LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

January 2025

To All Leicester, Leicestershire, and Rutland General Practitioners and Practice Managers.

Dear Colleagues

LLRLMC NEWSLETTER

Welcome to our **JANUARY** Newsletter which includes feedback from our LMC Board meeting, and other current issues.

No time to read this newsletter? Then listen to the Podcast:

SUMMARY VERSION (18 MINUTES)

FULL VERSION (1 HOUR 8 MINS)

SUMMARY OF IMPORTANT INFORMATION:

Translation of Clinical Documents
Medical Examiner Service Update
General Practice is Awesome! It's Official!

Topics in this newsletter:

1) LMC Meeting JANUARY 2025
2) British Medical Association: Annual Representative Meeting
3) Collective Action
4) Minor Surgery
5) Accelerated Access to GP Records
6) Translation of Clinical Documents
7) Bariatric Surgery and Weight Loss Services
8) General Practice Awards
9) Medical Examiner Service Update
10) Medicines Authorisation and Administration Record (MAAR) Charts
11) Reforming Elective Care for Patients
12) Floods, Business Continuity, Opel reporting and DOS rating
13) Advertise your job vacancies for free
14) Upcoming LMC Events
15) Final Thoughts

As always if you have any comments, questions, or suggestions please contact the LMC

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

1. LMC MEETING JANUARY 2025.

The LMC met on 8 January.

The LMC discussed a variety of issues, and other important areas are covered elsewhere in this newsletter.

Richard Mitchell (CEO, UHL) attended. He updated the Board regarding UHL issues. We also discussed:

- Consultants and other staff advising GPs to provide smoking cessation services including prescribing. We requested that he informs UHL staff that this service is provided by Local Authorities and not by general practices.
- Consultants writing to general practices expecting them to prescribe Ozempic or Mounjaro for weight loss. We requested that consultants are advised that at present GPs cannot arrange this.
- Virtual and remote clinical services being provided by UHL or indirectly via LPT asking for prescriptions for acute problems (e.g. COPD service asking for prescription for antibiotics and/or steroids). The view of the LMC is that these patients remain under the care of a non-GP service and therefore should not be asked for acute prescriptions.

We also had an interesting presentation from Will Monaghan (Group Chief Digital Information Officer for UHL and UHN) regarding the implementation of digital services within the hospitals. He told us about developing an updated Patient Demographic Service, an Electronic Patient Record to replace the current paper records, and electronic prescribing. In addition, he also told us about a proposed partnership with Microsoft to develop the use of Artificial Intelligence in clinical services.

It is good that UHL is looking towards the future, but the LMC was clear that this should not be at the expense of developing the electronic tools to support current clinical work bringing UHL into the 20th Century and improve interoperability with general practice.

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2. BRITISH MEDICAL ASSOCIATION: ANNUAL REPRESENTATIVE MEETING.

Last year I raised worrying changes that were happening in the British Medical Association. The central BMA had unilateral without notice changed the elections for representatives to the Annual Representative Meeting (ARM) from being limited to doctors who were active in local structures (Divisions) to being elected by all local BMA members. Whilst this would seem to be positive move to improve democracy, it meant that across the UK, doctors who have devoted years to representing colleagues and have significant knowledge and understanding of the problems within not only their own speciality, but across the whole area, were replaced by candidates promoted by the single-issue undemocratic organisation 'Doctors Vote.'

The ARM is the important body that sets policy for the BMA. I have always supported and promoted better representation, young keen doctors, and succession planning (which is why I championed the changes to our LMC Board leading to an elected GP Registrar, GP within 5 years of qualification, and sessional GPs) but this must not be at the expense of general practice have an equal and appropriate voice within the BMA.

Last year's election had a 2% turn out, resulted in a lower proportion of women representatives, and led to a significant reduction in GP members of the ARM and therefore ability to ensure that BMA policy is pro-GP.

