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2024 Annual Conference of England LMC Representatives

Friends House, London
Friday, 22 November 2024

Truth and trust: valuing family doctors

Conference of England LMC Representatives

Agenda

To be held on

Friday 22 November at 09.00
Friends House, 173-177 Euston Road, London NW1 2BJ

Chair Elliott Singer (Waltham Forest)
Deputy Chair Clare Sieber (West Sussex)

Conference Agenda Committee
Elliott Singer (Chair of Conference)
Clare Sieber (Deputy Chair of Conference)

William Denby (Hampshire and Isle of White)
Paul Evans (Gateshead and South Tyneside)
Simon Minkoff (Manchester)
Roger Scott (Liverpool)
Deborah White (Cleveland)

Members of the England LMC Conference Agenda Committee 2024

Dr Elliott Singer
Chair of the Agenda Committee

Dr Clare Sieber
Deputy Chair of the Agenda Committee

Dr Will Denby
Member of the Agenda Committee

Dr Paul Evans
Member of the Agenda Committee

Dr Simon Minkoff
Member of the Agenda Committee

Dr Roger Scott
Member of the Agenda Committee

Dr Deborah White
Member of the Agenda Committee

The Agenda for 2024 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 11 September 2024. 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 by **noon on Wednesday 20 November 2024.**

Chosen motions / Amendments / Riders
Each representative can choose up to 3 chosen motions which have not been prioritised for debate in the agenda. The ballot for chosen motions is open and will **close at noon on Wednesday 20 November**. Please click here to submit.

If you wish to submit an amendment (standing order 29) or rider (standing order 30) you can do this by emailing Karen Day at kday@bma.org.uk. The deadline for this is **Noon on Wednesday 20 November**.

Emergency motions / New business
In this agenda are printed all notices of motions for the annual conference received up to noon on 11 September 2024. This means there may be important new business which arose after this date. If you wish to submit a motion for new business, please email Karen Day at kday@bma.org.uk by **noon Wednesday 20 November.**

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.

Part 1 of The Agenda
This can be found before the update on motions from Conference of England LMCs 2023, which will include the motions bracketed under each prioritised motion, as well as the motions contributing towards the themed debate.

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 **noon Wednesday 20 November 2024** – please click here.

CONFERENCE OF ENGLAND LMCs ELECTIONS

The following elections will be held:

Chair of conference

Chair of conference for the session 2024-2025 (see standing order 63)- nominations will be open at 12pm midday on Friday 15 November and close at 10am on Friday 22 November 2024.

Deputy chair of conference

Deputy chair of conference for the session 2024-2025 (see standing order 64)- nominations will be open at 12pm midday on Friday 15 November and close at 12pm midday on Friday 22 November 2024.

Five members of LMC England conference agenda committee

Five members of the England conference agenda committee for the session 2024-2025 (see standing order 65)- nominations will be open at 12pm midday on Friday 15 November and close at 1pm on Friday 22 November 2024.

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 Friday 22 November 2024
Voting closes for all positions: 2pm Monday 25 November 2024
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

Friday 22 November 2024: Friends House

Item	Time
Webinar for new attendees – 13 November 2024	13.00 – 14.00
A teach-in for new attendees is being held at the back of main auditorium	08.30
Opening business	09.00
Chair of GPC England report	09.20
Commissioning transparency	09.30
GP employment	09.50
Sessional GPs in ARRS	10.10
Primary care doctors	10.30
Special allocation schemes	10.40
GP IT	11.00
Major issue debate – Collective action	11.10
Advice and guidance	12.10
Lunch	12.30
Salaried GP contract	13.30
Clinical	13.50
PCSE deductions	14.20
Online consultations	14.40
CQC ratings	14.50
Cameron Fund	15.10
Soapbox	15.20
Chosen motions / emergency business	16.00
Community pharmacy	16.30
GP models of care	16.40
Final business	16.50
Close of conference	17.00

OPENING BUSINESS 09.00

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 09.20

COMMISSIONING TRANSPARENCY 09.30

To submit a speaker slip for Motion 4 – please click here

* 4 AGENDA COMMITTEE TO BE PROPOSED BY BUCKINGHAMSHIRE: That conference:
(i) decries the lack of public visibility of Integrated Care Boards (ICBs), which leaves GPs dealing with patient dissatisfaction where commissioning gaps exist
(ii) demands that all ICBs provide a dedicated patient contact line to respond to, and gather information from, patients affected by gaps in commissioned services
(iii) calls on commissioners to be brave and go public when they no longer have the funds to commission services that are safe and dignified.

4a BUCKINGHAMSHIRE: That conference calls on commissioners to be brave and go public when they no longer have the funds to commission services that are safe and dignified.

4b OXFORDSHIRE: That conference decries the lack of public visibility of clinical commissioning bodies, which leaves GPs dealing with patient dissatisfaction where commissioning gaps exist. Conference demands that all ICBs provide a dedicated patient contact line to respond to, and gather information from, patients affected by gaps in commissioned services.

GP EMPLOYMENT 09.50

To submit a speaker slip for Motion 5 – please click here

* 5 AGENDA COMMITTEE TO BE PROPOSED BY BEDFORDSHIRE: That conference:
(i) believes that practices want to employ more GPs, because GPs have the training and skills to manage the complex demands that patients present with
(ii) deplores the situation where newly qualified GPs are struggling to find any employment on completion of training
(iii) calls for financial support for practices to help them to employ GPs
(iv) condemns all organisations that strip out GPs from their services and replace them with less qualified alternatives.

5a BEDFORDSHIRE: That conference:
(i) believes that practices want to employ more GPs, because GPs have the training and skills to manage the complex demands that patients present with
(ii) calls for financial support for practices to help them to employ GPs.

5b BEDFORDSHIRE: That conference:

(i) deplores the situation where newly qualified GPs are struggling to find any employment on completion of training

(ii) asks GPCE to work with NHSE to provide support for newly qualified GPs looking for work and for practices who want to employ them.

5c BUCKINGHAMSHIRE: That conference condemns all organisations that strip out GPs from their services and replace them with less qualified alternatives.

5d WIRRAL: That conference notes with dismay that a significant proportion of GPST3 doctors who completed their GP training this year are going to be unemployed; and called on the Government to take an urgent action to address this.

SESSIONAL GPs IN ARRS 10.10

To submit a speaker slip for Motion 6 – please click here

* 6 AGENDA COMMITTEE TO BE PROPOSED BY GLOUCESTERSHIRE: That conference notes the recent inclusion of GPs in the Additional Roles Reimbursement Scheme (ARRS) and:

(i) believes this represents an admission that the PCN DES and ARRS have failed to provide meaningful support to general practice and our patients, and have only worsened the GP recruitment and retention crisis

(ii) insists that ARRS relaxations to employ GPs in practices are too little too late and carry unacceptable restrictions

(iii) urges the government to allow recruitment of all GPs to PCNs under the ARRS, and calls for GPCE to negotiate that the funding be opened up to all GPs regardless of qualification date

(iv) requests that GPCE negotiates that all ARRS funding is returned to the core contract

(v) demands that NHSE agrees to inject funds directly into practices to enable them to employ GPs as they wish.

6a GLOUCESTERSHIRE: That conference notes with concern that the inclusion of GPs into the ARRS funding has been restricted to those who recently qualified, thus limiting both employment opportunities for senior GPs and flexibility for employers in difficult to recruit areas and calls for GPCE to negotiate that the funding be opened up to all GPs regardless of qualification date.

