Conference News

Annual Conference of Local Medical Committees Representatives

13-15 May 2026

Part I: Resolutions

Part II: Election results

Part III: Remainder of the agenda

PART I

ANNUAL CONFERENCE OF LOCAL MEDICAL COMMITTEES
MAY 2026

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) housekeeping changes
   (ii) motions, amendment and rider submission
   (iii) Claire Wand fund.

   Proposed by Alastair Taylor, deputy chair of agenda committee

   Parts (i), (ii) and (iii) carried unanimously

SAFE WORKING

5. That conference notes that GP practices are expected to deliver care in environments that are increasingly unsafe due to excessive workload, inadequate staffing, and insufficient funding. Conference is concerned that despite safe working limits being a fundamental requirement for patient safety, they are not embedded in general practice across the UK. Conference calls on the BMA to:

   (i) ensure workload limits reflect consultation complexity and supervision responsibilities
   (ii) demand funding and contractual mechanisms that allow practices to meet minimum safe working standards, opposing contractual requirements that mandate increased access without corresponding resource
   (iii) support practices who refuse unsafe working conditions that arise as a direct consequence of systemic underfunding
   (iv) lobby UK governments and NHS bodies to ensure that when practices reach safe capacity, excess demand is met by appropriately commissioned alternative services, rather than being absorbed by general practice
   (iv) lobby UK governments to move away from access / volume metrics and move towards activity-based performance measures that value continuity, expertise, and population health outcomes.

   Proposed by Fahreen Dhanji, Leicester, Leicestershire and Rutland LMC

   Part (i) carried nem con
   Parts (ii), (iii), and (iv) carried overwhelmingly
   Part (v) carried overwhelmingly as a reference

WORKLOAD LIMITS

6. That conference believes that current workload in general practice is unsafe for patients and GPs, and that the absence of clear limits enables ongoing exploitation of the profession. It therefore:

   (i) calls on the GP committees of all four nations to agree and publish evidence-based guidance on a safe maximum number of patient facing consultations per whole time equivalent GP per day, and a safe maximum patient list size per WTE GP, explicitly adjusted for deprivation and case mix
   (ii) insists that agreed safe limits are adopted by governments, commissioners and NHS bodies as the basis for all access, performance and contractual requirements, and that no scheme should assume activity beyond these thresholds without commensurate workforce and funding
   (iii) demands that where practices are persistently operating above agreed safe limits, there is a defined mechanism for LMCs to support them to cap demand, restrict registration or reconfigure services on patient safety grounds, without contractual sanction
   (iv) calls for clear medico legal and professional guidance for GPs who take steps to limit unsafe workload in line with these thresholds, including collective support where practices or individuals are challenged for prioritising patient safety.

Proposed by Eithne MacRae, Liverpool LMC

Part (i) carried as a reference
Parts (ii), (iii), and (iv) carried overwhelmingly

CORRESPONDENCE FROM SECONDARY CARE

7. That conference notes an increasing number of letters from secondary care colleagues, such as referral rejections and clinic letters, are signed by generic titles, such as 'on behalf of the department team', creating a lack of clinical accountability. We call upon the GPCs and BMA to work with stakeholders to mandate that all clinical correspondence from secondary to primary care:

   (i) include the name, job role and department of the attending clinician
   (ii) include the name of the attending clinician's medical supervisor if the attending clinician is not a consultant doctor
   (iii) where prescribing advice is given, make clear if this advice is being given by a professional with prescribing rights
   (iv) include a clear communication route for the receiving GP to contact to discuss the letter content if required in a timely fashion.

