NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

July 2025

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

Dear Colleagues

LLRLMC NEWSLETTER

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

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

JULY PODCAST
(50 MINUTES)
INCLUDES CRITIQUE OF NHS 10-YEAR PLAN

SUMMARY OF IMPORTANT INFORMATION:

- Nominate a GP Colleague to win a prestigious award. Click for Information. **Click to Nominate.**
- NHS 10 Year Plan – The Good, the Bad and the Ugly.

Topics in this newsletter:

If you currently hold an ICB role, and are at risk of being made redundant, please consider joining a Trade Union. The BMA is concerned regarding the status of these roles and whether you will be given proper recognition.

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

Click here to join the BMA Register to show support for a new regulator to replace the GMC!

1. LMC MEETING JULY 2025.

The LMC Board met on 9 July 2025. Dr Andrew Furlong (MD, UHL) and Dr Scott Knapp (Emergency Department, UHL) attended. We discussed various interface issues between ED and general practice.

Dr Furlong discussed the recent change to the NerveCentre Patient Demographic Service (PDS). This is the first step to improved IT systems for UHL. If you experience any issues due to the update, please send us the details. We will forward to UHL so they can sort it out.

LLR LMC WEBSITE. This has been up and running for a few months now. We have received much positive feedback, but we are aware that there are a few issues including missing documents and broken links. If you come across any of these please Contact the LMC

The Board discussed a paper on Communication written by Dr Ebrahim Mulla. This was one of the three key LMC developments identified at our last away day. After discussion we agreed to all 17 recommendations, and the LMC will present these to constituents once we have worked through the practicalities.

It was Dr Praveen De Silva's (ST3/Resident Doctor Representative) last meeting. He was thanked for his contributions and presented with a gift.

The LMC has received three nominations for his replacement Registrar/Resident Doctor to join the LMC Board, and the ballot will be circulated to all LLR registrars soon. In line with previous agreement, this will be the first election using Single Transferable Voting (STV).

As a reminder, any GP, Registrar or Practice/PCN Manager in LLR can attend and observe at an LMC meeting. Contact the LMC if you are interested.

Return to top of letter

2. UHL GALA AWARDS EVENING.

Once again UHL has kindly offered to host an award for general practice at their evening extravaganza award ceremony on the evening of Friday 3rd October at Athena Leicester, Queen St, LE1 1QD.

Nominations can be made by any general practitioner, practice or other manager, member of practice staff, or patient. The award will be to recognise the "GP who has made the greatest positive impact on General Practice in LLR in the last year."

Last year's winner receives their award.

The nominator will need to provide a supporting statement of up to 300 words, which should indicate how the nominee has fulfilled one or more of the following criteria:

- Provided leadership to general practice.
- Developed new service(s)
- Supported the development of general practice.
- Supported diversity, inclusivity, and/or health equality.

Nominators should include specific example(s) of how the nominee has achieved one or more criteria, and what impact it has had.

The closing date for nominations is **Monday 28th July 2025**. UHL will arrange shortlisting, and the three shortlisted nominees will be invited to attend the award ceremony with their nominator where the winner will be announced and presented with an award.

This is a great opportunity to celebrate a colleague whose great work has gone unrecognised.

If you have any questions, please contact the LMC.

Return to top of letter

3. NHS 10 YEAR PLAN.

After an exceedingly long and painful gestation the NHS 10 Year Plan has arrived. It has various targets in it, the longest being for 2040.

As an aside the plan was launched with lots of buzz and press releases without the actual document being shared with anyone (not even the press). This modus operandi was started by other recent governments, as it means that the only 'story' available is the government one, and they have full control of the narrative with no possibility of any challenge. I had hoped that this government would be more transparent but plus ca change.

There are other sources that are worth looking at to understand the content and potential effects:

- Podcast by Katie Brammall-Stainer
- BMA
- RCGP
- The Kings Fund
- GP Online Podcast
- Pulse Today

I have read all 168 pages and am going to add my own summary and views. I do not cover everything in the plan, just the parts that I feel are most pertinent to general practice and other areas of interest. Overall, the plan is like the Curate's Egg – good in parts.

As many of you know (newsletters passim) I have been around for a bit now – my first job in management in a Regional Health Authority was in 1993. General Practice has survived multiple reorganisations. The fundamental basics of a GP providing holistic longitudinal care with continuity to a registered list of patients has existed since the National Insurance Act 1911 (which also established Local Medical Committees). Indeed, I have heard independent contractor general practice being referred to as the Cockroach of UK Healthcare- does not matter what is thrown at it, it will continue to survive.

The plan is designed to deliver the three 'shifts' previous announced by the government:

- Shifting from hospital to community
- Shifting from analogue to digital
- Shifting from sickness to prevention

I will divide my commentary into:

- The Good
- The Bad
- The Ugly
- I never knew that
- What were you sniffing Wes?

