pensions has been a substantial barrier to recruitment and retention. The government expects the NHS, PCNs, ICSs and social care to work as a 'system'. Could the GPC invite DoHSC, the Treasury and HMRC to demonstrate what system working should look like, and resolve this issue together.
211. OXFORDSHIRE: That conference believes that NHS staff including GPs should have the option of an NHS pension scheme that is tax-unregistered.
212. NORTHERN IRELAND EASTERN: That conference instructs GPC UK to demand that the UK government provides an immediate solution for the harm being caused to the entire NHS by the current UK NHS pension scheme.
213. AVON: That conference asks for negotiators to seek assurance from the pensions authority that practices will not be penalised regarding final pay controls where staff members wages are increased as a result of the national living wage.
214. SURREY: That conference deplores the continuing problems all general practitioners are experiencing with PCSE managing their pension contributions.

## PREMISES

215. COVENTRY: That conference believes that failure to significantly invest in and expand the general practice estate in order to take account of new roles, additional trainee numbers and an expanding population is:
- (i) a deliberate attempt to deem widespread numbers of practices less than fit for purpose
  - (ii) undermining the model of practices based in the community, with longstanding connections there and strong continuity of care
  - (iii) part of a plan to centralise neighbourhood teams under the auspices of community or acute trusts rather than general practice networks
  - (v) to be derided at a time when there has been disproportionate investment in other areas of estate such as community diagnostic hubs.
216. WARWICKSHIRE: That conference believes that failure to significantly invest in and expand the general practice estate in order to take account of new roles, additional trainee numbers and an expanding population is:

- (i) a deliberate attempt to deem widespread numbers of practices less than fit for purpose
  - (ii) undermining the model of practices based in the community, with longstanding connections there and strong continuity of care
  - (iii) is part of a plan to centralise neighbourhood teams under the auspices of community or acute trusts rather than general practice networks
  - (iv) to be derided at a time when there has been disproportionate investment in other areas of estate such as community diagnostic hubs.
217. HULL AND EAST YORKSHIRE: That conference believes that capital budgets should be divided between NHS providers based on the percentage of patient contacts each provider delivers.
218. DERBYSHIRE: That conference recognises the urgent need to expand the classes of clinical room stipulated in HBN 11 and other NHS regulations to create confidential consulting spaces for a wider variety of primary care team members such as mental health workers, GPs and other clinicians consulting remotely which do not require all the facilities which the existing specifications mandate and is limiting both expansion of premises and expansion of clinical capacity and instructs GPCs to negotiate accordingly.
219. NORFOLK AND WAVENEY: That conference requests that GPC undertakes negotiations with government to ensure that:
- (i) all local authorities enable and prioritise health for accessing Section 106 and CIL monies for new housing developments, and that they are easier for general practice to access to support local primary care estates improvements
  - (ii) enable the combination of S106 and CIL from multiple small developments to sufficiently fund a project
  - (iii) the Premises Cost Directions clauses pertaining to S106 and CIL contributions allow the developer contribution to be used flexibly to reduce the practice contribution to a project first, before reducing the NHS contribution, that they can enable 100% funding of a scheme, and can be used in a way that it does not need to be subject to abatement.

## PRIMARY CARE VS GENERAL PRACTICE

220. AVON: That conference believes that the general practice gatekeeping role is well and truly broken and it is time to adapt to a new front door for primary care, where GPs are one of a number of primary care professionals who patients are triaged into.
221. AVON: That conference is concerned about the rise in urgent care demand on primary care and directs GPC to negotiate in the strongest terms that:
- (i) ambulance dispatches require re-triaging by a commissioned service
  - (ii) paramedics wishing to discuss patients should do so with a specifically funded service.
222. COVENTRY: That conference believes that NHSE's lack of support for general practice, compared to hospital trusts, in the ability to suspend targets at a time of unprecedented pressure this winter, shows a lack of understanding of the reality of general practice. We call for the removal of the 12-week consultation period prior to suspension of QOF and its replacement with increased local flexibility being granted to ICBs who have better knowledge of the local situation.
223. WARWICKSHIRE: That conference believes NHS England should take action commensurate to the scale of the climate and ecological crisis by:
- (i) recognising sustainability and carbon emission reduction as priorities in all primary care contractual targets / arrangements / negotiations
  - (ii) accelerate the decarbonisation of the GP estate by granting access to the public sector decarbonisation fund, giving parity with secondary care healthcare bodies
  - (iii) invest in system wide schemes to safely reuse medical equipment, reducing our reliance on single use plastics
  - (iv) invest in system wide schemes to improve/promote access to recycling facilities, including medicinal waste.

