LOCAL LEICESTERSHIRE
MEDICAL LEICESTER
COMMITTEE RUTLAND

March 2025

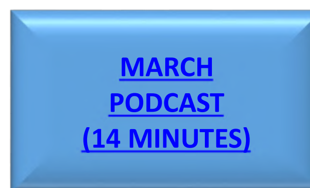
To All Leicester, Leicestershire, and Rutland General Practitioners and Practice Managers.

Dear Colleagues

LLRLMC NEWSLETTER

Welcome to our **MARCH** 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 OF IMPORTANT INFORMATION:

Contract changes for 2025/26 – **IMPORTANT**
Medicines Optimisation – should your practice sign up?
Minor Surgery – reduce or stop the service?
FIT Testing – Safety netting will be crucial
Read moving and inspirational citations about unsung heroes in general practice

Topics in this newsletter:

1) LMC Meeting MARCH 2025
2) Local Medical Committees England Special Conference
3) Safe Working and Collective Action
4) Minor Surgery
5) Medicines Optimisation for 2025/26
6) LMC CQC Meeting
7) Maternity Leave Changes for Salaried GPs
8) AGM and General Practice Awards
9) Legacy NHS.UK Email addresses
10) LMC and the Media
11) Contract Changes for 2025/26
12) GP TeamNet
13) Rates Rebates 2017 / GL Hearn
14) Recycling Food Waste – Environment Act 2021
15) Correction to QOF VI Indicators for 2023/24 – UPDATE RE PAYMENTS
16) Chickenpox – Notifiable Disease
17) Faecal Immunochemical Testing (FIT) – from April 2025
18) Upcoming LMC Events
19) Final Thoughts

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

1. LMC MEETING MARCH 2025.

The LMC Board met on 13 March 2025. In addition to standing agenda items, and those covered elsewhere in this newsletter it included:

1) Feedback from Dr Andrew Furlong (Medical Director UHL) and questions to him.
2) Presentation from the Clinical Bed Bureau Team. Although there has been some negative feedback regarding how long it can take for them to consult with the right clinician, the feedback from Board members who have used the service (including me) is positive. We would advise all clinicians who feel a patient needs hospital care to contact Bed Bureau first. This can improve the patient journey and helps to off load the emergency department. If you encounter any problems or issues with this service, please contact the LMC.
3) Presentation and discussion with the ICB regarding the proposed Neighbourhood Health Service. This is the government's plan to transform health services by promoting integrated working between NHS, Local Authorities, Social Care and other partners. NHS England guidance can be found here. The aim is for this to underpin delivery of the three government aims:
    a. **from hospital to community** – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
    b. **from treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
    c. **from analogue to digital** – greater use of digital infrastructure and solutions to improve care

   It is easy to be cynical that this is yet another reorganisation which is unlikely to have enough time to embed before yet another change, but this is government policy and so the LMC will work with the ICB to ensure that general practices as the main provider of healthcare remain the central hub of any structure. We also need to make sure that it works as well as it can. Like every reorganisation, success will largely depend on whether enough resources are provided in terms of management, clinical expertise, and funding.

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2. LOCAL MEDICAL COMMITTEES ENGLAND SPECIAL CONFERENCE.

Your LMC represented you at this Special Conference on 19 March. It was called by Local Medical Committees across England who passed the following motion "That conference believes that NHS general practice in England is no longer sustainable as a business model … and that a special conference of LMCs is required to discuss and determine what escalatory steps will be needed to ensure the survival of what still remains of English general practice."

Your LMC proposed various motions for debate including that the Carr-Hill Formula is not fit for purpose and must be replaced. The conference was held 'in camera' with an agreement that representatives will not share the details of what was discussed.

The day included two open mic discussions about the deal for 2025/26 and what is going to be needed for the completely new contract to replace the current GMS contract.

This is the start of the process. There is much more work to be done by GPC England, but for the first time for years there is a chink of light for the future of partnership-based holistic general practice.

Your LMC team in our seats keen and early for the afternoon session.

Dr Grant Ingrams representing your views.

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3. SAFE WORKING AND COLLECTIVE ACTION.

As the GPC has accepted the proposed changes to the 2025/26 contract then we are no longer 'in dispute' and therefore the nationally co-ordinated Collective Action stops

However, it is important that the tenets of Collection Action continue. There are three main parts:

1) Changes based on **clinical safety** including limiting number of contacts to a safe level and increasing normal GP appointments to 15 minutes in recognition of increasing complexity. It is important that practices consider this to be the new 'norm' and that any practice that has not yet implemented these changes look into doing so.
2) '**Mind the gap**' with GPs refusing to be an 'all you can eat buffet' service, continuing to decline to provide unfunded/non-contracted services or those which are underfunded.
3) Actions designed to cause **irritation to the system** – like not signing up to new data extractions, or not using ScriptSwitch etc. Although, this may change, we would urge practices not to do so yet. The exception to this is the advice that practices, who wish to comply, should now sign up to the PC DES on-line component.

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The GPC has issued the following statement:

Thank you to those who have participated in the collective action tracker surveys so far.

The March action tracker survey will be the final one in its present format. Future iterations will incorporate significant modifications. The survey is open and will close at 5pm on Monday 31st March. The survey link will be shared via the bulletin, social media and SMS messages will be sent to GP partner members on Monday. We would be grateful if could share this link with your networks and practice managers. We appreciate your relentless effort in encouraging practices to participate in the survey.

As you will be aware from the Special Conference, GPC England has now fully agreed to the 2025/26 contract. GPCE had received the received the Government's commitment in writing "to working with GPC England to secure a new substantive GP contract within this Parliament, without preconditions, based on collaborative work, and in the spirit of mutual trust and good faith...with General Practice at the heart of a neighbourhood health service."

GPCE will focus on key aspects of the current 2025/26 contract and look forward to beginning work with the Government on a substantive new contract that can provide safety, stability and hope to general practice. GPCE recommends practices to continue to prioritise their delivery of safe, high-quality patient care and to work with LMCs and ICBS to renegotiate local contracts that are under resourced or are required to fill gaps in service for some of our most vulnerable patients.

