NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

LOCAL LEICESTERSHIRE MEDICAL COMMITTEE LEICESTER RUTLAND

February 2026

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

Dear Colleagues

LLRLMC NEWSLETTER

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

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

FEBRUARY PODCAST
GRANT INGRAMS, FAHREEN DHANJI AND CHARLOTTE WOODS IN CONVERSATION
(32 MINUTES)

SUMMARY OF THIS MONTH'S MUST DOS:

- Sign up for LLR LMC annual awards and AGM gala evening with celebrity guest
- Ensure your practice Safeguarding Admin Lead has signed up to the LMC Event
- Print out revised MCCD guidance and keep in your MCCD book for easy reference
- Check whether your practice is charging for what it can
- Consider our advice regarding Joy Connect before turning back on
- Is general practice as we know it close to extinction? Listen to the GPC E Podcast

Topics in this newsletter:

1) LMC Meeting February 2026
2) Death Process and MCCD - UPDATE
3) LPT Write to SystmOne
4) LMC is on the move
5) Increase in Voluntary Levy
6) What can practices charge for?
7) Delayed letters from Derby Hospital
8) LLR Shared Care Record and ReSPECT form
9) Transferring Care Safely (TCS)
10) Clinical Bed Bureau
11) Government Neurodiversity Survey
12) Immediate Removal of Violent Patients and SAS service
13) Awards Ceremony and AGM
14) Joy Contract Management Service
15) Employment Rights Act 2025
16) Non-Maternity Group B Strep Result
17) GPC E Update on Neighbourhoods and the future of the GP Contract
18) GP Member of ICB Board
19) Podcasts
20) Upcoming LMC Events
21) Advertise your Job Vacancies Free with the LMC
22) Available to Work
23) Final Thoughts

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

STOP PRESS
See Final Thoughts for our initial summary and comment on contract changes for 2026/27

1. LMC MEETING – FEBRUARY 2026.

The LMC Board met on 11 February 2026. Gang Xu (Medical Director, UHL) attended on behalf of UHL, and LMC members raised with him:

- **Dexascan results** – initial message still being sent via Pathlinks, even though it does not include the result, and practices are reporting that patients see this via NHS App and presume that full result is available. The LMC has asked for this message not to be sent (only the final full result).
- **Duplicate letters** – this is causing significant additional admin work for practices. One practice informed the LMC that it is costing them £1,500 additional per month. There appears to be multiple causes, and the LMC will work through these with UHL. It is planned to turn off all hard copies being sent very soon.
- **Badgernet.** In addition to practices not being informed when a patient is pregnant as we highlighted last month, where letters are generated, these can be sent multiple times. Each time a midwife updates a letter, another copy is sent to the GP. ON one occasion a midwife had ended up sending 8 versions.
- **Delayed letters from DVT clinic**. Gang reported that this problem has now been solved.
- **Colonoscopy.** The board raised two issues. The first that the report now contains pictures, leading to longer and multiple documents for the same procedure increasing practice workload and that biopsy results are being recorded in the GP's name. Gang advised that there had been problems with the software which are being resolved.
- **Unsent Letters**. Gang reported that there was a backlog of 11,000 unsent letters from 2024. These have been reviewed and the board were advised no patient safety concerns had been identified. The plan is not to send these to practices. Going forward the board were told that there is now a robust/automated review process which identified any letter not sent within 2 weeks of creation.

The LMC Board discussed other issues including:

- **Letters from LPT on SystmOne**. Tanya Hibbert and Sam Harmer attended on behalf of LPT. Details as per here.
- **Hepatology referral pathways**. Dr Toby Dellahooke (Consultant Hepatologist) attended. We discussed the various concerns raised by different practices about the pathway. Dr Dellahooke explained that if the screening tests were done in advance the patient can be sent to the right clinic first time. The LMC advised that this would only be acceptable if there was a very easy way of requesting the tests. It was agreed that Dr Dellahooke would liaise with biochemistry and the Sunquest ICE team to ensure the single tick process on ICE resulted in the tests being done that hepatology need.
- **Clinical science team**. Dr Ginny Lee attended and heard about concerns reported by GPs. She apologised for recurrent issues related delays or multiple results being sent to practices. She advised that this was due to a third-party application provided by Keystone Software Company. The recent issue with repeat results being sent was due to a mistake Keystone and not UHL, and they have raised this with them so it will not happen again.

ANY GP, GP REGISTRAR, OR PRACTICE/PCN MANAGER IN LLR
CAN ATTEND AND OBSERVE A MONTHLY LMC BOARD MEETING.
CLICK ON THIS BOX IF YOU ARE INTERESTED

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2. DEATH PROCESS AND MCCD - UPDATE.

There have been some changes to the Death Process and processing of MCCDs. These are included in the updated LMC guidance which can be found here. The lead Medical Examiner for LLR is now Dr Richard Porter. There has been a change to some of the telephone numbers, and these are now as per the revised guidance.