As a declaration of interest, I have represented general practice at ARMs for most years since 1992 and am standing again. The vote will be open within the next week or so, and I am asking that all GP BMA members vote, and when doing so, give GPs who are standing your highest preferences.

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3. COLLECTIVE ACTION.

It is important that practices continue with Collective Action. As we have discussed before this is partly about resetting the new normal for general practice promoting safe working, and stopping unfunded or underfunded work, but also about causing disruption to the system and thereby increasing the ability of our national representatives to negotiate a more appropriate replacement contract for April 2025 onwards.

We are planning to have a further face to face meeting to discuss the future of Collective Action, which will be combined with details of the new GP contract. Please hold the date 8th April 2025.

GPCE continues to request practices to complete a tracker survey. The **January action tracker survey will open on Monday 13 January** for two weeks, closing at 5pm on Sunday 26 January via this survey link. No identifiable data will be created because of this survey. The more responses GPCE receives, the better we can use this data to pressurise the government for change.

The BMA has now published more information on each collective action to support practices which can be found on the updated BMA's GP collective action webpage and the refreshed Safe Working Guidance Handbook.

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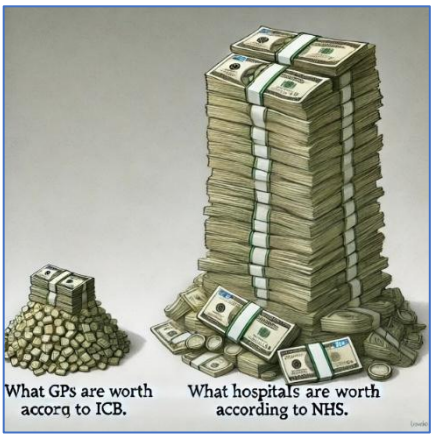
4. MINOR SURGERY.

The LMC Board continues to consider our strategy for Minor Surgery from April 2025. We have written to Dr Caroline Trevithick (CEO, LLR ICB) to request to commence discussions for 2025/26. In addition, we are liaising with other LMCs and have highlighted this with GPC England.

THE ONGOING LMC VIEW IS THAT IT IS UNACCEPTABLE FOR GP PARTNERS TO BE EXPECTED TO SUBSIDISE THE NHS.

It is unacceptable that Leicester, Leicestershire and Rutland GPs **are subsidising the NHS by £197,109 from their own pockets** for the privilege of providing a minor surgery service. There are 345 GP Partners in LLR, meaning that each partner is paying an average of **£571 per year**.

Last month I quoted the hospital NHS Tarriff for a joint injection from 2022/23, however I have now located the amount for 2024/25 which has increased from the £571.00 to **£611.00**[1] (a 7% increase, compared to the **ZERO%** increase that the ICB gave to general practices).



In the meantime, please calculate how much you are subsidising the NHS each year for this service, discuss within your practice team, and consider:

1) As part of **Collection Action**, stop providing the service completely and refer patients to secondary care.
   a. The Enhanced Service enables practices to claim for procedures done but does not require practices to perform any specific procedure.
   b. Continue to provide the service until you have used any drugs purchased by the practice.
2) **Cherry pick procedures**. Only provide those which take less time/experience and so can be provided within the funding provided. Refer all others to secondary care.
3) Decide to continue to provide the service but set a limit that your practice is willing to **subsidise the NHS**. Once the limit is reached either create a waiting list or refer to secondary care (consider giving patients a choice).
4) Calculate the amount your practice is **subsidising the NHS**, and:
   a. Inform your patients.
   b. Write to your MP
5) Discuss the issue and your proposed changes with your **PPG**.
6) **Do not sign up** to the Minor Surgery Enhanced service for 2025-26 until the LMC advises it is appropriate to do so.

The LMC will continue to update you about this crucial matter.

For information, suggestions, advice or support please contact the LMC.

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[1] 23-25NHSPS_Annex-A_2024-25.xlsx

5. ACCELERATED ACCESS TO GP RECORDS.

The LMC was disappointed although not surprised that in the LLR GP Newsletter for week commencing Monday 6 January 2025, the ICB were pushing accelerated access with a less than veiled threatening approach.