224. WARWICKSHIRE: That conference believes that NHSE's lack of support for general practice, compared to hospital trusts, in the ability to suspend targets at a time of unprecedented pressure this winter, shows a lack of understanding of the reality of general practice. We call for the removal of the 12 week consultation period prior to suspension of QOF and its replacement with increased local flexibility being granted to ICBs who have better knowledge of the local situation.
225. NORTH STAFFORDSHIRE: That conference rejects the Fuller report declaring it to be a Trojan horse for further embedding the disastrous PCN project.

## PRIMARY / SECONDARY INTERFACE

226. GATESHEAD AND SOUTH TYNESIDE: That conference admires the BMA rate cards produced for junior doctors and consultants, and calls for the same to be produced, with use encouraged, in order to enable practices to charge secondary care for unfunded work, at standardised, costed rates.
227. DEVON: That conference understands that workload shift from secondary to primary care must be halted if general practice is to survive. UK GPs:
- (i) deplore the lack of understanding of GP funding and contracts by secondary care colleagues
  - (ii) demand that unfunded and unnegotiated workload shift from secondary care to general practice halts in order to allow the profession to survive
  - (iii) demand that commissioners are made responsible for, and empowered to, achieve the aims in (ii).
228. WIGAN: That conference notes its existing policy on addressing the problem of unrelenting GP workload increase caused in part by transfer of non-contracted work by secondary care to GPs, but also notes that local voluntary concordats at the interface and 'inappropriate work push back' campaigns produce only short-lived relief. It calls upon GPC to seek heavier contractual protocols and controls within the NHS standard contract and a meaningful withholding of contractual income as a spur to diligent observance.
229. NOTTINGHAMSHIRE: That conference deplores the continued failure of commissioners to effectively manage the standard hospital contract with the endless flow of secondary work moving into general practice with no barriers. We implore GPC to work with commissioners nationally to implement:
- (i) requirement for trust action plans to manage shift of secondary care work to practices, held to account locally
  - (ii) forced ring-fencing of trust budgets to put measures into place to ensure all work done at trust level where appropriate eg admin cell to intercept hospital letters to ensure no breach of hospital contract
  - (iii) local NHS to be charged with sorting out the shifting of work as a system problem, not a GP capacity problem.
230. GATESHEAD AND SOUTH TYNESIDE: That conference deplores the appalling state of mental health services across the UK, with particular reference to those for eating disorders and transgender patients and calls for those commissioning and leading such services to be made personally liable for the failings of such services, in a manner similar to that of GP partners.
231. MID MERSEY: That conference urges NHSE to revisit the roll out of the national medical examiner system outside acute trusts. The new system will unnecessarily increase workload for GPs in the community, despite false reassurances by medical examiners. This conference believes that the roll out in its current form is a perfect example of the multitude of reasons why GPs struggle to treat people who need care, rather than unnecessary bureaucracy.
232. BEDFORDSHIRE: That conference asks GPC to remind political parties of the importance of the GP role as gatekeeper, as the idea has been floated by some politicians, of abolishing this role, which would be a sure-fire way to ensure the final demise of the NHS as it drowns under demand from patients exercising their new "right" to self-refer into the system.

