

LMC UK Conference 23-24 May 2024: Updates on 2023 Resolutions

Motion No.	Topic	Motion	Update
4	Survival of general practice	<p>Motion by CAMBRIDGESHIRE: That conference requests that the BMA supports GPC UK by undertaking a series of FOI requests to:</p> <p>(i) determine the number of practices which have been dispersed; merged; novated; or reprocured via APMS across the UK</p> <p>(ii) determine the total cost of NHS-funded management consultancies across the UK since the contracts were devolved to single nations</p> <p>(iii) extrapolate how many patients are now ‘without’ a GP assuming recommended ratio of 1 whole-time equivalence to registered list size</p> <p>(iv) then publicise the real crisis around a depletion of patient choice, and fractured continuity of care by the destruction of general practice.</p>	<p>(i) - The BMA submitted the first FOI request to NHS England on 24/1/2024 and the responses were shared with GPCE officers in February 2024. APMS not applicable in devolved nations.</p> <p>(ii) - The BMA has already gathered the total cost of NHS-funded management consultancies across England only. DN are not aware of any management consultancies engaged in this context. The figures were obtained from NHSE’s Annual Reports which are publicly available. The total cost of consultancy services for the devolved nations would differ due to their own health systems and budgets.</p> <p>(iii) – It is not possible to conclude exactly how many patients are ‘without’ a GP, however we can infer the number of people registered with GP practices in England and provide the GP to patient ratio from the statistics published by NHS England. The latest statistics (as of February 2024) show that there was another record-high of 63.20 million patients registered with practices in England – an average of 10,018 patients registered per practice. As a result, a full-time equivalent GP is responsible for an average of 2,298 patients. The BMA’s data hub contains more information and data on general practice, GPs and registered patients for each nation.</p> <p>(iv) – No FOI request has been submitted. The BMA’s report on ‘Exploring innovation in general practice’ published in November 2023 informed on the decline of ‘continuity of care’ in English general practice. The report explored different methods of measuring and improving continuity of care which could be adopted by general practice. Existing work is ongoing on highlighting state of general practice in respective nations.</p>
5	GMC / IA	<p>Motion by GATESHEAD AND SOUTH TYNESIDE: That conference thanks the GMC for confirming they will not act against junior doctors taking industrial action and demands that the same pledge be extended to GPs, should they also invoke their legal right to take industrial / coordinated action.</p>	<p>The GMC’s position on Industrial Action is clear, in that it will only become involved if breaches to Good Medical Practice occur. Its stance is set out in a set of FAQs on its website. Therefore, the resolution isn’t technically accurate in that the GMC could still act if it felt GMP was being contravened. The GMC’s stance will automatically cover GPs if industrial or coordinated action takes place.</p>
6	Cost of living crisis	<p>Motion by NORTHERN IRELAND CONFERENCE OF LMCS: That conference notes with dismay the destabilising effect of rapidly increasing expenses and energy costs which are being absorbed by GP practices and instructs GPC UK to negotiate an urgent package of support measures for all practices.</p>	<p><u>England</u>: GPCE closed its now annual practice finance survey for practice managers to complete in January 2024 and the results were shared with DHSC/NHSE during the contract consultation period. Around 10% of practices responded:</p> <ul style="list-style-type: none"> • Two thirds reported that they are concerned about their short and long-term financial stability • More than half had experienced cashflow issues in the last 12 months • Almost three in four practices reported being “very/extremely worried about the impact of inflation on practice finances”, eg due to considerable rises in practice running and salaried staff costs. • 23% – the average reported decrease in contractor/partner income for 2022/23, ie dropping by almost one quarter compared with the previous financial year. <p>Unfortunately, this reasonable sample and evidence base from over 600 practices around England was ignored. Practice contract baseline funding (Global Sum) – including contractor GPs, salaried GPs, other employed staff and other practice expenses – eroded by 8.7% across the 2019-24 contract. CPI inflation, which that contract was based upon, was +21.2% between April 2019 – April 2023. However, investment only grew by 12.5% in the same period. This amounted to erosion of c£800m, but, as of 1st April 2024, an additional 1.9% (£179m) has been added to in Global Sum. That means it’s currently over £600m short. That’s without factoring in GP (-11.5% for contractors and -33% for salaried GPs) and practice-employed staff average pay erosion since 2008/9, or determining exactly how much investment good, value for money general practice actually requires. Government says it will honour the 2024/25 DDRB pay uplift award, but, even though contractors will be included for the first time since 2018/19, and DDRB will <i>consider</i> rising practice costs/expenses for the first time since 2014/15, it doesn’t seem like a significant number of practices can wait. There is little faith it will be sufficient anyway, so plans are being set in train to prepare for profession-wide industrial action.