NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

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

Dear Colleagues

LLRLMC NEWSLETTER

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

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

MAY PODCAST
GRANT INGRAMS, FAHREEN DHANJI AND CHARLOTTE WOODS IN CONVERSATION
(25 MINUTES)

SUMMARY OF THIS MONTH'S MUST DOS:

- THERE STILL HAS BEEN **NO CHANGE TO THE GP CONTRACT YET**, AND **DO NOT SIGN THE CONTRACT VARIATION NOTICE**. SEE SECTION 6 FOR MORE INFORMATION.
- Ensure your practice is engaging with collective action – finding out about what data sharing you are signed up to, and the additional action of turning off/ignoring Medicines Optimisation Software.
- 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.
- Sign the Rebuild General Practice Petition or one of the other highlighted petitions.

Topics in this newsletter:

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

1. LMC MEETING – MAY 2026 / LMC CONFERENCE

The May LMC Board meeting was cancelled as it clashed with the Conference of LMCs UK in Belfast that several Board members attended. Unfortunately, I could not be there due to my health issue, and I greatly missed it, being the second that I have missed since first attending in 1992. I was even phoned by a journalist after the conference asking why I had not attended. Once again LLR LMC had some crucial motions that were chosen for debate. Once a motion has been passed it becomes policy for the GPC to deliver on.

The first main motion of the day following the introductory business was to be proposed by LLR LMC which Dr Fahreen Dhanji did on our behalf and can be watched here. This debate, including quoting our own Dr Fahreen Dhanji, was reported in Pulse Today.

AGENDA COMMITTEE TO BE PROPOSED BY LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference notes that GP practices are expected to deliver care in environments that are increasingly unsafe due to excessive workload, inadequate staffing, and insufficient funding. Conference is concerned that despite safe working limits being a fundamental requirement for patient safety, they are not embedded in general practice across the UK. Conference calls on the BMA to:

(i) ensure workload limits reflect consultation complexity and supervision responsibilities
(ii) demand funding and contractual mechanisms that allow practices to meet minimum safe working standards, opposing contractual requirements that mandate increased access without corresponding resource
(iii) support practices who refuse unsafe working conditions that arise as a direct consequence of systemic underfunding
(iv) lobby UK governments and NHS bodies to ensure that when practices reach safe capacity, excess demand is met by appropriately commissioned alternative services, rather than being absorbed by general practice
(v) lobby UK governments to move away from access / volume metrics and move towards activity-based performance measures that value continuity, expertise, and population health outcomes.

Next, we had a motion 'in the bracket' with composite Motion 8 that Dr Nutan Kumari spoke very elegantly to and was passed in all parts. Watch her speech here.

8 AGENDA COMMITTEE TO BE PROPOSED BY NOTTINGHAMSIRE: that conference believes that the GP's clinical autonomy and right to refer are fundamental to safe and effective patient care, and calls on governments and health bodies to ensure that:

(i) any advice and / or guidance systems are optional, clinically appropriate, properly resourced, do not delay access to clinical care, and patients are able to resume their place in the waiting list if the practice disagrees with the advice
(ii) performance incentives must not be achieved through the discharge of patients without assessment so that all discharges include clear clinical ownership and transparent accountability (iii) reductions in referral-to-treatment waiting lists reflect genuine clinical review or treatment rather than administrative removal
(iii) clear, nationally agreed standards are developed defining the responsibilities of hospitals for patients on waiting lists, including timely communication, clinical oversight, and ownership of investigations and follow up.

Next was another motion written by LLR LMC and proposed by Dr Fahreen Dhanji and passed. Click here to watch her speech:

13 LEICESTER, LEICESTERSHIRE AND RUTLAND: That conference is concerned about the growing number of software programmes that undermine patient safety, increase GP workload, and reduce the accuracy of GP held patient records and demands that before any programmes are rolled out in any UK nation, that the JGPITC is consulted.

You may recall from newsletters passim that we had raised the inappropriateness for patients to be able to write Google Reviews as practices cannot normally respond due to risk of breaching patient confidentiality. Many other LMCs had also raised this so we sent a motion on this to the conference, which was passed, so it is now GPC E policy for them to persuade Google that, like schools, people should not be able to post comments about general practices.

Finally as you have likely heard or read a motion was passed that included that conference "*directs GPC UK to work with all GPCs to ballot the profession on a plan B option for general practice provision that includes consideration of a means-tested, subscription-based service, such as those being offered currently by NHS dentists.*

This was very much a last resort but is in response to year after year of imposed changes to GP contracts which is making the situation worse for practices, the health economy.