The ME service reports ongoing confusion about when a patient can be certified as dying of OLD AGE. The revised guidance includes the national guidance which is:

Avoid 'old age' alone

Old age, 'senility' or 'frailty of old age' should only be given as the sole cause of death where all the following circumstances apply:

- the deceased was over 80 years old
- you have personally cared for the deceased over a long period - this is difficult to define, but we would suggest at least several months
- you have observed a gradual decline in your patient's general health and functioning
- you are not aware of any identifiable disease or injury that contributed to the death
- you are certain that there is no reason that the death should be reported to the coroner

You may mention old age or frailty as a contributory cause, especially if it explains the severe effect of a condition that is not usually fatal.

You should also be aware that the representative of the deceased may not regard old age as an adequate explanation for the death and may request further investigation.
It is unlikely that patients would be admitted to an acute hospital if they had no apparent disease or injury. It follows that deaths in acute hospitals are unlikely to fulfil the conditions above. You can specify old age as a cause of death, but you should also mention in part 1 or part 2, as appropriate, any medical or surgical conditions that may have contributed to the death.

Example 6

Part	Disease or condition	Duration
1a	Pathological fractures of femoral neck and thoracic vertebrae	1 day
1b	Severe osteoporosis	10 years
1c	Old age	
2	Fibrosing alveolitis	15 years

Or

Part	Disease or condition	Duration
1a	Old age	
2	Non-insulin dependent diabetes mellitus, essential hypertension and diverticular disease	5 years

While there is no statutory age limit or restriction on referring to 'old age', a death certified as due to old age or senility alone will usually be referred to the coroner unless all the conditions listed above are fulfilled and there is no other reason that the death should be referred. Similar terms, such as 'frailty of old age', will be treated in the same way.

The ME office requests that if a GP needs advice that they send an email first giving details of the deceased patient, the concern/question, and when the GP would be available and how, so the staff can be prepared for the call and ensure an ME is available.

The ME service currently processes 74% of MCCDs sent by GPs are processed within 3 days, with a target to reach 80%. This reflects that some cases are complex requiring large sets of notes to be considered etc.

For any comments or queries click here.

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3. LPT WRITE TO SYSTMONE.

In last month's newsletter we included details about the ongoing patient safety issue due to letters being written and visible on SystmOne but not formally sent so practices are unaware that the letters are there.

The day that the newsletter was circulated, the LMC received multiple calls and emails from the ICB and LPT regarding this. I would like to thank those practices that supported the LMC by taking action.

Tanya Hibbert and Sam Harmer attended on behalf of LPT attended our February 2026 LMC meeting and presented proposed solutions.

We are now working closely with LPT, and we are now close to resolving this patient safety issue that has been known about for at least 8 years.

Their current proposal is to change their processes so that letters will not be visible on GP SystmOne units until they have been sent to the practice.

Since the board meeting, we have been disappointed to hear that some practices have been contacted to try and pressurise them to restart sharing with LPT. The LMC has advised LPT that this behaviour is inappropriate. If your practice is contacted in this way, please let the LMC know.

For comments or queries please email the LMC.

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4. LMC ON THE MOVE.

After years of being kindly hosted by Glenfield Surgery we are on the move.

The current office only has room for two desks and there is no meeting place. When I visit the office, I must stand in the corner!

From 1st April 2026, we are moving to new premises at the DOCK, Space City, 30 Exploration Drive, Leicester LE4 5JU.

This will allow the LMC to expand as we provide more services, allow meetings of the management team, and with constituents. The space also has room for LMC Board meetings.

Due to savings made on using Hotel Business Meeting rooms for regular board meetings and catering costs, the monthly cost will be the same as we are paying currently. The board has agreed a one-off budget of £10,000 for purchasing furniture and other fixtures and fittings.

For comments or queries please email the LMC.

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5. INCREASE IN VOLUNTARY LEVY.

LMCs are funded via what is termed as a statutory levy. I recently asked other LMCs what their levy was. Of the 75 LMCs in England, only 9 replied. The range was 27 to 61 pence per patient with an average of 44.1. The current LLR LMC levy is below average at 42p. As previously reported, we continue to run with a surplus so there is no plan (or requirement) to increase this.

In addition to the statutory Levy, the LMC raises a voluntary levy which they pass onto the General Practitioners Defence Fund (GPDF).

There have previously been significant concerns about how the GPDF was run, which we first reported in our November 2022 newsletter. In our December 2024 Newsletter, we reported that the GPDF had been turned around with a change in directors, ethos and governance processes. In addition, the voluntary levy was reduced from 6p per patient to 3p per patient as a short-term measure to reduce the excessive reserves from £17million to £10million.

The reserves have now been reduced, and the GPDF board have agreed to increase the levy to 5p per patient from 1st April 2026.

The GPDF was originally created to support the work of the GPC. Although they still do this in 2018 the GPDF changed to divert some funds to support LMCs. This has been increased over time, and your LMC (like all others) now depend on this funding for our day-to-day work. It includes funding: the LMC Support Network; yearly LMC conference; a dashboard that collates information from various national databases into one that can be interrogated at LMC or even individual practice basis; and support for legal help where a local issue could have a national impact.

Your LMC Board agreed to support the change in levy which is still lower than before 2024. Dr Amit Rastogi (Board member, Treasurer) represents your LMC's view on the GPDF.

For comments or queries please email the LMC.

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6. WHAT CAN PRACTICES CHARGE FOR?