</p> <p><u>Wales</u>: GPC Wales undertook a survey of practices in April 2023 and asked questions about energy costs and other expenses. Practices reported a median increase in gas prices of 9.7% between Q3 2021 and Q3 2022, and a</p>

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7	Collapse of the NHS	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY FORTH VALLEY: That conference acknowledges patients are increasingly seeking healthcare privately, including travelling abroad for surgery. We call on the GPCs to work with appropriate authorities and stakeholders to:</p> <p>(i) ensure patients are not required to seek approval from their NHS GP prior to accessing private healthcare</p> <p>(ii) obligate private providers to inform patients of the total cost of recommended investigations, treatments and follow-up, highlighting these may not be provided by their NHS GP</p> <p>(iii) obligate private providers to act upon investigations undertaken, and not simply pass results or further management suggestions onto NHS GPs to action</p> <p>(iv) ensure that those who cannot access required follow up are not left without adequate specialist care</p> <p>(v) ensure any involvement in a patient's care by an NHS GP as requested by a private healthcare or insurance provider is remunerated appropriately.</p>	<p><u>Scotland</u>: We have written to Scottish Government regarding the interface between the private sector and general practice (as well as overseas treatment) and have agreed to work together on producing case studies for what should happen as a basis on which to define and limit the extent of general practice involvement.</p> <p><u>Northern Ireland</u> – This matter has been discussed at length with DOH/SPPG in particular in relation to people going overseas for treatment.</p> <p><u>Wales</u>: GPCW have called for national action on this via GP Forum. This led to the development and issue of a Welsh Health Circular focusing on private obesity surgery and subsequent NHS care responsibilities (WHC/2024/005). This will require implementation nationally and locally and we will continue to monitor this developing issue. We continue to push for further guidance.</p> <p><u>England</u>: GPCE has issued guidance on responding to private healthcare. Patients have a right to NHS services even if they have been consulted / diagnosed / treated privately for the same condition. GPCE has also repeatedly raised the specific issue of patients seeking bariatric surgery abroad and being left without essential follow up care, which according to NICE should last two years minimum. Although the NHS has a public checklist for NHSE does not appear to have any satisfactory solution in place and is unwilling to take responsibility for ensuring the care these patients subsequently sometimes need is resourced.</p> <p>The BMA Private Practice and Professional Fees committees work in collaboration with GPCE on the matters highlighted in this resolution.</p>
8	GP working schedules	<p>Motion by CONFERENCE OF ENGLAND LMCS: 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 contract or new GMS contracts 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>The Sessional GPs Committee found in its 2022 survey that salaried GPs are completing approximately 25% above their contracted hours each week. Unmanageable workload is a key concern for our members and using sessions can contribute to a lack of understanding about how many actual hours most GPs are working in order to deliver their roles and provide safe patient care.</p> <p>Last year, the Sessional GPs Committee released its workload control guidance for salaried GPs in England, Scotland and Wales. The guidance provides advice on how to approach your employer to request to be paid for all hours worked, as well as encouraging the use of the BMA's Dr Diary app to monitor your working hours in hours.</p>