233. LOTHIAN: That conference is appalled by the suggestion of some politicians that GPs lose the gatekeeper role for initial referral into specialist services within the NHS and believes that such changes, while possibly reducing GP demand initially, would create a huge extra burden for the NHS, increasing workload in the longer term, and driving future investment into services which may not always be needed.
234. DERBYSHIRE: That conference insists that in circumstances where other health care professionals such as for example paramedics, community based services or specialist outreach hospital staff interact with patients in the community without a direct and specific invitation from the patient's GP; it is not for GPs to make physician type decisions and such health care professionals own employing organisation must make their own arrangements for physician inputs which do not rely upon the patient's GP input. GPCs negotiators to take action accordingly.
235. DERBYSHIRE: That conference notes that although co-location of GPs alongside emergency departments has temporarily relieved some of the pressures experienced in emergency departments, such arrangements have only increased overall demand as they have de facto degenerated into an expensive 24/7 walk in service increasing public expectations; and:
- (i) insists such services should be curtailed through abolishing the "walk up" capability, and
  - (ii) monies saved should be spent in improving access in traditional primary care
- and that GPCs must negotiate accordingly.
236. DERBYSHIRE: That conference recognising the changing patterns of care and blurring of the boundaries of responsibility for patients between primary and secondary or community care demands that when a GP referral is declined or downgraded that:
- (i) the patient be informed directly in writing that their referral has been downgraded / refused together with a statement of the reasons for the downgrade / refusal and an estimate of the wait to be seen
  - (ii) that the referring GP be informed in writing that their referral has been downgraded / refused and such written notice MUST include ALL of the following information:
    - (a) the reasons for the downgrading or refusal of the referral
    - (b) the name and status of the person authorising the downgrade or refusal
    - (c) the employing authority of the person authorising the downgrade / refusal
    - (d) an effective contact telephone number, email address and postal address where the GP can follow up the matter
    - (e) an estimate of the wait to be seen
- and instructs GPCs to negotiate accordingly.
237. GLOUCESTERSHIRE: That conference holds that rectification of any secondary or ancillary care system errors that have impact on GP practices must be fully resourced and funded.
238. LINCOLNSHIRE: That conference believes that government, national health bodies, commissioners and secondary care do not understand the GMS contract. National government initiatives are often based on work that would be non-GMS. Secondary care shift workload through non-compliance with their own contract, misunderstanding of ours and by the increasing use of A&G. All this workload is unresourced and we request GPC to:
- (i) commission a national digital tool to collate and report secondary care breeches incorporating an indicative "breech fee IOS" which can also be used to inform discussions with all organisations as to the volume and potential cost of these breeches
  - (ii) utilise the tool to represent inappropriate flow of workload in discussions to cease this non-contractual work
  - (iii) demand that in recognition of A&G being a solution to secondary care waiting lists resulting in additional workload to general practice, additional funding should be allocated to support this activity or general practice will no longer engage with this service.



239. NORFOLK AND WAVENEY: That conference notes with concern the increasing number of referrals made by GPs to secondary care being rejected without clear reason and:
- (i) believes that this is a major factor affecting GP workload, morale, and retention
  - (ii) calls for GPC to request the enforcement of the contractual obligation of clinician-to-clinician dialogue before a referral can be rejected or a patient can be 'signposted' elsewhere
  - (iii) requests that the Standard NHS Contract should be changed so that if such rejections take place, the reason is made in writing by a named clinician with the clear reason why
  - (iv) requests that the legal responsibility taken by the individual making the decision to reject a referral is clarified to them in the same way that GPs are clearly informed that as prescribers of drugs, they take full legal responsibility in shared care agreements
  - (v) asks GPC to request a contractual obligation for trusts to enable a two week fast-track system back in, rather than the GP having to re-complete a full proforma' when the clinical situation is unchanged.
240. OXFORDSHIRE: That conference notes that current "interface" arrangements often result in workload transfer from secondary to primary care, and:
- (i) demands that ICBs exercise robust commissioner oversight of the "interface", by consulting with LMCs and responding to inappropriate workload transfers and breaches of contracts in both primary and secondary care
  - (ii) believes that GPs should be able to invoice requesting organizations for non-contractual work done.
241. NOTTINGHAMSHIRE: That conference notes that there is a tier of patients that do not meet current Special Allocation Scheme (SAS) criteria but are too chaotic for everyday general practice to manage often being removed from all practices within a given locality. We request that:
- (i) GPC works with national commissioners to amend the SAS criteria to include this cohort of patient without requiring police reporting / intervention
  - (ii) that practices are empowered contractually to refuse to re-register patients whom they have removed from their practice for up to eg 24 months.
242. AVON: That conference has already agreed that new work in general practice is appropriately costed and resourced. However, some LMCs have found that when new work in general practice is proposed, a local enhanced service (LES) to resource the work is difficult because the ICBs say the LES pot is financially ring fenced. GPC is asked to ensure that:
- (i) as new work is passed to primary care from secondary care, the cost of the work is adequately resourced according to a national LMC template
  - (ii) the work is costed at the same price as when provided in secondary care
  - (iii) the costs of LES pot in each area are open to be reviewed
  - (iv) the LES pot which may be ring fenced can be increased as new work is assigned to primary care
  - (v) as new work in primary care is developed, old work that is currently being financed by a LES should not be removed from the pot
  - (vi) if new work for general practice is not appropriately funded, general practice should refuse to deliver the work GPC is required to take on board these sentiments in any negotiations.
243. BERKSHIRE: The conference notes with disappointment, that transfer of workload from secondary care to primary care is increasing in spite of centralised efforts to reduce this. Conference:
- (i) demands BMA run a national interface steering group to focus minds on the issue
  - (ii) demands funding is redirected to follow any transfers of workload in future
  - (iii) recommends that funding be "clawed back" from secondary care and redirected to primary care, where it can be shown that there has already been a transfer of workload without transfer of resource.
244. LEEDS: That conference believes that the shift of unfunded work from secondary care to general practice has increased not decreased, despite work by GPCs in all four nations, and that this is a significant cause of the unsustainable workload pressures in general practice, and therefore calls for GPC UK to convene a pan-professional event with the aim of producing a clear and measurable action plan to address this issue.
245. GLOUCESTERSHIRE: That conference believes that the proposed medical examiner death certification process needs to allow clinical access to relevant deceased GP patient records only and that the administration and management cost and time from this process must be centrally resourced and funded.

