

# Annual Conference of UK LMC Representatives



**THURSDAY 14 MAY 2026**

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

## **MOTION 12: AGENDA COMMITTEE TO BE PROPOSED BY WEST SUSSEX**

**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.

There was a good debate about the pressures of having to meet ratings' targets and one like Google reviews which are difficult to respond to owing to patient confidentiality. Whilst views were expressed about accountability and the need to respond to criticism constructively, the motion was supported in full.

## **Motion 13: LEICESTER, LEICESTERSHIRE AND RUTLAND**

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 Joint General Practitioners Information Technology Committee (JGPITC) is consulted. Non-controversial motion that was supported unanimously.

## **MOTION 14: AGENDA COMMITTEE TO BE PROPOSED BY CAMBRIDGESHIRE**

**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 Medicines and Healthcare products Regulatory Agency (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.
- vi. Not unexpectedly, there was a vigorous debate reflecting on use of AI and whether or not it enhanced General Practice or increased workload, or perhaps a combination of both. The motion was carried in its entirety.

## **MOTION 15: AGENDA COMMITTEE TO BE PROPOSED BY BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE**

**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 General Practitioners Committee (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 British Medical Association (BMA.)

A passionate debate that was supported in its entirety. The debate covered areas such as hidden demand, over-medicalisation and risking worsening health inequalities. Conference supported potential benefits but demanded better Regulation (MHRA-level approval), Transparency to patients and clear medico-legal accountability.

## **THRIVE, NOT JUST SURVIVE - DR MAITIÚ O’FAOLÁIN, IRISH MEDICAL ASSOCIATION**

An insightful presentation from our Irish colleagues which was full of humour and realism. Whilst acknowledging some similarities and the marked differences between NHS General Practice and the Irish General Practice, it was an eye opener for most of the delegates. The model seems to have the balance between state funded general practice free at the point of use for the ones that need it, whilst allowing practices to flourish via supplementing their income via private services.

## **MOTION 16: AGENDA COMMITTEE TO BE PROPOSED BY NORTHERN IRELAND EASTERN**

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 General Medical Services (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.

Another passionate debate that was supported in full, reflecting the current challenges faced by GPs in UK. This will serve as the anchoring subsequent motion about shifting to Plan B.

Four Nation Updates  
NORTHERN IRELAND - DR FRANCES O’HAGAN  
WALES – DR GARETH OELMANN

Contrasting narratives in the four nations – Wales have been able to make a deal which is seen as positive. Scotland have started the journey of rebuilding the practice-based contract. They have managed to get to a policy of 1 Full-Time Equivalent (FTE) GP for 1000 patients. National Insurance (NI) have significant challenges – ongoing for the best part of a decade and they are surviving by limiting the number of consultations per day. England is a different kettle of fish altogether and the mood in the room of GP representatives was a very sombre one indeed. There were many ‘statements’ made in relation to England and these need to be considered with caution as per previous years in that they seldom ended up being accurate.

## **SESSIONAL GP UPDATE**

Dr Kim Rollinson and Dr Amy Small, the Sessional GP Committee co-chairs gave an update on the work currently being undertaken by the committee, emphasising that sessional GPs and GP partners are not in conflict and should work together.

## **MOTION 17: DYFED POWYS**

**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.**

While the motion was ultimately carried, several points raised during the debate were difficult to ignore. These included concerns that out-of-hours contracts are sometimes awarded for multiple years at a time, which can affect the rates that provider organisations are able to pay. It was also noted that the General Practitioners Committee (GPC) is not involved in negotiating out-of-hours contracts. Despite these concerns, there was clear support for the motion in the room, and it was carried

## **MOTION 18: SESSIONAL GPs COMMITTEE**

**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.**

This motion was presented by the Sessional GP Committee with the aim of reducing variation in working conditions for sessional GPs. The proposal was to introduce a lead employer model, similar to that used for GP registrars. The debate prompted strong views, and there was a noticeable sense of tension between GP partners and sessional GPs. Some delegates took issue with references to “unscrupulous employers”, pointing out that the vast majority of practices do not fit this description. Concerns were also raised about practical challenges and possible unintended consequences. Several speakers felt that reducing variation could also reduce flexibility, potentially leading to more rigid working arrangements and the loss of benefits that some sessional GPs currently enjoy, such as term-time contracts or shorter working days. The motion was lost.

## **CAMERON FUND**

The valuable work of the Cameron Fund was highlighted, supported by several moving case studies. Attention was drawn to the Fund’s financial position, which has been running at a deficit for a number of years, and delegates were encouraged to offer financial support where possible.

## **MOTION 19: WAKEFIELD**

**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 demonstrable 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.

This was a well-presented, uncontroversial motion that was warmly received.

Debate on this motion included many first hand accounts of patient behaviour that, while not serious enough to warrant immediate removal or placement on a special allocation scheme, creates significant and ongoing challenges for practices. Both parts of the motion were carried.

**DR KRISHNA KASARANENI**  
**Executive Officer**

**DR LAURA SMY**  
**Executive Officer**