

Conference of Representatives of Local Medical Committees

Agenda

23 and 24 May 2024

Celtic Manor, Newport, Wales

A full-page background image showing a person walking away from the viewer on a sandy beach. The sun is low on the horizon, creating a long, shimmering path of light on the water and sand. Several birds are flying in the sky to the right.

**YMA O HYD
'STILL HERE'**

Conference of Representatives of Local Medical Committees

Agenda

To be held on

Thursday 23 May 2024 at 11.00 and Friday 24 May 2024 at 09.00

To take place at [The Celtic Manor Resort, Newport, Cardiff NP18 1HQ](#)

Chair Matthew Mayer (Buckinghamshire)

Deputy Chair Alastair Taylor (Glasgow)

Conference Agenda Committee

Matthew Mayer (Chair of Conference)

Alastair Taylor (Deputy Chair of Conference)

Andrew Buist (Co-Chair of GPC UK)

Tanya Beer (Somerset)

Ursula Brennan (Eastern, Northern Ireland)

Paul Evans (Gateshead and South Tyneside)

Robert Hodges (Gloucestershire)

Rachel McMahon (Cleveland)

Thilla Rajasekar (Kent)

Euan Strachan-Orr (Liverpool)

Members of the UK LMC Conference Agenda Committee 2024

Dr. Matt Mayer



Chair of the Agenda Committee

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

Dr. Alastair Taylor



Deputy Chair of the Agenda Committee

Alastair Taylor is the deputy chair of the Annual Conference of Representatives of LMCs. He works 5 clinical sessions as a GP Partner in Scotland. His representative roles include: Treasurer of Glasgow Local Medical Committee, Chair of Scottish LMC Conference as well as being member of various IT committees including the Joint GPIT Committee. He sits *ex officio* on Scottish GPC Executive, GPC England and GPC UK.

Dr. Ursula Brennan



Member of the Agenda Committee

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

Dr. Tanya Beer



Member of the Agenda Committee

Tanya is a portfolio GP working 5 sessions in a large practice in North Somerset plus another 2 sessions for Gwent Urgent Primary Care with experience of sessional, partnership and locum work. She was born and bred in Wales and forged the early years of her GP career in the Welsh examining valleys before moving to the outskirts of Bristol. With 10 years of LMC committee experience under her belt, this is her first year on the Agenda Committee.

Dr. Paul Evans



Member of the Agenda Committee

Paul is a GP sole contractor in Gateshead, who lives in hope of becoming a proper grown-up partner one day, when GP finances in England improve enough to persuade his salaried colleagues to join him. Away from General Practice, he enjoys chairing Gateshead & South Tyneside LMC and the NE Regional LMC, serving on BMA Council, working constructively with hospital and commissioning colleagues to make benefit glorious future of GP and going for long runs to recover from having to talk to people so much. This is Paul's final year as a member of the Agenda Committee and he highly recommends it to anyone who likes both detail and robust discussion about where, precisely, the punctuation should go.

Dr. Robert Hodges



Member of the Agenda Committee

Bob Hodges is Chair of Gloucestershire LMC and a first time member of the agenda committee. He is a GP partner in Gloucester and is an enthusiastic assistant doctor for Gloucester Rugby. With a daughter currently set on getting into medical school he is also concerned parent, worried about the future of medical careers in the UK. His commitment to expansive dog walking and great beer is unrivalled at a regional level. He is passionate about not using the word passionate excessively, but dearly loves General Practice and the independent contractor model and believes that General Practice is the answer and not the problem.

Dr. Rachel McMahon



Member of the Agenda Committee

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

Dr. Euan Strachan-Orr



Member of the Agenda Committee

Euan Strachan-Orr is a portfolio GP working across Merseyside in a variety of roles in and out-of-hours, recently taking a 6 session salaried role in Liverpool with a view to partnership. This is his second year as an elected Agenda Committee member of the UK LMC Conference. Euan previously chaired the BMA GP Trainees committee. He is a member of Liverpool LMC. He is a long-suffering, season ticket holding Evertonian.

Dr. Thilla Rajasekar



Member of the Agenda Committee

Raj is the Kent LMC representative at the UK conference Agenda committee. He is a GP Partner at Kingsnorth, Ashford in the heart of Kent. Along with his 6 sessions as a GP at his practice, he also carries out minor surgeries and vasectomies for patients from all practices across East Kent. He also leads the local UTC unit in Ashford. He has an amateur passion for photography, travel, long walks and likes to enjoy a wee dram in good company and stunning Scottish scenery.

Dr. Andrew Buist



Member of the Agenda Committee and co-chair of GPC UK

Andrew Buist has been Chair of GPC Scotland since 2018 and Joint Chair GPCUK since 2022. He is a former Chair and Secretary of Tayside LMC and is a GP partner in Blairgowrie, Perthshire.

NOTES

Under standing order 17.1, in this agenda are printed all notices of motions for the annual conference received up to noon on 1 March 2024. Although 1 March 2024 was the last date for receipt of motions, any local medical committee, or member of the conference, has the right to propose an amendment to a motion appearing in this agenda, and such amendments should be sent [via the link](#) by 12noon Monday 20 May.

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

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

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

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

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

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

Item	Deadline for submission
Chosen motions (see note below)	12noon on Monday 20 May
Notification of rider	12noon on Monday 20 May
Notification of amendment	12noon on Monday 20 May
Emergency motions / new business	12noon on Monday 20 May

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

Elections at LMC UK conference

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

1. Chair of LMC UK conference 2025
2. Deputy chair of LMC UK conference for 2025
3. Seven members of the LMC UK conference agenda committee 2025
 - a. *At least one of whom shall represent each of the four UK nations and not more than one of whom shall be a sitting member of the GPC UK*
4. Seven members of the UK general practitioners committee 2024-2025
5. One 'early career' GP to be co-opted to the UK general practitioners committee 2024-2025
6. Forty-seven members* to attend the Annual Representative Meeting (ARM) of the BMA in Belfast, 24-25 June 2024
7. Three trustees to the Claire Wand Fund 2024-2027

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

Eligibility—to vote in BMA elections

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

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

Election schedule

Nominations

Nominations open for representatives to GPC UK 2024-25 – **12pm Thursday 18th April 2024**

Nominations close for representatives to GPC UK 2024-25 – **12pm Thursday 16th May 2024**

Nominations open for representatives to the ARM 2024 – **12pm Thursday 2nd May 2024**

Nominations open for all other positions – **10am Wednesday 22nd May 2024**

Nominations close for all positions (except GPC UK) – **11am Friday 24th May 2024 (2nd day of conference)**

Voting

Voting opens for representatives to GPC UK 2024-25 – **5pm Thursday 23rd May 2024 (1st day of conference)**

Voting opens for all other positions – **12pm Friday 24th May 2024 (2nd day of conference)**

Voting closes for *all* positions – **2:15pm Friday 24th May 2024**

Results for all elections, apart from Conference Agenda Committee, will be published shortly after voting closes.

Results for the Conference Agenda Committee will be announced after the ARM in June.

For more information, please see the attached guidance (Appendix 1) or email the Elections team at elections@bma.org.uk.

Schedule of business

Thursday 23 May 2024

Item	Time
Opening business	11.00
GPC UK Chairs – Dr Andrew Buist and Dr Alan Stout	11.20
State of the NHS and safe workload	11.40
Clinical, prescribing and dispensing	12.30
Lunch	13.00
GP workforce crisis across the four nations – Major issue debate	14.00
Sessional GPs Chair – Dr Mark Steggles	14.50
Sessionals and portfolio ways of working	15.00
Funding	15.10
Continuity of care	15.30
Contingency time	16.10
Managing expectations	16.20
Digital, technology and data	17.10
Close	17.30

Friday 24 May 2024

Item	Time
Wider workforce	09.00
GP Registrars Chair – Dr Malinga Ratwatte	09.50
GP Registrars and training	10.00
Premises	10.10
Conference and GPC	10.20
GPDF report	11.30
GPDF	11.40
GPs and the wider BMA	11.50
Charities	12.20
Lunch	12.30
Soapbox	13.30
Options for the future	14.00
Chosen motions	15.00
Emergency business	15.10
Closing business	15.20
Conference close	15.30

OPENING BUSINESS

11.00

RETURN OF REPRESENTATIVES

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

STANDING ORDERS

- 2 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the standing orders (appended), be adopted as the standing orders of the meeting.
- 3 AGENDA COMMITTEE TO BE PROPOSED BY THE DEPUTY CHAIR: That conference accepts the proposed changes to the Standing Orders, as recommended by the Agenda Committee and as outlined in Appendix 3 regarding:
 - (i) Membership
 - (ii) Agenda inclusion
 - (iii) Elections
 - (iv) Representation at ARM

REPORT OF THE AGENDA COMMITTEE

- 4 THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE): That the report of the agenda committee be approved with permission to again include an election for an 'early career' GP to GPC UK for the 2024-2025 session.

GPC UK CO-CHAIRS – DR ANDREW BUIST AND DR ALAN STOUT

11.20

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

- * 5 GLASGOW: That conference calls on the four governments to publicly acknowledge that with regard to workload in general practice:
- (i) there are limits to what GPs can safely undertake
 - (ii) lack of capacity leads to safe limits being exceeded
 - (iii) patients may have to wait longer for appointments with their GP practice, just as they do for appointments with secondary care.
- 5a NORTHERN IRELAND WESTERN: That conference believes that current GP workload across all areas of the UK is unsafe and unsustainable and instructs GPC UK to work with NIGPC, GPC England, SGPC and GPC Wales to promote the safe working in document in general practice and support practices in implementing it.
- 5b SUTTON: That conference calls upon urgent safer working within general practice to be facilitated by:
- (i) the promotion of a defined number of consultations which a GP can undertake safely in a day to be promoted across general practice
 - (ii) to factor into the working day the time taken to supervise allied members of staff including First 5 GP
 - (iii) the provision of named contacts in secondary care whom patients on waiting lists can contact to discuss any concerns about their non-acute referrals
 - (iv) the implementation of primary / secondary care interface groups by a set date to ensure all inappropriate transfer of work is addressed, with sick notes following hospital admission and consultant to consultant referrals being dealt with as a priority.
- 5c COVENTRY: That conference believes that the continuing increase in the number of patients per full time equivalent GP is not sustainable and calls for:
- (i) practices to be encouraged and supported in formally closing lists where necessary to maintain the standard of patient care and the welfare of staff
 - (ii) funding to be made available to general practice to employ an appropriate number of GPs to maintain patient care and the welfare of staff
 - (iii) practices to be encouraged and supported in escalating concerns regarding unsustainable workload within the relevant local system and refusing to undertake non-core contractual work where necessary.
- (Supported by Warwickshire LMC)
- 5d KENT: That conference calls for all general practice activity to be accurately monitored to enable more appropriate workload planning, to include calls, administrative tasks and prescriptions.
- 5e LIVERPOOL: That conference believes that the increasing, spiralling, growing and sometimes inappropriate workload being shouldered by GPs is unsafe and unsustainable and calls on GPC UK to review the medico-legal implications of:
- (i) GPs working beyond the BMA safe working guidelines
 - (ii) GPs being inappropriately sent results to investigations that they did not request, and thus are not in a position to safely interpret nor act upon
 - (iii) inappropriate transfer of work from secondary to primary care.

- 5f TOWER HAMLETS: That conference applauds our colleagues across the four nations who, despite a shrinking workforce and struggles with limited practice premises space, have managed to increase the number of appointments offered to patients to levels above those prior to the Covid pandemic and:
- (i) insists that primary care NHS teams stop referring to there being a problem with general practice access and recognise that the issue relates to the safe capacity that the general practice workforce can offer, which is insufficient to meet patient demand
 - (ii) formally asks that, in recognising the work being done by general practice, the Ministers for Health and Social Care publicly state that the only sector of the NHS to increase capacity since the pandemic is general practice
 - (iii) requires GPC UK to provide support to any practice challenged for implementing BMA Safe Working in General Practice guidance.
- 5g WIGAN: That conference calls upon the Secretary of State for Health and Social Care, health ministers and senior health managers to openly recognise that general practice in the UK has reached a critical tipping point of safe working limits and sustainability . It calls upon these and others to curtail the incessant stream of expectations and calls that it absorbs additional activity: there is no longer a 'working as normal 'in general practice.

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

- * 6 KENSINGTON, CHELSEA AND WESTMINSTER: That conference deplores the current ambulance wait times, offers allyship to paramedics who are working with insufficient staffing levels, and calls for:
- (i) acknowledgement that longer ambulance wait times change the risk: benefit ratio for patients and GPs when deciding to wait for ambulance conveyance compared to transferring using their own or public transport
 - (ii) access to real-time information for patients and GPs for ambulance conveyance so that patients can make an informed decision on whether to transfer to hospital independently
 - (iii) ambulance services to advise patients and GPs regarding, and take clinical and legal responsibility for determining, the safest mode of conveyance.

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

- * 7 DORSET: That conference deplores the existing state of NHS dentistry, and the consequences of poor access for both patients and primary care. General practitioners are being inappropriately called upon to prescribe for and treat dental conditions. Conference therefore:
- (i) recognises that general practitioners are not contracted, funded, qualified or indemnified to treat dental conditions and calls upon GPC UK to reiterate this to the Departments of Health and NHS organisations in all four nations
 - (ii) calls upon GPC UK to voice support for our dental colleagues and lobby the Departments of Health in all four nations for an appropriately remunerated dental service including full emergency provision
 - (iii) supports general practitioners in refusing to see or treat dental conditions in line with GMC standards of Good Medical Practice
 - (iv) calls upon the UK government to adequately fund a media campaign educating the general public on appropriately accessing dental health care.

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

- * 8 LIVERPOOL: That conference is appalled at the lack of adequate ADHD and other neurodiversity services across the NHS, with demand for services continuing to rise sharply, impacting on GP workload. We call upon the GPCs to work with and lobby relevant stakeholders to:
- (i) fund and commission comprehensive local NHS ADHD and other neurodiversity services, delivered by appropriately trained and regulated clinicians, with the responsibility for initiating, monitoring, prescribing, and titrating any medications prescribed
 - (ii) ensure that no GP is expected to take over responsibility of ADHD medication prescribing or monitoring without a shared care agreement and appropriate funding to facilitate any required monitoring
 - (iii) provide support to GPs who do not feel comfortable facilitating shared care agreements for prescribing ADHD medications following an assessment that they do not feel has been conducted to a suitable standard
 - (iv) produce clear patient resources to explain NHS ADHD services and the role of GPs in ongoing prescribing, where felt appropriate, under shared care agreements
 - (v) allow patients to self-refer to NHS ADHD and other neurodiversity services, without the requirement to consult their GP.
- 8a HERTFORDSHIRE: That conference asks GPC / BMA to:
- (i) recognise the common gap of provision across the countries of a service able to provide ADHD / ASD assessments for patients in a timely manner
 - (ii) work with the respective health ministries to fill the gap in ADHD / ASD services
 - (iii) state that GPs should not be required to hold the clinical risk and responsibility for these patients indefinitely and respond to patient frustrations during the excessive wait times for assessment.

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

- * 9 GATESHEAD AND SOUTH TYNESIDE: That conference has grave concerns about a deal between a national government and a pharmaceutical company to circumvent usual procedure in bringing a drug (inclisiran) to market and:
- (i) believes that such an approach risks patient safety
 - (ii) demands that any future attempt to fast-track drugs to UK patients via GPs be subject to ratification by relevant GPCs
 - (iii) demands that any new drugs to be prescribed, administered or dispensed in general practice are made available only when a safe pathway and relevant funding has been agreed with the relevant GPCs.

GP WORKFORCE CRISIS ACROSS THE FOUR NATIONS – MAJOR ISSUE DEBATE

14.00

TD1 BARNET: Given the continuing attrition of GPs from the workforce, conference believes that there needs to be a wider debate as to the definition and role of a general practitioner and instructs GPC to facilitate that debate so as to reaffirm our values, retain our current GP workforce and attract new GP registrars.

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

Speakers may wish to consider the following questions:

- As a GP contractor, what difficult workforce decisions will you be forced to make in order to keep your practice afloat?
- What might attract you to relocate to a different area in order to find work as a GP?
- How do we support salaried GPs who are facing redundancy and locums/Out of Hours GPs who cannot find work?
- Should LMCs have a greater role in negotiating with large organisations who employ GPs such as hospital trusts, Out of Hours providers or multinational companies?
- How confident do GP Registrars feel in finding your preferred type of work post CCT, and what mitigations and plans have you made should you be unable to secure work post-CCT?
- What positive examples of recruitment and retention initiatives have you seen in your area?

TD2 NORFOLK AND WAVENEY: That conference notes with great concern reports of unemployment of newly qualified GPs and requests:

- (i) financial help is made available for practices in remote and rural areas to support employment of GPs who incur extra travel and time costs
- (ii) the 'golden hello' is reinstated for newly qualified GPs
- (iii) newly qualified GPs have a clear and supported career path for the first 5 years
- (iv) core funding uplifts to financially support GP recruitment rather than perverse incentives which encourage practices to employ to non-GP roles.

TD3 NORFOLK AND WAVENEY: That conference notes with concern the rapid increase in non-GP roles which could adversely affect training and patient experience for newly qualified GPs. It requests:

- (i) financial incentives for practices to employ GPs in their first five years post-CCT
- (ii) protected time for training and direct patient contact for these GPs
- (iii) avoidance of supervisory roles for newly qualified GPs.

- TD4** CAMBRIDGESHIRE: That conference is dismayed that the New to Practice Fellowship (which played an important role in the retention and development of First 5 GPs in England) has had its funding withdrawn and hence to future proof the role of the GP calls for a UK wide First5 Fellowship scheme open to any First5 GP in a substantive post to be created with the aims of:
- (i) supporting newly qualified GPs with peer support, structured learning and networking opportunities
 - (ii) specifically equipping newly qualified GPs with skills in safe supervision of the wider general practice workforce
 - (iii) including a specific, funded leadership training stream to encourage, foster and train GP leaders of the future thus strengthening the case for retaining the independent contractor model
 - (iv) raising the profile of GPs through the recognition and celebration of the work of outstanding First5 fellows.
- TD5** SOMERSET: That conference demands that funding to support newly qualified GP retention is returned to a national ring-fenced fund that is equitably dispersed, in order to prevent areas of the country from continuing to lose GPs as a result of the current inequitable funding allocation.
- TD6** OXFORDSHIRE: That conference recognises that newly qualified GPs may face difficulties when entering the workplace and recommends supporting the practice and GP with additional funding for the first year post Certificate of Completion of Training.
- TD7** GP REGISTRARS COMMITTEE: That conference is concerned about the inequity created by the availability of additional roles reimbursement scheme (ARRS) funding for the recruitment of other roles except general practitioners in primary care and is wary that this creates a dangerous precedent for the whole UK and calls on the BMA to:
- (i) demand that recruitment of general practitioners should not be excluded from any funding envelope
 - (ii) oppose any attempts to implement an ARRS-like scheme across the devolved nations, which excludes the recruitment of general practitioners.
- TD8** GLOUCESTERSHIRE: That conference believes that the current trend to remove minor illness and less complex cases from GP practice workload:
- (i) harms continuity of care and the relationship building this requires
 - (ii) risks de-skilling a generation of GPs so that once the cohort of GPs who have seen thousands of colds retires, they will no longer be able to function as an effective first point of contact
 - (iii) is a highly inefficient way of funding healthcare, removing economies of scale, opportunities for early intervention, and diverting funds from the core providers of primary care.
- TD9** SOMERSET: That conference acknowledges the invaluable contribution experienced GPs and other clinicians make to the quality and efficiency of care provided in practices, recognises the urgent need to retain these experienced clinicians, and therefore demands that 'seniority payments' are reintroduced for GPs and extended to other members of the general practice workforce.
- TD10** BOLTON: That conference acknowledges the benefits the GP fellowship offers newly qualified GPs and the practices that employ them and condemns the abolition of the GP fellowship programme, which could:
- (i) undermine GP retention
 - (ii) erode standards in general practice.