6b LIVERPOOL: That conference notes the recent inclusion of GPs in the Additional Roles Reimbursement Scheme (ARRS) and believes this represents an admission that the PCN DES and ARRS have failed to provide meaningful support to general practice and our patients and have only worsened the GP recruitment and retention crisis. We, therefore:

(i) condemn any suggestion that a GP can be classed as an ‘additional role’ in general practice

(ii) oppose any further expansion of the PCN DES at the expense of funding the core GP contract

(iii) call upon GPCE to negotiate with DHSC and NHS England to deliver a significant uplift to core GP funding, to help GP Practices to recruit and retain GPs directly, rather than rely on GPs via PCNs

(iv) call upon GPCE to negotiate with DHSC and NHS England to transfer all funding for the PCN DES to core GP funding, allowing each practice to individually recruit a clinical team according to the bespoke needs of their patient population.

6c WAKEFIELD: That conference moves that the introduction of salaried GPs to the ARRS scheme should be rejected as it could be the prelude to the profession becoming a salaried service with poor terms and conditions. It could herald the end of the independent contractor status and the loss of patients individual GP as they are subsumed to a PCN organisation.

6d MID MERSEY: That conference:
(i) insists that ARRS relaxations to employ GPs in practices is too little too late and carries unacceptable restrictions
(ii) demands that NHSE agrees to inject funds directly in practices to enable them to employ GPs in their practices as they wish.

6e HULL AND EAST YORKSHIRE: That conference is frustrated by the lack of clarity around inclusion of newly qualified GPs in the ARRS and:
(i) urges the government to allow unrestricted recruitment of all GPs to PCNs under the ARRS
(ii) mandates the use of the BMA salaried model contract for all PCN employed GPs
(iii) mandates the use of the BMA salaried GP pay range for all PCN employed GPs
(iv) calls for support for a national, electronic, platform to match GPs with practices and PCNs.

6f SOMERSET: That conference believes that employment of GPs within the PCN ARRS funding is only a short-term solution and:
(i) believes that this is the start of a salaried model and risks the future of the partnership model
(ii) requests that GPCE negotiates that all ARRS funding is returned to the core contract.

6g NORTH AND NORTH EAST LINCOLNSHIRE: That conference calls on NHSE to match the ARRS and global funding uplift to avoid partners bearing any disparity in resulting employment costs.

6h LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference urgently looks at the funding model of ARRS and reduces the need for such hoops to be jumped through and demands that GPCE negotiates that all ARRS funds are distributed to individual practices based on their individual needs, in preference as part of the global sum.

6i LAMBETH: That conference believes that investment in core funding is the key to a successful, sustainable general practice:
(i) it calls for the government to provide additional funding to the core contract to address the GP unemployment crisis
(ii) believes that the additional £82m described as 'emergency funding' and added the £1.4bn ARRS pot to fund newly qualified GPs should be added into core and not given to PCNs
(iii) it believes that emergency funding provided to PCNs will not address the continuing GP employment crisis.

6j CLEVELAND: That conference is concerned about the risk of exploitation of GPs who are employed within the Additional Roles Reimbursement Scheme, and therefore mandates GPCE to work with the Sessional GP Committee to ensure:
(i) the development of a reasonable job plan to support the salaried GP, not solely focused on the needs of the PCN
(ii) career development and mentorship is offered within the job plan, particularly for newly qualified GPs
(iii) if this is to be a short-term role, a supported exit
(iv) pay is in line with the BMA salaried GP pay range
(v) contract terms no less favourable than the model contract for salaried GPs must be used.

6k WIGAN: That conference notes that the 'emergency measure' which has produced an additional £82 million of ARRS funding to allow PCNs to recruit 1000 more salaried GPs, whether or not it succeeds is just that and must not mask the deficiencies in 'core' practice funding nor deflect the NHSE from properly funding the incentivisation and recruitment of principals in general practice.

6l AVON: That conference demands that all PCN funding, including existing ARRS funding, is moved into the core contract and declares this as a red line for the 2025 / 2026 contract negotiations.

6m BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference believes the use of Additional Roles Reimbursement Scheme (ARRS) staff seeing undifferentiated patients increases re-consultation rates in comparison to GP led appointments and urges GPCE to:

(i) demand NHSE produces national data sets to examine this issue and consider the cost-effectiveness of the ARRS scheme

(ii) continue to campaign for the ARRS funding to be delivered into the core contract instead.

6n COVENTRY: That conference believes that general practices have been held back from developing and delivering continuity of care by the inflexibility of, and fund diversion to, the PCN DES. We ask that if the DES is to continue, it is urgently reviewed to resolve the following areas:

(i) non sensical inflexibility in the ARRS funding needs removing to allow PCNs to employ any staff they see fit.

(ii) any underspends at year end should be directly reinvested back into local primary care.

(iii) an end to the current situation where PCNs have become unfunded training and mentoring organisations taking GPs and nurses away from patient contact, with a properly funded training budget to fully cover backfill time.

(iv) all new monies for GP employment should go into the core GMS not the ARRS, so that GPs are employed directly by the practices, preventing erosion of continuity of care and a 'two-tier' approach to employing GPs.

(Supported by Warwickshire)

6o MERTON: That conference believes that the current proposals for ARRS recruitment of GPs are unhelpful and discriminatory and will do nothing to alleviate the plight of the many hundreds of GP colleagues who are unemployed. Conference calls on NHSE to facilitate the appropriate employment of GPs and nurses through adequate resourcing of the core contract, rather than through ARRS which is subject to variability and which as a DES may be withdrawn at any time.

6p WORCESTERSHIRE: That conference applauds the Health Secretary's August commitment to including general practitioners and nurses in the ARRS scheme but requests GPCE ensure:

(i) that there is urgent and clear guidance on how this proposal will be financed

(ii) that this funding should be practiced based

(iii) the Health Secretary is advised that an appropriate increase in core funding is a better use of the money.

PRIMARY CARE DOCTORS 10.30

To submit a speaker slip for Motion 7 – please click here

* 7 GATESHEAD AND SOUTH TYNESIDE: That conference rejects the concept of primary care doctors as it is a retrograde step in both safety and efficiency in patient care.

SPECIAL ALLOCATION SCHEMES 10.40

To submit a speaker slip for Motion 8 – please click here

* 8 MANCHESTER: That conference:
(i) notes the variable provision of special allocation schemes in England
(ii) notes that some special allocation schemes operate in shared premises exposing practice staff and patients to unnecessary risk of violence
(iii) instructs GPCE to develop, with suitable stakeholders if necessary, a new fit for purpose set of minimum standards for a special allocation scheme that serves the needs of patients, protects the public and values teams, and
(iv) instructs GPCE to negotiate with NHSE such that new improved standards for the special allocation scheme are agreed and implemented uniformly across England.

8a WIRRAL: That conference recognises the increasing violence against primary care staff as unacceptable and calls for the establishment of a national mechanism for reporting violence against healthcare staff for the purposes of improving:
(i) data collection and public awareness
(ii) workplace risk assessment
(iii) documentation and registering of patients with a history of violence to staff
(iv) alert systems for practices "at risk" of, and actually experiencing, violence.

8b HAMPSHIRE AND ISLE OF WIGHT: That conference believes that NHSE is failing in its statutory duty to prioritise both patient and NHS staff safety, resulting in patients and staff being harmed as a consequence and calls for:
(i) urgent action from NHS England to rectify both aspects
(ii) GPCE working with the BMA, to expose this through a public campaign
(iii) GPCE to call for a judicial inquiry to investigate this.

