



General Practitioners Committee

## Conference News

Conference of Representatives of Local  
Medical Committees  
19 - 20 May 2016

- Part I: Resolutions
- Part II: Election results
- Part III: Motions not reached
- Part IV: Remainder of the agenda

# PART I

## ANNUAL CONFERENCE OF LOCAL MEDICAL COMMITTEES MAY 2016

### RESOLUTIONS

#### Report of the agenda committee

- (6) 1. That conference, in order to facilitate its own policy of asking the GPC to ensure adequate representation on GPC of LMC representatives within their first five years post CCT, agrees to hold a ballot during conference to enable the Chair of the Representation Sub-Committee to identify the most suitable GP to co-opt (to have the full voting rights of any GPC member) for the forthcoming session. Candidates must be Representatives of LMCs at this conference, and must have gained their CCT after 19 May 2011. Only representatives at Conference will be entitled to vote.  
**(Proposed by Katie Bramall-Stainer, Hertfordshire LMC and Representation Subcommittee Chair)  
Carried unanimously**

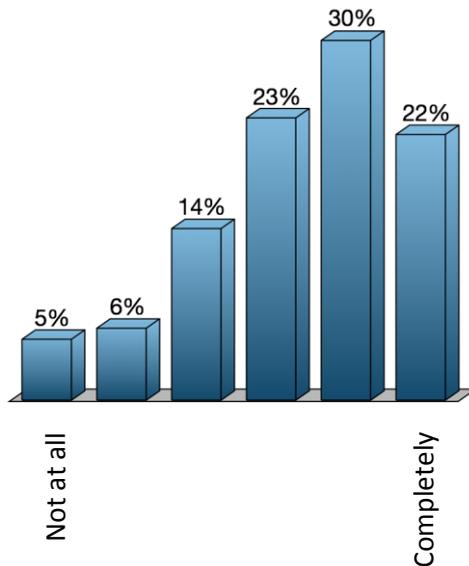
#### Themed debates

At the LMC Special Conference in January 2016, four main themes were debated, calling for the negotiation of a rescue package for general practice. Since then, GPC produced and published their [Urgent Prescription for General Practice](#).

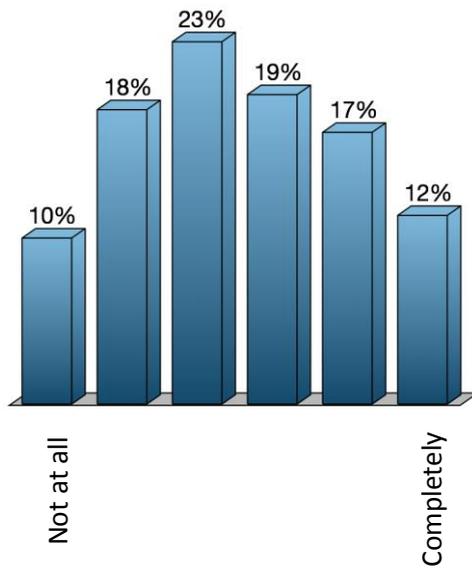
The following major issue debates were held covering similar themes. Voting representatives at conference were invited to indicate on a scale of 1 (not at all) to 6 (completely) the extent to which they support current GPC policy in this, as outlined within the Urgent Prescription (see Appendix 1)

#### Funding of General Practice

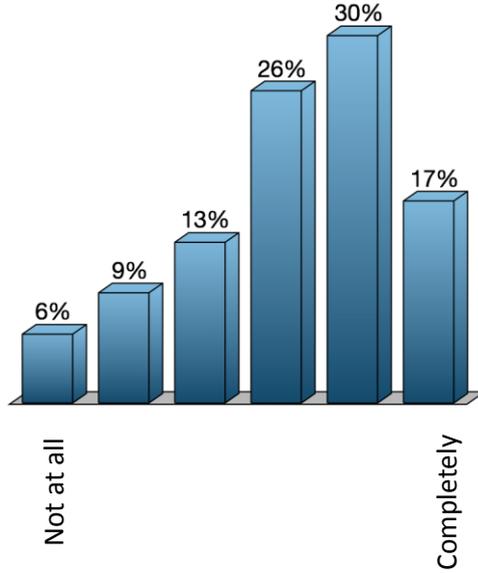
The votes were as follows:



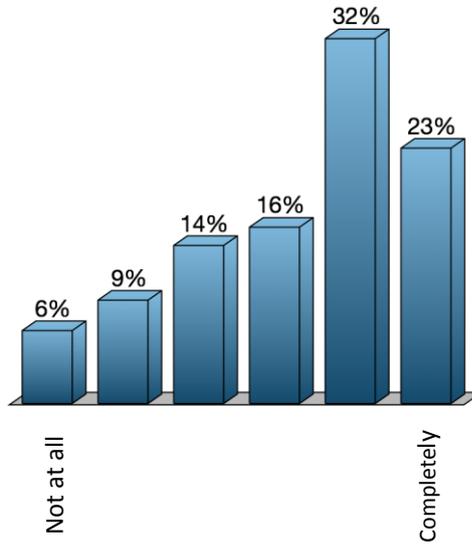
Workload in General Practice



General Practice Workforce



Empowering Professionalism



## Information management and technology

- (8) 2. That conference believes that GP IT needs fully funded:
- (i) improved support services
  - (ii) fast and reliable broadband connections
  - (iii) scanning, digitising and shredding of paper records
  - (iv) interoperability
  - (v) a fit for purpose national primary care IT specification
- (Proposed by Alan Francis, Hull and East Yorkshire LMC)**  
**Parts (i), (ii), (iv) and (v) Carried unanimously**  
**Part (iii) Carried**
- (9) 3. That given the rise of multi-agency integrated digital care records and patient access to their own records, conference:
- (i) requests particular consideration of the needs for confidentiality of adolescents and vulnerable adults
  - (ii) calls for a national Data Sharing agreement
  - (iii) demands that the workload implications are addressed.
- (Proposed by Peter Gledhill, Bedfordshire LMC)**  
**Carried**

## Seven day GP service

- (10) 4. That conference believes that the current emphasis on 7-day working is a political push for the unachievable particularly in the light of the continued under-resourcing of primary care and insists that the 7-day mantra be abandoned and any additional resource available should be used to enhance the weekend emergency cover services.
- (Proposed by Christopher Browning, Suffolk LMC)**  
**Carried**

## Urgent Care

- (11) 5. That conference is concerned by the lack of integration between the out-of-hours GP care providers with each other and in-hours GP services and calls for an integrated IT system across all out-of-hours providers.
- (Proposed by L-J Evans, Dorset LMC)**  
**Carried**

## Junior doctors dispute

- (12) 6. That conference is appalled at the government's handling of the junior doctor's dispute and
- (i) strongly condemns the imposition of the new unsafe and unfair contract on junior doctors
  - (ii) believes the dispute has damaged doctors' morale and lost the goodwill of hard working staff
  - (iii) confirms support for the junior doctors and calls on the GPC to set out what steps practices can take to demonstrate this.
- (Proposed by Simon Hodson, Shropshire LMC)**  
**Carried**

## Response of the profession

- (S12) 7. That conference with regards to the General Practice Forward View;
- (i) welcomes the acknowledgment of significant past underfunding and commitment to increased spending
  - (ii) believes that most of the investment promised is conditional upon practices delivering transformation and service change
  - (iii) recognises that only some of the demands of the profession have been included, and instructs GPC to continue to press for further dedicated resources to support GPs
  - (iv) does not believe that there is sufficient urgency in the measures described
  - (v) is concerned that the present financial state of the NHS makes the prospects of these financial flows unlikely.

**(Proposed by Alan Mills, Cambridgeshire LMC)**

**Carried**

- (S20) 8. That conference does not accept the General Practice Forward View is an adequate response to the GPCs statement of need within the BMAs Urgent Prescription for General Practice, and considering this to be sufficient grounds for a trade dispute, unless the government agrees to accept the Urgent Prescription within 3 months of this conference, the GPC should ask the BMA to:
- (i) ballot the profession on their willingness to sign undated resignations
  - (ii) ballot the profession on their willingness to take industrial action
  - (iii) ballot the profession as to what forms of industrial action they are prepared to take
  - (iv) produce a report to practices on the options for taking industrial action that doesn't breach their contracts.

**(Proposed by Jackie Applebee, GPC)**

**Carried**

## Premises

- (13) 9. That conference believes that NHS Property Services is not fit for purpose and has:
- (i) failed in its mandate 'to provide a quality service to its tenants'
  - (ii) failed in its core value 'caring – helping the NHS to deliver better and more sustainable clinical care and services'
  - (iii) not been made accountable for its mismanagement and lack of action
  - (iv) demanded charges that are unrealistic, unaffordable and destabilising to practices.

**(Proposed by Gaurav Gupta, Kent LMC)**

**Parts (i) and (ii) Carried**

**Parts (iii) and (iv) Carried unanimously**

## Overseas patients

- (14) 10. That conference believes that overseas visitors should be able to attend UK general practitioners but:
- (i) this should only be on a private fee-paying basis
  - (ii) any fees paid should be retained in full by the general practice
  - (iii) it remains open to the government to offer NHS care free to overseas visitors at walk-in-centres, urgent care centres, and accident and emergency departments, and patients can be offered these alternatives.