Many of the items on the collective action menu will be superseded by the 2025/26 contract agreement, and so we will publish updated guidance for members, practices and LMCs to provide the necessary clarity. We also still have the template letters available within our long-standing safe working guidance to help practices manage workload and limit capacity to deliver safe, high-quality care.

We will be adjusting the tracker survey in April to reflect the shift to local action. Please refer to our GP Campaign page for more information on these changes.

The LMC will keep practices up to speed with developments, but we would welcome GP/practices views on this.

IMPORTANT – URGENT ACTION NEEDED

PCN DES – CAPACITY AND ACCESS FUNDING – SIMPLER ONLINE REQUESTS

The LMC recommends those PCNs whose member practices wish to comply with the 2024/25 CAIP **on-line component** within this financial year make such a declaration **AS SOON AS POSSIBLE** before the 31st March deadline. PCNs are then eligible to receive the 2024/25 CAIP payment associated with this component.

If you would like any more help or information, please contact the LMC.

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4. MINOR SURGERY.

The LLR ICB's position continues that they have no intention to discuss the Minor Surgery DES for 2025/6.

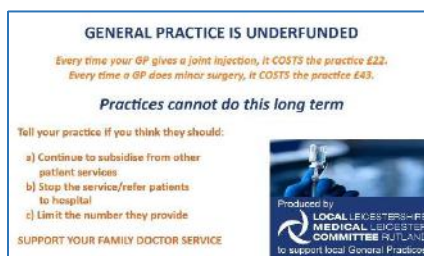
THE ONGOING LMC VIEW IS THAT IT IS UNACCEPTABLE FOR GP PARTNERS TO BE EXPECTED TO SUBSIDISE THE NHS.

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**.

The LMC continues discussing with other East Midlands LMCs but now advises practices to choose one of the following:

1) **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).

Please use the letter and infographic as below.



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PRACTICE HEADED PAPER

Letter to patients

Dear All

You may be aware that the amount of funding for GP services has reduced significantly over the past decade. The total amount for the NHS has been eroded and general practice's share has shrunk from 11% to less than 6%.

Together with an increasing workload due to an ageing population and increased health problems, these are the major reasons why we are unable to provide the level of service our patients deserve.

Some services are contracted locally by the Integrated Care Board (ICB). The funding for many of these services has been stagnant for many years and the funding no longer covers the cost of providing the service.

One such service is Minor Surgery which includes joint and other steroid injections for pain relief and draining abscesses or removing small skin lesions.

For each steroid injection the funding the practice receives is £43.54, but cost is £65.32. The funding for draining abscesses or removing skin lesions is £87.57 but the cost is £130.47. For comparison the NHS pays a hospital £611.00 for one steroid injection.

We have decided that we can no longer continue to subsidise minor surgery by taking funding allocated for other patient services.

Therefore, from 1 April 2025 we will make the following changes *{Choose one option}*

OPTION ONE
The practice has decided to stop all minor surgery. If you need one of these procedures, we will refer you to the hospital or another accredited service.

OPTION TWO
The practice has decided to continue with providing steroid injections but not any other procedure. If you need one of these procedures, we will refer you to the hospital or another accredited service.

OPTION THREE
The practice will continue with *{only steroid injections* ***or*** *all procedures}* but we will be limiting the number of procedures we carry out each month. If your GP decides you need a procedure you will be added to a waiting list, and we contact you once a date can be arranged.

The practice has not taken this decision lightly, but we must ensure that providing a minor surgery service does not undermine our ability to provide other services. If you agree that this position is inappropriate, please complain to the ICB, your MP or local councillor.

Yours faithfully

The Partners
XXX practice

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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5. MEDICINES OPTIMISATION FOR 2025/26.

*This article has been written by **Dr Fahreen Dhanji** (LLR LMC, Deputy CEO) and **Dr Reema Parwaiz** (LLR LMC Board Member and Lead for Medicines).*

The LMC have raised concerns with the ICB medicines team regarding the MOF in CBS. In summary:

- Mixed payment model – core section worth 45p/registered patient. Additional funding available dependant on efficiency savings (see section 2 below).
- Decreased workload - 2 sections (core and efficiency sections). The quality component has been removed due to the current financial position of the ICB.
- The MOF will be for 1 year
- Practices must attend if invited to a progress meeting with the ICB regarding any part of framework. Post verification checks will be taken in July and Dec 25.

Section 1 – Core - 45p/registered patient and involves 4 parts:

1. Reviewing all red and amber eclipse alerts (currently doing as part of this year's MoF).
2. Reviewing red drugs (hospital only prescriptions), non-drug tariff specials, DNP (do not prescribe).
3. Attend 2 x 1 hour meds optimisation webinars – dates given in advance, recordings can be reviewed if unable to attend, option to work at bigger scale e.g. PCN attendances etc.
4. Review Stoma/continence appliances quantities.

This equates to £4,500 for a 10,000-patient list size.

Section 2 – Efficiency program – which we have asked to be paid to practices dependant on the work done. This needs to be completed by **June 2025.**

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DPP4 inhibitor Formulary Alignment:

- Gliptin switch to cheaper formulary choice for those patients with CrCl ≥30mL/min switched to generic sitagliptin where clinically appropriate.
- Patients co-prescribed DPP4 inhibitor and GLP-1 mimetic moved to single medication.

Payment model to be based on work done:

- If ≥70% of patient cohort is switched (measured in Dec 25 against a baseline taken in March 25 from the clinical system) = £70/patient switched.
- If ≥ 60% switched, then £60/patient switched
- If ≥ 50% switched, then £50/patient switched
- £7.50 given for patients reviewed but not switched.

Payment for your practice would depend on how many patients a practice has that are eligible to have this change -it may be worth running a search before signing up!

Also note for every switch you do the ICB saves at LEAST £25 PER prescription for any swaps you have done. This means that when you have switched them by June there will be 9 prescriptions (July-March) where you will have saved the ICB a total of £225/patient, but you will have been only rewarded with a fraction of this amount which at the maximum of £70 is only 31% of what you will have saved the ICB.