8c WALTHAM FOREST: That conference is genuinely shocked and disappointed by the recent episodes of racism and violence across the UK and offers its unequivocal support to all colleagues who have been directly or indirectly affected by these events.
(Supported by City & Hackney, Newham, Redbridge and Tower Hamlets LMCs)

8d MANCHESTER: That conference notes the risk presented to practices recently, secondary to violent disorder in our communities, resolves that practices are guided to note their obligations to protect the health and safety of their teams and patients, over and above the contractual expectations in their GMS / PMS / APMS contracts, and
(i) commends the systems and localities that have expressed support of this approach, and
(ii) instructs GPCE to negotiate confirmation / clarification from NHSE for this basic principle to support and reassure practices.

8e MANCHESTER: That conference:
(i) notes that non-crime hate incidents are reportable to the police
(ii) encourages surgeries to report hate incidents to their local police requesting a crime reference number, and
(iii) instructs GPCE to provide support to practices who are required to remove patients should a risk assessment indicate this action to be required in the interests of patient and staff safety.

8f DORSET: That conference believes that current systems fail to protect general practice from unreasonable behaviour and vexatious complaints by patients. Therefore, conference calls for:
(i) the establishment of an England wide 'contract of behaviour' between general practice and the general public
(ii) the establishment of mechanisms to allow patients who have breached such a contract to be allocated to specialist practices similar to SAS scheme practices
(iii) direct action from NHS England to allow practices to streamline the processing of complaints which are clearly vexatious in nature
(iv) clear government messaging that abuse of the complaints process is not acceptable
(v) the definition of abuse of NHS staff be expanded to consider patient behaviour on digital forums.

GP IT 11.00

To submit a speaker slip for Motion 9 – please click here

* 9 AGENDA COMMITTEE TO BE PROPOSED BY CITY AND HACKNEY: That conference condemns the chronic underfunding of GP IT provision which is having a shameful impact on practices and:
(i) notes that there has been no uplift in GP IT capital funding, which includes the funding for SMS messaging and IT support, in over five years
(ii) recognises that limiting text message funding, will transfer financial pressure onto practices, many of whom are already under immense strain
(iii) requires NHSE to explain how they can achieve the objectives outlined in 'modern general practice model' without adequately investing in general practice IT
(iv) requests that GPCE work with NHSE clinical digital leads in developing the business case to convince the DHSC to fully fund all digital tools that enable safe secure direct communication with patients
(v) insists that core GP IT funding be properly prioritised within NHS budgets to support necessary workforce expansion.

9a CITY AND HACKNEY: That conference is appalled by the lack of investment into general practice IT and:
(i) notes that there has been no uplift in GPIT capital funding, which includes the funding for SMS messaging and IT support, in over five years
(ii) believes that the approach not to fully fund all SMS messaging will act as a future disincentive for practices to adopt new technologies
(iii) requires NHSE to explain how they can achieve the objectives outlined in 'modern general practice model' without adequately investing in general practice IT
(iv) request that GPCE work with NHSE clinical digital leads in developing the business case to convince the DHSC to fully fund all digital tools that enable safe secure direct communication with patients.
(Supported by Newham, Redbridge, Tower Hamlets and Waltham Forest LMCs)

9b CLEVELAND: That conference condemns the chronic underfunding of GP IT provision, which is having a shameful impact on practices' ability to support necessary workforce expansion and insists that core GP IT funding be properly prioritised within NHS budgets.

9c TOWER HAMLETS: That conference has significant concerns about plans to curtail funding for, and thus limit the number of SMS text messages each practice can send to their patients and:

(i) recognises that limiting text message funding, will transfer financial pressure onto practices, many of whom are already under immense strain
(ii) recognises that this will result in practices reducing their use of this service and forcing them to use less efficient methods of communication
(iii) is concerned that alternatives including the NHS app are less accessible to patients with poorer IT literacy
(iv) predicts that these changes risk an inadvertent domino effect of reducing clinical capacity at practice level, as clinical appointments will be used for work historically managed via SMS text messages
(v) instructs GPCE to inform NHSE, that any SMS funding restrictions will severely adversely impact patient care, general practice efficiency and in turn the wider health care system.

(Supported by City & Hackney, Newham, Redbridge & Waltham Forest LMCs)

9d GLOUCESTERSHIRE: That conference calls for a national strategy to standardise and support digital health innovations in primary care, ensuring equitable access to remote consultations while addressing digital literacy and infrastructure challenges.

9e BERKSHIRE: That conference notes the lack of specific funding for information technology within primary care networks and demands that IT funding is made available for PCNs, either via the practice based network contract DES or directly from NHSE in order to deliver the modern general practice model.

9f CLEVELAND: That conference recognises the increased long-term costs of providing digital telephony and demands that these be reimbursed.

9g BERKSHIRE: That conference notes that current funding and IT systems in general practice are inadequate to meet the demands of 21st-century healthcare and believes that the appropriate use of artificial intelligence (AI) solutions can significantly reduce GP workloads and improve patient outcomes. Conference:

(i) urges GPCE to negotiate with NHSE to ensure the implementation of effective regulations and funding that enable AI to be used in general practice to streamline administrative tasks, including the processing of notes, referrals, and other non-clinical duties
(ii) believes that the adoption of AI technologies should be used to mitigate workload and workplace burnout, thus maintaining a sustainable number of GPs in practice
(iii) believes that AI should act as an assistant, supporting GPs rather than replacing them
(iv) recommends that AI advancements are used to enhance, not expand, GP roles, and rejects any unfunded extension of responsibilities through "mission creep"
(v) demands that any new AI systems should be fully funded through ring-fenced funding in addition to the General Medical Services (GMS) contract.

9h BERKSHIRE: That conference decries the often short term and inadequate nature of funding for GP IT innovation, and calls for a refocusing of the GP IT frameworks, to reduce the dependence on “bolt on” software packages to provide functionality that, by 2024, should be available within the core clinical systems.

9i LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes that in 2024 there are still issues with how patient information flows between various parts of the NHS. The current introduction of the RAVS is being seen as a way forward to see vaccinations done in secondary care in patient notes however the reverse isn’t happening, resulting in patient safety concerns. This is just one example hence we call upon NHS England to honour the 2003 agreement to mandate that any new introduction of IT programs needs to be signed off by the joint general practitioner information technology committee (JGPITC).

9j CHESHIRE: That conference recognises that many general practices wish to embrace digital transformation and innovation but that short-term non-recurrent digital funding, restrictive procurement frameworks and last-minute changes to procurement rules have become a barrier to digital transformation, leaving general practice to innovate at its own risk. We call on GPCE to work with NHSE to secure guaranteed, multi-year funding for digital transformation in general practice that supports innovation beyond just the digital tools that support the primary care access recovery programme.

MAJOR ISSUE DEBATE - COLLECTIVE ACTION 11.10

A large number of motions were received on the topic of the GPCE Collective Action. As these actions are current developing with different successes and challenges across England, the Agenda Committee felt that conference could best explore the topic by undertaking a major issue debate.

The purpose of the major issue debate is to enable LMCs to share and provide GPC England with examples of what the successes and challenges have been with phase 1 of Collective Action. It is also an opportunity to debate views on how Collective Action should develop in phase 2 which would include seeking the view of sessional GPs and GP Registrars on what they believe are the actions that they would be able and prepared to take in support of the next phase of Collective Action.

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 major issue debate are included in Part 1 of the Agenda and are numbered TD1 to TD13.

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 successes, challenges and next step for Collective Action. At the conclusion of hearing from speakers, the Chair of GPCE will summarise the debate. Following conclusion of the debate, voting members of conference will be asked to vote on motion 10 as proposed by the Chair of Conference.