- TD11** DORSET: That conference recognises the damaging effect that the current working environment is having on GP mental and physical health and calls for specific additional funding to enable all GPs to have protected time in their work plan for self-care, supervision, coaching and mentoring.
- TD12** GRAMPIAN: That conference feels GPC UK must promote the role of the general practitioner as the heart of the general practice multi-disciplinary team and that without enough GPs, general practice will fail.
- TD13** LIVERPOOL: That conference believes that the NHS should be doing more to actively retain GPs within the workforce and calls upon GPC UK to explore schemes that will facilitate GP retention.
- TD14** LIVERPOOL: That conference believes that if we wish to have a robust, GP led primary care system, we must have:
- (i) adequate numbers of medical students
 - (ii) sufficient resource to provide an excellent educational experience in general practice for medical students
 - (iii) sustained investment in GP estates to allow, amongst other things, space to train the GPs of the future in person.
- TD15** COVENTRY: That conference believes the current attrition rate of fully qualified general practitioners is unsustainable and calls for:
- (i) ring fenced budgets to support GPs with mentoring
 - (ii) clear commitment to the continuation of the retainer scheme with an end to the postcode lottery
 - (iii) a new expectation of a supported session for CPD throughout the length of career for all GPs to be implemented progressively over a five year period.
- (Supported by Warwickshire LMC)
- TD16** AVON: That conference believes that general practice is in an existential crisis and demands that GPC UK develops a clear strategy to outline the role, purpose, and unique qualities of a GP.
- TD17** GLASGOW: That conference demands a national grass roots approach to GP recruitment and calls for collaboration between all secondary schools, undergraduate and postgraduate centres for education to address the recruitment crisis.
- TD18** HAMPSHIRE AND ISLE OF WIGHT: That conference laments the increasing exodus of GPs from the NHS, of particular concern is the loss of mid to late career GPs who will be difficult and costly to replace in the short to medium term and calls on government of the four nations to implement seniority payments that reward long service and commitment for all GPs.
- TD19** DORSET: That conference is extremely concerned about the continuing decline in GP workforce numbers. It calls on the Health Improvement Organisations in each of the four nations, such as NHSEI in England and Healthcare Improvement Scotland, to undertake an urgent GP workforce review to:
- (i) better understand the true GP workforce
 - (ii) quantify how many hours GPs are working each week
 - (iii) conduct exit interviews for all GPs leaving or reducing sessions
 - (iv) commission independent modelling to accurately assess what current and future GP numbers are required to deliver safe and effective general practice.

- TD20** KENSINGTON, CHELSEA AND WESTMINSTER: That conference, in underpinning the professionalism of GPs, believes:
- (i) that, like all doctors, GPs should be supported professionally and contractually to maintain their knowledge and skills through upskilling and training
 - (ii) that the boundaries of the GP expert generalist continue to expand year on year but cannot be limitless
 - (iii) that there must be a robust process to determine whether any new areas of work are within the reasonable boundaries of a GP expert generalist
 - (iv) in their investigations, the GMC must take into account the training that was made available and whether the issue that has triggered the investigation was appropriate to be undertaken by a GP expert generalist
 - (v) that GPC UK or the four nation GPCs should formally negotiate with the NHS in each of the four nations to deliver changes to the GP contract that support and adequately resource the required initial and continued training to undertake any appropriate new work.
- TD21** WORCESTERSHIRE: That conference is appalled that national retention initiatives such as the GP fellowship scheme and mentoring schemes have been withdrawn when the rate of attrition of GPs is high and GP wellbeing is falling and insists that these are reinstated with immediate effect.
- TD22** LAMBETH: That conference notes the concern expressed by GP registrars over future employment prospects, related to inadequate increase in core funding, the focus on recruitment via ARRS contracts and lack of premises to accommodate them and calls on GPC UK to:
- (i) review the impact these roles have on GP training
 - (ii) produce an impact assessment, reporting to the conference of UK LMCs no later than the 2025 conference.
- TD23** CAMBRIDGESHIRE: That conference watches in dismay while general practice, so often the unrecognised foundation of the NHS, loses highly effective and experienced expert generalists from the workforce and is at risk of imminent collapse and calls upon GPC UK to take urgent action by:
- (i) insisting on direct "core" investment in practices to keep pace with inflation
 - (ii) negotiating for GPs to be included general practice MDT funded programmes
 - (iii) reversing disinvestment by ICBs and health boards in cost effective evidence-based retention work.

SESSIONALS AND PORTFOLIO WAYS OF WORKING

15.00

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

- * 10 **SESSIONAL GPS COMMITTEE:** That conference believes general practitioners working in urgent care or out of hours settings should, when adequately funded by commissioners, be engaged on terms which:
- (i) include paid time for handling any complaints, significant event analyses, inquests and service-specific mandatory training
 - (ii) honour the pay awards recommended by the DDRB, with appropriate backdating when needed
 - (iii) allow income to be superannuated in the NHS pension scheme without reduction in the gross rate of pay
 - (iv) provide holiday entitlement when engaged as a worker or employee in keeping with other NHS employees rather than the statutory legal minimum.

FUNDING

15.10

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

- * 11 **AGENDA COMMITTEE TO BE PROPOSED BY AYRSHIRE AND ARRAN:** That conference is deeply concerned about the ongoing failure by governments to adequately invest in general practice services, as highlighted by the Kings Fund Report of February 2024, and:
- (i) calls for a recognition and public acknowledgement of the impact that this is having on our patients' ability to access GP services
 - (ii) believes that the current system of adjusted GP capitation payments has failed to account for demand and activity per patient over the years
 - (iii) condemns the approach of investing into short-term piecemeal schemes, with complex funding systems, which has prevented long-term planning and investment into the general practice workforce
 - (iv) instructs the GPCs to determine what 'reasonable provision' means in terms of the funding we are given to deliver GMS
 - (v) demands that GP contracts provide for an automatic uplift in funding to cover inflationary pressures, along similar lines as the state pension "triple lock", including but not limited to pay recommendations issued by DDRB and / or government, changes to the National Living Wage, and increases in practice running costs.
- 11a **AYRSHIRE AND ARRAN:** That conference is deeply concerned about the ongoing failure by government to adequately invest in general practice services and:
- (i) asserts that this is causing the collapse of general practice as we know it in the UK
 - (ii) calls for a recognition and public acknowledgement of the impact that this is having on our patients' ability to access GP services
 - (iii) calls for a recognition of the health and economic impact this is having on general practitioners and their teams
 - (iv) demands that adequate investment is put directly into general practice.

- 11b** BUCKINGHAMSHIRE: That conference:
- (i) believes UK general practice requires an overall increase in funding through global sum that provides for well defined, adequate, and reasonably comprehensive essential primary medical services
 - (ii) demands costing of any new contractual proposal, to ensure new contracts do not destabilise general practice
 - (iii) demands simplification of the multitude of currently existing funding streams into the global sum, so that practice stability is no longer dependent on pursuing smaller, often short-term, funding streams with associated complex administrative costs and/or targets
 - (iv) demands that GP contracts provide for an automatic uplift in funding to cover inflationary pressures, along similar lines as the state pension "triple lock", including but not limited to pay recommendations issued by DDRB and / or government, and inflationary increases in practice running costs.
- 11c** CLEVELAND: That conference welcomes the uplift to the national living wage and demands that NHS GP practices should be properly funded to cover the cost of increased staff expenses as a result.
- 11d** WALTHAM FOREST: That conference recognises the perilous state of UK general practice and that:
- (i) the major reason for this is the lack of investment by successive governments into core general practice funding
 - (ii) the approach of investing into short term schemes, with complex funding systems, has prevented long-term planning and investment into the general practice workforce, which would have increased the safe capacity general practice could offer our patients
 - (iii) any future scheme to increase general practice workforce that excludes the ability to appoint either GPs or practice nurses should be rejected by the relevant GPC, by LMCs and by the wider GP community in their entirety.
- 11e** OXFORDSHIRE: That conference notes with dismay the continued tendency to fund healthcare in a piecemeal fashion, resulting in fragmented and incomplete "episodes of care", and calls instead for a consolidation of funding into core essential GP primary medical services, to allow GPs to ensure proper continuity of care for their patients.
- 11f** CROYDON: That conference instructs BMA to determine what 'reasonable provision' means in terms of the funding we are given to deliver GMS, and to advise on the maximum number of appointments we should be offering under such funding arrangements.
- 11g** MID MERSEY: That conference considers that the current system of adjusted GP capitation payments has failed to account for demand and activity per patient over the years and asks GPC to work to introduce an evidence based method founded on accurate measurement of clinical and administrative workloads at system and/or practice level.
- 11h** GRAMPIAN: That conference welcomes the Kings Fund report in February 2024 "Call for radical refocusing of health and care system to put primary and community services at its core" which is based on England's health system and believes that the same principles will apply throughout the four nations and calls on all four governments to follow this advice and dramatically increase the proportion of health spending in general practice and community services.

- 11i LINCOLNSHIRE: That conference acknowledges the King’s Fund report of February 2024 “Making care closer to home a reality” that states the “failure to grow and invest in primary and community health and care services ranks as one of the most significant and long-running failures of policy and implementation in the NHS and social care for more than 30 years” and that:
- (i) conference fully supports this statement
 - (ii) respective governments have fundamentally misled the public, reduced positive health outcomes whilst building rhetoric and distrust of our hardworking and committed profession
 - (iii) we request GPC executives use this independent report to highlight the real term disinvestment by government in general practice and our grave concerns of the subsequent negative impact on health outcomes of our patients
 - (iv) we demand that any agreement for further shift of workload or services into general practice nationally or locally must be economically viable to general practice as determined by GPCs and LMCs respectively.
- 11j GRAMPIAN: That conference inspired by the Kings Fund believes the following statement to be true for all four nations “the failure to grow and invest in the primary and community health and care services, despite successive governments stating a commitment to this agenda, is one of the most significant and long-running policy failures of the past 30 years” and calls for GPC UK to request, that our political leaders urgently put aside political differences and collaborate across party boundaries to reform and save the NHS before it is too late.
- 11k NORFOLK AND WAVENEY: That conference calls for increases to core funding over piecemeal initiatives which carry considerable cumulative administrative burden.
- 11l DEVON: That conference demands that in addition to information provided by DDRB, increases in the nationally agreed minimum wage(s) must be considered when looking to uplift a general practice contract.
- 11m DERBYSHIRE: That conference insists that all extra funding to primary care must go directly to core funding as alternative funding routes fail to deliver for practice, patients or the NHS.
- 11n AYRSHIRE AND ARRAN: That conference calls on governments to directly invest financial resource into general practices to:
- (i) enable expansion of the GP workforce
 - (ii) facilitate safe working
 - (iii) enable GPs to manage the ever increasing complexity of their role.
- 11o CENTRAL LANCASHIRE: That conference believes all future GP contracts should be automatically uplifted in line with RPI inflation to combat the historical underfunding of GP services.
- (Supported by Cumbria, Lancashire Coastal, Lancashire Pennine and Morecambe Bay LMCs)
- 11p CROYDON: That conference instructs GPC to negotiate appropriate funding for all extra work flowing into general practice that is generated by new national screening programmes, including the management of clinically significant incidental findings (where such work is not more appropriately handled by direct referral into secondary care).

- 11q DERBYSHIRE: That conference believes that general practice is the cornerstone of the NHS. However, over the past 20 years the stone has become fractured due to the pressure for primary care to be delivered by a multiplicity of providers:
- (i) conference asserts that what has been done in the name of integration is dis-integrating the NHS
 - (ii) conference demands that general practice once again can take back the control of the wider community team
 - (iii) conference demands that all the funding that is currently being subsumed by the many providers for employment and management be returned to general practice as core funding.
- 11r COVENTRY: That conference calls for recognition of the pivotal role of independent contractors, particularly general practitioners (GPs), as the cornerstone of healthcare provision in the United Kingdom since the establishment of the National Health Service (NHS) in 1948. That conference acknowledges the dedication and commitment of independent contractors in delivering high-quality, patient-centred care to communities across the nation, often under challenging circumstances and that emphasis is placed on the urgent need for increased support and resources to ensure the sustainability and effectiveness of independent contractor practices in the evolving healthcare landscape and that GPC work towards:
- (i) establishment of a committee for independent contractors under BMA
 - (ii) comprehensive workforce support measures to address recruitment and retention challenges and promote the well-being of healthcare professionals within independent contractor practices
 - (iii) enhanced financial support for independent contractor practices to address existing funding gaps, mitigate financial pressures, and promote sustainable business models.
- (Supported by Warwickshire LMC)
- 11s WORCESTERSHIRE: That conference believes that the independent contractor model is being undermined through:
- (i) a lack of funding and resource within the current GMS contract
 - (ii) a desire to change the delivery of primary medical services to a model that uses cheaper staff with insufficient training to diagnose and manage complex presentations
 - (iii) calls on GPC to deliver a patient facing campaign which highlights the risks of such a model.
- 11t HULL AND EAST YORKSHIRE: That conference believes general practice should have the same funding made available to them as is written off by their respective governments to the financial deficits of other providers in the previous financial year.
- 11u SUFFOLK: That conference welcomes the recent Kings Fund report concluding that underfunding of primary and community care is the most significant government policy failure of the last thirty years and seeks to reverse this trend by calling for primary care to receive at least 11% of the NHS healthcare budget from 2025 onwards.
- 11v DERBYSHIRE: That conference insists that re-instatement of an EXPLICIT GP practice expenses reimbursement mechanism for general practice as such a system served both the taxpayer and the profession well over 38 years including at times of high inflation until 2004. Such a mechanism:
- (i) is essential to the survival of the independent contractor provision of GP services
 - (ii) prevents government from financially abusing GPs through painting gross increases in primary care resourcing as net GP pay
 - (iii) permits proper financial planning of services at times of significant inflation.

- 11w CROYDON: That conference instructs BMA to negotiate a new contract which:
- (i) values and protects the partnership model
 - (ii) defends the rights of patients to see their family GP
 - (iii) sets funding at a level which enables us to offer appropriate capacity
 - (iv) defends us against unfunded workload shift from hospitals and other providers
 - (v) is inflation proof.
- 11x MERTON: That conference:
- (i) agrees that the recent initial proposal by NHSE to uplift core general practice in England by 1.9% is insulting and counterproductive and that resource for general practice in the rest of the UK has also significantly lagged behind inflation and has not in any way matched the increasing demands put on primary care in general and on general practice in particular
 - (ii) demands that the UK governments finally recognise the value of modern general practice and commit to realistic increases in core general practice to ensure the stability and development of general practice and to make it fit for the 21st century.

CONTINUITY OF CARE

15.30

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

- * 12 **AGENDA COMMITTEE TO BE PROPOSED BY STOCKPORT:** That conference firmly believes that arranging ongoing specialist care when patients move inside the UK, should not fall to GPs, and demands that:
- (i) specialist teams should be responsible for identifying, handing over and arranging patients' specialist care to equivalent specialist providers when a patient moves area
 - (ii) in this situation the patient joins the care pathway at the same point that they occupied in their former location and should only be placed on a waiting list if they were previously on one
 - (iii) the ongoing specialist care, including the direct prescribing of shared care drugs, should be the responsibility of the original specialist team until a hand-over to local specialist services has been completed and, where necessary, a local shared care protocol has been agreed with the patient's new GP.
- 12a STOCKPORT: That conference firmly believes that arranging ongoing specialist care when patients move inside the UK, should not fall to GPs, and demands:
- (i) recognition that when patients who need ongoing specialist care move within the UK the current practice of having the GP refer them to a local specialist generates risk for the patient and the GP
 - (ii) a UK wide process should be developed for specialist teams to identify and liaise with equivalent specialist teams in different areas to allow direct hand-over of care for patients with ongoing specialist care needs
 - (iii) specialist teams should be responsible for identifying, handing over and arranging patients' specialist care to equivalent specialist providers when a patient moves area
 - (iv) the ongoing specialist care, including the direct prescribing of shared care drugs, for patients transferring between specialists within the UK, should be the responsibility of the original specialist team until a hand-over to local specialist services has been completed and, where necessary, a local shared care protocol has been agreed with the patient's new GP.

- 12b DEVON: That conference deplores the current system of transitioning health care arrangements when a patient relocates from one UK country to another or indeed within an individual country , and:
- (i) insists that when a patient under secondary or community based care relocates, a direct referral from the existing specialist to the specialist in the new location takes place without any recourse to general practice
 - (ii) demands that in this situation the patient joins the care pathway at the same point that they occupied in their former location and should only be placed on a waiting list if they were previously on one.
- 12c LIVERPOOL: That conference notes the issues faced by patients being treated under shared care arrangements when they relocate. We call on the GPCs to work with relevant stakeholders to mandate that patients under a shared care arrangement are referred by the treating specialist team directly to a new local specialist team who must then arrange a new shared care arrangement with the patient's new GP.
- 12d DORSET: That conference laments the impact on long secondary care waiting lists on general practice teams and their patients and calls for:
- (i) a mandatory requirement for secondary care providers to inform and update patients on waiting times
 - (ii) all secondary care trusts to provide single point of access for patients with queries about their outpatient appointments or ongoing hospital care.
- 12e WELSH CONFERENCE OF LMCs: That conference calls for the stopwatch that counts secondary care waiting times to start at time of the GP making a decision to refer and not when multiple tests and processes demanded of primary care by secondary care driven pathways have been completed.
- 12f DERBYSHIRE: That conference believes that the backlog of work in secondary care is having a massive impact on primary care which is reducing availability of appointments for patients. Conference demands that secondary care:
- (i) create a service that manages the care of all patients referred into them until the medical specialist can engage with the patient
 - (ii) contacts the patients proactively and ensures that they are aware of where on the pathway journey they are
 - (iii) provide clinical support for a patient's symptom control whilst on the waiting list without involvement of the GP.
- 12g MERTON: That conference notes that patient care has become increasingly challenging and fragmented, with frequent episodes of unilateral pathway changes affecting primary care being imposed without consultation or consideration of the potential consequences of workforce requirements or resourcing.

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

- * 13 GRAMPIAN: That conference believes in the value of appropriate continuity of care and calls on GPC UK and RCGP to collaborate on tools for measuring continuity and develop possible contractual solutions that provides payments to general practice teams for work that supports continuity of care for each devolved nation to debate and adopt if appropriate.

- 13a HERTFORDSHIRE: That conference requests that the GPC / BMA supports a practice’s contractual entitlement to provide same day care to their registered patients “delivered in the manner determined by the contractor’s practice in discussion with the patient” against the imposition of alternative models, to protect ensuing continuity of care, patient safety and GP workload diversity.
- 13b DERBYSHIRE: That conference recognises that the core GP contract funding by capitation is fundamentally flawed. Practices which deliver more doctor or nurse time for patients results in lower remuneration for partners and new contracts must reward continuity of care reflecting clinician input.
- 13c KENT: That conference calls on the government to revise the current funding formula to help narrow health inequalities, rather than widen them.

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

- * 14 **AGENDA COMMITTEE TO BE PROPOSED BY GLOUCESTERSHIRE:** That conference is concerned at the continuing development of relevant healthcare computer systems that do not integrate adequately with general practice clinical systems and calls for:
 - (i) a review of stand-alone maternity clinical record keeping systems to ensure that patients who are pregnant are not subject to clinical safety risks due to disjointed care, and lack of safeguarding transparency
 - (ii) maternity clinical records are to be interoperable with GP systems.
- 14a GLOUCESTERSHIRE: That conference calls for a review of stand-alone maternity clinical record keeping systems to ensure that patients who are pregnant are not subject to clinical safety risks due to disjointed care, and lack of safeguarding transparency.
- 14b GLOUCESTERSHIRE: That conference is concerned at the continuing development of relevant healthcare computer systems that do not integrate adequately with general practice clinical systems and requests that:
 - (i) maternity clinical records are inter operable with GP systems
 - (ii) all areas have a system that allows hospital teams to access relevant data for clinical care of patients within hospital
 - (iii) electronic phlebotomy ordering is available to all clinical staff enabling the results to return to the requesting clinician.

CONTINGENCY TIME

16.10

Plenary session

As an LMC which specialises in high quality practice level data, Michael Harrison and Dr Parul Karia from Bedfordshire and Hertfordshire LMCs will be giving a plenary talk on how we can push back against the negative media narrative around general practice and bust some of the political myths surrounding GP access and patient satisfaction.

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

- * 15 **AGENDA COMMITTEE TO BE PROPOSED BY NORTH YORKSHIRE: That conference recognises the increasing incidence of aggressive, threatening and violent incidents occurring in general practice and:**
 - (i) demands that the criteria for inclusion in violent patient schemes should be relaxed
 - (ii) calls on all UK governments to ensure that the funding for violent patient schemes is uplifted to provide appropriate resource
 - (iii) mandates GPC UK to lobby governments for more severe sanctions for perpetrators.

- 15a NORTH YORKSHIRE: That conference demands that given the rapidly increasing incidence of aggressive, threatening and violent incidents occurring in general practice, inclusion in the violent patient scheme should be relaxed and facilitated to ensure such actions have appropriate consequences.

- 15b NORTH AND NORTH EAST LINCOLNSHIRE: That conference recognises the increase in abuse directed towards general practice staff and:
 - (i) calls on all UK governments to review funding for violent or special allocation schemes and ensure it is appropriately resourced and uplifted
 - (ii) calls on GPC UK to lobby for fully funded security reviews and equipment for all practices delivering these services
 - (iii) is clear that no amount of retention initiatives will be effective for general practice staff without this abuse being addressed.