Overall, as an LMC, we believe the workload required from practices for Section 1 outweighs the financial return. Section 2 will generate varying amounts for each practice.

We have expressed our disappointment to the Medicines Optimisation team and will be advising practices accordingly. We encourage practices to conduct their own calculations to determine whether participation is viable for them.

Fahreen and Reema

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6. LMC CQC MEETING.

*This article has been written by **Sarah Gibson**, LLR LMC Board Member (Practice Manager Representative – County).*

The LMC have held a Safeguarding and CQC event aimed at our practice managers across LLR. Due to the popularity of the content we had to repeat the event twice which we were thrilled about.

We were extremely lucky to have Dr Amit Rastogi presenting the updated RCGP guidance on safeguarding which was a fantastic opportunity for Practice managers to get face to face training from the child safeguarding lead which usually is not available to us.

We then had two of our local CQC inspectors Vanessa Twigg and Brandon Brine come and speak to us about CQC inspections, common themes, and top tips with an open Q&A. We are very grateful to Vanessa and Brandon for taking the time to come and speak to us and share their knowledge. I personally felt it incredibly useful to know where, as a practice, to focus on.

The feedback so far is overwhelmingly positive, and we hope that everyone that attended found it useful. Presentations are being shared with any FAQs; we also hope that this will lead onto other events to focus on areas that were highlighted.

I would like to say a big thank you to our presenters, Amit, Vanessa and Brandon, but also a huge thank you to Charlotte and Meera who arranged the event and made sure everything went smoothly behind the scenes.

Sarah

The CQC Inspectors will not provide advice about how a practice provides services, but during the presentation they gave the following recommendations:

- Ensure your Statement of Purpose is up to date.
- Ensure that you have kept the CQC updated about who is the Registered Manager and that any changes in partners have been made.
- Policies should be personalised for your practice – do not just download policies from elsewhere. During a visit the CQC inspector will check whether staff are aware and implementing what is in your policies.
- Child Safeguarding. Ensure staff training is up to date and documented. In preference have a named Safeguarding Lead, a Deputy Safeguarding Lead (for when the named lead is on leave), and an identified Admin Lead. Make sure that your staff now what to do if they have a concern. Ensure that your register is up to date (should not have adults on it). Ensure that not only the index child is coded, but also other members of the same household and other close relatives.
- Ensure everyone is on top of their Tasks/Workflow/Results, with items acted on within a reasonable time.
- Significant Events and complaints. CQC like to see evidence that they are discussed, reflected on and changes implemented. For audits they like to see completed audit cycles to demonstrate improvements. For a visit they like to see these collated.
- Ensure that the practice is signed up to receive CAS and MHRA alerts.
- In preference a signed version of ReSPECT forms should be available on SystmOne. During an inspection they will check a random selection of Care Plans/Respect forms.
- Ensure that all clinical staff are supervised, and that this is recorded (and in preference coded on SystmOne). Any ARRS staff should also be supervised.
- HR files should be up to date. They should included DBS checks done for staff and at intervals in a practice policy (if a new member of staff is working whilst waiting for a DBS check – have you done a risk assessment). Evidence of annual appraisals – during a visit they may look for those done 2 to 3 years before. References for all new staff.
- Staff ‘suggestion box’ with evidence that you consider staff views.
- Ensure that all staff are aware of your arrangement for Freedom to Speak Up (FTSU) and whistleblowing.
- Ensure carers are coded and consider reviewing carers.
- If you decide not to keep all the CQC suggested emergency medications at the practice, carry out a Risk Assessment to explain why
- As a rule of thumb, if you are unable to comply with any CQC or otherwise recommended process or procedure etc carry out and record a Risk Assessment.

This list is not exhaustive, but we hope helps to understand the approach that the CQC takes when assessing a practice.

For any comment or feedback please [contact the LMC.]

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7. MATERNITY LEAVE CHANGES FOR SALARIED GPS.

GPC UK have agreed a change to the Model Contract for Salaried GPs in the terms and conditions relating to maternity leave.

They have produced [guidance], resources and template letters to aid the implementation of this change. The new maternity leave benefits are as follows:

- **8 weeks of full pay**, less any SMP (statutory maternity pay) or MA (maternity allowance) receivable, including any dependants' allowances.
- **18 weeks of half pay**, *rather than 14 weeks*, plus any SMP or MA receivable, ensuring the total does not exceed full pay.
- **13 weeks at SMP or MA**, as entitled under the statutory scheme.

They advise that implementing the new maternity leave pay change, will not just help individuals, but also strengthen our profession. These enhanced benefits reflect GPC England's commitment to supporting salaried GPs throughout their working lives.

Next Steps: GPC UK recommend all practices discuss these changes with their salaried GPs. Following which, we recommend that a contract variation letter is issued to each salaried GP to reflect these changes. Further information and the relevant contract variation letters can be found on our website.

If you have any questions, please get in touch via info.gpc@bma.org.uk.

All GMS and PMS practices are required to offer terms 'at least as favourable' as those in the BMA Model Contract. Practices can claim in respect of the first two weeks up to £1,143.06 per week; and in respect of any week £1,751.52 per week up to a total of 26 weeks (See Part 4 of Statement of Financial Entitlements).

GPC UK advise that the revised term will be implemented from 1 April 2025.

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

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8. ANNUAL GENERAL MEETING AND GENERAL PRACTICE AWARDS.

General Practice is Awesome!

It's Official!

The LMC held its Annual General Meeting and first Awards Ceremony on 11 March 2025. It was well attended and was a great evening.

After a very quick formal AGM as required under the articles of the Limited company Dr Samira Anane (Deputy Chair, GPC E) told us about the contract changes for 2025/26 and the start of the process for a completely new GP contract.

The highlight of the evening was the award ceremony. Samira read out the citations for all short-listed candidates and then made a presentation to the winners and runners-up. The citations are moving and inspiring and demonstrate the unsung heroes that work across our area in general practice.