**(Proposed by Russell Brown, East Sussex LMC)**

**Carried**

## GP locums

- (15) 11. That conference affirms that locum GPs are an essential part of the GP workforce and in this current workforce crisis:
- (i) rejects the principle that the Department of Health can unilaterally fix a market price for services
  - (ii) rejects compulsory reporting by practices of locum payments
  - (iii) affirms that practices and locum GPs should be allowed to mutually agree terms and conditions
  - (iv) rejects any attempt to cap the fees charged by GP locums.
- (Proposed by Faisal Baig, Sessional GPs Subcommittee)**  
**Carried**

## Medical certificates and reports

- (17) 12. That conference calls for:
- (i) an extension of self-certification for illness from 7 to 14 days
  - (ii) a change in legislation to allow other health care professional such as midwives, allied health professionals and nurse practitioners to complete 'fit notes' for patients.
- (Proposed by Rachel Fraser, Scottish Conference of LMCs)**  
**Carried**

## Chosen motions

- (T3-1) 13. That conference calls for the urgent incorporation of contingency planning for large numbers of patients being left without general practice services at very short notice into all NHS emergency preparedness and resilience planning.  
**(Proposed by Peter Holden, Derbyshire LMC)**  
**Carried unanimously**
- (T1-10) 14. That conference insists that the GPC:
- (i) secure a commitment from government that spending on primary care increases to at least 12% of the total NHS spend
  - (ii) secures an agreement to suspend all further PMS redistribution and MPIG erosion
  - (iii) produces a nationally agreed and costed menu of 'GMS plus' services
- (Proposed by Jim Kelly, Kent LMC)**  
**Carried**
- (T1-25) 15. That conference, in the light of the recent findings of research published in the British Journal of General Practice, calls upon GPC negotiators to ensure that the huge difference in premature multi-morbidity across the social spectrum is taken into account in the allocation of funding and resources for general practice.  
**(Proposed by Ronnie Burns, Glasgow LMC)**  
**Carried**
- (P6-1) 16. That conference believes that 'New Models of Care' are no substitute for the lifetime doctor-patient mutual investment company of 'Old Models of Care'.  
**(Proposed by Helena McKeown, Agenda Committee)**  
**Carried**
- (T2-1) 17. That conference asserts that rising demand and falling resources mean patient safety can no longer be guaranteed in NHS general practice, and asks GPC to open negotiations with the government to
- (i) define the contents and scope of the core primary care contract

- (ii) acknowledge that additional work will require additional resources
- (iii) consider how public demand for health care can be better managed.

**(Proposed by Nick Bray, Somerset LMC)**

**Carried**

- (T4-20) 18. That conference as part of the 'rescue package', presses the GPC to urgently publish a list of procedures and services that are not part of contracted essential and additional services
- (i) which should be implemented nationally
  - (ii) and that practices providing these services should be given additional payments
  - (iii) and would advise practices undertaking these services without additional funding to consider giving notice of terminating the services.

**(Proposed by Sian Whyte, Buckinghamshire LMC)**

**Carried**

- (S-9) 19. That conference recognises that a new process for issuing of Firearms Certificates by the police commenced on 1 April 2016 which involves additional work for general practitioners and instructs the GPC to work with the BMA Professional Fees Committee to urgently revise this dangerous scheme and actively support GPs refusing to participate in this process until:
- (i) the process is changed so that certificates are only issued after (rather than before) GPs are involved
  - (ii) there is clarification regarding payment for the work involved
  - (iii) there is clarification of the medico-legal validity of the process.

