

Conference of England LMC Representatives

Agenda

To be held on

Thursday 23 November at 10.00

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

Friday 24 November at 08.30

[BMA House, Tavistock Square, London WC1H 9JP](#)

Chair Shaba Nabi (Avon)

Deputy Chair Elliott Singer (Waltham Forest)

Conference Agenda Committee

Shaba Nabi (Chair of Conference)

Elliott Singer (Deputy Chair of Conference)

Paul Evans (Gateshead and South Tyneside)

Matthew Mayer (Buckinghamshire)

Simon Minkoff (Manchester)

Zoe Norris (Humberside)

Clare Sieber (West Sussex)

Members of the England LMC Conference Agenda Committee 2023

Dr Shaba Nabi: Chair of the Agenda Committee



Person most likely to rank motions according to their spice levels and require vindaloo for the final cut

Dr Elliott Singer: Deputy Chair of the Agenda Committee



Person most likely to be late for a meeting in London because he lives in London

Dr Paul Evans: Member of the Agenda Committee



Person most likely to need a suitcase full of omeprazole due to his penchant for Chilli Cool

Dr Matt Mayer: Member of the Agenda Committee



Person most likely to ditch England Conference for UK Conference just because he is the Chair

Dr Simon Minkoff: Member of the Agenda Committee



Person most likely to forget to turn on the tracked changes when he re-writes the entire agenda

Dr Zoe Norris: Member of the Agenda Committee



Person most likely to bribe the rest of the committee with delicious baked goods and expensive lipsticks

Dr Clare Sieber: Member of the Agenda Committee



Person most likely to take the Standing Orders with her to Spain as a good holiday read

The Agenda for 2023 Annual Conference of England LMC representatives

Under Standing Order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 13 September 2023. Although this was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be emailed to the secretariat via the LMC conference inbox which is info.lmcconference@bma.org.uk by **9am on Monday 20 November 2023**.

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.

The Summary of the Agenda

This contains only the motions to be debated at their approximate times, together with details of the themed debates and break-out rooms.

Part 1 of The Agenda

This can be found after the update on motions from Conference of England LMCs 2022, which will include the motions bracketed under each prioritised motion, as well as the motions contributing towards each themed debate and break-out room.

Part 2 of The Agenda

This can be found through a hyperlink after Part 1 of the Agenda and will take you to a separate document. This will include the following:

- A motions: Motions which the agenda committee consider to be a reaffirmation of existing conference policy, or which are regarded by the chair of GPC England as being non-controversial, self-evident or already under action or consideration, shall be prefixed with a letter 'A' – [Please click here for a link to the separate document](#)
- AR motions: Motions which the chair of GPC England is prepared to accept without debate as a reference to the GPC shall be prefixed with the letters 'AR' – [Please click here for a link to the separate document](#)
- Motions not prioritised for debate: These are motions which have not been prioritised for debate, either due to insufficient time, or because they are incompetent by virtue of structure or wording – [Please click here for a link to the separate document](#)
- Standing Orders for England LMC Conference – [Please click here for a link to the separate document](#)

While the Agenda Committee has done the best job it can of prioritising motions for debate in the normal way, avoiding where possible existing policy, we know that some of the motions not prioritised for debate are also important to you, and you can use the chosen motions ballot form to nominate motions from Part 2 of the Agenda which you would like to see debated at the appropriate time during the conference. The online system will also be used to allow representatives to vote for their three preferences in advance. Further details will be sent to representatives nearer to the conference. The ballot for chosen motions is open and will close at **9am Monday 20 November 2023** – [please click here](#).

CONFERENCE OF ENGLAND LMCs ELECTIONS

The following elections will be held:

Chair of conference

Chair of conference for the session 2023-2024 (see standing order 63) - nominations will be open at 12pm midday on Thursday 16 November and close at 10am on Thursday 23 November 2023.

Deputy chair of conference

Deputy chair of conference for the session 2023-2024 (see standing order 64) - nominations will be open at 12pm midday on Thursday 16 November and close at 12pm midday on Thursday 23 November 2023.

Five members of LMC England conference agenda committee

Five members of the England conference agenda committee for the session 2023-2024 (see standing order 65) - nominations will be open at 12pm midday on Thursday 16 November and close at 1pm midday on Thursday 23 November 2023.

How to take part

When nominations open, eligible representatives may nominate themselves using the following link:
<https://elections.bma.org.uk/>.

To take part in elections you must have a BMA website account. It is strongly recommended that representatives obtain a BMA website account in advance of conference to ensure there are no complications. If you do not currently have an account, please call the following number to create a temporary non-member account: **0300 123 1233**. Once your account is created, please email the elections inbox (elections@BMA.org.uk) with your temporary account number (7 digits) so we can grant you access to the election. More information can be found in the attached Election guidance.

Voting opens for all positions: 2pm on Thursday 23 November 2023

Voting closes for all positions: 2pm Friday 24 November 2023

Results will be announced shortly after voting closes.

It is strongly recommended that representatives obtain a BMA website account in advance of conference to ensure there are no complications.

The Cameron Fund is the GPs' own charity

It is the only medical benevolent fund that solely supports general practitioners and their dependants. We provide support to GPs and their families in times of financial need, whether through ill-health, disability, bereavement, relationship breakdown or loss of employment. We help those who are already suffering from financial hardship and those who are facing it.

The Cameron Fund is a membership organisation with full membership open to GPs and former GPs and associate membership open to GP Registrars and those working in the GP profession. Full members can stand for and vote in elections for local Trustees.

Applications are welcome from GPs or former GPs, GP Registrars, their families, and dependants. We also welcome referrals from Local Medical Committees and other organisations or individuals who know of someone who needs our help. Applicants do not need to be members of the Cameron Fund.

We are incredibly grateful for all donations and donations can be made here:

<https://cafdonate.cafonline.org/24639>

www.cameronfund.org.uk

Thank you.



Schedule of business:

Please note that all timings are approximate and subject to change. Proceedings can run behind or ahead of time

Thursday 23 November 2023: Friends House

Item	Time
Opening business	10.00
Chair of GPC England report	10.20
Covid vaccination programme	10.30
ADHD	10.40
Shared care of medication	11.00
GP to patient numbers	11.10
Workload capping	11.30
GP contracts	11.50
Themed debate 1: The future of working at scale	12.10
Lunch	13.00
Reinforced Autoclaved Aerated Concrete (RAAC)	14.00
Salaried job plan	14.10
GP performers list suspensions	14.40
ARRS supervision	14.50
Themed debate 2: Interface solutions	15.10
Enhanced services	15.50
GP retention	16.10
Chosen / emergency motions	16.20
Digital / IT	16.50
Close	17.00

**Friday 24 November 2023:
BMA House in the morning
Friends House in the afternoon**

Item	Time
Registration at BMA House	08.30
Rotating break-out rooms Comfort breaks will be 10.00 – 10.15 and 11.15 – 11.30	08.45 – 12.30
Lunch	12.30
Return to Friends House for Break-out room feedback	14.00
Separation of planned and unplanned care	14.30
Appraisal	15.10
Reaffirming contract policy	15.20
Closing report by Chair of GPC England	16.10
Final business	16.20
Close of conference	16.30

Summary of Agenda – Motions prioritised for debate

Thursday 23 November 2023: Friends House

OPENING BUSINESS

10.00

- 1 THE CHAIR: That the return of representatives of local medical committees (AC3) be received.
- 2 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the standing orders be adopted as the standing orders of the meeting.
- 3 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the report of the agenda committee be approved.

CHAIR OF GPC ENGLAND REPORT

10.20

COVID VACCINATION PROGRAMME

10.30

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

- * 4 AGENDA COMMITTEE TO BE PROPOSED BY WORCESTERSHIRE: That conference is dismayed by the inconsistent and chaotic approach of NHS England towards delivery of Covid vaccines, particularly the significant reduction in the IOS payment and the changes to vaccination programme timelines, and asks that GPC England:
- (i) negotiates with NHSE to ensure that IOS payments for Covid for future years are increased to at least 2022-2023 levels
 - (ii) negotiates annual inflationary rises for all vaccination IOS payments
 - (iii) negotiates that general practice is offered terms no less favourable than pharmacies
 - (iv) demands that, in the future, general practice is given at least six weeks' notice in advance of any changes in the timeline of the Covid vaccination programme, or additional funding should this lead time not be met
 - (v) rejects any future vaccinations programmes that have an IOS payment less than previously agreed and will strongly advise the profession to decline signing up.

ADHD

10.40

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

- * 5 LEEDS: That conference, in recognition of the increased awareness and identification of ADHD, expected prevalence rates, significant secondary complications and impact on an individual, the NHS, the wider system, and society as a whole; we demand:
 - (i) the prompt establishment of an NHS England Any Qualified Provider (AQP) list of neurodevelopmental services, including private providers available through NHS Right-to-Choose
 - (ii) an England-wide self-referral mechanism to a single-point-of-access offering screening and triage to deem “clinical appropriateness” and care-navigation to inform and enable patient choice
 - (iii) that urgent measures are taken by NHS England to remedy the fact that NHS ADHD Services across all ages in have been chronically underfunded for years
 - (iv) a direct enhanced service to cover the implementation of an ADHD annual health check, that would also properly fund the workload for ADHD medication shared-care agreements
 - (v) accredited career pathways in ADHD for interested GPs and other primary-care HCPs, with nationally funded mechanisms to enable the training and subsequent skills to be utilised.

SHARED CARE OF MEDICATION

11.00

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

- * 6 AGENDA COMMITTEE TO BE PROPOSED BY KINGSTON AND RICHMOND: That conference demands that GPC England negotiates an agreed national voluntary shared care drug scheme that:
 - (i) ensures universal availability for patients
 - (ii) is equitable and fully funded for participating practices
 - (iii) is added to only with the agreement of elected representatives of general practice
 - (iv) also applies to private specialist providers.

GP TO PATIENT NUMBERS

11.10

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

- * 7 GLOUCESTERSHIRE: That conference asks GPC England to seek to establish the absolute minimum number of GPs (by WTE) that are required to meet the basic needs of a standard population size, and collate these statistics, in order to:
 - (i) provide a dataset that complements and gives context to the new OPEL type GP alert systems being established

- (ii) assist the GPC England executive to hold NHS England and the Secretary of State to account when they fail to meet their obligation to ensure the provision of primary care services
- (iii) clearly demonstrate the superior quality and value created by traditional general practice compared with corporate and private sector alternatives reliant on 'GP lite' models.

WORKLOAD CAPPING

11.30

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

- * 8 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference asserts that NHS England's use of the term "arbitrary" when referring to the workload limit is disgraceful and reasserts that the demand pressure on general practice has long since exceeded the threshold of safety, and:
 - (i) argues that simple quantification of appointments is disingenuous and needs more nuanced classification to reflect clinical complexity and value of time spent
 - (ii) supports the BMA Safe Working Guidance and calls for safe working limits to be considered a "red line" in contract negotiations, and for wider system overflow support to be mandated where OPEL reporting systems are indicating high levels of demand on practices
 - (iii) demands that NHS England make suitable provision for all practices across England to divert urgent workload when their daily safe working limits have been reached
 - (iv) supports a new above-practice triaging service to manage excessive demand on general practice, which must not include the option to refer back to general practice
 - (v) encourages the establishment of waiting lists for routine GP appointments in order to reveal, and to go some way toward quantifying, this demand and hidden workload.

GP CONTRACTS

11.50

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

- * 9 AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference notes the recent announcements regarding private providers of NHS general practices withdrawing from their contracts and:
 - (i) calls for an end to APMS as a contractual option for general practice
 - (ii) demands that, any new or re-tendered GP core contract is offered as a GMS contract when the successful applicant is able to hold such a contract
 - (iii) demands that no funding over and above standard GMS should be provided to commercial organisations wishing to run NHS general practice contracts in England.

THEMED DEBATE 1 - THE FUTURE OF WORKING AT SCALE

12.10

The purpose of this themed debate is to remove the mental shackles of the PCN DES and for LMCs to discuss what their constituents may want from a future model for working at scale.

Existing GPC England Policy on PCNs is as follows:

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

Following the discussions about the future of the PCN DES at the England Conference of LMCs in 2022, there was a mixed response to whether representatives thought their constituents would be prepared to continue the PCN DES in its current form beyond its scheduled end date in April 2024.

This debate will be conducted under Standing Order 50 and the motions submitted by LMCs that the Agenda Committee considers are best covered by this themed debate are included in Part 1 of the Agenda and are numbered TD1 to TD20.

The format of the debate will be in soapbox style without the need for the submission of speaker slips. Any member of conference may take part by speaking from the microphones in the hall, rather than the podium, with a time limit of one minute per speaker. Speakers will be asked to focus their discussions on the art of the possible, and the statements to be voted for at the conclusion of this debate.

At the conclusion of the debate, voting members of conference will be asked to vote on a scale of one to six on the following statements:

- My constituents have an appetite for working at scale in the future (vote pre and post-debate)
- My constituents wish to share clinical staff with other practices
- My constituents wish to share non-clinical staff with other practices
- My constituents wish to share back-office functions with other practices
- My constituents wish to share estates with other practices
- My constituents wish to provide private services through working at scale
- My constituents wish to tender for NHS services through working at scale

LUNCH

13.00

REINFORCED AUTOCLAVED AERATED CONCRETE (RAAC)

14.00

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

- * 10 BUCKINGHAMSHIRE: That conference is appalled to learn of the emerging scandal surrounding the use of reinforced autoclaved aerated concrete (RAAC) in many buildings necessary for public life, and calls on GPC England to demand:
 - (i) urgent government funded surveys of all primary care estates, to identify any facilities constructed from RAAC
 - (ii) prompt provision of state funded support for any practice found to have RAAC in order to make it safe either through repair or rebuild
 - (iii) a public enquiry to investigate why the known dangers of RAAC have been ignored by government for so long.

SALARIED GP JOB PLAN

14.10

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

- * 11 CAMBRIDGESHIRE: That conference is dismayed that despite salaried GPs being offered model contracts, practices are not held accountable for the job plans they create leading to unmanageable workloads, increased risk of burnout and lack of retention and calls on the GPC England to publish gold standard job plans including a certification symbol for adopting practices to:
 - (i) ensure that true workload of salaried GPs is realistic, fair and follows previously published BMA safe working guidance
 - (ii) create parity in salaried roles across different practices thus reducing inequalities in areas
 - (iii) support workload conversations between salaried GPs and partners in a manner which maintains good relationships.

GP PERFORMERS LIST SUSPENSIONS

14.40

To submit a speaker slip for Motion 12 – [please click here](#)

- * 12 LEWISHAM: That conference is appalled that GP performers lists suspensions payments are both punitive and inequitable and as a matter of urgency, calls on government to amend these regulations to:
 - (i) establish the principle that suspended GPs are entitled to 100% of normal earnings not 90% as per the current regulations
 - (ii) increase the weekly ceiling on locum payments, so that these are annually set at a realistic level that will fully reimburse the locum payments for the suspended GP
 - (iii) entitle all GPs to receive suspension payment, including partners who have been expelled from their partnership due to the suspension.

ARRS SUPERVISION

14.50

To submit a speaker slip for Motion 13 – [please click here](#)

- * 13 AGENDA COMMITTEE TO BE PROPOSED BY NEWCASTLE AND NORTH TYNESIDE: That conference believes that Additional Roles Reimbursement Scheme (ARRS) staff have not been nationally supported to develop adequate competence within primary care and:
- (i) all ARRS staff should be supervised similarly to GP registrars for three years from commencing their role
 - (ii) GPC England needs to insist that, as per GMC guidance, levels of supervision should be guided by the needs of the individual rather than a blanket approach
 - (iii) all ARRS roles and associated supervisors need to have funded and protected time for supervision and learning
 - (iv) no further push for advanced access whilst the inefficiencies of this model are restructured.