THE GOOD

Decommissioning of poorly performing providers. You may think this is odd for an LMC to support, and this could also be included in the Ugly section. The context is crucial. If a practice is poorly performing, they have the ICB and CQC on their backs already. The latter has quite happily closed practices in LLR with minimal notice. However, regardless of how bad hospitals and individual departments are – when was the last time you heard of one being closed? When working for an RHA and then NHS E I was party to closing hospitals and services who were either persistently underperforming or so unsafe that they should not be allowed to continue. Currently the worst-case scenario is a slap on the wrist by CQC and perhaps a change in Chief Executive. The plan says there should be a lower threshold and quicker path to closing poor units. Of course, there is a risk that this is overused to eliminate smaller partner-run practices.

Carr- Hill formula. The plan recognises the inverse care law is still alive and kicking. It refers to the areas of highest need having the lowest number of GPs. It also recognises that the Carr-Hill Formula needs replacing. However, it does not join the dots in that the reason partnership is currently less attractive is due to ongoing underfunding and increased micromanagement and bureaucracy. What is needed is a reinvigorated GP contract increasing funding, respect, and job satisfaction. To quote from Field of dreams "If you build it, they will come." Incidentally, the Health Foundation is inviting some practices to participate in an independent review of the local Health Equity payments. If approached, please consider taking part as this will not only be your chance to feedback your views of the local scheme, but the evaluation will feed into national discussions about the replacement of Carr-Hill.

A New Era for General Practice. The plan recognises the current patient dissatisfaction with GP services., It promises increased capacity with "thousands" more GPs, reduction in bureaucracy, and roll out of AI technology including scribes. It promises that those who need it "will get a digital or telephone consultation the same day." What, of course, it does not say, is neither how are practices going to see increased funding so they can employ these additional GPs, nor how will the necessary increase in premises be funded.

The Plan recognises the significant importance of **public health and social factors** on health. For example, it proposes a 'Start for Life' programme for all communities and better partnerships with schools etc. It refers

to the Tobacco and Vapes Bill which will mean that children turning 16 this year will never legally be sold tobacco.

Improved support for roll out and implementation of **new technologies** is promised. I hope that this will be implemented, as improvement in technologies too often has been due to GPs just doing it instead of central leadership. This should avoid a repeat of the current 'wild west' of IA scribes (newsletters passim) caused by lack of central leadership and support. Why is every practice having to develop their own DPIA, DCB0160 etc? The only response by the centre has been an unhelpful nannyish guide by NHS England and a letter from the national CCIO telling us all off.

Further development of the **NHS App** to be the single portal to hold patient information and to be able to order repeat medications and to request and arrange appointments will be helpful to patients and practices. This was how the App was originally envisage, although when I met the NHS App team in 2018 with a colleague (their team looked like they had an average age of 12), we had to dampen their enthusiasm and create a list of what was achievable then, and what would have to wait for, mainly secondary care, technology to catch up. But this will need the DHSC to mandate suppliers to enable the App to be used as planned (compare with the report in last month's newsletter about how TPP decided that information from SystmOne practices would be displayed differently). The Plan then spoils it by claiming that the NHS App "will give everyone the knowledge they need … to ensure there are always 2 experts in every consulting room."

Genomics. I was not sure which heading to put this under. There are plans to increase genomics for both newborns and adults. The advantages are better targeting of preventative and effective treatments. If badly handled the disadvantages will include people living under the cloud of high risk of a non-preventable serious illness all their life, significantly increased insurance premiums, unable to ever have a mortgage, and widening health inequalities.

Cherry picking. They state that they will not tolerate this (as happens at present) or other 'gaming' by independent providers.

Power. The plan states that power will be pushed out to local systems and providers. This would be good if it happens. However, the first negative Daily Fail or other headline is likely to cause politicians to reverse this.

CQC. The plan envisages that in future CQC visits will be determined by the outcome of AI driven data. If the indices are ones truly in the control of the practice, that it considers different demography, that the first contact will be to ask the practice whether they are aware of the cause the difference, if they have plans to rectify then this should be beneficial. As mentioned before (newsletters passim) you cannot inspect quality into a system. The only downside is that they plan to continue routine inspections every 3 to 5 years as well, but I hope that once the new system is embedded the routine visits are phased out as they will no longer be needed.

They promise to completely reform **mandatory training**. I would ask that one of the first to look at is the Oliver McGowan training which is OTT and unhelpful for most GPs.

Medical training is going to get an overhaul, they say they will learn from the Leng review about introducing other staff groups to clinical teams, and prioritise UK medical graduates for foundation year posts, and prioritise medical graduates together with other doctors who have worked in the NHS for a 'significant period' for specialist training posts.

Single National Formulary. If there is a strong/majority general practice voice when drawing this up nationally it will take away every area developing and maintaining their own local formularies which at times seem to be dependent upon how forceful secondary care colleagues can be in promoting a specific drug and trying to dump responsibility onto general practitioners because it is more convenient for them.