- 15c KENT: That conference demands that all staff undertaking home visits have adequate safety equipment provided, including body cameras.

- 15d NORTH YORKSHIRE: That conference recognises the increase in violent attacks on health care staff in general practice and demands BMA / GPC to lobby government for more severe sanctions for perpetrators.

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

- * 16 NORTH ESSEX: That conference notes that the vital safeguarding work GPs undertake is complex, demanding, and characterised by a need to share detailed, highly sensitive information with partner agencies in an often short timeframe, and as such:
- (i) recognises that this places an enormous burden on clinicians and administrative teams
 - (ii) recognises that this work is currently either unresourced in many areas, or covered by a variety of different local arrangements, despite the legislation and guidance governing the work being laid out nationally
 - (iii) calls for a Safeguarding DES in each nation of the UK that meets this resourcing need and recognises the many hours of unfunded work that GPs currently do in this area.

DIGITAL, TECHNOLOGY AND DATA

17.10

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

- * 17 GLOUCESTERSHIRE: That conference recognises that artificial intelligence (AI) is likely to impact the provision of care significantly over the next decade and calls for appropriate controls to ensure the safe introduction of systems in primary care, in particular that:
- (i) only a doctor with full training and appropriate levels of experience will be able to effectively challenge an AI when it produces questionable results
 - (ii) AI has the potential to improve consistency and safety of doctor led care, but only when doctors are enabled and indemnified to challenge it
 - (iii) while AHPs are likely to see similar gains in productivity, consistency and safety the use of AI will not remove the need for doctor oversight of patient care
 - (iv) that any introduction of AI should take lessons from sectors such as aviation and ensure that doctors are not so far removed from routine cases that they become de-skilled
 - (v) that GPCs should make it clear that primary care without GPs, especially in a world of data hungry AI, will lead to an unsustainable increase in cost and ultimately a two tier NHS.
- 17a LAMBETH: That conference notes the potential benefit and risks associated with future developments in AI. Conference call on GPC UK to carry out research on the benefits and risks of using artificial intelligence as a triage tool for general practice and report back to next year's conference with the results.

CLOSE

17.30

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

- * 18 AGENDA COMMITTEE TO BE PROPOSED BY GATESHEAD AND SOUTH TYNESIDE: That conference has increasing concerns about the development and promotion of physician associates in general practice and:
- (i) agrees that GPs, as expert medical generalists, cannot and should not be replaced by physician associates
 - (ii) condemns the use of physician associates in general practice for anything other than administrative or simple procedural duties
 - (iii) believes that the GMC is complicit in the government's agenda to create a cheaper and inferior delivery model of primary care by using PAs in place of GPs
 - (iv) insists that patients are made fully aware of the role of any health care professional before any consultation
 - (v) necessitates that all GPC UK members openly declare any interest, financial or otherwise, in PAs from this point onwards.
- 18a GATESHEAD AND SOUTH TYNESIDE: That conference has increasing concerns about the role played by the BMA and RCGP in the development and promotion of physician associates in general practice and calls for GPC UK to:
- (i) condemn the use of physician associates in general practice for anything other than administrative or simple procedural duties
 - (ii) necessitate that all GPC UK members openly declare any interest, financial or otherwise, in PAs from this point onwards
 - (iii) declare no confidence in the current RCGP leadership
 - (iv) denounce the practise of any Royal College accepting financial sponsorship from firms promoting PAs
 - (v) sever ties with the RCGP until confidence is restored that the College will act in the best interests of its doctor members and patient safety.
- 18b LIVERPOOL: That conference is deeply concerned about GPs losing their jobs and being unable to find work, while the use of physician associates within general practice increases. We:
- (i) condemn the expansion of physician associates in general practice
 - (ii) agree that GPs, as expert medical generalists, cannot and should not be replaced by physician associates
 - (iii) agree that physician associate numbers increasing within general practice carries significant patient safety risks, and will result in poorer quality care being delivered to patients, and call for GPC UK to campaign publicly, highlighting this to patients
 - (iv) urge GPC UK to lobby relevant stakeholders, including the GMC, to provide a physician associate competency framework, with clear guidance on scope of practice to protect patient safety.
- 18c BRO TAF: That conference insists that patients are made fully aware of the role of any health care professional before any consultation.
- 18d BEDFORDSHIRE: That conference:
- (i) believes that the employment in practices of AHPs rather than of sessional GPs can be a false economy, if the employment decision is driven by economic rather than clinical factors, and
 - (ii) calls on GPC UK to remind all practices of the range of support that sessional GPs can provide.

- 18e LAMBETH: That conference notes the impact of allied health professionals working in general practice and:
- (i) believe that there is inadequate guidance on how best to utilise physician associates in general practice
 - (ii) believes that this is leading to inappropriate staff seeing undifferentiated patients
 - (iii) asks GPC UK to urgently develop such guidance to protect the profession and the public.
- 18f GLOUCESTERSHIRE: That conference requests appropriate legislation requiring health practitioners to clearly identify their role, qualifications and designation, both verbally and on name badges, to ensure that transparency and patient safety is maintained.
- 18g HIGHLAND: That conference considers that physician associates are a workforce that can be better utilised in secondary care settings than dealing with the undifferentiated and unscheduled presentations that are frequently encountered in general practice, especially where patients may be frail and with multiple morbidities.
- 18h WORCESTERSHIRE: That conference believes that the physician associate role:
- (i) should not be regulated by the General Medical Council but rather the Health and Care Professions Council
 - (ii) should be reviewed as a result of cases of patients suffering harm following misdiagnosis
 - (iii) is creating confusion for patients who make assumptions that they are medically trained professionals
 - (iv) requires supervision by general practitioners and that this should be appropriately remunerated.
- 18i DERBYSHIRE: That conference whilst recognising the value of working in multidisciplinary teams with clearly defined and easily identifiable roles notes the development of “PAs” – physician associates and demands that in order that the public not be misled or deceived such healthcare workers:
- (i) shall be renamed physician assistants, never be called “doctor” in a healthcare setting even if they have a PhD, nor have grading structures which could permit confusion as to whether they hold a medically registrable qualification in the traditional sense
 - (ii) must hold their registration through the Health Professions Council and NOT through the General Medical Council
 - (iii) must only be appointed to work to a named responsible registered medical practitioner (or a named deputies), one of whom who is immediately available, appropriately indemnified AND specifically consents in writing to supervise a physician ASSISTANT
 - (iv) must take personal responsibility for their professional actions
 - (v) must NOT treat or discharge patients presenting with undifferentiated problems.
- 18j AYRSHIRE AND ARRAN: That conference is deeply concerned by the decision that the GMC will regulate PAs (physicians associates) and AAs (anaesthesia associates) and:
- (i) believes that the GMC is complicit in the government’s agenda to create a cheaper and inferior delivery model of primary care by using PAs in place of GPs
 - (ii) believes that the GMC is contributing to confusion for the public around the clear roles and responsibilities of each professional group
 - (iii) demands that the GMC only regulates doctors.
- 18k MID MERSEY: That conference believes that:
- (i) ARRS staffing and heavy endorsement relating to physicians associates is causing redundancies of GPs
 - (ii) general practice cannot be substituted by physicians associates.

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

- * 19 NORTHERN IRELAND WESTERN: That conference calls on GPC UK to call on the UK government and devolved nation governments via the devolved nation GPCs to ensure that general practitioners are the main provider of primary care and ensure that any plans of replacing this professional workforce with non-medical professional entities be rejected.

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

- * 20 AGENDA COMMITTEE TO BE PROPOSED BY CAMBRIDGESHIRE: That conference notes that personnel in new roles coming into general practice require a significant amount of training, supervision, and support from existing general practitioners and calls upon GPC UK ensure that:
 - (i) any GP in a supervisory role is understood to be offering enhanced clinical expertise to complement and support those that are being supervised
 - (ii) protected time and appropriate remuneration should be provided to any GP taking on supervisory roles
 - (iii) all GPCs liaise with MDOs to develop guidance that defines and explicitly describes the role of supervisor to different cohorts of colleagues
 - (iv) constraints be placed on how many colleagues a single GP can simultaneously supervise to protect the safety of patients
 - (v) the role of GPs in primary care is protected by ensuring that AHPs supplement rather than substitute, with high quality, cost-effective care provided by services that are GP-led and GP-delivered.
- 20a CAMBRIDGESHIRE: That conference is alarmed by the current expectation that all GPs, of any level of experience, can and should supervise and take clinical responsibility for the decisions of non-GP colleagues, and calls upon GPC UK to ensure that:
 - (i) only GPs who are qualified and trained to supervise colleagues can do so and that this training is provided
 - (ii) that no GP should be obliged to supervise in this role
 - (iii) protected time should be allocated to any GP taking on this role
 - (iv) appropriate remuneration should be provided for this supervisory role.
- 20b CAMBRIDGESHIRE: That conference calls on GPC UK to work with relevant bodies to agree a set of standards for any GP in a supervisory role to be given:
 - (i) clarity about the specific skillsets, qualification and experience of all supervisees prior each supervisory shift to ensure adequate understanding of the team members' capabilities to ensure delivery of safe patient care
 - (ii) paid time to reflect the numbers of patients seen by the wider team in formally debriefing team members after the completion of patient-facing care to enable good team processes, including opportunistic development and training
 - (iii) acknowledgement that any GP in a supervisory role is understood to be offering enhanced clinical expertise to complement and support those that are being supervised
 - (iv) recognition that the supervisee remains holding the clinical responsibility for their own care that they offer the patient and the supervisee is responsible for recognising their own knowledge or skills limitations and for requesting support.

- 20c DEVON: That conference feels the word supervision is used lightly by many in central government without a full understanding of the clinical and professional responsibility that supervising colleagues entails, and asks that:
- (i) all GPCs liaise with MDOs to develop guidance that defines and explicitly describes the role of supervisor to different cohorts of colleagues including PAs and AHPs
 - (ii) supervision responsibilities be explicitly defined and limited in the contracts of sessional doctors, as well as remaining optional
 - (iii) supervision of the wider general practice workforce be associated with protected time
 - (iv) constraints be placed on how many colleagues a single GP can simultaneously supervise to protect the safety of patients.
- 20d HIGHLAND: That conference recognises that a multi-disciplinary team can provide various forms of support to the GP workforce, but that factors such as rapid expansion of teams or inconsistent staffing levels can cause difficulties for team dynamics and demands that GPs must retain decision-making around safe arrangements for supervision of other clinicians.
- 20e DERBYSHIRE: That conference notes that personnel in new roles coming into general practice require a significant amount of training, supervision, and support from existing general practitioners and:
- (i) such activities must be appropriately resourced financially and with dedicated professional time
 - (ii) general practitioners can only be responsible for staff whom they directly employ.
- 20f SOMERSET: That conference:
- (i) clinicians working in general practice, such as pharmacy technicians, paramedic practitioners and physician associates are fully qualified independent professionals registered with formal regulatory bodies:
 - (ii) decries the fact that they are currently required to retrain in order to work independently in general practice
 - (iii) is concerned that this undermines their transferable skills and prevents them from fulfilling their full potential to support practices, and
 - (iv) insists that their professional training is reviewed and amended to allow their skills to be fully applicable to working in general practice as soon as they are qualified.
- 20g MID MERSEY: That conference believes that general practice is unsafe in the hands of physicians associates and demands that in the name of patient safety we call for the re-establishment of a workable skill mix within general practice.
- 20h MORGANNWG: That conference calls for protecting the role of GPs in primary care by ensuring that AHPs supplement rather than substitute.
- 20i LIVERPOOL: That conference believes that a complex patient is only safely identified in retrospect and reinforces the role of the expert general practitioner as the gold standard against which all other staff should be assessed.
- 20j CLEVELAND: That conference affirms the essential value of GPs, and insists that high quality, effective and cost-effective general practice can only be provided by services that are GP-led and GP-delivered.

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

- * 21 **AGENDA COMMITTEE TO BE PROPOSED BY WELSH CONFERENCE OF LMCs:** That conference believes that the inability of GP registrars to complete the RCGP Simulated Consultation Assessment (SCA) exam in November 2023 due to a "technical fault" had a significant impact on registrars, on top of other wider concerns regarding the assessment. Conference:
- (i) calls upon RCGP to provide any candidate who is unable to undertake the SCA, due to a no fault attempt failure, full reimbursement of all costs incurred, a resit opportunity within two weeks of the original examination, and financial compensation for the undue stress caused
 - (ii) calls upon RCGP to provide easy access wide ranging IT support to candidates prior to the examination, including if required, providing equipment and in-person support within the GP practice prior to the examination
 - (iii) considers the SCA unfit for purpose and unreflective of general practice
 - (iv) demands an urgent review of the cost of the SCA by RCGP and other stakeholders, to review funding arrangements and running costs, aiming to mitigate costs to candidates.
- 21a WELSH CONFERENCE OF LMCs: That conference considers the SCA as an examination to be unfit for purpose. It asks for an urgent review of the cost of the examination and of the support offered to candidates. We call for any candidate who has been unable to undertake their examination due to technical issues or other RCGP failure to be entitled to:
- (i) full reimbursement of all costs incurred
 - (ii) a resit opportunity within two weeks of the original examination date
 - (iii) financial compensation for the undue stress caused.
- 21b LIVERPOOL: That conference notes with disdain the IT issues suffered by candidates attempting the "Simulated Consultation Assessment" as part of the MRCGP Examination since its introduction. We call upon the GPCs to liaise with the RCGP to:
- (i) ensure the RCGP provides easy access IT support to candidates prior to the examination, including providing equipment (not limited to camera, microphone and headsets) should it be required by the candidate, and also if required, in-person IT support within the GP practice prior to the examination
 - (ii) provide easy access support from the RCGP on the examination day, should issues arise, to facilitate same day conclusion of the examination
 - (iii) update examination guidance from the RCGP to facilitate a repeat "Simulated Consultation Assessment" attempt within two weeks, free of charge, for a candidate who was affected by a no-fault issue which meant the examination could not be completed.

- 21c GATESHEAD AND SOUTH TYNESIDE: That conference agrees that the inability of GP registrars to complete the RCGP Simulated Consultation Assessment (SCA) exam in November 2023 due to a "technical fault" had significant impact on trainees. This meeting:
- (i) depends full explanation and apology from the RCGP, and assurances that these mistakes are not repeated
 - (ii) expects financial compensation for trainees and practices affected by this debacle
 - (iii) believes that RCGP must be solely focussed on general practitioners and should have no role in the training of PAs
 - (iv) believes that failure in RCGP to urgently debate and implement the above should result in a vote of no confidence in the RCGP.
- 21d LAMBETH: That conference calls on the GPC UK to support the GP registrars committee and that:
- (i) clarity is sought on the costs of professional exams
 - (ii) a strategy is developed to reduce and mitigate the professional examination costs
 - (iii) differential attainment in exams are adequately addressed.
- 21e LAMBETH: That conference:
- (i) notes the high cost of professional exams and ongoing professional development
 - (ii) believes that the professional examination costs reflect the cost of a doctor and should be borne by the State and not the individual
 - (iii) calls on GPC UK to work with the new Health Secretary to develop strategies to mitigate the examination costs of GP registrars as a priority.
- 21f CITY AND HACKNEY: That conference is concerned about the RCGP adopting the simulated consultation assessment for GP registrars in light of fewer than 1% of GP consultations being conducted via video link and requests that:
- (i) GP training and assessments should prepare trainees for a lifelong career in general practice
 - (ii) assessments should examine trainees on in-person and telephone consultations as these are the types of consultation they will be undertaking.
- 21g GP REGISTRARS COMMITTEE: That conference recognises the considerable work GP examiners undertake in marking RCGP Simulated Consultation Assessment examinations but that unacceptably, general practice is alone in passing on examiner costs to registrar candidates. It calls upon the BMA to:
- (i) lobby RCGP and relevant other stakeholders such as statutory education bodies to scope alternative methods for examiner funding which do not pass this expense on to registrar candidates
 - (ii) following scoping, lobby RCGP adoption of an alternative funding model with greater parity to secondary care speciality examiners and SPA sessions which is not passed on to individual practices
 - (iii) urge adoption of this alternative funding model within the next two years.

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

- * 22 AGENDA COMMITTEE TO BE PROPOSED BY NORFOLK AND WAVENEY: That conference believes that GP premises are in dire need of upgrade and current underfunding is short sighted. We call for the GPCs to lobby governments to:
- (i) invest in general practice estate infrastructure to ensure they are fit for purpose in the 21st century
 - (ii) negotiate grants to enable improvements in premises for the use of teaching and training
 - (iii) request analysis of areas in the UK where GP recruitment is most difficult and prioritise these areas for financial help with premises
 - (iv) mandate the transparency of section 106 money (or national equivalent) for healthcare, allowing GP practices and LMCs to influence this spend
 - (v) allow accessible healthcare by funding estates in primary care, enabling services from secondary care to take place in primary care.
- 22a NORFOLK AND WAVENEY: That conference deplores the fact that despite the increase in both medical undergraduate and postgraduate teaching and training taking place in general practice, required adjustments in premises have not been supported. It calls for GPC to urgently:
- (i) negotiate grants to enable improvements in premises for the use of teaching and training
 - (ii) request analysis of areas in the UK where GP recruitment is most difficult and prioritise teaching practices in these areas for financial help with premises
 - (ii) request financial help with premises for practices offering excellence in teaching, to enable them to expand this vital service.
- 22b AVON: That conference demands GPC UK must negotiate increased funding for GP estates, to ensure in future we are not sitting on each other's laps and have a building fit for purpose and:
- (i) recognise and fund space in GP estates
 - (ii) mandate the transparency of section 106 money for healthcare, allowing GP practices and LMCs to influence this spend
 - (iii) allow accessible healthcare by funding estates in primary care, enabling services from secondary care to take place in primary care
 - (iv) fund estates in primary care for space for neighbourhood teams to work together.
- 22c KERNOW: That conference believes that GP premises are in dire need of upgrade and current underfunding is short sighted. What we have is often not fit for purpose and certainly not fit for the future. Conference calls on our representative bodies to lobby their governments for proportionate and fair investment to enable us to deliver modern and sustainable general practice in modern, well maintained buildings with adequate clinical space.
- 22d MERTON: That conference calls upon government to invest in general practice estate and IT infrastructure to ensure that are fit for the 21st century.
- 22e MID MERSEY: That conference believes that the Government's Estates Policy is woefully inadequate and needs a major overhaul in order to provide a fit for purpose primary care service.

- 22f CAMBRIDGESHIRE: The vital expansion of GP training has not been fully planned for and conference calls for GPC UK to support:
- (i) increased funding for training practices to enable high quality teaching and training be given the time it deserves rather than squeezed into jam packed clinical days
 - (ii) adequate planning for help to expand GP practice premises to accommodate the expansion in GP registrar numbers
 - (iii) a national UK recruitment campaign focussed on the five pillars of general practice (expert generalism, management of risk and uncertainty, holistic care, patient advocacy and continuity of care) to inspire future GPs and educate the general public on the need for GPs.
- 22g CAMBRIDGESHIRE: That conference is frustrated in a lack of planning for healthcare services resulting in general practices being required to accept significant numbers of patients from new housing developments without planning for the services required, investment to support these new registrations, or understanding of the strain this places practices under, and calls GPC UK to campaign for a change in the planning regulations which would require the development of a UK strategy compelling local healthcare commissioners to:
- (i) be proactively involved in the assessment and planning stages of new housing developments to ensure healthcare services are a key part of the development plans
 - (ii) ensure there is appropriate commissioning of healthcare services for these new developments, whether this be from existing providers or new contracts
 - (iii) provide a minimum level of investment required by law per new household to ensure that there is sufficient funding to cover the healthcare needs of this new population.
- 22h LAMBETH: That conference recognises the urgent need to consider the viability of the general practice estate to deliver the growth in GP numbers, as well as the evolving needs of an aging, sicker population. Conference calls:
- (i) on GPC UK to work with any incoming government to develop a fit for purpose strategy to ensure that general practice has the physical infrastructure to deliver for the needs of the population over the next 20 years
 - (ii) on GPC to negotiate to ensure digital infrastructure is fit for purpose to deliver for the needs of the population over the next 20 years.

CONFERENCE AND GPC

10.20

CONFERENCE REFORMS - MAJOR ISSUE DEBATE

In accordance with Conference policy from 2023, the Agenda Committee has carried out a review of the UK LMC Conference, taking on board feedback from the workshops at the 2023 Conference. This review is detailed in the attached document (Appendix 2).

