Conference News

Conference of England Local
Medical Committees Representatives

7 November 2025

Part I: Resolutions
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PART I

ANNUAL ENGLAND CONFERENCE OF LOCAL MEDICAL COMMITTEES NOVEMBER 2025

RESOLUTIONS

STANDING ORDERS

3. That conference accepts the proposed changes to the Standing Orders, as recommended by the Agenda Committee and as outlined in Appendix 2 regarding:

(i) members of conference – 3.5, 3.6, 6, 8
(ii) preparation of the agenda – 22.3, 26
(iii) procedures – 29, 30, 31, 32
(iv) rules of debate 34, 35
(v) elections 63.2, 64.2, 65.3

Proposed by the Agenda Committee

(i) Carried unanimously
(ii) Carried unanimously
(iii) Carried unanimously
(iv) Carried unanimously
(v) Carried unanimously

ONLINE CONSULTATIONS AND ACCESS

5. That conference is deeply concerned that the 2025 / 26 contract variation requires practices to maintain continuous online, telephone and physical access throughout core hours (08:00–18:30). Conference:

(i) rejects the government's contractual requirement for GP practices to guarantee universal patient access throughout all core hours, condemning it as a cynical political stunt that is unfunded, unsafe, and knowingly undeliverable in the context of current workforce collapse
(ii) insists that practices must retain flexibility to deliver access in ways that reflect the needs and demographics of their patient population
(iii) insists that online consultations may be curtailed when safe working limits have been reached
(iv) demands the immediate removal of these access mandates, which reduce care to box-ticking targets and put patients at risk
(v) mandates GPCE to prepare options for action, including non-compliance with access requirements, should government refuse to revise the 2025 / 26 contract variation.

Proposed by Chandra Kanneganti, North Staffordshire

(i) Carried overwhelmingly
(ii) Carried unanimously
(iii) Carried nem con
(iv) Carried unanimously
(v) Carried overwhelmingly

10 YEAR HEALTH PLAN

6. That conference asserts that the three core aims of the 10 Year Health Plan cannot be delivered without GP leadership, alongside full and transparent assurance on funding streams, and calls on GPCE to:

(i) insist that implementation of the Plan must not be imposed by trusts or ICBs, but instead be co-designed and led by GPs and general practice–led organisations, with oversight and review by LMCs, rejecting any proposals which marginalise GP leadership
(ii) not accept the development of Single Neighbourhood Provider or Multi Neighbourhood Provider contracts as fulfilling the Secretary of State's commitment to renegotiate the GMS contract
(iii) demand adequate funding to back up the plan, rejecting any attempt by ICBs to shift unfunded workload to general practice under the guise of integration or transformation
(iv) advise practices to disengage from participation in neighbourhood provider structures unless they are demonstrably led by general practice, with equitable representation and control
(v) issue guidance to support practices in resisting contractual or structural involvement in neighbourhood models that undermine independent contractor status or partnership led care.

Proposed by Richard Van Mellaerts, Kingston & Richmond

(i) Carried nem con
(ii) Carried nem con
(iii) Carried unanimously
(iv) Carried overwhelmingly
(v) Carried unanimously

DISPENSING

7. That conference notes the financial and structural pressures dispensing practices face and calls on GPCE to:

(i) urgently demand a national review of dispensing fee structure and discount abatement to prevent practices dispensing at a loss
(ii) include renegotiation of the dispensing contract alongside the renegotiation of the GMS contract
(iii) ensure all IT requirements for fulfilling the dispensing element of dispensing doctors' contracts are fully funded and included in the long awaited national implementation of electronic prescribing across all dispensing practices.
(iv) formalise a structure to consult with them when negotiating dispensing issues, including a named dispensing lead within the GPCE executive structure
(v) negotiate immediate abolition of the one mile rule so that dispensing doctors can compete fairly with pharmacies and patients can choose where to have their prescriptions fulfilled.

Proposed by Andrew Mercer, Devon

Voted on block. Carried nem con

RIGHT TO CHOOSE

8. That conference is concerned about the varying pathways and treatment under the Right to Choose Framework and requires that:

(i) GPs be provided with a comprehensive, up-to-date list of approved Right to Choose providers
(ii) all Right to Choose providers be able to prescribe medications on an ongoing basis if shared care is not agreed by the GP
(iii) there be nationally agreed service standards and KPIs for the awarding and delivery of NHS Right to Choose provider contracts to ensure consistency of service provision
(iv) there be defined escalation routes for GPs and patients, while holding ICBs accountable for monitoring and acting on concerns
(v) there be an independent review of each Right to Choose provider's value for money.