THEMED DEBATE – INTERFACE SOLUTIONS

15.10

The large number of motions received on the topic of the Interface between primary and secondary care reflects the ongoing challenges which have not yet been resolved.

The purpose of this themed debate is to provide GPC England with a clear steer for what is required to address some of these issues, as well as sharing what is working well within your individual LMC areas.

Existing GPC England policy on the Interface is as follows:

- Trust staff to request their own prescriptions, investigations and referrals
- Trusts to have email/telephone contacts for reporting “workload dumps” and for patients experiencing delays in secondary care
- Resource for Advice and Guidance pathways
- GPs cannot be mandated to use Advice and Guidance by commissioners or providers
- GPs should be free to refer to a secondary care colleague without pre-referral interference
- Financial penalties for trusts when hospital contracts are breached around the interface issue, and funding moved into general practice

This debate will be conducted under Standing Order 50 and the motions submitted by LMCs that the Agenda Committee considers are best covered by this themed debate are included in Part 1 of the Agenda and are numbered TD21 to TD53.

The format of the debate will be in soapbox style without the need for the submission of speaker slips. Any member of conference may take part by speaking from the microphones in the hall, rather than the podium, with a time limit of one minute per speaker. Speakers will be asked to focus their discussions on solutions to the interface challenges, what is working in their area, and the Agenda Committee Motion to be proposed by the Chair at the conclusion of this debate.

At the conclusion of the debate, voting members of conference will vote on the following motion proposed by the Chair:

AGENDA COMMITTEE to be proposed by the CHAIR: That conference instructs GPC England to:

- (i) produce an up-to-date suite of guidance and tools for practices on the interface between private providers and general practice
- (ii) clearly define what work is and is not core GMS, and produce a suite of resources to empower practices to reject this work if they so choose
- (iii) carry out research to quantify the cost impact of unfunded secondary care work undertaken by general practice
- (iv) produce and promote legally and contractually enforceable levers for practices to use to financially penalise other providers for unfunded work inappropriately shifted into general practice
- (v) work with the BMA's Consultants Committee, Junior Doctors Committee, and Specialist, Associate Specialist and Specialty Doctors Committee, to negotiate with NHS England the rapid implementation of electronic prescribing for secondary care, including the ability connect with community pharmacy.

ENHANCED SERVICES

15.50

To submit a speaker slip for Motion 14 – [please click here](#)

- * 14 AGENDA COMMITTEE TO BE PROPOSED BY AVON: That conference demands that general practice funding is consolidated into the GMS payment and calls for:
 - (i) the cessation of all locally enhanced services in England
 - (ii) the removal of QOF from GP workload
 - (iii) additional funding in the core contract for services such as phlebotomy, spirometry and ECGs.

GP RETENTION

16.10

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

- * 15 AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference is disheartened to note that recruitment and retention of general practice is at its lowest level currently, believes the NHS England Long Term Workforce Plan is a missed opportunity to support retention of GPs and calls for:
 - (i) removal of the five-year maximum eligibility limit to the NHS England GP Retention Scheme
 - (ii) levelling up of ICB investment in the NHS England GP Retention Scheme across the country
 - (iii) increased government investment in the NHS England GP Retention Scheme
 - (iv) consideration of ways to retain and support GPs further down the line in their careers, so that GPs enjoy their work for longer and avoid burnout and early retirement
 - (v) all GP retention or fellowship programmes to be open to all GPs on an equitable basis.

CHOSEN / EMERGENCY MOTIONS

16.20

DIGITAL / IT**16.50**

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

- * 16 DERBYSHIRE: That conference believes that if it takes 20 minutes to switch on your computer in the morning then Steve Barclay should not be investing in robotic penguins.

CLOSE**17.00**

Friday 24 November 2023:
BMA House in the morning
Friends House in the afternoon

REGISTRATION AT BMA HOUSE FOR BREAK-OUT GROUPS

08.30

The second day of conference will start at BMA House at 08.30 for registration, for an 08.45 start time. Please be aware of the following considerations:

- Be punctual so we can start on time
- If you have luggage, **do not bring it to BMA House** as there is nowhere to store it. You can either leave it at the hotel or drop it off to Friends House before arriving at BMA House.
- Representatives will be asked to move between break-out rooms in a manner which allows one-way flow within BMA House. Please adhere to the instructions you have been given.
- Unless you have declared mobility issues in advance to the secretariat, please avoid using the lifts which are small and cannot accommodate large numbers of representatives.

There will be 3 topics for discussion:

TOPICS	FACILITATOR	CIRCUIT
Slicing the Pie	Simon Minkoff	A
	Clare Sieber	B
Contractualising Continuity	Elliott Singer	A
	Matt Mayer	B
Dissecting Care	Zoe Norris	A
	Paul Evans	B

Members of Conference will be divided into six groups which will be identified to you at registration at the start of day one of conference. These six groups will be divided in half to form two circuits – circuit A and circuit B – with three break-out rooms in each circuit covering the three topics for discussion. Conference members will rotate through the three break-out rooms in each circuit and circuit A and circuit B will cover identical topics, but with different facilitators.

The rotation within each circuit will be through the following rooms:

- Circuit A:
 - Snow room: Ground floor
 - Paget room: Ground floor
 - Courtyard Suite: Ground floor
- Circuit B:
 - Bevan room: 3rd floor
 - Harvey room: 3rd floor
 - Worcester room: 1st floor

The break-out rooms will run until lunchtime and members of conference will reconvene at Friends House at 14.00 when the outputs of each break-out room will be shared by the facilitators.

SLICING THE PIE – BREAK-OUT GROUP

The purpose of this break-out group is to discuss how to achieve an equitable formula for patient funding. The pros and cons of the current funding formula will be discussed, together with considering which patient factors may be important when negotiating funding within a new GP contract.

Existing GPC England and GPC UK Policy on the Funding Formula is as follows:

- Carr Hill formula is no longer fit for purpose
- A new funding formula needs to reflect patient demographics, deprivation and health seeking behaviour on an individual practice level
- The difference in premature multi-morbidity is taken into account in the allocation of funding
- Any revised funding formula should ensure no practice loses out

Desired outputs from this break-out group:

- A set of principles to steer the GPC England Officer Team when negotiating the funding formula for the next contract, or it may conclude that “if everyone is special, then no-one is special!”



CONTRACTUALISING CONTINUITY – BREAK-OUT GROUP

The purpose of this break-out group is to discuss how to include continuity measures within any new contract. It will focus on the principles of defining, measuring and incentivising continuity.

Existing GPC UK Policy on Continuity is as follows:

- We move away from a target-based GP contract and be rewarded for prioritising continuity

Desired outputs from this break-out group:

- To reach a consensus on whether we want continuity to be incentivised within any new contract and how we wish this to be done



DISSECTING CARE – BREAK-OUT GROUP

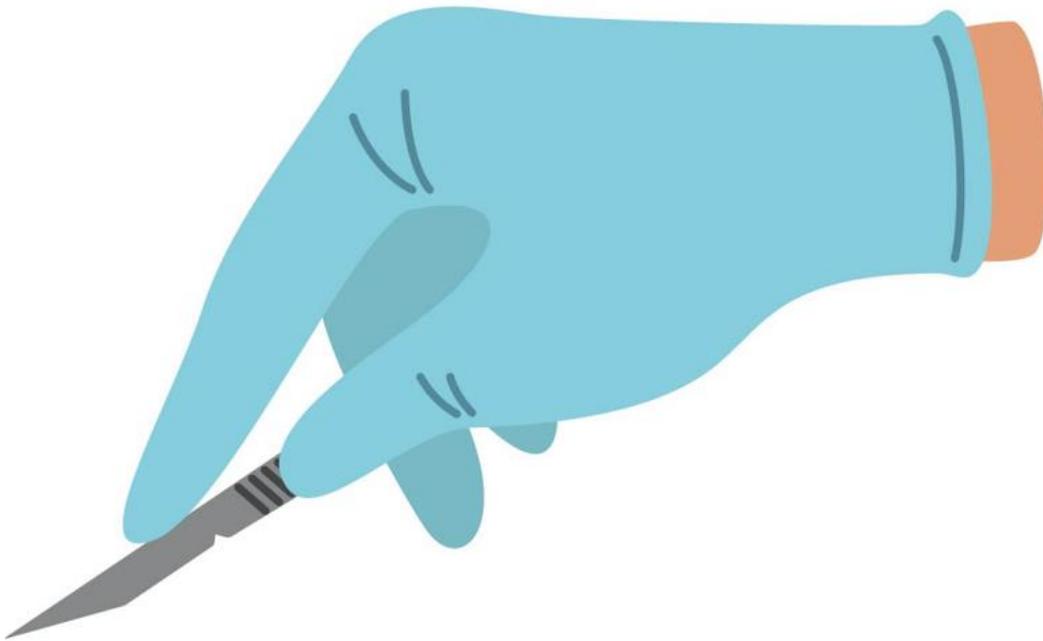
The purpose of this break-out group is to raise awareness of the issues surrounding the separation of planned and unplanned care. Discussion will focus on the impact of this separation on the patient, the GP, and the system.

Existing GPC England Policy on the separation of planned and unplanned care is as follows:

- Acknowledge that isolated, acute presentations make up a tiny percentage of general practice workload and their removal risks fragmentation of continuity of care

Desired outputs from this break-out group:

- To reflect on the risks and benefits of shedding our in-hours unplanned care, before debating this within a binary motion after the workshop discussions.



LUNCH

12.30

BREAK-OUT ROOM FEEDBACK

14.00

SEPARATION OF PLANNED AND UNPLANNED CARE

14.30

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

- * 17 WALTHAM FOREST: That conference believes that the current workload for general practice is unsustainable, and:
 - (i) believes that the time has come to separate acute on-the-day care from planned general practice care
 - (ii) insists that the separation of care be an essential component of a new GMS Contract
 - (iii) requests that GPC England negotiates a separate service for the provision of on-the-day acute care for patients currently seen by GPs.
 - (iv) requests that GPC England stipulates that a new GMS contract clearly indicates the situations when a patient would benefit from moving between acute care services and planned care services and the mechanism to enable this
 - (v) requests that GPC England negotiates a new GMS contract which focuses on continuity of care, care of long-term conditions, preventative healthcare and end of life care.

APPRAISAL

15.10

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

- * 18 WEST SUSSEX: That conference believes that GPs should not have to bear costs associated with mandatory annual appraisal and implores GPC England to insist that these costs are reimbursed in full.

REAFFIRMING CONTRACT POLICY

15.20

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

- * 19 AGENDA COMMITTEE TO BE PROPOSED BY KENT: That conference calls on GPC England to:
 - (i) include in its negotiations with NHSEI / DHSC that existing conference policy of an activity-based contract is part of the new contract

- (ii) include in its negotiations with NHSEI / DHSC that existing conference policy of PCN into core is part of the new contract
- (iii) include in its negotiations with NHSEI / DHSC that existing conference policy of more flexibility for private services the NHS cannot provide is part of the new contract
- (iv) include in its negotiations with NHSEI/DHSC that existing conference policy of the removal of home visits from core contract work is part of the new contract
- (v) formally ballot members once the outcome of negotiations for the new contract with NHSEI / DHSC are known.

CLOSING REPORT BY THE CHAIR OF GPC ENGLAND 16.10

FINAL BUSINESS 16.20

CLOSE OF CONFERENCE 16.30

Update on motions from Conference of England LMCs 2022

	Motion	Update
	SAFETY IN GENERAL PRACTICE	
5	<p>That conference believes general practice in England is unsafe due to a shortage of doctors and a lack of investment; that this problem must be owned by government, and:</p> <p>(i) believes that focusing on patient safety is more appropriate than trying to meet high patient demand and therefore calls for GPC England to use “safe capacity” and avoid “access” in communications and negotiations</p> <p>(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</p> <p>(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</p> <p>(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.</p> <p>Proposed by Lisa Harrod-Rothwell, Kensington and Chelsea</p> <p>Carried</p>	<p>(i) GPC England’s guidance on safe working is intended to help practices switch to a focus of patient safety over meeting unmanageable demand. Many practices are or have implemented these recommendations, which are possible given the GMS and PMS contracts allow contractors the flexibility to provide services in the best way for patients. If practices implement these guidelines, they will find they have the headspace to make changes that keep staff safe whilst they work, improve retention and recruitment, and thus patient outcomes.</p> <p>(ii) GPCE’s position on the under resourcing of the workforce, and how unsafe NHS general practice is becoming aligns with that of LMCs. Unfortunately, this situation is reflected across the NHS. GPCE members are taking every opportunity to lobby stakeholders, remind ministers, MPs, civil, public servants and organisations of influence (e.g. think tanks), that serious commitments to change this situation are urgently needed. The forthcoming contract negotiating window must deliver these commitments to avoid the profession being forced, like other groups of doctors, into industrial disputes. Government/Treasury must also put spending commitments in place to ensure the goals for expanding the GP workforce within the NHS Long Term Workforce Plan are achieved.</p> <p>(iii) The GPAS (general practice alert state) has the potential to fulfil this request from conference. Every LMC is encouraged to ensure it is adopted, but unfortunately uptake remains relatively low. There is more to do to maximise the outputs from the dashboard to ensure GPCE can use the data in its evidence for change when lobbying and negotiating.</p> <p>(iv) Given 2024 will be a General Election year, 2024/25 will be a “stepping stone” year of securing incremental gains to lay the necessary foundations for positive change with a new government. Realistically, however, GPCE and LMCs need to be crystal clear what such a workload sensitive contract will look like, and the profession will need to be united in its willingness to fight for such a change through several facets, and, if necessary, leverage garnered by collective or, indeed, potential industrial action. Resolve, determination and a willingness to trust the eventual agreed process will be paramount from all GPs.</p> <p>The longer-term trend shows that the NHS is losing GPs at an alarming rate: over the past year (up to August 2023) it lost the equivalent of 269 fully qualified full-time GPs. This means that, on average, the NHS lost 22 fully qualified FTE GPs per month</p>

		over the past year. The GP pressures webpage is regularly updated with these figures.
	MENTAL HEALTH SERVICES	
6	<p>That conference, whilst recognising their staffing crisis, is concerned about the diminishing access to mental health services and:</p> <ul style="list-style-type: none"> (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 England to look at ways of ensuring that the current service inadequacies do not fall to general practice <p>Proposed by Peter Holden, Derbyshire</p> <p>Carried</p>	The Public Health and Healthcare team are undertaking a major research project into mental healthcare in England. It will seek to make policy recommendations for improving access to mental health services. A report is expected in November 2023.