TD1 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference insists that GPCE negotiate for GPs to "stay safe" and ensure that a daily limit of 25 patient contacts is formally recognised by the next GP contract.

TD2 AVON: That conference believes it is time for GPs to take back control of the primary / secondary care interface landscape and demands that GPCE takes steps to protect the workload of general practice by:
(i) developing a standard template letter which is mandated for any organisation wishing to interface with general practice
(ii) negotiating repatriation or funding of all non-core, interface activity on a national level
(iii) working with GPDF to develop a public facing campaign regarding non-core activities.

TD3 CLEVELAND: That conference endorses the BMA guidance on safe working in general practice and:
(i) believes that these principles should apply to equally to all clinical members of the practice team
(ii) mandates GPCE to work with relevant stakeholders such as the RCN to expand their guidance to incorporate the full practice team.

TD4 CAMBRIDGESHIRE: That conference is delighted that the BMA GP collective action campaign has called for a minimum 10.7% uplift to core GP funding but asks that GPCE ensure this is additional resource rather than a re-allocation of PCN budgets.

TD5 MANCHESTER: That conference welcomes and commends the GPCE safe working guidance, and:

(i) notes that implementation provides evidence of a quality service that is safe, effective and well-led
(ii) recommends implementation by each and every practice in England for the purpose of assuring the short term ongoing viability of their practices (but notes this may not be a long term solution over contractual reform)
(iii) advises all GPs to consider how they can write an item for their annual appraisal personal development plan reflecting on the guidance and implementing quality improvement for the benefit of patients; and
(iv) instructs GPCE to publicise this message to GPs in England.

TD6 DEVON: That conference calls upon the British Medical Association (BMA) to:

(i) proactively contact its non-GP members working in secondary care to outline their responsibilities under the secondary care contract, as well as their obligations under GMC guidelines and local formularies.
(ii) ensure that non-GP BMA members are fully informed of their role in any workload transfer processes, specifically emphasising tasks that are not appropriate for GPs to undertake.
(iii) encourage a collaborative approach between primary and secondary care by making it clear that secondary care clinicians should not delegate work to GPs that falls outside of the GP contract.
(iv) proactively advocate for adherence to best practices and guidelines that protect GPs from being inappropriately burdened with tasks that should remain within secondary care, thereby ensuring a sustainable and effective healthcare system.

TD7 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference addresses the unprecedented onslaught of the unfunded and non-contracted transfer of work from secondary to general practice with no sanctions or consequences imposed on trusts for not upholding the NHS standard contract, in particular with regards to referrals and onward care which still result in referrals being rejected or work being passed back to general practice inappropriately. We insist that NHS England should outline clear consequences on NHS Trusts if the NHS standard contract is not complied with, and that this should be negotiated and monitored by GPCE.

TD8 WIRRAL: That conference observes that despite several many steps already taken by GPs on primary secondary care interface issues, many GPs are still experiencing inappropriate and unfunded work transfer from the secondary care; and called on GPCE to address this issue as a matter of priority.

TD9 EALING, HOUNSLOW AND HAMMERSMITH AND FULHAM: That conference recommends that GPCE negotiates that all hospital letters from secondary care to general practice are standardised with:

(i) name of author of letter ie name of clinician who reviewed patient (incl face to face or remotely) and their profession, job title and grade
(ii) supervising consultant for department
(iii) name of hospital site clearly indicated (not just trust) and date of clinic
(iv) distinct management plans which the hospital specialist plan to complete (including prescriptions, fit notes, investigations, results, diagnosis, management plan and follow up (including onward referrals for related issues and clear timelines for follow up)
(v) clear contact details of hospital department including telephone number (and email address where appropriate) to enable patients to directly raise queries relating to their ongoing care including appointments, investigations, results, diagnosis, management plan and follow up (including onward referrals for related issues).

TD10 CAMBRIDGESHIRE: That conference is frustrated by the ongoing interface issues between general practice and secondary care around management of hospital test results. Despite the AoRMC guidelines being in place, these issues remain commonplace. We propose that:

(i) GPCE emphasise to the Royal Colleges the importance of their members following this guidance

(ii) all communication of results (including bloods, imaging and pathology/histology) arranged by secondary care must be communicated by their own department. This work should not be passed to general practice

(iii) GPCE negotiate a system of financial penalties for hospitals who do not follow this guidance, and GPs are also recompensed.

TD11 DERBYSHIRE: That conference deplores the ongoing, unfunded transfer of work from secondary care into general practice and:

(i) directs GPCE to work with NHSE and insist that the NHS standard contract includes clear financial penalties for failure to comply with contractual regulations regarding interface working and

(ii) ensure that ICBs pass all such penalties through to general practice to reflect the additional cost of work transferred as a result of any failure by trusts and other organisations holding an NHS standard contract to comply.

TD12 HERTFORDSHIRE: That conference:

(i) notes with frustration that many clinically appropriate referrals from GPs into secondary care are rejected with little reason

(ii) calls upon GPCE to insist that NHSE and government require that secondary care rejections should only be made by a named senior clinician, whose full contact details are provided, clearly stating the reason for the rejection

(iii) calls upon GPCE to insist that NHSE and government require that all secondary care rejections also be sent directly to the patient with direct contact details for the rejecting secondary care service should the patient wish to complain.

TD13 REDBRIDGE: That conference has grave concerns regarding secondary care waiting list initiatives which discharge patients who have missed an out-patient appointment, with the advice that the patient is re-referred by the GP if needed and:

(i) believes that this approach leads to inappropriate workload transfer to general practice

(ii) recognises this pathway unnecessarily convolutes the patient journey

(iii) recommends that all hospital trusts have a readily accessible method via which patients can directly cancel or rearrange appointments to prevent these appointments being recorded as a missed appointment

(iv) recommends that NHSE mandate that all patient correspondence discharging non-attenders contains contact details to enable patients who missed an appointment to self refer back to secondary care.

(Supported by City & Hackney, Newham, Tower Hamlets and Waltham Forest LMCs)

* 10 AGENDA COMMITTEE TO BE PROPOSED BY THE CHAIR: That conference applauds the GPCE on their approach, professionalism and persistence in running the campaign to save general practice, and commits to supporting them in encouraging practices to follow GPCE leadership and partake in collective action and:

- (i) recognising that collective action is a powerful tool, emphasises that collective action is necessary to safeguard general practice and recommends that GPCE further coordinates general practice to implement those collective actions that are most popular
- (ii) acknowledging that 'restore the core' is vital for the sustainability and survival of GP practices, urges GPCE to make this a main slogan for campaigns and work starting with the next contract negotiations
- (iii) believing that even more needs to be done to improve the public understanding of the value that GPs provide to England's health economy and overall patient care, asks BMA and GPDF to jointly agree and fund a rolling public campaign promoting the successes and value of general practice
- (iv) is concerned this is not having enough impact to drive the changes needed to ensure the survival of general practice, calls on GPCE to ballot the profession for more significant industrial action.

10a TOWER HAMLETS: That conference applauds the courageous leadership of the BMA in uniting the profession and:

- (i) notes the overwhelming, unprecedented vote in favour of collective action by GP contract holders, demonstrating that the current state of general practice is unsustainable
- (ii) recognises that collective action is a powerful tool and that greater unification around specific actions will have greater system-wide impact, giving greater impetus to legislative change
- (iii) recommends that GPCE further coordinates general practice to agree on and implement those collective actions that are most popular
- (iv) emphasises that collective action is necessary to safeguard the future of general practice.

