NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

April 2026
To All Leicester, Leicestershire, and Rutland General Practitioners and Practice Managers.

Dear Colleagues

LLRLMC NEWSLETTER

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

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

APRIL PODCAST
GRANT INGRAMS, FAHREEN DHANJI AND CHARLOTTE WOODS IN CONVERSATION
(28 MINUTES)

SUMMARY OF THIS MONTH'S MUST DOS:

- THERE HAS BEEN **NO CHANGE TO THE GP CONTRACT YET**, AND **DO NOT SIGN THE CONTRACT VARIATION NOTICE** WHEN YOUR PRACTICE RECEIVES IT. SEE SECTION 6 FOR MORE INFORMATION.
- Consider not engaging with the Medicines Optimisation Framework for 2026/27
- Check if your practice is paying the Voluntary Levy, and if not consider started doing so to support the work of the LMC and national representation of general practice.

Topics in this newsletter:

CONGRATULATIONS

We are pleased to announce that Dr Fahreen Dhanji (Deputy CEO, LLR LMC) has been elected to represent Leicester, Leicestershire, Rutland, and Northamptonshire on the BMA's General Practitioner Committee for England for the next three years. Please join us in our congratulations and we look forward to our local views being given an even higher prominence nationally.

1. LMC MEETING – APRIL 2026.

The LMC Board met on 8 April 2026. No one was available from the UHL Executive team to attend the meeting, although Richard Mitchell did provide an update to some of the ongoing issues in advance.

One GP Registrar attended to observe the LMC Board 'in action.' If you have never attended an LMC Board meeting, but would be interested to see what happens, please email enquiries@llrlmc.co.uk. This is open to any GP, GP Registrar or Practice/PCN manager working in LLR.

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. BADGERNET.

The LMC continues receive questions from practices following the implementation on Badgernet, we have written about this before, see previous newsletters - October 2025, November 2025, January 2026 and February 2026).

We want to address some of the key questions we continue to get from practices which tend to come from the practices where the midwife is based within their building.

a. How will the practice know when our patients are pregnant?
Practices will be sent information relating to their patient's pregnancy as a letter via MESH, which the midwife will enter via Badgernet and then flow through to practice systems.

BadgerNet is designed to support real-time, digital maternity records and improve communication across care settings and should not impact patient care and will provide all the information if temporary/new midwife is dealing with patients care as all information will be accessible.

It has been recognised that during implementation stage this might have seen a delay in communication (prior to Feb 26) and we recognise that there might be some missing data prior to Feb, but this has now been resolved and live. Practices can request a breakdown of data for that period by emailing – uhl-tr.digitalmidwives@nhs.net

Now that implementation of stage 1 has been completed, practices should be receiving correspondence – if this is not happening, please let LMC know.

b. Do we no longer know who is in the building, so a fire risk?
Midwives should be providing practices with a clinic list on arrival to act as a sign-in/out sheet for the practice.

c. How does the practice communicate to midwives, we used to be able to do this via S1?
This something that the LMC has raised with the midwifery team, and they will be providing a designated email address for practices to use to contact the midwifery team going forward – we will keep practices updated too.

d. Prescriptions
Management of prescriptions is phase 2 and an area the LMC will be working on with the midwifery team and ICB.

UHL advise that all IT issues (including multiple copies) have been ironed out, and I hope that most practices will have been able to work through the other issues with their midwife.

If you come across a related problem which cannot be sorted out by working with your midwife please let the LMC know.

For comments or queries please email the LMC.

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3. LPT – PRESCRIBING BY COMMUNITY SPECIALIST TEAMS.

For a long time the LMC has had intermittent communications from practices about interface problems relating to prescribing by specialist community services including district nurses and the Diana Service.

The LMC view is that prescribing by these services should be arranged in line with the arrangements for all outpatient prescribing included in the standard NHS Contract.

If a medication is needed immediately then the service making the clinical decision regarding the requirement should prescribe it.

If not needed urgently, then the specialist service can request the general practice to prescribe, but the LMC expects this to be in line with the principles set out in the LMC's Position Statement on Shared Care Agreements and also in line with BMA, CMC, and NHS England guidance.

The LMC is now working with LPT regarding these issues, but if you have any examples of good or poor practices of an LPT service requesting a general practice to prescribe medication that they advise, please email the LMC with the details.