CHILDHOOD IMMUNISATIONS		
7	<p>That conference recognises the importance of childhood immunisations and applauds the work that general practices have done in the last year despite many knowing that this work would go unrewarded through QOF payments. Conference demands that:</p> <ul style="list-style-type: none"> (i) NHSEI and the government recognise that patients can make informed decisions (ii) NHSEI recognise the difficulties in achieving QOF targets, particularly in areas with high patient turnover and areas with marginalised communities thereby discriminating against practices in inner cities and high levels of deprivation (iii) GPC England negotiate with NHSEI a QOF target with a lower threshold for payment for childhood immunisations (iv) GPC England negotiate with NHSEI that exception reporting should be incorporated into all QOF targets. <p>Proposed by Emma Radcliffe, Tower Hamlets</p> <p>Carried</p>	<p>GPCE raised this with NHS England as a matter of urgency, both during the year and as part of annual negotiations for the 23/24 GMS contract.</p> <p>Following these discussions, NHSE agreed to alter the thresholds for the QOF targets related to childhood immunisations, including the removal of the repayment mechanism for achieving below 80% coverage for routine childhood programmes and the lower thresholds reduced to 81% – 89% (depending on the indicator) and the upper thresholds raised to 96%.</p>
GENDER DYSPHORIA		
8	<p>That conference is dismayed by the lack of adequate gender dysphoria services and believes it is imperative that GPC England ensures NHSEI:</p> <ul style="list-style-type: none"> (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. 	<p>GPC England continues to lobby NHS England to highlight the lack of a commissioned and appropriately resourced service. GPCE has written to NHS England on a number of occasions asking what steps have been taken to commission an appropriate and accessible service to enable ongoing access to care for this group of patients who have specific and specialised care needs.</p> <p>In addition, we have asked for an update on the development of national guidelines and appropriately commissioned services for such specialised prescribing.</p>

	Proposed by Zishan Syed, Kent Carried	
	PATIENT ACCESS TO RECORDS	
9	<p>That conference, with regard to the implementation of accelerated patient access to full primary care records:</p> <ul style="list-style-type: none"> (i) has serious concerns regarding the implementation of patient access to full primary care notes (ii) notes the programme is unfunded, lacks safeguards against patient harm or data loss, and thus has the potential to cause patient harm and distress (iii) laments the lack of relevant training and support that has been given to practices (iv) believes the programme poses unacceptable risk to general practice in terms of workload, complaints, and liability (v) tasks GPC England to ensure that the programme is paused until all outstanding issues have been addressed. <p>Proposed by David Herold, Worcestershire Carried</p>	<p>GPCE has been engaging with NHSE on this for almost two years We secured a delay in autumn of 2022, resulting in the go-live date being postponed from November 2022 to 31 October 2023 and have continued dialogue with colleagues at NHSE, DHSC and other stakeholders to represent and convey the concerns of the profession.</p> <p>The BMA considered bringing a judicial review against government although ultimately decided against this in favour of continued engagement from July 2023 on the issues of concern.</p> <p>Most recently, GPCE’s guidance, templates, and tools have focused on detailing the risks involved in launching the accelerated access to records programme and measures practices (acting as data controllers for the GP-held record) could take to mitigate them.</p> <p>We are working with other interested parties (e.g. RCGP, Refuge and other domestic abuse charities) to make representations to NHSE to secure flexibility for practices who have identified increased risks, and to support how practices can best decide to actively engage their patients; as well as inform and make plans with their ICB teams in order for patients to safely access prospective online records.</p> <p>We are in wider conversations with the BMA around what potential ongoing support may be to such practices, should contractual action be taken against colleagues in the future.</p>

ENERGY / INFLATION CRISIS		
10	<p>That conference believes that the rise in energy prices is having a catastrophic impact on the financial viability of English 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.</p> <p>Proposed by Simon Hodson, Shropshire</p> <p>Carried</p>	<p>GPCE ran two surveys on inflation, one in 2022 and one at the start of 2023. A range of case studies were also collated to help demonstrate the impact of inflation on practices to NHSE. Both the surveys included a series of questions on energy prices.</p> <p>Through the case studies, we also demonstrated both quantitatively and qualitatively how energy prices have been impacting practices, GPCE made a very strong case to Government/DHSC/NHSE on the impact of inflation during the negotiations in January 2023. These arguments were accepted and ultimately led to greater flexibility in the way PCNs/practices could use the Investment and Impact Fund, as well as later investment in the Primary Care Recovery Plan (almost £1 billion) and an additional 3.9% uplift to the staffing expenses element of global sum (£233.14m with on-costs).</p>
CQC BIAS		
11	<p>That conference notes, in practices with minority ethnic CQC Registered Managers, the evidence of adverse outcomes arising from CQC inspections and calls for:</p> <ul style="list-style-type: none"> (i) publication of CQC inspection outcomes stratified by the protected characteristics of practice CQC leads including ethnicity and gender (ii) publication of diversity data including protected characteristics of CQC inspectors (iii) publication of CQC's plan to improve its representation of the population should its data demonstrate a diversity gap (iv) local intelligence to be used to support CQC inspections where their searches indicate concerns (v) a practising NHS GP Specialist Advisor to be part of every CQC inspection team inspecting NHS general practice. <p>Proposed by Anthony O'Brien, Devon</p> <p>Carried</p>	<p>GPCE has engaged with CQC on this throughout the year. A CQC update on its 2022 ethnicity report was published in March 2023, with BMA staff and the then GPCE deputy chair and Contracts and Strategy policy lead attending meetings to establish the best way to collect ethnicity data from practices.</p> <p>Data published by the CQC in January 2022 states that within GP inspection teams in CQC's Primary Medical Services (PMS) directorate, 21% of inspectors (46/216) and 17% of inspection managers (8/48) identify as being part of an ethnic minority group. Among the senior roles within the PMS directorate, 13% of those who make decisions about ratings identify as being from an ethnic minority background (due to small numbers, the underlying figures are not available). 32% (65/204) of GP specialist advisors are from an ethnic minority background and 30% (61/204) from a non-ethnic minority background. The other 38% of GP specialist advisors did not state their ethnicity.</p> <p>CQC has published equality objectives for 2021-2025 which includes its approach to its own workforce. At this stage there is no proposal from CQC to include a practising NHS GP Specialist Advisor to be part of every CQC inspection team inspecting NHS general practice as their teams are going through a restructuring exercise.</p>
FEDERATED DATA PLATFORM		
12	<p>That conference notes with concern NHS England's plans to procure a £360m contract for a Federated Data Platform from a single supplier, raising questions over the safety of patient data and the oversight of any</p>	<p>GPC has continued engagement with NHSE and other relevant stakeholders to ascertain the ultimate scope and operation of the Federated Data Platform (FDP).</p> <ul style="list-style-type: none"> (i) BMA has formally signalled support for OpenSAFELY to expand its mandate beyond covid research & planning and

<p>company that might potentially seek to exploit that data. In order to maintain the highest level of public trust this conference calls on the BMA to work with NHS England to:</p> <ul style="list-style-type: none"> (i) determine if the four existing secure data platforms supported by the BMA / RCGP Profession Advisory Group can provide some or all of the requirements of the proposed platform (ii) scrutinise organisations submitting tenders to ensure a demonstrable positive track record on security, privacy and ethics (iii) mitigate from the outset against vendor lock-in and ensure the commitments to modern, open working methods from the 13 June paper Data Saves Lives and 6 September paper on Secure Data Environments, both of which draw on the Goldacre review, are enshrined. <p>Proposed by Mark Coley, GPC England</p> <p>Carried</p>	<p>provide data for a range of uses within its secure environment. This has been welcomed by OpenSAFELY.</p> <ul style="list-style-type: none"> (ii) BMA has continued work already underway to scrutinise vendors, where possible, however this has been made difficult due to a lack of formal involvement in the process. We expect that an announcement will be made by the end of October 2023 and pending the outcome of this, we anticipate setting out concerns following the announcement. (iii) BMA expects to be closely involved in the launch and operation of the FDP and will represent the concerns of the profession as they develop in response to the ementation of the successful vendor’s platform.
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FULLER STOCKTAKE		
13	<p>That conference believes the implementation of the Fuller Stocktake report is failing and calls upon NHSE and the Government to:</p> <ul style="list-style-type: none"> (i) mandate LMC involvement for all ICS work streams concerning the report (ii) provide immediate funding to deliver an emergency primary care estates solution (iii) acknowledge that isolated, acute presentations make up a tiny percentage of general practice workload and their removal risks fragmentation of continuity of care (iv) instruct ICSs to publish their progress and evidence of primary care engagement on a quarterly basis. <p>Proposed by Rolan Schreiber, North and North East Lincolnshire</p> <p>Carried</p>	<p>GPCE and the BMA have monitored the ongoing implementation of the Fuller Stocktake, as well the wider role of general practice within ICSs. This has included repeatedly raising the importance of general practice’s voice and meaningful representation input within ICBs specifically, including in evidence submitted to Parliamentary committees and the Hewitt Review.</p> <p>We have also continued to call for major investment into primary care and general practice estates, including in our December 2022 report <i>Brick by Brick</i>. More recently, we have called for a nationally funded intervention to address any presence of RAAC in GP premises.</p> <p>It will be important to lay foundations in the forthcoming contract negotiations to secure substantial contract reform in 2025/26 and beyond, rather than simply ineffective, inefficient and insufficient rapid access ‘wins’ for ministers/politicians.</p> <p>Conference should consider carefully which elements of the Fuller stocktake it wishes to progress. Including how best to balance political targets around access against the appropriate commissioning of unplanned urgent care alongside continuity and holistic care of the registered list, with its evidence of reducing inefficiencies across the wider NHS.</p> <p>Reform will be expected with a new government, following the general election in 2024. Representatives would therefore be wise and open to debate all potential solutions.</p>
INTEGRATED CARE SYSTEMS (ICS)		
14	<p>That conference instructs GPC England to ensure that:</p> <ul style="list-style-type: none"> (i) GMS / PMS monies and pre-existing general practice budgets must be ring fenced within all ICSs for exclusive use in general practice (ii) distribution of funding at place, system and ICB level should be proportional based on the amount of activity delivered by each sector (iii) representation at place, system and ICB level should be proportional based on the 	<p>GPCE and the BMA have continued to lobby on the importance of general practice playing a central role in the ongoing development of ICSs and ICBs specifically, including in evidence submissions to the Hewitt Review and parliamentary inquiries into ICS development. This has included stressing the importance of a meaningful voice and input for LMCs within ICB boards, Localities, and at Place.</p> <p>More specifically, we have also supported LMCs’ calls for the ringfencing and increased resource into general practice and primary care funding within ICBs and will continue to do so.</p>

	<p>amount of activity delivered by each sector</p> <p>(iv) all proposals at ICS, system or place level must include a GP practice workload, stability, and clinical risk impact assessment, and address any adverse implications that are identified before agreement</p> <p>(v) ICSs are held accountable for local system operational failings and for safe GP / patient ratios.</p> <p>Proposed by Lisa Harrod-Rothwell, Westminster</p> <p>Carried</p>	
GP CONTRACT		
15	<p>That conference views core hours as a relic of history and:</p> <p>(i) notes that they total 52.5 hours per week, starting earlier and finishing later than most other jobs, including childcare</p> <p>(ii) believes that they indirectly discriminate against GPs who wish to have families</p> <p>(iii) is concerned that due to the still-patriarchal nature of English society, this is discrimination that mostly affects female GPs</p> <p>(iv) requests that any new contract reduce core hours to 0900-1700hrs, but with practices to start earlier/finish later on some days, as per extended hours, in order to meet local need and practice ability to staff this.</p> <p>Proposed by Paul Evans, Gateshead and South Tyneside</p> <p>Carried</p>	<p>GPCE will certainly be taking this resolution from conference into contract negotiations for 24/25 and future years where more substantive contractual change is expected.</p> <p>GPCE and the Sessional GPs Committee are working together to ensure safe working guidance for both contractors and salaried GPs is implemented by all practices, and LMCs support with implementing this guidance at practice level is essential. It is vital that GPs and practice staff are empowered to take back control of their working conditions to safeguard and deliver safe patient care within the capacity they actually have, rather than continually going above and beyond and strongly risking burnout / ill-health.</p> <p>By following our safe working guidance, we will increase leverage when negotiating with ministers and public and civil servants because Government will have to invest in the workforce to guarantee additional necessary capacity. The additional workforce introduced via PCNs has not reduced GP or practice workload overall.</p>

GP CONTRACT		
16	<p>That conference:</p> <p>(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</p> <p>(ii) demands that any new BMA model contracts (such as may be required alongside any new GMS contract) define GP working schedules in terms of hours rather than sessions</p> <p>(iii) demands that any workforce data collection (eg for NHS workforce planning) be done on the basis of hours worked, not contracted sessions.</p> <p>Proposed by Raman Nijjar, Oxfordshire</p> <p>Carried</p>	<p>The Sessional GPs Committee recognises the significant amount of work being completed by GPs outside of their contracted hours and is investigating the move towards hours rather than sessions as part of its work on the model contract and workload control.</p> <p>There has been discussion around how using hours in general practice, rather than sessions, would more accurately reflect work undertaken and underpin the Job Plan. We are working closely with the GP Registrars Committee, who are also interested in progressing this motion.</p> <p>This has been taken into account in the development of the annual leave calculator and the workload control guidance including the salaried GP pro rata overtime rate card.</p>
ENHANCED ACCESS		
17	<p>That conference with regards to the enhanced access requirements of the PCN DES:</p> <p>(i) believes that extending the times of providing services is not a solution but exacerbates the problems faced in primary care</p> <p>(ii) has enormous concerns that this will destabilise existing out-of-hours GP services, with harm resulting to patients</p> <p>(iii) demands that this scheme be repealed from April 2023.</p> <p>Proposed by Bethan Rees, Hertfordshire</p> <p>Carried</p>	<p>Discussion around the extended access component of the PCN DES is included within the ongoing talks around the future of the DES and improving flexibility of expenditure to support practice sustainability in line with Conference policy. This will continue to be a central part of GPCE’s negotiations for 2024/25.</p>

INTERFACE		
18	<p>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:</p> <ul style="list-style-type: none"> (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. <p>Proposed by Lucy Clement, Leeds</p> <p>Carried</p>	<p>GPCE seeks continual assurances from NHSE in its monthly Operational Group meetings, and in meetings with the government minister, that the commitments within the Primary Care Recovery Plan (which oblige ICBs/Trusts to fulfil their commitments relating to the NHS Standard Contract and the primary / secondary care interface) receive full compliance across England's 42 ICSSs.</p> <p>GPCE sent a letter, co-signed by RCGP and Healthwatch, regarding the impact that the rejection of referrals is having on patient care. The letter outlined proposed greater collaborative efforts in establishing agreed referral systems between general practice and secondary care, with GPCE asking for support from NHSE that this be mandated to ICBs and Trusts. This theme was also a central tenet of CQC's annual report to which GPCE also formally responded using the opportunity to highlight the workload shift which has been particularly stark post-pandemic.</p> <p>This work is to support LMCs in reminding systems/Trusts of their obligations outlined within the Primary Care Recovery Plan, and to share intelligence with GPCE where local systems are failing to fulfil their obligations, so such examples can be shared with NHSE for rapid investigation and resolution.</p> <p>Part iv will be taken forward in the 2024/25 contract negotiations.</p>
DEFENCE OF GENERAL PRACTICE		
19	<p>That conference believes the relentless denigration of general practice continues to drive a crisis of recruitment and retention and that GPC England:</p> <ul style="list-style-type: none"> (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. <p>Proposed by Annie Farrell, Liverpool</p> <p>Carried</p>	<p>Response from the BMA media team:</p> <p>"GPCE already benefits from access to the BMA's leading communication professionals. The BMA's in-house media team – as part of the wider communications and policy directorate – supports GPC England to provide proactive and reactive commentary on issues impacting the profession, including defending the reputation of GPs in response to any hostile and negative media coverage.</p> <p>Alongside this, the BMA, in partnership with GPDF, commissioned the Rebuild General Practice campaign between March and June 2023, delivered by a third-party agency which is in process and complementing the work of the BMA and GPCE.</p> <p>The work of the BMA and the RGP campaign has played a significant part in seeing the volume of anti-GP rhetoric in the media subside considerably in recent months, and we will</p>