A review of the rising legal costs of **clinical negligence claims**. Having experienced the current scheme from both sides it only appears to work for the lawyers. I hope that the outcome may even be the adoption of a no-fault compensation scheme like that in current use in New Zealand (and even for some specialities in some parts of the USA).

THE BAD

The plan is extremely light on **general practice**. It regularly makes sweeping statements about the NHS where it actually means hospital and not general practice. When reading it I found myself shouting at the plan 'not in general practice's name.' One example is that it repeatedly refers to productivity plummeting without any recognition that this does not apply to general practice which has demonstrated significantly increased productivity – for example the number of GP appointments in England increased by so much in May 2022 (15%) that it had a significant effect on Gross Domestic Product.

Personal Health Budgets. The plan envisages that by 2030, 1 million patients will have a PHB. In theory this places patients in the centre of their own care with more control. In reality the NHS is (should) be funded for the average cost of the care of a patient. With a PHB, if underspent patients will be looking at how to spend up to their budget. If overspent the NHS promises that no one will be without care so they will still provide care.

Contracts for **Neighbourhood Providers** (approx. 50k Population) and multi-Neighbourhood Providers (approx. 250k population). The NHS already has Neighbourhood providers - they are called general practices. If they reversed the starvation of investment and support, then once again, we could all host other services in our premises. These providers will also be able to hold contracts for general practices, which will be in competition and possibly undermine other local practices. This was tried before with PCTMS, PMS (with initial bribes), APMS etc, none of which have gained traction.

The concept of **Neighbourhood Centres** mirrors Alan Milburn's previous dalliance with the same policy before (Darzi Centres) which failed due to poor understanding of general practice, patient wants, and willingness to invest the significant amount of money needed to pump prime them.

THE UGLY

A repeated idea is the development of a **Single Patient Record** (SPR). This is not the first government to have this brainwave, and in the past, when involved at a national level, we have been able to see it off.

You can see the attraction to patients (many of whom believe this is already the case), and managers. The reasons why it is a bad idea include:

- **Curation**. The reason everyone is so interested in general practice's records is that we carefully curate them – constantly protect them from incorrect diagnoses, ensure important concepts are coded correctly etc. A few years ago, we had a sudden increase by a dozen in patients with SMI. Probably an indication of our flock, but this was because the prison system had changed their initial health consultation template, which added the code 'psychotic illness' with a free text of yes or no, and this was being written into our SystmOne Unit. Putting aside the incompetence of the person who had created the template, this caused significant additional work, contacting the prison service and asking them to correct each record individually. If there was a SPA, then who would be responsible for maintaining the record?
- **Quality payments** (QoF/IIF etc). If we are going to continue with any quality or performance related payments it is imperative that this is from information within the full control of the practice. It would be inappropriate for practices to lose funding due to incorrect data added by another organisation.
- **Confidentiality**. Patients will only provide GPs with their most private or embarrassing information if they have confidence that the information is only accessible to their GP. Once people know that their single record is accessible to Uncle Tom Cobley and all, they will withhold information that we need to do our jobs. If a struggling single-mum knows that their record could be accessed by Social Services, are they likely to still be as open with their GP about their problems?

- **Data controller/Medicolegal**. A unified record would require the status of Data Controller to move from the practice to someone else (probably the SoS). Although many practices would see this as being a positive move, my own personal view is that I want to retain ownership and control of my patients' data. I do not want others having constant ability to change/update/delete the record. Whilst I would presume that an audit trail would apply, I suspect that patients and others will assume what they see when accessing the record is the whole truth.
- **Wood for trees**. This of us who are suffering from SystmOne sharing will know the disadvantage of having a record with large swathes of entries by community and other staff. Intermittent admissions requiring ITU stays could make it difficult to spot the background trends in eGFR etc.
- **Patient safety**. All the above result in reduced patient safety.

Although better designed software and the use of IA could ameliorate some of these problems, they will not overcome the 'human factor' with related errors. I hope that they will come to appreciate the many downsides to a truly single patient record. Their aims could also be achieved by improved interoperability with the ability to view different records in a combined view or alongside. This is the aim of the Local Health and Care Record programme which has been under development for almost a decade at significant cost to the NHS.

Patient Power Payments. The concept that funding for NHS organisations will be based at least in part on patient experience seems superficially attractive. For hospitals covering a large diverse area it may actually work as planned. However, if general practice was included it would result in downward spiralling of practices, particularly affecting those providing services to deprived populations. Practices in more deprived areas received lower levels of funding, and patients from more deprived areas tend to be more negative about their practices. We know from LLR data that there is a direct correlation between the amount of funding a practice receives and patient satisfaction. Combined with the proposal that CQC should have a lower threshold for closing failing practices this is likely to mean that young GPs are highly unlikely to join a partnership with an inner-city practice. Also, the 'I pay your wages' brigade may in the future be in the position of being able to actually reduce your income – so sick notes, antibiotics, benzodiazepines, and opiates for everyone!