Whether or not a practice can charge for a service is a common query we receive in the LMC Office. Although sometimes these may require individual consideration, GPs and Practice Managers should be aware of the main guidance.

When Can I Not Charge?

GMS Regulation 24 (but this is the same for all Personal Medical Services contracts whether GMS, PMS or APMS) says that "the contractor either itself or through any other person demand or accept from any of its patients a fee or other remuneration for its own benefit or for the benefit of another person in respect of":

- Provision of any treatment (even if not under the contract)
- Prescription for any drug, medicine or appliance (except as per Regulation 25)
- A Debt and Mental Health Evidence Form (DMHEF) (including any examination needed to complete the form)

Providing a medical certificate as listed in Schedule 2:

- Relating to incapacity to work, claiming state benefits or proxy to draw pensions (the schedule includes a long list of other legislation related to this)
- Registration of a still birth
- To enable payment relating to a mental disorder
- To establish unfitness for jury service
- Support late application for reinstatement or non-availability to take up civil employment for a member or reserve member of armed forces.
- To enable person to be registered for postal or proxy voting on grounds of physical incapacity.
- Prescription exemption certificate
- Council Tax Exemption for a Severely Mentally Impaired person. TIP: This is one that practices frequently get wrong.

Providing a report to a coroner about one of your deceased patients.

When Can I Charge?

Regulation 25 specifies when a contractor can charge (please read in full via link), and in summary covers:

- From a statutory body for services rendered for the purposes of that body's statutory functions. **TIP**: Make sure your practice has a process in place for invoicing the ICB for safeguarding work, including the provision of safeguarding reports and attendance at safeguarding conferences. See LMC guidance regarding how to charge.
- A routine examination and/or opinion for a school, employer or another body who is responsible for the patient's welfare.
- For treatment where the contractor is providing services as a specialist working for a hospital which is not covered by the contract and given at accommodation for private services or a registered nursing home.
- Section 158 of the Road Traffic Act 1988. **TIP:** Practices should have a system to identify when a patient is asking for examination after an RTA and they have not been examined before. The chargeable fee is a paltry £21.30 which can normally be reclaimed for the patient's insurance company.
- Where a patient falsely claims to be on your registered list, the practice can give any necessary treatment and charge a 'reasonable' fee.
- Attending and examining a patient at a police station at their request in connection with possible criminal proceedings against them.

- Attending and examining a patient for the purpose of a medical report or certificate at the request of a commercial, educational, not for profit organisation.
- Attending and examining relating to a claim for compensation by the patient.
- Travel vaccinations which are not paid for under the contract (see LLR LMC Guidance).
- Prescribing or providing drugs, medicines or appliances required solely in anticipation of the onset of illness or injury whilst the patient is outside the UK.
- Medical examination regarding
    - wearing a seat belt
    - creating a report about an RTA or criminal assault
    - whether a patient is fit to travel
- Testing a patient's eyesight not covered by primary ophthalmic services.
- Where the contractor is authorised to dispense drugs, medicines or appliances under Section 126 of the NHS Act 2006.
- For prescribing or providing drugs or medicines for malaria chemoprophylaxis.
- An exemption certificate confirming that the patient should not be tested or vaccinated regarding coronavirus for clinical reasons

What Can I Charge?

The LMC, BMA, or even groups of practices cannot advise practices what to charge for services where a fee has not been negotiated. To do so is price fixing and a breach of competition law.

Practices should consider how long a form or service takes to provide, what staff it requires (e.g. GP, admin, or both) what other costs (excluding premises, but can include an element for consumables, energy and reception time etc). The BMA has produced a fee calculator to help practices to decide what to charge.

For comments or queries please email the LMC.

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7. DELAYED LETTERS FROM DERBY HOSPITAL.

The LMC had a meeting with the University Hospitals of Derby and Burton NHS Trust, at their request to discuss an issue with 13,759 letters not being sent from the Royal Derby Hospital to general practices. This has been caused by an error in the Lorenzo Hospital EPR system which due to a programming oversight resulted in letters relating to patients born in March not to be sent between 2016 until it was fixed in October 2024.

This problem only affects those practices where some of their patients attend Derby Hospital.

We are advised that about 300 letters have not been sent to practices in LLR, although about 100 of these are for one practice. Derby Hospital have agreed to pay £15 per letter to practices for the additional cost of processing. As practices cannot be paid by the hospital directly affected practices will by paid by LLR ICB who will then reclaim from the hospital. Practices will be informed once we have clarified the claim process.

Derby Hospital will contact your practice if you have been affected.

For comments or queries please email the LMC.

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8. LLR SHARED CARE RECORD AND RESPECT FORM.

In the December LMC Newsletter, we providing information about the LLR Shared Care Record (ShCR).

On of the proposals is that ReSPECT forms will be hosted on this record regardless of where they are created (general practice, UHL, LPT etc).

There were presentations at the last various PLT meetings regarding this which have led to many concerns raised by practices.

I have been involved in this project although had not received an update for a few months, so have now met with the project team again. They advise that the project is far from being ready for a go live date, and they have many outstanding issues that need to be resolved first.

They apologise that the presentation at the PLT was premature and has led to so much concern and confusion.

The LMC view is that for this to work, it needs to be seamless from a practice point of view and not creating additional work (unless this is funded).