For comments or queries please email the LMC.

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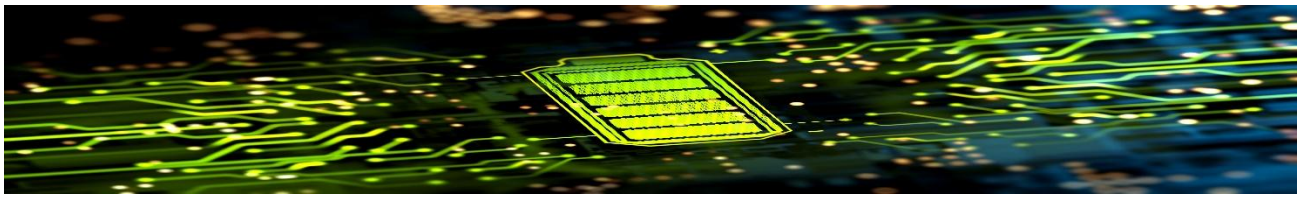
4. VOLUNTARY LEVY.



We have previously explained the background to the Voluntary Levy which funds national services on behalf of GPs, most recently in our February Newsletter.

Although there has been previous controversy, the current process is robust and ensures that the raised funds benefit general practices. The levy funds various services that LLR and other LMCs rely upon to be able to perform efficiently and effectively, and this includes an LMC Support Network and a searchable database of various parameters at ICB, PCN and Practice Level.

We have recently identified that a sizeable minority of practices have not been paying the levy for some time. We suspect that those practices stopped when there were significant concerns about the probity and effectiveness of the fund. LMC now fully supports the GPDF and we recommend that all practices contribute their fair share.

The LMC wrote to the practices currently not contributing and already a number have replied agreeing to start payment. The LMC office will be contacting the other practices again. It would be helpful to understand why practices have not committed to contributing to the voluntary levy so please let us know. Also, if it would be helpful, please contact the LMC and we could meet with your practice/partners to discuss any concerns you may still have.

For comments or queries please email the LMC.

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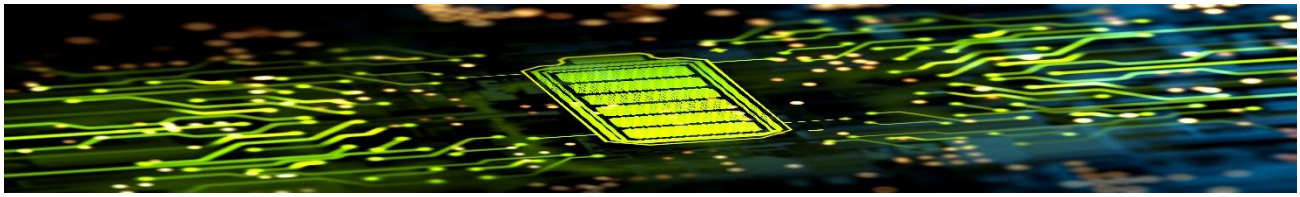
5. CQC TOOLKIT – A NEW SERVICE.



The LMC is aware of how much distress a CQC assessment causes and how much additional work it creates.

I hope you or one of your team were able to attend one of the previous meetings that the LLR LMC arranged with our then local CQC inspectors.

To further support practices, one of our Board Practice Managers (Sarah Gibson) has created a toolkit to take practices through what policies and other documentation practices should have in place for an inspection, and what else to expect so you can prepare in advance.

The Toolkit is currently being quality assured to make sure it is as robust and useful as possible, and in line with the current changes of the CQC new framework. If you are advised of a CQC inspection before we have circulated the final version, please email the LMC Office, and we will try and ensure that you can access it in time to help you through the process.

With our significant thanks to Sarah for her fantastic work on this!

It was unfortunate that we had to postpone the recent LMC/CQC webinar around the new CQC framework and what this will mean for practices going forward – however, we have received assurance from the CQC that a new date will be coming soon for LLR practices!

For comments or queries please email the LMC.

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6. CONTRACT IMPOSITION FOR 2026/27 AND BMA ACTION.

The Referendum of GPs about the imposed contract for 2026/27 by the GPC of the BMA is now closed.

Almost 17,000 GPs and GP registrars voted, with 98.9% voting against the imposed contract and calling on the Government to return to negotiation with the BMA's GP Committee for England to jointly develop and agree a brand-new contract.