(Supported by City & Hackney, Newham, Redbridge & Waltham Forest LMCs)

10b TOWER HAMLETS: That conference applauds the GPCE on their approach, professionalism and persistence in running the campaign to save general practice and commits to supporting them in encouraging practices to follow GPCE leadership and increasingly partake in collective action.
(Supported by City & Hackney, Newham, Redbridge & Waltham Forest LMCs)

10c NORTH STAFFORDSHIRE: That conference acknowledges that 'restore the core' is vital for the sustainability and survival of GP practices. This conference urges GPCE to make this a main slogan for campaigns and work towards restoring the core starting with the next contract negotiations.

10d SURREY: This conference believes that even more needs to be done to improve the public understanding of the value that GPs provide to England's health economy and overall patient care and asks BMA and GPDF to jointly agree and fund a rolling public campaign promoting the successes and value of general practice.

10e CLEVELAND: That conference wholeheartedly supports GPCE's leadership of collective action in relation to the April 2024 GMS contract imposition, is concerned this is not having enough impact to drive the changes needed to ensure the survival of general practice and calls on GPCE to ballot the profession for more significant industrial action.

10f LIVERPOOL: That conference notes the exceptional result of the BMA GP ballot for Collective Action, and subsequent list of actions for GP practices to take. We also believe the DDRB recommendations for 2024/25 for general practice are wholly inadequate to address the ongoing crisis within general practice. We instruct GPCE to:

(i) continually track GP practice engagement in the actions recommended, to understand what action is being taken, and feed this back to LMCs to help local coordination
(ii) regularly review the list of actions recommended that GP practices take, aiming to have a list of actions that GPCE advise every GP practice should uniformly adopt, rather than a list to select from
(iii) consider undertaking a statutory ballot of GPs for industrial action should there be no improved contractual offer from DHSC / NHS England by 30 November 2024, which could include actions that may constitute a contractual breach
(iv) provide practices with clear legal advice on how any action recommended by GPCE may impact on an individual practice's contractual obligations, and possible legal consequences of taking any action recommended.

10g WIRRAL: That conference notes that imposition of contract is not acceptable by grassroots GPs as demonstrated by the result of the referendum recently carried out amongst GPs and the informal ballot of GP contractor. It:

(i) endorses the actions so far taken by the GPCE in entering dispute with the NHSE
(ii) endorses the ongoing collective action called by GPCE
(iii) calls on GPCE to tackle the government with more vigour and engages it for a better negotiated contract for 2025 onward.

ADVICE AND GUIDANCE 12.10

To submit a speaker slip for Motion 11 – please click here

* 11 AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference recognises that Advice and Guidance and Advice and Referral schemes have reduced secondary care workload and outpatient waiting lists, whilst leading to an unsustainable transfer of workload to general practice and:

(i) insists that practices heed GPCE advice and avoid using Advice and Guidance, insisting instead on face-to-face outpatient appointments, unless A&G is in the best interests of patients

(ii) calls for GPCE to demand an obligation for all trusts to provide separate advice and separate direct referral options per specialty within ERS to replace existing Advice & Refer options so the referring clinician can choose whichever is most appropriate

(iii) calls for GPCE to negotiate a standard time frame across England within which advice responses should be received by the referring clinician should advice be sought

(iv) calls for GPCE to negotiate a standard structure and quality of response to be adhered to including consideration of whether the components of the advice can be fulfilled within contractual services provided by general practice.

(v) recommends that the system wide financial savings generated by these schemes are shared with general practice, to remunerate workload transfer, rather than savings just be absorbed by hospital trusts.

11a TOWER HAMLETS: That conference recognises that Advice and Guidance and Advice and Referral schemes have reduced secondary care workload and outpatient waiting lists, whilst leading to an unsustainable transfer of workload to general practice and:

(i) is concerned that, although this work is inadequately resourced, GPs are reluctant, and in some cases unable, to cease use of these pathways

(ii) insists that practices heed GPCE advice and avoid using Advice and Guidance, insisting instead on face-to-face outpatient appointments, unless A&G is in the best interests of patients

(iii) recommends that the system wide financial savings generated by these schemes are shared with general practice, to remunerate workload transfer, rather than savings just be absorbed by hospital trusts.

(Supported by City & Hackney, Newham, Redbridge & Waltham Forest LMCs)

11b BARKING AND HAVERING: That conference believes Advice and Guidance responses are increasing unfunded work burden in general practice, not being delivered in a timely manner and are sometimes the only option for referral into some trusts and calls for GPCE to:

(i) demand an obligation for all trusts to provide separate advice and separate direct referral options per specialty within ERS to replace existing Advice & Refer options so the referring clinician can choose whichever is most appropriate

(ii) negotiate a standard time frame across England within which advice responses should be received by the referring clinician should advice be sought

(iii) negotiate a standard structure and quality of response to be adhered to including consideration of whether the components of the advice can be fulfilled within contractual service provided by general practice.

11c HAMPSHIRE AND ISLE OF WIGHT: That conference is concerned about the potential increase in medico-legal risk and workload that will be placed on GPs by NHSE proposals for Advice & Refer and calls for GPCE to negotiate a pause in implementation until expert opinion can be sought regarding risk and workload implications can be better understood.

11d NORFOLK AND WAVENEY: That conference believes the inappropriate transfer of workload from secondary care to general practice is unsustainable and detrimental to patient care. Conference calls upon GPCE to work with NHS England and Integrated Care Boards (ICBs) to develop and implement a policy to financially charge secondary care providers for inappropriate workload transfers, including follow-up investigations, administrative tasks, and post-operative checks outside GP contractual obligations.

LUNCH 12.30

SALARIED GP CONTRACT 13.30

To submit a speaker slip for Motion 12 – please click here

* 12 AVON: That conference believes that core general practice funding in England will never be restored to the levels required for a thriving partnership, and we need to take steps to protect the salaried GP contract in England in preparation for a fully salaried service.

CLINICAL 13.50

To submit a speaker slip for Motion 13 – please click here

* 13 AGENDA COMMITTEE TO BE PROPOSED BY BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE: That conference believes that obesity is a national emergency but current service provision is woefully inadequate. Conference:

(i) calls for streamlined referral pathways that allow GPs to promptly recognise eligible and motivated patients without the need to go through a tick boxing exercise to justify a referral

(ii) calls for government to go further with public health measures to tackle the causes of obesity in the first place

(iii) is concerned that the lack of NHS services is resulting in patients obtaining anti-obesity medication via unregulated routes and potentially exposing themselves to clinical harm

(iv) demands that NHSE reaches agreement with the pharmaceutical industry to provide sufficient stock of GLP1 analogues.

13a BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference believes that obesity is a national emergency but current service provision is woefully inadequate. Conference calls upon NHS England to:

(i) urgently provide sufficient funding for the development of adequately resourced local weight management services that can offer holistic lifestyle, pharmacological and surgical interventions for weight control

(ii) develop streamlined referral pathways that allow GPs to promptly recognise eligible and motivated patients without the need to go through a tick boxing exercise to justify a referral

(iii) call on the government to go further with public health measures to tackle the causes of obesity in the first place

(iv) develop provision for patient self-referral pathways.

13b NEWHAM: That conference endorses an obesity management strategy to improve both the quality of life and long-term health outcomes in this patient population and:

(i) is concerned that the lack of NHS services is resulting in patients obtaining anti-obesity medication via unregulated routes and potentially exposing themselves to clinical harm
(ii) demands that NHSE reaches agreement with the pharmaceutical industry to provide sufficient stock of GLP1 analogues, to enable their use as part of this strategy
(iii) recommends that GPCE lobby both NICE and DHSC to align professional guidelines for obesity with the availability of NHS services.