Selling patient data. The plan openly says that they will gain 'commercial value' from access to anonymised data. At least this is more honest that the Care.Data programme when the DHSC was stating that data was not being sold at the same time as providing a 'price list' (which 'someone' very inconveniently shared with one or two journalists). The other issue about Care-Data was that the data was anonymised and not aggregated which meant that using a jigsaw approach knowing one or more health reference points you can identify individual records (for example a researcher on behalf of a newspaper was able to correctly identify Tony Blair's complete medical record). The ability to protect data has improved, but the involvement of the company Palantir does noy instil confidence.

I NEVER KNEW THAT

More than a quarter of the population now have at least one long term condition and now account for 65% of NHS spending. We are aware from local data that the number of patients with multiple LTCs has increased by 14% since 2019.

The plan reports that approximately 1.5million people in England are purchasing Mounjaro or Ozempic privately (2.2% of the adult population)!

We all know that excessive alcohol consumption is harmful, but were you aware that the estimated societal cost of alcohol harm in England was £27.4 billion per year (1.2% of GDP) and that 4% of the population drink 30% of the total alcohol consumed?

WHAT WERE YOU SNIFFING WES?

Integrated Health organisations. This is one of the more 'interesting' ideas and the greatest risk to partnership based general practice. This is the proposal that an organisation (most likely an acute Trust like

UHL) will hold the whole health budget for an area – so for secondary and primary care including general practice. Although the 10-year plan laughingly says that a GP could hold the contract, I am more likely to become the next Dalai Lama. The plan says this is based upon HMOs in the USA – a health system notorious for universality of care, developed primary medical health services, and cost effectiveness. The plan picks up on the Darzi report's observation that the pendulum must swing to move funding from secondary to primary care. With Acute Trusts at the helm, it is extremely unlikely that any of this funding will come to general practice but will only be used for community services provided and run by the hospital.

Those of us who experienced the formation of NHS Trusts under the National Health Service and Community Care Act 1990, will understand how much of a terrible idea it is. Initially many Trusts combined acute secondary care services with mental health and community services. Acute hospitals always have been and always will be financial black holes sucking in all the resources available. The lived experience is that these combined trusts resulted in asset stripping of the mental health and community parts by the acute hospital services. Within a truly short time the centre required Trusts to divide into the separate components. Although general practices provide 90% of healthcare for 6% of the budget, hospital boards who spend most of the healthcare budget do not understand what we do, and most consultants have no respect for GPs. This uneven relationship will mean that unless DHSC require the majority of an IHO board to be GPs, the primary care budget will once again be stripped with a view that GPs should be subservient to the needs of the hospital.

Foundation Trusts. The plan re-envisages FTs. These were previously a bright idea of Alan Milburn in 2002 and created by the Health and Social Care (Community Health and Standards) Act 2003. The problem before was that to achieve the necessary financial balance, hospitals cut the only budget that they had easy control over – staffing. This directly led to scandals and patient harm. Although Mid-Staffs Hospital was the only one to achieve notoriety, many other Trusts were in a similar situation. So having failed spectacularly before, one of Wes' bright ideas is to have another go. Those who had sight of draft copies of the NHS Plan advise that there was a final chapter written by Alan Milburn about how the plan would be implemented -this chapter and any reference to Milburn was expunged before the final version was published.

The plan claims that two thirds of hospital out-patient appointments can be replaced by "**automated information**, digital advice, direct input from specialists, and patient- initiated follow ups." Whilst in total agreement that hospitals have much to learn from general practice about how to use information technology more efficiently, the reality is that this will no-where near reduce outpatients by 2/3rds let alone factoring in the cost of consultant time and related increased risk.

The NHS Plan complains that **everything is 9 to 5**. First this is an insult to our colleagues in general practice OOH and the hospital which provides 24 hours per day, seven days a week healthcare. Second, patients overall want routine care during normal 'office hours.' When I am doing Extended Hours in the evening or at a weekend the most common comment I get is why am I contacting them at an inconvenient time. From my own experience I do not want to work a long week and then must attend an outpatient appointment late at night or at a weekend when I need to rest.

The plan lulls you into a false sense of security about how improved digital technology can improve healthcare. It then comes out with the statement "as digital access becomes the norm many patients will get **instant access to a clinician** removing the need to wait for advice or carer." Whilst I would love to be working in a system where we have so much capacity that we could have a clinician sitting around just waiting for a patient to call, without significant additional investment this is not going to happen.

SUMMARY

There is much good in the NHS 10year plan, but also many parts which I hope will be kicked into the long grass before permanent harm is caused to general practice.