Proposed by Pranav Lakhani, Liverpool LMC

Parts (i) and (iv) carried unanimously
Part (ii) carried as a reference
Part (iii) carried nem con

REFERRALS

8. That conference believes that the GP's clinical autonomy and right to refer are fundamental to safe and effective patient care, and calls on governments and health bodies to ensure that:

(i) any advice and / or guidance systems are optional, clinically appropriate, properly resourced, do not delay access to clinical care, and patients are able to resume their place in the waiting list if the practice disagrees with the advice
(ii) performance incentives must not be achieved through the discharge of patients without assessment so that all discharges include clear clinical ownership and transparent accountability
(iii) reductions in referral-to-treatment waiting lists reflect genuine clinical review or treatment rather than administrative removal
(iv) clear, nationally agreed standards are developed defining the responsibilities of hospitals for patients on waiting lists, including timely communication, clinical oversight, and ownership of investigations and follow-up.

Proposed by Jessica Court, Nottinghamshire LMC

Parts (i), (ii), and (iii) carried unanimously
Part (i) carried as a reference

GP TRAINING

9. That conference recognises that the current three-year GP specialty training programme does not adequately prepare trainees for the realities of modern general practice including partnership, business leadership and supervision and calls for:

(i) greater emphasis within GP training on developing the skills required to supervise, support and lead multi-disciplinary primary care teams safely and effectively
(ii) specific training in the critical appraisal and safe use of data, digital tools and AI-driven clinical decision support systems
(iii) sufficient supervised experience of acute presentations, even where such cases are routinely triaged to other healthcare professionals within the practice
(iv) equal access to self-development time and study leave as hospital specialty-based colleagues
(v) implementation of a four-year GP training programme, with the fourth year specifically focused on the business, contractual, leadership and partnership aspects of general practice, and not incorporating irrelevant ward based service provision.

Proposed by Andrew Kabza, Avon LMC

Parts (i), (ii), and (iv) carried
Part (iii) carried unanimously
Part (v) carried as a reference

GP TRAINERS

10. That conference understands that some practices are considering the viability of continuing to be training practices in the current challenging climate and conference:

(i) highlights the ethical dilemma of encouraging new colleagues to enter a speciality facing significant sustainability challenges regarding its survival
(ii) acknowledges the dedication of GP trainers in maintaining high-quality educational opportunities despite relentless pressures re practice finances, clinical workload, lack of training rooms at practices, increasing numbers of trainees in difficulty and overall reductions of first time pass rates
(iii) calls for negotiation on behalf of GP trainers to receive appropriate financial reimbursement that reflects the time and effort required to deliver high quality training for today's wider spectrum of trainees
(iv) supports GP trainers being prepared to refuse to take on any new trainees possibly from as soon as October 2026 onwards unless practices receive sufficient investment to support ongoing viability to remain a training practice.

Proposed by Tillmann Jacobi, North Yorkshire LMC

Part (i) and (iv) carried
Parts (ii) and (iii) carried overwhelmingly

GOOGLE REVIEWS AND SOCIAL MEDIA

12. That conference believes that public rating systems and consumer style online review scores for GP practices, including Google reviews, are inappropriate, misleading and harmful to patient care and staff wellbeing, and calls on the four national GP committees to work collectively to:

(i) press for the removal of numerical ratings and league style comparisons of GP practices from public-facing platforms
(ii) seek formal recognition that confidentiality obligations prevent practices from correcting inaccurate, incomplete or unbalanced public commentary
(iii) press for the development of fair and proportionate mechanisms for responding to public criticism of general practice that protect patient confidentiality, professional standards and staff safety
(iv) petition Google to extend their policy of blocking reviews of schools to all UK general practices.

Proposed by Matt Greenwood, West Sussex LMC

Carried overwhelmingly

JGPITC

13. That conference is concerned about the growing number of software programmes that undermine patient safety, increase GP workload, and reduce the accuracy of GP held patient records and demands that before any programmes are rolled out in any UK nation, that the JGPITC is consulted.