Conference is asked to debate the review document and its enclosed recommendations, with a view to voting on the proposed motions beneath which, if passed, will form policy for reform. There will follow an invitation for speakers from the floor to contribute to the debate with regard to all of the motions and brackets below, with speeches no longer than **one minute each** from the microphones.

- TD2-1 AGENDA COMMITTEE: That conference demands Standing Orders be amended to require that motions which are specific to a single nation may not be prioritised for debate, unless the devolved nation conference chair for that nation has requested it be raised to a UK level.
- TD2-2 AGENDA COMMITTEE: That conference demands Standing Orders be amended to reflect the will of devolved nation conferences to clarify that UK Conference policy is directed to GPCUK and shall neither bind nor direct any devolved nation GPC unless and until the LMC Conference for that devolved nation passes such policy.
- TD2-3 AGENDA COMMITTEE: That conference believes that the LMC Secretaries Conference is a valued resource for LMCs, and it calls for it to be combined with the UK Conference on a trial basis in order for its advantages to be more widely available to all members of Conference.
- If the above motion is carried, then the following options will be voted on via a 1-6 vote:
- (i) Secretaries Conference should be held the day before the UK LMC Conference at the same venue
 - (ii) Secretaries Conference and the UK LMC Conference should be merged into a single two-day event with consequent loss of debating time and CPD
 - (iii) Secretaries Conference and the UK LMC Conference should be merged into a single 2.5 day event with some loss of debating time but no loss of CPD.
- TD2-4 AGENDA COMMITTEE: That conference mandates GPDF to continue to subsidise and support the delivery of a conference dinner, aside from expenses for alcohol.
- TD2-5 AGENDA COMMITTEE: That conference believes that the venue for the UK LMC Conference should rotate through all four nations. When deciding the venue, the chair shall consult with devolved nation conference and GPC chairs, to ensure a venue which showcases the host nation and is optimal for travel and accommodation.
- TD2-6 AGENDA COMMITTEE: That conference supports the Agenda Committee’s recommendation that a fully hybrid conference is not feasible but believes that remote access options for CPD components should be explored and instructs the Agenda Committee to continue work on this area.
- TD2-7 AGENDA COMMITTEE: That conference instructs the Agenda Committee to review the method of seat allocation to the UK Conference, in discussion and collaboration with GPC UK, to ensure a more inclusive Conference, whilst nevertheless ensuring that the four-nation balance of Conference is not in any way diminished, and ensuring Conference is representative of all constituencies.
- TD2-8 AGENDA COMMITTEE: That conference calls for any seats allocated to an LMC which have not been registered by the registration deadline to be made available to other LMCs, from the same nation, in a manner which maximises inclusivity and diversity.

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

- * 23 AGENDA COMMITTEE TO BE PROPOSED BY DEVON: That conference notes with concern the absence of GPC England from the BMA's own articles and bye laws, unremedied for a full eight years since the [Meldrum Reforms](#), alongside the inequitable lack of a national council for England, and:
 - (i) notes with regret, under the articles and bye-laws, the subsequent requirement to undertake a referendum of BMA divisions in December 2023 in order for GPC England to be able to submit evidence to the DDRB, whilst devolved nation GPCs were able to submit via their devolved national councils

- (ii) demands the BMA create a national council for England as a matter of urgency
- (iii) believes that if, and when, a national BMA council for England has been created, the BMA UK council be reformed into a smaller executive body with strategic oversight for pan-UK issues
- (iv) demands that any change to the membership of GPC UK be dependent on the enshrinement of GPC England within the BMA's articles and bye-laws, as a matter of equity with the GPCs of Scotland, Wales and Northern Ireland.

23a DEVON: That conference notes with concern the absence of GPC England from the BMA's own articles and bye laws, unremedied for a full eight years since the [Meldrum Reforms](#), and the inequitable lack of a national council for England:

- (i) notes with regret, the subsequent requirement to undertake a referendum of BMA divisions in December 2023 in order for GPC England to be able to submit evidence to the DDRB, whilst devolved nation GPCs were able to submit via their devolved national councils
- (ii) demands the BMA create a national council for England as a matter of urgency
- (iii) believes that if and when a national council for England is created, it would benefit the UK Council to be reformed into a smaller executive body with strategic oversight
- (iv) demands that any change to the membership of GPC UK be dependent on the enshrinement of GPC England in the structures of the BMA on an equitable level to the GPCs of the other three nations.

23b GATESHEAD AND SOUTH TYNESIDE: That conference notes with concern the absence from the BMA's articles and bylaws of GPC England since the disastrous [Meldrum reforms](#) and:

- (i) notes with regret the necessity, under the articles and bye-laws, of a council vote and a subsequent referendum of BMA divisions in December 2023 in order to permit GPC England to submit evidence to the DDRB, whilst devolved nation GPCs were able to submit via their devolved nation councils
- (ii) demands parity with the devolved nations by the creation by the BMA of an English council, as a matter of the greatest urgency
- (iii) requires that, when all four nations have councils the BMA council be considered for reform into a smaller body with strategic oversight for pan-UK issues
- (iv) demands that GPC England be enshrined within the BMA's articles and bye-laws, as a matter of equity with the GPCs of Scotland, Wales and Northern Ireland
- (v) insists that any changes to the membership, structure and working arrangements of GPC UK be paused until all four nations have equitable arrangements for representation structures.

23c LIVERPOOL: That conference notes with concern the absence of GPC England from the BMA's own articles and bye laws, un-remedied for a full eight years, since the disastrous [Meldrum Reforms](#), and:

- (i) notes with regret, the consequent requirement to undertake a referendum of BMA divisions in December 2023, in order for GPC England to be able to submit evidence to the DDRB, whilst devolved nation GPCs were able to submit evidence via their devolved national councils
- (ii) demands the BMA create a national council for England as a matter of urgency
- (iii) believes that when a BMA national council for England is created, that BMA UK Council be reformed into a smaller executive body with its main function being strategic oversight
- (iv) demands that any change to the membership of GPC UK be halted until GPC England is enshrined in the structures of the BMA on an equitable level to the other devolved nations.

- 23d WEST PENNINE: That conference notes with concern the absence of GPC England from the BMA's own articles and bye laws, unremedied for a full eight years since the disastrous [Meldrum Reforms](#), and:
- (i) notes with regret, the consequent requirement to undertake a referendum of BMA divisions in December 2023 in order for GPC England to be able to submit evidence to the DDRB, whilst devolved nation GPCs were able to submit via their devolved national councils
 - (ii) demands the BMA create a national council for England as a matter of urgency
 - (iii) believes that if and when a national council for England is created, the UK Council be reformed into a smaller executive body with strategic oversight
 - (iv) demands that any change to the membership of GPC UK be halted until GPC England is enshrined in the structures of the BMA on an equitable level to the other devolved nations.
- (Supported by North Essex, Kent, North Staffordshire and Cambridgeshire LMCs)
- 23e WALTHAM FOREST: That conference is astounded that the BMA's articles and bye-laws do not recognise GPC England, and:
- (i) notes that devolved nation GPCs are able to submit evidence to the DDRB via their devolved national BMA councils
 - (ii) demands the BMA create a national council for England as a matter of urgency
 - (iii) believes that following the formation of a national council for England, the UK Council should be reformed into a smaller executive body with strategic oversight
 - (iv) demands that any change to the membership of GPC UK must be halted, until GPC England is enshrined in the structures of the BMA on an equitable level to the other devolved nations.
- (Supported by Bexley LMC, Brent LMC, City & Hackney LMC, Ealing, Hammersmith & Hounslow LMC, Greenwich LMC, Kensington, Chelsea & Westminster LMC, Merton LMC, Newham LMC, Tower Hamlets LMC)
- 23f MANCHESTER: That conference notes with concern the absence of GPC England from the BMA's own articles and by-laws, unremedied for a full eight years since the disastrous [Meldrum Reforms](#), and:
- (i) notes with regret the consequent requirements to undertake a referendum of BMA divisions in December 2023 in order for GPC England to be able to submit evidence to the DDRB, whilst devolved nation GPCs were able to submit via their devolved councils
 - (ii) demands the BMA creates a national council for England as a matter of urgency
 - (iii) believes that if and when a national council for England is created, the UK Council be reformed into a smaller executive body with strategic oversight, and
 - (iv) demands that any change to the membership of GPC UK be halted until GPC England is enshrined in the structures of the BMA on an equitable level to the other devolved nations.
- 23g HULL AND EAST YORKSHIRE: That conference notes the existence of national BMA councils for all devolved nations except England and:
- (i) directs the chairs of each GPC to support the creation of a national BMA council for England
 - (ii) believes the current situation creates inequalities in representation between the four nations
 - (iii) seeks clarification over the relationship between the BMA, the GPC committees and the conferences of local medical committees in England, Wales, Scotland and Northern Ireland.

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

- * 24 AGENDA COMMITTEE TO BE PROPOSED BY GPDF: That conference calls on GPDF to comprehensively illustrate and define the costs of prior conferences with a view to proposing a consistent and transparent total cost envelope for the UK Conference, to be presented to the Annual Conference of 2025 and available to all members thereafter.

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

- * 25 CLEVELAND: That conference values the LMC Support Network and instructs the GPDF to fund the reasonable costs of this in the long-term.

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

- * 26 AGENDA COMMITTEE TO BE PROPOSED BY LAMBETH: That conference has significant concerns about visible reduction in the representation of GPs within the BMA over the last two years, including changes to procedures for electing representatives to the 2024 BMA Annual Representative Meeting, and:
 - (i) believes that with the exception of the GPCs, the BMA no longer adequately represents all GPs
 - (ii) calls upon the GPC UK to consider GP relevant motions passed at ARM, but not to enact them unless they are consistent with UK LMC conference policy
 - (iii) requires the GPCs to analyse the evolving political movements in other branches of practice so that they may be better understood, learned from and that GPs can be appropriately protected from any conflicts of interest
 - (iv) calls on GPC UK to explore options regarding improving and safeguarding GP representation within the BMA, to prevent decisions about general practice being made by a body in which GPs are a minority
 - (v) requires GPC UK, GPDF and NIGPDF to explore and, if viable, enact and fund GP trade union representation independent of the BMA, whilst retaining close links with secondary care colleagues.
- 26a LAMBETH: That conference has significant concerns about visible reduction in the representations of GPs within the BMA over the last two years and:
 - (i) believes this is as a result of deliberate actions by a significant political group within the organisation
 - (ii) calls on GPC UK to explore options regarding the role of GP representation within the BMA

- (iii) requires GPC UK to explore forming a profession and trade union for GPs independent of the BMA.
- 26b BUCKINGHAMSHIRE: That conference is alarmed at short notice changes to procedures for electing representatives to the 2024 BMA Annual Representative Meeting that were implemented without consultation. Conference:
- (i) believes that GP representation has been significantly diminished as a result, and that this is detrimental to the interests of our branch of practice
 - (ii) supports demands for a Special Representative Meeting to be held to scrutinise these changes to ensure all due process has been followed in their implementation
 - (iii) instructs GPC to consider what steps to take to protect the interests of general practitioners if these changes are upheld
 - (iv) asks GPC to analyse the evolving political movements in other branches of practice so that they may be better understood, learned from and that GPs can be appropriately protected from any conflicts of interest
 - (v) calls on GPC to explore options to mitigate risks posed to the LMC structure and the interests of GPs more widely from the loss of GP representation at BMA ARM and BMA committees.
- 26c GATESHEAD AND SOUTH TYNESIDE: That conference calls upon GPDF to explore and, if viable, enact and fund GP representation outwith the BMA, whilst retaining close links with secondary care colleagues.
- 26d LIVERPOOL: That conference believes that with the exception of the GPCs, the BMA no longer adequately represents all GPs and calls upon GPC UK to liaise with the wider BMA to work to re-establish the BMA as a strong union for all GPs.
- 26e GATESHEAD AND SOUTH TYNESIDE: That conference recognising that branch of practice autonomy is paramount, notes motions passed at ARM may be contrary to the democratically expressed wishes of UK LMC conference, and:
- (i) calls upon GPC UK to consider GP relevant motions passed at ARM but not to enact them until passed as motions by UK LMC conference
 - (ii) instructs the agenda committee of UK LMC conference to list for consideration by UK LMC conference all GP relevant ARM motions that are not currently consistent with UK LMC conference policy
 - (iii) demands that safeguards be put in place to prevent decisions about general practice being made by a body in which GPs are a minority.
- 26f GLASGOW: That conference is concerned that GPC UK is not being adequately supported by BMA and GPDF and calls for BMA and GPDF to ensure that there is adequate funding to support the effective functioning of GPC UK.
- 26g GATESHEAD AND SOUTH TYNESIDE: That conference notes with alarm recent structural changes within the BMA and is concerned that changes were pushed through without clarity on where general practice as a branch of practice (BoP) would fit in new workplace based structures and:
- (i) is concerned that sessional and LTFT GPs are likely to be disadvantaged representationally
 - (ii) fears that, as a result of said changes, issues critical to general practice are likely to receive lesser priority than those of other BoPs
 - (iii) has great concern that an ARM with <10% of representatives being GPs has the ability to elect multiple members to GPC UK without a similar degree of reciprocity
 - (iv) demands the pausing of, to permit scrutiny, equalities impact assessment and improvements where necessary to be made

- (v) calls upon general practice as a BoP to disengage from ARM 2024 if it proceeds without changes having been ratified by SRM.

CHARITIES

12.20

LUNCH

12.30

SOAPBOX

13.30

OPTIONS FOR THE FUTURE

14.00

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

- * 27 BUCKINGHAMSHIRE: That conference believes that the NHS needs GPs more than GPs need the NHS.

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

- * 28 AGENDA COMMITTEE TO BE PROPOSED BY WEST SUSSEX: That conference wishes for our governments to offer GMS contracts that have been agreed by negotiation and:
 - (i) demands that a GMS contract amendment can only be imposed on general practice at times of national emergency and not when negotiations prove difficult
 - (ii) believes that UK governments have failed to provide the necessary investment to ensure the survival of GMS
 - (iii) believes that being prepared to walk away may be more effective than industrial action
 - (iv) mandates the GPCs to develop viable alternatives to GMS, including actively supporting GP practices to work outside the NHS
 - (v) empowers the GPCs to use the threat of mass resignation to improve the NHS offer to practices.

- 28a WEST SUSSEX: That conference recognises that, despite a wealth of evidence supporting the benefit and returns on investment into GP partnerships, the government remains fixed in its determination to do the opposite and calls upon the BMA:
- (i) to recognise that reason does not work with the reasonable
 - (ii) accept that the only way to strike a good deal may not be to strike but to be prepared to walk away
 - (iii) offer viable alternatives and actively support GP practices work outside the NHS
 - (iv) use the threat of mass resignation to improve the NHS offer to practices.
- 28b HIGHLAND: That conference wishes for our governments to offer GMS contracts that have been agreed by negotiation and demands for these to be funded in a way that will make an independent contractor model viable going forward.
- 28c BRO TAF: That conference asks that GPC UK explore alternative models of primary care given that UK governments have failed to provide the necessary rescue package to ensure the survival of GMS.
- 28d BUCKINGHAMSHIRE: That conference believes all options have to be on the table for future GP contract negotiations, including “walking away” from the GMS contract.
- 28e DEVON: That conference demands that a GP contract amendment can only be imposed on general practice at times of national emergency and not when negotiations prove difficult.
- 28f HIGHLAND: That conference welcomes the reports from financial audit of NHS funding and calls on our governments to recognise the value of health care provided through GMS contract arrangement.
- 28g NORTHERN IRELAND SOUTHERN: That conference is appalled by the inaction of all of the NHS commissioning structures across the UK in addressing the worsening pressures facing primary care and instructs GPC UK, NIGPC, GPC England, SGPC and GPC Wales to fully explore if taking industrial action is an option for GP partners.
- 28h LAMBETH: That conference supports all strategies employed by the relevant GPC across the four nations, up to and including industrial action where appropriate, to better improve the core financial settlement to general practice.

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

- * 29 GLOUCESTERSHIRE: That conference regrets that the NHS is underfunding general practice to such an extent that patients are increasingly looking to access care privately and:
- (i) insists that GPs should have the ability to treat patients privately in the same way that other appropriately trained clinicians can
 - (ii) requests that GPCs in the four nations ensure there are no contractual restrictions on practices seeing private patients, subject to appropriate fair systems in place
 - (iii) that practices are not unfairly penalised financially by seeing private patients in NHS facilities.

- 29a OXFORDSHIRE: That conference believes GP contractors should be able to take on private work alongside their NHS contract and:
- (i) demands that restrictions on use of practice premises for this be removed
 - (ii) demands that restrictions on times and types of private work be removed
 - (iii) believes mixed NHS and private work may have positive effect on GP recruitment and retention.
- 29b CROYDON: That conference asks GPC to negotiate a lifting of the restrictions on providing private practice, so that practices can find new sources of income to support themselves by providing their own patients with care not commissioned from the NHS or for which there are long waits for services. In particular we ask that practices be allowed to:
- (i) offer private care to their own patients, where that care is not locally available on the NHS
 - (ii) offer private care to their own patients, where that care is not nationally available on the NHS
 - (iii) offer private care to their own patients, where NHS waits are long and the patient would want to be managed more quickly
 - (iv) offer private GP appointments to their own patients where the NHS is only prepared to offer non-GP appointments, often in other locations (such as for Fuller-type same-day care)
 - (v) advertise such services freely.
- 29c KENT: That conference acknowledges the commitment of GPs to provide comprehensive NHS services. With diminished funding and increased demand there is a place for private GP services. Conference calls upon the GPC to negotiate:
- (i) removal of the clause of the GMS contract that prohibits GPs from seeing their own patients privately
 - (ii) developing a framework for providing private GP services
 - (iii) developing a communication strategy to support GPs who want to offer private services.

CHOSEN MOTIONS

15.00

EMERGENCY BUSINESS

15.10

CLOSING BUSINESS

15.20

CLOSE

15.30

Conference of Representatives of Local Medical Committees

Agenda: Part II

(Motions not prioritised for debate)

Agenda: Part II

(Motions not prioritised for debate)

A and AR Motions

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

PRIMARY / SECONDARY INTERFACE

- A** 30. WELSH CONFERENCE OF LMCs: That conference believes if a physician/specialist reviews a patient and recommends a test, eg x-ray, they should order it themselves and not simply ask the GP to request it. If they do not have the authority to request this themselves, they should have a line manager / clinical director who does have authority.
- A** 31. MERTON: That conference demands that the UK governments place importance on improving communication between secondary and primary care, and that where this involves transfer of patient care, there are clear and agreed safety mechanisms in place, which have been agreed with the LMCs.
- A** 32. DORSET: That conference laments the lack of information and access provided to patients with questions around treatment in secondary care and calls for:
- (i) a secondary care patient accessible "front door" to allow direct interaction regarding patient issues
 - (ii) secondary care to communicate their results to patients promptly
 - (iii) secondary care to deliver direct patient communications utilising up-to-date technology appropriately.
- AR** 33. GLASGOW: That conference recognises the benefits of using remote consultations and specialist allied health professionals in secondary care, however demands:
- (i) where remote consultations take place in secondary care all further actions which require to be undertaken to complete the patient review (eg bloods or examinations) must be organised, actioned and acted on by secondary care
 - (ii) where the service relies on a consultation by an allied health professional this must not result in additional work for the GP and any action that the allied health professional cannot complete should be escalated within the service.
- AR** 34. SUFFOLK: That conference believes that when a GP refers a patient, the provider should take full clinical responsibility for managing the symptoms the patient has been referred for. If the provider wishes to reject the referral, they must contact the patient before discharging them back to general practice.

- AR** 35. GLOUCESTERSHIRE: That conference is dismayed at the increasing volume of work transferred from secondary care to general practice and insists that:
- (i) all hospitals should have access to electronic prescribing as a matter of priority
 - (ii) all hospitals should have access to sick notes, preferably electronically and that hospitals should utilise this properly
 - (iii) a formal review of advice, guidance and other interactions with hospitals to ensure inappropriate work is not transferred to general practice and risk and responsibilities are properly assessed and laid out.