LOCAL MEDICAL COMMITTEE LEICESTERSHIRE LEICESTER RUTLAND

Outstanding Contribution to General Practice

Janet Dobbie (Winner)

It is with great admiration and respect that I nominate Janet Dobbie for this prestigious award. Janet has been an integral part of the NHS for an astonishing 60 years, serving as a nurse for four decades as a Practice Nurse. At 82 years of age, Janet's commitment to her role remains unwavering, continuing to work two days a week as a Practice Nurse, revalidating only two years ago after officially retiring from full-time practice. Her dedication and passion for patient care are truly exceptional. Throughout her remarkable career, Janet's knowledge, experience, and compassionate approach have been invaluable to the NHS, particularly during challenging times. Her calm, efficient, and highly skilled approach during the unprecedented crisis of covid was a shining example of her professional excellence. Moreover, Janet's legacy extends beyond her clinical practice. She has mentored numerous young nurses, imparting her wealth of knowledge and wisdom to ensure the next generation of healthcare professionals continues to thrive. Her mentorship has been instrumental in shaping the careers of many nurses, including the entire Practice Nurse team at her current practice. Janet Dobbie's exemplary service, dedication, and lasting impact on both her patients and colleagues make her an outstanding candidate for this award. She truly embodies the spirit of nursing—compassionate, skilled, and selfless—and is a role model for all in the healthcare profession.

Bridget Roberts (Runner up)

Over many years Bridget had dedicated herself to Primary Care across Leicester, Leicestershire, and Rutland. She has led as Practice Manager Practices across the county and provided superb strategic leadership and commitment to improving quality. Since leaving her role as a manager she has provided consultancy services to Practices to assist them in organisation development and CQC preparation. In addition, she is a leading member of the Practice Manager Academy and provides training courses for upcoming and new Practice Managers. Bridget also through working with the Training department and Deanery runs training courses for the GP Fellowship Programme. Her commitment to Primary Care and her work with many Practices and individuals is exemplary.

Greatest Leader

Lynne Keeling (Winner)

Lynne is the current Practice Manager of Manor House Surgery. She has worked in the surgery for over 25 years. Her leadership is second to none. Those of us who have worked in other surgeries in the past, under the management of others have never before come across such incredible leadership. She is fair and firm, executing all her duties with exemplary aplomb, but at the same time caring for every member of staff in ways both large and small. She makes every staff member feel appreciated and part of the team. This also includes the ethos of welcoming any temporary staff, to the practice. We are sure this is why people often comment on the friendly and welcoming nature She is the heart and soul of the practice and will sadly retire in the coming months. She has no idea of the impact she has, and what an incredible leader she is. She will be missed hugely by all of us at Manor House and will be missed within the locality too. She will

probably be horrified to find out we have nominated her for this award but believe it would be a fitting accolade at the end of her amazing career. We wish her all the very best for her retirement. She would be a deserving winner of this award, as we truly believe she is the Greatest Leader

Dr Basil Hainsworth (Joint runner-up)

It is a privilege to recommend Dr. Basil Hainsworth, whose unparalleled commitment to primary care in LLR has spanned an exceptional 35 years. As the founder of The Parks Medical Centre, Dr. Hainsworth transformed a single-handed practice into a thriving research and training hub. His dedication as a full-time GP, even today, exemplifies his enduring passion for patient care. Dr. Hainsworth's influence extends beyond his clinical work. A visionary leader and mentor, he played a pivotal role in shaping the future of medical careers as a key advisor to Tony Blair on the Modernising Medical Careers initiative. His tenure as PEC Chair and his instrumental contributions to reforming the Local Medical Committee (LMC) have left a lasting legacy on healthcare governance. Dr. Hainsworth's remarkable career, leadership, and passion for mentorship make him an invaluable pillar of the medical community.

Vicky Kershaw (Joint runner-up)

Vicky is a remarkable individual who has been an integral part of Merridale for many years as the Business Manager and recently, as the interim PCN Manager. Her dedication to her team and their well-being is unparalleled. Vicky consistently places the needs of her staff before her own, fostering a supportive and safe environment that enables everyone to thrive. Her office is not just a workspace; it is a sanctuary where employees feel heard, valued, and respected. This year has been particularly challenging, with turbulence in both her professional and personal life. Yet, she faces every obstacle with unwavering grace and resilience. She leads by example, demonstrating a strength of character that inspires those around her. Vicky's ability to encourage and uplift her team ensures that everyone sees their potential, even when they doubt themselves. Winning this award would be a fitting recognition of Vicky's exceptional contributions and affirm that her approach to leadership and compassion is not only noticed but deeply appreciated. She truly embodies the qualities of an exemplary leader and a kind-hearted individual.

Rising Star

Tara Tomkins (Winner)

Tara is a true rising star in general practice. She joined Bridge Street Medical Practice in 2009 at just 17 years old as a business administration apprentice and completed her qualification in two years with Loughborough College. Her dedication and passion led to rapid career progression—receptionist in 2011, senior receptionist in 2015, assistant manager in 2018 (alongside a two-year diploma in team leadership), and most recently, practice manager in 2023. Tara inspires those around her. She brings positivity, a "can-do" attitude, and an approachable nature that staff truly admire. She creates a welcoming and supportive environment and is responsible for the excellent staff morale scores in our latest survey. When our previous practice manager left suddenly, Tara stepped up without hesitation. She took on key management tasks, sought ways to expand her knowledge, and ensured the practice continued running smoothly. Resourceful and proactive, she balanced leadership responsibilities while maintaining strong relationships with both staff and patients. We have watched Tara grow in confidence over the years, developing into an outstanding leader. Her

dedication, rapid progression, and commitment to excellence make her a perfect candidate for the Rising Star Award. Bridge Street Medical Practice is incredibly proud of her journey.

Dr Sakshi Sadhu (Runner-up)

I have known Sakshi as an outstanding trainee. Sakshi has been working in my practice for more than three years, initially as a trainee GP and more recently as a salaried GP. She has been an absolute pleasure to work with. As a recently qualified GP, she has shown immense drive, completing the CS course, taking on leadership roles within her practice, continuing to look at appropriate opportunities to contribute to improving General practice locally. She is no doubt a rising star and it is a privilege to nominate her for this. She is always ready to lend a helping hand and support her colleagues. During her time, she has demonstrated leadership skills by developing an induction handbook for incoming GP trainees. She has also developed a keen interest in dedication and training. She has done introductory presentations for foundation doctors and inspires them to pursue a career in general practice. She is currently pursuing higher qualification in medical education and remains keen to contribute to medical training. She will undoubtedly continue to rise and inspire many around her.