Proposed by Fahreen Dhanji, Leicester, Leicestershire and Rutland LMC

Carried unanimously

AI

14. That conference, noting the rapid proliferation of Artificial Intelligence (AI) driven tools (including ambient scribes, clinical triage, and decision support) in primary care, believes current governance arrangements are inadequate, and demands that:

(i) AI medical tools have a minimum class IIb MHRA approval
(ii) patients must be made aware that AI is being used in their care and have the ability to opt out
(iii) any patient data formulated in whole or part by AI must identify the role AI played and must provide a unique reference to the product used to aid yellow card reporting to the MHRA
(iv) no commissioner or digital supplier can require practices to deploy AI or automated triage without: a locally owned Data Protection Impact Assessment (DPIA), full transparency about data flows and hosting, and explicit opt out rights for practices on safety grounds
(v) implementation costs are not borne by individual practices and the necessary workload under data protection legislation is carried out centrally to reduce this burden on practices.

Proposed by Hayley Haworth, Cambridgeshire LMC

Parts (i), (ii), and (iii) carried overwhelmingly
Part (iv) carried unanimously
Part (v) carried nem con

DIGITAL ACCESS

15. That conference believes and that the promotion of an "Amazon style", unlimited GP access model is prioritising the wants of the worried well at the expense of the "needs" of the most clinically vulnerable and that the current four nations approach to digital-first policies, including mandatory access, is not fit for purpose and:

(i) believes this will drive over medicalisation, creating an environment for clinician burnout and unsafe practice
(ii) demands fully funded, nationally supported digital access tools for general practice across the four nations, including unrestricted clinical messaging and communication functions, rather than cost limited systems driven by wider NHS financial pressures
(iii) calls for GP practices to have free and autonomous choice of digital access platforms, enabling delivery models that reflect local population need, practice capacity, and patient demographics
(iv) calls on the GPC to lobby for digital access policies that prioritise clinical need, continuity of care, and health equity over arbitrary access targets and response times
(v) calls on all governments in the four nations to pause and re-evaluate their policies in partnership with the BMA.

Proposed by Shamit Shah, East Somerset, Swindon and Wiltshire LMCs

Part (i) carried nem con
Part (ii) carried overwhelmingly
Part (iii) carried
Parts (iv) and (v) carried unanimously

PLAN B

16. That conference recognises that current GP contracts are failing patients and practices alike, that more GPs are opting to work outside the NHS and:

(i) calls for contracts that permit GPs to provide private services to their NHS patients when those services are not contractually available to their NHS patients
(ii) believes that general practice within the NHS is no longer financially viable and a move towards a hybrid NHS and private GP service is the only option for the future
(iii) calls for a strategy for exiting GMS contracts and future working outside the NHS
(iv) directs GPC UK to work with all GPCs to ballot the profession on a plan B option for general practice provision that includes consideration of a means-tested, subscription-based service, such as those being offered currently by NHS dentists.

Proposed by Michael McKenna, Northern Ireland Eastern LMC

Parts (i) and (ii) carried overwhelmingly
Parts (iii) and (iv) carried

OUT OF HOURS

17. That conference condemns the gradual but persistent pay erosion of out of hours (OOH) GPs across the UK and mandates GPC UK to work with the four nation GPCs to ensure DDRB uplifts apply to OOH GPs' rates of pay in all future contract negotiations.

Proposed by Alan Woodall, Dyfed Powys LMC

Carried overwhelmingly

ABUSE OF GPs

19. That conference believes current regulations inadequately protect staff and doctors from repeat abuse and therefore calls on the governments to:

(i) strengthen the rules governing vexatious patients, so that patients removed for abusive or threatening behaviour cannot re-register with another practice or after a period of time the same practice unless there is demonstratable evidence of behaviour change
(ii) ensure that the schemes for violent patients are expanded to include patients who are persistently abusive and for the requirement to report incidents to the police to be removed as a condition for accessing these schemes.