**(Proposed by Anthony O'Brien, Devon LMC)**

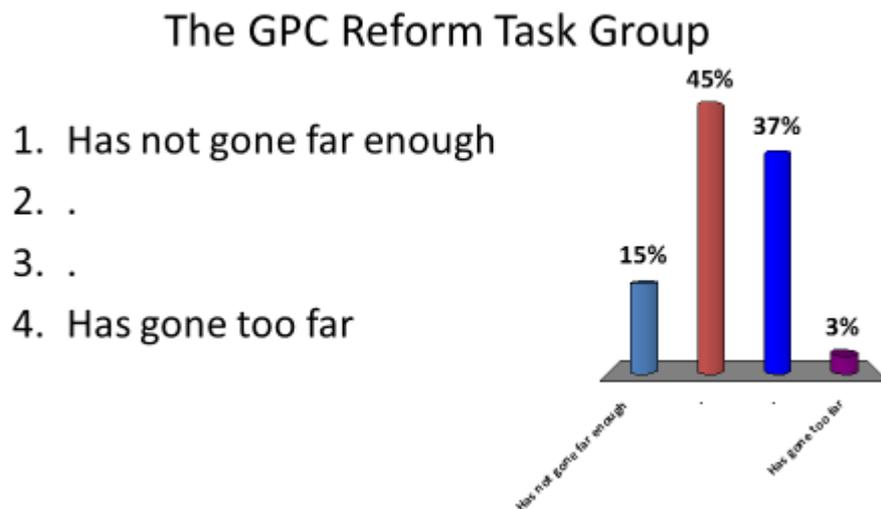
**Parts (i) and (iii) Carried**

**Part (ii) Carried unanimously**

### Themed debate – GPC Reform Task Group

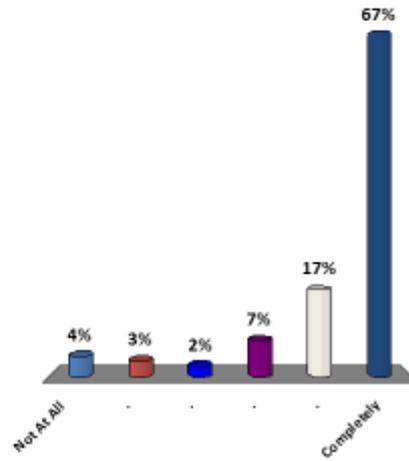
Voting representatives at conference were invited to indicate on a scale the extent to which they support different policy areas within the GPC Reform Task Group Report.

The votes were as follows:



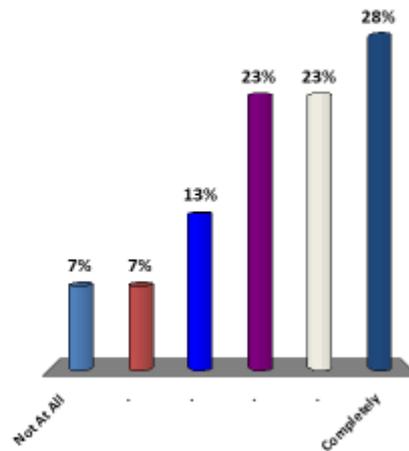
## Creation of GPC England

1. Not At All
2. .
3. .
4. .
5. .
6. Completely



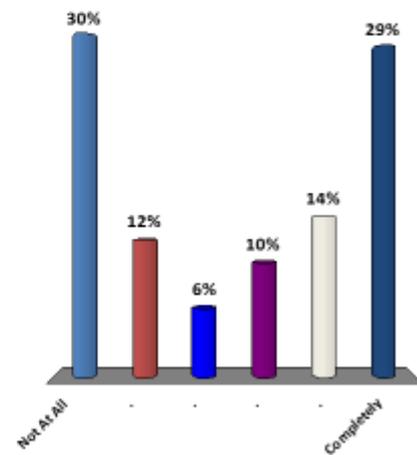
## Move to multi-member constituencies

1. Not At All
2. .
3. .
4. .
5. .
6. Completely



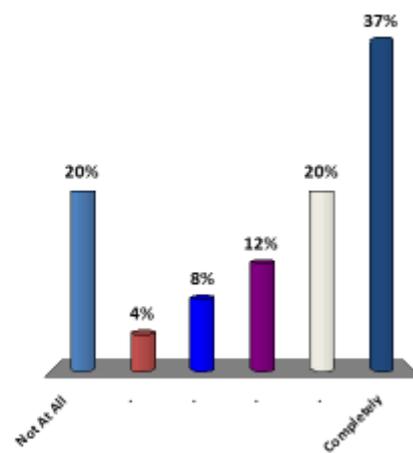
## Electorate to be LMC members rather than all GPs

1. Not At All
2. .
3. .
4. .
5. .
6. Completely



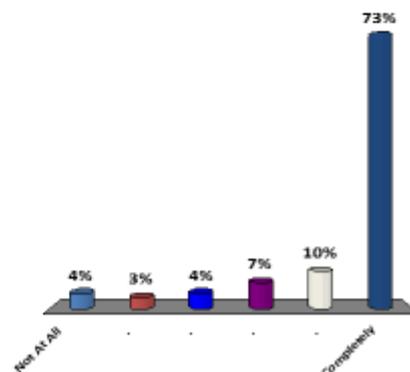
## Other executive members to be appointed

1. Not At All
2. .
3. .
4. .
5. .
6. Completely



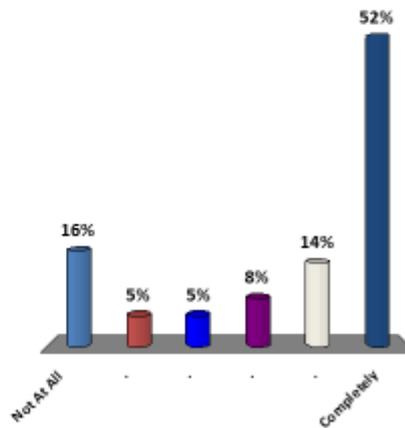
## GPDF should provide or release additional funding for support, advice, training and development for LMCs