Dr Samira Anane (Deputy Chair, GPC England) and
Dr Adam Crowther (Chair, LLR LMC)

The LMC plan that this will become an established annual event. Please contact the LMC with suggestions of categories, and please remember to nominate your unsung general practice hero next year!

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9. LEGACY NHS.UK EMAIL ADDRESSES.

When the NHS first devised a system-wide email service they opted to use the X400 standard instead of SMTP. Although X400 had advantages, SMTP was to become the industry standard (think Betamax and VHS, but if you do not understand these terms, please do not ask me as I dislike being reminded that I am old/outdated).

In the early 2000s the NHS decided to re-commission NHS email. As a member of the then NHS Messaging Service Management Board, together with a very small group we drew up the requirements for the replacement. The new system would be SMTP, would not need to be configured for each device but could be accessed by remote devices and via an online portal. The email address would be a single address for the whole of your working life which followed you from workplace to workplace and indeed could be attached to more than one workplace at a time. Initially I also insisted on Email to SMS and Email to Fax facilities, but these have since been removed.

The new NHSmail service was contracted centrally and provided free to all NHS organisations. I was therefore surprised when I moved to work in LLR in 2016 that locally it had been agreed to continue the old X400 style addresses (these included the practice ODS code e.g. some.one@GP-Cxxxxx.nhs.uk) albeit using a local SMTP server. I insisted that I would not change to using an X400 style address but continued with my NHSmail address for work (the neat gji@nhs.net – a benefit of having one of the first addresses set up for me). I also asked the question of how much was the local NHS economy spending/wasting on this local Email service which appeared to be a vanity project.

Move on a few years, and all GPs/practices in LLR have now been moved to NHSmail addresses.

But since the migration, LHIS have been running a process that has automatically forwarded e-mails sent to the legacy nhs.uk addresses (e.g. GP-Cxxxxx.nhs.uk) to the relevant nhs.net address.

These automatic forwarders will be decommissioned on June 30th 2025. As a result, from this date, any E-mails sent to legacy addresses will no longer be delivered, and the sender will receive a delivery failure notification.

To ensure that you continue receiving e-mails, you must contact the sender and ask them to update your E-mail address. It is crucial to ensure that practices are aware that any important senders are using your newer NHSmail emails. **In particular please check with CQC, regulators (GMC NMC, GPC etc), MHRA for alerts that they have the correct email addresses.**

For all technical enquires related to this article please contact: LHIS service desk number 0116 295 3500 or lhis.servicedesk@nhs.net

Any comments or concerns, please contact the LMC

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10. LMC AND THE MEDIA

One issue I noted when I was initially co-opted to LLR LMC was that there was no planned or promoted interaction with the media. At my previous LMC we had developed a strong relationship allowing us to ensure that the voice of GPs was heard.

The LMC publishes intermittent Press Releases (see here), the most recent being about Bariatric Surgery which followed our February 2025 newsletter article.

On 5 March 2025 I was interviewed for a BBC East Midlands article regarding the effect of immigration on the NHS – see here.

I have also pre-recorded interviews with the BBC to be aired on 21st March and 23rd March regarding the effect of the Covid pandemic on general practice.

On 12 March 2025 I did an interview with Magic FM about the worrying outcome of a study published in Archives of Disease in Childhood regarding glycerol intoxication in children related to drinking Slushies and the proposed revised public health advice that children under the age of eight should not drink these.

It is often disappointing when doing pre-recorded interviews that the selected short sections do not include all the points that you feel are important.

It is important that the LMC ensures that the voice of general practice is heard. If you or your practice needs advice or support regarding interactions with the press (either good or bad), the LMC, ICB, BMA or your MDO can help.

Any comments or concerns, please contact the LMC.

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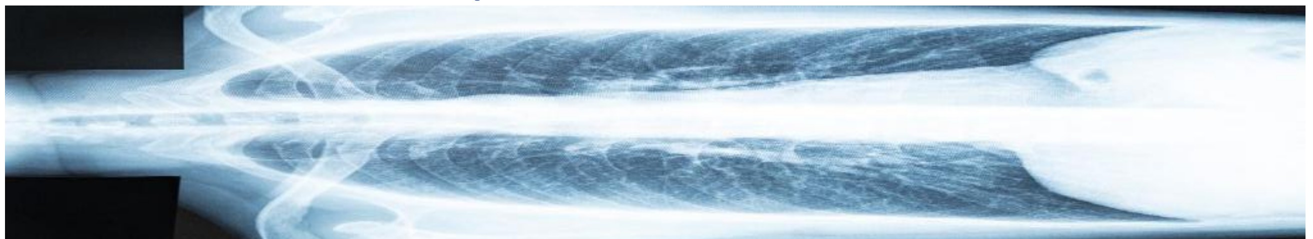
11. CONTRACT CHANGES 2025/26.



Changes in the GMS contract for 2025/26 have been agreed by GPC England.