This represents an unequivocal rejection of both the imposed contract but also the way that the Government currently choses to interact with our nationally elected representatives.

Responding to the vote BMA GPC England chair Dr Katie Bramall said:

"These proposals heap unsafe, unfunded additional workload on to practices, forcing GPs to deliver more with less, putting patient care at risk. Patient groups and GPs alike are united in their concerns around Hospitals rejecting GP referrals to access appropriate specialist care. When the Government promised a 'shift from hospital to the community' we did not think this would be their own waiting lists.

"Mandating unlimited access without the staff, time, or infrastructure needed to deliver it is not a plan, but a fast-track to collapse GP services, pushing GPs to either walk away due to the moral injury it inflicts, or force them to close their doors due to the pressures placed on them. In some settings it may even tip family doctors to 'do a dentist' and see if they can offer a better, safer service privately.

"GPs simply want to provide the safe care their patients need, but they know they are being set up to fail with this imposed contract, the referendum result speaks for itself."

The next step will be for the GPC to propose one or more industrial type actions for general practices to undertake to put further pressure on the Government and NHS England to see sense.

The GPC has a webpage dedicated to the Imposed Contract Changes for 2026/27 which they will keep up to date as more information become available: Campaigning on the future of General Practice

IMPORTANT: AS OF YET THERE HAS BEEN NO CHANGE IN CONTRACT FOR ANY PRACTICE (REGARDLESS OF THE ERRONEOUS EMAIL FROM THE ICB CONTRACT TEAM WHICH SUGGETSED THERE HAS BEEN).
PRACTICES DO NOT NEED TO MAKE ANY CHANGES AT PRESENT AND SHOULD CONTINUE TO WORK AS PER LAST YEAR'S CONTRACT AS IMPLEMENTED ON 1ST OCTOBER 2025.

So why has there been no change in contract?
GP Regulations and Contracts are set out as legislation:
The National Health Service (General Medical Services Contracts) Regulations 2015

Therefore, GPs' contracts cannot be changed until there has been a change in the legislation.

The process for changing the regulations and contracts is by secondary legislation. Secondary legislation, or delegated legislation, is law created by ministers or public bodies under authority granted by a primary Act of Parliament, known as a "parent" Act. It fills in operational details, such as regulations, orders, or rules, which allow acts to function in daily life. Statutory Instruments (SIs) are the most common form. The appropriate current primary Act of Parliament that enables this is the National Health Service Act 2006.

So, to change our contracts, first the changes will need to be made to the Regulations by secondary legislation. Most secondary legislation uses the "negative procedure." Under this procedure the proposed legislation is laid in parliament, and both houses have the opportunity of voting it down (annulling). If the legislation has not been annulled within the timescale set out, then it becomes law.

Once the regulations have become law, the changes will then need to be set out as change in wording to the Standard General Medical Services and Primary Medical Services Contracts.

The changes are then set out in a Contract Variation Notice which the ICB as commissioners need to serve on general practices.

The changes do not become a contractual requirement for practices to implement, until either the practice has signed the Contract Variation Notice, or a period of 14 days has passed since it was served on the practice.

As at the time of writing this newsletter (12 April 2026) I cannot find any reference to the required secondary legislation having been laid down, so it is highly unlikely that the changes will become contractual for at least another two months.

THE LMC ADVISES PRACTICES NOT TO SIGN THE CONTRACT VARIATION NOTICE WHEN IT ARRIVES
THERE IS NO CONTRACTUAL REQUIREMENT TO SIGN AND IT MAKES NO DIFFERENCE AS THE CHANGES ARE IMPLEMENTED AFTER 14 DAYS, BUT IT HIGHLIGHTS THAT YOU DO NOT CONDONE ANOTHER POORLY THOUGHT-OUT CONTRACT IMPOSITION.

STATEMENT OF FINANCIAL ENTITLEMENTS

The entitlement to fees and other funding from the NHS as per the regulations/contract is set out in the Statement of Financial Entitlements. This document is another crucial one that all Practice Managers and lead financial partners should have a working knowledge of and be able to find their way around.

The SFE is also set out in legislation, but the Directions (Secondary Legislation) which implement the changes for 2026/7 have already been issued as the National Health Service, England, General Medical Services Statement of Financial Entitlements Directions 2026 which came into force from 1 April 2026, and therefore mean that the increase in payments should be passed onto practices with April payments. Please note that it is quite common for more than one legal direction changing the SFE to be published during any financial year.