NON NHS AND PRIVATE GP WORK

- A** 36. BRADFORD AND AIREDALE: That conference rejects any suggestion that GP involvement in firearm licensing should be compulsory.
- A** 37. TAYSIDE: That conference regards the current discussions on Firearm Certification and acknowledges:
- (i) this is, and should remain, outwith GMS services
 - (ii) the applicant, or their employer, should continue to meet the full fees for completion of the report and this should not fall to the taxpayer
 - (iii) reports should continue to ask GPs for facts regarding past medical history and not an opinion on fitness to hold a license.
- A** 38. TAYSIDE: That conference believes that private healthcare providers should be required to issue sickness certification for those patients accessing their services for the expected duration of absence from work, including expected recovery time.
- AR** 39. WEST SUSSEX: That conference is concerned by the increasing levels of unnecessary workload directed to practices, and demands that the BMA:
- (i) insist that private providers can refer patients directly to NHS specialist colleagues
 - (ii) support practices to charge providers of care for the time spent on inappropriate workload that should be undertaken elsewhere.
- AR** 40. BRO TAF: That conference calls for a mechanism to allow for any initial GP appointment that occurs as a direct result of a private secondary care review of a registered patient to be reimbursed on a pro rata basis to the original private consultation.
- AR** 41. TAYSIDE: That conference is concerned that schemes, such as the EC04 Flex scheme, have been developed without consultation with general practice despite the direct impact this has resulted in, and calls for all four nation negotiators to:
- (i) inform government(s) that any such future scheme will not be supported or facilitated by general practice if full and collaborative discussions have not been undertaken
 - (ii) stress to government(s) the negative impact on GP practices and that other parts of the Health and Social Care system are better placed to support this work
 - (iii) ensure the guidance and regulations are clear and easy to follow without risk of inappropriate involvement of GP practice teams where this is unnecessary.

SESSIONALS AND PORTFOLIO WAYS OF WORKING

- A** 42. WEST SUSSEX: That conference strongly supports the use of the BMA Model Contract by all GP employers who employ salaried GP colleagues.
- AR** 43. SESSIONAL GPS COMMITTEE: That conference believes that the disparity in maternity leave entitlement between salaried GPs and all other employed NHS doctors, which sees GPs receiving four fewer weeks half pay entitlement is unjust, contributes to the large gender pay gap seen in general practice and calls on GPCs to:
- (i) amend the model contract so that the period of half pay entitlement is extended from 14 to 18 weeks
 - (ii) negotiate uplifts to the SFE to ensure practices are enabled and adequately reimbursed to engage GP cover for such periods of leave.

CLINICAL, PRESCRIBING AND DISPENSING

- A** 44. NORTHERN IRELAND NORTHERN: That conference deplores the ongoing shortages in prescribed medications causing increased workload for GPs and their staff as well as stress for patients and we call on GPC UK to press all government bodies to develop improved supply chains and straightforward pharmacy based solutions when shortages occur.
- A** 45. DERBYSHIRE: That conference demands the BMA will work with other bodies to ensure that when a prescription for a drug at a specified dose is issued by general practice, pharmacists are able to supply alternative medications of the same drug at the same dose in different forms, dose sizes to make the required dose or generic brands without a need for the prescribing practice to reissue a new prescription.
- A** 46. WANDSWORTH: That conference demands that practices should be able to exception report families who refuse to have vaccinations and have signed a disclaimer which is sent and retained by a central NHS body.
- A** 47. CAMBRIDGESHIRE: That conference is dismayed by the lack of progress on the dispensing policy from 2022 LMC UK Conference calling for the dispensing doctor fee envelope to be renegotiated and:
- (i) notes in the two years since this motion the situation has worsened, eroding essential funding and destabilising practices in rural and remote locations
 - (ii) calls on GPC UK to take immediate action as mandated by the 2022 policy, and to provide feedback to this conference in 2025 on the actions taken to avoid mid-year fluctuations in dispensing payments and allow cost neutral changes to dispensing doctor drug reimbursement pursuant to the 2021 DHSC review.

- AR** 48. DEVON: That conference asserts that dispensing practices, serving nine million patients in the UK, should never be expected to operate and dispense at a loss. This could result in instability and risks the viability of rural general practice. Conference is asked to:
- (i) support a review into the process determining dispensing fees, which have devalued by 20% since 2019, putting pressure on dispensing practice operating costs
 - (ii) immediately and regularly review the dispensing practice discount abatement mechanism (clawback), which no longer reflects current discount rates and therefore financially penalises every dispensing practice every time they dispense these items
 - (iii) secure full NHS funding to implement the Electronic Prescription Service in all dispensing practices.

HEALTH INEQUALITIES AND POPULATION HEALTH

- A** 49. CLEVELAND: That conference expresses grave concern that a lack of GPs within the NHS workforce is exacerbating population health inequalities.
- A** 50. HIGHLAND: That conference implores trusts and health boards to be candid with governments about the extent of service gaps and asks governments to also recognise this situation.
- A** 51. LIVERPOOL: That conference believes that in some parts of the UK there are problems with the transition of children's clinical care to adult services and calls upon GPC UK to ensure that there is a seamless transition of clinical care from children's to adult services.
- AR** 52. HIGHLAND: That conference raises as a matter of concern that the needs of populations in remote and rural areas are not being fully met by our GMS contracts and asks GPCs and governments to work towards delivering solutions that can flex for areas which have sparse populations and workforce gaps.

GPC / LMCs / BMA POLITICAL STRUCTURE

- A** 53. CENTRAL LANCASHIRE: That conference believes that the practice of commissioners imposing change to general practice through contractual routes rather than through enabling GP practices is of concern and the requirement for consultation with LMCs needs enforcement at a regional and / or national level.
- (Supported by Cumbria, Lancashire Coastal, Lancashire Pennine and Morecambe Bay LMCs)
- A** 54. CAMBRIDGESHIRE: That conference has reflected on the frustration of working hard to submit motions to UK Conference for inclusion in the agenda, of proposing, debating and voting on these motions only to then feel a distinct sense of déjà vu the following year, and calls on GPC UK to update conference on progress made following the 2022 policy which required GPC UK to publish an annual action plan and formal biannual report on the BMA website.

GP REGISTRARS AND TRAINING

- A** 55. HIGHLAND: That conference endorses the rich learning experiences that can be gained in general practice settings, welcomes investment towards training medical students, and wishes GPs to be adequately resourced in fulfilling educational roles.

- A** 56. NORFOLK AND WAVENEY: That conference asks GPC to work with the appropriate organisations to support GP training within general practice through negotiating appropriate funding uplifts to reflect the increase in costs and required workforce.

GENERAL PRACTICE ESTATES

- A** 57. MERTON: That conference calls upon government as a matter of urgency to review the impact of unpredictable service charges by NHS landlords on the viability of practices, which are unable to make solid budgetary plans for the future.
- A** 58. MERTON: That conference calls upon government to address the issue of historic service charges that have been imposed on practices by NHS landlords, without proper justification and without any attempt to verify the contractors use offer genuine value for money.
- A** 59. TOWER HAMLETS: That conference, with respect to the funding and ownership of practices premises, recognises the different approaches that the devolved nations have taken but insists that full rent and service charge reimbursement should be available for GP premises, regardless of building ownership or which nation the practices reside in.
- AR** 60. HIGHLAND: That conference believes that a general practice premises strategy will be of benefit to every integrated care body and calls on GPCs and LMCs to take this up with governments and relevant bodies.

PROFESSIONAL STANDARDS, MEDICO LEGAL AND REGULATION

- A** 61. TAYSIDE: That conference calls on all elected political representatives to ensure that when they contact a GP practice on behalf of a constituent who has raised an issue with them, that the service the patient was seeking is actually available on the NHS and is the responsibility of general practice and not some other part of the system.
- A** 62. CENTRAL LANCASHIRE: That conference believes repetitious NHS reorganisations are an unprecedented waste of time and money, unravel effective working and professional relationships to the detriment the GP profession and patient populations alike.

(Supported by Cumbria, Lancashire Coastal, Lancashire Pennine and Morecambe Bay LMCs)
- AR** 63. NORTHAMPTONSHIRE: That conference should support the notion that GPs are not responsible for providing clinical supervision for staff not employed by the practice, eg midwives, ambulance technicians and nurses employed by community trusts or secondary care.
- AR** 64. WEST SUSSEX: That conference supports the inclusion of general practitioners on the GMC's Specialist Register and asks the BMA to actively lobby other interested organisations to support this recommendation.

WIDER PRACTICE TEAM

- A** 65. EAST SUSSEX: That conference calls for the inclusion of non-medical clinicians within the Statement of Financial Entitlements eligibility for payments for sickness and parental leave.
- AR** 66. GLOUCESTERSHIRE: That conference insists that all appropriately trained clinical staff in the community can request the appropriate x-ray, ultrasound and other radiological investigations commensurate with their skill set, without the need to involve a GP.
- AR** 67. WEST SUSSEX: That conference is concerned at the lack of occupational health services available to general practice staff, and demands the BMA negotiates such provision is universally available for all staff working in general practice.

DIGITAL, TECHNOLOGY AND DATA

- A** 68. HULL AND EAST YORKSHIRE: That conference believes essential IT tools for delivery of safe and effective patient care should be recurrently funded by national governments and not left to be resourced from underspends on an annual basis.
- A** 69. GLASGOW: That conference recognises the significant impact Subject Access Requests is having on GP practice workload and calls on the UK Government to amend data protection legislation to allow GP practices to levy a reasonable fee when responding to Subject Access Requests.
- A** 70. WEST PENNINE: That conference demands a universal, acceptable, standard of IT provision and support.
- A** 71. LIVERPOOL: That conference believes that efficient general practice is hampered by the inadequate IT provision within secondary care and calls on all health departments to improve connectivity and interoperability with the IT infrastructure in primary care.
- AR** 72. LIVERPOOL: That conference believes that in a truly national health service, it should be possible to transfer GP patient records seamlessly when a patient moves to or from a devolved nation and England, or between devolved nations, and asks the four GPCs to look into facilitating this as a matter of urgency.
- AR** 73. SUTTON: That conference calls upon IT and digital funding to be sufficient so that:
- (i) non-clinical and clinical staff have access to computer at work including when practice premises expand
 - (ii) adequate number of laptops being made available to a practice depending on the clinical staff or non-clinical staff who may need to work flexibly including for child care and or limited practice premises
 - (iii) new access software or accessory tools are tested and funded recurrently if felt to be worthy of recommending to GP to take this up.

- AR** 74. CROYDON: That conference instructs GPC to negotiate full funding for all telephony and messaging costs associated with the move to triaged and digital services by those practices who offer such a system.
- AR** 75. HIGHLAND: That conference is appalled at the level of additional strain put upon general practice staff when IT systems mandated for patient care fail and demands that trusts and boards have suitable contingency plans in place and can make available sufficient resource to practices.

PENSIONS

- A** 76. LEEDS: That conference:
- (i) welcomes changes to pension arrangements that increased the Annual Allowance (AA) in 2023 and abolished the Life Time Allowance (LTA) in April 2024
 - (ii) believes the AA and LTA pension changes are fundamental to retaining experienced GPs in the workforce
 - (iii) calls on the next UK government to retain these arrangements and work with the BMA to resolve other outstanding pension issues that still adversely impact UK GPs.
- AR** 77. CAMBRIDGESHIRE: That conference notes with dismay the potentially discriminatory treatment of GPs, predominantly GP locums, by NHS pension services, by denying these actively contributing GPs full access to the benefits of the NHS pension service, into which they contribute, and calls upon GPC UK to prioritise efforts to redress this inequality by:
- (i) negotiating equal access to all NHS pension service benefits for all currently active contributing members of the NHS pension service
 - (ii) negotiating equal access to all NHS pension service benefits for all non-retired, non-deferred members who have contributed to the NHS pension service within that financial year.

FUNDING PRINCIPLES, PAY / DDRB AND RESOURCES

- A** 78. NORTHERN IRELAND EASTERN: That conference is appalled by the lack of a comprehensive and recurrent, additionally funded general practice indemnity scheme which is available in all areas of the UK and available to all members of the practice team.
- A** 79. CLEVELAND: That conference rejects the suggestion within the 2023 DDRB Report that the fee for GP appraisal work should not remain within the DDRB's remit and instructs the GPCs to continue to provide evidence to the DDRB in respect of GP appraisers.
- A** 80. BUCKINGHAMSHIRE: That conference believes that commissioners should pay practices on time for work done, and that interest should accrue on any late payments.
- AR** 81. NORTH AND NORTH EAST LINCOLNSHIRE: That conference notes that while all other provider groups across the UK are able to incur and have written off financial deficits, the total financial deficit currently incurred by general practice in all four nations is £0.

PARTNERSHIP AND CONTRACTOR MODELS

- A** 82. NORTHERN IRELAND WESTERN: That conference calls on the UK government and the devolved governments to prioritise GP partnership as part of current and future workforce planning partnership, with a specific focus on financial enhancement to support stabilisation within the workforce.

FUTURE PROOFING THE ROLE OF THE GP

- AR** 83. GP REGISTRARS COMMITTEE: That conference is concerned about the ongoing expansion of multi-disciplinary team roles without a proportional increase in general practitioners, which may lead to inadequate supervision of non-doctors members of the MDT and calls on the BMA to:
- (i) publish recommendations on safe multi-disciplinary team clinical supervision requirements
 - (ii) publish recommendations on minimum ratios of general practitioners to other categories of multi-disciplinary team clinical roles
 - (iii) ensure every multi-disciplinary team member has a named on site GP supervisor who has protected time to ensure adequate supervision can be provided.
- AR** 84. CAMBRIDGESHIRE: That conference calls on GPC UK to work with GPDF in delivering a public communication campaign ahead of the general election, to educate the public regarding the clinical strength and necessity of UK general practice.
- AR** 85. COVENTRY: That conference condemns ongoing government efforts to mislead the public regarding continuing reductions in full-time equivalent GPs through conflation of this with GP registrars and other healthcare professionals.
- (Supported by Warwickshire LMC)

GP REGISTRARS AND TRAINING

- AR** 86. GP REGISTRARS COMMITTEE: That conference calls on the BMA to lobby the RCGP and relevant statutory education bodies to issue clear guidance stating that all general practices that provide training to GP registrars and / or foundation doctors must provide them with adequate equipment to perform their clinical duties. This equipment should:
- (i) include, but not be limited to: sphygmomanometer, thermometer, adult and paediatric pulse oximeters, otoscope, direct ophthalmoscope, tape measure, alcohol gel and personal protective equipment
 - (ii) incorporate the reasonable adjustments the GP registrar or foundation doctor is entitled to
 - (iii) be available both on general practice premises as well as when undertaking home visits
 - (iv) be maintained in reasonable working condition with adequate supplies of single use items
 - (v) be fully funded by relevant statutory education bodies.

GREENER GENERAL PRACTICE

- AR** 87. KENT: That conference calls for care closer to home to be prioritised to reduce the carbon footprint and focus on local and digital solutions for patients' needs.

- AR** 88. HIGHLAND: That conference is confident that when provided with the right support, that practices can reduce the volume of material waste generated in general practice, improve how it is separated and processed and help our NHS become more sustainable, and asks for GPCs to push for practices to be provided with assistance in pursuit of this.

Agenda: Part II

Motions suitable for submission to the UK LMC Conference
but not prioritised for debate

PRIMARY / SECONDARY INTERFACE

89. WANDSWORTH: That conference calls for an immediate end to the inappropriate transfer of unfunded work from secondary care to general practice and demands that if such requests continue:
- (i) they must be made via an appropriate referral form which the GP can decline to accept
 - (ii) that the responsibility of the patient remains with the secondary care clinician until the GP has accepted the referral
 - (iii) that any such work if accepted should be fully funded.
90. AVON: That conference believes it is time for GPs to take back control of the primary / secondary care interface landscape and demands that GPC UK 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.
91. HIGHLAND: That conference welcomes the reductions in travel and other benefits realised by remote consulting, but:
- (i) notes with concern that there are instances where the assessment performed remotely by secondary care clinicians is incomplete
 - (ii) asserts that GPs must not be asked to do assessments that would ordinarily be done by a specialist at their outpatient clinics
 - (iii) highlights that in some rural areas patients have had healthcare needs met through specialists travelling out to provide peripheral clinics
 - (iv) asks that patient experience be a driver for how these services are organised.
92. DERBYSHIRE: That conference insists that in circumstances where other health care professionals (such as for example paramedics, community based services or specialist outreach hospital staff) interact with patients in the community without a direct and specific prior invitation from the patient's GP; it is not for GPs to make physician type decisions and such health care professionals own employing organisation must make their own arrangements for physician inputs which do not rely upon the patient's GP input.

93. DERBYSHIRE: That conference recognising the changing patterns of care and blurring of the boundaries of responsibility for patients between primary and secondary or community care demands that when a GP referral is declined or downgraded that both the GP and the patient be informed by the receiving organisation directly and in writing that the referral has been downgraded / refused together with a statement of:
- (i) the reasons for the downgrading or refusal of the referral
 - (ii) the name, status and employing authority of the person authorising the downgrade or refusal
 - (iii) an effective hospital contact telephone number, email address and postal address where the GP or the patient can follow up the matter
 - (iv) an estimate of the wait to be seen.
94. WELSH CONFERENCE OF LMCs: That conference demands that all allied healthcare professionals advising GPs to prescribe medication for patients must include on the request their prescribing number or if they are not a prescriber the name of the doctor / prescriber advising the prescription.
95. WEST PENNINE: That conference requires that whenever a request is made for a GP to accept a shared care arrangement the requestor signature must be that of a medical consultant.
96. HERTFORDSHIRE: That conference calls for GPC / BMA to work with UK health ministries to have secondary care contracts:
- (i) provide secondary care doctors / nurses / specialists access to EPS to enable adequate prescription for their patients after clinical contacts
 - (ii) require that secondary care clinicians should not send letters to GPs following clinical contacts asking them to prescribe
 - (iii) minimise patient risk by requiring the secondary care clinician to initiate any new medication and stabilise the patient before asking the primary care clinician to take over clinical responsibility
 - (iv) instruct all secondary care clinicians to make any necessary and appropriate onward referrals to other specialities and for imaging directly, without referring back to the GP.
97. MID MERSEY: That conference believes the FIT Tests process is not fit for purpose and demands that pathways are treated in the same way as other cancer screening.
98. OXFORDSHIRE: That conference believes that the increase in "admissions avoidance", "virtual wards" and "intermediate care" schemes, whereby patients who previously have been admitted to hospital now remain at home or in community settings, is putting patients, GPs and other community health professionals at risk. Conference recommends any further roll out of such schemes be paused until sufficient evidence of the safety of existing schemes has been provided.
99. LIVERPOOL: That conference believes that prescribing advice for GPs should only be accepted from prescribers.
100. HIGHLAND: That conference is concerned that GPs are being asked to be involved with the emergency detention of patients who have mental health problems, also known as being sectioned, when other arrangements might have been more suitable, and asks for reporting of the use of emergency powers to include figures that reflect where this is known or suspected to have occurred.

101. WELSH CONFERENCE OF LMCs: That conference confirms that unlicensed drugs recommended by specialists should never be a default general practice prescribed item. The clinical responsibility should always rest with the specialist trained in using these specialist drugs for patients with specialist needs.

NON NHS AND PRIVATE GP WORK

102. HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the change in wording on www.nhs.uk regarding private referrals by GPs in 2023, which changed from “you may be charged” to “you will not be charged” was surreptitious and divisive and sets GP against their patients. It calls for the NHS to reverse this change in its advice to service users.
103. HAMPSHIRE AND ISLE OF WIGHT: That conference believes that in the context of ever-increasing rationing of services in the NHS, where GP referrals are requested for non-funded NHS services in the private sector, practices should retain the legal right to charge the patient for any service they offer pertaining to that referral.
104. LEEDS: That conference believes the workload created by requests from the Department of Work and Pensions for benefit related reports:
- (i) is having an impact on the recruitment and retention of GPs across the UK
 - (ii) directs GPC UK to work with DWP to develop other methods, including digital tools, to obtain medical related evidence for benefit claims which does not require a GP report.
105. HIGHLAND: That conference calls for further guidance from Chief Medical Officers on how primary and secondary NHS services should respond when patients seek or have obtained opinions, advice or interventions from private health care providers operating from within our country and beyond.

SESSIONALS AND PORTFOLIO WAYS OF WORKING

106. SURREY: That conference notes with dismay that motions in favour of sessional colleagues' interests have been voted down at previous conferences and proposes a separate forum where purely sessional related motions can be discussed by sessional GPs.
107. AVON: That conference demands that the BMA salaried model contract applies to all GP contract holders within the UK and is not restricted to those providers of a GMS or PMS contract.
108. GLOUCESTERSHIRE: That conference calls for GPC UK, in liaison with the Sessional GPs' Committee, to revise the BMA model contract so that it:
- (i) uses modern employment law terminology and removes extraneous clauses to ensure that the contract is understandable by employees and employers
 - (ii) reflects the introduction of the Clinical Negligence Scheme for GPs in England and Wales (and any future schemes in Scotland and Northern Ireland)
 - (iii) accounts for the greater flexibility needed by portfolio and part time GPs to encourage the retention of as many GPs as possible, including those who can only work in school term time
 - (iv) clarifies the concept of ‘session length’ and allows for alternative ways to account for time worked where agreed by both parties
 - (v) simplifies the allowance of professional development time in terms of hours per year (pro rata in WTE).