Proposed by Sharlina Sallehuddin, Dorset

(i) Carried overwhelmingly
(ii) Carried overwhelmingly
(iii) Carried overwhelmingly
(iv) Carried overwhelmingly
(v) Carried overwhelmingly

INTERFACE

9. That conference demands that GPCE:

(i) draft and coordinate the immediate dissemination of a formal letter, from practices and / or ICBs, to all local NHS trusts and private providers, stating clearly which tasks will no longer be accepted in primary care as per national guidance
(ii) develop and support mechanisms for practices to report repeated contractual breaches by trusts, with escalation pathways through LMCs, ICBs, and NHS England
(iii) explore and pilot a model for invoicing or financial penalty, on behalf of general practices, where trusts repeatedly and systematically fail to fulfil their contractual responsibilities, resulting in additional unfunded workload for primary care
(iv) issue clear legal and indemnity guidance to practices to support safe rejection of inappropriate workload in the face of pressure from secondary care providers.

Proposed by Rachel Ali, Devon

(i) Carried overwhelmingly
(ii) Carried overwhelmingly
(iii) Carried overwhelmingly
(iv) Carried overwhelmingly

SFE PAYMENTS

10. This conference expresses concern over the current discrepancy between maternity, paternity, adoption leave and shared parental leave reimbursement figures and the actual cost of average locum sessions. We call upon GPCE to:

    (i) advocate for a revision of the General Medical Services Statement of Financial Entitlements (GMS SFE) to ensure fair and adequate reimbursement that accurately reflects the true cost of locum sessions.
    (ii) negotiate amendments to the GMS SFE such that the current payments as specified in part 4 of the SFE are extended to all clinical staff.

Proposed by Jonny Hollow, Cornwall & Isles of Scilly

Voted on block. Carried unanimously

PARTNER LIABILITIES

11. That conference believes the current exposure of GP partners to a wide range of personal liabilities is unsustainable, and calls on GPCE to secure protection for GP partners by ensuring state backed indemnity is extended to cover claims associated with:

    (i) vicarious liability, where GP partners may otherwise be personally exposed for the actions of their staff or associates
    (ii) data sharing and information governance
    (iii) failures in AI triage, assessment, documentation and management leading to delay in treatment or direct patient harm
    (iv) the Equality Act 2010 and the Human Rights Act 1998
    (v) patients seeking compensation from general practice having paid for private medical assessment due to excessive secondary care waiting lists.

Proposed by Rachel Rutter, Gloucestershire

(i) Carried nem con
(ii) Carried nem con
(iii) Carried overwhelmingly
(iv) Carried overwhelmingly
(v) Carried overwhelmingly

GP TRAINING

12. That conference is concerned that the widespread use of blended learning in GP training dilutes professional standards and undermines registrar development, and:

(i) calls on GPCE to lobby RCGP, NHSE and the GMC to ensure blended learning is only used in targeted circumstances where clearly appropriate
(ii) demands that GMC approved curricula prioritise protected patient-facing clinical practice, with reasonable adjustments where required, as the default standard for GP training
(iii) insists that any blended learning component must be nationally quality-assured and explicitly justified, rather than left to local interpretation
(iv) insists that GP registrars must have protected time for structured learning, including patient facing and non patient facing components as the cornerstone of training
(v) demands an end to the use of blended learning as a default substitute for in-person education.

Proposed by Oliver Salazar, Chair GP Registrars Committee

(i) Carried unanimously
(ii) Carried overwhelmingly
(iii) Carried overwhelmingly
(iv) Carried overwhelmingly
(v) Carried overwhelmingly

UNDATED RESIGNATIONS

13. That conference, in view of there being little or no progress on having a substantive new GMS Contract that will help to ensure the survival of general practice in England, calls upon GPCE to collect undated resignations from GP contract holders, to be used as part of collective or industrial action that could be recommended by GPCE.