Proposed by Claire Barnsley, Wakefield LMC

Parts (i) and (ii) carried nem con

MEDICINE SHORTAGES

20. That conference notes medicine shortages are increasingly frequent and result in significant delays to patient care and additional, avoidable workload for general practice. Conference believes community pharmacists are appropriately trained and professionally regulated to make safe, clinically equivalent supply decisions within defined parameters. Therefore conference:

(i) calls on GPC UK to work with the pharmacy regulatory bodies to seek to influence a change of the regulations to allow pharmacists to substitute between different preparations of the same medicine at the same strength and dose without requiring GP authorisation
(ii) believes the current legal requirement for pharmacists to refer back to GPs for clinically equivalent substitutions during shortages is inefficient and unsafe for patients
(iii) calls for amended medicines legislation to allow pharmacists to locally initiate serious shortage protocols where national protocols are unavailable or delayed and establishing a swift claims process to ensure pharmacies are not financially penalised
(iv) requests that any such changes are supported by clear national safeguards, documentation requirements, and accountability frameworks to protect patient safety and reduce workload transfer to general practice.

Proposed Emma John, Dorset LMC

Carried unanimously

DISPENSING

21. That conference believes that dispensing practices across all four nations are operating under outdated and unfit dispensing contracts with inadequate uplifts, in the context of increased rural community pharmacy closures, and calls on GPCs to:

(i) negotiate with governments across all four nations for a modernised dispensing contracts that reflect current workload, costs and clinical responsibilities, and supports the sustainability of dispensing practices
(ii) secure meaningful, recurrent uplifts to dispensing remuneration
(iii) negotiate the full funding and roll-out of electronic prescription services for dispensing practices across all four nations
(iv) lobby for a change in regulations to permit the temporary expansion of a dispensing practice's area where an existing pharmacy within the area is unable to meet its contractual obligations.

Proposed by Shamit Shah, Bath and North East Somerset, Swindon and Wiltshire

Carried unanimously

LONG TERM CONDITIONS

22. That conference recognises that long-term condition (LTC) management within general practice has expanded incrementally and inconsistently across the four nations, without clear contractual definition, national agreement, or commensurate resource, and calls for:

(i) a jointly agreed UK-wide definition of what constitutes core LTC management under the GMS / PMS contract, recognising that the manner of delivery is determined by the GP Contractor in discussion with the patient
(ii) commissioner acceptance that where a LTC service is commissioned as enhanced in any UK nation or system, it shall not be assumed to be core work elsewhere
(iii) formal commissioning, with appropriate funding, training, and specialist support, where general practice is expected to initiate, titrate, stabilise, or provide specialist-level monitoring of LTCs
(iv) clear agreement that inclusion of an LTC within incentive programmes (eg QOF) does not itself confer responsibility for treatment initiation, dose escalation, or specialist oversight.

Proposed by Shaba Nabi, Avon MC

Carried overwhelmingly

LOCAL ENHANCED SERVICES

23. That conference believes that the current commissioning of local enhanced services in the UK is underfunded, unsustainable and lacks transparency. Conference demands:

(i) that all such local services are commissioned on a full-cost recovery basis including staffing, premises, and indemnity with automatic annual inflationary uplifts for all enhanced service funding to prevent stealth cuts to practice income
(ii) that no service be commissioned or amended without formal consultation with the relevant LMC and a Primary Care Workload Impact Assessment
(iii) that no scheme be withdrawn without mapping of current service delivery, realistic alternative provider capacity and impact and capacity assessments
(iv) that any underspend in primary care budgets remain ring-fenced for general practice rather than being absorbed into secondary care deficits
(v) the urgent publication of a 'Commissioning Gap Analysis' across all four UK nations to highlight the widening disparities in service availability and funding levels between England, Scotland, Wales, and Northern Ireland.