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

To submit a speaker slip for Motion 14 – please click here

* 14 AGENDA COMMITTEE TO BE PROPOSED BY CLEVELAND: That conference:

(i) believes the unfunded additional work associated with the medical examiner process is placing an unacceptable burden on general practice
(ii) believes that previous funding from cremation forms should be reinvested into general practice to directly support the medical examiner process.
(iii) demands that funding be provided to support a weekend and bank holiday service within the new death certification system.

14a CLEVELAND: That conference recognises the increased challenges of supporting timely burial for faith groups within the new death certification system and demands that funding be provided to support a weekend and bank holiday service.

14b HULL AND EAST YORKSHIRE: That conference believes:

(i) the unfunded additional work associated with the medical examiner process is placing an unacceptable burden on general practice
(ii) that previous funding from cremation forms should be reinvested into general practice to directly support the medical examiner process.

14c BERKSHIRE: That conference calls on NHSE to urgently fund the administrative costs of GPs writing Medical Certificates of Cause of Death (MCCDs) and engaging with medical examiners' offices, both in hours and out of hours.

To submit a speaker slip for Motion 15 – please click here

* 15 LEEDS: That conference accepts the need for cost-effective prescribing policies and demands that:

(i) NHS England launches a national campaign to promote the expectation for patients to purchase medication available over the counter at pharmacies without seeking a prescription from the GP
(ii) the government establishes an effective method to identify and support low-income individuals and families who cannot afford to pay for over the counter medication
(iii) the government introduces a maximum profit margin cap for pharmaceutical companies that would prevent over-the-counter medicines being unnecessarily expensive
(iv) NHS England acknowledges the additional workload for practices to adhere to system financial saving and / or rationing strategies in relation to prescribing and that demands national funding is provided for such work.

15a DEVON: That conference is exasperated by the various underfunded and haphazard medicines optimisation schemes across the country and:

(i) asserts that repeated medicine switches for cost saving purposes only potentially saves money for ICB prescribing budgets but increases costs due to additional patient consultations in order to manage the fallout of switches
(ii) deplores the potential damage to doctor patient relationships that these repeated switches produce
(iii) demands that GPs should prescribe generically unless there is clinical reason to do otherwise and that any subsequent cost saving switches occur at the community pharmacy level
(iv) demands that all patient queries generated by community pharmacy switches are dealt with by community pharmacy.

15b KERNOW: That conference is concerned regarding medicines optimisation schemes which promote frequent cost saving medication switches and:

(i) asserts that GPs prescribe generically unless there is clear reason to prescribe a branded medicine
(ii) that potentially cost saving medicine substitutions occur in the dispensing pharmacy with any and all subsequent queries managed by the dispensing pharmacy
(iii) deplores the unaccounted costs of subsequent GP consultations in order to manage the consequences. These cost are both financial and in damage to doctor patient relationships.

PCSE DEDUCTIONS 14.20

To submit a speaker slip for Motion 16 – please click here

* 16 GATESHEAD AND SOUTH TYNESIDE: That conference notes PCSE's actions of deducting monies from practices unannounced, at seemingly inexplicable intervals and without justification or explanation, and:

(i) believes that such deductions, often for large sums of money, risk the financial destabilisation of practices
(ii) demands that the repayments of monies deducted wrongly by PCSE be repaid to practices within 10 working days
(iii) necessitates that all deductions by PCSE must be preceded by both warning and justification, in order to enable practices to challenge and / or prepare as needed
(iv) instructs GPCE to explore the possibility of legal action against PCSE for the time, stress and expense caused to practices through such deductions.

16a KENSINGTON, CHELSEA AND WESTMINSTER: That conference recognises the impact of poor administrative / clinical support services have on the GPs' ability to work effectively and calls on GPCE to work with national commissioners to:

(i) jointly agree clear relevant contractual standards when commissioning national services and products
(ii) ensure that end user feedback is used to demonstrate effective delivery of the contract deliverables and standards
(iii) reimburse practices for financial losses, distress, inconvenience or damage to practice reputation when standards are not met.

ONLINE CONSULTATIONS 14.40

To submit a speaker slip for Motion 17 – please click here

* 17 HULL AND EAST YORKSHIRE: That conference:
(i) believe the current capacity and access requirement for online access to be available throughout core hours is unachievable
(ii) calls upon GPCE to issue guidance around steps practices can take to mitigate the risk of unrestricted online access
(iii) supports practices in switching off online access when workload pressures exceed safe limits.

17a KERNOW: That conference believes 24 hour digital access to general practice a serious risk to the stability of practices and as such would decline any contract that enforces such, as evidenced by the challenges of Babylon Health.

CQC RATINGS 14.50

To submit a speaker slip for Motion 18 – please click here

* 18 MANCHESTER: That conference believes that the use of "single word judgements" for general practice services by CQC is damaging and unhelpful, and calls on GPCE to negotiate:
(i) removal of these ratings altogether
(ii) a change in inspection methodology to move from a judgemental approach to a supportive quality improvement process
(iii) additional support for practices to manage the workload in dealing with a CQC inspection.

18a KENT: That conference demands that the Department of Health and CQC learn from the recent events in education, following the tragic death of Head Teacher Ruth Perry and the response of Ofsted, and:
(i) apply the coroner recommendations to CQC inspections of general practice, particularly paying attention to the wellbeing of practice managers and GP partners
(ii) reconsider the use of one word ratings as outcomes for CQC inspections
(iii) abide by defined reasonable timeframe standards when issuing reports
(iv) ensure when reports are delayed the report and accompanying press release contains an additional statement to reflect the work the practice has done in the intervening time period.

18b LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes again that the CQC experiment has failed with no discernible consequential change in the quality of general practices, which the CQC often criticise for not achieving the uncontracted or unachievable within current funding restraints. That in view of the failed, expensive and extremely stressful CQC process demands:
(i) that it is accepted you cannot inspect quality into a system
(ii) that, similar with Ofsted, CQC immediately stops providing single term outcomes to inspections
(iii) that CQC is replaced by a regulatory framework based on monitoring, with on-site visits limited to practices where concerns are raised and are held jointly with the ICB (or its successor) and LMCs.

18c HAMPSHIRE AND ISLE OF WIGHT: That conference is concerned over potential bias towards hospital and secondary care in the appointment of Professor Sir Mike Richards to review CQC's assessment frameworks and calls for:
(i) a co-chair from general practice to help craft the future CQC
(ii) a cessation of all inspections whilst awaiting the outcome of the review
(iii) all current CQC resource to be laser focused on supporting current services recover rather than creating new ways to chastise them.

18d SOUTH STAFFORDSHIRE: That conference demands CQC inspections of GP practices are suspended until we can be sure it is fit for purpose and will not give reports that risk suicide of a CQC lead GP or manager.

18e BIRMINGHAM: That conference:
(i) applauds the changes made in the regulations of educational establishments and demands that for the future CQC avoid using pejorative one word gradings for GP practices
(ii) CQC must in future take into account needs and desires of local population in particular where local populations do not engage in national screening and vaccination programmes.

18f WEST SUSSEX: That conference expresses deep concern at the detrimental impact that CQC inspections have on general practice staff. It believes that the current inspection framework is in urgent need of reform and calls for the immediate abolition of the reductive and harmful single-word judgments. This conference mandates GPCE to campaign vigorously for these changes, to protect the wellbeing of general practice staff and ensure a fairer, more supportive regulatory process.

18g HULL AND EAST YORKSHIRE: That conference demands the immediate cessation of single-word inspection ratings by the Care Quality Commission.

18h SEFTON: That conference calls upon the CQC to follow the lead of Ofsted and drop the discredited practice of applying simple phrase investigation / assessment statements to general practice.