## UK GOVERNMENT

246. GATESHEAD AND SOUTH TYNESIDE: That conference, noting recent political announcements, wishes to clarify that GPs will under no circumstances be involved in immigration issues, other than for the provision of healthcare, and that any attempts to involve GPs will be robustly rejected.
247. DERBYSHIRE: That conference castigates the governments and their agents for abusing NHS health care staff through their:
- (i) covert campaign of media briefings against the profession, and in particular general practice
  - (ii) failure to speak up in support of general practice coupled with their failure to educate patients about responsible use of the NHS
  - (iii) utter failure to recognise staff exhaustion and moral injury since the pandemic
  - (iv) deliberate blindness to the scale of psychological distress amongst GPs and their staff
  - (v) economic exploitation of healthcare professions in comparison to the rest of society through selective acceptance of Review Body recommendations

and instructs the GPCs and BMA Council to mount a concerted coordinated publicity campaign including public demands that such bullying cease and for urgent ministerial action on workforce well-being issues.

248. SOMERSET: That conference considers that GPC would be more powerful in their negotiations with HMG if GPC members worked alongside independent professional negotiators paid for by the GPDF.
249. DEVON: That conference has serious concerns with the notion that general practice is a political football that can be played with by UK government for their own political gain. This behaviour and incitement of the media must halt if the profession is to survive. General practice cannot bear the brunt of inadequate resourcing in all nations by our political leaders.
250. WIRRAL: That conference notes with great disappointment that the government has little or no care for NHS other than making political gains from it. It therefore asks GPC to:
- (i) specifically educate the government and politicians on the importance of NHS in our civil society
  - (ii) calls on the government to see NHS as more important than political football and invest better in it
  - (iii) intensify and broaden the campaign on "Save our NHS" as lives and livelihoods of many depend on NHS.
251. AVON: That conference is yet again disturbed by the continuing decline in the numbers of general practitioners and other clinicians and staff in general practices. The government needs to:
- (i) review GP training and recruitment
  - (ii) review support for GP portfolio careers
  - (iii) provide support for the mental health of all GPs and clinicians
  - (iv) review the NHS pension debacle
  - (v) ensure that practices are financially viable

GPC must include these provisions in its negotiations with the government on the GP contract.

252. AVON: That conference directs GPC to seek confidential legal advice on the minimal standard required for provision to meet the terms of the current contract, with a view to industrial action. In light of NHSE and NICE guidelines such as statins for all or FIT test for all, conference directs GPC to issue its own clinical guidance, to help protect GPs from clinical negligence claims.
253. LANCASHIRE COASTAL: That conference believes that the developing centralised regional NHS management are very good at spending money on their management costs and very poor at improving the delivery of services.
254. SEFTON: That conference fully supports the recent actions of nurses, ambulance crews, junior doctors, and other NHS workers in pursuit of restoring the real value of their salaries. The de facto policy of allowing NHS staff, whether employees or independent contractors, to become poorer in real terms every year must end. It is impossible to see how any solution to the NHS workforce crisis can be successful without a commitment to the maintenance of the real value of salaries and earnings.