1. Not At All
2. .
3. .
4. .
5. .
6. Completely



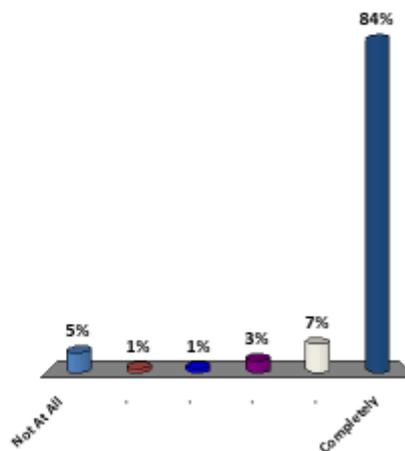
### One-day LMC UK conference

- 1. Not At All
- 2. .
- 3. .
- 4. .
- 5. .
- 6. Completely



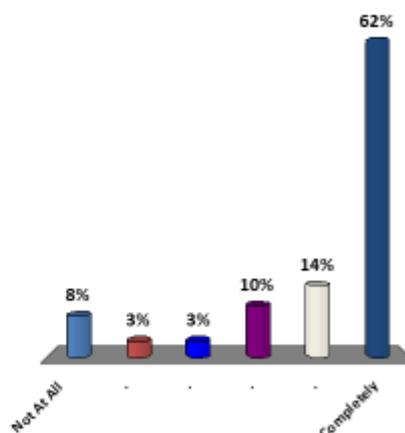
### One-day LMC England conference

- 1. Not At All
- 2. .
- 3. .
- 4. .
- 5. .
- 6. Completely



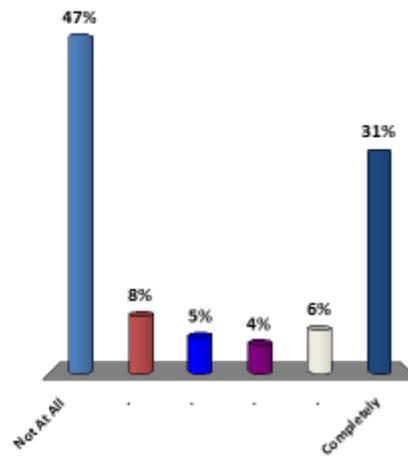
### One nominee from each LMC should form the reformed GPDF

- 1. Not At All
- 2. .
- 3. .
- 4. .
- 5. .
- 6. Completely



## The Dinner should not happen

1. Not At All
2. .
3. .
4. .
5. .
6. Completely



**PART II**  
**ANNUAL CONFERENCE OF LOCAL MEDICAL COMMITTEES**  
**MAY 2016**

**ELECTION AND CO-OPTION RESULTS**

**Chair of Conference – Guy Watkins**

**Deputy Chair of Conference – Mary O’Brien**

**Seven members of GPC (in alphabetical order):**

Ivan Camphor  
Stephanie De Giorgio  
Michael Haughney  
Peter Horvath-Howard  
Michael Ingram  
Krishna Kasaraneni  
Chaand Nagpaul

**LMC representative within their first five years post-CCT co-opted to GPC**

Rachel Ali

## PART III

### ANNUAL CONFERENCE OF LOCAL MEDICAL COMMITTEES MAY 2016

#### MOTIONS NOT REACHED

Conference standing orders provide for LMCs to be informed of motions which have not been debated at conference, and invite proposers of such motions to submit to the GPC memoranda of evidence in support. Memoranda of evidence in support, **must be received by the end of September** for the GPC's consideration.

All motions in part II of the agenda were **not** reached, except for those shown in part I of this document.

#### GP locums

- (16) DERBYSHIRE: That conference requests our profession to come together to agree a fair and reasonable cap on GP locum fees. (Motion will fall and not be debated if (iv) of Agenda Committee motion is passed)

## PART IV

### ANNUAL CONFERENCE OF LOCAL MEDICAL COMMITTEES MAY 2016

#### REMAINDER OF THE AGENDA

##### Information management and technology

- (9) That given the rise of multi-agency integrated digital care records and patient access to their own records, conference:
- (i) requires the transfer of data controller status from individual primary care provider organisations
  - (ii) advises patients should be given their paper notes for safekeeping.
- (Proposed by Peter Gledhill, Bedfordshire LMC)**  
LOST

##### Urgent care

- (11) That conference is concerned by the lack of integration between the out-of-hours GP care providers with each other and in-hours GP services and calls for:
- (i) a radical redesign and integration of all current out of normal hours services
  - (ii) work that comes to a practice after 6pm to be directed to OOH services
  - (iii) an out-of-practice daytime visiting service
  - (iv) community urgent care centres which patients can access when their practices have no more capacity for same day access.
- (Proposed by L-J Evans, Dorset LMC)**  
LOST