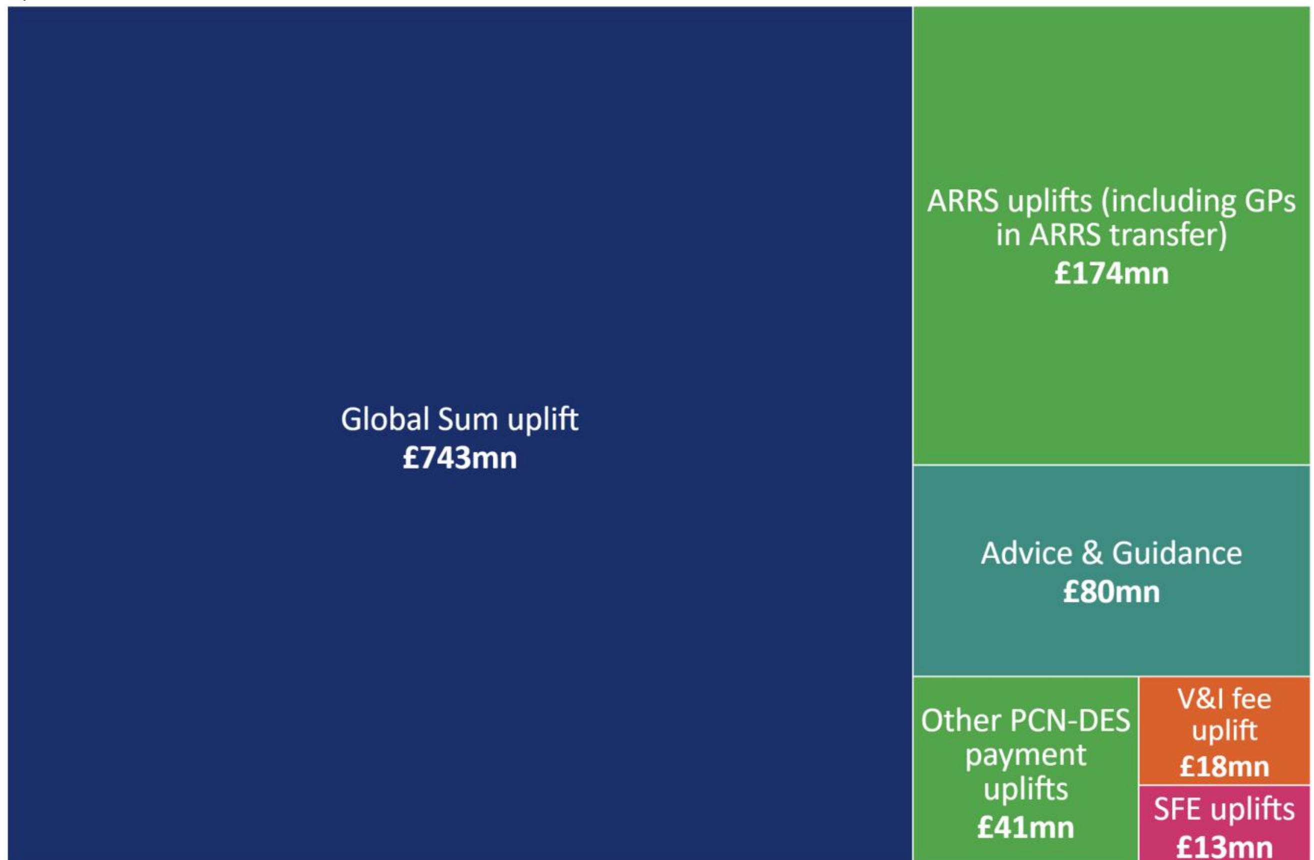
Dr Samira Anane (Deputy Chair of the BMA's General Practitioners Committee) presented to our AGM on 11 March 2025 details of the contract changes for 2025/26 and the proposed completely new contract. The GPC agreed the 2025/26 changes on the proviso that Wes Streeting (Secretary of State for Health and Social Care) wrote to the profession before 19 March 2025 undertaking that a new agreed contract will be implement before the end of this parliamentary term. The letter was well written and included a commitment "*to working with the GPC England to secure a new substantive GP contract within this Parliament, without preconditions,*

based on collaborative work, and in the spirit of mutual trust and good faith, with general practice at the heart of a neighbourhood health service". He full letter can be seen here.

The details of the changes can be found on:

- NHS England's website.
- BMA's website.
- video by Katie Brammall-Stainer (Chair, GPC England).

Total 2025/26 GP contract changes
Consisting of: £889mn announced new funding, £80mn new funding for A&G, and £100mn transferred from QoF.



The deal for 2025/26 was always going to be an interim position, treading water until a completely new contract can be agreed. The overall figures seem reasonable, although as the global sum uplift will be distributed using the Carr-Hill formula which we know is not fit for purpose.

Summary of Financial Changes:

- Total contract funding will increase by **£889 million**, raising the total contract value from **£12.3 billion (2024/25) to £13.2 billion (2025/26)**.
- This represents **7.2% cash growth** (4.8% real growth after inflation) and accounts for workforce costs, premises expenses, and increasing patient needs.
- An assumed **2.8% pay raise** for staff is built into the funding.
- The **Doctors' and Dentists' Review Body (DDRB) will make pay recommendations later in 2025**, and if a higher uplift is advised, additional funding may be allocated to cover the increase.

The major concerns from my analysis are:

- Recirculation of 141 QoF points to nine cardiovascular disease prevention indicators which include a significant increase in the upper thresholds.
- Requirement to keep online consultation tool open from 1 October 2025 for the duration of core hours for non-urgent appointment requests, medication queries and admin requests. This must NOT be allowed to undermine safe working and the principle that practices have a finite daily capacity. At our AGM Dr Samira Anane (Deputy Chair, GPC England) told us that this may result in practices having to develop a waiting list for patients with non-urgent requests.
- Requirement for GP Connect to be enabled and allowing community pharmacists to send data to practices. Dr Samira Anane advised us that NHS England had agreed to involve the Joint RCGP/BMA GP IT Committee in developing their plans, but it is crucial that neither pharmacies or other organisations should be able to write coded data directly into GP Clinical Systems. Most of us use SystmOne and are well aware of the problem with maintaining accuracy of patient records and their curation when others can add information unfettered.
- A patient charter to be published by NHS England with a requirement that every practice includes on their website. Any charter must be realistic and not raise patient expectations that an underfunded, pressurised practice working from inappropriate premises do not have any hope of being able to deliver.
- That the additional funding in the Global Sum is distributed between practices using the Carr-Hill Formula which is not fit for purpose.
- Some practices once the increase in National Insurance Contributions and the increase in National Living Wage have been taken into account may see an overall loss in real terms.

From 2019/20 to 2023/24 the uplift in the Global sum was minimal and well below inflation as part of the five-year deal. During this time, funding was, in effect, gradually transferred from practices to the PCN DES, and in particular ARRS. This is the second year where a noticeable increase has been made to the Global Sum, although cost pressures, including rise in Employer National Insurance Contributions, will effectively wipe out any benefit for some practices. To return general practice to the same financial position as before the pandemic will require a significantly higher increase.