CLINICAL, PRESCRIBING AND DISPENSING

109. LEEDS: That conference is alarmed at the increase in unavailability of commonly prescribed drugs and medication and:
- (i) is concerned that this is significantly increasing GP workload
 - (ii) is concerned that this is causing distress to increased numbers of patients which can often lead to abuse directed at general practice and community pharmacy staff
 - (iii) demands that the UK government publicly acknowledge the problem, explain the causes and commit to resolving them.
110. NORTH AND NORTH EAST LINCOLNSHIRE: That conference supports a single formulary across all providers in a system footprint to reduce unnecessary medication changes resulting in delays for patients and increased workload for general practice.
111. HERTFORDSHIRE: That conference asks GPC UK and the BMA to consider ways to enable:
- (i) pharmacists to prescribe alternative preparations without the authorisation of a GP
 - (ii) integrated computer systems where shortages are flagged when prescribing and alternatives are listed
 - (iii) no added administrative requirements for GP practices, if medication is not available or is switched.
112. GATESHEAD AND SOUTH TYNESIDE: That conference is concerned that vaccination rates are falling and infectious disease outbreaks rising and:
- (i) believes that vaccination is a key role for GP surgeries to provide, particularly in areas of deprivation, given the advantages of continuity, access and local credibility
 - (ii) notes the evidence of reduced uptake in areas where vaccination has been moved out of general practice
 - (iii) is concerned that we will see further outbreaks of preventable infectious diseases as a result of reduced vaccine uptake and international migration
 - (iv) demands that vaccination be primarily provided from GP surgeries, with item of service fees annually uplifted to match inflationary costs
 - (v) demands that the GMC act against doctors using social media to propagate unevidenced anti-vaccination messages, noting the harm such messages cause to individuals and the wider population.
113. KENSINGTON, CHELSEA AND WESTMINSTER: That conference is frustrated by the ludicrous process for stock purchasing vaccines in which practices guess the demand for practice administration, while unaware of national marketing campaigns for competitors, and calls on the UK's NHS departments and UKHSA to work with GPC UK to ensure effective use of resources by providing:
- (i) a future coherent strategy with data to support and inform systems of the likely capacity and demand requirements by each 'type' of provider and
 - (ii) a different solution to the current ordering and provision of stock so that all providers can be supplied with 'just enough, just in time'.
114. WANDSWORTH: That conference considers that given the very high prevalence of ADHD (equivalent to diabetes but with a greater risk of loss in life expectancy) it is clear that only primary care has the potential capacity to treat this group of vulnerable patients and demands that adequate funding is put in place to enable the diagnosis and treatment of ADHD to take place in primary care, which would require a training package thereby having the potential of greatly reducing the current spend on RTC providers.

115. BOLTON: That conference believes the extra funding used to expand the NHS Pharmacy First Service could have been used to fund general practice to deliver this additional capacity to patients, whom the practices know well. This would have:
- (i) delivered a cost effective and efficient additional community capacity for the NHS
 - (ii) ensured properly trained clinicians assess patients
 - (iii) ensured clinicians with full access to patient records would have assessed patients
 - (iv) ensured appropriate follow up plans and safety netting back to the original clinician.
116. MID MERSEY: That conference believes current targets for immunisations and vaccinations are nothing short of a disaster and are destabilising general practice.
117. MID MERSEY: That conference believes the “tug of war” delivery of flu vaccinations is confusing and biased and could have a catastrophic outcome.
118. BRADFORD AND AIREDALE: That conference reaffirms that medical certificates should routinely be self-certificate to 14 days and that after three months, employers use occupational health services, rather than GPs to confirm ongoing ill health.

HEALTH INEQUALITIES AND POPULATION HEALTH

119. AVON: That conference believes that successive governments have paid lip service only to reducing health inequalities, that the GP contract does not remotely address the issues for these groups of patients and demands that patients in areas of high deprivation are managed outside of the GMS contract.
120. KENSINGTON, CHELSEA AND WESTMINSTER: That conference abhors the size and scale of current health inequalities gaps and funding gaps to practice who serve populations with the highest need and:
- (i) recognises the vital role of the GP practice and its place in the local community in addressing health inequalities
 - (ii) calls for national enhanced service funding across the UK for practice level community engagement to reach undeserved communities / populations
 - (iii) calls for funding for practices to design and deliver local health intervention to reduce health inequalities.
121. LAMBETH: That conference believes that population health management is not the responsibility of general practice.
122. HIGHLAND: That conference seeks to avoid unintended inequity to be arising through a contract for general medical services, and asks GPCs and our governments to work towards finding solutions that:
- (i) adequately address the needs of populations in remote and rural areas
 - (ii) accommodate those additional costs required to deliver necessary services in remote areas
 - (iii) mitigate for the impact of staffing deficits occurring across both the GP workforce and multi-disciplinary team.

123. GREENWICH: That conference has significant concern on how system transformation which impacts on general practice is managed and:
- (i) acknowledges that there have been too many instances of large scale system changes which have created dire, crippling workload consequences for local general practices
 - (ii) requires clear four nation guidance clarifying the requirement for general practice consultation and engagement during the development and implementation of system transformation plans.
124. LAMBETH: That conference notes that NHS bodies are increasingly collating patient data for research, population health management and performance management, and believes this work needs to be done in the most secure and reliable way possible. Conference calls on the GPC to promote use of trusted research environments, reproducible analytical pipelines and use of database software in preference to spreadsheets.
125. HIGHLAND: That conference recognises there is variation in the use of primary care services by patients in different locations and call upon improved use of data to drive the provision of services based upon need.
126. HERTFORDSHIRE: That conference requests that GPC / BMA negotiate with the health ministries to devise a campaign that properly explains to patients why their GPs are in crisis and face extended funding and workforce issues, compounded by Covid, the UK financial pressures, plus the multiple escalating health burdens facing the general population.

EQUALITY, INCLUSION AND DIVERSITY IN GENERAL PRACTICE

127. HIGHLAND: That conference endorses childcare as a useful and necessary support for the health and care workforce and wishes for the better provision of facilities to be made available to the NHS's independent contractor workforce including those located in rural areas.
128. HIGHLAND: That conference recognises that GP out of hours (OOH) services benefits from having the role of a GP central to these services and wishes to nurture a close professional relationship between in-hours GP practices and OOH services, where both parties are proactive in sharing their own and seeking understanding of the other's perspective.

FUTURE PROOFING THE ROLE OF THE GP

129. CAMBRIDGESHIRE: That conference believes general practice risks obliteration, and that for the sake of the health of our patients and the survival of the NHS, GP leaders including GPC UK should be calling for:
- (i) the depoliticisation of the NHS to free it from the scourge of political election cycles
 - (ii) a Royal Commission into the future of the NHS across the UK
 - (iii) a public communication campaign about the consequences to patients and the wider NHS of the collapse of general practice
 - (iv) an end to the erosion of the core fundamentals of general practice exemplified by documents such as the Fuller stocktake
 - (v) lessons to be learnt from the fate of NHS dentistry, to prevent the same fate for patients requiring general practice care.

130. BARNET: That conference views the development of acute hub models as presenting a fundamental risk to the stability of practices and the role of the general practitioner by reducing care to transactional episodic interventions and instructs GPC to reassert the underlying principles of why we are GPs- providing holistic and continuous care to our patients.
131. CAMBRIDGESHIRE: That conference believes prior to any implementation of new models of care for general practice, there must be proven research based evidence, formally evaluation to understand the clinical outcomes on chronic disease and impact on health equity with no expansion of such new model permitted until formal evaluation by an independent body has been completed having reviewed these measures over a reasonable length of time and with ongoing iterative processes.
132. LEEDS: That conference calls on all political parties in the UK General Election to commit to:
- (i) policies that will improve the recruitment and retention of GPs
 - (ii) increased investment in to core practice funding
 - (iii) increased investment to enable improved and new practice premises
 - (iv) fully funding any additional work done in the community
 - (v) respecting all those who work in general practice and not using language which is critical of GPs and their teams.
133. CAMBRIDGESHIRE: That conference notes the irony of motions about continuity of care in general practice being in themselves a source of continuity for LMC conference motions over the years, but yet believes it is vital that general practice leaders and representatives, including GPC UK, proactively and visibly promote the hitherto unacknowledged and undervalued solution of continuity of care with a GP to the British public, who are at risk of losing access to this evidence-based, cost-effective and proven treatment.
134. CAMBRIDGESHIRE: That conference calls on GPC UK to initiate a fully funded UK campaign based on the five pillars of general practice (expert generalism, management of risk and uncertainty, holistic care, patient advocacy and continuity of care) to raise awareness of the importance and value of the profession of the general practitioner and to counteract the current climate of negativity towards general practice.
135. DERBYSHIRE: That conference castigates the governments and their agents for abusing NHS health care staff through their:
- (i) covert campaign of media briefings against the profession, and in particular general practice
 - (ii) failure to speak up in support of general practice coupled with their failure to educate patients about responsible use of the NHS
 - (iii) utter failure to recognise staff exhaustion and moral injury since the pandemic
 - (iv) deliberate blindness to the scale of psychological distress amongst GPs and their staff
 - (v) economic exploitation of healthcare professions in comparison to the rest of society through selective acceptance of Review Body recommendations.
136. OXFORDSHIRE: That conference notes negativity about general practice from politicians, including recent comments from Lord Bethell that "GPs don't face huge amounts of complexity" and that "most interactions" (in general practice) "are incredibly straightforward". Conference demands that politicians cease these harmful, toxic statements immediately, and instead recognise the exceptional potential of general practice and the essential role that GPs play in sustaining efficient, safe services.

137. NORFOLK AND WAVENEY: That conference notes the increase in initiatives and targets within general practice contracts has led to a drive in data collection rather than any true improvement in access. Instead, it requests that:
- (i) practices without GP recruitment issues have their systems analysed at high level, without threat to others, so that good practice can be shared
 - (ii) practices with good patient satisfaction have their systems analysed at high level, without threat to others, so that good practice can be shared
 - (iii) efficiency of triage systems compared to traditional access to the GP is audited.
138. DORSET: That conference acknowledges that clinical sessions represent only a fraction of the true GP workload and calls for the introduction of:
- (i) consultant style sessions with protected time to undertake admin, CPD, service improvement and leadership roles
 - (ii) workplace planning that acknowledges and addresses this
 - (iii) media comms to dispel the myth that ‘all GPs are working part time’.
139. KENSINGTON, CHELSEA AND WESTMINSTER: That conference thanks colleagues across the four nations for placing safety at the heart of their practise, despite a workforce crisis, real terms reductions in revenue, and rising patient numbers, and:
- (i) calls on ministers to place patient safety before innovation or technological advancement
 - (ii) requires the departments of health to introduce an independently triaged reporting system for safety concerns arising across interfaces with general practice
 - (iii) calls on NHS primary care teams to conduct safety audits on the management, investigation, resolution, and reporting of safety interface concerns raised between general practice and NHS organisations
 - (iv) requires GPC UK to provide support to any practice challenged for taking action on the grounds of ensuring and protecting patient safety, including implementing BMA Safe Working in General Practice guidance
 - (v) mandates GPC UK to work with ministers and NHS leaders to develop an annual reporting mechanism detailing the safety concerns reported by general practice, the actions taken, and the outcomes of those interventions.
140. MID MERSEY: That conference believes Pharmacy First is nothing short of shuffling deck chairs on the Titanic and demands that this funding is passed back to general practice and recognise the unique skill set of and historic provision of these services by general practice.

GPC / LMCs / BMA POLITICAL STRUCTURE

141. GLASGOW: That conference with regard the UK GPC and the composition of its membership:
- (i) believes it is ineffective due to its size and the preponderance of one nation’s representation
 - (ii) believes it should be formed largely by representatives of the nations’ GPCs, Sessional GPs and GP Registrars Committees
 - (iii) believes it should restrict its activity to matters which properly fall to be determined by a UK body
 - (iv) calls on UK GPC to agree a reform within the next year.
142. SOMERSET: That conference believes that local medical committees (LMCs), having existed since the inception of the NHS, should receive equivalent benefits to those available to the NHS commissioners and providers with whom they negotiate terms and conditions on behalf of general practice providers, and therefore believes that LMCs should be recognised as NHS bodies.

143. AVON: That conference believes that despite existing conference policy of 2021, nothing has been done to ensure representation within LMCs, and calls upon GPC UK and GPDF to facilitate a minimum standard for all LMCs to include:
- (i) an optimal governance structure for the medical leadership of LMCs
 - (ii) an elections process for the appointment of committee and board roles
 - (iii) published data for the protected characteristics of workforce within LMCs.
144. LINCOLNSHIRE: That conference recognises that the GMS contract is a relationship between contract holders and the NHS. Given the mounting challenges faced by contract holders and their practices, we believe:
- (i) that at least 50% of members of GPC Executive teams involved in negotiations of the GMS contract should be GMS contract holders
 - (ii) that any referendum or equivalent vote regarding the GMS contract is amongst GMS contract holders, GP or non-GPs rather than the current system of GP BMA members only.
145. LAMBETH: That conference notes the support given to GP registrars last year to organise a GP registrars conference and that it has not happened and calls on GPDF to fund an annual GP registrars conference.

GP REGISTRARS AND TRAINING

146. CLEVELAND: That conference has concerns about the quality and relevance of the secondary care component of GP training and mandates the GPCs to work with relevant stakeholders to:
- (i) improve the linkage with general practice while in a secondary care placement
 - (ii) develop learning objectives which link more closely with the skills required to be a GP
 - (iii) increase the number of hospital specialities that any individual will experience during their training programme
 - (iii) reduce the duration of any single hospital based placement to a maximum of two months (WTE).
147. CLEVELAND: That conference believes that GP registrars should be attached to a single GP practice for the whole of their training scheme and mandates the GPCs to work to achieve this.
148. WELSH CONFERENCE OF LMCs: That conference recognises the need to reform GP training to meet the ever-shifting needs of patients and the future models of care and calls on the Welsh and UK governments to:
- (i) increase the funding and capacity for GP training
 - (ii) involve GP trainees and their representatives in the design and implementation of any changes to the GP training pathways
 - (iii) ensure that training provides sufficient exposure to areas needed for future practice such as mental health, health inequalities, planetary health, and digital health.
149. KENT: That conference recognises GP trainer / educational supervisor training is currently a postcode lottery and non-transferable between regions leading to trainers stopping their vital work, and demands the GPC negotiate with the appropriate bodies to:
- (i) standardise GP trainer / educational supervisor training across the UK
 - (ii) ensure the qualifications are transferable to all parts of the UK.

150. NORFOLK AND WAVENEY: That conference asks GPC to work with the Royal College of General Practitioners to enable registrars to work additional sessions, under supervision, if they are willing and able to do so.
151. AVON: That conference, in light of the proliferation of allied healthcare professionals within general practice, believes that it is time to relax some of the excessive training hoops for GP registrars, and requests that GPC UK negotiates this with the RCGP.
152. OXFORDSHIRE: That conference believes that current GP training programmes and RCGP membership exams do not adequately prepare new GPs for the realities of working in UK general practice. Conference demands:
- (i) engagement with the wider GP profession to define priorities for GP training
 - (ii) a reduction in the volume of “evidence gathering” expected by GP training frameworks, as these currently take trainees and trainers an excessive amount of time to complete
 - (iii) demands GPC hold RCGP to account for any failings of current GP training and advise them on what is really needed to ensure stability of UK general practice
 - (iv) demands legal reform of the role of the Royal College and GMC in determining GP competencies and entry onto the GP register.
153. CAMBRIDGESHIRE: That conference acknowledges that GP roles are evolving and, since teaching and training must reflect the skill mix expansion currently taking place in general practice, it calls upon GPC UK to lobby relevant bodies for clear guidance and modifications to the training programme for GP registrars specifically in the areas of triage and supervision of allied health professionals due to concerns that:
- (i) GP registrars at completion of GP training (especially those whose training was largely during the Covid-19 pandemic) lack experience in managing urgent and unscheduled care in unpredictable and unfamiliar environments
 - (ii) newly qualified GPs are not adequately prepared for the role and responsibility of supervising non-Dr clinicians and its medico-legal implications
 - (iii) due to the current ongoing loss of full-time equivalent numbers of GPs from the profession, the ratio of supervising GP to non-dr clinicians is likely to be high which will be unsafe and prohibits the development of a deep understanding of the skill set and knowledge of the supervisee leading to unsafe patient care.

PROFESSIONAL STANDARDS, MEDICO LEGAL AND REGULATION

154. DEVON: That conference notes the shift of focus of the GMC from regulating doctors to regulating "medical professionals" including physicians' associates and anaesthetists' associates with concern and unrest and is appalled at the lack of understanding of general practice shown by Lord Bethel in stating that most consultations in general practice are not complex.
155. BRADFORD AND AIREDALE: That conference demands a clear system to protect whistle blowers in primary care be developed, that is not reliant on local reporting.

156. DEVON: That conference acknowledges that there are several preferred learning styles in addition to "Reflector", and:
- (i) demands that GPs preparing for and undergoing their appraisal should not be compelled to undertake reflection if it is not, in their opinion a learning style which benefits them
 - (ii) asserts that appropriate resources should be developed to ensure that GPs can develop and demonstrate their learning in ways which tessellate with their preferred learning style(s).
157. GRAMPIAN: That conference is concerned regarding the GMC's work on alternative routes to CCT to become on the GP / specialist register without adequate consultation and calls on conference to oppose these changes and demand appropriate consultation with RCGP and GPC UK to allow full assessment of the proposals before further action.
158. LEEDS: That conference welcomes the "bureaucracy busting concordat" and the seven principles within it to reduce unnecessary bureaucracy and administrative burdens in general practice published by the Department of Health and Social Care in England in 2022, believes that these principles should be adopted across all UK governments, and calls on the next UK government to ensure they are used to ensure that within the first year of office the unnecessary bureaucracy and administrative burdens in general practice have been demonstrably reduced.
159. KENSINGTON, CHELSEA AND WESTMINSTER: That conference derides senior decision makers who do not understand general practice but use their limited personal perspective as evidence when making politically motivated comments about GPs and practices and:
- (i) questions why senior decision makers continually try to change the part of the NHS that sees the vast majority of the patients for a small proportion of the overall budget
 - (ii) openly invites any senior decision makers to meet with their local LMC to discuss the function and value of general practice to their community
 - (iii) requests GPC UK to produce information to senior decision makers outlining the evidence on how the UK general practice model benefits patients and healthcare costs
 - (iv) requests GPC UK to produce information to senior decision makers on the impact of moving to a transactional healthcare based model.
160. HERTFORDSHIRE: That conference recognises the immense pressure placed on GPs through ongoing government mandated bureaucracy, and calls on GPC / BMA to research and present the following information to the public on behalf of all GPs:
- (i) amount of GP time spent each year in undertaking and preparation for appraisal / revalidation, and what this represents in lost patient appointment time
 - (ii) amount of GP time spent each year in undertaking and preparation for regulatory inspections, and what this represents in lost patient appointment time.
161. CITY AND HACKNEY: That conference notes the GMC requirement to be competent and keep your professional knowledge and skills up to date but is concerned that, with ever-increasing demands being placed on general practitioners, the concept of a competent GP is becoming harder to define and:
- (i) believes it is unrealistic to expect a GP to know all current guidelines and pathways across every speciality
 - (ii) requests that the GMC clearly defines and has reasonable expectations in stating a GP is competent.

WIDER PRACTICE TEAM (NON-CLINICAL ROLES)

162. DERBYSHIRE: That conference in the light of the evolving role of practice managers supports:
- (i) their accreditation and registration by a governing body
 - (ii) increased funding to support the wider practice management team
 - (iii) the ability for practice managers to become partners.

CAPACITY DEMAND AND MISMATCH

163. LAMBETH: That conference notes the government response to any vaguely health related question is "see your GP" and asks GPDF to maintain a website explaining what GPs cannot do.