The article reiterated NHS England's opinion without considering the actual legal position. General Practices, as Data Controllers must ensure they comply with data protection regulations. NHS England cannot dictate what this means. If there is a problem it is the practice as data controller that will fined by the ICO or taken to court, and not the ICB or NHS England.

The LMC reiterates the advice in our December Newsletter.

If you followed BMA guidance and carried out the legally required DPIA and concluded that there were risks which could not be mitigated for, then if contacted by the ICB please send them a copy of your DPIA and how you continue to advise and promote patients to consent to access. If the ICB uses bullying or threatening language, please let the LMC know.

If your practice went ahead with enabling accelerated access to all patients and you have one or more examples of patients coming to harm due to it, please let the LMC know. Examples of harm have been reported elsewhere, and the BMA is currently collating a database.

For information, suggestions, advice or support please contact the LMC.

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6. TRANSLATION OF CLINICAL DOCUMENTS.

In Section 2 the LLR GP Newsletter for the Week Commencing 6 January 2025 (Reminder if interpretation and translation services) it erroneously stated "Written translation can be requested but the costs will need to be picked up by the individual practice"

The responsibility for provision of this service clearly lies with the ICB. The NHS England guidance states "Integrated care Boards (ICBs) are responsible for ensuring translation and interpretation services are available for patients accessing primary care.[2]"

[2] NHS England » Interpreting and translation in primary care

I have written to the ICB and asked that they issue a correction and provide details how practices can access this service.

In the interim if you need to have a document translated, please contact the ICB first to ask how this can be arranged llricb-llr.primarycareteam@nhs.net. If you have followed the ICB guidance in their Newsletter and paid for a document to be translated the LMC recommends that you send the invoice to the ICB and request to be reimbursed.

For any comment or feedback please contact the LMC.

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7. BARIATRIC SURGERY AND WEIGHT LOSS SERVICES.

The LMC is concerned about the current mess regarding weight loss services.

Tier 2: Commissioned by Local Authorities. Although this is available in Leicestershire and Rutland it is not currently available for patients in Leicester City.

Tier 3: Commissioned by NHS/ICB. Currently the local service is unavailable for new referrals. We are aware of one out of area provider where patients can be referred to under the 'Right to Choose' initiative – Oviva (the LMC is not endorsing or recommending this service, but purely advising that there are other alternatives).

Tier 4: Commissioned by NHS/ICB. Currently the local service is unavailable for new referrals.

In view of the lack of Tier 4 services, and that patients often look for an 'easy fix.' It is not surprising that an increasing number are turning to cheaper private providers abroad in Turkey and other countries.

This is leading problems for general practice. Despite numerous meetings with the ICB and UHL consultants, we have been unable to agree a definitive position.

The NICE Quality standard [QS127] states that all patients who have had surgery should be followed up by the bariatric service for two years. They advise that follow-up care should include "regular health check-ups, tests to make sure they are getting the nutrients they need, support with their diet, help to increase physical activity and psychological support if needed."

The UHL service says that if the patient was not eligible for NHS care, then they are not eligible for NHS follow up. The LMC view is that if a patient is not eligible for NHS follow up then this includes follow up by general practice.

In essence, the scenarios for patients having bariatric surgery privately are:

- Low risk surgery but entitled to NHS care. Patient should be referred to NHS Bariatric service for follow up.
- Low risk surgery but not entitled to NHS care. Patient should be advised that they must seek support from the private provider who carried out the operation, or another private provider in England.
- Very high risk surgery. The UHL service has said that as these are high risk, they will provide follow up care, and the patient should therefore be referred. The LMC is seeking for definitions regarding which procedures this would cover.

- Complication. If a patient suffers from a complication, then the NHS will provide care, and the patient should be referred as urgently as the clinical need.