18i DERBYSHIRE: That conference notes that CQC have been rated as inadequate and therefore CQC has no right to be inspecting practices and:
(i) agrees that mass disengagement from CQC by general practices is the right thing to do
(ii) demands that GPCE issues guidance to protect any practice which refuses to engage with CQC.

18j LIVERPOOL: That conference notes OFSTED will no longer use one or two word ratings when reporting on schools. We call on the CQC to cease using one or two word ratings when reporting on GP practices, as well as other health and social care services.

BERKSHIRE: That conference notes the interim report of the review into the operational effectiveness of the Care Quality Commission, and the Health Secretary's response that the CQC 'is not fit for purpose', and calls for:
(i) a complete overhaul of the CQC's inspection and assessment system
(ii) GPCE to negotiate the reimbursement of legal fees incurred as part of a successful challenge of a CQC inspection report
(iii) GPCE to lobby for CQC standards to be aligned to current workforce and workload capacity
(iv) the CQC to put significant investment into recruiting inspectors with experience of working in general practice.

18k BUCKINGHAMSHIRE: That conference directs GPCE to advocate for the end of one word ratings for Care Quality Commission (CQC) inspections of GP practices. Conference urges the government to explore alternative methods of assessment that reflect the complexities and nuances of general practice performance, akin to the recent national announcement to move away from similar one word rating systems in education.

CAMERON FUND 15.10

SOAPBOX 15.20

CHOSEN MOTIONS / EMERGENCY BUSINESS 16.00

COMMUNITY PHARMACY 16.30

To submit a speaker slip for Motion 19 – please click here

* 19 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference recognises the necessity of community pharmacy and demands that:

(i) NHS England funds their core work of dispensing appropriately

(ii) their survival not be made contingent upon doing work traditionally and contractually the remit of general practice

(iii) Pharmacy First schemes follow guidelines on prescribing and ensure appropriate antibiotic stewardship

(iv) the wastefulness of paying a seventh of a practice's GMS fee per patient for a blood pressure check that then generates more work for the practice be terminated with immediate effect and the money put into pharmacy dispensing fees

(v) the increasing tendency of NHS England to pit general practice and community pharmacy against each other in zero-sum games for scant funding be ended.

19a DEVON: That conference asserts that the Pharmacy First scheme has been implemented with the aim of providing patients with more accessible healthcare services, particularly for minor ailments and conditions. While this initiative has the potential to improve patient convenience and reduce pressure on general practice, concerns have been raised regarding impact on workload and antibiotic stewardship within the general practice setting. Conference therefore asks for GPCE to:

(i) assess the workload that Pharmacy First shifts both away from, and back to general practice

(ii) press for clear assessment of Pharmacy First schemes to follow guidelines on prescribing and ensure appropriate antibiotic stewardship.

19b HULL AND EAST YORKSHIRE: That conference, regarding Pharmacy First:

(i) believes the requirement for patient referrals to come from general practice should be removed

(ii) believes delivery of this model must not come at the expense of core community pharmacy provision.

19c GATESHEAD AND SOUTH TYNESIDE: That conference recognises the necessity of community pharmacy and demands that:

(i) NHS England funds their core work of dispensing appropriately
(ii) their survival not be made contingent upon doing work traditionally and contractually the remit of general practice
(iii) noting six of the seven conditions for which pharmacists are paid to provide antibiotics can be 'diagnosed' without actually seeing and examining the patient under their contract, antibiotic-prescribing rights be removed from community pharmacy and the money put into pharmacy dispensing fees
(iv) the wastefulness of paying a seventh of a practice's GMS fee per patient for a blood pressure check that then generates more work for the practice be terminated with immediate effect and the money put into pharmacy dispensing fees
(v) the increasing tendency of NHS England to pit general practice and community pharmacy against each other in zero-sum games for scant funding be ended.

19d CAMBRIDGESHIRE: That conference is concerned that the NHS Pharmacy First scheme is failing to both 'save up to 10 million general practice team appointments a year' and help patients 'access quicker and more convenient care' as initially promised by NHS England. It asks that GPCE work with Community Pharmacy England to investigate the scheme's outcomes since its inception in January 2024, specifically looking at prescribing rates, antibiotic stewardship, clinical outcomes, dispensing waits, the proportion of patients immediately redirected to general practice and re-presentation to GP for the same issue (delay of care and failed care episodes).

19e OXFORDSHIRE: That conference notes that community pharmacies have received funding through the "Pharmacy First" scheme (which combines consultation for minor illness with the provision of treatments including prescription medicines), and recommends that this scheme is offered as soon as possible to community pharmacies and dispensing practices equally, as a "minor illness enhanced service", with the future possibility of opening it up to non dispensing practices if they can be allowed to supply the relevant medicines directly.

GP MODELS OF CARE 16.40

To submit a speaker slip for Motion 20 – please click here

* 20 AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference believes that Integrated Neighbourhood Teams are a laudable concept and:

(i) advises NHSE to keep general practice at the centre of these teams
(ii) recommends that community services including health visitors, midwives and district nurses are based around GP practices, rather than around another organisational structure
(iii) advises that community service managers recognise the value of this collaborative work and provide protected time for their staff to attend MDT meetings at GP practices, which will improve outcomes for vulnerable patients
(iv) calls for community nursing staff and associated resource to be moved into general practice in order to undertake the work required by general practice.

20a TOWER HAMLETS: That conference believes that Integrated Neighbourhood Teams are a laudable concept and:

(i) advises NHSE to keep general practice at the centre of these teams
(ii) recommends that community services including health visitors, midwives and district nurses are based around GP practices, rather than around another organisational structure
(iii) advises that community service managers recognise the value of this collaborative work and provide protected time for their staff to attend MDT meetings at GP practices, which will improve outcomes for vulnerable patients.

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20b GATESHEAD AND SOUTH TYNESIDE: That conference believes the separation of district nursing services from general practice to have been a gross error and calls for the reversal of this, with community nursing staff and associated resource moved into general practice in order to undertake the work required by general practice.

FINAL BUSINESS 16.50

CLOSE OF CONFERENCE 17.00

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.

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

The Conference of England LMC Representatives' Standing Orders can be accessed via this link and will take you to a separate document.

LMC ENGLAND CONFERENCE

November 2024

Update on resolutions from 2023 LMC ENGLAND Conference

Topic	Motion No.	Motion	Team	Update
Covid Vaccination Programme	4.	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.	C&I PG / Officer leads Samira and Julius Staff lead Nick Duckworth	IoS fees remain a live item in contract negotiations. The need for a sufficient uplift to the IoS payments across all vaccination programmes has been repeatedly raised with NHS England and DHSC, and is a key objective for 2025/26 negotiations.
ADHD	5.	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:	C&I PG / Officer lead Samira Staff leads Nick	This is being developed by the Clinical and Interface policy group to be taken forward in discussions with NHS England.

		(i) 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 (ii) 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 (iii) 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 (iv) 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.	Duckworth / Cat Ohman / Rob K	
Shared Care of Medications	6.	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.	Prescribing Policy Group / Officer Leads Samira and Julius Staff leads Greg Lewis and Cat / Healthcare Delivery	The GPCE Prescribing and Dispensing policy group has started work relating to this resolution and is in the process of drafting a 'Principles to shared care prescribing' with an aim of publishing this on the BMA website. Actual implementation of parts i-iii will depend on contract negotiations. With regard to iv) the policy group does not agree with sharing care with private providers.
GP to Patient Numbers	7.	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	ETW PG / Officer Lead Samira Staff leads Christopher Scott (RET Team) / Daniel Button	GPCE's vision for General Practice calls for a gold standard of 1 FTE (full-time equivalent) GP per 1,000 patients by 2040. The BMA called for increased resource for general practice in our Autumn budget submission and will be making further calls on the Secretary of State in our submission to the NHS 10 Year Plan consultation and forthcoming spending review.