Development of Neighbourhood Services should be positive for general practice, promoting flow of funding to primary care and general practice. But the risk that the project is dominated by UHL, and the thinly veiled

threats to partner based general practices (particularly small organisations/those not working to scale) outweighs any theoretical benefit.

The plan is published at a time when Wes Streeting has also promised a revised general practice contract to be developed together with the profession and implemented prior to the end of this parliament. Without a more attractive/supportive contract for partner run practices, the NHS 10-year plan's options for other bodies to run general practices are likely to happen, destabilising traditional general practices.

I hear that there is a cabinet reshuffle coming soon. Expect Wes to retain his position for now, as Keir Starmer will need to lay the blame on him when the 10-year plan does not deliver an improved NHS overnight, I understand that Liz Kendall is a front runner to replace him – so those GPs working or living in her area, please let her know your views.

For any comments or queries click here.

Return to top of letter

4. DEATH PROCESSES.

First a great thank you too all general practices. Although there were some initial hiccoughs, most deaths are now being processed without issue.

There are a few things to note:

1) Before sending an MCCD consider asking an admin person to check for common errors:
    a. Not signed
    b. Contributing Causes of Death enter in part 1(d) completed rather than in part 2.
    c. No contact details given for the GP.
    d. Address included as 'home address' rather than the actual address.
2) When referring to the coroner, please
    a. clearly indicate whether you have discussed with a Medical Examiner, and
    b. attach a summary of the patient record including the last 6 months consultations, past/current medical conditions, and a list of current medications.
3) The ME office has appointed a new Medical Examiner Officer to support community deaths, called Tony. He will not ask you about, nor can he help you with, clinical questions, but he can assist with the process.
4) Professor Peter Furness has retired, and been replaced with **Dr Richard Porter** (Consultant, Intensive Care Medicine) as Lead ME.

For comments or queries please email the LMC.

Return to top of letter

5. BOARD REMUNERATION

The LMC has not revisited the rate at which we remunerate Board members or anyone else working on behalf of the LMC for work done.

In our document 'Fit for the Future' we agreed to clearly set out how different posts were remunerated. With the recent review of our Pastoral services all posts are now handled the same way:

Position	Rate
GP Board Members	Standard Hourly Rate
Chair	Half Standard Session
Chief Executive	Four Standard Sessions[1]
Deputy Chief Executive	Two Standard Sessions[1]
Treasurer	Half Standard Session
GP Pastoral Support Officer	Half Standard Session
PM Board Members	Half Standard Hourly Rate

The Board has agreed the principle that it is important Board members are fairly remunerated for their time.

The rates were last reviewed in 2022, at which time no change was made. There has been no inflationary uplift since then.

The current rates are:

- Standard Hourly Rate: £90.00
- Standard Sessional Rate: £15,000.00

Uplift in recognition of cost-of-living increases:

The Board considered the following options.

Option	Description	Pros	Cons
1	No change	No increase in cost.	Does not recognise inflation
2	Increase in line with Bank of England Inflation Calculator[2]. *New Hourly Rate: £102.00[3]* *New Sessional Rate: £17,061.00[3]*	Recognises inflation.	Does not recognise any increase in complexity/additional work. Increases costs
3	Reconstitute a Remuneration Committee (RC)	Could consider different weights for different roles.	Would take several months to arrange, report, and for LMC and constituents to agree. Cost of attendance at RC meetings, and cost of administrative support.

After discussion, the LMC Board agreed that the second option was the preferred one.

[1] *The LMC Constitution allows up to 6 sessions for a CEO and Deputy CEO. How this is divided is up to the discretion of the CEO, and this reflects the current arrangement.*

[2] https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

[3] Rounded to nearest whole £

Ongoing uplifts

The Board further considered a method to ensure that the rates remain up to date. They considered the following options:

Option	Description	Pros	Cons
1	No ongoing agreement. Any further increase only after proposal and agreement by Board.	Allows decision based upon current situation.	Increased bureaucracy. Requires dedication of Board time on an annual.
2	Increase each year from April by the DDRB recommended increase for Salaried GPs.	Does not require any separate Board time to consider.	Determined by DDRB and factors influencing the salaried GO workforce.
3	Increase each year from April using the Bank of England Inflation Calculator.	Does not require any separate Board time to consider.	Would not reflect if there is any restoration of pay for GPs.
4	Constitute a Remuneration Committee annually.	Would allow a more nuanced local decision.	Cost and additional office work in arranging and paying for the work.

After discussion, the Board considered Option 3 to be the preferred one.

Implementation

We are asking for constituents to advise if they do not feel these rates are appropriate.

The rates can be met out of current income without any need to increase the Levy.

If there are no concerns raised by constituents, the rates will apply from 1st August 2025 (it will not be backdated).

For comments or queries please email the LMC.