9	UK Salaried Model Contract	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY GP TRAINEES COMMITTEE: That conference believes that the model contract for salaried GPs must be strengthened, with improved advised rates of pay, and calls on GPC UK and the Sessional GP Committee to:</p> <p>(i) rapidly arrange mechanisms to renegotiate the model contract, with ongoing review reinstated</p>	<p>The Sessional GPs Committee have considered the model contract in its entirety and decided that to reopen negotiations risks losing the benefits which it holds. It was therefore agreed that, should minor amends be required, these are achieved internally to prevent the advantageous terms and conditions being watered down.</p>

			<p>The committee have proposed an amendment to the model contract to bring the maternity leave and pay for salaried GPs in line with hospital doctors, but due to inadequate SFE uplifts this has not been agreed.</p> <p>The committee have also started its campaign for full pay restoration for salaried GPs and promotion of the model contract, two workstream which aim to improve pay and conditions for salaried GPs across the UK.</p>
10	The Role of the Expert Generalist	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY GRAMPIAN: That conference recognises that GPs have a key role in primary care with providing continuity, dealing with complex physical and psychosocial presentations whilst leading the MDT team and:</p> <p>(i) agrees that GPs are expert medical generalists whose training allows them to deal with complexities in patient presentations that no other members of the primary care team can</p> <p>(ii) recognises the importance of RCGP exam and CCT to ensure GPs have been trained to a high standard to enable them to deal with the complexities involved in being a GP in 2023</p> <p>(iii) demands the GMC immediately merge the specialist register with the GP register and recognise the profession as specialists in primary care.</p> <p>(iv) calls on UK government to appreciate this key role GPs play by rebranding GPs as consultants in family medicine.</p>	<p>(i) resolution does not request action</p> <p>(ii) resolution does not request action</p> <p>(iii) The GMC is not legally empowered to merge the GP and Specialist register. This move requires legislation and therefore falls to the government/DHSC to bring forward. DHSC plans to abolish both the GP and specialist register and replace these with annotations to the main GMC register – annotations which will describe specialist status. These plans are expected to be included in wider amendments to medical regulation due in 2025/26. The BMA will be engaging with the range of consultations that will bring about these reforms.</p> <p>(iv) GPs are currently entitled to brand themselves as consultants in general practice / family medicine / primary care. The RCGP recently published that it is redefining the role of a GP as a 'doctor who is a consultant in general practice'</p>
11	Primary Care	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY LIVERPOOL: That conference believes that the terms primary care and general practice are neither synonymous nor interchangeable and believes that:</p> <p>(i) general practice is part of primary care</p> <p>(ii) primary care funding is being used to obfuscate a lack of funding in general practice</p> <p>(iii) appropriate recognition be given to the specialism of general practice in all arenas.</p>	<p><u>Wales:</u> GPCW agrees and the Save Our Surgeries campaign calls for resource restoration directly into general practice rather than into adjacent primary care initiatives such as urgent primary care centres (UPCC) or NHS 111 services.</p> <p><u>England:</u> In its most recent annual accounts (published 01/2024, for 22/23) NHSE did not have an overall spend for primary care, in fact it abandoned any 'easy to read' breakdowns of overall departmental spend but did give detailed expenditure listings including 'G/PMS, APMS and PCTMS', separate from dental services</p>
12	Primary Care Doctors	<p>Motion by NORFOLK AND WAVENEY: That conference asks GPC to reject the GMC's proposed changes to the Performers' List to enable non-CCT holders to work within general practice as primary care doctors.</p>	<p>A BMA position on this issue was published in June 2023, produced by GPC UK and SASC UK. The statement rejects the proposed changes and this was reflected in our submission to the NHSE consultation (the PL is managed by NHSE not the GMC) on changing the regulations. NHSE agreed more work was needed to consider the implications before a change to the PL regs could be introduced, and they set up a stakeholder working group to look into this. Unfortunately, this group has only met once so far despite repeated requests from the BMA to reignite the workstream, and we anticipate that the proposal to change the regulations will be on the agenda for NHSE this year.</p>