Other concerns have been around information governance/data protection. These will all need to be worked through, assessed and information provided to practices in advance of any go live.

If you have any concerns or questions please send to liz.mcintyre3@nhs.net and copy in the LMC.

For comments or queries please email the LMC.

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9. TRANSFERRING CARE SAFELY (TCS).

The LMC regularly receives concerns from practices about the TCS process. It is not ideal, but is an improvement compared with most of the country where no interface process exists (and who express awe when explaining about our TCS).

The LMC view is that the current process removes the clinician-to-clinician direct dialogue which can be beneficial in sorting out interface issues, and we are keen that this is restored.

The LMC also feels that TCS forms should be sent to patients, so they are not surprised coming across it when browsing their record online and can understand the GPs point of view when an interface issue has gone wrong."

To paraphrase Winston Churchill – TCS is the worst form of interface process except for all those other processes that have been tried from time to time.

TCS have shared examples where the language used by clinicians is inappropriate for a professional communication, and we would ask everyone to ensure that however frustrated or angry they are (and I fully understand these emotions thinking about some of the letters I have received) the language is moderate.

If you do not receive a reply or the reply is inappropriate, please send an 'unresolved' TCS. If you are unsure about whether a reply is accurate, appropriate, disrespectful or downright rude, please forward to the LMC and we can liaise directly with that organisation.

For comments or queries please email the LMC.

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10. CLINICAL BED BUREAU

When writing these newsletters, we are often asked to include information by the ICB etc which we think is not our job to do so and so decline. But I wanted to mention the Clinical Bed Bureau as I have experienced the difference it can make over the past few years.

A close relative has had many emergency admissions over the past 4 years. Most of these have involved being taken by ambulance to ED, with waits of 4 to 13 hours in ED before being sorted out or admitted to a ward.

They needed another admission with sepsis just before Christmas. Their GP advised/agreed that an admission was needed but then told me to phone 111 or 999 for an ambulance. I pushed back and requested that they phoned bed bureau. The outcome was that instead of spending many hours in ED waiting to be seen and sorted they were admitted directly to SDEC, and full assessment and care was started very quickly.

Bed Bureau is not perfect – there is not a pathway for everything and like the rest of the NHS, capacity is limited so sometimes you have to wait too long for them to answer – but it is normally better than the alternative from a patient point of view. If you have a bad experience with Bed Bureau consider sending a TCS, but also let the LMC know so we can raise it directly.

I tell our registrars or medical students when debriefing about a patient who clearly needs admitting that you only ever send a patient to ED without phoning Bed Bureau first if you hate them.

If you have any concerns or suggestions with the Bed Bureau Service let the LMC know.

For comments or queries please email the LMC.

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11. NATIONAL REVIEW INTO NEURODIVERSITY

The government has set up an Independent Review of Mental Health Conditions, ADHD and Autism. The terms of reference can be seen here. The review will cover children, young people and adults and will examine:

- the factors behind trends in prevalence
- the impact of clinical practice, including social and cultural factors and the risks and benefits of medicalisation
- ways to promote the prevention of mental ill health
- ways to create resilience and improve early intervention

This is the review previously promised by Wes Streeting. Kate Bramall (GPC Chair) met with Wes Streeting (SoS for Health and Social Care) and Simon Opher (Minster of Health) last week and agreed that it is exceptionally important for GPs to contribute their thoughts and experience in significant numbers, not least to balance the views of pressure groups.

The shared mailbox to receive submissions is independentprevalencereview@dhsc.gov.uk and we would encourage you to consider making a submission.

For comments or queries please email the LMC.

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12. IMMEDIATE REMOVAL OF VIOLENT PATIENTS AND SAS SCHEME.

Practices can arrange removal of a patient with immediate effect if they have acted violently or behaved in such a way that practice staff or anyone else in the practice has feared for their safety. As part of this process the practice must report the incident to the police. Full LMC guidance can be downloaded here.

Following removal, the patient is automatically referred to the Special Allocation Scheme (SAS). Patients can appeal against the allocation.

On more than one occasion the LMC has been contacted by a practice where a practice has removed a violent patient, but following a successful appeal by the patient to be allocated to the SAS scheme, the patient has been advised they can return to receiving care from the original practice (and the practice is advised to consider removing the patient on reasonable grounds). The LMC view was that this inappropriate and did not follow the regulations.

We have met with the ICB to advise that this process is wrong. If the practice has followed due process to remove a patient, it is immaterial to the practice if the patient then successfully appeals the SAS allocation. The patient should remain removed from their list. The ICB has accepted our view and the letter to the patient and practice in this situation has been changed.

For comments or queries please email the LMC.

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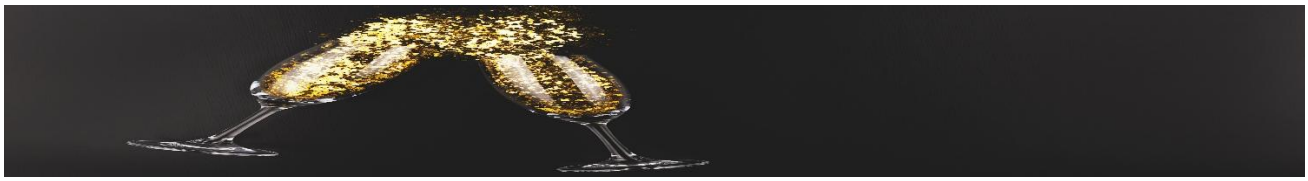
13. LLR LMC AWARD CEREMONY AND AGM.