DIGITAL, TECHNOLOGY AND DATA

164. MORGANNWG: That conference calls for national specifications for GP clinical software systems to mandate a robust call-recall system to facilitate chronic care.
165. KERNOW: That conference supports a UK wide group and framework to assess and approve new digital solutions, once approved these should be directly accessible to general practice, integration with existing cornerstone architecture must be mandatory.
166. HAMPSHIRE AND ISLE OF WIGHT: That conference believes that the current patchwork of IT systems in use by NHS providers spanning both secondary and primary care is failing our patients and driving inefficiency. We call for unified integrated IT system across all NHS providers.
167. LIVERPOOL: That conference believes that in these days of unrestricted travel between England, Wales, Scotland and Northern Ireland, it should be feasible to have prescriptions requested by a GP in one part of the UK, transmitted electronically, and dispensed by a pharmacy in another part of the UK, within a National Health Service. GPC UK is asked to facilitate this being achieved.
168. LAMBETH: That conference notes that many NHS databases regarding GP practice performance are held on Microsoft Excel files. This may lead to inaccuracies in the reporting of data, inaccuracies in payments and the potential for incorrect penalties being applied. These may not become evident for some time, and as in the case of the Horizon post office scandal could have significant detrimental impact on those impacted. Conference calls on GPC UK, to develop to develop and communicate a reporting tool that can provide assistance to GPs should these scenarios arise as a proactive measure.
169. LAMBETH: That conference supports the continual digitalisation of general practice but laments the failure of the government to invest in this. Conference calls on GPC UK to ensure that all negotiations with the government continue to include this as a key focus of future strategy.
170. HIGHLAND: That conference expresses concern about the inconsistency of IT support available to general practices, too often called upon due to the mandated use of bespoke, legacy and end-of-life IT systems, and asks GPCs to press for better orchestration of support from those responsible NHS bodies and IT suppliers.

171. HIGHLAND: That conference is not satisfied with the user experience that clinicians have when using electronic referral systems and asks GPCs to seek better technology that can improve the safety and efficiency of making referrals electronically.
172. HIGHLAND: That conference recognises the necessity of having the provision of useful information online for patients about services available locally, with consistent NHS branding, and asks GPCs to push for this work to be adequately resourced to bring on more GP practices and improved functionality.
173. WARWICKSHIRE: That conference notes that LMCs are sent new, or amended, data sharing agreements frequently with no resource for the work involved in scrutinising them. Given that the DSAs are frequently variations on a theme and each LMC is reviewing these individually or in small groups conference believes that GPC should co-ordinate a group of LMC officers from different areas who review and hopefully agree, these on a wider footprint. This would reduce quantity, improve quality and as a system ensure conversations occur only once and hence, improve cost efficiency.
- (Supported by Coventry LMC)
174. MID MERSEY: That conference demands that the GPC lobby for parliamentary time to re-establish the debate for the merger of medical lists to enable practitioners to consult.

FUNDING PRINCIPLES, PAY / DDRB AND RESOURCES

175. BARNET: Considering the pointless and below inflation recommended DDRB uplift, which has resulted in discontentment between GPs, conference calls upon GPC to review further involvement with the DDRB, when we should have uplifts which are at least in line with inflation.
176. HIGHLAND: That conference recognises that additional service costs occur when delivering services to remote and rural areas, that current funding mechanisms fail to adequately compensate for this and demands that GPC negotiators raise this with governments and seek to rectify this or mitigate for it.
177. SESSIONAL GPS COMMITTEE: That conference is appalled by the sustained devaluing of general practitioners by governments across the UK, which has led to a 33.5% real-terms erosion in income for salaried GPs since 2008 and calls on GPCs to negotiate with governments to:
- (i) achieve full pay restoration for salaried GPs
 - (ii) negotiate uplifts to payments outlined in the Statements of Financial Entitlements to ensure practices are enabled and adequately reimbursed to engage locum GP cover for such periods of leave.

PARTNERSHIP AND CONTRACTOR MODELS

178. DERBYSHIRE: That conference recognises clinical administration is a necessary part of safe patient care, and the GP contract must be revised to explicitly reflect the clinical administrative burden that follows each patient facing session of clinical activity akin to administration programmed activities found in the hospital consultant contract. It instructs GPCs to negotiate accordingly.

179. DERBYSHIRE: That conference notes from experience that six patient facing sessions in general practice together with the associated clinical administrative and liaison burden takes at least 37.5 hours a week to complete and from henceforth six patient facing sessions will be considered "FULL TIME".

GREENER GENERAL PRACTICE

180. LEEDS: That conference believes the UK government has done far too little to help general practice and the wider NHS to reduce its impact on climate change, and demands that the next government:
- (i) invests in improved practice premises that enables general practice to reduce its energy use and carbon footprint
 - (ii) improves recycling and reuse opportunities and reduces the use single use items
 - (iii) implements electronic prescribing from hospital prescribers to community pharmacy to reduce the travel requirement for patients to hospital pharmacies.
181. LIVERPOOL: That conference believes that the NHS car lease scheme, which is currently only available to NHS employees should also be available to those working in general practice and calls upon GPC UK to examine the feasibility of having the NHS car lease scheme available to general practice.

GP WORKFORCE CRISIS ACROSS THE FOUR NATIONS

182. GLOUCESTERSHIRE: That conference believes that a key skill in general practice, that of watchful waiting and measured, balanced risk assessment, is being lost and call for:
- (i) a recognition of the training undertaken to enable short, focused consultations as valuable tool to reduce over investigation, unsustainable costs and unmanageable demand on the NHS
 - (ii) the end of audit tools that force GPs to work with the same boundaries as AHPs, effectively reverting practice to that of a junior doctors clerking
 - (iii) GPCs to work with regulatory authorities, MDOs and the GMC to ensure that this vital skill is safely enabled.

Agenda: Part II

Motions unsuitable for submission to the UK LMC Conference due to being nation specific, not specific or relevant to general practice or due to procedurally invalid wording

PRIMARY / SECONDARY INTERFACE

183. KENT: That conference demands that there is a Directed Enhanced Service for shared care that is appropriately funded to reflect the workload this brings to general practice.
184. DERBYSHIRE: That conference notes that although co-location of GPs alongside emergency departments has temporarily relieved some of the pressures experienced in emergency departments, such arrangements have only increased overall demand as they have de facto degenerated into an expensive 24 / 7 walk in service increasing public expectations; and
- (i) insists such services should be curtailed through abolishing the “walk up” capability and
 - (ii) monies saved should be spent in improving access in traditional primary care.
185. CROYDON: That conference instructs GPC to negotiate changes to the hospital contract that:
- (i) prevent secondary care from trying to impose new forms or pathways on general practice without negotiation and agreement from the local LMC
 - (ii) impose financial penalties where hospitals fail to meet their contractual obligations around timely discharge and outpatient summaries
 - (iii) that such penalties be paid to a fund for the education of local GPs and general practice staff
 - (iv) impose financial penalties where system failures in other providers leads to extra work in general practice (such as the dumping of large volumes of old results en masse)
 - (v) that such penalties are paid to the practice to fund the extra work involved.
186. MID MERSEY: That conference believes GPs should retain the right to refer into secondary care and that this is not replaced by mandatory advice and guidance as this action will decimate and demoralise the workforce even further.
187. NORTHAMPTONSHIRE: That conference should support the cessation of Advice and Guidance being used as a tool for triaging referrals requesting a face to face appointment.
188. LINCOLNSHIRE: That conference welcomes the NHS England document “Delivery plan for recovering access to primary care” highlighting the workload shift from secondary care to general practice in England, but as an opportunity for all nations to refresh their focus on ending this capacity, resource and morale drain and that:
- (i) GPCs emphasise in discussions with their respective NHS bodies the significant impact on capacity and wellbeing of general practice if this workload shift remains
 - (ii) GPCs emphasise in discussions with their respective NHS bodies that this workload shift puts patient safety at risk
 - (iii) GPCs advise their respective NHS bodies that contractual levers must be devised and implemented and then are enforced by commissioners when secondary care breach their contractual obligations
 - (iv) GPCs, when negotiating with their respective NHS bodies, demand that general practice can appropriately charge secondary care providers, and receive remuneration as defined by GPCs, for services received when they undertake said workload shift due to patient safety concerns

- (v) GPCs develop clear legal guidance for general practices and explanatory communications for patients, for general practices who do not undertake this workload shift but are concerned regarding liability for any patient harm or litigation.
189. CROYDON: That conference instructs GPC to negotiate for funding for all new work generated by Advice and Guidance and similar referral management systems.

NON NHS AND PRIVATE GP WORK

190. SUFFOLK: That conference demands NHSE take a national position, accompanied by patient facing publicity, on managing post-surgical bariatric patients who have had treatment abroad, to protect GPs from working outside of their competence.

SESSIONALS AND PORTFOLIO WAYS OF WORKING

191. CROYDON: That conference asks BMA to negotiate consultant status for GPs, so that GPs employed by hospitals and ICBs in clinical roles can enjoy the same terms and conditions as our hospital consultant colleagues.

CLINICAL, PRESCRIBING AND DISPENSING

192. LEEDS: That conference is alarmed at the increase in people becoming infected with measles in the UK and:
- (i) demands a much more robust response by all UK governments and national public health bodies
 - (ii) directs GPC UK to negotiate a significant increase to item of service payments for vaccinations
 - (iii) believes all schools must review every new pupil's vaccination record and actively encourage parents to ensure children are fully vaccinated to protect both their children and other pupils in the school.
193. BERKSHIRE: That conference notes with dismay, the recent increase in rates of vaccine preventable disease (eg measles), and:
- (i) believes current funding arrangements have been demonstrably inadequate to prevent these outbreaks
 - (ii) demands that funding arrangements that involve a “cliff edge” or achievement cut-off, whereby a contractor falling below a percentage threshold loses payment for work done, must be reformed
 - (iii) demands additional resources be provided to those contracted to deliver the relevant immunisation programmes, for example by offering increased item of service payments, and / or allowing payment for vaccines delivered outside of the usual national schedule timings.
194. NORTHAMPTONSHIRE: That conference support the notion of primary care being paid £45 for an ABPM / HBPM per check in line with national pharmacists contract.

195. GATESHEAD AND SOUTH TYNESIDE: That conference deeply regrets that in the five years since LMC UK conference of 2019 there remains no universal safe, funded service for the provision of healthcare for trans patients across any of the four nations and:
- (i) believes this shames all health secretaries, NHS leaders and commissioners who have failed to commission such a service when such a model has been developed in areas where the need has been recognised and acted upon
 - (ii) notes the number of patients requiring such services to explore their gender identity in a safe environment with expert clinicians and, if required, proceed with treatment is rising
 - (iii) despairs at the fact that no NHS IT system developer has worked out and implemented a way to electronically transition a patient record across genders and demands that this be urgently rectified as a matter of patient safety
 - (iv) is concerned that, in the absence of a safe, effective NHS system patients have a choice of using an array of private sector providers of variable quality, or asking their GP to perform this work unresourced and without relevant expertise
 - (v) demands that the health systems of all four nations do not let pass another five years without enacting safe, evidence-based, resourced, free-to-use services for this complex cohort of patients.
196. SOMERSET: That conference supports the campaign by the Cystic Fibrosis Trust that Cystic Fibrosis should be added to the list of conditions for which prescribed treatments are exempt from prescription charges.
197. NORFOLK AND WAVENEY: That conference calls for GPC to negotiate a change to the pharmaceutical regulations to enable the provisions of regulation 61 to apply where the patient has no reasonable access to a pharmacy due to its temporary closure or inability to source the medication, and for its enactment to be for local ICB determination rather than only applying during an emergency as determined by the Secretary of State.
198. GATESHEAD AND SOUTH TYNESIDE: That conference notes that whilst no UK nation has a resourced, easily accessible service for patients with eating disorders, the mortality rate of such patients continues to be unacceptably high and:
- (i) believes this to be a mark of failure of will on the part of those commissioning, or not, such services
 - (ii) understands that, ethically, it is potentially defensible to not commission adequate healthcare for vulnerable groups but asks that, if this is the case, relevant NHS bodies are honest and provide the workings to demonstrate why they believe the lives of such patients are not worth preserving
 - (iii) demands that all national GPCs work with relevant commissioning bodies to ensure that a safe, effective service is developed and provided across the UK, in order to enable such patients to receive the care they need and to prevent unnecessary deaths.
199. BEDFORDSHIRE: That conference calls on GPC UK to renegotiate the ARTP training requirement, as the current system is removing spirometry from much of general practice.
200. DORSET: That conference notes the current GLP-1 shortages and the significant impact it is having on patients with diabetes. We call on the BMA to lobby the government to
- (i) run a public campaign to temper the demands for GLP-1 for weight loss, when supplies will be limited at least until the end of 2024
 - (ii) educate the public about not buying privately or requesting repeatedly from the NHS for weight loss, so that existing stock in the UK can be prioritised for diabetic patients
 - (iii) optimise the purchase of reliable supplies of GLP-1s as a matter of urgency.

201. KENSINGTON, CHELSEA AND WESTMINSTER: That conference demands that when issuing guidance, the national organisations for healthcare improvement (HIS in Scotland, NICE in England, Wales and, Northern Island) recognise the complexities of general practice patients' presentations and needs, and:
- (i) take into account the implications of implementing single disease guidance on common co-morbidities
 - (ii) include information that enables GPs to assess the risk: benefit of potential interactions of frequently co-prescribed medications used to treat common co-morbidities
 - (iii) include in the guidance an impact assessment on the workforce capacities, capabilities and consultation time required to deliver their published advice and guidance
 - (iv) in order to improve the quality of the guidance and user experience, ensure that all published advice and guidance has a feedback mechanism specifically considering if the guidance has the appropriate level of clarity, was possible within the constraints of the NHS to follow and was able to be applied to the patient
 - (v) when updating guidance include a section on how feedback from clinicians about the guidance has been incorporated into the update.
202. CROYDON: That conference notes that the current NHS management model is driving the NHS at full speed over a cliff and instructs GPC to ask the Department of Health to please change the drivers. In particular we ask the Department of Health to:
- (i) restore clinical commissioning
 - (ii) restore the borough as the unit of commissioning local services
 - (iii) agree to a medium-term strategy of a shift of appropriate work (and all associated funding and staff) out of hospitals and into community settings where they can be more effectively and efficiently delivered under the aegis of local GPs
 - (iv) agree to a long term strategy of evolving hospitals into financially smaller, leaner, more productive and efficient organisations who serve rather than dominate the local healthcare economy.
203. GATESHEAD AND SOUTH TYNESIDE: That conference notes both the workload involved for GPs as a result of medicine shortages and the climate and ethical impacts of current supply chains and calls for GPC UK to work with relevant bodies to:
- (i) take steps to ensure minimal emissions from manufacturing and transport of medicines destined for UK patients by encouraging UK and / or EU manufacture of essential medicines
 - (ii) resurrect the planned vaccine research and manufacturing site that was promised in the Covid pandemic to ensure UK supply of critical vaccines
 - (iii) enable tax benefits for their manufacturers and distributors for medicines produced and transported sustainably
 - (iv) ensure that any non-UK / EU medicines required to be imported have no content from regimes involved in oppression of minorities and / or genocide
 - (v) show the carbon footprint alongside the tariff price in both the BNF and when prescribing electronically.
204. KENT: That conference demands that all parts of NHS, including dentistry, emergency departments and pharmacies, should be integrated with automatic digital alerts for drug interactions and prescribing risks to improve patient safety.

HEALTH INEQUALITIES AND POPULATION HEALTH

205. KENSINGTON, CHELSEA AND WESTMINSTER: That conference believes that national senior NHS decision makers are failing our patients with long term conditions, resulting in increased mortality and morbidity, and calls for:
- (i) a report that describes the current patient need and models the future need
 - (ii) an analysis of the unmet need and the aetiology, at national and local levels
 - (iii) acknowledgement of the significant upskilling of, and responsibility falling to GPs over the past 20 years in meeting the increasingly complex needs of patients with long term conditions
 - (iv) a fully funded defined minimum offer to all people with long term conditions, wherever they live in the UK, that is deliverable within the current workforce constraints and communicated to patients
 - (v) a workforce plan to meet the current and future needs of those with LTCs.
206. BEDFORDSHIRE: That conference:
- (i) recognises the value of a population health approach to patient care, and
 - (ii) calls on GPC UK to work with commissioners to find ways to embed a population health approach into general practice, and
 - (iii) calls on GPC UK to work with commissioners and secondary care to ensure that general practice receives a fair proportion of any savings created by population health teams.
207. BEDFORDSHIRE: That conference:
- (i) recognises that “prevention is better than cure”, and
 - (ii) recognises that GPs and ancillary staff are well placed to offer advice, and
 - (iii) believes that, rather than concentrating on medications for weight loss and lowering cholesterol, health ministries in the four UK nations should be supporting programmes which teach healthier eating patterns and promote exercise and mental well-being, and
 - (iv) believes that GPs must have access for their patients to adequately resourced services that can help patients with lifestyle related disease.
208. BEDFORDSHIRE: That conference:
- (i) wonders why “Call the Midwife” is considered nostalgia, when so many of the issues dealt with – poverty, overcrowding, abuse, addiction, poor education, fear of confronting illness, are still faced every day in general practice, and
 - (ii) calls for a unification of social care and healthcare throughout the four nations and a recognition that we cannot support ill and vulnerable individuals without recognising that physical welfare and social welfare are co-dependent.
209. MID MERSEY: That conference believes that the current state of mental health service provision across the country is providing undeliverable service models due to the complexity of funding streams via ARRS.
210. BRO TAF: That conference notes the evidence published in January 2024 on the removal of larger wine measures on reducing alcohol intake and calls for 250ml servings of wine in licenced premises to be outlawed.

211. AYRSHIRE AND ARRAN: That conference welcomes initiatives to support asylum seekers in local communities but calls on government to:
- (i) recognise that the resource currently provided by MEARS is way below the standards required
 - (ii) control the unregulated purchase of housing stock in often deprived and unequipped communities as it is leading to additional strain on already over-stretched community services
 - (iii) recognise that the current situation is potentially harmful for already traumatised, asylum seeking individuals
 - (iv) provide additional resource to allow practice teams to fully manage the often complex needs of this population.
212. BEDFORDSHIRE: That conference believes that a significant support to continuity of care would be a well-funded:
- (i) midwifery service, and
 - (ii) health visiting service, and
 - (iii) community / district nursing service.
213. SEFTON: That conference is alarmed at the increasing numbers of adults in the UK who are unable to afford an adequate level of nutrition for themselves and their children. This amounts to a growing public health crisis which places an avoidable burden of chronic ill health on the people living in unnecessary hunger and on health care services, now and in the future . It calls upon the government to determinedly end this malaise and treat it as the emergency it has become.

EQUALITY, INCLUSION AND DIVERSITY IN GENERAL PRACTICE

214. GLASGOW: That conference recognises the additional challenges that new IMGs may face when beginning their training in the UK and:
- (i) calls for a resourced extended induction period to be made available to help new IMGs familiarise themselves with local healthcare practices if the IMG considers that this would be helpful to them
 - (ii) calls for a funded buddy scheme providing guidance and support to be available if the IMG would find this helpful, and
 - (iii) calls for funded training for practice managers or GP trainers to assist understanding of the challenges which may be faced by IMGs.
215. SOMERSET: That conference is appreciative of the significant number of International Medical Graduates currently working in the UK, but:
- (i) believes that this valuable workforce will only wish to remain in the UK long term if they are also able to bring their family to the UK to work
 - (ii) is concerned that the “skilled worker visa” minimum salary increase being introduced in April 2024 jeopardises this and could put yet another nail in the coffin of general practice, and
 - (iii) instructs GPC to seek an exemption for all health care workers from these restrictions.
216. MORGANNWG: That conference calls for an independently managed monitoring system to resolve and eliminate any form of discrimination, bullying or harassment.

FUTURE PROOFING THE ROLE OF THE GP

217. LAMBETH: That conference recognises the success of the General Practice Fellowship scheme in attracting and retaining general practice staff during an incredibly difficult time for the profession and:
- (i) is surprised and disappointed that these schemes in England have ended, without any clear replacement
 - (ii) calls on GPC UK to work with others, across the four nations, to ensure that suitable local schemes to replace these fellowships are introduced with a focus on new to practice staff and not just absorbed into existing budgets.
218. DERBYSHIRE: That conference supports the development and implementation of new to partnership schemes and seeks to overcome the barriers to newly qualified GPs entering into partnership by demanding DHSC ensure these schemes are in place in all four nations.
219. SANDWELL: That conference observes GPC have not outlined a vision for the future of a sustainable, satisfying and safe profession for GPs, patients and the nation. GPC have not developed the fee-per-item model which was policy since 2021 (reaffirmed in 2023) and GPC have outlined no safe exit strategy for partners (also policy since 2021) in the event of the collapse of our noble profession. Conference wishes to express its grave disappointment at this position and mandates immediate action on these issues.
220. KENSINGTON, CHELSEA AND WESTMINSTER: That conference recognises the importance of the values and principles of general practice in delivering effective care and patient experience and:
- (i) stresses the importance and benefits of patients being able to see their own doctor, build a long-term trusted relationship and receive holistic care from cradle to grave
 - (ii) recognises the importance of understanding the patient's context, ideas, concerns and expectations and that this has a value far greater than just giving a simple label and course of action
 - (iii) recognises the complexity of undifferentiated illness and that diagnosis is much more than a machines' predictive-value of a list of symptoms
 - (iv) deplores the erosion of continuity of care and holistic care and in doing so rejects moves towards a transactional model of general practice
 - (v) calls on NHSE to conduct robust public and GP engagement prior to implementing any models of care which impact on patients being able to see their doctor or moves care away from their neighbourhood.
221. CROYDON: That conference deplores policies such as the Fuller Model and believes that the current NHS plans for primary care appear to entirely ignore the developments in the theory and practise of general practice over the last 50 years, to the great detriment of the NHS and our patients.
222. EALING, HOUNSLOW AND HAMMERSMITH AND FULHAM: That conference acknowledges that across all four nations, general practice is in crisis and:
- (i) finds the significant variations between systems and provision of general practice care across the four nations of the United Kingdom unacceptable
 - (ii) believes that solutions need to be done on a UK-wide basis
 - (iii) insists that the NHS in each of the four nations work together and with GPC(UK) in co-ordinating a response to address the UK-wide general practice crisis.