Proposed by Rob Barnett, Liverpool

Carried

PARTNERS SUBCOMMITTEE

14. That conference understands that GPCE has a challenging task in representing the needs of locum, salaried and contractor GPs simultaneously and:

(i) commends the current leadership for achieving uplifts for salaried and contractor GPs in the last year
(ii) recognises that GP partners carry specific responsibilities as contract holders and are significant contributors to LMC funding via levy payments
(iii) calls on GPCE to work with the BMA to improve the support available to partners through the BMA
(iv) noting the balance of contractor and sessional-role GPs on the GPCE executive, suggests that formalising executive and policy lead minima and maxima would be helpful, in order that both groups have senior representation.

Proposed by Shaun Aval, Gateshead and South Tyneside

(i) Carried
(ii) Carried
(iii) Carried
(iv) Carried as a reference

PRACTICE PAYMENTS

15. That conference believes that the current system where GP practices receive monthly and ad hoc payments from NHS bodies in a manner that is opaque, archaic, and without clear breakdown or reconciliation is unacceptable. No such system would be acceptable in any other sector of work or business, where clear itemisation and transparency of income are standard practice and calls:

    (i) for clarity and itemisation for payments as the current lack of clarity creates unnecessary administrative burden for practices, hinders effective financial planning, and undermines confidence in the accuracy of payments
    (ii) on NHSE and integrated care boards to modernise payment systems urgently, ensuring that all practice payments are accompanied by a full, timely, and comprehensible breakdown, in line with contemporary accounting standards
    (iii) on GPCE to prioritise this issue in national negotiations, recognising that transparent payment systems are fundamental to the financial viability and accountability of general practice.

Proposed by Reema Parwaiz, Leicestershire & Rutland

Voted on block. Carried unanimously

PREMISES

16. That conference recognises that general practice estates are increasingly unfit for purpose, with 63.8 million patients now registered in England and 16.5% more patients per GP since 2015, and that despite the recent £102 million primary care utilisation and modernisation fund, nearly three-quarters of practices applying for upgrade funding have been unsuccessful, leaving many unable to expand capacity or modernise facilities, and:

    (i) calls on the government to commit to recurrent, needs based capital investment in English general practice premises, replacing one-off selective funds with a sustainable long-term programme
    (ii) insists that such investment is allocated equitably and according to estate need, prioritising practices operating from overcrowded, outdated or inaccessible premises, particularly in areas of high patient demand and health inequality
    (iii) calls on GPCE to ensure that funding levels reflect the true cost of modernisation, including sufficient space to accommodate the expanded multi-disciplinary teams envisaged in the 10 Year Health Plan.

Proposed by Ben Curtis, Cambridgeshire

Voted on block. Carried unanimously

DATA CONTROLLER

17. That conference notes that patient data is an asset desired by many and:

(i) notes that without patient data being shared with other organisations much of the 10 Year Health Plan will fail
(ii) requires that GPs remains data controllers, with any contractual changes ending this to be rejected by GPCE.

Proposed by Peter Kenworthy, Gateshead & South Tyneside

(i) Carried nem con
(ii) Carried overwhelmingly

ASK THE GPCE OFFICER TEAM

Please view the live recording of the Conference to revisit this part of the Agenda (located at 4h 37m).

CHOSEN MOTIONS / EMERGENCY BUSINESS

256. That conference, in light of the recently published NHSE Medium Term Planning Framework:

(i) welcomes the long-overdue review of the Carr-Hill Formula, recognising the need for fairer and more sustainable core GP funding
(ii) rejects the assumption that increased use of artificial intelligence, including ambient voice technology, will meaningfully release capacity in general practice, when general practice remains the most efficient and productive part of the NHS
(iii) rejects the introduction of referral templates ahead of mandatory *Advice and Guidance* processes and insists that once general practice has reached the limits of its capabilities, it is a matter of Good Medical Practice (GMC) that referrals must be accepted
(iv) states clearly that general practice is not commissioned or structured as an emergency service
(v) condemns the proposed 90% target for same-day urgent care, noting that the definition of what is 'clinically urgent' often differs between patients and clinicians, warning that such a target risks undermining continuity of care.