The GPC England resolved in their first meeting following conference to ballot the profession regarding this.

As I could not be part of the debate at conference, I have sent this to one of the LMC support groups: "I do not think that many practices would survive going fully private whilst there remained an NHS rump. Any other solution would depend upon the government changing how the NHS is funded but I would be loathed to be a part of this when the international evidence is that health systems which are insurance based have much greater administrative overheads and do not lead to better healthcare. The national and international data shows that the more a system invests in their primary medical care the better health outcomes are and the lower overall cost. We should be majoring on telling politicians, the media and the public this. If only HPERU still existed because we could do with a proper analysis following the fall of the percentage of NHS funding going to general practice against proxies for the health of the nation like the life expectancy rates which faltered and then have fallen since the % started to reduce under the conservatives. The infant mortality rate in Leicester City has fallen to the second lowest in England and in a meeting with PH colleagues to discuss the possible causes they had not even thought to look at ratio of GPs to population, which just happens to be the second lowest in England, thus, in my view, just demonstrating what Barbara Starfield found in her research published in 1994 that there was a direct relationship between infant mortality and ratio of primary care physicians to the population. Sorry that I was not fit enough to attend the conference to put forward this alternative view."

This has been reported by Pulse Today the BMA has given this response. The BMA's press release can be read here:

The LLR LMC team that successfully navigated several proposals from our area to become GPC E policy. From Left to Right: Dr Shiraz Makda, Dr Nutan Kumari, Dr Ebrahim Mulla, Mrs Sarah Gibson, Dr Fahreen Dhanji.

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2. REBUILD GENERAL PRACTICE AND OTHER PETITIONS.

General practice is the front door to the NHS and still provides most healthcare — but it is under increasing pressure. Patients are finding it harder to access care, and GPs are struggling to provide the continuity and quality of care they were trained to deliver.

1. Rebuild General Practice has launched a petition calling on government to restore capacity, protect continuity of care, and secure the future of the family doctor model. You can sign the petition here

2. There is also a 38 degrees Petition demanding that the new Health Secretary, Mr James Murray MP to remove Palantir as a supplier to the NHS. Click here to add your name.

3. Dr Tom Kane on behalf of the BMA has started a petition regarding the Government's proposal to reform the GMC, that such reform should ensure fairness for patients and doctors, legally protecting the working title of doctor, being a single-profession regulator, having a legal duty of care to the doctors its investigates, reverting to the criminal standard of proof, disallowing appeals against tribunal decisions if they do not think them harsh enough, becoming subject to investigation when complaints

are made against them, and returning to a governing body with majority of members elected by doctors. Click here to sign. The government's proposed changes can be found here.

4. Keep Our NHS Public has started a petition on the NHS to properly invest in staff and not to replace staff with AI as per the new NHS Workforce plan. To Sign this petition click here or use the QR Code below:

For comments or queries please email the LMC.

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3. LPT – PRESCRIBING BY COMMUNITY SPECIALIST TEAMS.

As per the April Newsletter, the LMC has now met with LPT regarding the community speciallist services that they are responsible for, including the Diana Children's Service.

We made it clear that general practices are neither contracted nor funded to provide specialist services including prescribing on behalf of their services, we also referred to the NHS England and GMC guidance. We quoted some examples of unprofessional behaviour by their staff relating to this. The LPT team agreed that the situation was not right, and apologised. They said that they would take it back to their teams.

If a specialist service decides that medication should be given it should be treated the same as in any other interface between secondary and prinary care. If needed staright away the specialist service should arrange the prescription, otherwise they should ask the general practice if they would prescribe, including being clear on the indication and dose etc. We further noted that Mr Stephen Kinnock MP (Minister for Healh) had confirmed that general practices can turn down these requests on clinical or capacity grounds – ie if the GP does not feel they have sufficient knowledge and experience as per the GMC requirement, or the practice not being contracted or funded to provide the service is unable to help on that occasion.

If you have new occurances of this nature, please contact the LMC so we can take it up with LPT.