"I've been waiting for this moment for all my life."

Following the success of the last years' awards, we will be hosting the awards once again this year to share positivity and the good work of the General Practice 'family' in LLR.

The award ceremony will be part of the AGM which will take place at the Marriott Leicester on the evening of 4th March 2026 (see events).

NOMINATIONS ARE NOW CLOSED

The winners and runners up of the three categories will be announced and presented with an award by our celebrity guest, Dr Phil Hammond at the AGM in the following three categories:

- **Outstanding Contribution to General Practice**
- **Greatest Leader**
- **Rising Star**

Phil Hammond trained as a GP, and is a broadcaster, comedian, and commentator on health issues. He is best known for his humorous commentary on the National Health Service. He first came into the public spotlight writing a column for *The Independent* newspaper, where he wrote with a strong pro-patient rights line and as *Private Eye*'s medical correspondent "MD." He is currently appearing in a Radio 4 comedy called 'Doctors on Hold' with his old colleague Dr Tony Gardner set in a typical GP surgery, struggling to cope with cuts and an increasingly impatient set of patients.

I look forward to seeing you all there!

For comments or queries please email the LMC.

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14. JOY CONTRACT MANAGEMENT SERVICE.

In our August 2025 Newsletter we highlighted an issue with Joy Contract Management Service (Joy CMS) which we expanded on in our September 2025 Newsletter.

The issue was that the programme breaches the UK GDPR Article 5 principle of accuracy as when it writes into SystmOne after an entry made elsewhere by a Social Prescriber it erroneously records someone within the practice as having made the entry.

Although the ICB initially suspended the service, we have been advised that the ICB will now write to practices to invite them to consider turning this function back on.

As part of this the Joy company has produced a 'mitigation.' This document correctly mentions that there is not a data breach (which has never been suggested) but does not recognise the breach of the data principle of accuracy. The proposed change does not alter that the information will continue to erroneously record the 'entered by' as someone within the practice and not the Social Prescriber who actually made the entry.

It is up to practices to decide whether they wish to turn this system on, but before doing so I would advise that you carry out a risk assessment of the ongoing inaccurate recording of the data, and add it to the practice risk register.

For comments or queries please email the LMC.

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15. EMPLOYMENT RIGHTS ACT 2025.

The Employment Rights Bill is now the Employment Rights Act 2025. It became law on 18 December 2025, and will introduce additions and amendments to existing legislation, including the Employment Rights Act 1996.

ACAS has provided a recorded webinar regarding key measures and employer actions that can be accessed here.

The provisions are being implemented over time, and the current timeline can be seen here.

A summary of the changes can be found on this government Factsheet.

The LMC is arranging a webinar to help practices navigate the significant changes that this Act implements, and we will contact practices once this has been finalised.

For comments or queries please email the LMC.

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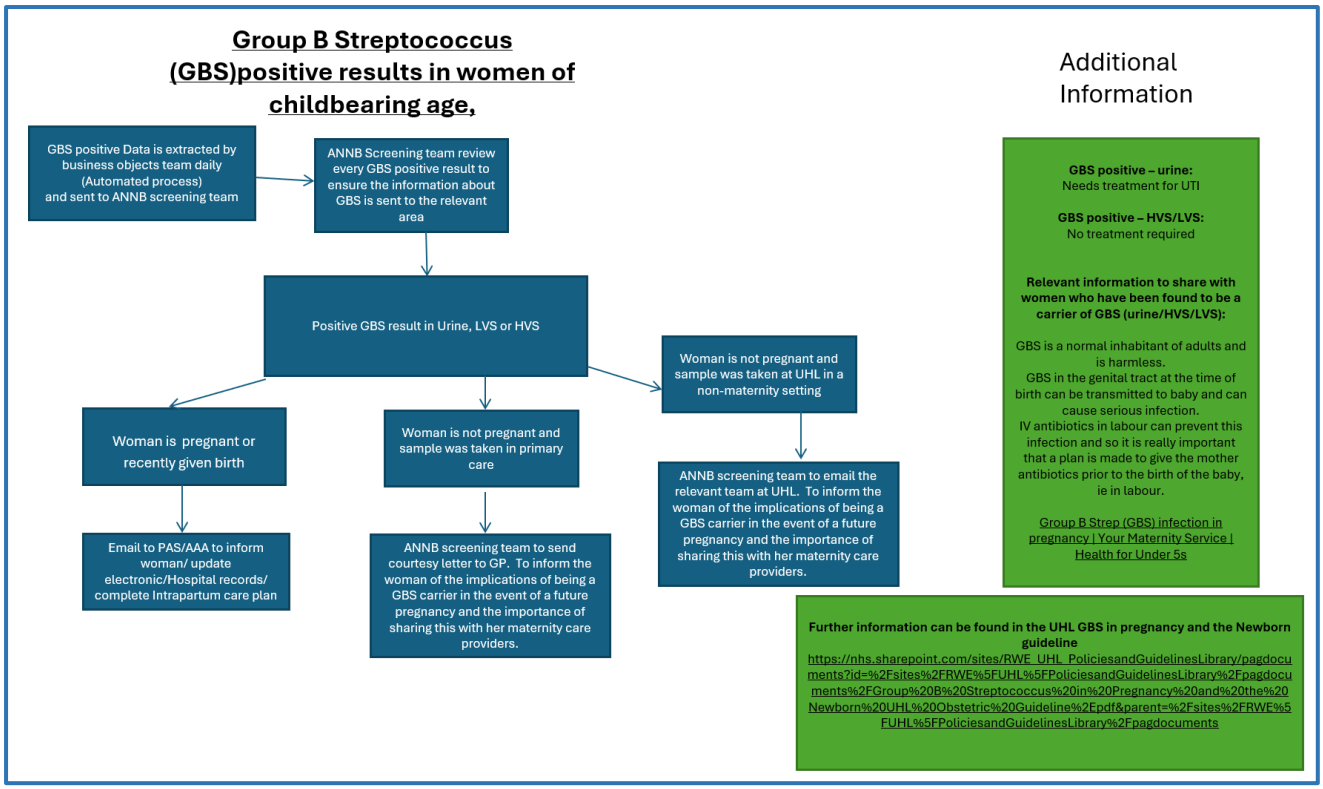
16. NON-MATERNITY GROUP B STREP RESULT.