##### Chosen motions

- (T3-33) That conference believes that should the workforce crisis remain unresolved, regulations will have to be changed to remove the right of the public to have direct access to a GP.  
**(Proposed by Richard Wood, Buckinghamshire LMC)**  
LOST
- (T1-10) That conference insists that the GPC act on its mandate to seek a new national core contract which links payment to activity.  
**(Proposed by Jim Kelly, Kent LMC)**  
LOST

## Themed debates

Current GPC policy as set out in the [Urgent Prescription for General Practice](#)

### THEMED DEBATE – FUNDING OF GENERAL PRACTICE FAIR AND SUSTAINABLE FUNDING AND RESOURCES

**Problem:** The percentage of NHS funding spent on general practice has fallen from 10.4% in 2005/6 to 7.4% in 2014/15, leaving practices receiving an average of only £141 per patient to deliver a year of general practice care. This means general practice has an effective funding deficit of at least £2.5bn.

**Impact:** General practice does not have sufficient funds for workforce, premises or services to meet the growing needs of patients and this is undermining the safety of care delivered.

**Actions:**

- Government must commit to incremental recurrent funding in general practice, to reach a minimum of 11% of NHS spend. This would require funding the current deficit of at least £2.5bn in addition to the £8.3bn spent on general practice in England in 2014/15 and £9.8bn spent across the UK. This funding commitment will require a rebalancing of NHS resources to where care is delivered, in the context of care moving out of hospital.
- Provision of an immediate stabilisation fund for general practice to provide emergency support to vulnerable practices at risk of closing, or where safe patient care is significantly compromised.
- Establish a healthcare resilience task force within each CCG or locality area to provide support to vulnerable or at risk practices, which could include the provision of management resources, clinical input, proactive support, eg for unfilled vacancies, project management support or technology support which could be called upon at short notice for a practice in crisis. This should be developed in liaison with LMCs and needs to operate in a non-threatening and non-judgemental culture to support openness.
- Increases in indemnity insurance costs for all primary care practitioners should be fully reimbursed or paid for by NHS England, and steps taken to introduce a sustainable system of indemnity for those working in primary care comparable with clinicians working in secondary care.
- The funding allocation formula for practices should fairly reflect the workload of practices, including activity common to all practices that is not related to the demographics of the patient population.
- Practices serving atypical populations should be supported through dedicated bespoke funding allocations.
- A long term mechanism should be agreed to calculate and fully fund practice expenses including direct reimbursement of expenses incurred specifically to deliver NHS services.

## THEMED DEBATE – WORKLOAD IN GENERAL PRACTICE

### REDUCING WORKLOAD TO ENSURE DELIVERY OF SAFE AND HIGH QUALITY CARE

**Problem:** Consultation rates and numbers have dramatically increased. The needs of many patients have become much more complex, with many being less confident to manage self-limiting conditions. Additionally, increasing amounts of work have moved from secondary care to general practice, often inappropriate and unfunded, and the bureaucratic burden on practices and practitioners has increased.

**Impact:** Workload pressures are undermining the safety of care to patients, with 93% of GPs reporting that heavy workload has negatively impacted on the quality of patient services. 9 in 10 GPs believe that the 10 minute consultation is inadequate to meet patients' needs. 34% of GPs are considering retiring in the next five years, and 17% of GPs are considering less than full-time working due to workload pressures, hence reducing GP capacity further.<sup>2</sup>

**Actions:**

- Set a national standard for a maximum number of patients that GPs, nurses and other primary care professionals can reasonably deal with during a working day to maintain delivery of a safe and high quality service.
- Establish locality hubs to which practices can refer urgent patients when they have reached the capacity threshold for safe care on any given day. These hubs will not be walk-in-centres, but services that practices can refer to when required. Their primary purpose will be to provide the support necessary for a sustainable service at practice level. See Locality hubs for further information. These hubs can ultimately:
  - become centres for training, development and recruitment
  - host much of the wider primary healthcare team
  - organise care home provision
  - control and cost care being moved into the community from hospitals and other sources.
- Provide organisational development funding and support to enable collaboration between practices and others within their locality, including the development of practice networks and multispecialty community organisational arrangements, building on current GMS/PMS contracts. Such networks can be used to:
  - support individual practices with workload, including the development of locality hubs
  - encourage sharing of back office functions and administrative support
  - expand services in primary care, with the managed transfer of care out of hospital
  - develop the general practice and primary care workforce, aligning the diversity of the GP profession with local identity
  - develop sustainability.