		<p>continue to challenge robustly should we see this begin to pick up again.</p> <p>Additional funding from GPDF to allow further joint campaigning work is very welcome and something the BMA would be keen to progress.”</p>
	WORKFORCE	
20	<p>That conference believes that doctors who are not on the NHS England Medical Performers List should be allowed to undertake general practice primary medical services under the clinical supervision of a general practitioner.</p> <p>Proposed by Richard Brown, Croydon</p> <p>Carried as a reference</p>	<p>A BMA position statement on the idea of the ‘Primary Care Doctor’ was published by GPC UK and SASC UK in June 2023:</p> <p>“We do not believe that general practice currently has the staff, financial or premises resources to accommodate an intake of "primary care doctors", nor do we believe that the proposals are being designed to benefit doctors who want to make the switch into primary care. The proposals will not increase the number of GPs, nor will they help secondary care doctors who wish to train to be GPs.”</p> <p>Following this, the DHSC reported that they would not immediately be making permanent changes to legislation to make it easier for non-GP doctors to work in general practice settings.</p> <p>They have stated that they still want to consider future options and have set up a working group for this purpose (on which we have representation).</p>
	Junior doctors’ industrial action	
24	<p>That conference notes that the Junior Doctor Committee of the BMA will be balloting all junior doctors in England, including GP registrars, to undertake industrial action in 2023 due to the lack of progress in negotiations with the English government towards addressing the real-terms pay erosion that has occurred in junior doctor wages since 2008. We ask conference to:</p> <p>(i) offer our public support to all junior doctors, specifically GP registrars, in pursuing full pay restoration to 2008 levels</p> <p>(ii) call on GPC England, to work with GP Registrars Committee, to develop guidance for GP practices, LMCs, GP registrars and GP training programme directors on how to inform, empower and support GP registrars around industrial action</p>	<p>The GP Registrars Committee collaborated closely with GPCE to create comprehensive guidance aimed at assisting GP practices, LMCs, GP registrars, and GP training programme directors in effectively informing, empowering, and supporting GP registrars during periods of industrial action. This effort included the development of webinars and resource materials.</p> <p>Throughout the pay restoration campaign, GPCE has provided its public support to all junior doctors, with a particular emphasis on GP registrars.</p> <p>The deficit in the GP registrars flexible pay premia in England was exacerbated by the implementation of the 2016 contract, and this has been fed into and is a significant part of the asks being presented in the current negotiations being led by UK JDC.</p> <p>These actions reflect the BMA’s ongoing commitment to support GP registrars and junior doctors in their fight for FPR.</p>

	<p>(iii) call on the BMA to create a public information campaign to educate the public as to why GP registrars are being balloted for IA and the effects of chronically falling GP registrar pay on retention rates of GPs post-CCT</p> <p>(iv) note the deficit in the GP registrars flexible pay premia in England, which was identified during the 2018 Junior Doctor contract negotiations, and call on the BMA to lobby the Department of Health and Social Care to address this in order to achieve pay parity with the pay of junior doctors training in hospital medicine.</p> <p>Proposed by David Smith, GP Trainee Chair</p> <p>Carried</p>	
BMA Resolution Process		
400	<p>That conference registers its deep concern that at this time of great instability in general practice the elected chair of GPCE has been disallowed to undertake her duties by the BMA and:</p> <p>(i) notes with concern the optics of this action being taken against a colleague in the final stages of pregnancy</p> <p>(ii) believes this episode to be contradictory to the recommendations of the Romney report into institutional sexism within the BMA</p> <p>(iii) finds the lack of transparency around the circumstances unacceptable and at odds with the BMA's own values</p> <p>(iv) has no confidence in the "Resolution Process" for BMA members.</p> <p>Proposed by Katie Bramall-Stainer, Cambridgeshire</p> <p>Carried</p>	<p>The BMA's Resolution Process is run independently and externally to the BMA, as recommended by the reviews conducted by Daphne Romney KC and Orla Tierney.</p> <p>The Resolution Process has recently been extensively revised in light of these reviews to ensure that the required support is made available to all parties, and to ensure that lessons are learned from concerns received about member behaviour.</p> <p>The process is confidential to protect both complainants and respondents and it is intended that the process is concluded as quickly as possible in all cases.</p>

Part 1 of the Agenda

Part 1 of the Agenda includes the motions bracketed under each prioritised motion, as well as the motions contributing towards each themed debate and break-out rooms.

Thursday 23 November 2023: Friends House

OPENING BUSINESS

10.00

- 1 THE CHAIR: That the return of representatives of local medical committees (AC3) be received.
- 2 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the standing orders (appended), be adopted as the standing orders of the meeting.
- 3 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the report of the agenda committee be approved.

CHAIR OF GPC ENGLAND REPORT

10.20

COVID VACCINATION PROGRAMME

10.30

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

- * 4 AGENDA COMMITTEE TO BE PROPOSED BY WORCESTERSHIRE: That conference is dismayed by the inconsistent and chaotic approach of NHS England towards delivery of Covid vaccines, particularly the significant reduction in the IOS payment and the changes to vaccination programme timelines, and asks that GPC England:
- (i) negotiates with NHSE to ensure that IOS payments for Covid for future years are increased to at least 2022-2023 levels
 - (ii) negotiates annual inflationary rises for all vaccination IOS payments
 - (iii) negotiates that general practice is offered terms no less favourable than pharmacies
 - (iv) demands that, in the future, general practice is given at least six weeks' notice in advance of any changes in the timeline of the Covid vaccination programme, or additional funding should this lead time not be met
 - (v) rejects any future vaccinations programmes that have an IOS payment less than previously agreed and will strongly advise the profession to decline signing up.

- 4a WORCESTERSHIRE: That conference does not support the move towards national vaccination centres and demands that:
- (i) practices are not forced to withdraw from delivery of Covid and influenza vaccinations due to insufficient item of service payments in future years
 - (ii) general practice is offered terms no less favourable than pharmacies in terms of delivery to the local population.
- 4b TOWER HAMLETS: That conference is dismayed by the inconsistent and chaotic approach of NHS England towards delivery of Covid vaccines, particularly the significant reduction in the IOS payment and the changes to vaccination programme timelines, and asks that GPC England:
- (i) negotiates with NHS England to ensure that IOS payments for Covid for future years are increased to at least 2022-2023 levels
 - (ii) negotiates annual inflationary rises for all vaccination IOS payments
 - (iii) demands that, in the future, general practice is given at least six weeks' notice in advance of any changes in the timeline of the Covid vaccination programme
 - (iv) rejects any future vaccinations programmes that have an IOS payment less than previously agreed and will strongly advise the profession to decline signing up.
- 4c LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference deplores the lack of joined up thinking evident in the specifications around the current provision of seasonal vaccinations. This is shown in the lack of foresight in enabling coordination of flu and covid vaccinations and then the fact that last minute changes to specifications were made which show that there is no appreciation or understanding of the disruption this causes to the day to day running of practices.
- 4d DERBYSHIRE: That conference insists that a formal review of the flu campaign costing is completed and approved by GPC England, since the last costings review took place in 2009.
- 4e OXFORDSHIRE: That conference believes general practice in England has a proven track record of successful population vaccination programmes, and:
- (i) deplores NHS England's reduction in funding of the Covid-19 vaccine programme for 2023/24, the excessively short lead times involved in the acceleration of the programme and the resulting extra workload to GPs
 - (ii) recommends GPC England negotiate a standard framework for vaccination programmes, to resource adequately the cost, time, staffing and the impact on general medical services involved, and establish standard minimum lead times for planning and implementation. Conference believes that any vaccination programme that does not adhere to such standard minimum lead times should attract additional funding to compensate for the additional short-notice efforts that are required for "faster than standard" planning and implementation.
- 4f SUFFOLK: That conference lauds the nimbleness with which the profession has responded to the recent short notice changes in Covid and influenza vaccination requirements but notes that these last-minute panicky alterations come at a significant cost in terms of stress on practices and their workforce. Conference requests GPC England to agree with NHS England that the arrangements for

vaccination for 2024 will be agreed with the profession by 31 March 2024 and that this agreement will be funded in such a way that practices are unlikely to reject the arrangements on economic grounds alone.

- 4g MERTON: That conference calls upon the government to ensure that future immunisation and vaccination campaigns are fully planned and mapped out in a timely manner, so that practices can have confidence when placing vaccine supply purchases and arranging clinics.
- 4h MID MERSEY: That conference demands that primary care is allowed to run the national influenza and Covid vaccination programme without inappropriate and late intervention by others not directly involved in service provision:
- (i) there should be no changes to the enhanced service without sufficient notice being given
 - (ii) no changes should be made without direct discussion with those actually running the service
 - (iii) there should be no difference across the UK for the same service provision by clinicians – the service should attract the same fee across all the nations
 - (iv) that NHS England is transparent regarding their vision for the future of general practice vaccination programme delivery to avoid the risk of undermining general practice year on year.
- 4i LAMBETH: That conference condemns NHS England for its unfair commissioning arrangements for seasonal influenza and covid vaccination programmes and calls upon GPC England to negotiate a standard national price for all vaccines subject to annual uplift in line with the Consumer Prices Index.
- 4j LEEDS: That conference is seriously concerned at the rise in cases of measles and calls for:
- (i) a major and sustained public campaign by government to promote the benefit of MMR immunisation
 - (ii) an increased item of service payment for all vaccinations.
- 4k DEVON: That conference is outraged at the chaos surrounding NHS England communications surrounding vaccines and:
- (i) deplores the lack of recognition by NHS England of the world leading excellence in vaccine program delivery provided by general practice
 - (ii) asserts that the actions of NHS England in proposing a delayed start to the seasonal influenza vaccine program may leave large cohorts of vulnerable patients at clinical risk and risks the whole NHS system becoming overwhelmed should there be an early rise in influenza cases in a largely unvaccinated population
 - (iii) demands that NHS England adhere to their own specifications regarding vaccination campaigns rather than countermanding them to suit their own agenda
 - (iv) demands an overhaul in the seasonal vaccination and Covid vaccination specifications to render them cost effective and practical for general practice to provide in the future.

- 4l NORTH YORKSHIRE: That conference judges the reduction in the Covid-19 service charge along with the delay in the Flu campaign start date as a direct attack on general practitioners who have been integral in the mass vaccine roll out and demand that:
- (i) item of service charge is returned to previous levels
 - (ii) inflationary adjustments are made to all such services
 - (iii) contractual specifications that any changes to mass vaccination provisions will only apply in a state of national health emergency.
- 4m BRADFORD AND AIREDALE: That conference believes childhood vaccinations are now no longer viable in some areas and payment systems need urgent review.

ADHD

10.40

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

- * 5 LEEDS: That conference, in recognition of the increased awareness and identification of ADHD, expected prevalence rates, significant secondary complications and impact on an individual, the NHS, the wider system, and society as a whole; we demand:
- (i) the prompt establishment of an NHS England Any Qualified Provider (AQP) list of neurodevelopmental services, including private providers available through NHS Right-to-Choose
 - (ii) an England-wide self-referral mechanism to a single-point-of-access offering screening and triage to deem “clinical appropriateness” and care-navigation to inform and enable patient choice
 - (iii) that urgent measures are taken by NHS England to remedy the fact that NHS ADHD Services across all ages in have been chronically underfunded for years
 - (iv) a direct enhanced service to cover the implementation of an ADHD annual health check, that would also properly fund the workload for ADHD medication shared-care agreements
 - (v) accredited career pathways in ADHD for interested GPs and other primary-care HCPs, with nationally funded mechanisms to enable the training and subsequent skills to be utilised.
- 5a WANDSWORTH: That conference calls for there to be more information and training that is resourced appropriately for GPs about the diagnosis and treatment of neuro-developmental disorders in order for GPs to diagnose and treat patients and offer support to those GP colleagues who are neuro-divergent.
- 5b HULL AND EAST YORKSHIRE: That conference, regarding provision of services for Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorders:
- (i) condemns the current service provision across England as woefully inadequate for both adult and paediatric patients
 - (ii) believes the gap in adequately commissioned services puts patients at risk and practices under pressure

(iii) calls for a national solution from NHS England to avoid the current postcode lottery and rationing of care for patients.

5c GATESHEAD AND SOUTH TYNESIDE: That conference, is appalled by the ongoing failure of NHS England and many ICBs to commission services for some of our more vulnerable patients and calls for:

- (i) funded, evidence-based care to be mandated in all ICB areas for ADHD
- (ii) funded, evidence-based care to be mandated in all ICB areas for gender dysphoria
- (iii) funded, evidence-based care to be mandate in all areas for eating disorders
- (iv) all specialist mental health services to be provided as standard by secondary care, with an optional, funded DES that practices may take up if they have the expertise and wish to do so
- (v) investigation and removal of all ICB boards who fail to commission adequate services for specialist areas of mental health care.

5d GATESHEAD AND SOUTH TYNESIDE: That conference is concerned about the 'freezing' of referral acceptance by certain right-to-choose providers of ADHD services and:

- (i) believes that this exemplifies again the tendency of the private sector to believe, incorrectly, that it can provide NHS services better than the NHS, with a suitable profit margin to spare
- (ii) calls for the cessation of all such contracts and the repatriation of said patients into NHS care.

5e GATESHEAD AND SOUTH TYNESIDE: That conference has concerns about the proliferation of providers for ADHD care, and other specialist services and calls for:

- (i) a requirement for all mental health service providers that they have a self-referral SPOC system
- (ii) that all providers be regulated at national level in order to avoid the patchwork that we currently have
- (iii) that the element of this work that can be done in general practice be costed and a national level optional DES be created by GPC England and NHS England.

5f MID MERSEY: That conference demands the government address the issue of postcode lottery relating ADHD services across England.

SHARED CARE OF MEDICATION

11.00

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

* 6 AGENDA COMMITTEE TO BE PROPOSED BY KINGSTON AND RICHMOND: That conference demands that GPC England negotiates an agreed national voluntary shared care drug scheme that:

- (i) ensures universal availability for patients
- (ii) is equitable and fully funded for participating practices

- (iii) is added to only with the agreement of elected representatives of general practice
- (iv) also applies to private specialist providers.

- 6a KINGSTON AND RICHMOND: That conference demands that a national shared care drug scheme be developed that:
- (i) ensures shared care drug schemes are universally available and equitably applied
 - (ii) that practices receive funding everywhere for this workload and patients have equitable access to care
 - (iii) that new drugs only be added to the scheme with the agreement of elected representatives of general practice
 - (iv) that a standard protocol for shared care with private providers be agreed and applied.
- 6b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that the NHS is currently providing patients with complex needs, for example patients undergoing gender reassignment or patients with an eating disorder, with a very poor quality of service. The GPC England must negotiate with NHS England an agreed position that protects GPs from:
- (i) being bullied or emotionally blackmailed into prescribing outside of their competence
 - (ii) having to provide additional unfunded and uncontracted pre-referral investigations or other tasks
 - (iii) being left to monitor complex patients that they do not have the expertise or capacity to do so.
- 6c NORTH YORKSHIRE: That conference does not support the post-code lottery and demands:
- (i) referral thresholds should not be consistent without allowing manipulation at ICB level
 - (ii) local interpretation of national contracts should be rejected
 - (iii) prescribing policies should be national to avoid multiple prescribing committees reaching different conclusions and service level provision.
- 6d LEEDS: That conference notes the increased number of drugs that require shared care arrangements to be delivered safely and, rather than local variation in funding and requirements, calls for GPC England to negotiate a directed enhanced service to provide national consistency and ensure the workload of any new addition is fully funded.

GP TO PATIENT NUMBERS

11.10

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

- * 7 GLOUCESTERSHIRE: That conference asks GPC England to seek to establish the absolute minimum number of GPs (by WTE) that are required to meet the basic needs of a standard population size, and collate these statistics, in order to:

- (i) provide a dataset that complements and gives context to the new OPEL type GP alert systems being established
- (ii) assist the GPC England executive to hold NHS England and the Secretary of State to account when they fail to meet their obligation to ensure the provision of primary care services
- (iii) clearly demonstrate the superior quality and value created by traditional general practice compared with corporate and private sector alternatives reliant on 'GP lite' models.

