Annual Conference of UK LMC Representatives

Sheffield LMC

FRIDAY 15 MAY 2026

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

PARTNERSHIPS IN PERIL

An interactive session was hosted by 2 early career GPs, canvassing opinion from conference on the appetite for the partnership model. There was widespread support for the continuation of independent contractors, with an acknowledgement that General practice is the only part of the NHS which is not operating in deficit. Some sessional GPs voiced that they would prefer to be employed by GP partners than by trust-led organisations.

There was acceptance that without an increase in support for new partners, and an increase in core funding, the partnership model is being put at risk by Government across all 4 devolved nations.

The discussion moved on to cover mitigations that could be taken by the profession to preserve the partnership model – including the suggestion that General Practitioners Committee (GPC) lobbied for a hybrid NHS/private contract as part of future negotiations. This was particularly notable as over previous years the suggestion of a private service has seemed unpalatable to conference, perhaps indicating the peril that many GPs are now experiencing in the NHS

THEMED DEBATE - GP REPRESENTATION

A controversial consequential motion pushing for the creation of a GP partners committee within GPC to ensure parity with the sessions GPC committee, and for the advent of a dedicated sessionals Local Medical Committee (LMC) conference was proposed for debate:

TD1-1: That conference recognises that GP partners and sessional GPs require equitable representation within GPC UK structures and:

i. Instructs GPC UK to establish a formal GP partner subcommittee to address partner-specific contractual, financial and leadership issues
ii. Calls for a dedicated and funded annual conference of sessional representatives of LMCs to be convened from the 2027 / 2028 session to form policy on sessional GP matters.

This motion was passionately debated by members of conference. Some of the opinions expressed included:

- conflicting views on whether the current LMC conference was more representative of partners or session GPs,
- some expressed views that LMC levies were paid for by contractors more so than sessional GPs and therefore conference should reflect contractors views
- conflicting views on whether GPC England executive team was adequately representative of the split of sessions and partners in England
- concern about the additional funding that setting up an extra annual conference and a new partners committee would cost – and how this money could be better utilised

- concern about the message this would send to Government, NHS England (NHSE), the profession and the public that General Practice was not unified

The General Practitioners Committee England (GPCE) chair spoke to highlight that in their view GPCE executive was representative of partners in England and was firmly in support of the partnership model, with sessional GPs being welcome to attend the existing annual LMC conferences via their LMCs.

A request to move to 'next business' without formally voting on this divisive motion was tabled and passed

MOTION 20: MEDICINE SHORTAGES

Dorset LMC proposed a motion to seek changes to improve the process for issuing replacements for out of stock medications that would benefit patients, pharmacists and GPs:

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.

This non-controversial motion was passed unanimously in all parts

MOTION 22: LONG TERM CONDITIONS

Avon LMC proposed a motion to lobby for recognition of the expansion of long-term condition workload within General Practice since the last major contract negotiation, and the requirement for clear contractual definitions and adequate funding for the work which is deemed by the definitions to be within the core contract

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 General Medical Services / Personal Medical Services (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 programs (eg Quality and Outcomes Framework (QOF) does not itself confer responsibility for treatment initiation, dose escalation, or specialist oversight.

The motion was carried overwhelmingly, and it was felt that this would be helpful to include in the anticipated GP contract reform negotiations with the Department of Health

MOTION 23: LOCAL ENHANCED SERVICES

Birmingham LMC proposed a motion highlighting current issues with the commissioning of LCSs across the UK, including underfunding and the subsequent 'postcode lottery' with non-universal coverage across all areas of the nation

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.

The motion was passed in all parts, however (v) was carried as a reference, as GPC UK felt it would not be possible to publish a Commissioning Gap Analysis, and that this was a role of the devolved GPC executive teams. The LMC Support Network is already collecting information from England LMCs on the available LCSs in each area

LMC SUPPORT NETWORK

Michael Wright of Notts LMC and manager of the LMCSN delivered an update on the work the LMCSN has been doing on behalf of LMCs and the profession over the past year.