Although Group B Streptococcus is normally consider a harmless commensal, if it is cultured from a urine, vaginal or rectal sample in a women of childbearing age it is important to flag so that antibiotics can be given during childbirth to avoid GBS infection in a newborn.

There was an incident where GBS was found on a sample taken in the ED department and due to the result being mishandled led to a complaint. To avoid future problems UHL have developed a flowchart (see below). Although this has minimal effect on general practices we have been asked to make you aware.



For comments or queries please email the LMC.

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17. GPCE UPDATE ON NEIGHBOURHOODS AND THE FUTURE OF THE GP CONTRACT.

The Government has indicated they will share their final position on the 2026/27 GP contract changes in England during the week commencing 22 February 2026.

It is vital the Government recognises the critical situation GPs face with increasing workloads, stretched finances and an exhausted workforce. In the meantime the BMA has just published a 30-minute podcast where the GPC England Chair, Dr Katie Bramall, and Deputy Chair, Dr David Wrigley, talk about where we are at the moment in general practice and the real challenges faced as a profession.

Listen to the podcast >

Read the transcript

GPC E have also created two bite-sized briefings on what GPs need to see from NHS England to fill the vacuum around 'Neighbourhoods' as well as expanding on the themes covered with our profession being critically endangered, and facing extinction:

- **Facing extinction – 'Neighbourhood health - lead or be led'**
- **Facing extinction – 'Why this campaign, and Why Now?'**

At the GPC England meeting on Thursday Feb 26th the proposed changes to the contract will be scrutinised, debated and the offer from Government will be voted on.

GPC E are holding further webinars where they will discuss the new contract and what the next steps are for the profession. You can use the links below for these.

- Thursday 5 March, 12-1:30pm – register here
- Tuesday 10 March, 7-8:30pm – register here
- Wednesday 18 March, 12-1:30pm – register here

These discussions are vital to the whole profession, and GPC E want your feedback and to bring you along with them so please feed in any queries you have to info.gpc@bma.org.uk

For comments or queries please email the LMC.

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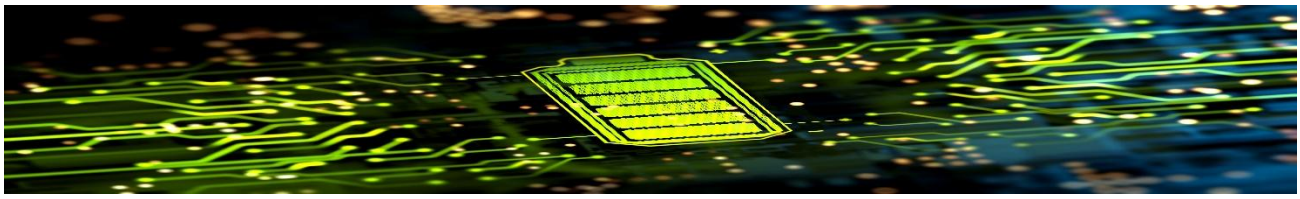
18. GENERAL PRACTITIONER MEMBER OF ICB BOARD.



The ICB Constitution as advised by NHS E guidance requires the ICB Board to have a General Practitioner (Contractor) as a member. Although they are not a formal representative, they have an important role to provide a voice of general practice particularly at this crucial time when Neighbourhoods could represent a significant threat to general practice (see section 17).

The ICB will soon be asking for nominations. Any GP who is also a contractor is eligible. The national guidance requires that the successful candidate has the confidence of all GP contractors, and so the LMC has agreed once more to survey all GP contractors if they support those nominated. The final decision will be made by an ICB appointment panel.

For comments or queries please email the LMC.

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19. 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.

All LLR LMC podcasts and other video content can be found on our YouTube channel.