16	GP Recruitment and Retention	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY WIGAN: That conference believes that more strident efforts should be taken to induce medical students and newly qualified doctors to choose general practice as their medical career path, and calls upon governments to provide financial incentives:</p> <p>(i) that provide an MOD-style sponsorship for GP VTS</p> <p>(ii) that include a medical student debt cancellation scheme</p> <p>(iii) with eligibility based on a prescribed number of years' service as a salaried or principal GP.</p>	<p>Competition ratios for GP training have been increasing year-on-year, from 1.28:1 in 2016 up to 2.67:1 in 2023, with increases every year in that period and a huge jump from 2.07:1 in 2022, it is increasingly difficult to make the case that incentives are required in this area.</p>
17	GP Recruitment and Retention	<p>Motion by WAKEFIELD: That conference is aware that in some areas 86% of GP trainees are NHS naïve at the point of entry to training. These require much more assistance than those with NHS knowledge. A fully funded NHS induction course is needed for this group of trainees as is extra reimbursement, to recognise the extra workload for their trainers.</p>	<p>Disappointingly, NHSE have this year withdrawn the general practice fellowship programme for new GPs which provided support with PCN portfolio working and learning and development, meaning that the induction offer for new GPs has taken a backward step this year. At a national level, the GPC is pushing for the reinstatement of the scheme and the GP registrars committee has written to ICBs to encourage them to continue offering it locally.</p> <p>While the trainers' grant was uplifted by 6% last year, the sum on offer remains inadequate to ensure that practices are able and willing to take on the additional workload that comes with providing GP training, and we continue to make the case that this needs to increase if the supply of GPs is to be maintained.</p>
18	MRCGP	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY NORTH WALES: That conference, in respect of the MRCGP examination:</p>	<p>(i) We have not received any reports this session of GP registrars having to extend training due to lack of availability of exam sittings, so active lobbying has been withheld for now.</p>

		<p>(i) asks GPC UK and its component committees to lobby and work with RCGP and other stakeholders to ensure no GP trainee is forced to extend their training due to lack of availability of examination sittings</p> <p>(iv) notes the significant financial impact MRCGP examination and mandatory RCGP membership fees have on GP trainees and calls upon GPC UK and its component committees to lobby governments and education bodies to fund the first attempt at MRCGP examinations.</p>	<p>(iv) We have written to the RCGP to seek their support in lobbying for comprehensive national funding all aspects of GP training, and we will consider next steps based on their response.</p>
19	GP Trainees Conference	<p>Motion by GP TRAINEES COMMITTEE: That conference notes the significant value GP trainees derive from attending LMC conferences across the UK. We call on:</p> <p>(i) GP trainees committee to organise an annual UK GP trainees conference</p>	<p>GPRC discussed taking this resolution forward at its meeting in December. The committee overwhelmingly voted to not take it forward for several reasons.</p> <p>The committee has identified numerous priorities for the current session that demand attention. Given the committee's limited resources, they felt that dedicating the necessary time and resources to organising a conference would compromise their ability to address other pressing matters effectively. They also felt that the financial implications of organising an additional conference cannot be overlooked given the BMA's finances.</p> <p>Considering these, the GPRC made the decision to prioritise other activities over pursuing this resolution further.</p>
20	GPCUK	<p>Motion by LIVERPOOL: That conference, with respect to GPC UK:</p> <p>(i) expects the committee to represent the interests of all GPC committees and focus on addressing pan-UK issues affecting all components GPC committees, including sessional and GP trainee committees</p> <p>(ii) demands clarity on the composition of GPC UK</p> <p>(iii) expects any changes to the composition of GPC UK to allow it to function as intended, focusing on pan-UK issues, without any one component committee dominating the membership of the committee.</p>	<p>A briefing paper will be circulated to all members of conference regarding the progress that has been made this session in reforming the membership and purpose of GPCUK. It is believed that the proposed changes, as outlined in the briefing paper, fully align with the expectations outlined in this resolution.</p> <p>The proposed reforms have been agreed by GPCUK but are subject to approval by BMA Council and the BMA's Annual Representative Meeting before they can be implemented.</p>