223. DORSET: That conference urgently calls upon NHS commissioners in all four nations to acknowledge that primary care leadership is essential to the delivering the aspirations around integrated care and calls for:
- (i) investment in leadership and management training for the transformation, design, and delivery of primary care services within all four nations
 - (ii) recognition of the need for primary care to be strongly and effectively represented at place, integrated care system and regional levels and that LMCs have a key representative role
 - (iii) adequate funding to support specific leadership training for general practitioners that is accessible, time protected, and embedded within organisational budgets and culture.
224. GRAMPIAN: That conference recognises the need for other healthcare professionals and secondary care colleagues to better understand the role of a GP and recommends that GPC UK, RCGP and other appropriate agencies collaborate to produce a teaching aid to address educational needs , which by default will promote primary-secondary care interface groups and aid the healthcare system to fully recognise the value of general practice with patient centred, community driven, holistic care.
225. BEDFORDSHIRE: That conference calls on GPC UK to:
- (i) ask the UK health ministries to report as to whether diagnosis and detection rates are back to pre-covid levels
 - (ii) ensure that practices are helped to develop robust pathways to ensure that patients will be referred to a GP after a second consultation with a non GP in general practice for any problem which might have a more worrying underlying cause
 - (iii) consider how trainee doctors will acquire the skills which enable them to identify such symptoms.
226. WEST PENNINE: That conference notes with great concern that NHS England have recently ended two GP retention schemes, another indication of how little value is place on support and retention for GPs.
227. NORFOLK AND WAVENEY: That conference supports the call by the BMJ Commission to establish an Office for NHS Policy and Budgetary Responsibility to provide expert and independent scrutiny of plans and policies for primary and secondary care over the next 15-20 years, rather than the current strategies of constant changes in NHS policy with no testing or reviews of policies to see how they are working in practice on the NHS coal face.
228. OXFORDSHIRE: That conference believes the NHS is no longer "comprehensive, universal, and free at the point of access", as delivering truly comprehensive services would take more resources than the UK currently allocates to NHS healthcare. Conference:
- (i) recommends it is time to rephrase the "comprehensive" NHS as an "equitable" NHS, with equitable access to NHS services to be based on clinical need, not ability to pay
 - (ii) affirms support for the NHS principle of separation, in simple terms meaning that NHS care and private care should be kept "as separate as possible" to avoid NHS subsidy of private healthcare
 - (iii) affirms support for GPs who feel they have no alternative other than to increase their provision of private services, as long as this does not undermine the NHS "principle of separation".

PROFESSIONAL STANDARDS, MEDICO LEGAL AND REGULATION

229. MANCHESTER: That conference is concerned to note reports of some physician associates practising outwith their knowledge, skills, experience and competencies and:
- (i) notes that there is an established role for a well-managed multi-disciplinary team in primary care / general practice
 - (ii) believes that current undergraduate training requires enhancements to support doctors working with PAs
 - (iii) believes that current postgraduate training requires enhancements to support doctors supervising PAs
 - (iv) calls on the General Medical Council to ensure that patient safety and confidence is always paramount in considering any referral under Good Medical Practice, and
 - (v) instructs the BMA to produce comprehensive guidance for all doctors outlining the managerial, educational, medico-legal and ethical considerations for leading, supervising and working with PAs.
230. NORTHAMPTONSHIRE: That conference should support the profession's view that physician associates should be regulated by a regulator that is not responsible medically qualified doctors.
231. NORTH WALES: That conference views with concern the decision to change the world recognised title of physician assistant to physician associate, which can only lead to confusion amongst patients, and urges reversal of this decision.
232. GRAMPIAN: That conference is concerned that the UK government has supported regulation of the PA role through the GMC in a way that is dangerously similar to doctors and calls for legislation that prevents PAs to be utilised as alternatives to fully qualified doctors potentially resulting in lowered standards of care and increased risk of patient harm.
233. LAMBETH: That conference regrets the failure to adequately consult on the regulation of physician associates prior to the development of legislation. Conference therefore calls on GPC UK to engage with the GMC to ensure the regulation of PAs does not further negatively erode the value of our professional status.
234. AVON: That conference condemns the GMC for facilitating the regulation of physician associates and believes that the inevitable widespread public confusion between doctors and medical associated professionals is intentional.
235. WIRRAL: That conference noted that legislation bringing the physician associate (PA) role under GMC regulation has now been passed by both Houses of Parliament and:
- (i) expresses disappointment that the profession's concerns were completely ignored
 - (ii) demands that adequate resources must be made available for the supervision of PAs
 - (iii) requests the regulator (GMC) to educate the public clearly who PAs are and what their roles entail.

236. MID MERSEY: That conference:
- (i) believes that the GMC's intention to regulate physicians associates is unacceptable
 - (ii) demands that physicians associates should have their own regulatory body as the current proposal will create a two tier system and cause confusion.
237. KENSINGTON, CHELSEA AND WESTMINSTER: That conference deems the scapegoating, moral injury and lack of psychological safety faced by GPs, in the context of whole NHS system failure, to be entirely unacceptable and calls for:
- (i) GPC UK to work with the GMC to ensure that the demand: workforce capacity context is taken into consideration in its investigations
 - (ii) the GMC to provide greater transparency to the profession regarding how it contextualises the impact of demand on the workforce capacity when coming to decisions about an individual practitioner
 - (iii) GPC UK to work with CQC to ensure the demand: workforce capacity context is taken into consideration in their processes and decision-making to avoid the continuing and self-perpetuating negative impact on recruitment and retention
 - (iv) an effective mechanism for LMCs to escalate system issues that impact on patient safety in general practice that are outside the gift of practices to address and have failed to be addressed locally
 - (v) a review of the patient feedback survey required as part of GPs' revalidation so that the GP is not held responsible for system failings and pressures which are outside the gift of the individual GP to address.
238. DERBYSHIRE: That conference believes that the lack of support is inhibiting the remediation of doctors who are in the regulatory process, especially those who are self-employed, and demands final support:
- (i) for the provision of an educational supervisor
 - (ii) for the provision of a work place supervisor / reporter
 - (iii) to incentivise a practice to employ a doctor with conditions or undertakings.
239. KENT: That conference demands that regulatory bodies responsible for the inspection of general practices (CQC, care inspectorate Scotland / Wales) learn from the recent events in education where sadly a head teacher took their own life, and:
- (i) apply the coroner recommendations to their organisations
 - (ii) abide by defined reasonable time frame standards when issuing reports
 - (iii) 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.
240. KENT: That conference demands the GPC negotiate for a new, independent, body to oversee breaches in contractual responsibilities, relating to unsuitable transfer of work to general practice. This body would have the power to fine organisations in breach of this contract or reimburse general practice for the additional work required.
241. CROYDON: That conference asks the BMA to undertake a vote of no-confidence in the GMC after its decision to regulate professionals other than doctors.
242. WAKEFIELD: That conference believes that CQC measures general practice against unrealistic expectations and that practices should not be condemned to poor ratings when they are providing a good service if the rising demand, underfunding and poor morale that these factors contribute to, is taken into account.

243. WAKEFIELD: That conference recognises that an excessive amount of GP time is taken by vexatious complainants. A solution must be found other than removing them from the list and sending the problem to someone else. This could include a separate service for them similar to violent patient schemes, or NHSE handling their complaints and only asking practices to respond to genuine and new issues, or the removal of their right to complain.
244. SOMERSET: That conference:
- (i) believes that the Care Quality Commission (CQC) is not currently fit for purpose
 - (ii) insists that we cannot wait for a tragedy related to a CQC inspection to be the catalyst of change as occurred with Ofsted, and
 - (iii) demands an urgent review of the function, remit and powers of the CQC.
245. GATESHEAD AND SOUTH TYNESIDE: That conference notes that BMA support is no longer taking on cases in which concerns are raised to NHS England, and:
- (i) affirms the 2023 Bewick report and that malicious referrals to NHS England and / or GMC can be an abuse of process and part of a corrosive culture of bullying
 - (ii) commends the support offered by LMC officers to GPs facing investigation
 - (iii) demands GPs receive BMA representation in NHS England hearings to ensure members receive appropriate employment and legal support.
246. BRADFORD AND AIREDALE: That conference believes the avenue of assisted dying should be open as an option, to a well-defined group of patients.

WIDER PRACTICE TEAM (CLINICAL ROLES)

247. SOMERSET: That conference welcomes the sick pay, paternity leave, and maternity pay entitlements available to salaried GPs and PCN employed staff but insists that all clinicians working in general practice should have equivalent entitlements and instructs GPC to negotiate the inclusion of this in the GMS Contract.
248. SOMERSET: That conference instructs GPC to resist the planned closure of the Advanced Practice e-portfolio training route and the stringent Advanced Practice Digital Badge requirements imposed by NHSE which will limit the ability of general practice to expand its workforce.
249. SOMERSET: That conference insists that general practice can no longer provide 93% of NHS consultations funded from a derisory 7% of the NHS budget, and therefore demands that the majority of future funding investment in ARRS roles is directed into the GMS Contract.

CAPACITY DEMAND AND MISMATCH

250. LIVERPOOL: That conference believes that due to over a decade of chronic underfunding of health and social care, the NHS is broken, rather than just overwhelmed.
251. LIVERPOOL: That conference believes that the National Health Service is an illusion and is at risk of being prosecuted under the Trades Descriptions Act, as it is neither national, nor focusing on sustaining health and wellbeing, nor sufficiently funded to deliver a service of which we all can be proud.

252. NORFOLK AND WAVENEY: That conference believes that triage and new access proposals have fundamentally changed the ability of the GP to efficiently manage undifferentiated illness, holistic care and provide opportunistic health promotion. It requests that:
- (i) continuity of care is prioritised and valued
 - (ii) acute care provision is not separated from long term conditions management as this creates fragmentation and poor patient care.
253. DORSET: That conference deplores the continuous deluge of government campaigns to “see your doctor” simply encouraging the public to contribute drastically but unnecessarily to GP workload. It therefore demands that the Department of Health and Social Care always:
- (i) produces helpful education, resources and support for self-care, or appropriate signposting to self-referral services rather than an automatic “see your GP”
 - (ii) follows a consultation process with the profession, before launching further public health campaigns
 - (iii) takes a holistic approach, balancing the effect on public anxiety, and resource implications for the profession, together with the message behind any campaign.
254. WEST SUSSEX: That conference:
- (i) recognises the NHS 'universal offer' of care is unachievable given current levels of funding
 - (ii) calls on all politicians to be honest with the public that this is the case
 - (iii) calls on a medically led initiative to create a policy for NHS prioritisation of care
 - (iv) to involve patients in these discussions.
255. SEFTON: That conference believes that the decision by government ministers to stall plans to double the number of doctors in training by 2031 is a betrayal of those who placed faith in the NHS workforce plan and the UK population whose hopes of substantial future improvement in health care services are undermined. It calls upon the current government to restore the plan to expand doctor training and calls upon future governments to deliver on it.

DIGITAL, TECHNOLOGY AND DATA

256. DERBYSHIRE: That conference believes that the lack of inter-operability or communication between computer systems is significantly increasing workload for administrative staff and clinicians in primary care, whilst potentially impacting patient safety and patient satisfaction demands BMA lobby DHSC to ensure full interoperability of all systems in any new contract awarded.
257. BATH & NORTH EAST SOMERSET, SWINDON & WILTSHIRE: That conference is dismayed by the additional unfunded workload generated by patient online access, both in terms of administrative time and increasing clinical queries, often regarding clinically insignificant results. Conference calls on:
- (i) GPC UK to campaign for appropriate funding to recognise this additional workload managed by practices
 - (ii) NHS Digital to introduce a national helpline for patients experiencing technical problems with the NHS app to divert queries away from practices
 - (iii) UK government to run media campaigns highlighting that GP surgeries unfortunately do not have capacity to deal with multiple queries about results otherwise filed as satisfactory.

258. NEWHAM: That conference, regarding data sharing agreements (DSAs):
- (i) recognises the ever-increasing number of DSAs that practices are expected to sign
 - (ii) acknowledges the level of expertise required to adequately review these
 - (iii) questions why there has not been any additional resourcing for general practice to undertake this work
 - (iv) requires development of a national agreement so that there is a responsibility, for the body requesting the practice to sign the DSA, to fund the workforce required to review the DSA and associated documentation.
259. SUFFOLK: That conference demands that the Department of Health improve IT systems in the NHS by:
- (i) mandating hospitals to use EPS thereby allowing electronic delivery of prescriptions to community pharmacies and dispensing doctors and reversing the decline in outpatient prescribing
 - (ii) broadening the scope of EPS to include real time exemption checking for surgeries, PA items and full functionality for dispensing doctors
 - (iii) enabling hospitals, through use of a single electronic patient record or otherwise, to allow two way dialogue with patients on their referral lists without recourse to primary care.
260. MID MERSEY: That conference believes that the current steps to share patient data without adequate safeguards for research and academia is inappropriate and unsafe and demands that the “hands in the bucket” approach to this data be halted with immediate effect.

PENSIONS

261. BUCKINGHAMSHIRE: That conference believes the administration of NHS pensions has been abysmal, and demands government consider fines and / or a change of contractors for this administration in future.
262. BRADFORD AND AIREDALE: That conference highlights the totally appalling service being provided by PCSE in relation to administering the GP pension payments on behalf of the NHS Business Services Authority resulting in significant financial problems for practices through cash flow challenges and personal GP tax implications, and demands:
- (i) PCSE set up a dedicated pension task force team to work with practices through dedicated and named individuals to address the historic pension payment errors and misadministration of the pension certificates since PCSE became responsible for administering GP pension payments
 - (ii) practices are compensated for the amount of time spent having to work with PCSE to deal with these historical pension payment and certificate errors
 - (iii) PCSE moving forward provide practices with dedicated named individuals who can deal with any practice queries to ensure future payments and certificates are processed in an effective, timely manner.
263. HERTFORDSHIRE: That conference asserts that the current primary care pension support services are not fit for purpose, and asks GPC to ensure that the:
- (i) primary care support function supporting pensions in each nation has clear KPIs agreed with GPC, and
 - (ii) KPIs for the pension support function include penalties for poor performance including, where warranted, the removal of the contract to provide such a function
 - (iii) contract for the primary care support function for pensions includes clauses whereby practices can charge the provider for the additional practice time if the provider goes beyond set time limits in dealing with / concluding an individual case.

FUNDING PRINCIPLES, PAY / DDRB AND RESOURCES

264. WIGAN: That conference declares that the Secretary of State for Health and Social Care is jeopardising the health and wellbeing of the peoples of England Wales and Northern Ireland by failing to seek a meaningful settlement of the junior doctors dispute. It calls upon the Secretary of State to table an offer equivalent to that made by NHS Scotland in order to catalyse meaningful negotiations.
265. HIGHLAND: That conference believes that any national centre for excellence in remote and rural health should be backed with sufficient resource to allow it to produce tangible benefits for the remote and rural GP workforce.
266. MID MERSEY: That conference demands ARRS funding be transferred to core general practice to sustain the current level of demand and remove the inequity in the current model.
267. MID MERSEY: That conference believes that the government's 1.9% uplift in the Global Sum is unrealistic and devalues general practice and demoralises the workforce.
268. DERBYSHIRE: That conference recognises that the NHS will continue with winter pressures in future years and directs GPC to negotiate a QOF year-end be moved from 31 March to 30 June.
269. CROYDON: That conference instructs GPC NOT to negotiate long term funding plans with NHSE that do not take inflation or the possibility of pandemics or other Acts of God into account.
270. NORFOLK AND WAVENEY: That conference supports the recent call by the BMJ commission for the next government to recommit to the founding principles of the NHS which make it free at the point of use and funded through collective contributions.
271. HAMPSHIRE AND ISLE OF WIGHT: That conference believes no-one in the UK government is willing to have a mature conversation about the costs to the taxpayer to restore an adequately funded free-at-delivery health system in any of the four nations and it calls for GPC UK to:
- (i) work with other UK medical professional bodies to issue a joint statement on the effect underfunding is having on the health of the nations
 - (ii) work with other UK medical professional bodies to issue a joint statement on the effect underfunding is having on the morale of the medical profession and the reputational damage they are suffering
 - (iii) demand that the Health and Social Care Joint Select Committee and DHSC work with the profession to start a sensible conversation about a future UK health system that is based on honesty and realistic costings and not on magic money trees.

PARTNERSHIP AND CONTRACTOR MODELS

272. BOLTON: That conference welcomes the extra funding that the primary care network contract brings to general practice, but that the contract has not delivered the key initial ambitions. That is, the PCN contract has not:
- (i) enabled greater provision of proactive care
 - (ii) enabled greater personalised care
 - (iii) coordinated integrated health and social care for our communities.

273. EALING, HOUNSLOW AND HAMMERSMITH AND FULHAM: That conference has concerns about proposal in England to develop same day access hubs under the guise of the Fuller Stocktake recommendations and:
- (i) believes that this will worsen the patient experience
 - (ii) that this encourages patients to seek medical attention for self-limiting conditions and an increasing reliance on health care professionals
 - (iii) that this will increase workload pressures on the general practice workforce
 - (iv) that this may worsen the retention of staff by reducing their experience and job satisfaction
 - (v) requires urgent action by GPCUK to challenge the role out of this in England and prevent it spreading to the devolved nations.
274. MID MERSEY: That conference believes PCNs are fundamentally undermining core general practice and are not fit for purpose.

GREENER GENERAL PRACTICE

275. DERBYSHIRE: That conference recognises the significant carbon footprint of general practice and calls on DHSC to provide urgent ring-fenced funds to support a reduction in unnecessary waste and excessive CO2 emissions generated by general practice. Conference demands specific funding to support:
- (i) a boiler replacement scheme to urgently replace ageing and inefficient heating systems
 - (ii) sensor lighting across the general practice estate where not present
 - (iii) funded recycling collections from general practice including a mask recycling scheme
 - (iv) the funded reintroduction of sterilisation services and a move away from single use items.
276. BRADFORD AND AIREDALE: That conference recognises the climate crisis continues unabated despite the BMA goal of carbon net zero and demands:
- (i) the principle of carbon net zero should immediately be part of all future conference planning
 - (ii) climate crisis and sustainability should be integral to future policy debate and decisions
 - (iii) resources be provided by NHSE to assess each practice carbon footprint
 - (iv) all resources be provided to facilitate carbon saving changes to general practice from mapped footprints.
277. NORTHERN IRELAND SOUTHERN: That conference expresses incredulity that electronic GP prescribing is not available in one country of the UK.
278. TOWER HAMLETS: That conference recognises that to reduce the nation's carbon footprint we all have a role to play and requests that publications frequently used by GPs are only available in digital format. These include:
- (i) BNF
 - (ii) MIMMS
 - (iii) BMJ.

STANDING ORDERS

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STANDING ORDERS

CONFERENCES

Annual conference

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

Special conference

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

Membership

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

Representatives

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

Observers

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

Interpretations

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

Motions to amend standing orders

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

Suspension of standing orders

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

Agenda

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

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

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

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

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

Other duties of the agenda committee include:

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

Procedures

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

Rules of debate

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

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

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

Allocation of conference time

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

Motions not published in the agenda

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

Quorum

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

Time limit of speeches

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

Voting

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

Majorities

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

Elections

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

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

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

Returning officer

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

Claire Wand award

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

Motions not debated

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

Distribution of papers and announcements

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

Mobile phones

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

The press

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

No smoking

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

Chair's discretion

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

Minutes

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