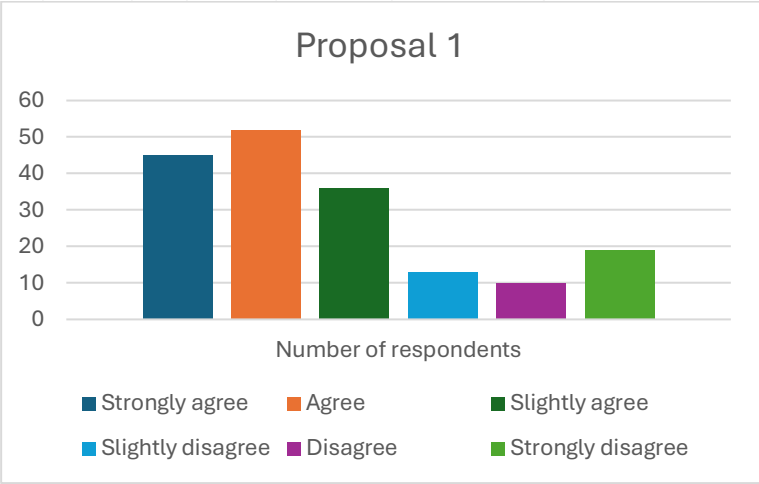
Proposed by Rupeysh Jha, Birmingham LMC

Parts (i) and (ii) carried overwhelmingly
Parts (iii) and (iv) carried nem con
Part (v) carried as a reference

THEMED DEBATE – CONFERENCE REFORMS

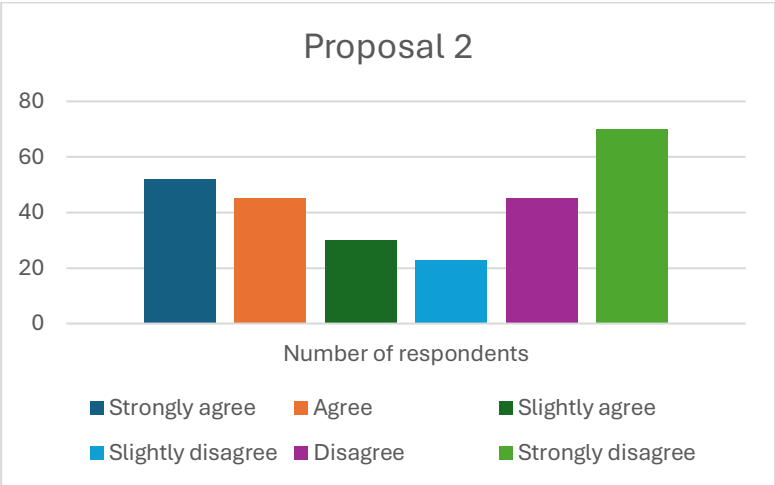
TD2-1. **Proposal 1:** The overall seating allocation to UK LMC Conference should be adjusted to make membership of the conference more representative of the four nations, and more similar to the proportional membership of GPC UK.

Proposed by Proposed by Matt Mayer, chair of agenda committee



Proposal 2: The overall membership of the UK LMC Conference should be made smaller, whilst also ensuring that every LMC in the UK is entitled to attend, and also contingent upon the firm condition that any and all cost savings made by such restructuring be passed on to the individual nation conferences, particularly England to ensure sufficient policy-forming resource.

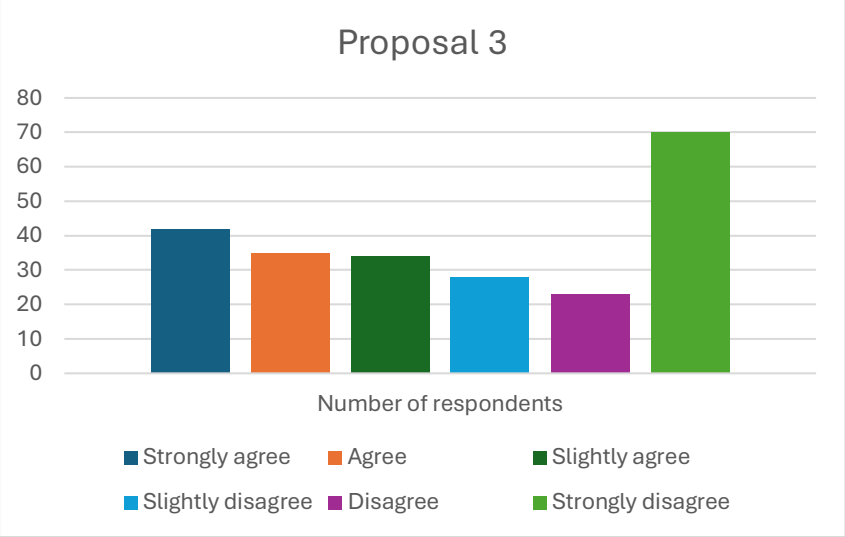
Proposed by Proposed by Matt Mayer, chair of agenda committee