For comments or queries please email the LMC.

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7. ADVICE & GUIDANCE/SINGLE POINT OF ACCESS FOR REFERRALS.

This section just reiterates our advice in the March Newsletter. But the LMC office continues to receive questions about it. However, since last month the ICB/UHL have engaged with us regarding the proposed pathways for gastro and HPB, and a task and finish group is being set up which we have been reassured will include LMC representation.

In the 2026/27 imposed contract Advice and Guidance will no longer be a separately funded Enhanced Service but becomes part of 'core.'

The next proposed step is to move away from Advice and Guidance to a Single Point of Access. This will provide just one route for a GP regardless of whether there is a barn-door requirement for a referral or not.

As part of this NHS England has issued the document: "Elective Single Point of Access: Technical Guidance for 2026/27" which for reasons which may or may not be clear is unavailable on the NHS England website.

The guidance implies but does not explicitly state that the main purpose is to reduce the number of referrals (and therefore the secondary care waiting list) although it does include the statement: "We must evolve how outpatient care is delivered: how clinicians across settings work together, where care is delivered, and who is best placed to provide it." The document also makes it clear that the Referral to Treatment 'clock' does not start at the time of the GP SPoA referral, but only when the patient is "accepted onto a waiting list."

The guidance includes "this creates an early opportunity for primary and secondary care clinicians to discuss and review the patient's case and **agree** the most appropriate next step." It must not become a method of further dumping of unfunded or clinically inappropriate work onto general practice.

It also states that "a general practice clinical enquiry or referral is clinically reviewed and may result in advice, straight-to-test diagnostics, referral to an alternative service, or acceptance onto a consultant-led elective pathway." My reading is that this clearly states that if the referral needs to be redirected to a different speciality, then the hospital should do this.

The guidance states that "Commissioners should consider engaging with local medical committees (LMCs)." The LMC has now been approached by the ICB to engage with them.

The guidance clearly states that "Local guidelines should be discussed and agreed between the commissioner and primary … care providers." I only became aware of revised local guidelines when I was sent an email by the ICB telling me of the changes to both Gastroenterology and HPB Advice and refer model from 1st April 2026. We have made it clear to the ICB that no such change should be announced without prior agreement with the LMC about the pathways.

The LMC has been given assurance by the ICB and UHL that when they have the working groups set up, the LMC will be invited to represent LLR GPs – only preliminary discussions have taken place to date.

NHS England does not understand their policy and have not thought it through. On 12th March we learned that Dr Amanda Doyle (NHS England's Director for Primary Care) stated that she recognised that using the SPoA will mean "additional work in core general practice" and that this was funded via transfer of the A&G Enhanced Service funding into core funding (whilst conveniently forgetting that this funding was never meant to cover transfer of additional unfunded work from secondary to primary care but purely the admin costs), that Jess' rule should be recognised by trusts but "does not … create an automatic right to referral," whilst at the same saying that it "does not impact the referrer's decision to refer." But she did note "It also means the onus is not

on the GP to decide whether a referral should be for advice and guidance or an outpatient appointment, or simply to obtain diagnostics that aren't accessible in the community," and I am so glad that she is worried about my befuddled GP state of mind and inability to decide whether my patient just needs advice or a referral.

We previously advised regarding wording that practices could add to the end of every A&G/Referral letter in our May 2025 Newsletter. We now suggest that practices consider using the revised wording as below:

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

If you believe that the patient should be considered by a different speciality then as per NHS England and local LLR Consultant to Consultant guidance please arrange directly without requiring the GP to arrange this.

Any pathway which includes an expectation that general practices must carry out additional investigations etc - in line with NHS England guidance - must be agreed with the Local Medical Committee in advance.

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.

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8. MEDICINES OPTIMISATION FRAMEWORK 2026/27.

In our March 2026 newsletter, we provided our critique of the MOF for 2026/27 and advised practices to consider not signing up to it or not implementing it in view that the required increased workload and responsibilities was not properly reflected in the attached funding.

We are aware that many practices have already resolved not to engage in the MOF for 2026/7 and we would encourage all other practices to consider this.

For comments or queries please email the LMC.