WORKLOAD CAPPING

11.30

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

- * 8 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference asserts that NHS England's use of the term "arbitrary" when referring to the workload limit is disgraceful and reasserts that the demand pressure on general practice has long since exceeded the threshold of safety, and:
 - (i) argues that simple quantification of appointments is disingenuous and needs more nuanced classification to reflect clinical complexity and value of time spent
 - (ii) supports the BMA Safe Working Guidance and calls for safe working limits to be considered a "red line" in contract negotiations, and for wider system overflow support to be mandated where OPEL reporting systems are indicating high levels of demand on practices
 - (iii) demands that NHS England make suitable provision for all practices across England to divert urgent workload when their daily safe working limits have been reached
 - (iv) supports a new above-practice triaging service to manage excessive demand on general practice, which must not include the option to refer back to general practice
 - (v) encourages the establishment of waiting lists for routine GP appointments in order to reveal, and to go some way toward quantifying, this demand and hidden workload.
- 8a DEVON: That conference is outraged to hear that NHS England do not recognise the BMA workload limit of 25 patient contacts and:
 - (i) asserts that NHS England's use of the term arbitrary when referring to the workload limit is disgraceful and flies in the face of patient safety as well as established safe working limits across many comparable nations
 - (ii) requires GPC England to negotiate the safe working limit as a "red line" in forthcoming negotiations regarding the NHS England general practice contract
 - (iii) demands that NHS England make suitable provision for all practices across England to divert urgent workload when their daily safe working limits have been reached.
- 8b GLOUCESTERSHIRE: That conference reasserts that the demand pressure on general practice has long since exceeded the threshold of safety and encourages the establishment of a system waiting lists for routine GP appointments in order to reveal, and to go some way toward quantifying, this demand and hidden workload.

- 8c** WORCESTERSHIRE: That conference supports the BMA Safe Working Guidance and calls for safe working limits to be addressed in future contract negotiations and for wider system overflow support to be mandated where OPEL reporting systems are indicating high levels of demand on practices.
- 8d** BRADFORD AND AIREDALE: That conference recognises that the environment of general practice has changed immeasurably since the 10 minute appointment was introduced as standard, and that GPC England:
- (i) recognises that we need to evolve from this norm in order to adapt to our changing expanding role
 - (ii) actively endorses that GPs shouldn't be patient facing for more than three hours per 'session'
 - (iii) maintains that not all appointments are alike
 - (iv) argues that simple quantification of appointments is disingenuous and needs more nuanced classification to reflect clinical complexity and value of time spent
 - (v) insists that clinician continuity in certain cohorts should reflect this and be incentivised and celebrated.
- 8e** CLEVELAND: That conference supports a new above-practice triaging service to manage excessive demand on general practice, which must:
- (i) not be delivered via NHS 111
 - (ii) be delivered using flexible clinical assessment rather than protocols
 - (iii) be delivered by appropriately trained staff
 - (iv) not include the option to refer back to general practice.
- 8f** KINGSTON AND RICHMOND: That conference believes that the principles of the safer working document should be applied in all practices and:
- (i) NHS England should put in place escalation policies for all practices that breach the BMA recommended safe working limit of 25 contacts per day
 - (ii) that system wide approaches be taken by NHS England to manage excessive demand on general practice
 - (iii) that divert systems be available to all practices in the event of unmanageable demand.
- 8g** GLOUCESTERSHIRE: That conference applauds the GPAS Opal reporting to a national scale and:
- (i) requests that GPDF continue funding until general practice is in a better position
 - (ii) recommends its use to all LMCs
 - (iii) requests that representation on its use as a national tool be reinforced to areas not currently using it.
- 8h** WEST SUSSEX: That conference calls upon the GPC England Executive to recognise that the preservation of English general practice is impossible without the preservation of English general

practitioners, and asks the negotiating committee to prioritise GP welfare and sustainability at every stage of the new contract negotiations, with particular regard to:

- (i) recognising the importance to patients and doctors of working to agreed safe limits
- (ii) making provision for alternative disposition of patient demand once those limits have been saturated
- (iii) obtaining acknowledgement from NHS England that general practice is an important, varied, subtle and skilled speciality, and not the default option for un-commissioned and unresourced work
- (iv) implementing effective contractual levers for GPs to require immediate action from commissioners when faced with extra-contractual work
- (v) working together regarding media depiction of general practice, which has systematically negatively impacted the profession over recent years.

8i GLOUCESTERSHIRE: That conference believes in order to create a safe and manageable workload in general practice, part of the solution has to focus on reducing increases in patient demand often with unrealistic expectations conference calls for:

- (i) research into the reasons for the continuing increase in demand and the types of presentations that should not be coming directly to general practice and could be managed in other ways
- (ii) consider the implications of instituting a payment for missed appointments to help increase the value the public attach to a GP appointment
- (iii) request significant resource is allocated to mass media campaigns encouraging patients to self-care and use healthcare services more appropriately.

8j WEST SUSSEX: The Safe working guidance seems to be the main GPC England strategy with which to try and influence government. Even this sensible advice seems difficult for many practices to implement, and therefore conference calls on GPC England to:

- (i) publish how many practices have implemented this guidance, and if this data is not yet held, explain why not
- (ii) note that the campaign seems to have gone largely unnoticed and review how this is being communicated to NHS colleagues and the public
- (iii) consider how to improve our public image as a profession - despite working harder than ever, and delivering more for less (eg Covid vaccines, more appointments, cramped premises etc) we seem to have lost all goodwill
- (iv) since there seems little appetite for strike action amongst GPs, if, or perhaps when the government ignores our issues, and below inflation contract increases continue, set out for the profession what our next options are.

8k BEDFORDSHIRE: That conference notes with dismay that NHS England considers the BMA suggestion of 25 contacts per clinician as a maximum safe number to be 'arbitrary'.

- 8l** BEDFORDSHIRE: That conference finds it unacceptable that:
- (i) NHS England, in not accepting the BMA's limit on GP contacts, seems to fail to appreciate that an overstressed GP will make mistakes
 - (ii) despite receptionists being encouraged to become care navigators, the triage systems are imperfect and receptionists not adequately trained to assess urgency
 - (iii) in comparison to general practice, 111 has more tested algorithms and does apply urgency stratification
 - (iv) practices are not allowed to stratify urgency and to assign patients to waiting lists for non-urgent issues (especially where they have been offered but declined an alternative option)
 - (v) the GP crisis, which is not of GPs' making, is pushing them to the brink of physical and mental collapse and will only accelerate the brain drain which is afflicting the profession.
- 8m** CLEVELAND: That conference supports the capping of workload to safe levels for all individuals working within general practice, and mandates that these limits are enshrined in all contracts.
- 8n** BRADFORD AND AIREDALE: That conference demands:
- (i) no phone consult should be in a timetable slot of less than 10 minutes
 - (ii) no face-to-face appointment should be in a slot of less than 15 minutes
 - (iii) clear pathways are developed for overflow patients
 - (iv) capacity over and above the safe working levels from the current workforce should be commissioned routinely
 - (v) GMC be compelled to refer to safe working levels routinely.
- 8o** NORFOLK AND WAVENEY: The workload within general practice is unsustainable and resulting in burnout and the loss of GPs and their staff from the profession. Conference asks GPC England to emphasis the work-life balance and wellbeing of all GPs within negotiations and calls for:
- (i) manageable, safe workloads for all GPs, including the acknowledgment of administrative tasks, to enable safe patient care and personal well-being
 - (ii) enhanced professional support networks for all GPs, including peer mentoring and funded professional development programmes and protected time for learning
 - (iii) future workforce planning to accurately reflect the number of GPs required to enable safe working for all GPs.

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

- * 9 AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference notes the recent announcements regarding private providers of NHS general practices withdrawing from their contracts and:
- (i) calls for an end to APMS as a contractual option for general practice
 - (ii) demands that, any new or re-tendered GP core contract is offered as a GMS contract when the successful applicant is able to hold such a contract
 - (iii) demands that no funding over and above standard GMS should be provided to commercial organisations wishing to run NHS general practice contracts in England.
- 9a TOWER HAMLETS: That conference believes that the fact that Centene wish to sell their stake in general practice underscores that the private sector has no place in providing NHS services and furthermore:
- (i) believes that Centene should not be able to renege on their contract and walk away leaving the NHS to pick up the pieces
 - (ii) asserts that if a global multinational walks away from providing general practice due to lack of financial viability despite their large opportunities to provide services at scale it is clear that general practice is woefully under resourced
 - (iii) demands that government make good the chronic under resourcing of general practice immediately
 - (iv) demands that, any new or re-tendered GP core contract is offered as a GMS contract when the successful applicant is able to hold such a contract
 - (v) demands that private companies cease to provide NHS services.
- 9b LEEDS: That conference believes that the re-procurement of short-term APMS GP contracts is leading to companies with no local connections with the community the practice is situated in winning contracts and does not believe this is in the best interests of the people in those communities and therefore calls for an end to APMS as a contractual option for general practice.
- 9c DEVON: That conference notes the recent announcements regarding private providers of NHS general practices withdrawing from their contracts and that often these providers have received additional funding. Conference:
- (i) asserts that this is evidence that general practice in England is underfunded and in the “too difficult” pile for commercial organisations
 - (ii) demands that no funding over and above standard GMS should be provided to commercial organisations wishing to run NHS general practice contracts in England.
- 9d BUCKINGHAMSHIRE: That conference notes Centene / Operose, a company that has run more than 50 GP practices across England, has recently placed its primary care operations up for sale. Conference asks GPC England to investigate these concerning signs of instability in the provision of primary care

services by private corporations, and to report back on the potential impact this will have on the wider primary care health economy.

THEMED DEBATE - THE FUTURE OF WORKING AT SCALE

12.10

The purpose of this themed debate is to remove the mental shackles of the PCN DES and for LMCs to discuss what their constituents may want from a future model for working at scale.

Existing GPC England Policy on PCNs is as follows:

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

Following the discussions about the future of the PCN DES at the England Conference of LMCs in 2022, there was a mixed response to whether representatives thought their constituents would be prepared to continue the PCN DES in its current form beyond its scheduled end date in April 2024.

This debate will be conducted under Standing Order 50 and the motions submitted by LMCs that the Agenda Committee considers are best covered by this themed debate are included in Part 1 of the Agenda and are numbered TD1 to TD20.

The format of the debate will be in soapbox style without the need for the submission of speaker slips. Any member of conference may take part by speaking from the microphones in the hall, rather than the podium, with a time limit of one minute per speaker. Speakers will be asked to focus their discussions on the art of the possible, and the statements to be voted for at the conclusion of this debate.

At the conclusion of the debate, voting members of conference will be asked to vote on a scale of one to six on the following statements:

- My constituents have an appetite for working at scale in the future (vote pre and post-debate)
- My constituents wish to share clinical staff with other practices
- My constituents wish to share non-clinical staff with other practices
- My constituents wish to share back-office functions with other practices
- My constituents wish to share estates with other practices
- My constituents wish to provide private services through working at scale
- My constituents wish to tender for NHS services through working at scale

TD1 LEEDS: That conference:

- (i) welcomes the decision to re-purpose most of the 23/24 Investment and Impact Fund (IIF) and enable PCNs to pass this directly to practices

- (ii) believes PCNs should not be required to achieve against Local Capacity and Access Improvement plans in order to obtain the remaining 30% of re-purposed 23/24 IIF payments
 - (iii) that all remaining 23/24 IIF money should be passed directly to practices, particularly as they are already facing increased winter pressures
 - (iv) demands that the IIF is abolished from 24/25 and all funding permanently transferred to global sum.
- TD2** SHROPSHIRE AND TELFORD: That conference calls for equitable funding for both practice and ARRS staff, in line with Agenda for Change, to eliminate inequity in pay and conditions for clinicians in similar roles in different parts of the NHS.
- TD3** GATESHEAD AND SOUTH TYNESIDE: That conference is delighted that the PCN DES five-year-deal is due to end in spring 2024 and calls for any successor deal to:
- (i) incentivise collaborative working only when it benefits practices and patients
 - (ii) come with a high-trust, low-administration operational requirement for practices
 - (iii) permit the utilisation only of staff that practices want, without restriction
 - (iv) support practices to deliver better general practice, not to transfer work from secondary care
 - (v) be fully inflation proofed.
- TD4** NORTH YORKSHIRE: That conference reaffirms previous policy re PCNs being less efficient in delivering care, unpopular with patients and demands any new contract to make engagement with PCNs voluntary.
- TD5** BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference agrees with the concept of a Digital Transformation Lead to help PCNs in an increasingly technological climate and welcomes the funding provision for this. However, conference notes that those with true digital expertise are few and far between and believes their effectiveness could be maximised by being employed at a higher level across a number of PCNS. Conference therefore calls upon NHS England to:
- (i) protect existing funding even where PCNs are struggling to recruit effectively
 - (ii) allow flexibility of the ARRS funding to allow such positions to be at either individual PCN level or working across a number of PCNS
 - (iii) recruit centrally to these positions, where so desired by the PCNs, to ensure that there is a consistent offer of digital expertise across PCNS.
- TD6** DORSET: That conference values the support of ARRS staff and allied healthcare professionals in providing high quality community care and support to GPs in England, although acknowledging that their efforts come with substantial transfer of risk and workload to the patient's GP. Conference requests changes to the terms of the PCN DES to result in:
- (i) staff only requesting tests that they themselves would feel confident to follow up and action
 - (ii) staff only assessing patients they feel competent to fully assess within their own skill set, and not as a conduit to achieve a GP assessment by proxy

- (iii) staff only working with service structures where there is adequate provision for escalation of queries without involving a GP
- (iv) funding to provide the establishment of such structures where they do not currently exist.

TD7 HAMPSHIRE AND ISLE OF WIGHT: That conference acknowledges NHS England's desire to continue to invest in Primary Care Networks (PCNs) and:

- (i) welcomes the increasing scope of roles that are included in the ARRS scheme; specifically advanced nurse practitioners from April 2023
- (ii) believes increasing the numbers of general practitioners working in primary care is the best way to provide both better patient care and also sustainability of NHS general practice
- (iii) requests GPC England strongly negotiate with NHS England to increase the scope of ARRS roles to include salaried general practitioners
- (iv) believes there is a significant dormant workforce of qualified general practitioners who could be enticed back into the profession via ARRS roles.

TD8 WORCESTERSHIRE: That conference believes that additional roles staff are now embedded in general practice and provide a useful supportive role but insists that:

- (i) additional roles staff do not replace the role of the GP in dealing with complexity and continuity of care
- (ii) prescribing rights should be introduced for physician associates
- (iii) funding for additional roles staff should also recognise the associated supervision of these roles and funding should be brought into core GMS so that practices can decide how best to staff their surgeries
- (iv) additional roles staff cannot be the government's only solution to a dwindling GP workforce and retention and recruitment of GPs must be addressed urgently to prevent further attrition
- (v) siphoning off certain medical complaints and leaving GPs to manage only chronic disease will be to the detriment of the patient doctor relationship and will lead to further attrition of the workforce.

TD9 COVENTRY: That conference demands that should the PCN DES continue:

- (i) the control and choice of sign up remains with the practices
- (ii) it is clearly restated in the DES that the ARRS staff are primarily employed to support work in the individual practices and the PCN retains autonomy within the system
- (iii) there is clarity on ARRS staff indemnity cover with a commitment to support and fund any work not covered by CNSGP
- (iv) there is clarity on clinical director indemnity cover with a commitment of financial support to cover this
- (v) there is clear direction about all Tax and VAT issues around PCNs.