- Ensure GPs and other practice team members are enabled to routinely offer 15 minute consultations or longer where necessary for patients with greater needs such as complex or multiple morbidity. This may result in a waiting list for routine appointments in the interests of patient safety. To mitigate this, NHS England and commissioners can expand capacity by resourcing locality hubs, skill-mix, manage demand, and commission direct access to other providers in order to release GP capacity
- Optimising the care of patients in their own home:
  - dedicated community nursing teams fully integrated with GP practices, to provide case management of frail elderly patients including being the first point of contact for appropriate home visits.
  - CCGs to arrange patient transport services for appropriate patients to attend GP surgeries, as is currently the case for similar patients accessing hospital outpatient clinics
  - expansion of community nursing independent prescribing to avoid contacting a GP for the sole purpose of issuing a prescription
  - CCGs to commission specialist and multi-professional rapid response teams or similar to support early discharge of patients. This will help to avoid inappropriate demands on GPs, and will serve patients' needs with timely dedicated support
  - hospitals to directly arrange community nursing, rehabilitation or social support in the community for patients being discharged from hospital.
- Separate contractual arrangements, such as a new Directed Enhanced Service or multi professional contract, for dedicated care of patients in nursing and residential homes, and frail elderly housebound patients, providing significant new funding to enable the creation of multi-professional teams and appropriate specialist input to better meet the needs of this group of patients.
- Establish a national list of services that are not included in core GMS which practices can choose if they wish to provide, with pricing benchmarks nationally set that can be locally adapted according to any variations.
- Stem inappropriate clinical and bureaucratic workload shift onto GP practices, including the following:
  - define a specification for appropriate, related internal hospital referrals, eg a rheumatologist to a pain clinic, with the practice to be copied in
  - ensure that hospital initiated investigations are followed up and actioned by the requesting clinician, including communicating with the patient, in keeping with the recent NHS England guidance
  - hospital clinicians to use HFP10s and be enabled to use an electronic prescription service for the initiation and ongoing prescribing of specialist medication – ending the current inappropriate workload and clinical governance risk of GPs prescribing outside their competence and for clinical decisions for which they are not responsible
  - hospital practitioners prescribing a full course of treatment when initiated in outpatient

clinics

- enable community nursing teams and other allied health professionals to be trained and accredited to prescribe independently, and to make appropriate direct referrals where appropriate (eg to an incontinence nurse or social services)
  - end employers of community nurses insisting on patient specific directions for items that have been prescribed
  - introduce pathways for granting permission for low priority procedures to be streamlined, including appeals procedures that do not necessarily involve the GP
  - hospital practitioners to issue fit notes for patients at discharge or in out-patient clinics for full duration of recovery
  - enable patients to contact hospital clinicians directly for queries relating to their clinical management in hospital, rather than being redirected to their GP
  - enable patients to book all transport to hospital appointments directly with the service without the need to involve the practice
  - enable hospital doctors to directly book investigations using a commissioned and resourced community phlebotomy service as opposed to asking the GP to do so
  - information about all patient contacts being sent electronically or added directly to the patient record within 48 hours of a patient being seen
  - ensure that discharge processes from secondary care are always followed and that community support for the patient has been arranged by the hospital where needed prior to discharge
  - ensure all shared care protocols are only implemented if the GP is willing and able to take on the additional clinical responsibility and workload and is additionally resourced.
- Ending inappropriate workload shift with effective CCG commissioning, to be taken forward locally with the support of LMCs:
    - LMCs, practices and CCGs should coordinate local strategies, including electronic service alerts via templates on clinical systems for CCGs to take action
    - CCGs should put in place troubleshooting staff to address problems of inappropriate workload shift flouting local commissioning agreements, to avoid practices incurring bureaucratic time
    - all hospitals should provide a dedicated GP helpline to address primary/secondary care interface problems
  - Universal access to and promotion of Pharmacy First (or other minor ailment) schemes, including the provision of medications without charge for patients who are exempt from prescription charges.
  - Enable patients exempt from NHS prescription charges to directly access products such as gluten-free products, other food supplements, dressings, appliances and stoma products

without the need for GPs to prescribe these items, with appropriate regulatory changes made to make this possible.

- End the GP role in assessing the eligibility for bus passes, parking badges, housing, gym membership and other similar non-NHS work and ensure that this work is commissioned from an appropriate source by the requesting organisation, eg the local authority or CCG.
- Clear definition, funding and enforcement of payment of all collaborative services.

## THEMED DEBATE – GENERAL PRACTICE WORKFORCE

### AN EXPANDED WORKFORCE IN AND AROUND THE PRACTICE

**Problem:** In the last decade the number of hospital consultants has increased by 48%, while GP numbers have increased by only 14%, and since 2009 the number of GPs per head of population has declined. GP training posts are not being filled, and increasing numbers of older GPs are planning to retire. There is a similar recruitment and retention crisis in practice nursing, with a fall of community nurses of 38%. Further, there are increasing numbers of GP partner vacancies, adding often unmanageable workload burden on a smaller pool of partners.