Featured Podcast

- 2025 05 21 Interview with Louise Pinder, HM Senior Coroner, Rutland, and North Leicestershire.
- December 2025 An LLR LMC Christmas carol

Monthly Podcasts

- February 2026 LLR LMC Podcast – Conversation between Charlotte Woods, Fahreen Dhanji and Grant Ingrams
- January 2026 LLR LMC Podcast - Conversation between Charlotte Woods and Grant Ingrams
- December 2025 LLR LMC Podcast
- November 2025 LLR LMC Podcast
- October 2025 LLR LMC Podcast
- September 2025 LLR LMC Podcast
- August 2025 LLR LMC Podcast
- 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 2024 LLR LMC Podcast

Recordings of Webinars

- 2026-02-09 TPP Automate Induction
- 2025-10-09 What a GP needs to know about their pension
- 2025-10-01 eLearning Platforms presentation
- 2025-09-23 LMC Webinar on GP Contract Changes from 1 December 2026
- 2025-09-16 Leicester City Council: An Introduction to NHS Health Check Contracts for 2025
- 2025-07-30 LLR LMC Understanding Notional Rent Reviews & Improving property Webinar
- 2025-06-25 LLR LMC webinar with DR Solicitors Partnership Agreements what you need to know

Other Podcasts

- 2025 09 18 Dispute with NHS E/GPCE Dr Katie Bramall
- 2025 03 05 BBC East Midlands Today re Migration
- 2025 07 08 NHS 10 Year Plan Dr Katie Bramall
- 2023 01 13 GPs in crisis: East Midlands doctors reveal difficult and desperate challenges | ITV News Central
- 2022 11 22 Greatest Hits Radio re GP Crisis

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

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20. UPCOMING LMC EVENTS.

Please find below confirmed LMC events. Book early to avoid disappointment as they are often over-subscribed.

If you have any suggestions about any additional topics that the LMC could cover in future, please let the LMC know.

An up-to-date list of all upcoming LMC Training and Events is available on the LMC Website.

Some webinars are recorded – see the list in our 'Podcasts' section.

Wednesday 4th March 2026, 7pm to 10pm
Annual General Meeting and Award Ceremony
"I've been waiting for this moment for all my life."

Join us for our annual general meeting which will include a meal, a reflection on the previous year, a talk by a celebrity doctor, and award ceremony. Click here for more information.

- **Target Audience:** Anyone working in general practice in LLR
- **Date:** Wednesday 4th March
- **Venue:** Marriott Hotel, Smith Way, Leicester, LE19 1SW
- **Time:** 7.00pm – 10.00pm
- **Speakers:** **Dr Phil Hammond**

AGENDA

6.30 – 7.00pm: Arrival, Dinner & Networking
7.00 – 7.25pm: Highlights of the year with presentation of the LLR LMC Annual Report followed by Q&A session.
7.30 – 8.30pm: Be inspired by our guest speaker, the renowned Dr Phil Hammond – MD of Private Eye.
8.30 – 9.30pm: Celebrate General Practice with the LMC awards presentation by Dr Phil Hammond.

Please email the LMC to register.

Tuesday 10th March 2026, 10am to 12midday
Safeguarding Networking Admin Lead Event

We would like to invite LLR Safeguarding Admin Leads to the next Safeguarding Networking Admin Lead Meeting, which the full details are below.

This session provides an opportunity to share ideas and learning relating to the administrative (non-clinical) aspects of safeguarding. The group aims to act as a forum for peer support and a shared resource to help practices deliver this function effectively within General Practice.

- **Target Audience:** Safeguarding Admin Lead
- **Date:** Tuesday 10th March
- **Venue:** NSPCC, 3 Gilmour Close, Leicester LE4 1EZ
- **Time:** 10am to 12midday
- **Speakers:** **Dr Amit Rastogi (LMC Board member and LLR ICB Safeguarding Lead)**

Please email the LMC to register

Tuesday 17th March 2026, 12.30pm to 2pm
Meet the new CQC Team

The LMC will be hosting a lunchtime introductory webinar with the new CQC team covering Leicester, Leicestershire and Rutland (LLR).

We warmly invite GPs, Practice Managers and colleagues working across General Practice to join this important session.

This webinar will provide an opportunity to meet the new local CQC team and gain clarity on current expectations and inspection processes.

The session will cover:

- Meeting the new assessors and local team – Surupa Santra and Emily Shepherd
- Update on changes within CQC and how this will affect practices
- Walk through of an inspection – pre-inspection, on the day, and post-inspection
- Case studies of Outstanding, Good and Requires Improvement – what impresses them during an inspection?
- Hints, tips and common themes where practices can trip up
- Question and answer session

We recognise that within a 1.5-hour session it will not be possible to explore each of these areas in significant depth. However, this introductory webinar is intended to provide a helpful overview and an opportunity for engagement. We also hope to follow this session with a series of more focused webinars going forward, allowing deeper exploration of specific topics highlighted by practices.

- **Target Audience:** GPs, Practice Managers, Other relevant members of your team
- **Date:** Tuesday 17th March
- **Venue:** MS Teams
- **Time:** 12.30pm to 2.00pm
- **Speakers:** New CQC inspectors for LLR area

Please email the LMC to register

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21. 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.