If you are unsure whether a patient may be entitled to follow up by the UHL, then the bariatric service has advised that if you send an Advice and Guidance, they will advise whether they would be eligible.

In the meantime, NICE issued guidance in December 2024 about making tirzepatide available to patients in general practice (rolled out over a 12-year period). We have advised the ICB that if there is no national contract and they are expecting general practice to provide this service, then it will need to be properly specified and funded with no expectation that general practice will just subsume the additional work. It also possible that the tiered approach may be removed, but again we must make sure that any replacement is not based upon an expectation that general practice will pick up the pieces – we are not a free lunch.

The LMC will provide additional support including information for patients once we are clearer on the detail.

Please contact the LMC to let us know if you have any concerns or problems.

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8. GENERAL PRACTICE AWARDS.

The LMC has been considering how we can further promote general practice and provide recognition of the fantastic work that practices continue to do despite the challenges that have been put in our way over the past decade.

Last year the LMC partnered with UHL who kindly offered to include an award for general practice as part of their annual award ceremony.

This year the LMC intends to build on this by providing our own awards. This will be incorporated into our Annual General Meeting:

Date: Tuesday 11th March 2025
Venue: Hilton Hotel, 21 Junction Approach, Leicester LE19 1WQ
Time: 6.30pm dinner – 7.15pm start
Dress: Smart casual

In addition to the awards, there will also be a presentation by Dr Samira Anane, Deputy Chair of the GP Committee in England who we hope will be able to update us about the proposed GP Contract for April 2025 onwards.

The nominations will be for individuals working within general practice in the following categories:

1) Outstanding Contribution to General Practice
2) Greatest Leader
3) Rising Star

The LMC will short list up to 3 people who work in general practice (GPs, Practice Managers, Nurses, Pharmacists etc) for each category and the nominee 'plus one,' and their nominator will be invited to attend the evening event.

The winners will be presented with an award and certificate.

The full details including how to nominate an awesome colleague will be sent in an email – please keep an eye open for this.

Please contact the LMC to let us know if you have any comments.

Please note: LMC Board members are not eligible to be nominated or to nominate.

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9. MEDICAL EXAMINER SERVICE UPDATE

The LMC have been consulting with the ME service, coroners, registrar service, and funeral directors about feedback following the change in the death processes from September 2024.

Just as a reminder this is a statutory process that was forced onto the profession with no consultation. The project was a complete dog's dinner from start to finish and indeed has still not been completed (for example the promised electronic MCCD which I was involved in the first version over 2 years ago is still not live). So, we are stuck with it and all we can do is to try and help the system run smoothly.

As hard as we worked to try and provide guidance in advance, the situation was changing up until the very last moment. Indeed, on the go-live day (9 September 2024) the Chief Coroner issued Guidance No 47, which included the hitherto unmentioned nugget that **ALL** natural deaths must be referred to the ME service even if there clearly was no identifiable cause of death. This also came as a complete surprise to the ME Service.

As predicted in advance, the ME service is causing delays to registration of deaths and creating unfunded additional workload for GPs.

Due to not fully understanding the different challenges there would be on taking on all community deaths (despite warnings from myself and others) the ME service was ill-prepared leading to unacceptable delays currently running at about 2 weeks.

Although GPs are getting this right most times, GPs can do their part to minimise delays and distress for the relatives and loved ones of our deceased patients. I have been told about the following:

- Old MCCDs being completed and sent to registrar (please check and if you still have your old MCCD book – **SHRED ANY UNUSED OLD MCCD CERTIFICATES**).
- Address on MCCD being given as 'home' rather than actual address (mistake not picked up by ME service).
- Qualification on MCCD being given as 'Doctor' or 'GP' rather than registered qualifications (mistake not picked up by ME service).
- Coroner referring a death back to the GP, but GP not acting on it.
- ME service advising GP that a death should be referred to the coroner, but this being not done until chased on multiple occasions by the coroner.
- Providing out of date contact information for relatives which is used by both the ME service and Registrars. This has included on one occasion the name and phone number of the spouse who had died a couple of years earlier.

