

Annual Conference of UK LMC Representatives



WEDNESDAY 13 MAY 2026
AFTERNOON SESSION

SHEFFIELD LMC EXECUTIVE ATTENDANCE: Krishna Kasaraneni Gareth McCrea
Danielle McSeveney Laura Smy

CHAIR'S ADDRESS

Dr Katie Bramall acknowledged the ongoing tensions within GPC and recognised that much of the frustration is often directed towards her personally. She encouraged GPs to support one another, celebrate each other's successes, and approach discussions with kindness and understanding. She explained the first step of collective action: asking practices to send a template letter regarding data-sharing agreements. She emphasised that the letter had been carefully drafted and that this initial action would not impact patient care, but would serve to put ICBs and the wider health system on notice of future actions.

The BMA have significant concerns about the blurring of professional boundaries, particularly in relation to GPs and physician associates. She reiterated the BMA's position that the GMC should remain a regulator for doctors, with meaningful professional representation, and confirmed that the BMA would continue to pursue this issue.

MOTION 5: AGENDA COMMITTEE TO BE PROPOSED BY LEICESTER, LEICESTERSHIRE AND RUTLAND:

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
- (v) 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.

Whilst there was some debate around this proposal, and (v) was taken as a reference, it was otherwise carried overwhelmingly

Concerns were expressed that safe working definitions could lead to unintended consequences. The challenges of accurately defining GP workload and the risks of reducing it to a simple numerical target were highlighted, not all consultations are equal and much of the GP workload is unseen. Concerns regarding the potential for it to become the basis of performance management targets were raised.

It was also noted that the GP committees in England, Scotland, Wales and Northern Ireland have already each published safe working guidance in recent years.

MOTION 6: AGENDA COMMITTEE TO BE PROPOSED BY MID MERSEY:

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.

This motion followed in a similar vein to the previous one. (i) was taken as a reference due to issues with adjusting for deprivation and case mix and also recognising that some practices had a diversified team which was working well for their population.

The debate was well rehearsed with issues related to safe working, the affect on GP quality of life and other points previously raised. The motion was carried.

MOTION 7: AGENDA COMMITTEE TO BE PROPOSED BY LIVERPOOL:

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.

Although there was a caution regarding (ii) in recognition of the vast experience and contribution of SAS doctors, this motion was uncontentious and all parts carried.

PLENARY SESSION

LMC colleagues from North London shared their experiences of implementing an agreed primary and secondary care consensus document. This mirrored the work, led by Clare Bannon, that has happened in South Yorkshire.

MOTION 8: AGENDA COMMITTEE TO BE PROPOSED BY NOTTINGHAMSHIRE:

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.

This was uncontentious and passed in all parts.

GP REGISTRARS CHAIR

Dr Olivar Salazar called for a unified profession, levelling GPs and trainees and training and working conditions for GP registrars across the four nations stating that trainees are no longer willing to be sidelined.

MOTION 9: AGENDA COMMITTEE TO BE PROPOSED BY AVON:

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.

There was considerable discussion around this motion, with differing views on the current length of training. While many felt that greater emphasis should be placed on management training, there was little support for extending the overall duration of training. Capacity constraints, including limitations in both training premises and available trainers, were highlighted as significant barriers to any extension.

Concerns were also raised that the current curriculum already leaves insufficient time to cover all clinical aspects adequately. Some participants suggested that this may be reflected in the current 40% failure rate in the SCA.

There was further concern about extending training for individuals who had not entered the Vocational Training Scheme (VTS) directly from Foundation training, as many of these trainees may already have substantial prior experience. As an alternative means of developing management and leadership skills, there were calls to reinstate the funded New tno Partnership scheme.

Little iv was taken as a reference in recognition that hospital-based colleagues often don't have adequate access to self-development opportunities and protected study time.

Despite extensive debate and the concerns raised, the motion was ultimately carried with (iv) as a reference.

MOTION 10: NORTH YORKSHIRE

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 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
- (iv) support ongoing viability to remain a training practice.

The current challenges facing GP training were acknowledged, as was the significant contribution GP trainers make to the future of the profession. There was a call for (iv) to be taken as a reference point recognised the potentially detrimental impact this could have on trainee cohorts. Despite these concerns, there was substantial support for this point. It was suggested that even pausing the recruitment of new trainees for a single intake would send a strong and powerful message about the urgent need to improve training conditions. The motion was subsequently passed in all its parts.

MOTION 11: KENT:

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.

Whilst this motion was debated and it was highlighted that the GMC now offer private health care to its staff. The GPC comments made it clear that this is just not something that GPC would be able to facilitate, and the motion wasn't carried.

DR LAURA SMY
Executive Officer