Proposal 3: The following principles should be applied to any reduction in representative numbers:

(a) Standing Order 4 (1 seat per LMC) should remain unchanged, ensuring every LMC in the UK is entitled to attend the UK conference (124 voting seats)
(b) The number of remaining seats (241 voting seats) should be approximately halved (to 116 voting seats), bringing the total number of voting representatives down by one third, from 365 to 240, and these 116 seats should be allocated to each of the four nation conferences such that the total number of voting seats for each nation is approximately proportional to the size of that nation's own conference
(c) The manner in which each nation fills its allocation of the 116 seats shall be delegated to that nation's LMC Conference

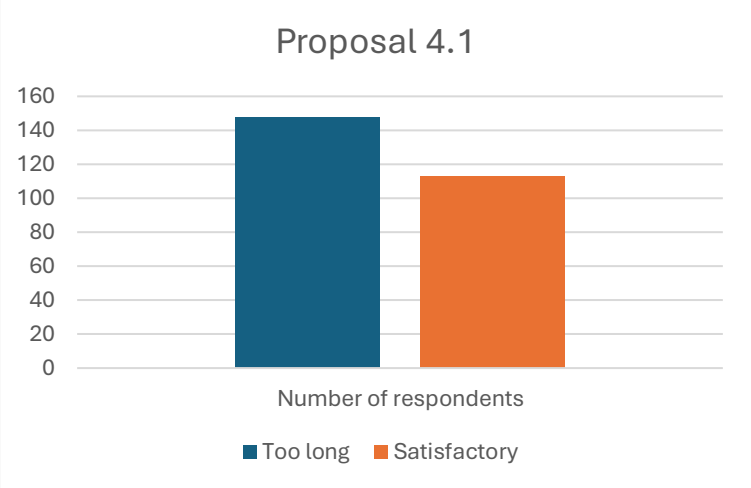
Proposed by Proposed by Matt Mayer, chair of agenda committee



Proposal 4.1: Following the trial merger with Secretaries Conference, the current time duration of the combined event is:

(a) Too long
(b) Satisfactory

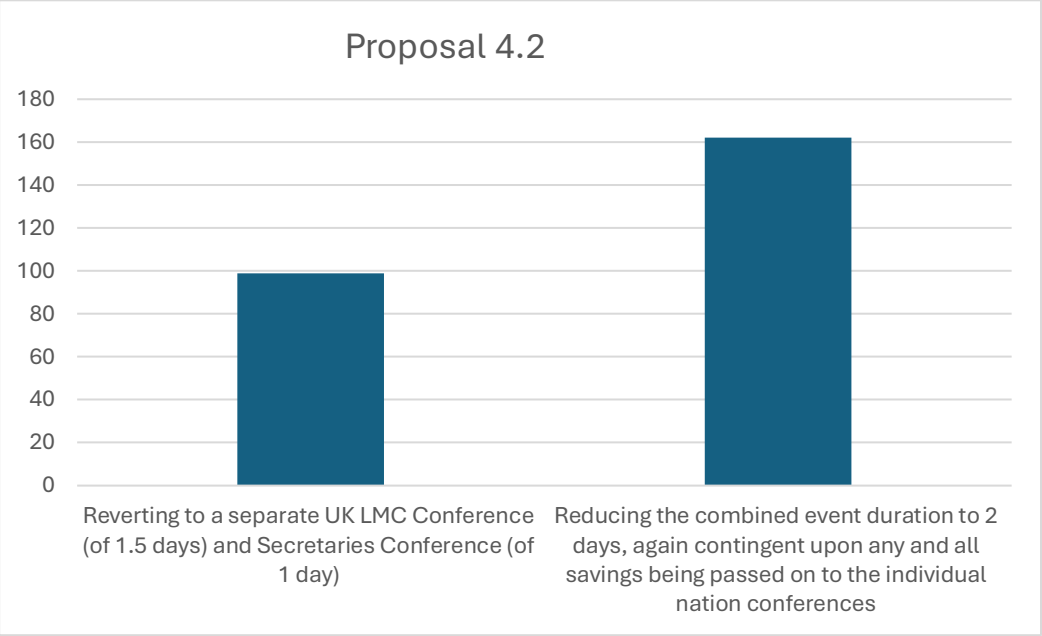
Proposed by Proposed by Matt Mayer, chair of agenda committee