The problems reported by GPs about the ME service include:

- Delays (as above), and relatives unable to get through to the ME service.
- MEs being pedantic about the cause of death insisting on changes that would seem inappropriate.
- MEs insisting on change in cause of death due to additional information that they have available to them from hospital records. My view is that the legal requirement is for the GP to complete the MCCD with a cause of death to their best belief and knowledge using the information available to them at the time that they complete it.

I am told that Funeral Directors have had many relatives in tears as they have not been able to make any arrangements for the burial or cremation.

The LMC will continue to work closely with the ME service and other stakeholders to try and make the process as smooth as possible, but we must recognise that this is a mandated process with limitation due to the statutory requirements. I plan to develop further guidance based on common scenarios to assist GPs.

The one thing that both Prof Peter Furness (Senior ME) and I completely agree on is that the process is far from ideal, and that one big improvement would be to take GPs out of completing the MCCD, with our only responsibility being to provide basic information to the ME service.

VERIFICATION OF DEATHS

The LMC have been advised that DHU have told relatives that they do not verify deaths occurring out of hours, and they had to wait until the practice was next open.
The ICB has confirmed that DHU are contracted to provide this service. Please send a TCS and inform the LMC if you hear someone from DHU saying this to you or a relative etc.

Any comments or concerns, please contact the LMC

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10. MEDICINES AUTHORISATION AND ADMINISTRATION RECORDS (MAAR) CHARTS

The LMC has received increasing concerns about community services (district nurses, carers, residential homes) requesting GPs to complete MAAR charts more and more frequently.

There is no legal or professional requirement for GPs to complete MAAR charts, if the instructions are clear on the prescription which include what and how to give and the frequency.

There are some medications where written instructions of some sort would still be important (for example insulin).

Declining to do this unfunded, uncontracted and unnecessary work constitutes one of your 'ten a day' collective actions.

The LMC will work with the ICB Medicines team to develop appropriate guidance.

Any comments or concerns, please contact the LMC

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11. REFORMING ELECTIVE CARE FOR PATIENTS.

The long-awaited announcement from the government about proposed changes for the NHS was predictable It highlights that yet again, despite the report by Lord Darzi that they commissioned and the undeniable fact that without proper investment in general practice the health of the nation will continue to decline, the government plans to focus on the hospital service, throwing their support and funding behind them.

Unfortunately the fingers of NHS England can be seen all over this report, and applying Occam's Razor (see passim) it is clear that they still hate general practice.

Whilst it is crucial for the waiting lists for elective surgery to be reduced this must not be at the expense of general practice. Lord Darzi's report highlighted the problems caused by reducing general practice's share of NHS funding particularly affecting deprived areas increasing health inequalities, and how the health of the nation has suffered. But the main reference to general practice is that ICBs' should "implement all requirements in the Delivery plan for recovering access to primary care," but then just to highlight that they

are still purely focussed on secondary care includes this emphasis "including those that support effective working across primary and secondary care." This recovery plan was launched May 2023, and I do not know about you, but I have not experienced any groundswell improvement in general practice since then.

There is one opportunity which entrepreneurial GPs are likely to punch on, which is their proposed 'fee splitting' paying GPs £20.00 for every Advice and Guidance sent instead of a referral. Of course, to have any value for patients there will need to be a change in response from UHL. I do use A&G from time to time, but my current experience is:

- long delay in getting a reply (especially gynaecology)
- sometimes the reply comes from someone much less experienced than an average GP.
- response more often than not just says 'refer'
- response asks you to arrange tests that you have never heard of, have no idea how to interpret, and sometimes cannot even arrange from general practice.

Although the plan believes that an additional 1.6 million A&G requests will lead to a reduction in 0.8 million referrals, the reality is that the main effect will be purely to delay care for patients, and what few referrals are saved will be at the expense of general practices providing the additional work and care for no additional resources.