Return to top of letter

6. ADVICE AND GUIDANCE ENHANCED SERVICE.

All LLR practices have now signed up to Advice and Guidance.

An Advice and Guidance episode will include using the e-Referral Service **OR** dedicated email **OR** a telephone call. Practices must have a protocol which should include what is in paragraph 6.2.1 of the Enhanced Service. Consider using the SNOMED CT concept '**Choose and Book Advice and Guidance Request**' (820641000000100) to record referrals. Referrals via LUCID are not eligible for the payment under the Enhanced Service.

Practices will receive £20 per episode (i.e. if two A&Gs are sent regarding the same patient and issue, only one fee will be paid).

The amount is capped nationally, and at present the amount being claimed by practices is varying considerably. Please ensure you have a process to make claims in a timely manner each month. If the cap is reached the ICB are not willing to contribute any further funding so the scheme will stop.

The wait for some specialties for A&G replies is excessive – especially for gynaecology. UHL are looking into this, and I have asked the ICB to circulate the current response times for all specialties to practices.

Community Investigations. The consultants at UHL do not have access to the results carried out by community providers. This includes Echocardiograms, Spirometry, 24 Hour Blood pressures, ECGs etc. ***Please remember to attach these results separately to an A&G request***.

As an additional reminder, the ERS service enables a referrer to preauthorise the provider to convert an A&G request to a referral, and we would recommend that practices tick this on the ERS referral as default. In addition, the purpose of A&G is NOT to allow inappropriate transfer of work from hospitals to practices. We therefore recommend that you consider adding the message below to each A&G request. Also, if you are requested to refer a patient despite preauthorising conversion from A&G to a referral, OR you receive an A&G expecting your practice to do work that would normally be considered to secondary care, please raise via TCS, and consider letting the LMC know (anonymised only).

The purpose of Advice and Guidance is not to act as a method of transferring hospital work to general practice, and we ask you to respect this.

This A&G request includes preauthorisation to convert it to a referral. If your advice is that the patient needs to be referred, please convert without sending back for the practice to do this.

For comments or queries please email the LMC, but please note that the LMC cannot provide HR advice.

Return to top of letter

7. PHARMACY FIRST – INCORRECT CODING OF PREGNANT PATIENTS.

NHS England has declared a 'major incident' following reports that some GP records recorded that a patient is pregnant when they were not.

Codes indicating pregnancy have been filed in those records, generated by Pharmacy First as 'structured messages' (i.e. messages with codes built in, similar to lab reports), using a new module called Update Record (part of GP Connect).

Initial investigations suggest that the technology is operating correctly, but users in pharmacies had incorrectly recorded pregnancy.

Approximately 16,000 patients were recorded as pregnant, and investigation to establish which records are false is underway, to allow correction.

It is not yet clear whether it is being investigated how many patients were recorded as 'not pregnant' when they are were.

Many practices have been partially protected because they have not enabled Update Record. They may have however have correctly transcribing the incorrect information, reproducing the error.

The Joint GP IT Committee has been expressing concern about the quality of codes used in the Pharmacy First messages for almost 2 years.

At present the GP Connect Functionality to enable direct writing is not mandatory but will become so from 1 October 2025

At present, practices should make all clinicians aware of this error and be vigilant especially when prescribing.

This is a prime example of why a Single Patient Record (see section on NHS 10-year plan) could increase patient safety risk and decrease accuracy of records.

For comments or queries please email the LMC.

Return to top of letter

8. PODCASTS.

The LMC is developing a library of Podcasts.

The main Podcasts are monthly roundups based on the newsletters, but the library will be expanded to include interviews with other local people important to general practice.

Featured Podcast

- 2025 05 21 Interview with Louise Pinder, HM Senior Coroner, Rutland, and North Leicestershire.

Monthly Podcasts

- July 2025 LLR LMC Podcast
- June 2025 LLR LMC Podcast
- May 2025 LLR LMC Podcast
- April 2025 LLR LMC Podcast
- March 2025 LLR LMC Podcast
- February 2025 LLR LMC Podcast
- January 2025 LLR LMC Podcast (Long Version)
- January 2025 LLR LMC Podcast (Short Version)
- December 2025 LLR LMC Podcast

Other Podcasts

- 2025 03 05 BBC East Midlands Today re Migration
- 2025 07 08 NHS 10 Year Plan Dr Katie Brammall Stainer

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

Return to top of letter

9. UPCOMING LMC EVENTS.

The LMC has started to confirm its events schedule for 25/26 and are pleased to announce the events below are confirmed. Please book early to avoid disappointment.

Friday 18th July 2025, 1pm to 2pm.

LMC online seminar with CQC on MHRA alerts

The LMC meets regularly with the CQC to discuss different topics and themes around inspections, as well as any changes locally and nationally which might have taken place and have an impact on LLR practices.