22	Professional Standards	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY LOTHIAN: That conference recognises the incredible strain that GPs and other doctors across the UK are working under, and:</p> <p>(i) calls on regulators to be cognisant of these pressures when investigating and responding to complaints related to stresses upon the system</p> <p>(ii) applauds the move to a light touch, supportive, wellbeing focused appraisal process adopted in Scotland during the pandemic and supports the maintenance of this approach to appraisal going forward in all four nations</p> <p>(iii) rejects any assertion that GPs must use commercial packages for the presentation of appraisal evidence, insists that appraisal evidence can always be presented without cost to the appraisee, and instructs GPC UK to negotiate to this end.</p>	<p>(i) The BMA has called upon both the GMC and the CQC in England to be cognisant of the significant pressure doctors are under. The GMC's decision-making guidance does include consideration of systems pressure and other factors that may have affected a doctor's ability to meet Good medical practice.</p> <p>(ii) The AoMRC medical appraisal approach does embed the light touch supportive approach to appraisal across the UK and has been adopted by NHS England and others.</p> <p>(iii) GPC England has taken up this issue with NHS England and DHSC during contract negotiations, calling for costs to be covered by NHS England. While unsuccessful for 2024/25 it will continue to pursue this aim.</p> <p><u>Wales:</u> It is our understanding that appraisal in Wales as operated by HEIW is similar to the Scottish example. Regarding iii), the appraisal system MARS is provided centrally at no cost to GPs.</p>
23	Public Health	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY TOWER HAMLETS: That conference notes how the effects of the Strep A campaign in December 2022 caused widespread panic and unprecedented demand that could not be met by a system under pressure and:</p> <p>(i) calls on governments and public health bodies to take into consideration the wider system effects of sending public health messages around single diseases</p> <p>(ii) calls on governments and public health bodies to perform a comprehensive significant event analysis of the effects of national communications surrounding the Group A Streptococcal outbreak in December 2022</p> <p>(iii) believes that GPs are not responsible for the management of communicable disease outbreaks as this is the role of public health</p> <p>(iv) believes that general practice is not responsible for the management of asymptomatic communicable disease contacts, as it is the role of public health protection teams to arrange chemoprophylaxis</p> <p>(v) calls on the relevant national agencies to ensure mechanisms are put in place to commission the prescribing of any necessary and timely treatments.</p>	<p><u>Northern Ireland</u> – NIGPC met with the Director of Public Health, PHA and representatives from SPPG/DOH on 7.12.22 regarding the communication sent to all practices and pharmacies. A meeting was also held with PHA and Belfast Trust regarding the situation re Strep A and the way forward.</p> <p><u>Wales:</u> Regarding (i) – (ii), GPC Wales participated in a lessons learned exercise alongside Public Health Wales following the Strep A/iGAS outbreak in Wales, when GPCW raised concerns about the impact of the PHW communications upon hard stretched GP practices.</p> <p><u>Scotland:</u> The impact on GP workload was raised with Scottish Government during the Strep outbreak in 2022 and the need for consideration of general practice capacity has been repeatedly emphasised during previous public health campaigns.</p> <p><u>England:</u> We raised the issue of (antibiotics) supply with the Department of Health and Social Care and called for effective public health messaging on Strep A to ensure that it was clear where to go for help and to reassure the vast majority of people that they will not go on to become seriously unwell. Following this, NHS England and the UK Health Security Agency published joint interim guidance for clinicians.</p>

25	Future formats for conference	<p>Motion by HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the current format of the UK conference of LMCs is no longer as relevant compared to nation specific conferences due to the divergence of contracts across the four UK nations (and the consequent limited number of UK issues for debate). Conference therefore requests a wholesale review of the current format of the UK Conference of LMCs, and such a review to report back in advance of the 2024 UK conference of LMCs and to include reflections on:</p> <ul style="list-style-type: none"> (i) relevance to all four UK nations and subject matter for debate (ii) timing and length of conference (iii) cost of conference including costs for individual LMCs (iv) method of attendance including virtual and hybrid options (v) recommendations for future formats. 	<p>Please see the briefing paper that has been produced by the LMC UK Conference Agenda Committee to aid representatives in their considerations during the major issue debate on conference reforms scheduled for 10.20am to 11.30am on Friday, 24 May at conference.</p>