The plan is heavily dependent upon 'innovations' including use of NHS App and Patient Initiated Follow Up (PIFU). Whilst I fully support these projects it must be recognised that they have a significant risk of increasing health inequalities. The report does not even recognise this, let alone consider any mitigation.

The plan includes various case studies to promote "new ways of working", but the only persisting one about primary care just emphasizes the lack of understanding of the expertise there is in general practice and that they still hate general practice. This is about digital otoscopy, earwax removal and hearing checks. Whilst a laudable service, you cannot help wondering why this contract was not offered to general practices rather than community pharmacists. The service would be more joined up, less training would be needed, it would be lower risk, and the kit would be used to benefit other patients as well as for training purposes.

Case study: South West London offers hearing assessments in the community

The ICB implemented a 12-month hearing health pilot pathway across 20 community pharmacies using a mobile-based three-in-one otoscopy device, enabling trained pharmacy staff to perform digital otoscopy, earwax removal and hearing checks on patients.

7,648 patients were referred by 72 GP practices to the 20 community pharmacies where 36% of patients were seen within 1 week, and 87% within 4 weeks. Almost 70% of patients were able to complete their treatment and only 3% of completed appointments resulted in a recommendation for the patient to be referred to secondary care, including ENT or audiology.

Patient experience of the service was incredibly positive with 99% of patients reporting they were happy with the service received, and 98% would recommend it to family and friends.

I do need to refer to the 'case study' that was in the first version, which has not only been removed, but expunged from history (instead of a revised version being published the original has been changed).

The 'case study' is produced below (fortunately someone had taken screen shot), and as you see, in the future, to diagnosed rhinitis in a more modern and dependable way you will need a nurse practitioner, CT scan, and an MDT meeting including an ENT registrar. Either NHS England have no idea of the expertise that general

practitioners have, or in future they plan not to have any GPs. **MRCGP AKT Question**: Using the information available and applying Occam's Razor, do you think a) NHS England hates general practitioners, b) NHS England have no idea what skills general practitioners have, c) NHS England plans to have no GPs in the future, or d) All of the above

Example of a reformed elective pathway: ear, nose and throat (ENT)

Sarah has sinus pain and hearing issues. She makes an appointment with her GP using the NHS App. The nurse practitioner assesses her and refers Sarah directly to the local community diagnostic centre (CDC) for a CT scan. The CDC is in her local shopping centre so Sarah books an appointment to coincide with errands she needs to do that day. She receives her CT scan result via the NHS App when she arrives home from shopping, and at the same time the result goes to her GP practice.

The nurse practitioner and ENT registrar discuss Sarah's presentation and diagnostics at a multi-professional meeting. They agree the rhinitis can be managed in primary care without Sarah needing to go to hospital, but her hearing loss does need a consultant's care.

Sarah is told about her referral and chooses her appointment using the NHS App at a time and location that best fits around her life. She chooses a hospital on the NHS App based on the information it shows about waiting times, hearing loss, clinical outcomes and patient satisfaction rates.

At the appointment, she receives multiple investigations and treatment on the same day, including a hearing test by an audiologist, a further MRI scan, a nasoendoscopy and a prescription. The audiologist makes an onward referral for a hearing aid.

Sarah has another appointment 2 weeks later to discuss her ongoing care. She booked this appointment on the NHS App and was offered a remote consultation or the option to go to a community-based clinic to see the consultant. At the same time, Sarah is provided with more information about her condition via the NHS App and decides she is happy with the progress of her care and doesn't need a follow-up appointment. She tells the consultant via the NHS App and receives information on how she can initiate an appointment if things change.

And whilst not strictly directly related, this document was written under the direction of Amanda Pritchard (NHS Chief Executive) who continues to demonstrate her strong grasp of health care systems and medicine, and on 9 September tweeted the following to help the NHS cope with the current surge of Influenza and RSV:

Henry Ford said, "If You Always Do What You've Always Done, You'll Always Get What You've Always Got." I do not understand why the NHS England Board who have overseen the development of the crisis in the NHS including deliberately removing funding from general practice are still in post.