Proposal 4.2 – To be voted on if (a) selected in 4.1.

This problem is best solved by:
(c) Reverting to a separate UK LMC Conference (of 1.5 days) and Secretaries Conference (of 1 day)
(d) Reducing the combined event duration to 2 days, again contingent upon any and all savings being passed on to the individual nation conferences

Proposed by Proposed by Matt Mayer, chair of agenda committee



NEIGHBOURHOODS

24. That conference believes that there is inherent risk in general practice engaging in proposed neighbourhood models of care and instructs GPC UK and the respective GPCs / LMCs to:

(i) ensure that the independent contractor model is kept central to the delivery of general practice
(ii) keep constituents close to discussions and informed at all stages of the process should they progress
(iii) ensure any movement of work from secondary to primary care is appropriately funded to ensure stability for practices and avoid deterioration to access for patients
(iv) engage with relevant bodies to ensure that the interests of members are protected and appropriately represented
(v) ensure that practising GPs are central in the development and leadership of new management structures.

Proposed by Conor Moore, Northern Ireland Southern LMC

Part (i) carried nem con
Parts (ii), (iii) and (iv) carried unanimously
Part (v) carried overwhelmingly

WIDER MDT

25. That conference notes with concern that the widespread deployment of non-medical practitioners has created risks to patient safety and undermined the professional integrity of general practice, and calls on the BMA to:

(i) oppose workforce substitution models that dilute GP expertise or transfer clinical risk without appropriate safeguards
(ii) require that any further expansion of multi-disciplinary roles in general practice is contingent on nationally agreed scopes of practice, supervision requirements, indemnity cover and accountability frameworks
(iii) insist that GP supervision work is formally recognised as non core, requiring additional contractual time, funding and indemnity
(iv) affirm and defend GP-led models of care as essential to continuity, patient safety, and clinical leadership within general practice.

Proposed by Austin Nichol, Glasow LMC

Carried overwhelmingly

COMMISSIONING TRANSPARENCY

26. That conference requires GPC UK to actively and openly lobby for a requirement for commissioning bodies to publish:

(i) significant new spending decisions
(ii) expenditure on external consultancy firms
(iii) commissioning intentions and contract awards relevant to primary care
(iv) a point of contact to direct all patient complaints received by practices related to non-commissioned services.

Proposed by Marek Jarzembowski, Merton LMC

Carried overwhelmingly

REFUSE TO ACCEPT DISCHARGE

27. That conference notes high profile cases in which mental health patients have been discharged back to general practice due to "failure to engage" with treatment. We call upon GPCs to work with stakeholders to enable a mechanism by which the GP can "refuse to accept" such a patient being discharged to GP care if the GP has sufficient concern regarding the welfare of the patient or others, due to the patient's mental health condition.