26	The Independent Contractor	<p>Motion by WARWICKSHIRE: That conference supports protection of the independent contractor model of GP partnership and believes that:</p> <ul style="list-style-type: none"> (i) the GP partnership model is deliberately portrayed as inefficient and unsustainable in order to facilitate abolishment of the partnership model and a transition to a salaried service (ii) the current model has the ability to thrive, if provided with adequate primary care funding alongside greater GP involvement and autonomy in key decision making. 	<p><u>Northern Ireland</u> – At the NILMC conference 2023 there was an open debate on <i>Future models for sustainable, safe, simplified Northern Ireland General Practice</i>.</p> <p>Most delegates still believe in the partnership model including newly qualified GPs who attended.</p> <p>In response to the crisis facing general practice, in late 2023 BMA NI published two documents; Our Plan to Save General Practice, sets out some of the key challenges and Safe Working for GPs aims to enable GPs to define and manage their workloads to a safe level. Our Plan to Save General Practice includes a section on ‘incentivising partnership’</p> <ul style="list-style-type: none"> • Our plan to save general practice • Safe working for GPs in Northern Ireland <p><u>Wales</u>: We agree and our Save Our Surgeries campaign calls for resource restoration into GMS via a higher % of NHS WALES spend in general practice. An increase in practice funding would in the short term, secure the future for general practice from its current precipitous state, and in the medium term, allow GMS to enhance its natural role in prevention and to improve citizen well-being, in line with the aspirations of A Healthier Wales. Our analysis of FOI requests made to Health Boards about contract handbacks and managed practices between 2018/19 - 2022/23 suggests that a directly managed service would offer worse value for money than the partnership model, costing 33% more per patient than the global sum allocation.</p> <p><u>England</u>: We continue to make the case for the IC model of general practice. We regularly highlight on social and traditional media, key performance indicators including figures on loss of GP surgeries and FTE GP numbers to demonstrate the increase in patients per GP. We have also obtained key stats from a series of FOIs to NHS England and ICBs which we will use to demonstrate the effectiveness of the IC model.</p> <p>We published Exploring Innovation in General Practice which highlights 8 GP practices across England who have innovated despite contractual, financial, and capacity constraints. The case studies demonstrate the potential for the independent contractor model to thrive with the right resourcing and flexibility.</p>
27	Firearms	<p>Motion by BERKSHIRE: That conference notes the tragic loss of life in Plymouth in August 2021 and the subsequent renewed media attention on firearms licensing. Conference:</p> <ul style="list-style-type: none"> (i) believes that assessment of eligibility to possess firearms is a matter for police forces, not GPs (ii) believes that the role of GPs in the licensing process is to provide medical facts, not provide an opinion on eligibility (iii) demands that BMA work with representatives of police forces and government to agree processes whereby relevant factual information can pass from the GP data controller to the police directly, reducing the possibility of an applicant tampering with the information provided (iv) demands that the work involved in delivering firearms licensing be properly resourced, for example through a fee paid by the applicant 	<p>The issue of firearms at the BMA stretches over many committees and is led by the Professional Fees Committee (PFC), as this is non-NHS work. Working with the PFC, GPC UK have been extremely influential in making the UK safer by suggesting policies and practices that limit access to firearms for those deemed unfit or unauthorised to hold a firearms licence.</p> <p>The BMA have multiple, written assurances that the responsibility for deciding who may hold a firearms licence relies solely on the local constabulary. Through an agreement with the Home Office, NPCC, and the BMA, the applicant’s GP will be asked to provide factual medical information which will provide the constabulary with information critical to decide a request for a firearms application.</p> <p>The BMA, RCGP, Home Office, and NHS Digital regularly meet to revise the current system, and work towards improving the current system and related IT infrastructure. The Home Office has issued guidance on the medical arrangements here: https://assets.publishing.service.gov.uk/media/63e284a78fa8f50e89351509/Revised_Firearms_Licensing_Statutory_Guidance_Feb_2023.pdf</p>