We have been fortunate to have the local CQC inspectors to deliver face to face events for our members, and for the people that attended will be aware that MHRA alerts remains a consistent area of challenge for CQC when inspecting.

Our local inspector, Vanessa Twigg has agreed to deliver a focused online seminar for LLR practices on MHRA alerts. This will go through what CQC looks for in this area, what good looks like and address any questions/myths or concerns.

Target Audience:	Partners, Practice Managers, Practice Pharmacists
Date:	Friday 18th July 2025
Venue:	Remote by MS Teams
Time:	1.00 – 2.00pm
Speakers:	**Vanessa Twigg,** Inspector, Care Quality Commission

Wednesday 25th July 2025, 1pm to 2pm.

Is your Partnership Agreement up to date?

What you need to know about Partnership Agreements.

If you have answered 'no' to the above, it might be beneficial for you to attend the above LMC online seminar. The LMC recognises the importance for practices having a well drafted and up to date partnership agreement. As a result of this, we are pleased to confirm that we will be hosting a lunchtime online seminar on Partnership Agreements for practices of LLR to attend. The session will be presented by Daphne Robertson, Dr Solicitors on Wednesday 25th July, 1.00 – 2.00pm.

Partnership Agreements – what you need to know:

- Why a deed is so important and how to ensure it is valid.
- Key clauses in a well drafted partnership agreement
- Common issues/pitfalls
- Dispute resolution
- Q&A

Target Audience:	GP and other Partners, Practice Managers, anyone considering partnership.
Date:	Wednesday 25th July 2025
Venue:	Remote by MS Teams
Time:	1.00 – 2.00pm
Speakers:	**Daphne Robertson,** Founder and Senior Partner, DR Solicitors

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

Wednesday 30th July 2025, 1pm to 2pm.

Understanding Notional Rent Reviews & Improving Property Webinar

The LMC will be hosting a lunchtime online seminar on Notional Rent Reviews & Improving property.

The Notional Rent Webinar – Your Expert Guide – is designed to help practices gain a thorough understanding of the entire Notional Rent review process. How to ensure your practice receives the correct rent and ways in which you can increase your practice's reimbursement. This online seminar will provide valuable insights that can be utilised by both Partners and Practice Managers. There will be many opportunities to ask questions throughout the session, with plenty of time allocated at the end for discussion.

Agenda

- Changes under the Premises Cost Directions 2024
- The facts about Notional Rent Review deadlines in figures letters (CMR 6s).
- How Notional Rent is calculated.
- Your CMR 1 Form – avoiding potentially costly mistakes.
- Checking your Notional Rent figure is correct.
- How to challenge your Notional Rent figure.
- Common discrepancies in Notional Rent valuations.
- Improving practice property and abatements.

Target Audience:	Premises owning GPs and other Partners, Practice Managers, anyone considering buying into GP premises.
Date:	Wednesday 30th July 2025
Venue:	Remote by MS Teams)
Time:	1.00 – 2.00pm
Speakers:	**Rebecca Reynard** Director of Agency and Sales, GP Surveyors

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

Tuesday 9th September 2025, 1pm to 2pm.

Succession Planning & Partnership Change Webinar

The LMC will be hosting a lunchtime online seminar on Succession planning & Partnership change.

The GP Property & Partnership Change online seminar is designed to assist practices undergoing or anticipating partnership changes. This online seminar is tailored for practices owned or co-owned by partners and is ideal for current Partners, GPs considering joining partnerships, and Practice Managers responsible for managing partnership changes. Participants will leave the session with a solid understanding of the crucial factors in managing partnership changes, how to identify potential issues and available solutions.

Managing partnership change

- Partnership agreements
- Property at partnership change
- Valuations – buying in, cashing out & avoiding disputes.

Succession planning and property

- Identifying potential issues
- Finding the right solution for the practice's circumstances
- Leases – the key considerations
- The importance of an NHS approved lease.
- Sale and Leaseback.

Target Audience:	GP and other Partners, Practice Managers, anyone considering partnership.
Date:	Tuesday 9h September 2025
Venue:	Remote by MS Teams
Time:	1.00 – 2.00pm
Speakers:	**Rebecca Reynard** Director of Agency and Sales, GP Surveyors

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

Return to top of letter

10. ADVERTISE YOUR JOB VACANCIES FREE WITH THE LMC.

The LMC continues to advertise vacancies associated with General Practice/PCN in LLR – this is a free service for LLR practices, and we hope extends reach outside the usual mailing groups.

The LMC regularly receives **negative feedback** about adverts on the LLR global Listservers, so we would encourage everyone to use the LMC facility instead.

This platform is open to everyone to view; including the public, and other organisations who may be interested in reviewing the vacancies.

All we require is the relevant details relating to the vacancy e.g. advert and any supporting information you wish to be included like Job Description, person specification, how to apply and a contact person for role.

To advertise please email the LMC.

Looking for a role? All our open vacancies are available -click here.