255. LAMBETH: That conference decries politicians, in government or in opposition, who think that they are experts in how the NHS can be fixed, when they have never worked at the front line delivering patient care and calls on the government/s to take the advice of experts working in the field to make any changes to the way the NHS is funded and managed.
256. LEWISHAM: That conference calls upon government to provide adequate remuneration and support to GPs to enable them to undertake effective safeguarding work with vulnerable adults and children.
257. LOTHIAN: That conference calls for nothing less than full independence of the DDRB to make recommendations, free from government interference or caps on recommendations, to enable it to regain the trust of the profession.

## INDEMNITY

258. NORTH STAFFORDSHIRE: That conference notes the concerns expressed by indemnity providers that the goodwill shown to clinicians in the pandemic will be lost under a deluge of litigations and demands the following:
- (i) immunity from civil and criminal liability for any injury or death alleged to have been sustained because of any acts or omissions undertaken in good faith
  - (ii) a repeal of S2(4) of the Law Reform (Personal Injuries) Act 1948
  - (iii) that an independent body defines the NHS health and social care package which can give an appropriate standard of care for all patients irrespective of the cause of the patient's care requirements
  - (iv) a cap on future earnings costs of patients who are affected by negligence claims
  - (v) that we move to a New Zealand no fault compensation scheme.
259. LOTHIAN: That conference believes that when doctors are called to court to stand as a witness it is regularly unnecessary, and that this adds to existing pressures in general practice and is a very poor use of the public finance.

## COMMISSIONING

260. BEDFORDSHIRE: That conference calls on GPC to work with the NHS to develop useful and more individually targeted advice about diet and weight loss for patients, which could be much more effective than, for example, choosing to spend so much money on a new lipid lowering medication with very little data behind it.
261. AVON: That conference deeply regrets the lack of standardised healthcare provision for babies who are resident in a mother and baby unit and directs GPC to negotiate a new national enhanced service specification to ensure equality of access for these children that promotes good practice in safeguarding.

## ENGLAND

262. MID MERSEY: That conference strongly believes in the retention of home visits as part of the core contract:
- (i) we must provide for the most vulnerable of patients
  - (ii) we must not allow further fragmentation of the service we provide
  - (iii) we must retain palliative care provision and if home visits go, palliative care provision will follow.

At the November conference, there was a last-minute addition to the vote which resulted in a 50/50 split.

A home visit when clinically appropriate is a vital part of the work we do. Visits to the frail elderly can literally be lifesaving/ enhancing. We must protect those most vulnerable in our society.

263. DERBYSHIRE: That conference recognises that the extra funding to primary care via the PCN model is not delivering for practice, patients nor the NHS and urges GPC England to negotiate accordingly.

264. NORTH YORKSHIRE: That conference demands the return of an individual practice funded extended hours service which:
- (i) will maintain patient continuity and access as a quality marker
  - (ii) improves efficiency for practices
  - (iii) maintains income with individual practices.
265. SUFFOLK: That conference notes that NHSE appear not to understand HMRC rules on VAT or PCN structures, and by extension that UK law applies to the NHS. Conference therefore asks GPC to explain this to the NHS before negotiating a full legal review, with HMRC input, of their contracting arrangements extending, but not limited to, the most pressuring issues of PCN contract liability and dispensing doctor VAT.
266. EAST SUSSEX: That conference recognises that continuity of care is the cornerstone of effective general practice, and believes this is being undermined by:
- (i) NHS England's continuing determination to commission enhanced access appointments rather than adequately support core hours services
  - (ii) commissioning stop-gap urgent services which undermine practice based care.
267. LINCOLNSHIRE: That conference believes that the concerns that the creation of Integrated Care Systems in England would divert resources for primary care into protecting secondary care providers has become a reality this winter and that general practice funding being diverted to other parts of the NHS is a UK issue not limited to England. We recommend GPC:
- (i) emphasis to NHS bodies and government that allowing this practice further undermines the ability of general practice to provide safe care for patients
  - (ii) negotiates with NHS bodies that additional funding streams intended for general practice are clearly badged for use only in general practice so that commissioners cannot divert this funding
  - (iii) negotiates that additional funding streams and the associated aims of initiatives must be straightforward to administer and be fully deployed to only general practice within a specific period of time.