For comments or queries please email the LMC.
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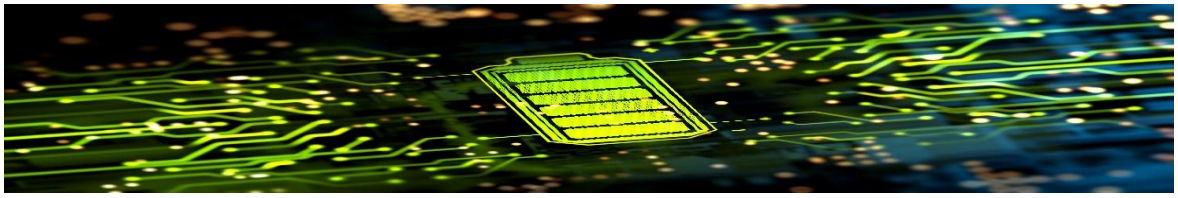
4. VOLUNTARY LEVY.



In our April Newsletter we raised the issue that a minority of practices were not paying into the Voluntary Fund for the GP Defence Fund which is crucial for supporting bit national negotiating but also increasingly the work of Local Medical Committees.

Thank you for the practices that now agreed to start paying and it is apparent that practices didn't realise rather than not supporting such levy.

There now remains very few practices not contributing in LLR, so if your practice is not paying – we ask you to please consider starting to do so to support this important fund. The LMC Board is of the view, that for fairness, we will need to decide what services are funded via GPDF and therefore cannot be provided to these very few practices. I am loathed to have to do this, but the Board feel that we no longer have a choice.

If your practice is uncertain whether to pay, please contact the LMC and we can arrange a Teams meeting to discuss with your partners and managers (this would also look good in your CPD 😉).

For comments or queries please email the LMC.

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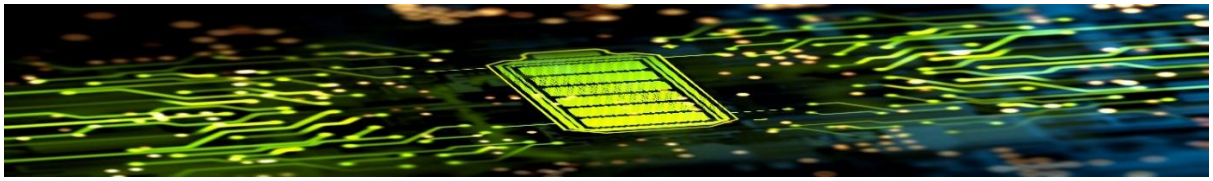
5. CHANGES TO UNIVERSAL CREDIT PAYMENTS.



We have been sent the following information from GPC England which we think practices need to be aware about.

On 6 April 2026 the Department for Work and Pensions (DWP) made changes to Universal Credit payments, meaning that patients who are assessed to meet the Severe Conditions Criteria will receive the highest benefit entitlement. These criteria will be used to identify those with the most severe, lifelong health conditions or disabilities, who are unlikely to improve, and those who are not expected to ever be able to work.

When making a claim, if they think they meet the Severe Conditions Criteria, patients will be asked to send DWP any supporting medical evidence they already have.

DWP does not expect GPs and their teams to do any additional work for this new Criteria. In the event that a patient requests evidence from a GP team to support their claim, please advise them that the DWP, if they need it, will request any further information they require from the patient directly in the standard way. There is no need to provide any additional evidence directly to patients.

For comments or queries please email the LMC.

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

FIRST IMPORTANT: AS OF YET THERE HAS STILL BEEN NO CHANGE IN CONTRACT FOR ANY PRACTICE (REGARDLESS OF THE RECENT ERRONEOUS NHS BULLETIN ABOUT EMAILS FOR COMMUNICATING WITH PHARMACIES WHICH IMPLIED THERE HAD 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.

For the detail about what must happen before the contract changes become contractual, please see the LLR LMC April Newsletter. As at the time of writing this newsletter (28 May 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 yet another two months.

I also note that NHS England's webpage about the 2026/27 contract is still blank in their section about the "GP Model Contracts and Contract Variations" – see here.

The LMC has also issued a press release about the imposed contract, Collective Action, and the association between poor national policies, disinvestment in general practice, and the negative effect this is having on the health of the nation. Click here to read.

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.

COLLECTIVE ACTION

In summary the first part of Collective action is for practices to compile a list of bodies that they are sharing data with and to send every new requested DSA to the BMA and the second part starting from 1st June is to stop using medication optimisation software and for GPs to prescribe the medication that they feel is most appropriate for their patients.

Your LMC strongly advises that every practice participates in the Collective Action as recommended by GPC England of the BMA. The action and all related documents have been checked by a leading KC to ensure that they do not put practices at risk of contractual or other legal breach.