(Supported by WARWICKSHIRE)

- TD10** CLEVELAND: That conference requests a formal steer from GPC England on the financial profitability of the PCN DES to empower practices ahead of the April 2024 opt-out window.
- TD11** LIVERPOOL: That conference believes that any agreement to the current PCN contract must contain, as a minimum, an inflationary up-lift, backdated to 2019.
- TD12** KINGSTON AND RICHMOND: That conference believes that the PCN DES has failed practices, patients and GPs by adding unnecessary workload, complexity and administrative burden on general practice:
- (i) has created an unevidenced industry of itself, for which there is limited evidence of improved patient care
 - (ii) must be drastically altered to allow organic collaborations of local practices to serve the needs of their patients, and end the current "one size fits all" approach
 - (iii) must allow complete flexibility of employment of ARRS staff depending on the needs of practices and the local population.
- TD13** WEST SUSSEX: That conference is frustrated with the restrictions imposed regarding ARRS roles and calls for GPC England to demand that NHS England allow the recruitment of both clinical and non-clinical staff from any professional background, who will support the delivery of patient care appropriate for local populations, as local GPs see fit.
- TD14** NOTTINGHAMSHIRE: That conference is concerned about the growing requirements on practices through the PCN DES and requests that GPC England negotiates with NHS England to ensure that a significant proportion of funding is ring-fenced out of PCN budgets for practices individually to decide how to use on joint working.
- TD15** NOTTINGHAMSHIRE: That conference believes that elements of the capacity and access payments of the PCN DES are too heavily reliant on subjective feedback from patients, many of whom may not have contacted their practice for a period of years. We therefore request that GPC England negotiates with NHS England to ensure that PCN DES payments linked to patient surveys are removed in favour of criteria reflecting how practices are providing care.
- TD16** NOTTINGHAMSHIRE: That conference believes that capacity and access payments within the PCN DES put too much emphasis on patient surveys, many patients who may not have been in contact with their surgeries for years. We request that GPC England negotiates with NHS England to ensure that the PCN DES changes payments to be made based on the reality of what practices are doing, not on how people feel about it.
- TD17** CLEVELAND: That conference, in respect of our ARRS staff:
- (i) respects and values their contribution within the GP workforce
 - (ii) is concerned about the lack of clarity over the funding mechanism after March 2024
 - (iii) is concerned about the lack of clarity regarding resourcing and support outside of the Network DES
 - (iv) demands contractual clarity for the long-term.

- TD18 HARINGEY: To make the most use of the current ARRS funding available and ensuring that the funding is fully invested, conference calls for the removal of the proscriptive designation of role type and the cap on the maximum reimbursable amount per role, so that recruitment can be more flexibly aligned to planned service need requirements and workforce availability.
- TD19 BERKSHIRE: That conference believes the funding provided by the Network Contract “PCN DES” has failed to keep pace with the real cost of employing staff under the ARRS (additional roles reimbursement scheme) and demands that GPC England negotiate for a new contract to cover the real costs involved.
- TD20 WORCESTERSHIRE: That conference believes that local enhanced services must always be offered at practice level and that there should be no obligation for PCN wide coverage unless this is agreed with individual practices.

LUNCH

13.00

REINFORCED AUTOCLAVED AERATED CONCRETE (RAAC)

14.00

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

- * 10 BUCKINGHAMSHIRE: That conference is appalled to learn of the emerging scandal surrounding the use of reinforced autoclaved aerated concrete (RAAC) in many buildings necessary for public life, and calls on GPC England to demand:
- (i) urgent government funded surveys of all primary care estates, to identify any facilities constructed from RAAC
 - (ii) prompt provision of state funded support for any practice found to have RAAC in order to make it safe either through repair or rebuild
 - (iii) a public enquiry to investigate why the known dangers of RAAC have been ignored by government for so long.
- 10a SEFTON: That conference calls upon GPC England to secure from NHS England a commitment to adequate funding to support the unplanned costs borne by GPs in owner occupied/ leased premises who are required to find alternative temporary premises whilst problems with RAAC (Reinforces Autoclaved Aerated Concrete) are being fixed. This is a necessary concomitant of maintaining access to general practice which the NHS England has its overriding priority.

SALARIED GP JOB PLAN

14.10

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

- * 11 CAMBRIDGESHIRE: That conference is dismayed that despite salaried GPs being offered model contracts, practices are not held accountable for the job plans they create leading to unmanageable workloads, increased risk of burnout and lack of retention and calls on the GPC England to publish gold standard job plans including a certification symbol for adopting practices to:
 - (i) ensure that true workload of salaried GPs is realistic, fair and follows previously published BMA safe working guidance
 - (ii) create parity in salaried roles across different practices thus reducing inequalities in areas
 - (iii) support workload conversations between salaried GPs and partners in a manner which maintains good relationships.

- 11a AVON: That conference asks the BMA to publish a model contract for GPs which includes a more detailed job plan similar to the model job plans produced for secondary care consultants, taking into consideration a more diverse range of professional activities including but not limited to expectations regarding the supervisory role of the GP, consultation clinics, on-call requirements, MDT meetings, CPD, non-NHS report and letter writing, and PCN / ICB / professional association duties, in order to move away from the unachievable expectation that all of the above can be completed in a 4 hour 10 minute session.

- 11b SURREY: That conference calls on GPC England to negotiate with NHS England to ensure that all providers employing GPs are contractually obliged to offer either the BMA model contract, or terms no less favourable, as per the current GMS contract.

GP PERFORMERS LIST SUSPENSIONS

14.40

To submit a speaker slip for Motion 12 – [please click here](#)

- * 12 LEWISHAM: That conference is appalled that GP performers lists suspensions payments are both punitive and inequitable and as a matter of urgency, calls on government to amend these regulations to:
 - (i) establish the principle that suspended GPs are entitled to 100% of normal earnings not 90% as per the current regulations
 - (ii) increase the weekly ceiling on locum payments, so that these are annually set at a realistic level that will fully reimburse the locum payments for the suspended GP
 - (iii) entitle all GPs to receive suspension payment, including partners who have been expelled from their partnership due to the suspension.

To submit a speaker slip for Motion 13 – [please click here](#)

- * 13 AGENDA COMMITTEE TO BE PROPOSED BY NEWCASTLE AND NORTH TYNESIDE: That conference believes that Additional Roles Reimbursement Scheme (ARRS) staff have not been nationally supported to develop adequate competence within primary care and:
 - (i) all ARRS staff should be supervised similarly to GP registrars for three years from commencing their role
 - (ii) GPC England needs to insist that, as per GMC guidance, levels of supervision should be guided by the needs of the individual rather than a blanket approach
 - (iii) all ARRS roles and associated supervisors need to have funded and protected time for supervision and learning
 - (iv) no further push for advanced access whilst the inefficiencies of this model are restructured.

- 13a NEWCASTLE AND NORTH TYNESIDE: That conference believes that, following the tragic case of Emily Chesterton, ARRS staff have not nationally been supported to develop adequate competence to see undifferentiated illness within primary care:
 - (i) all ARRS staff should be supervised similarly to GP registrars for three years from commencing their role. This would involve a short debrief after every session and a once weekly three hour tutorial
 - (ii) there should be a pause on recruitment of physician's associates in primary care until they are fully regulated
 - (iii) when speaking to a patient each member of the primary care team should introduce themselves clearly with their name and role
 - (iv) those who are non medical doctors but hold a PHD should not use their Dr title within patient facing healthcare settings, so as not to confuse patients
 - (v) patients are entitled to request an appointment with a qualified GP should their condition not improve after their initial appointment.

- 13b REDBRIDGE: That conference is concerned that NHS England expectations on the level of clinical supervision required for ARRS staff are unnecessary and impractical and that:
 - (i) the expectation to document each supervision session as described in the May 23 NHS England document 'Supervision guidance for PCN MDTs' is unrealistic
 - (ii) GPC England need to insist that, as per GMC guidance, levels of supervision should be guided by the needs of the individual rather than a blanket approach
 - (iii) an approach that requires documented daily meetings will significantly impact on the availability of GPs to directly manage patient care
 - (iv) GPC England needs to lobby NHS England to amend their supervision guidance, so it is in line with the GMC guidance.

- 13c GLOUCESTERSHIRE: That conference calls on NHS England to resource the required and safe levels of supervision of ARRs (Additional Roles Reimbursement scheme) roles and supports:
- (i) roadmap supervision of first contact practitioner roles to be resourced to a comparable level to GP training, on which roadmaps have been developed
 - (ii) reflective practice sessions for personalised care roles to be funded
 - (iii) all ARRs roles and associated supervisors to have funded and protected time for supervision and learning.
- 13d CENTRAL LANCASHIRE: That conference believes that the supervision and case review of Additional Roles Staff (ARRS) is adding to GP workload, reducing efficiency, and is actively working against the safe working guidelines set by the BMA.
- 13e NORTH YORKSHIRE: That conference deplores the PCN ARRS scheme which fails to recognise the clinical and administrative costs of employing staffs and demands:
- (i) protected resourced time for supervision
 - (ii) limitations on numbers until GP numbers rise to facilitate this workload
 - (iii) supervision training to be provided for all GPs both in training and post-qualification
 - (iv) no further push for advanced access whilst the inefficiencies of this model are restructured.
- 13f HERTFORDSHIRE: That conference:
- (i) believes that PCNs should be funded for MDT supervision, and
 - (ii) calls on GPC England to negotiate an amendment to the PCN DES to incorporate central funding for MDT supervision.

THEMED DEBATE – INTERFACE SOLUTIONS

15.10

The large number of motions received on the topic of the Interface between primary and secondary care reflects the ongoing challenges which have not yet been resolved.

The purpose of this themed debate is to provide GPC England with a clear steer for what is required to address some of these issues, as well as sharing what is working well within your individual LMC areas.

Existing GPC England policy on the Interface is as follows:

- Trust staff to request their own prescriptions, investigations and referrals
- Trusts to have email/telephone contacts for reporting “workload dumps” and for patients experiencing delays in secondary care
- Resource for Advice and Guidance pathways
- GPs cannot be mandated to use Advice and Guidance by commissioners or providers
- GPs should be free to refer to a secondary care colleague without pre-referral interference
- Financial penalties for trusts when hospital contracts are breached around the interface issue, and funding moved into general practice

This debate will be conducted under Standing Order 50 and the motions submitted by LMCs that the Agenda Committee considers are best covered by this themed debate are included in Part 1 of the Agenda and are numbered TD21 to TD53.

The format of the debate will be in soapbox style without the need for the submission of speaker slips. Any member of conference may take part by speaking from the microphones in the hall, rather than the podium, with a time limit of one minute per speaker. Speakers will be asked to focus their discussions on solutions to the interface challenges, what is working in their area, and the Agenda Committee Motion to be proposed by the Chair at the conclusion of this debate.

At the conclusion of the debate, voting members of conference will vote on the following motion proposed by the Chair:

AGENDA COMMITTEE to be proposed by the CHAIR: That conference instructs GPC England to:

- (i) produce an up-to-date suite of guidance and tools for practices on the interface between private providers and general practice
- (ii) clearly define what work is and is not core GMS, and produce a suite of resources to empower practices to reject this work if they so choose
- (iii) carry out research to quantify the cost impact of unfunded secondary care work undertaken by general practice
- (iv) produce and promote legally and contractually enforceable levers for practices to use to financially penalise other providers for unfunded work inappropriately shifted into general practice
- (v) work with the BMA's Consultants Committee, Junior Doctors Committee and Specialist, Associate Specialist and Specialty Doctors Committee, to negotiate with NHS England the rapid implementation of electronic prescribing for secondary care, including the ability connect with community pharmacy

- TD21** LEEDS: That conference recognises the value of electronic prescribing in general practice but also the continued inappropriate shift of work from secondary to primary care, and calls on GPC England, together with the BMA's Consultants Committee, Junior Doctors Committee and Specialist, Associate Specialist and Specialty Doctors Committee, to negotiate with NHS England the rapid implementation of electronic prescribing for secondary care, including the ability connect with community pharmacy.
- TD22** LEEDS: That conference notes that private providers continue to claim that NHS GPs can choose to enter amber-drug shared care agreements with patients, while the specialist shared care provision remains privately funded, leading to inconsistent practices across England and breakdowns in GP-patient relationships, and therefore we demand:
- (i) an NHS England position statement on the matter of mixing privately and NHS funded care in the specific instance of shared care agreements
 - (ii) that private providers are encouraged to partner with NHS providers to enable a smooth and ethical transition into NHS specialist services.
- TD23** LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference believes that communication between medical professionals should have include a named responsible clinician and that it is not acceptable

to receive missives from a “team”. For example in the case of a referral being declined by secondary care. This otherwise leads to a collusion of anonymity and a blurring of the clinical responsibility.

- TD24** BRADFORD AND AIREDALE: That conference demands all secondary care providers provide and publish a clear alternative to GP prescribing for shared care arrangements.
- TD25** KENSINGTON, CHELSEA AND WESTMINSTER: That conference abhors unfair transfer of clinical responsibility and calls on GPC England to work with:
- (i) IT system suppliers to ensure that all blood results received clearly state the requester who has clinical responsibility
 - (ii) NHS England to ensure that all communication of investigation results from other providers must clearly state who requested the test.
- TD26** NORTH YORKSHIRE: That conference recognises previous policy and conference motions have been ineffective in the primary secondary interface due to secondary care intransigence and contempt for primary care, conference demands a clear statement and guidance to practices on what work to reject outright as not GMS.
- TD27** NORTH YORKSHIRE: That conference demands GPC England publish clear instructions to practices that no proforma is needed to support a referral to any service and sets a date to abide by that guidance.
- TD28** HULL AND EAST YORKSHIRE: That conference notes that the "NHS England Screening Programme Specification" includes resource to obtain information from primary care relevant to cancer screening services. Conference calls on GPC England to:
- (i) publicise that the workload incurred in obtaining information for cancer screening services is non-core and unfunded
 - (ii) demand that an appropriately resourced alternative not involving general practice is agreed
 - (iii) negotiate that if no immediate solution is found, an appropriate enhanced service should be commissioned to support vital cancer screening services.
- TD29** WORCESTERSHIRE: That conference is concerned about the commissioning of new services by NHS England which require practices to use computer software that is incompatible with their own, will require training (which is not funded) and which puts the onus on GPs to chase results rather than receiving direct communications from the provider.
- TD30** NORTH AND NORTH EAST LINCOLNSHIRE: That, with the interface focus in the Primary Care Access Recovery Plan and ongoing challenges from interface difficulties, conference calls on GPC England to model a national interface solution for LMCs to lobby for and implement across all ICS areas.
- TD31** HAMPSHIRE AND ISLE OF WIGHT: That conference recognises that too often measures aimed at addressing secondary care waiting list back log result in additional risk and workload being transferred to primary care and calls for:
- (i) the cessation of advice and guidance pathways within cancer care as a priority over formal referrals

- (ii) the BMA to quantify the impact of all advice and guidance pathways on patient safety and GP workload
- (iii) GPC England to ensure that the outcome of this to be reflected in future contract negotiations.

TD32 WORCESTERSHIRE: That conference acknowledges the increasing expectation from secondary care and commissioners that GPs should have a high level of specialist knowledge in all clinical areas and insists that:

- (i) this risks patient safety and GP wellbeing
- (ii) referrals are never rejected without discussion with the referrer on the basis that the generalist is requesting specialist assessment and / or treatment
- (iii) the use of specific referral templates must be agreed with the local medical committee
- (iv) secondary care "Guidance for primary care" must not be mandated by integrated care systems
- (v) the advent of advice and guidance has resulted in GPs providing a first outpatient appointment on behalf secondary care and this must be funded.

TD33 MANCHESTER: That conference notes that ICBs are not managing workload transfer from secondary care to primary care in accordance with the national hospital contract and instructs GPC England to design a process for practices to invoice secondary care trusts for any non-contractual workload transfers.

TD34 KERNOW: That conference believes that general practice is adversely affected by additional workload generated:

- (i) by secondary care trusts when either failing to comply with the standard contractual obligation to prescribe urgently required medication from the outpatient setting or provide discharge medication and likewise
- (ii) by referral management services when insisting on additional investigations or appointments not directly impacting on the primary care management and decision to refer but are in order to either reduce the number of outpatient appointments or reduce secondary care processes once the patient is seen.

This additional work and cost should be recognised by an item of service payment from commissioners to practices. Conference calls on GPC England to demand that ICBs pay practices to carry out this work on behalf of the secondary care trusts.

TD35 SUFFOLK: That conference noting the tendency for waiting list management to default to general practice coupled with the lack of value added by general practitioners in such scenarios, conference instructs GPC England to equip practices with template letters - which may be issued to patients by care navigators, social media and other (non clinical) channels - allowing patients to, directly, update those entities holding the aforementioned list as to their clinical condition.