Proposed by Austin Nichol, Glasow LMC

Carried overwhelmingly

CHOSEN MOTIONS

253. That conference is deeply concerned that the Government's Immigration White Paper will worsen the ability of practices to recruit and retain IMG GPs, at a time when both IMG and UK trained graduates face a challenging landscape in higher training opportunities. Conference:

(i) notes that healthcare workers are identified as "high value" contributors who may retain a shorter route to settlement under current proposals, leaving uncertainty over the specific settlement pathway for GPs
(ii) notes that new requirements for dependants (including English language standards) are proposed without clarity on how family settlement timelines will align under the earned settlement model
(iii) calls on the UK Government to fully reimburse GP practices for all visa sponsorship costs — including the Immigration Skills Charge and sponsorship licence fees — to avoid further disincentivising employment of IMG GPs
(iv) warns that failing to address these issues risks driving away doctors trained within the NHS at public expense, worsening patient access and continuity of care
(v) instructs GPC UK to lobby across government departments so immigration policy supports — rather than undermines — GP workforce sustainability and the training pipeline.

Proposed by William Denby, Hampshire and Isle of Wight LMC

Carried unanimously

254. That conference believes that ensuring timely access to crisis care for suicidal patients is an urgent patient safety priority and essential for supporting GPs in managing high-risk mental health presentations:

(i) recognises that suicidal patients in the community often face delays or gaps in urgent mental health support from local services, placing them at significant risk
(ii) is concerned that general practitioners frequently lack timely access to crisis referral pathways and support services to manage these high-risk patients safely
(iii) notes that general practice is not the right place to support high risk patients and these gaps increase pressure on GPs, contribute to professional stress, and compromise patient safety
(iv) calls for the development of robust, easily accessible, and time-critical crisis response services to be mandatory within community mental health team contracts, alongside clear referral pathways for GPs, to avoid tragedies.

Proposed by Farai Chimbwanda, Dorset LMC

Carried overwhelmingly

255. That conference demands the government and NHS bodies acknowledge the severe operational strain and workforce impact caused by staff being removed from frontline care to meet mandatory training requirements, and take actions to:

(i) provide dedicated funding for practices to cover the cost of staff time spent away from patients during training
(ii) improve access to a wider network of local training sites and facilities to reduce travel time and geographical inequity for practice teams
(iii) empower practices to adapt mandatory training timelines based on local capacity, ensuring that the safe delivery of patient care remains the absolute priority.

Proposed by Rebecca Lye, Dorset LMC

Carried unanimously

PART II

ANNUAL CONFERENCE OF LOCAL MEDICAL COMMITTEES

MAY 2026

ELECTION RESULTS

Chair of UK Conference
Alastair Taylor

Deputy Chair of UK Conference
Euan Strachan-Orr

GPC UK
David Wrigley
Natalie Martin
Eithne Macrae
Jonathan Cox
Manu Agrawal
Katie Bramall-Stainer
Caroline Rodgers (early career seat)
Owen Barron (new to GPC seat)

"N.B. This list of successful candidates is different to the list announced at conference, as following review, unintentional errors in nomination forms were identified which impacted the application of constraints."

LMC UK Conf Agenda Committee
Patrick McNally
Clare Sieber
Tanya Beer
Thilla Rajasekar
Joseph Dugan (NI)
Andrew Thomson (S)
Bethan Roberts (W)

PART III

REMAINDER OF THE AGENDA

PRIVATE HEALTH CARE FOR GP STAFF

11. That conference recognises the impact of increasing NHS waiting times affecting GP staff wellbeing and return to work, and the detrimental effect this can have on patient care. Conference calls on the GPC UK to facilitate access to private healthcare for general practice staff to enable faster recovery and workforce sustainability.

Proposed by Thilla Rajasekar, Kent LMC
LOST

SINGLE LEAD EMPLOYER

18. That conference is concerned about the potential exploitation of salaried GPs by some unscrupulous employers and calls for a single lead employer arrangement to be explored in all four nations for employing salaried GPs.

Proposed by Bethan Roberts, agenda committee

LOST