Return to top of letter

11. AVAILABLE TO WORK

There is an increasing workforce crisis in General Practice, with many GPs unable to find a job or being underemployed.

The LMC has been continuing to spread the word on our local 'Available to Work' initiative. This is a free service which is open to LLR practices and GPs, Nurses and Practices and allows clinicians/practices the opportunity to share:

- availability of locums (GPs, practice managers, nurses)
- details of people looking for a more substantive post with LLR practices e.g. salaried GP, Salaried with view to partnership.
- to provide practices with details that could potentially fill such roles.

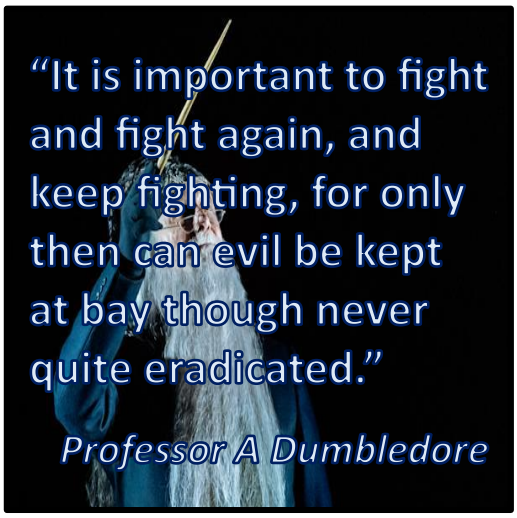
It is important to note that, the LMC does not endorse any adverts for vacancies (GP, PM, or Nurse), availability or opportunities which have been included on our website, and it remains the responsibility of interested parties for conducting relevant checks.

- FOR INDIVIDUALS: I am an individual who is available to work and wish to share my details with interested LLR practices
- FOR LLR PRACTICES: I am a LLR practice looking for role to be filled

Return to top of letter

12. FINAL THOUGHTS

Soon after achieving office the current Labour Government commissioned a report from Lord Ara Darzi. The findings included that the transfer of funding from Primary Care/General Practice to Hospitals should be reversed and that the GP Partner model provided the best financial discipline in the health service. On top of that whereas productivity in hospitals had plummeted it had significantly increased in general practice – so much so as to have a positive effect on GDP. Over and over, general practices have demonstrated that, as small organisations, we can be more nimble in adopting change and adapting to situations. The fantastic work that practices achieved to continue providing a health service during the Covid epidemic was testament to this – and that instead of practices picking up the scraps that the large vaccination sites had been unable to reach as the government thought would happen, GPs ended up delivering the lion share of Covid vaccinations.



With this in mind you would have thought that the long awaited 10 year plan would praise general practice and set out how it could be bolstered and rejuvenated.

But Wes Streeting and his mates hate general practice. Before the general election, Wes stated that he wanted to tear up the GP contract and force us to become ~~indentured slaves~~ salaried GPs, working from 'modern health centres.' He seemed to have no clue that GPs do not choose to work from dilapidated premises unfit for modern requirements but that we are forced to do so due to decades of under investment. I am advised that 120 of the 127 practices in LLR have indicated that their premises need improvement.

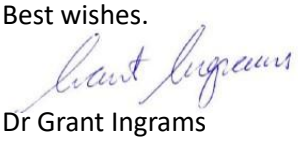
I do not fully understand why Wes, senior managers, commentators, and Gary who works in my local chippy all believe that general practices are inefficient outdated organisations that should be swept away. The evidence is the complete reverse.

So when the 10 year plan landed in my inbox I read anticipating that it will lead to a turn around of GP fortunes, but it does not. It refers to general practices working to scale, a lower threshold for failing practices to be closed, and that anyone else should be able to run general practices. It grudingly says "where the traditional GP partnership model is working well it should continue," although even this it is spoiled by continuing "but we will also create an alternative for GPs. We will encourage GPs to work over larger geographies by leading new neighbourhood providers."

So, Wes, you are chosing to move away from small, nimble, financially prudent, productive organisations to what? Well the 'big idea' appears to be, moving practices to Integrated Health Organisations run by Foundation Trusts – ie the part of the NHS where productivity has plummeted and despite funding soaring is constantly in deficit. We should also not forget that the previous daliance with Foundation Trusts led directly to the mid Staffs scandal (and similar situations in many other hospitals).

Wes, your vision will also kill the concept of 'the family doctor' that you say you want patients to experience, and the benefit of continuity of care that has been repreatedly proven to provide the highest quality, lowest cost healthcare. Your big idea is set to fail, and will never work as you have done nothing to engage those of us who provide 90% of healthcare for 6% of the budget. This is a shame as there are many good ideas in the 10-year plan that should be implemented.

Best wishes.



Dr Grant Ingrams
Chief Executive Officer, LLR LMC
Grant.Ingrams@llrlmc.co.uk