Any comments or concerns, please contact the LMC

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12. FLOODS, BUSINESS CONTINUITY, OPEL REPORTING AND DOS RATING.

The recent floods on Monday 6 January 2025 which brought much of our area to a standstill highlighted the importance for practices to have an up-to-date Business Continuity plan which is readily available to all key members of staff and partners even when the practice cannot be opened.

I was for a while stranded, trying various routes to navigate a way around unpassable flooded roads to get into surgery. This coincided with the government's announcement about 'Reforming Elective Care For Patients' with the request for media interviews that is now commonplace for the LMC. One upshot was that I found myself pulled over in 6 inches of water in a layby giving an interview with Nicky Cambell on BBC 5Live. I also had plenty of time to talk to a more local BBC researcher. Although initially the ask was to appear on BBC Radio Leicester, due to the number of staff that had not made it into various BBC Radio 'branches' by the time it went out live I was interviewed by Kevin Mccube who was based in the BBC Derby studio, but broadcasting across the whole of the East Midlands – the BBC had a robust continuity plan that allowed them to continue broadcasting and for once I was not dropped at short notice as the 'dead donkey.'

I would urge all practices to develop a continuity plan and keep it up to date. We have recently updated ours to include the logons for social media so anyone with access to the plan can inform patients of any adverse events. The CQC expects practices to be able to show what arrangements are in place to respond to emergencies and major incidents and they provide some guidance what practices should consider – click here.

Part of this process would be to use OPEL reporting. The LMC would encourage practices to use OPEL reporting whenever appropriate, for example when you have reached capacity (see LMC October 2024 Newsletter). By doing so, it highlights the problems that general practice faces. You should not feel penalised or receive any pressure from the ICB for using this system – if you do contact the LMC.

The LMC is of a view that as part of the OPEL process, practices should be able to request their Directory of Service (DOS) entry to be changed to amber or red in line with NHS England guidance (see below). We recommend that when you use the OPEL reporting you include whether your DOS RAG needs to be changed to amber or red in the free text – if the ICB refuses please contact the LMC.

When completing the OPEL reporting please ignore the question about Collective Action as this is inappropriate and has no place in the reporting process.

RAG	DoS definitions
Green	Service has capacity available. The service can accept referrals and is likely to meet any disposition timeframe.
Amber	Service has limited capacity. The service can accept referrals but they are busy and may not be able to meet the disposition timeframe. Alternative services should be considered where possible.
Red	Service has no capacity. The service is not able to accept referrals or has run out of appointments. Services will not present as an option (apart from an emergency department in a catch all event).
	Services can also be suspended by changing the service status to show it is 'suspended'.

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13. ADVERTISE YOUR JOB VACANCIES FOR FREE.

As a reminder, the LMC provides a free to use service to advertise all vacancies within general practice.

The LMC has received comments that they find adverts on the local Email Listservers to be annoying- to avoid this, sign up with us!

For further information email or phone the LMC (0116 296 2950). To access the job page **click here**.

Any comments or concerns, please contact the LMC

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14. UPCOMING LMC EVENTS.

The LMC has the following upcoming events.

CQC and Safeguarding event for Practice Managers

The LMC will be hosting a session for Practice Managers. This will be in two parts, the first about common inspection findings by the CQC and the second about safeguarding training for practice managers.

Date:	Tuesday 21st January 2025
Venue:	Hilton Hotel, 21 Junction Approach, Leicester LE19 1WQ
Time:	1.30 – 3.30pm (lunch from 1pm)
Dress:	Smart casual
Speakers:	**Vanessa Twigg** CQC Inspector (CQC session on common inspection findings) **Dr Amit Rastogi** LMC Board Member & LLR GP Named Safeguarding lead (Safeguarding training for practice managers)

To register for this event or to read more about this and other events, please click on **our training page.**

THIS EVENT IS NOW FULL – BOOK EARLY TO AVOID DISAPPOINTMENT

LMC AGM and Awards Ceremony

The LMC Annual General Meeting incorporating our inaugural awards ceremony will be held as below. For more information about the awards click here.