GP COLLECTIVE ACTION MAY 2026 – DATA SHARING AGREEMENTS

The GPC is urging GP partners and practices to take part in their current collective action, focusing on the flow of GP patient data outside practices, in the form of practice DSAs (data sharing agreements).

This action may reduce the liabilities on a partnership, and it will impact integrated care systems and the wider NHS Government agenda which is increasingly seeing a 'left shift' of work from hospitals into practices, without any commensurate resource to meet the challenge.

Action for practices:

- **If not already done so to write to the ICB's CICO (Dr Rowan Sil) using the template advised by the GPC E. A localised version of the letter can be downloaded here.**
- **Refer any new DSA requests to the BMA via gpcontract@bma.org.uk**
- **Carry out an audit of all existing DSAs that your practice is signed up to – see our guidance >**
- **Initiate a conversation with your PPG (patient participation group)**

Dr Rowan Sil (CCIO, LLR ICB) has sent a generic letter in response to the BMA letter to practices. His letter is correct in that the ICB may not know about every data sharing agreement every practice has in place. We recommend that once you have Dr Sil's reply that you then contact your Data Protection Officer (DPO) and ask whether they are aware of any additional data sharing agreements that the practice has in place.

The GPC has prepared a **range of resources** to help practices understand the need to take part in this collective action.

Taking part in this action will both help your practice stay safe and put further pressure on the Government to build on the progress made and secure safeguards for practices to be able to deliver their GMS contract safely. The action is straightforward and does not breach your contract. As we have experienced in LLR if practices work together this is powerful and can force positive change for general practice.

Access the GPC's guidance on their **campaign page** with the latest updates and guidance about the 26/27 contract changes and our dispute with Government, to help support you and your practices

GP COLLECTIVE ACTION JUNE 2026 – MEDICINES OPTIMISATION SOFTWARE

GPCE (GPs committee England) met 21 May, to discuss all the issues currently faced by general practice as well as the next steps for collective action given the imposed contract we are working under since April 2026.

GPC E have issued the following message about the next phase of Collective Action:
GPCE (GPs committee England) met, 21 May, to discuss all the issues we currently face as well as the next steps of our collective action given the imposed contract we are working under since April 2026.

GPC E have issued the following message about the next phase of Collective Action:

"*The next action, from 1 June, is where we ask you to remove or ignore any non-contractual medicines optimisation software, and amend your choices of acute prescriptions which may fall outside the remit of the ICB formulary. For example, issuing a branded or liquid formulation may still be a perfectly acceptable and justifiable choice for the care of the patient in front of you in the consultation. This action would not go so far as to breach any regulations pertaining to you or your contract. We know some of you may have this software added onto your system as part of a locally commissioned service and we will issue more guidance in the first week of*

June, unless action can be averted by Government. Your LMC will also be able to advise further on this in due course. We are not asking you to take this action now, but will write to you again in June, if this planned escalation cannot be averted.

We are urging GP partners and practices to take part in our current collective action *– see below for more information on this.*

After Wes Streeting's resignation, we have ***written*** *to the new health secretary, James Murray, to request an urgent meeting to resolve the current dispute arising from the imposed 2026/27 GP contract.* ***Read the BMA response statement >***

An aspect of considerable concern is the new Health Bill going through Parliament which was announced in the recent King's speech. The main issue before us is a proposed SPR (single patient record) containing all of our GP notes. Our politicians seem to be seeking considerable oversight and control of this data from what we have seen in the initial documents published. Confidentiality of our patients' data is of course fundamental to the patient-doctor relationship and any hint of politicians using this data for their own or commercial purposes will lead to a lack of patient trust. Any good intentions are obscured by the power grab and the complete lack of protections for patients. You may wish to ***read this briefing from MedConfidential >***

The committee has serious concerns about this bill, and the BMA will be fully analysing the legislation and making our views known about the significant concerns we have."

For comments or queries please email the LMC.

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7. ICB'S POSITION STATEMENT REGARDING TIRZEPATIDE FOR OBESITY

The ICB has shared their position statement regarding prescribing Tirzepatide for obesity. The document is so full of errors and inappropriate comments that we suggest if it is circulated practices should ignore it.

We have previously made it clear to the ICB that if they do not commission a service from General Practice, they cannot expect General Practices to prescribe Tirzepatide for obesity. Practices can choose to prescribe tirzepatide, but they would be doing so at the cost to the practice and only by diverting funds from other areas.