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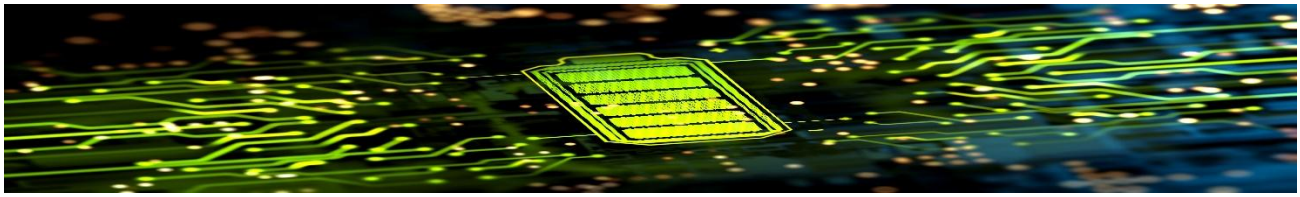
9. GENERAL PRACTITIONER MEMBER OF ICB BOARD.



Nominations for this post closed at 5pm Tuesday 17th March.

The LMC, as set out in the March 2026 Newsletter undertook a survey of which of the nominees had the support of the wider GP provider community and have provided the results to the ICB.

The ICB will carry out the appointment process, but the LMC is keen that the successful candidate is one who was demonstrated to have support as per the LMC survey.

For comments or queries please email the LMC.

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10. REASONABLE ADJUSTMENTS DIGITAL FLAG.

It is mandated that all NHS services (including general practice) will implement the Reasonable Adjustments Digital Flag by 30th September 2026.

I understand that this is currently unavailable in EMIS or SystmOne (but is available in Medicus). Currently it can only be accessed via the National Care Record Service (NCRS)

How do the digital flags work?

Each reasonable adjustment digital flag provides a national visible marker on a person's record (available via the National Care Records Service) which indicates any reasonable adjustments needed by a person with a disability, whenever they are seen or treated within all publicly funded health or social care services.

Reasonable adjustments are already a legal requirement under the Equality Act 2010 for all providers of publicly funded health or social care services, helping ensure their services are as accessible to disabled people as they are to everyone else. The reasonable adjustment digital flag supports providers to deliver this.

What are reasonable adjustments?

Reasonable adjustments are tailored to an individual's needs. They may include adjustments like providing wheelchair access, providing information in large print, or making provision so that a supporter or carer can accompany a disabled person during an appointment or meeting

What has changed because of the new information standard?

The new information standard has 3 important changes:

1. Change in law from advisory to mandatory status

All NHS and other publicly funded health and social care service providers that are not yet using the reasonable adjustment digital flag, MUST, from December 2025, ensure that they are familiar and compliant with the requirements in the new information standard and its accompanying guidance. See this summary checklist of actions for service providers. It follows legal changes in the Health and Care Act 2022 Amendment to the Health and Social Care Act 2012. Previously the requirement was advisory only.

2. Consent for the reasonable adjustment digital flag has changed from explicit consent to implied consent.

The new information standard changes the basis of consent required by a provider to share a person's personal information from explicit to implied consent. However, people can raise objections to their data being shared at any time, unless there is a valid reason why it should be shared. The Mental Capacity Act 2005 should be consulted with regards to decisions about capacity and competence.

3. Full national compliance timeline has changed

All NHS and other publicly funded health and social care providers must fully comply with the reasonable adjustment digital flag requirements by 30 September 2026. If their supplier's system software has not completed the onboarding process by this date, providers must instead be able to share, read, and write reasonable adjustment data directly via the NHS's National Care Records Service.

Three things that NHS, health and publicly funded social care providers must now do:

1. They **must** ensure all staff who use disabled people's records continue to learn about and understand reasonable adjustments. Free training is provided in partnership by NHS England and e-Learning for Health here: Reasonable adjustment digital flag - eLearning An updated version covering all health and social care sectors is expected to be launched by March 2026
2. They **must i**dentify people who need reasonable adjustments to access their care, record, and regularly review the reasonable adjustments they need on their own IT systems or via the NHS's National Care Records Service (previously known as "the spine"). This is in preparation for the data to be shared with other health and social care providers via the National Care Records Service by 30 September 2026.
3. The new information standard requires that all publicly funded health and social care service providers must be able to share, read and write reasonable adjustment data by 30 September 2026. Providers whose software suppliers have completed the national registration and onboarding process by this date will be able to use their software to access the digital flag. Alternatively, they can directly access the National Care Records Service data via its online portal. Health and social care providers are advised to establish if their software supplier has registered their interest in the onboarding process for reasonable adjustments. They can do so by consulting NHS England's national supplier interest list or Information about suppliers (NHS Futures collaboration workspace login required). If their supplier's software isn't registered, providers should ask them to do so. NB the list includes:
    - AccuRx
    - Ardens
    - EConsult
    - Engage
    - Eclipse
    - TPP
    - Optum (EMIS)