The LMCSN website has a number of resources available to LMCs, a development centre including mentoring and coaching, and an advice hotline

More recently, the LMC Databank has been developed by Local Medical Committee Support Network (LMCSN) in conjunction with Beds & Herts LMC, and funded by The General Practitioners' Defence Fund (GPDF). This includes a variety of practice, Primary Care Network (PCN), Integrated Care Board (ICB) and nationwide-data – including appointment data, funding, LCSs, patient satisfaction surveys and GP recruitment
An example was given of how this data was provided by LMCSN to an LMC in England, who were then able to successfully challenge a negative Care Quality Commission (CQC) rating of a practice – overturning the 'Requires Improvement' rating to 'Good'

South Yorkshire LMC have since contacted LMCSN to request that the data across South Yorkshire is shared with the LMCs to aid our local work with practices and SYICB

MOTION 141: IMMIGRATION

An additional motion was proposed by Hampshire & Isle of Wight LMC in support of the significant number of IMGs that contribute positively to our NHS General Practice, highlighted their concerns with the Government's Immigration White Paper and pushed for a reduction in bureaucracy for practices in employing these doctors, alongside greater support for IMGs with visa sponsorship
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.
Conference recognised the immense contribution of our IMG colleagues and the motion was carried unanimously in all parts

NEGOTIATING LOCAL ENHANCED SERVICE (LES) CONTRACTS BREAKOUT GROUP PRESENTED BY KENT LOCAL MEDICAL COMMITTEE (LMC)

This was a useful presentation from the Kent LMC team detailing the process they have undergone of the last couple of years with their Integrated Care Boards (ICB) renegotiating their local enhance services contracts. They described the use of a calculator to breakdown each detail of delivering a contract including consumables, staffing, training, pensions and a number of other costs to then negotiate fair terms. It is a similar tack to that which we have used locally with South Yorkshire ICB after both myself and Clare Bannon our British Medical Association (BMA) General Practitioners Committee for England (GPCE) rep and Barnsley LMC chair met with the Kent team just over a year ago.

Key aspects of their success include obtaining a significant uplift for practices to provide services, minimum annual uplifts embedded into all new contracts, Ardens templates developed to make coding and recording simple and easy for practices. These negotiations have included an IoS fee for both delivery of injectables including Inclisisran and Direct Oral Anticoagulant (DOAC) payments of £55.88 per patient.

They have ongoing negotiations currently looking at Monoclonal Gammopathy of Undetermined Significance (MGUS) monitoring, long acting reversible contraception (LARC) and IUD fittings and a dementia LES starting with care for patients in the area.

This was an exceptionally helpful session and has sparked further discussion within our Sheffield LMC team and the wider South Yorkshire LMC team.

THEMED DEBATE CONFERENCE REFORMS:

In 2024, following policy and workshops held in 2023, the UK LMC Conference began to undergo several reforms in order to make it fit for purpose for all four nations and their respective conferences and GPCs. The reforms focused on the function of conference: policy formation; Continuing Professional Development (CPD), collaboration, networking; attendance options; inclusivity, relevance, and reactivity. Prior to this year LMC UK conference spanned 2 days where UK wide discussions took place with a further 1 day secretary reserved for LMC secretary's where the agenda would also include an amount of CPD related to LMC function. This year we saw the result of previous discussions and votes on potential reforms and these 2 conferences were combined.

As an opportunity to discuss the success of this change and look to further years arrangements this debate gave space for all to voice their thoughts as to positives and negative of the alteration and proposed next steps framed into 3 proposals:

• 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

• 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

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

- 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)
- 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
- The manner in which each nation fills its allocation of the 116 seats shall be delegated to that nation's LMC Conference

General themes brought out in the debate included:
With regard to the loss of the LMC secretaries conference- missing the nuance of the specific needs of secretary's such as training, networking and succession planning. There is a risk of replication with 2 separate conferences.

With regards to reducing seats-this would reduce costs overall of conference but for Sheffield this would likely result in a reduction in allocated seats. This would also in turn reduce the networking and sharing of experience and learning which takes alongside this.

Overall many praised the CPD which was previously not a significant part of LMC conference with particular note given to a session delivered by Kent LMC on LCS negotiations.
Overall function of GPCUK: with devolved health contracts much it us questionable how much of that potentially discussed is relevant to all, multiple speakers spoke to increasing the time spent in devolved nation conference where this would be able to take place. The single day currently allotted to LMC England conference does frequently feel pressed for time and twice in recent years an extension to 2 years has been granted.

Voting on the above proposals saw and overall feeling that seats shouldn't be reduced, it was somewhat more split when it came to length of conference with 148 feeling 2 ½ days felt too long and 113 reporting it to be satisfactory length

Overall the sense was that the move to combine the conferences was felt to be successful and should be continued.

MOTION 24:

NORTHERN IRELAND SOUTHERN: 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.
vi. This was an uncontroversial motion and was passed in all parts.

MOTION 25:

GLASGOW:

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.

An important point was made on potential impact on safeguarding with reduced GP minor illness contacts with children leading to overall reduced contact with young children and potential missed opportunities. The speaker described a situation where they had been completing a safeguarding report for a child but there were long gaps where the child had been seen by a variety of allied health professionals through pharmacy first, walk in centres and within the surgery.

DR GARETH MCCREA
Vice Chair

DR DANELLE MCSEVENEY
Chair