Those who attended the LMC AGM on 12 March 2025 will have heard about the background to the changes from Dr Samira Anane. GPC England will be arranging webinars and as soon as these are announced we will circulate the details.

Any comments or concerns, please contact the LMC

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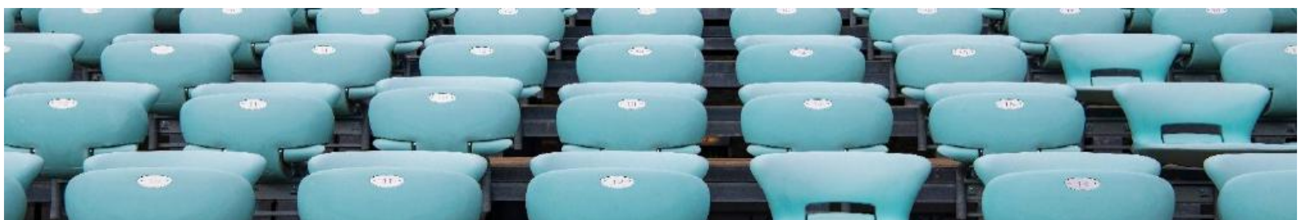
12. GP TEAMNET.



In the February 2025 newsletter I advised that the ICB/CQC had raised a concern about storing Patient Identifiable Data online using GP TeamNet.

GP TeamNet had advised that their system was not designed to store Patient Identifiable Data. From this in my podcast I mooted that if the platform cannot safely store Patient Identifiable Data, then the logical conclusion is that it cannot safely store Staff data. From an information governance perspective both patient data and staff data will include both personal data and special category data as defined in the UK GDPR.

Following this, practices contacted GP TeamNet who reassured them that their platform is safe to store Staff data but is also safe to store pseudonymised patient data.

Again, from an information governance point of view pseudonymisation does not change the lawful status of the data. Pseudonymised data is still personal (and special category) data.

In essence, Agilio (the software company who provide GP TeamNet) have confirmed that their software is designed to safely store personal and special category data but that as their system is designed to support practice compliance/policies they have made the decision that they will only accept pseudonymised patient data to be stored on their platform.

If a practice has uploaded patient identifiable data, they will not have breached information governance regulations but it would be against the software provider guidance so I would advise that they comply, remove the data and only upload pseudonymised patient data in future.

Any comments or concerns, please contact the LMC

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13. RATES REBATE – 2017 / GL HEARN

We have been contacted by several practices who have been contacted by a company called GL Hearn purporting to working on behalf of NHS England looking at possible reclaiming of significant amounts from practices relating to rates rebates in 2017.

We have contacted the ICB to clarify whether this is a bona fide request, and also regarding that due to the length of time that has passed, whether the potential debt is still claimable or now subject to the six-year limitation imposed by the Limitation Act 1980.

If your practice has received similar communication and you have not contacted the LMC please let us know. In the interim whilst the LMC is trying to unravel the situation we recommend that practices, acknowledge the request but do not agree to any action, just advising that you are seeking guidance.

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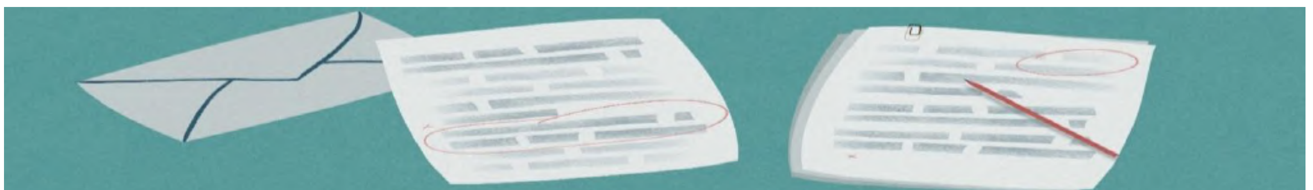
14. RECYCLNG FOOD WASTE – ENVIRONMENT ACT 2021.



From 31st March 2025 every general practice which employs 10 or more people (from 31st March 2027 for all businesses) will be required by law to separate food waste from other recycling. This is due to Section 57 of the Environment Act 2021

Practices will need to assess whether they are producing food waste. There is no legal or universally accepted definition of 'food waste,' however the Separation of Waste (England) Regulations 2024 defines food waste as

'biodegradable material resulting from the processing or preparation of food and drink including inedible food parts such as bones, eggshells, fruit and vegetable skins, tea bags and coffee grounds.'

From 31st March 2025 all practices will have to comply with new food waste separation legislation, and businesses that produce food waste must:

- Separate all food waste from other waste streams.
- Store food waste in separate bins from other waste.
- Arrange for the collection of food waste.

Whilst under Welsh waste laws, only businesses and non-domestic premises that produce more than 5kg of food waste per week must separate their waste, as yet DEFRA have set no such minimum for England and have stated 'there is **no** minimum food waste weight before the new regulations apply.'

If a practice does not generate food waste, but employees bring food to eat on the premises we recommend that practices display a notice stating the employees should take any food waste home with them.

Any comments or concerns, please contact the LMC

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15 CORRECTION TO QOF VI INDICATORS FOR 2023/24.

In our February newsletter we highlighted the error that NHS England had made in calculating payment for the QOF VI indicators for 2023/2024.

We advised that LLR ICB would be reclaiming overpayments and paying underpayments in the March pay run. We have now been advised that they plan to make all adjustments in full (payments due and clawbacks) in June 2025 to coincide with the payment of the lump sum for the QOF 24/25 achievement.

Please check with your practice manager how your practice will be affected and contact the LMC if you require any further support.

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16 CHICKEN POX – NOTIFIABLE DISEASE.

From 6 April 2025 Chickenpox will become a notifiable disease. This is in prelude to Chickenpox being added to the routine childhood schedule.