		(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. (iv) protect practices from inappropriate adverse CQC criticism about perceived lack of ‘access’ caused by inadequate resourcing to meet demand.	(Healthcare Delivery Team) / Greg Lewis (ICD Team)	Discussions are ongoing about a piece of work demonstrating the value of general practice. There is a substantial piece of work underway to push for safe staffing guidelines, underpinned by legislation which would enshrine Government accountability for safe staffing levels across the health service.
Workload Capping	8.	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.	ICD / Healthcare delivery Greg Lewis / Nicholas Duckworth / Margot Kuylen / Tom Bramwell	GPCE has made it a key aim of negotiations on a new contract to secure the contractualization of safe working limits, set out in the BMA safe working guidance, and GP to patient ratios. As per the ongoing collective action, the recommended cap of 25 appointments per GP per day is contractually possible already (as per GPCE’s extensive legal advice). The 2025/26 contract negotiations also represent an opportunity for GPCE to make the case for parts ii-v to be incorporated as part of general practice reform and meeting the Government’s manifesto commitment to bring back the family doctor.
GP Contracts	9.	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	C&R PG / Officer Lead Julius	GPCE will make it an aim of the 25/26 negotiating round to end APMS as a contractual option for general practice with any new or re-tendered GP core contract offered as a GMS contract (when the successful applicant is able to hold such a contract)

		(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.	Staff leads Greg Lewis / Nick Duckworth	
RAAC	10.	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.	Premises PG / Officer Lead David Staff lead Matina Loizou	GPCE continues to call/lobby for support for GP practices to eradicate RAAC, including a funded programme at ICB-level. The BMA also continues to call for an NHS-wide assessment of the quality of NHS estates, including the presence of RAAC. The recently announced dedicated capital fund to deliver around 200 upgrades to GP surgeries across England must be the first step.
GP Performer List Suspensions	11.	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	C&R PG / Officer lead Julius Staff leads Daniel McAlonan / Greg Lewis	GPCE will make it a key aim of the 25/26 negotiating round that suspended GPs should be entitled to 100% of normal earnings, not 90% as per the current regulation and all GPs entitled to receive suspension payment, including partners who have been expelled from their partnership due to the suspension.
ARRS Supervision	12.	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	ETW PG / Officer lead Samira Staff leads Nick Duckworth /	Discussions on the future of ARRS, including supervision requirements under the scheme, will form part of contract negotiations for 2025/26.

		(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.	Christopher Scott	
Themed Debate: Interface Solutions	13.	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 and the Dispensing Doctors Association, to negotiate with NHS England the rapid implementation of electronic prescribing for secondary care, including the ability to connect with community pharmacy.	C&I PG / Officer leads Samira and Julius Staff leads Cat Ohman / Nick Duckworth / Tom Bramwell	GPCE - and the BMA more widely – continue to closely monitor the interface between NHS general practice and private healthcare services. This issue has become increasingly prominent with the extent of NHS waiting lists for elective care, as well as particularly long waits for treatments and diagnoses in specific areas of care. GPCE has published guidance on this issue, available on the BMA website.
GP Retention	14.	That conference is disheartened to note that recruitment and retention of general practice is at its lowest level currently, believes the NHS England Long	ETW PG / Officer lead Samira Staff leads Chris Scott / Daniel Button	Discussions about the future of the GP retention were brought within the GP contract negotiations in recent years, but we have so far been unable to secure any of the improvements called for. Ring-fencing of GP retention scheme funding would make a considerable difference to equity of access to the scheme, but it remains a post code lottery with the risk of access being reduced as ICB funding is squeezed.

		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 Motion 1	15.	That conference believes that the current system for management of NHS pensions delivered by PCSE is not fit for purpose and calls for urgent radical reform and re-procurement of the provider in line with motions passed in previous years.	Pensions Committee / Officer lead David Hannah Sullivan / Michael Reid	In July 2024 the BMA's Pensions Committee launched a campaign encouraging GPs in England to take action to make sure their pension records are in order. This included a step by step guide and template letters on how to request information from NHS Pensions, check for missing years of data, and if this is information members have previously provided, advice on how to raise a complaint with Capita who deliver the PCSE function, plus take further action such as escalating to the regulator. This is an ongoing campaign. Guidance for GPs in England on getting your pension record up to date The Pensions Committee Deputy leading on GP matters and BMA staff continue to meet with Capita, NHS England and NHS BSA once every 2 months and continue to put pressure on them to fix the issues with missing years of data.

Chosen Motion 2	16.	That conference applauds the aspiration for clinical excellence across the NHS but believes: (i) that NICE guidance is often out of touch with the reality of working in general practice (ii) in the current climate practitioners should be judged against 'good enough' rather than unrealistic 'gold standards' (iii) that the GMC and NHS Performance teams should not be judging practitioner performance against NICE guidelines (iv) that GPC England should lobby for professional and clinical standards to be aligned to current workforce and workload capacity.	ETW & C&I PGs / Officer lead Samira Staff leads Christopher Scott / Nick Duckworth / Daniel McAlonan	Improving NICE's approach to guidance and increasing their consideration of its impact upon general practice, is a key part of the workplan for GPC England's 'Clinical and Interface' policy group for the current session.
Digital / IT	17.	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.	DID PG / Officer lead David Staff lead David Parkin	GPCE has continued to press the DHSC for improvements to all aspects of IT provision within primary care. With a new SoS and a new roadmap for the NHS, we are maintaining pressure both in routine engagement with the Department and in contract negotiations.
Separation Planned / Unplanned Care	18.	That conference believes that the current workload for general practice is unsustainable, and 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.	Officer lead KBS Staff lead Alex Ottley	GPCE has made negotiating a new contract one of its key commitments to secure from Government, DHSC and NHSE in the 2025/26 contract deal. The negotiating parties have been informed of this. The committee is also pushing to begin those negotiations on a new contract as early in 2025 as possible. As with the nGMS 2004 contract, this could take up to anything from 18 months to two years to conclude. The profession will need to remain organised to maintain leverage throughout negotiations. LMCs have a major role to play in this. In parallel, GPCE will seek to get this commitment included in the forthcoming NHS 10-Year Plan and

				an agreement between the negotiating parties on a 2025 Family Doctor Charter.
Appraisal	19.	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.	ETW & C&R PGs / Officer lead Julius Staff leads Chris Scott / Daniel McAlonan / Greg Lewis	A proposal around this was put forward to DHSC / NHSE in the 2024/25 contract negotiations. However, it was rejected by the then Government. It will be carried over and included in the objectives for the 2025/26 negotiations.
Re-Affirming Contract Policy	20.	That conference calls on GPC England to: (i) include in its negotiations with NHSE / DHSC that existing conference policy of an activity-based contract is part of the new contract (ii) include in its negotiations with NHSE / DHSC that existing conference policy of PCN into core is part of the new contract (iii) include in its negotiations with NHSE / 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.	C&R PG / Officer lead KBS Staff leads Alex Ottley / Nick Duckworth / Greg Lewis	GPCE will make it a key aim of the 25/26 negotiating round that all PCN funding should be moved into 'core' GMS. GPCE will also argue for the removal/reduction of the restriction placed upon practices to allow provision of private services to patients outside of their registered list and/or not provided on the NHS.

Sensitivity: Internal use