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22. 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

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23. FINAL THOUGHTS

This month, I was going to finish on with positive thoughts about how fantastic general practice is, and to reflect on the citations of the 21 GPs and team members who had been nominated for the three awards we are going to announce at the AGM on 4th March and be presented by Dr Phil Hammond.

I was also going to talk about Phil Hammond's career. He did not shy away from highlighting poor practice and was one of the first to raise the Bristol Heart Scandal. His more recent writing in the Private Eye is insightful, and his analysis of the management of the Covid pandemic and now the Lucy Letby case is well worth a read if you have not already done so.

However, on the day when I was finalising the newsletter, I had told the LMC team that there was no chance of including yet another article this month, and we had recorded the February podcast, a letter from Dr Amanda Doyle plopped into my inbox, announcing next year's imposed contract.

Evidenced by various independent research and reports (see Newsletters passim), general practice currently is:

- The most (only) productive part of the NHS.
- The only part of the NHS consistently financially solvent.
- Have absorbed significant additional work without transfer of funds.
- The part of the health service which, if properly supported/funded, would provide the highest improvement in the health of the nation.
- The only part of the NHS that complies with their contract (compare what happens to a GP practice if you do not deliver to the total lack of interest/enforcement when we repeatedly point out when secondary care providers do not compy with their Standard NHS Contract).
- The part of the NHS that provides the vast majority of healthcare (90%).
- The part of the NHS that has seen a 7% reduction in trained GPs compared with 48% increase in secondary care consultants.
- The only part of the NHS that has seen a real term reduction in funding, with percentage of NHS spend having reduced from 12% to 5.9%.

So, given this evidence, you would hope that the contract for next year would provide stability, off load practices, and improve funding.

Instead we have a revised contract which increases workload for minimal additional funding (a third of which is just reshuffling existing money).

The government is also making various anouncements through the media stoking up public expectation for a level of service which cannot be provided.

The fine details are not available yet, but from the letter and press information the main changes with some initial observations are:

1) Increased capacity by repurposing £292million for practices to use for recruiting additional GPs, and changing the ARRS GP scheme so it is not limited to just GPs qualified in previous 2 years.
2) Increase in various QoF requirements, the most significant of which are:
    - 2 new obesity areas relating to referrals to structured weight managemnet programmes (which currently do not exist in LLR) and prescribing GLP-1/GIP agonists.
    - Change to childhood vaccination indicators to include those to 'reward' improvements – ie they realise that despite huge efforts practices are unable to achieve the targets, so they are introducing more unachievable targets which many practices will devote a huge amount of resource into to trying to achieve. Of course, the government could have tackled the route causes of poor vaccination uptake, but again have taken the lazy approach of dumping on general practices and making them at fault when it does not work.
3) Extension of RSV vaccination to all adults aged over 80, and care home residents.
4) Requirement on PCNs to ensure care home residents are offered vaccinations.
5) Patients identified as clinically urgent will be dealt with on same day. This has received a lot of press, but no real change for practices, particularly as no change in the regulations so that GPs decide how the care is provided – so I hope that Wes has briefed all Hospital EDs to expect another spike in referrals/redirections from GPs.
6) Non-urgent patients to be given an appropriate response by end of next day. So I hope that on this one Wes will be informing the public why the wait for a routine GP appointment increases by a further 1-2 weeks.
7) Mandating use of A&G, although the letter includes the phrase 'where clinically appropriate' the decision about which can only remain with the GP deciding to refer.
8) Requirement for all practices to provide data and information about telephony, online and video consultations. They say this is not for performance management, but I predict as sure as eggs are eggs that DHSC will brief the press about this and I expect to see league tables in national and local newspapers.
9) Requirement to share data with Lung Cancer Screening Programme. This may seem to be an oddity, but your LMC as well as other LMCs across the country have been trying to sort out the practicalities

of this service which has a low pickup of cancers, but results in incidental findings for 30% of patients which is likely to result in significant additional unfunded work for general practices.

10) Requirement for practices to reconfirm a patient's nominated pharmacy whenever a new prescription is issued. They reckon that this will not result in additonal workload for practices, but I reckon it will. Let me know what you experience when this is enforced!
11) Requiring practices and PCNs to participate in a General Practice Staff Survey (which I presume will mirror the NHS Staff Survey) – including sharing staff contact details with them! So, Wes, what do we do when a member of staff declines to have their details shared? Again expect this to be used as an additional stick to beat you with – this is the experience in secondary care where an annual league table is produced.

So in essence a large raft of new must dos, increased workload, and new sticks for the government and patients to beat general practices with, all for the fantastic additional sum of £1.50 per patient. As the changes become clearer once the actual changes to the contract/regulations have been published, we will provide further updates.

Finally, it is sad to note that the government deliberately chose to circulate this two days before the GPC as our elected representatives were due to meet to consider the changes. This is at best disrespectful but at worse a sign of arrogance that they feel they know best with no requirement to listen to the wider profession.

Wes, if you are reading this, like your imposed contract last year this will have negative consequences that are clear to general practices, even if you cannot see them, and will speed up the extinction of NHS general practice.

Best wishes.

Grant Ingrams

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