Proposed by Tanya Beer, Avon

(i) Carried
(ii) Carried overwhelmingly
(iii) Carried nem con
(iv) Carried unanimously
(v) Carried unanimously

257. That conference instructs GPCE to demand that NHSE immediately cease its heavy-handed and aggressive policing of compliance with the October 1st contract changes while NHSE and GPCE are still in dispute. If GPCE are unable to secure written undertakings from NHSE to this effect, then this conference instructs GPC to escalate the dispute including the consideration of industrial action.

Proposed by Jeremy Mellins, Berkshire

Carried overwhelmingly

258. That conference believes that the increased use of allied health professionals to run clinics in secondary care leads to an increased workload for GPs and calls for GPCE to work with the BMA Consultants' Committee to demand that all:

(i) clinicians who are unable to prescribe have a named supervisor within their trust who can do the necessary prescriptions for them
(ii) clinicians who are unable to order specific tests have a named supervisor within their trust who can order these for them
(iii) discharge summaries and clinic letters need to make it clear who has seen the patient
(iv) discharge summaries and clinic letters need to be reviewed by a doctor to ensure that any demands on general practice fit within the provisions of the hospital contract and the GP contract.

Proposed by Pippa Vincent, Enfield

Voted on block. Carried overwhelmingly

259. That conference reaffirms its commitment to implementing BMA safe working levels in general practice and calls for:

(i) general practice to stop being used as the back stop to fill commissioning gaps or mitigate workload pressures in other NHS providers
(ii) ICB-commissioned urgent care services, including NHS 111 and ambulance services to ensure that they employ sufficiently trained and qualified clinicians to complete clinical episodes of care safely and independently to avoid unnecessary redirection back to general practice
(iii) national clinical algorithms used by NHS 111 and the ambulance service to be less risk averse and better designed to reduce inappropriate workload transfer into general practice
(iv) urgent treatment centres (UTCs) to be fully resourced and used appropriately, for urgent or same-day primary care needs rather than as an overflow mechanism for emergency departments or hospital services
(v) clear communication from NHSE to patients and other providers that general practice is not an emergency service and should not be used as such.

Proposed by Sharlina Sallehuddin, Dorset

Voted on block. Carried overwhelmingly

260. That conference, in light of GPC England's decision to enter into dispute with the current government, demands that a clear timeline be set for an indicative ballot of the profession, to seek engagement and mandate on the following forms of collective and industrial action:

(i) withdrawal from all shared care prescribing until safe, sustainable, and properly funded arrangements are in place nationally
(ii) non-compliance with GP Connect, in view of growing concerns over data protection, inappropriate third-party access, and the erosion of patient confidentiality
(iii) declining to issue sick notes, highlighting that the current process places an unnecessary and unfunded burden on general practice, and that the government and employers must commission a separate, dedicated service for sickness certification.
(iv) full-day walkouts, as a last resort to defend the survival of general practice and the safety of our patients.

Proposed by Shaba Nabi, Avon

(i) Carried overwhelmingly
(ii) Carried overwhelmingly
(iii) Carried
(iv) Carried

261. That conference views the 2025/26 GMS Contract as an imposition, as the safeguards that NHSE agreed were necessary prerequisites with GPCE have not been delivered, and NHSE has mandated contract delivery regardless, and instructs GPCE to:

(i) provide national guidance to LMCs and practices on the use of collective action
(ii) use all legal options available to enable the profession to undertake industrial action
(iii) prepare plan B for the continuation of general practice outside of the NHS
(iv) arrange for undated resignations to be collected by practices and held by an appropriate body until such time as they are required
(v) formally state to government, NHSE, and all interested parties, that the 2025/26 contract was imposed and not agreed, given that the contract in place is manifestly different to the deal that GPCE agreed.

Proposed by Mark Green, Berkshire

(i) Carried nem con
(ii) Carried nem con
(iii) Carried
(iv) Carried
(v) Carried overwhelmingly

262. That conference is concerned at NHS England plans to use the Primary Care Network (PCN) Learning Environment Scheme as a mechanism for accommodating increasing GP training numbers and calls for:

(i) PCNs to not be mandated or pressured to accept more trainees than can be safely and effectively supported, based on the physical capacity of their premises and the availability of trainers
(ii) PCNs to not face penalties or negative consequences for being unable to provide a designated number of training posts, where capacity limitations or resource constraints prevent certain practices from continuing as training environments
(iii) educators within PCNs to retain the freedom to design training programmes tailored to their local strengths, clinical specialties, and learning opportunities, and not be imposed with a rigid, centralised curriculum
(vi) GP trainees to be allocated to a named practice within a PCN.