TD36 SHROPSHIRE AND TELFORD: That conference believes the last 13 years of austerity in secondary care budgets have created immense service pressures and significant harms to our NHS. As trusts attempt to reconcile their finances, they are being forced to contract their services leading to a tidal wave of

new work being pushed into general practices and that this additional workload remains unrecognised by commissioners. Conference:

- (i) believes that 'left shift' is causing irreversible harms to general practice and our patients, and
- (ii) asks that future contract negotiations properly define GMS Services, and
- (iii) demands that work moved from other sectors is properly recommissioned adhering to the 'money should follow the patient' rule.

TD37 SUFFOLK: That conference notes that the effective absence, through long wait times or poor performance, of a clinical service usually results in substantial amounts of clinical and administrative work moving into general practice without funding and therefore instructs GPC England to:

- (i) develop a tool for LMCs and their constituents to quantify, in financial terms, the cost of such workload shift
- (ii) negotiate a mandatory mechanism, recognised nationally, by which English ICBs are obliged to shift funds accordingly.

TD38 WIGAN: That conference calls upon the NHS England to restate and promulgate its erstwhile position that the GP letter of referral is the 'Gold Standard' of referrals. The widespread re-emergence of arbitrarily introduced and unnecessarily detailed proforma referral templates by some secondary units and rejection of GP referrals if not fully completed is delaying patient assessment and treatment.

TD39 BARNET: Given the increasing workload shift from secondary to primary care, such as pathways and medicines optimisation review endpoints, and the consequent negative effect upon general practice capacity, conference calls upon ICSs to work with LMCs to develop a means of assessing the overall strategic and cumulative impact upon general practice of all the individual service provision changes, and for much needed resourcing to accompany any workload shift.

TD40 SURREY: That conference believes that:

- (i) despite the welcome clarification provided by the Standard Hospital Contract 2018, there has not been a consistent and continued reduction in the inappropriate transfer of workload from secondary to primary care
- (ii) these repeated breaches of contract are an ongoing cause of workload burden on general practice
- (iii) these breaches of contract represent a risk to patients, and
- (iv) demands that NHS England introduce financial penalties for trusts, to be paid directly to general practice for the time spent undertaking this work.

TD41 BERKSHIRE: That conference believes there has been an explosion of popularity of "shared care" arrangements and "advice and guidance", to the potential benefit of hospital workloads and patient waiting times, but to the detriment of general practice stability as resources have often failed to follow the shifts in workload. Conference:

- (i) demands that all "shared care" arrangements and "advice and guidance" should be adequately resourced

- (ii) reminds all GPs in England that "shared care" and "advice and guidance" are not core GMS workload, and therefore GPs are free to decline this work if it is not financially or operationally sustainable
 - (iii) recommends that GPs decline to enter into any new shared care arrangements, and decline to use "advice and guidance" options, where they deem this necessary to protect the stability of their core services
 - (iv) demands that GPC England ensure GPs are made aware of those work streams which remain optional under their contracts, and that non-delivery of these work streams would not place GP practices at risk of breach of contract.
- TD42** NEWHAM: That conference recognises the value of other providers of primary care including optometrists, dentists, pharmacists and physiotherapists but is concerned that current referral systems prevent them from making appropriate referrals to secondary care without referring the patient back to their GP, and asks GPC England to negotiate with NHS England:
- (i) appropriate referral pathways for other providers of primary care
 - (ii) an urgent update to the eRS, to enable these other providers to access and refer through it
 - (iii) an interim solution to enable other methods of referral until the eRS issues has been resolved.
- TD43** BERKSHIRE: That conference demands BMA issue guidance to GPs in England, to explain that "shared care" prescribing arrangements are examples of non-core, optional workload, and can therefore be declined without fear of being issued with any contractual "breach notice".
- TD44** REDBRIDGE: That conference seeks clarity from NHS England on why, when the NHS constitution supports patient choice and their legal entitlement to choose where they are seen for their first out-patient appointment, some trusts are declining referrals on the basis that the patient is out of area and ICBs are not challenging this.
- TD45** NOTTINGHAMSHIRE: That conference recognises that practices are being overwhelmed by the volume of shifting of work from secondary care into general practice, this needs to stop to enable practices to better manage their workload. Conference calls for GPC England to:
- (i) GPC England to negotiate contractual levers with NHS England to ensure robust contract management of all hospitals
 - (ii) work with GPDF to launch a national campaign aimed at hospital colleagues to upskill staff and medics to work to their contracts
 - (iii) work with NHS England on a national reporting tool for practices to show the impact on practice capacity but also to identify trends and therefore training needs in hospitals.
- TD46** NOTTINGHAMSHIRE: That conference accepts the need for comprehensive referrals to be made to help secondary care colleagues to assess the need of patients but rejects any commissioner led mandated use of pre-referral proforma or checklists / templates.
- TD47** SUFFOLK: That conference deplores the recent tendency for non-prescribing clinicians to instruct clinicians in primary care to prescribe medication and instructs GPC England to reverse this trend by

seeking a mandatory co-signatory with appropriate (prescribing) qualifications on all such correspondence.

- TD48** KENSINGTON, CHELSEA AND WESTMINSTER: That conference is concerned about the increased clinical responsibility placed on GPs through direct access testing and demands that, for any specialist test, this is part of a pathway in which a specialist opinion is provided as part of the report and onward referral is the responsibility of the clinician providing the specialist opinion.
- TD49** HERTFORDSHIRE: That conference believes that using advice and guidance reduces workload for secondary care but invariably increases workload for primary care. That conference calls on GPC England to negotiate:
- (i) that ICBs be required to provide financial reimbursements to GP practices for sending advice and guidance requests
 - (ii) that the system (and secondary care contract) be set up so that primary care referrals cannot be rejected by being turned into Advice and Guidance
 - (iii) that there is protection for GPs who do not feel able to complete specialist investigations and management plans requested by secondary care physicians, either because they believe it is outside their competence or because they believe it to be an inappropriate shift of work from secondary care to primary care.
- TD50** CLEVELAND: That conference requires robust management of the NHS standard hospital contract to reverse the normalisation of GPs doing the work on behalf of the hospitals.
- TD51** GREENWICH: That conference notes with concern the workload impact from the increasing transfer of prescribing activity from hospital specialities to general practice, and requests that GPC England:
- (i) commission research on the impact of this trend
 - (ii) utilise evidence about this trend to support future negotiations around general practice prescribing activity.
- TD52** WEST SUSSEX: That conference is concerned by the increasing levels of unnecessary workload directed to practices and demands that GPC England insist that commissioners allow autonomous providers to refer directly to associated specialities in all areas of England.
- TD53** CLEVELAND That conference requires GPC England to explicitly define the work that is covered by GMS essential services.

ENHANCED SERVICES

15.50

To submit a speaker slip for Motion 14 – [please click here](#)

- * 14 AGENDA COMMITTEE TO BE PROPOSED BY AVON: That conference demands that general practice funding is consolidated into the GMS payment and calls for:
 - (i) the cessation of all locally enhanced services in England
 - (ii) the removal of QOF from GP workload
 - (iii) additional funding in the core contract for services such as phlebotomy, spirometry and ECGs.

- 14a AVON: That conference calls for the cessation of all locally enhanced services in England. Locally enhanced services lead to postcode lotteries of care and cause confusion around what is in the core contract which is exacerbating workload pressures in general practice.

- 14b NORTH YORKSHIRE: That conference demands all available funding should be delivered through core and additional funding streams minimised.

- 14c MANCHESTER: That conference supports additional funding in the core contract for services such as phlebotomy, spirometry and ECGs, as results from these unfunded actions are currently required to secure aspiration payments.

- 14d KENT: That conference demands that general practice funding is consolidated into the GMS payment to enable practices to concentrate on seeing patients rather than chasing small amounts of funding for various tasks.

- 14e KENT: That conference demands that GPC England negotiate the removal of QOF from GP workload and transfers the associated funding to core GMS.

- 14f GLOUCESTERSHIRE: That conference understands that enhanced services are not being consistently applied throughout the country to reflect commissioning gaps and asks:
 - (i) GPDF to maintain a list of enhanced service specs, anonymised but attributable for LMCs use
 - (ii) GPDF to maintain a benchmark of funding provision for enhanced services
 - (iii) GPC England to consider whether many enhanced services are more England centric than local and to negotiate national service specs and funding for commissioning gaps England wide.

- 14g OXFORDSHIRE: That conference demands that GPC England negotiate for a new GP GMS contract to include:
 - (i) an overall increase in funding through global sum that provides for well defined, adequate, and reasonably comprehensive essential primary medical services

- (ii) a simplification of the multitude of currently existing funding streams into the global sum so that practice stability is no longer dependent on pursuing smaller, often short-term, funding streams with associated complex administrative costs
- (iii) an automatic uplift in funding to cover inflationary pressures, along similar lines as the state pension “triple lock”, including but not limited to pay recommendations issued by DDRB and/or NHS England, and inflationary increases in practice running costs, including but not limited to costs of utilities and consumables
- (iv) introduction of a break clause which allows GPs to reduce provision to basic primary medical services, in case of unilateral breach of contract by NHS England.

GP RETENTION

16.10

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

- * 15 **AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND:** That conference is disheartened to note that recruitment and retention of general practice is at its lowest level currently, believes the NHS England Long Term Workforce Plan is a missed opportunity to support retention of GPs and calls for:
 - (i) removal of the five-year maximum eligibility limit to the NHS England GP Retention Scheme
 - (ii) levelling up of ICB investment in the NHS England GP Retention Scheme across the country
 - (iii) increased government investment in the NHS England GP Retention Scheme
 - (iv) consideration of ways to retain and support GPs further down the line in their careers, so that GPs enjoy their work for longer and avoid burnout and early retirement
 - (v) all GP retention or fellowship programmes to be open to all GPs on an equitable basis.
- 15a CLEVELAND: That conference recognises the value of GPs who are working as locums or in non-practice settings and mandates that all GP retention or fellowship programmes must be open to these groups on an equitable basis.
- 15b LEEDS: That conference believes the NHS England Long Term Workforce Plan is a missed opportunity to support retention of GPs and others working in general practice and calls for a commitment by NHS England to address workload and practice funding to help workforce retention.
- 15c DORSET: That conference believes the retainer scheme is a crucial factor in curtailing the current exodus of GPs from the workforce. Conference calls for:
 - (i) removal of the 5-year maximum eligibility limit
 - (ii) levelling up of ICB investment in this scheme across the country
 - (iii) increased government investment in this scheme.
- 15d DEVON: That conference acknowledges and is grateful for initiatives such as the Fellowship and new to Practice Programmes for first five GPs in helping to ensure that they remain in the profession. But asks that consideration is made to ways of retaining and supporting GPs further down the line in their careers, so that GPs enjoy their work for longer, avoid burn out and early retirement.

- 15e WIRRAL: That conference is disheartened to note that recruitment and retention of general practice is at its lowest level currently and calls on GPC England to:
- (i) clearly, plainly and consistently articulate the main causes of it, which are issues relating to excessive workload, inadequate workforce, inadequate funding and problematic pension, to government
 - (ii) demand that the government address these issues honestly, sincerely and immediately
 - (iii) regularly and effectively communicate the negative effects of this problem to the public.
- 15f DERBYSHIRE: That conference notes that the current GP retainer scheme is too rigid and lacks flexibility and insists that the scheme allows for greater individualisation.

CHOSEN / EMERGENCY MOTIONS

16.20

DIGITAL / IT

16.50

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

- * 16 DERBYSHIRE: That conference believes that if it takes 20 minutes to switch on your computer in the morning then Steve Barclay should not be investing in robotic penguins.
- 16a LAMBETH: That conference condemns NHS England for the apparent disparity between published statements accentuating the ‘digital transformation’ of primary care whilst failing to spend adequately to ensure the digital infrastructure is in place to enable it and calls upon the GPC England to insist that ICB GPIT revenue funding is uplifted annually to reflect NHS England ambitions for the wider digital transformation of primary care in addition to that required to meet the core and mandated requirements of the GPIT Operating Model.
- 16b BRADFORD AND AIREDALE: That conference demands in a modern world, IT funding needs to be clearer and extended to future proof the service rather than enslave it in historical technology.
- 16c CLEVELAND: That conference is majorly concerned by the unreliability of the current general practice digital estate and demands significant investment.
- 16d HERTFORDSHIRE: That conference calls on NHS England to investigate the suitability and reliability of current IT platforms for general practice.

CLOSE

17.00

**Friday 24 November 2023:
BMA House in the morning
Friends House in the afternoon**

REGISTRATION AT BMA HOUSE FOR BREAK-OUT GROUPS

08.30

Registration at BMA House for Break-out groups: 08.30

The second day of conference will start at BMA House at 08.30 for registration, for an 08.45 start time. Please be aware of the following considerations:

- Be punctual so we can start on time
- If you have luggage, **do not bring it to BMA House** as there is nowhere to store it. You can either leave it at the hotel or drop it off to Friends House before arriving at BMA House.
- Representatives will be asked to move between break-out rooms in a manner which allows one-way flow within BMA House. Please adhere to the instructions you have been given.
- Unless you have declared mobility issues in advance to the secretariat, please avoid using the lifts which are small and cannot accommodate large numbers of representatives.

There will be 3 topics for discussion:

TOPICS	FACILITATOR	CIRCUIT
Slicing the Pie	Simon Minkoff Clare Sieber	A B
Contractualising Continuity	Elliott Singer Matt Mayer	A B
Dissecting Care	Zoe Norris Paul Evans	A B

Members of Conference will be divided into six groups which will be identified to you at registration at the start of day one of conference. These six groups will be divided in half to form two circuits – circuit A and circuit B – with three break-out rooms in each circuit covering the three topics for discussion. Conference members will rotate through the three break-out rooms in each circuit and circuit A and circuit B will cover identical topics, but with different facilitators.

The rotation within each circuit will be though the following rooms:

- **Circuit A:**
 - Snow room: Ground floor
 - Paget room: Ground floor
 - Courtyard Suite: Ground floor
- **Circuit B:**
 - Bevan room: 3rd floor
 - Harvey room: 3rd floor
 - Worcester room: 1st floor

The break-out rooms will run until lunchtime and members of conference will reconvene at Friends House at 14.00 when the outputs of each break-out room will be shared by the facilitators.

SLICING THE PIE – BREAK-OUT GROUP

The purpose of this break-out group is to discuss how to achieve an equitable formula for patient funding. The pros and cons of the current funding formula will be discussed, together with considering which patient factors may be important when negotiating funding within a new GP contract.

Existing GPC England and GPC UK Policy on the Funding Formula is as follows:

- Carr Hill formula is no longer fit for purpose
- A new funding formula needs to reflect patient demographics, deprivation and health seeking behaviour on an individual practice level
- The difference in premature multi-morbidity is taken into account in the allocation of funding
- Any revised funding formula should ensure no practice loses out

Desired outputs from this break-out group:

- A set of principles to steer the GPC England Officer Team when negotiating the funding formula for the next contract, or it may conclude that “if everyone is special, then no-one is special!”