Date:	Tuesday 11th March 2025

Venue:	Hilton Hotel, 21 Junction Approach, Leicester LE19 1WQ
Time:	6.30pm dinner – 7.15pm start
Dress:	Smart casual
Speaker:	**Dr Samira Anane** (Deputy Chair, General Practitioners Committee

Details how to book this event and to nominate a colleague for an award will be circulated separately.

Collective Action and the new GP Contract

The LMC will hold this session to give practices a chance to discuss collective action against the background of the new contract.

Date:	Tuesday 8th April 2025
Venue:	Hilton Hotel, 21 Junction Approach, Leicester LE19 1WQ
Time:	TBC
Speaker:	**TBC**

This event is not available to book at present, but will be available closer to the date by clicking on **our training page.** Please reserve this date.

For Further Information about these events click here, or register by emailing the LMC: enquiries@llrlmc.co.uk

Any comments or concerns, please contact the LMC

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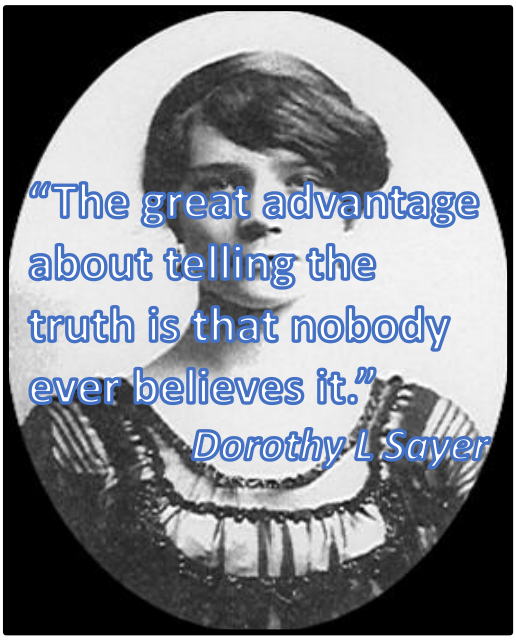
15. FINAL THOUGHTS

It was as a spotty youth that I first came across the concept of SEP whilst listening to Radio 4 (giving you an insight into my Essex childhood).



Even at the time I found this management tool a revelation, and have found myself using it over and over again. I remember quoting this and its origins to a number 10 civil servant when it dawned on him that he was going to have to tell the then PM that his favourite NHS IT project was coming off the rails and he was usuccessfully trying to persuade me to make a decision which could have been to the depriment of general practice.

I have studiously taught all mentees and padawan learners attached to me over the years about the concept of SEP and how best wielded.

Nowdays I am quoting it more frequently to young (and old) GPs as it is an imperative concept to embrace if you want to avoid burn out. It is also a bedrock to being able to implement collective action.

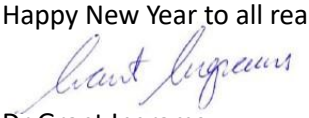
I have a feeling that until the NHS England heirachy changes to a group of folk who do not hate but actually value general practice we will be needing it more that more.

This seminal concept was coined by the modern day philosopher and guru Douglas Adams. It first appeared in a Radio 4 series and then latterly in book form as the Hitchikers Guide to the Galaxy.

The concept of “Someone Else’s Problem” (SEP) can be used alongside such other words of wisdom like “Poor planning on your part does not necessitate an emergency on mine” (Bob Carter).

So the next time a patient, carer, manager, solicitor, social worker etc. wants you to do something which you are not contracted or funded to do, signpost as appropriate, but remember SEP and engage your protective SEP field and just say no (remembering also that ‘no’ is in itself a complete sentence).

Happy New Year to all readers that managed to reach the end.



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