Proposed by Sharlina Sallehuddin, Dorset

(i) Carried unanimously
(ii) Carried unanimously
(iii) Carried overwhelmingly
(iv) Carried overwhelmingly

SALARIED GP PAY UPLIFT

18. That conference recognises that salaried GPs are a unique set of public sector workers who are frequently missing out on annual pay uplifts recommended by the DDRB. This occurs even when salaried GPs have a pay uplift term written into their contract and has consequences for their eventual pension. Conference asks that GPCE work with national bodies in the next 12 months to develop:

(i) a strategy such as those found in Wales and Northern Ireland that ensures every salaried GP in the country is awarded an annual pay uplift in line with DDRB recommendations as standard without them having to chase their practice for it
(ii) a funding stream that directly funds the uplift in its entirety so that partners are never out of pocket

Proposed by Caroline Rodgers, Cambridgeshire

(i) Carried
(ii) Carried

GPs IN ARRS

19. That conference is deeply concerned by the inappropriate use of the Additional Roles Reimbursement Scheme (ARRS) to employ newly qualified GPs at salaries significantly below market rate, and calls on GPCE to:

(i) condemn the introduction of ARRS GPs that has created a 'two tier' system of GPs, due to the restrictions associated with employing ARRS GPs
(ii) highlight the unacceptable situation in which some GPs face a real-terms pay cut upon qualifying, undermining the value of their professional status and contributing to workforce attrition
(iii) campaign for greater transparency and accountability in the deployment of ARRS funding to ensure it is not used to undercut core GP roles or exploit early-career doctors
(iv) urge that ARRS GPs be treated no differently to GPs directly employed by GP practices.

Proposed by Jessica Court, Nottinghamshire

Voted on block. Carried nem con

PRESERVING GMS

20. That conference believes the government's 10 Year Health Plan for England threatens the independent contractor status of GPs and:

(i) reaffirms the BMA's and GPCE's commitment to the independent contractor model in general practice
(ii) calls upon GPCE to develop a national communications strategy to inform the public and political stakeholders about what is at stake for patients if the GMS model is dismantled
(iv) mandates GPCE to undertake any and all actions necessary for the survival of GMS practice, up to and including industrial action.

Proposed by Anwar Tufail, North Staffordshire

(i) Carried nem con
(ii) Carried unanimously
(iv) Carried nem con

PART II
ANNUAL CONFERENCE OF ENGLAND LOCAL MEDICAL COMMITTEES NOVEMBER 2025

ELECTION RESULTS

Chair of England Conference
Clare Sieber

Deputy Chair of England Conference
Paul Evans

Five members of England Conference Agenda Committee
Deborah White
Euan Strachan-Orr
Shamit Shah
Robert Hodges
Vicky Theakston

PART III

REMAINDER OF THE AGENDA

PARTNERS SUBCOMMITTEE

14. That conference understands that GPCE has a challenging task in representing the needs of locum, salaried and contractor GPs simultaneously and

(v) requires GPCE and GPDF to investigate and enact a contractor-only contractor subcommittee of GPCE, its remit to focus solely upon issues pertinent to GP contractors, particularly the GMS contract.

Proposed by Shaun Aval, Gateshead and South Tyneside

LOST

SALARIED GP PAY UPLIFT

18. That conference recognises that salaried GPs are a unique set of public sector workers who are frequently missing out on annual pay uplifts recommended by the DDRB. This occurs even when salaried GPs have a pay uplift term written into their contract and has consequences for their eventual pension. Conference asks that GPCE work with national bodies in the next 12 months to develop:

(iii) a system where practices are held accountable for non-payment of the uplift.

Proposed by Caroline Rodgers, Cambridgeshire

LOST

PRESERVING GMS

20. That conference believes the government's 10 Year Health Plan for England threatens the independent contractor status of GPs and:

(iii) recognises that in times of significant challenge, adequate resourcing is essential, and therefore recommends that the GPDF levy be reviewed, with consideration of an increase from 5p to 7p per patient

Proposed by Anwar Tufail, North Staffordshire

LOST