The following motions were received to contribute towards this break-out group:

- B1** NORFOLK AND WAVENEY: That conference recognises the workload for GPs working in areas of deprivation and diverse populations is significantly higher than average, and calls for the GPC England to negotiate:
- (i) a simple funding structure to identify practices working in areas of deprivation and covering a diverse population to enable additional funding to support with patient care
 - (ii) enhanced and more easily accessible, funded, support services, such as interpretation services, to enable appropriate delivery of care and reduce health inequalities
 - (iii) incentives to encourage GPs and staff to work in areas of deprivation and diverse populations.
- B2** MANCHESTER: That conference believes funding for MDT input should be reintroduced for the most vulnerable and challenging patients, as consultation times for these patients are longer due to issues being picked up such as mental health, social care, other NHS and community failings.
- B3** LINCOLNSHIRE: That conference believes that to deliver safe services for patients, general practices must receive adequate and equitable funding and thus demands:
- (i) that NHS England, DHSC, and HM Treasury increase general practice funding to no less than £450 per weighted patient per year (£1.25 per patient per day)
 - (ii) that GPC England and NHS England agree a new funding formula which distributes funds more equitably to take into account; deprivation, morbidity, rurality, coastal location, and geographical isolation.
- B4** GLOUCESTERSHIRE: That conference believes that the Carr-Hill formula creates and entrenches inequality in healthcare provision in deprived regions, and directs GPC England to insist upon the creation of a replacement allocation system, as a fundamental part of the next GP contract round, that:
- (i) better reflects the challenges and meets the needs of deprived areas which are currently 'under-doctored' compared with other areas
 - (ii) is the product of academic rigour, but not expected to be 'perfect' in its initial incarnation
 - (iii) is published in detail and open to scrutiny
 - (iv) evolves over time to adapt to evidence and experience
 - (v) does not simply redistribute existing funding from comparatively less underfunded areas.
- B5** SOUTHWARK: That conference recognises that GPs have a part to play in population health and prevention of ill health and:
- (i) believes that the current focus on targets and dashboards has distorted general practice to such an extent that it is distracting GPs from other core areas of work including providing continuity of care
 - (ii) that appointment data for this activity should be captured

- (iii) instructs GPC England to negotiate with NHS England the proportion of consulting time practices spend on population and preventative health
 - (iv) calls upon the government to give public health medicine the required resources in terms of funding and staff to undertake this work.
- B6** NEWHAM: That conference demands that, in areas where there is sudden population growth due to either new care homes or asylum seeker residences, the ICB should:
- (i) undertake an impact assessment to recognise the impact that these additional patients will have on local general practice
 - (ii) commission specific services to support these patients as soon as they move into area
 - (iii) provide local general practices with accurate data on how many patients they need to plan to receive
 - (iv) provide additional appropriate resources and not rely on the ability of local practices to absorb this increased workload.
- B7** CLEVELAND: That conference supports contractual funding that is linked to the provision of a defined number of appointments, which should be adjusted for:
- (i) registered list size
 - (ii) weighted list size
 - (iii) availability of fully qualified GPs
 - (iv) availability of any clinical staff.
- B8** NEWHAM: That conference recognises the increased resource required to effectively support non-English-speaking patients and asks NHS England to:
- (i) acknowledge that patients requiring interpreters require longer consultations in general practice, typically double appointments
 - (ii) recognise that these consultations themselves may be more complex
 - (iii) accept that practices with a higher number of these patients can overall see fewer patients, due to the increased workload related
 - (iv) address the disparity between practices with high numbers of non-English-speaking patients and those without, through commissioning a DES that provides additional funding and hence additional resource to affected practices.
- B9** BUCKINGHAMSHIRE: That conference believes current arrangements for healthcare for refugees, asylum seekers and vulnerable migrants in England are inadequately funded, and:
- (i) believes that directing resources to the first place of registration fails to recognise the ongoing need for additional resource for these peoples' healthcare
 - (ii) calls for ongoing additional resources to be allocated in the GMS contract for the care of these patients

- (iii) recommends that a national enhanced service be developed, to allow practices to sign up to provide additional support for these patients, with appropriate additional resources
- (iv) calls for England to have parity with Scotland and Wales, where refused asylum seekers are entitled to free primary and secondary care on the same terms as any other resident; this is in contrast to England, where refused asylum seekers are currently not entitled to free NHS secondary care unless they meet additional qualifying requirements.

CONTRACTUALISING CONTINUITY – BREAK-OUT GROUP

The purpose of this break-out group is to discuss how to include continuity measures within any new contract. It will focus on the principles of defining, measuring and incentivising continuity.

Existing GPC UK Policy on Continuity is as follows:

- We move away from a target-based GP contract and be rewarded for prioritising continuity

Desired outputs from this break-out group:

- To reach a consensus on whether we want continuity to be incentivised within any new contract and how we wish this to be done



The following motions were received to contribute towards this break-out group:

- B10** KENSINGTON, CHELSEA AND WESTMINSTER: That conference requires that a future GMS contract is not compromised by poorly thought through manifesto promises or perverse government targets but incentivises and enables prioritisation of factors that have been shown to be important to patients:
- (i) continuity of care
 - (ii) longer consultation times for complex patients
 - (iii) high standards of care
 - (iv) patient choice in which health care professional they consult, where appropriate
 - (v) patient expectation of the type of consultation, where appropriate.
- B11** NORTH YORKSHIRE: That conference demands that continuity of care be prioritised in any new contract agreement and the relentless demands of rapid access and urgent care be rejected in favour of evidence based patient benefits from long term relationships with a known primary care physician.
- B12** NORTH YORKSHIRE: That conference demands the emphasis on any new contract must be on continuity, not urgent care.
- B13** BEDFORDSHIRE: That conference:
- (i) believe that continuity of care is an important and essential component of general practices, and
 - (ii) instructs GPC England to develop a method to measure and reward continuity of care in general practice.
- B14** CAMBRIDGESHIRE: That conference calls on GPC England to negotiate a simplified GP contract which uses continuity of care as a metric for the foundation of high-quality, high-trust, safe general practice improving GP recruitment and retention by allowing GPs to use the specialist generalist skills that we train for years to attain and in the process, helping deliver better care for our patients, a more satisfied patient population and a more stable general practice by:
- (i) rewarding the role of the GP as the family doctor by making continuity of care an aspirational target
 - (ii) encouraging GPs to work in practice teams focusing on providing continuity to a smaller subset of the practice list
 - (iii) allowing practices to use waiting lists for non-urgent clinical issues, enabling continuity whilst maintaining access.

DISSECTING CARE – BREAK-OUT GROUP

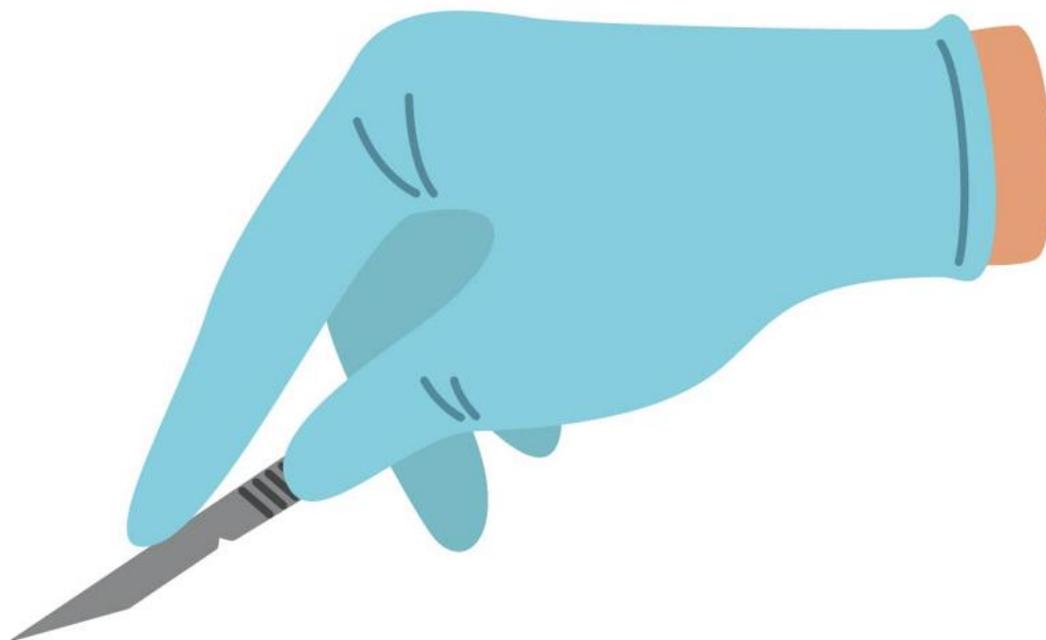
The purpose of this break-out group is to raise awareness of the issues surrounding the separation of planned and unplanned care. Discussion will focus on the impact of this separation on the patient, the GP, and the system.

Existing GPC England Policy on the separation of planned and unplanned care is as follows:

- Acknowledge that isolated, acute presentations make up a tiny percentage of general practice workload and their removal risks fragmentation of continuity of care.

Desired outputs from this break-out group:

- To reflect on the risks and benefits of shedding our in-hours unplanned care, before debating this within a binary motion after the workshop discussions.



The following motions were received to contribute towards this break-out group:

- B15** GATESHEAD AND SOUTH TYNESIDE: That conference has significant doubts about the Fuller Stocktake's intention to separate urgent care and long-term conditions and:
- (i) is unclear how any patient-facing general practitioner could deem this feasible
 - (ii) fears attempts to achieve this will harm continuity of care
 - (iii) has concerns that the 'urgent/acute' stream will largely consist of non-doctors, thus leading to missed diagnoses and patient harm
 - (iv) mandates GPC England to reject said document in contract negotiations.
- B16** NORTH YORKSHIRE: That conference has no confidence in the Fuller Report and calls for an immediate rejection of this process by GPC England.
- B17** HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the NHS England interpretation of the Fuller-Stocktake report is neither in the best interest of patients nor the profession and calls on the BMA to negotiate:
- (i) a halt to system plans to scale-up same-day access for urgent care to a single point of access
 - (ii) that continuity of care be placed at the centre of changes to primary care systems.

LUNCH

12.30

BREAK-OUT ROOM FEEDBACK

14.00

SEPARATION OF PLANNED AND UNPLANNED CARE

14.30

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

- * 17 WALTHAM FOREST: That conference believes that the current workload for general practice is unsustainable, and:
- (i) believes that the time has come to separate acute on-the-day care from planned general practice care
 - (ii) insists that the separation of care be an essential component of a new GMS Contract

- (iii) requests that GPC England negotiates a separate service for the provision of on-the-day acute care for patients currently seen by GPs.
- (iv) requests that GPC England stipulates that a new GMS contract clearly indicates the situations when a patient would benefit from moving between acute care services and planned care services and the mechanism to enable this
- (v) requests that GPC England negotiates a new GMS contract which focuses on continuity of care, care of long-term conditions, preventative healthcare and end of life care.

APPRAISAL

15.10

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

- * 18 WEST SUSSEX: That conference believes that GPs should not have to bear costs associated with mandatory annual appraisal and implores GPC England to insist that these costs are reimbursed in full.
- 18a SOMERSET: That conference believes that all doctors on the England Performers List should have equal access to appraisal support and receive payment for their time spent undergoing it.
- 18b DEVON: That conference rejects the direction of regional teams set forth to appraisers arranging face-to-face appraisals that the cost of venues should be carried by the appraiser and:
 - (i) the lack of freely bookable and free NHS England venues due to NHS England 'streamlining' is not the fault of appraisers
 - (ii) the obligatory annual appraisal in 'best practice' should be face-to-face in order to support the appraisee and not pushed virtually for convenience
 - (iii) deplores this move as exacerbating inequity between appraisee partners / salaried and their locum colleagues, the latter of whom are least likely to have fixed venues to undertake appraisals and be forced to rely on external, costly alternatives.
- 18c DEVON: That conference requires explanation as to why GPs in England are treated differently to colleagues in Scotland, Wales and Northern Ireland with regard to their obligatory annual appraisal given that:
 - (i) the MAG form is no longer fit for purpose and NHS England are advising the use of commercial appraisal systems with the cost to be born by the appraisee
 - (ii) appraisees in England have to carry the cost of attending an appraisal and are not remunerated at a sessional rate.

REAFFIRMING CONTRACT POLICY

15.20

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

- * 19 AGENDA COMMITTEE TO BE PROPOSED BY KENT: That conference calls on GPC England to:
 - (i) include in its negotiations with NHSEI / DHSC that existing conference policy of an activity-based contract is part of the new contract

- (ii) include in its negotiations with NHSEI / DHSC that existing conference policy of PCN into core is part of the new contract
- (iii) include in its negotiations with NHSEI / DHSC that existing conference policy of more flexibility for private services the NHS cannot provide is part of the new contract
- (iv) include in its negotiations with NHSEI/DHSC that existing conference policy of the removal of home visits from core contract work is part of the new contract
- (v) formally ballot members once the outcome of negotiations for the new contract with NHSEI / DHSC are known.

19a KENT: That conference calls on GPC England to:

- (i) include in its negotiations with NHSEI / DHSC that existing conference policy of an activity-based contract is part of the new contract
- (ii) include in its negotiations with NHSEI / DHSC that existing conference policy of PCN into core is part of the new contract
- (iii) include in its negotiations with NHSEI / DHSC that existing conference policy of more flexibility for private services the NHS cannot provide is part of the new contract
- (iv) formally ballot members once the outcome of negotiations for the new contract with NHSEI / DHSC are known.

19b MANCHESTER: That conference:

- (i) supports the removal of home visits from the core GMS contract
- (ii) requests that home visiting should be offered as a national enhanced service for practices wishing to continue to do so and have capacity to do so
- (iii) demands that the funding for this service should not be linked to any other pots of money, services, or local projects.

19c OXFORDSHIRE: That conference believes that GPs in England should be able to provide a much wider range of private services for their own NHS patients and demands that GPC England negotiate for the removal of current contractual barriers to this.

19d BERKSHIRE: Conference notes statements from the NHS England director of primary and community care, that NHS England is not in a position to negotiate a new five year contract, because NHS England itself has only a "one year funding settlement" from Government, to cover 2024 / 2025. Conference:

- (i) believes general practice is better served by the longer term stability of a five year settlement
- (ii) decries the short-termism of decisions that lead to only a one year contract being up for negotiation
- (iii) demands that GPC England negotiate for the removal of restrictions in the GMS contract that currently prevent GPs offering a range of private services to their NHS patients.

- 19e KENT: That conference demands that any new contract to replace current GMS allow practices to offer private services to their registered patients, in a manner to be determined by the practice in agreement with the patient.
- 19f BRADFORD AND AIREDALE: That conference demands an update on current policy to remove home visits on demand from the GMS contract and when we can expect it to be delivered.
- 19g BRADFORD AND AIREDALE: That conference demands clarity on the definition of “house bound” and would suggest “bed bound” as an alternative.
- 19h LINCOLNSHIRE: That conference congratulates GPC England for its work to improve the contract and in developing plans for industrial action but insists that industrial action should only follow meaningful engagement with government and attempts to negotiate a wholesale change to the GMS and PMS contracts which include adequate funding to provide safe patient services.
- 19i NORFOLK AND WAVENEY: That conference asks the GPC England to negotiate for:
- (i) the funding attributed to PCNs to be moved into the GP core contract to give more control to general practices to lead on working collaboratively at scale, while maintaining the benefits of continuity of care and meeting the specific needs of their patient population
 - (ii) clear, practical and financial alternatives to the PCN DES to enable the funding to be included in the GP core contract to protect the partnership and independent contractor model.
- 19j MID MERSEY: That conference demands the urgent distribution of ARRS funding through the global sum to general practice to ensure fairness and equity to all.
- 19k CAMBRIDGESHIRE: That conference calls on GPC England to negotiate the PCN DES funding into the Global Sum beyond 31 March 2024, specifically to provide a ring-fenced funding supplement for staffing without specification of role or function, enabling practices to retain or recruit to the specific roles they need, including GPs and practice nurses, to recognise diversity across practices which cannot be achieved in a "one size fits all" approach and to provide flexibility for practices to deliver better care directly to their local population through a more stable mechanism of support.

CLOSING REPORT BY THE CHAIR OF GPC ENGLAND 16.10

FINAL BUSINESS 16.20

CLOSE OF CONFERENCE 16.30

Part 2 of the Agenda

Part 2 (motions not prioritised for debate A and AR motions) of the Agenda [can be accessed via this link](#) and will take you to a separate document

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The Conference of England LMC Representatives' Standing Orders [can be accessed via this link](#) and will take you to a separate document