The Health Protection (Notification) Regulations 2010 have been amended to include 8 additional notifiable infections:

- Acute flaccid paralysis or acute flaccid myelitis (AFP or AFM)
- Chickenpox (varicella)
- Congenital syphilis
- Creutzfeldt-Jakob disease (CJD)
- Disseminated gonococcal infection (DGI)

- Influenza of zoonotic origin
- Middle East respiratory syndrome coronavirus (MERS)
- Neonatal herpes

Any comments or concerns, please contact the LMC

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17 FAECAL IMMUNOCHEMICAL TEST (FIT) FROM APRIL 2025.

From 1 April 2025 the process to arrange **Faecal immunochemical tests (FIT)** changes. Processing the tests will change from Nottingham to UHL.

Every practice should have already received the kits to give out to patients.

The most important aspect is that practices will no longer receive notification from the laboratory when a patient has not completed the test and will need to agree an internal process to safety net this process.

Every practice runs differently and so there will not be a single solution for all practices. The ICB has produced a document called "Safety Netting Symptomatic FIT testing in LLR GP practices" to support practices in developing their own process.

Any comments or concerns, please contact the LMC

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18. UPCOMING LMC EVENTS.

The LMC has the following upcoming events.

Senior Coroners and Medical Examiner

The LMC will be hosting a session for GPs and Practice Managers. This will include an update from both local Senior Coroners and Medical Examiner

Date:	Wednesday 26th March 2025
Venue:	TBC (probably remote by MS Teams)
Time:	1.00 – 2.30pm
Speakers:	**Mrs L Pinder** Senior Coroner for Leicestershire North and Rutland **Professor C Mason** Senior Coroner for Leicester City and Leicestershire South **Professor Peter Furness** Lead Medical Examiner for LLR

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

LOCAL MEDICAL COMMITTEE LEICESTERSHIRE LEICESTER RUTLAND

Leicester and Leicestershire Healthwatch: Enter & View Visits Webinar

The LMC has been approached by several practices about Healthwatch Leicester and Healthwatch Leicestershire, Enter & View visits.

As a result of the interest to know more about the Healthwatch Leicester and Healthwatch Leicestershire: Enter & View visits, the LMC has arranged a lunchtime talk to hear about them in more detail:

- what the visit entails
- the process
- share learnings
- who gets a visit and how practices are selected
- how to get the best of the visits

Date: Thursday 27th March 2025
Venue: Remote / MS Teams
Time: 1.00 – 2.00pm
Speakers: **Gemma Barrow** Healthwatch manager
Dulna Shahid Enter & View Lead (Volunteers)

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

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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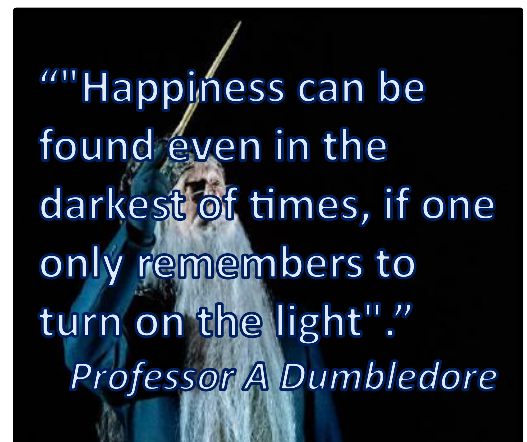
19. FINAL THOUGHTS

Blimey, LLR LMC speaks and the government acts. In my last newsletter and others passim I have raised the ongoing problems with NHS England and how I could not foresee general practice being turned around without wholesale change of the NHS England's Board whose ethos, policies and approach was the cause of the current crisis in general practice.



Last month I noted that the chair of NHS England had stepped down. This was followed on 25 February by Amanda Pritchard (Chief Executive) falling on her sword, and on 10 March announcement that the Chief Financial Officer Julian Kelly, NHS Chief Operating Officer Emily Lawson and Chief Delivery Officer and National Director for Vaccination and Screening Steve Russell also seeing the writing on the wall and leaving the sinking ship.

Then followed the bombshell on 13 March that Wes Streeting was abolishing NHS England entirely.

NHS England was invented as part of the 2012 disastrous Lansley Reforms which were described at the time as being a reorganisation “so big it could be seen from out of space.” The idea was to try and divide policy making (DHSC) from executive/organsational functions (NHS England). But as any ful kno politicians and Civil Servants never could and never will leave the NHS to function autonomously. The temptation to micromanage and to require immediate action in response to a tabloid headline will always be too strong.

LOCAL LEICESTERSHIRE
MEDICAL LEICESTER
COMMITTEE RUTLAND

In 1996 I was transferred from working in a Regional Health Authority public health department to the newly formed NHS Executive. This was created similarly to NHS England to be responsible for the effective management of the NHS. And, due to the inability of politicians to keep their hands off, by 2002 it ceased to exist with power centralised again.

I think I have now survived 20 reorganisations of the NHS. Each time this happens there is huge short and long term costs. Talented managers leave the NHS to work for firms that will value them. There is a huge cost of redundancies, with many staff then being reemployed to do the same work elsewhere in the system. Sorting out premises, IT and even headed paper is not inconsiderable.

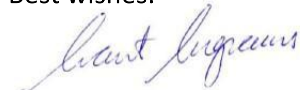
NHS England had subsumed various agencies like NHS X, NHS Digital, and Health Education England. Together with functions like GP appraisals new Quango(s) will need to be formed to continue this work.

The final 'cost' is one of opportunity. Regardless of how necessary the change (definitely), whilst the reorganisation is happening and the dust is settling, staff will understandably be more worried about their jobs than the work needed doing, and then a further lag whilst those left understand what their new roles are and what needs to be done.

At the same time ICBs are also required to contract their costs by 30%, and even more in LLR due to a 'system overspend.' This commonly translates into the local hospital blows its budget (again), and general practice's funding is further raided.

Managers are an easy target. With over 1.4 million staff, the NHS is the largest employer in Europe and the fifth largest globally. In the wider UK economy, as a whole, 9.5% of the workforce are managers, but in the NHS just 2% of the workforce are managers. The issue is not about quantity of managers, but quality, stability and whether the focus provided by the 'centre' is the right one.

Best wishes.



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