## STANDING ORDERS

<b>Index</b>		<b>Standing order</b>
Agenda		17-28
Allocation of conference time		53-58
Chair's discretion		80
Conferences	Annual	1
	Special	2
Rules of debates		35-52
Time limit of speeches		61-62
Major issues		28
Distribution of papers and announcements		76
Elections	Chair	66
	Deputy Chair	67
	GPC UK	68
	Conference Agenda Committee	69
Interpretations		10-14
Membership		3
Minutes		81
Mobile phones		77
Motions	A and AR	25-26
	C	27
	Composite	22
	Grouped	21
	Not debated	56
	Not included in the agenda	59
	Rescinding	24
	With subsections	23
Observers		9
Press		78
Procedures	Amendments	30, 32
	Rider	31, 32
Quorum		60
Representatives		4-8
Returning officer		73
Standing orders	Motions to amend	15
	Suspension of	16
Voting		63
	Majorities	64-65

# STANDING ORDERS

## CONFERENCES

### Annual conference

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

### Special conference

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

### Membership

3. The members of conference shall be:
  - 3.1 the chair and deputy chair of the conference
  - 3.2 365 representatives of local medical committees
  - 3.3 the voting members of GPC UK
  - 3.4 9 members appointed by the Scottish GPC
  - 3.5 3 members appointed by the Welsh GPC
  - 3.6 2 members appointed by the GPC (Northern Ireland)
  - 3.7 2 members appointed by GPC England
  - 3.8 the seven elected members of the conference agenda committee (agenda committee)
  - 3.9 the regionally elected representatives of the GP trainees committee, together with its immediate past chair
  - 3.10 the elected members of the sessional GPs committee
  - 3.11 the Chairs and Deputy Chairs of the England, Northern Ireland, Scotland and Wales nation LMC conferences
  - 3.12 the Chair of GPDF or their nominated deputy, who must be a registered medical practitioner.

### Representatives

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

## **Observers**

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

## **Interpretations**

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

## **Motions to amend standing orders**

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

## **Suspension of standing orders**

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

## **Agenda**

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

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

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

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



28. Major issue debate: The agenda committee may schedule a major issue debate. If the committee considers that a number of motions in Part I should be considered part of a major issue debate, it shall indicate which motions shall be covered by such a debate. If such a debate is held the provision of standing orders 44, 45, 46, 47 and 52 shall not apply and the debate shall be held in accordance with standing order 54.

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

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

**Procedures**

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

**Rules of debate**

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

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

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

### **Allocation of conference time**

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

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

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

### **Quorum**

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

### **Time limit of speeches**

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

### **Voting**

63. Except as provided for in standing orders 66 (election of chair of conference), 67 (election of deputy chair of conference), 69 (election of seven members of the agenda committee) and 70 (election of ARM representatives), only representatives of local medical committees may vote.

### **Majorities**

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

## Elections

66. Chair
- 66.1 At each conference, a chair shall be elected by the members of the conference to hold office from the termination of the BMA's annual representative meeting (ARM) until the end of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
- 66.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda of the conference with any election to be completed by the time indicated in the Agenda. Nominees may enter on the form an election statement of no more than 100 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
67. Deputy chair
- 67.1 At each conference, a deputy chair shall be elected by the members of the conference to hold office from the termination of the ARM until the termination of the next ARM. With the exception of those appointed under standing order 3.7, all members of the conference shall be eligible for nomination.
- 67.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda with any election to be completed by the time indicated in the Agenda. Nominees may enter on the form an election statement of no more than 100 words, excluding number and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
68. Seven members of the General Practitioners Committee UK
- 68.1 For six of the seats, any registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, whether a member of the conference or not, is eligible for nomination providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any parental, sickness or study leave absence. All GPs on the retention scheme, and medically qualified LMC secretaries, are eligible for nomination regardless of their level of commitment to providing or performing NHS primary medical services. For the seventh seat, only an LMC representative at conference may be nominated, and that LMC representative must never have previously sat on the GPC UK. This LMC representative must also be a registered medical practitioner whose exclusive or predominant medical commitment is to providing personally or performing NHS primary medical services for at least two sessions a week, providing that such a level of commitment has been maintained for at least the period of the six months immediately prior to the election, allowing for any parental, sickness or study leave absence. The members elected will serve on the GPC from the conclusion of the following ARM until the conclusion of the ARM one year thereafter.
- 68.2 Only representatives shall be entitled to vote.
- 68.3 Nominations, election statements and photographs must be received by the GPC office seven working days before the start of the conference.
- 68.4 Nominees may submit an election statement of no more than 100 words, excluding numbers and dates in numerical format, in a manner and format which will be specified by the Agenda Committee (that format being specified one calendar month before the start of conference). Recognised abbreviations count as one word.
- 68.5 Nominees may also submit a photograph in a format specified by the Agenda Committee (that format being specified one calendar month before the start of conference).