Details of how to read and write reasonable adjustments are available here: Guide to Using the Reasonable Adjustment Flag in NCRS – NHS England Digital

For comments or queries please email the LMC.

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11. DIGITAL EXCLUSION RISK ATLAS.

NHS England has recently announced the Digital Exclusion Risk Atlas (DERA). This is an online location-based analytical tool designed to help health and care system teams understand and identify patterns of digital exclusion across England.

It brings together a range of data indicators to highlight areas where people may face barriers to accessing and using digital health and care services. By improving visibility of these patterns, the Atlas aims to support more targeted interventions and contribute to efforts to reduce health inequalities.

Digital exclusion is influenced by multiple overlapping factors, including access to devices and connectivity, affordability and digital skills or confidence. The Atlas combines these indicators into a single overall risk score,

enabling users to explore geographic patterns of digital exclusion and identify areas where the risk may be higher.

As digital healthcare pathways continue to expand, the Atlas will support health and care systems to design and deliver more inclusive digital services.

It is an online tool. The introduction is accessible here and the tool is accessible here. This is the first time that digital exclusion has been recognised and taken seriously nationally.

The information is available at National, ICB, LA and PCN level, although from the PCN map you can get a good idea about the score for individual practices.

This tool will assist practices and PCNs with high scores in pushing back against ICB and national pressure to adopt digital solutions/

For comments or queries please email the LMC.

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12. 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

- **April 2026 LLR LMC Podcast – Conversation between Charlytte Woods, Fahreen Dhanji and Grant Ingrams**
- March 2026 LLR LMC Podcast – Conversation between Charlotte Woods, Fahreen Dhanji and Grant Ingrams
- 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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13. UPCOMING LMC EVENTS.

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

EMPLOYMENT LAW UPDATE & EMPLOYEE WELLBEING AND INCLUSION WEBINARS

We are pleased to invite LLR GPs and Practice Managers to attend two upcoming webinars delivered in partnership with DR Solicitors, focusing on key changes in employment law and workforce wellbeing.

The sessions will be led by Jane Crosby, Solicitor at DR Solicitors, who will provide expert guidance on recent developments and practical implications for general practice.

Session 1: Employment Law Update (Thursday 23rd April 2026, 1.00 – 2.00pm)

- New legislation for 2025: updates and trends in employment law, including changes to flexible working, holiday pay, and protection from harassment.
- The Employment Rights Bill update: a critical and current topic covering the impact on employers, including changes to “fire and rehire.”
- Compliance considerations from a GMS and PCN perspective

Session 2: Employee Wellbeing and Inclusion (Thursday 30th April 2026, 1.00 – 2.00pm)

- Mental health in the workplace: supporting employee mental and emotional health, managing burnout, and creating an open culture.
- Supporting neurodiversity: understanding neurodivergent staff, making reasonable adjustments, and building an inclusive environment
- Menopause at work: legal responsibilities of employers and guidance on creating menopause-friendly workplaces.
- Managing sickness absence, including long-term sickness

These sessions are designed to support practices in navigating legislative changes while fostering a supportive and inclusive working environment.

The sessions will take place via MS Teams and you able to reserve a place on either or both sessions by contacting us on enquiries@llrlmc.co.uk

We strongly encourage attendance from both GPs and Practice Managers given the relevance of these topics to workforce management and compliance.

SAFEGUARDING ADMIN NETWORK SESSION

We appreciate everyone that has attended our safeguarding admin group sessions to date. Your time and input have been valuable, and it is also great to see more practices join, and the Safeguarding What's App group becoming a helpful resource to support practices and developing.

We are pleased to confirm the details of the next face-to-face session. This time, we are planning for it to be a more workshop-based session.