			<p>The medical information can either be sent direct from the GP to the police or via the applicant. If the police have any concerns about the information having been tampered with they can contact the GP to check. If a third party doctor is providing the medical information, then the medical information must be sent direct from the practice to the third party doctor, and not via the applicant.</p> <p>The issue of fees continue to be an issue of contention amongst parties, including with BMA membership. Doctors are free to set their own fee for the firearms licence as this work is non-GMS. At this point, we believe the fee structure is for the GP and/or practice to resolve.</p> <p>The position of the BMA has been, and remains, that patient and public safety is paramount when it comes to firearms. This is closely followed by the fair treatment and remuneration of doctors.</p> <p><u>Northern Ireland</u> – The legislation in NI regarding Firearms differs from the rest of the UK. In January 2022 RCGPNI and NIGPC held a roundtable with representatives from the Department of Justice and the Police Service of NI to discuss GP involvement in the firearms certification process.</p>
28	Private Practice	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY BUCKINGHAMSHIRE: That conference notes that unlike dentists and pharmacists, GPs cannot currently offer many private services to their NHS patients, and believes that:</p> <p>(i) GP surgeries should at their discretion be allowed to offer their NHS patients paid-for services if these services are not routinely offered by the NHS</p> <p>(ii) GP surgeries should at their discretion be allowed to offer their NHS patients paid-for services if these services are routinely offered by the NHS but are not accessible in a time frame that the patient deems reasonable</p> <p>(iii) GPs can be trusted to manage potential conflicts of interests arising from offering paid-for services to their NHS patients</p>	<p><u>Northern Ireland</u> – this issue has arisen in current GMS contract negotiations with DoH/SPPG.</p> <p><u>Wales</u>: In line with resolution 1 from the Welsh LMC Conference 2023, the WLMC Conference Agenda committee chose this for debate at the 2024 Welsh conference. Part (i), (iii) and (iv) passed and will be taken forward by GPCW in coming year. (ii) was lost.</p> <p><u>England</u>: Fulfilling this motion if passed would require a change to the current national GMS contract and regulations through negotiation and agreement with Government / NHS England. Presently, private services cannot be provided to registered NHS patient lists, nor can they be provided to patients in core GMS contract hours in a building used to deliver NHS GP services to NHS registered patients.</p>
29	Pay Restoration	<p>Motion by AGENDA COMMITTEE TO BE PROPOSED BY BERKSHIRE: That conference applauds the organisation and courage of the Junior Doctors' Committee and:</p> <p>(i) fully supports junior doctors in England in their strike action and drive for pay restoration</p> <p>(ii) demands a similar approach to be taken by GPs for full pay restoration for general practice</p> <p>(iii) believes GPs must consider industrial action to achieve full pay restoration for general practice.</p>	<p><u>Wales</u>: (i) Welsh Junior doctors, including GP registrars, undertook a series of strikes in early 2024 with the full support of GPC Wales. (ii) As set out in the Save our Surgeries campaign by GPC Wales, the committee's priority is for resource restoration into general practice through the increase of the proportion of NHS Wales budget spent directly into GMS to the historic level of 8.7% within three years. (iii) The GPCW 2024 workload, workforce and wellbeing survey, launched in Mar 2024, takes forward the will of the Welsh Conference of LMCs for the committee to consider industrial action in that it contains questions as to the appetite of members to undertake IA to varying degrees.</p> <p><u>Northern Ireland</u> – BMANI asks communicated to the Health Minister at the beginning of February are for an above inflation pay uplift and a commitment to work towards full pay restoration. Junior doctors in NI took strike action on 6 March 2024 with the full support of NIGPC. NIGPC discussed the implications of industrial action at the committee meeting on 31.1.24. BMA Legal were in attendance to advise.</p> <p><u>Scotland</u> – SLMC conference passed a resolution instructing SGPC to bring forward a range of options for industrial/collective action in the event that Scottish Government does not engage meaningfully on reversing the underfunding of general practice.</p> <p><u>Sessional GPs Committee</u> – the sessional GPs Committee called for full pay restoration for all salaried GPs across the UK in this year's DDRB evidence. The committee is considering different avenues for achieving this.</p>