- 68.6 All nominees shall have the opportunity to take part in any hustings arranged by the agenda committee.
- 68.7 All lists of candidates, in whatever format, shall be in random order.
- 68.8 Elections, if any, will take place at conference and be completed by the time indicated in the Agenda.
- 68.9 The GPC UK shall be empowered to fill casual vacancies occurring among the elected members.
69. Seven members of the conference agenda committee
- 69.1 The agenda committee shall consist of the chair and deputy chair of the conference, the chair of the GPC UK and seven members of the conference, at least one of whom, subject to appropriate nominations being received, shall represent each of the four UK nations and not more one of whom shall be a sitting member of the GPC UK. In the event of there being an insufficient number of candidates to fill the seven seats on the agenda committee, the chair shall be empowered to fill the vacancy, or vacancies, by co-option from the appropriate section of the conference. Members of the conference agenda committee for the following conference shall take office at the end of the conference at which they are elected and shall continue in office until the end of the following annual conference.
- 69.2 The chair of conference, or if necessary, the deputy chair, shall be chair of the agenda committee.
- 69.3 Nominations for the agenda committee for the next succeeding year must be handed in on the prescribed form by the time indicated in the Agenda. Elections, if any, will take place at conference and be completed by the time indicated in the Agenda. Any member of the conference may be nominated for the agenda committee. All members of the conference are entitled to vote. Nominees may enter on the form an election statement of no more than 100 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers. Recognised abbreviations count as one word.
- 69.4 The result of the election to the agenda committee shall be published after the result of the ARM election of GPC UK members is known.
- 69.5 The two members of the agenda committee to be appointed to the joint agenda committee in accordance with article 53 of the BMA's Articles of Association shall be the chair of the conference and the chair of the GPC UK.
70. The representatives allocated to represent general practice at the BMA Annual Representative Meeting shall be members of the BMA both at the time of their annual appointment/election and throughout their term of office and shall comprise:
- 70.1 the chair and deputy chair of conference, if eligible
- 70.2 the chair of the GPC UK, if eligible
- 70.3 sufficient members of conference to fill the allocation of seats, elected on a regional basis in advance of conference by those members of the conference who are members of the BMA
- 70.4 should there be vacancies after the regional elections these shall be filled by the GPC UK from the unsuccessful candidates standing in those elections.
71. Three trustees of the Claire Wand fund
- 71.1 Nominations may be made only by representatives, and a representative may make not more than one nomination. Any registered medical practitioner who is, or has been, actively engaged in practice as a general medical practitioner under the National Health Service Acts, whether a member of the conference or not, is eligible for nomination.
- 71.2 Nominations must be handed in on the prescribed form before the time indicated in the Agenda. Elections, if any, will take place at conference and be completed by the time indicated in the Agenda. Only representatives in attendance at the conference may vote. Nominees may enter on the form an election statement of no more than 100 words, excluding numbers and dates in numerical format; to be reproduced on the voting papers.
- 71.3 Trustees will be elected on a triennial basis for a period of three years, to run from the termination of the next ARM.

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

### **Returning officer**

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

### **Claire Wand award**

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

### **Motions not debated**

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

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

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

### **Mobile phones**

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

### **The press**

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

### **No smoking**

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

### **Chair's discretion**

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

### **Minutes**

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