Location: NSPCC, 3 Gilmour Close, Beaumont Leys, LE4 1EZ
Date: Tuesday 2nd June 2026
Time: 9:30am – 12:00pm
Details: Light refreshments will be provided.

Overflow parking is available at the nearby Leicester Lions Speedway, Beaumont Park, LE4 1DS.

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.

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14. 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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15. 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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16. FINAL THOUGHTS

Another month and another independent report highlighting what we already know, and by extrapolation why current government policies will not save the NHS and deliver better health outcomes.

This report, however, also revisits the perrenial argument that the underlyinig problem with the NHS is how it is funded. I suspect that the timing may be related to the Reform Party stating its intention to consider adopting a French Style Social Insurance Healthcare System.

The new report (Bismarck versus Beveridge Revisited: Does the model shape the outcome?) has been witten by the independent think tank the Institute for Public Health Policy and published this month (April 2026). This report is a follow on from the report commissioned by the Health Sectretary in 2024, and analysed the funding systems and health opoutcomes of 22 contries, and includes a forward by Lord Ara Darzi.

There have been previous studies that have shown healthcare outcomes are not determined by the funding system but factors such as how well primary care is funded, and this is found yet again by this new research.

The findings are pretty stark: there is no evidence that social health insurance models outpeform tax-funded systems, or vice versa. Performance varies more within funding model categories than between them. The best-performing tax-funded systems, particularly in Scandinavia, compare favourably with the bext social insurance systems on most measures.

Tax-funded systems hold advantages on equity and administrative efficiency. Out-of-pocket spending is lower (3.2% in tax-funded systems versus 3.5% in SHI systems). Administrative costs consume 2.2% of health spending in ax-funded systems compared with 3.5% in SHI systems.

The NHS currently performs poorly against comparators on key quality indicators – on treatable mortality, it records 71 deaths per 100,000, the second-worst in the countries analysed.

The causes of poor NHS performance are not structural but practucal. Capiltal formation in the NHS stands at just 0.4% of GDP, roughly half the aveage of our comparators, and the shystem has been run at unsustainable pressure for too long. Spending increases have been poorly targetted and failed to address the drivers of weak performance.

The evidence points to four areas where targeted investment would make the most difference for the NHS.

- Capital investment: sustained investment is needed to address the NHS's long-standing infrastructure deficit. The government should revisit the capital settlement set out in the 2025 spending review.
- Primary and community care: a genuine shift towards neighbourhood care, with better access, more personalised support and more effective management of long-term conditions.
- Long-term and social care: serious resourcing of an area where the UK lags far behind comparators – the Netherlands spends around three times more on social care per capita than the UK.
- Public health and prevention: a more ambitious and better-resourced approach is necessary, given that generating improved outcomes through public health budgets is far more cost-effective than through NHS spend.

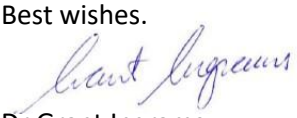
In summary this is yet another report concluding that the NHS has been asked to do too much for too little, and that quality would be improved by better investment in infrastructure (desparatekly needed in general practice) and a 'genuine shift' in resources from secondary to primary care. Despite the promise in this government's 10 year plan to increase the percentage of the NHS funding for generakl practice on the 15th April 2026 the Health Service Journal reported that it had fallen to the lowest level for a decade at 8.3%, which is 1% lower that 5 years ago, and 4% lower that 20 years ago. It is estimated that in real terms on average general practice is receiving £40 less per patient than a decade ago. This means that an average general practice with list size of 9,724 patients now receives £388,960 less per year to provide services to a

population with much higher need and at a time when there has been significant increase in employment and other costs.

Whether this further report which from my POV just states the bleeding obvious will persuade the government to recognise what the solution is and positively move money from secondary to pairmary medical services is unlikely. However there must come a point when even the most anti and GP-hating health policy makers become unable to ignore the growing Tsunami of evidence.

With regard to the infrastructure and and funding model I like an adapted quote of Winston Churchill in that "The NHS is the worst form of healthcare system except for all the others that have been tried from time to time."

Best wishes.



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P.S. As a footnote my major surgery went as planned and I am now gradually recovering from it. However I have further treatment planned and am currently signed off on sick leave at present for another 2 months. During this time I am still reading and responding to emails, but response time may be increased compared with previously..