**Impact:** The reduced capacity of the general practice and community workforce leads to increased workload burdens, increased practitioner burnout, delays in access to appointments, and care that is fragmented or potentially unsafe being provided. All these factors lead to a vicious circle, impacting further on morale, recruitment and retention. Governments' attempts to resolve some of these issues through the use of APMS contracts has often made the situation worse, not better.

**Actions:**

- While there are inadequate numbers of GPs currently, there needs to be use of skill-mix built within and around the framework of the GMS/PMS contract, to support GP pressures, ensure retention of the current GP workforce, while creating definitive solutions to improve recruitment to expand the GP workforce.
- A step change in GP recruitment initiatives with a clear and credible plan to recruit more GPs.
- Immediate resources to fund an expanded and comprehensive primary care team to reduce and relieve GPs' workload, including fully funded clinical professionals to work directly with practices, including pharmacists, mental health practitioners, advance nurse practitioners, physiotherapists, medical assistants and physician associates.
- Direct access to services to avoid GP first point of contact, eg:
  - extended scope practitioner eg direct access physio
  - specialist nurses for chronic diseases (eg diabetes, epilepsy, rheumatoid)
  - mental health services
  - Pharmacy First and minor ailment schemes

- health visitors
  - District nursing services
- Establish closer links between community pharmacists and practices where this can support GP workload.
  - Commission a comprehensive and nationally defined community nursing team to support and work with each practice in an integrated manner.
  - Expand the number of hospital based clinicians delivering care in the community working in partnership with primary care clinicians.
  - Dedicated funding to support GPs to develop portfolio careers and specialist skills to improve recruitment and retention, eg an individual professional development budget that a GP could use over the 5 year revalidation cycle
  - Establish training hubs for enhanced training for practice managers and other practice staff.
  - Further reduce the bureaucratic burdens of the returner scheme.
  - Improve the investment in and promote the retainer scheme.
  - Encourage permanent GP practice placements with inducement schemes.
  - Alongside the model GMS salaried GP contract, develop a nationally defined employed GP contract modelled on the hospital consultant contract for those GPs working for other providers or GP led organisations.
  - Investing in the GP out-of-hours service to enable an expanded and sustainable clinical workforce, addressing issues such as additional indemnity costs. This would also support the development of a clinically appropriate integrated seven-day *urgent care* service.

## THEMED DEBATE - EMPOWERING PROFESSIONALISM

### REDUCING THE REGULATORY BURDEN OF CQC

### REDUCING BUREAUCRACY AND DUPLICATION TO EMPOWER PROFESSIONALS

**Problem:** The process of CQC registration and inspection duplicates work already done by other bodies, is disproportionate and costly in time and resource, is not evidence based, is demoralising and therefore is not fit for purpose.

**Impact:** The 2016 BMA survey showed that 8 out of 10 GP practices report that preparing for a CQC inspection resulted in a reduction in time available to care for patients.<sup>6</sup> Almost 9 out of 10 GP practices said that on the day of the CQC inspection, staff had to reduce GP services available for patients. Three quarters of practices reported that staff suffered from significantly increased stress in preparing for and undergoing inspections, but only 1 out of 10 (11%) regarded their final CQC rating as a fair assessment.

**Actions:**

- Replace the current flawed and erroneous content and pattern of CQC visits and ratings, with targeted assessments of essential quality assurance processes where supported by evidence of risk of patient safety.
- End the duplication of the current CQC registration process and NHS England managed national performers list and performance management arrangements, with a single slimmed down cost-effective process funded by NHS England not practices.

**Problem:** The increased bureaucratic burden created to assess, performance manage and regulate general practice has dramatically increased in the last decade, costing significant amounts both in lost clinical time with patients and financial resource for the NHS and practitioners.

**Impact:** The burden of unnecessary bureaucracy has disempowered professional clinicians and undermined their morale, added unnecessarily to practice and NHS management workload, resulted in significant duplication, misled patients, and wasted millions of pounds that could have been better spent on direct patient care.

**Actions:**

- End the Quality and Outcomes Framework and invest the unweighted resource in the core GMS/PMS contract, developing in its place a professionally-led system that encourages and celebrates quality of care delivered and is not linked to financial targets.
- End the Avoiding Unplanned Admission enhanced service and invest the unweighted resource in the core GMS/PMS contract to enable practices to care for vulnerable patients without the added and unnecessary bureaucracy of this scheme.
- Review the bureaucracy and frequency of the appraisal process and reduce so-called 'mandatory' training requirements.
- Provide at least half a day of protected funded time every month for all GPs and practice staff to engage in learning and professional development.
- End the annual cycle of GP contract negotiation and provide stability of contract to practices.
- Reduce the bureaucracy involved in moving between the nations' performers lists, particularly when working in border areas.