The ICB have referred to the new QoF points. As one of the original designers of QoF it was never designed to fund activity other than the activity of quality assurance to ensure that services are provided. One of the initial and enduring principles has been that practices can except patients when a local service is not being commissioned. As a local service is not commissioned locally, it would seem appropriate for practices to exception report for these indicators.

We have advised the ICB about their legal obligations as this is a NICE technology appraisal. ICBs are required to commission services to implement NICE Tas by virtue of section 6 of The National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 and that section 8(b) makes it clear that that the ICB will need to allocate funds from its existing budget to do so.

The ICB has further suggested they could mandate general practices to prescribe. There is no contractual or other requirement for general practices to provide any specific service, indeed that it is a decision to be made by the practice is very clear in the contract. In the obiter statements in the case "**R (British Medical Association) v Northamptonshire County Council & Others [2020] EWHC 1664"** the judge made it clear that there was no requirement on general practices to provide safeguarding reports for free. This principle can therefore be applied to all services – i.e. there is no requirement for general practices to provide any service for free (unless there is a contractual or legal requirement to do so).

If you are contacted by the ICB and put under any pressure to prescribe, please contact the LMC.

For comments or queries please email the LMC.

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8. THE CAMERON FUND – THE GPS' OWN CHARITY.

The Cameron Fund is the GPs' own charity, the only medical charity which solely supports GP and their families in times of financial need, whether through ill-health, disability, bereavement, relationship breakdown or loss of employment.

Sir James Cameron started the charity in 1970 when he was Chair of the GMSC (forerunner of GPC England). He initially persuaded the Government to provide funding to start the fund, but since then it has relied upon donations.

To be eligible for assistance applicants must have worked as an NHS GP for at least one year, and ST3 GP Registrars can apply for interest-free loans for exams. The help is usually a monthly grant towards essential family living expenses, and by referring applicants to a Money Adviser who advises on benefits, debts and budgeting.

Over recent years there has been increase in GPs needing help, whilst the Cameron Fun income has struggled to keep pace. Half the income comes from the original investment fund, and it relies on donations from LMCs and individual GPs for the rest.

This is one import body that can support GPs finding themselves in difficulty that the LMC signpost members to.

Find out how you or someone else can apply for help, or how you can help by donating: www.cameronfund.org.uk

(Declaration of Interest: I have been a member of the fund for many years, although I am not on the group that makes funding decisions).

For comments or queries please email the LMC.

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9. BENZODIAZEPINES AND THE NERVOUS FLYER.

As we head into the main holiday season, I suspect many of us will yet again be asked by patients to be prescribed diazepam due to fear of flying, despite many good reasons that they should not be prescribed for this. I am aware that many practices already have developed their patient information, but one of the recurring issues is that not all doctors have the same policy with one or more still willing to prescribe. I referred to the vicarious liability that may occur for the partners if not all GPs are keeping to the same policy with the worrying case of partners facing a £10million legal claim in our November 2025 Newsletter when a salaried GP signed a fit for skydiving certificate despite the practice policy being not to sign similar certificates.

The following should be useful to use in discussions in your practice and help develop practice policy and information leaflets. It has been written by Dr Clare Hunter, a friend who is a GP with a special interest and training in aviation medicine.

This briefing provides a summary of important considerations when considering prescribing benzodiazepines at a patient's request for anxiety related to flying. As of now, no formal guidance has been identified.

1) Using any central nervous system (CNS) depressant can lead to longer reaction times and slower thinking (1)(2), which, during a flight, could significantly impair a passenger's ability to act in a life-saving manner during a safety-critical incident. There will be no one else to do it for them—cabin crew are there to guide, not to act on their behalf. Incapacitation from benzodiazepines poses a risk to everyone onboard during an emergency requiring evacuation. [Consider the difference in outcomes from two notable air incidents: BA2276 on 080915 (3) and BA28M on 220885 (4). After the Manchester incident, procedures were revised to include explicit instructions for evacuating quickly, calmly, and safely. Passengers unable to respond appropriately to such instructions are at risk of behaviours more like those seen in the Manchester incident than in the Las Vegas incident.]
2) The use of any CNS depressant may increase the risk of deep vein thrombosis (DVT). These drugs decrease REM sleep and increase non-REM sleep (5). REM sleep usually involves phasic distal muscle twitches (6); therefore, reductions in this sleep stage may increase the theoretical risk of sitting still without moving. The WRIGHT Project demonstrated that sitting for more than 4 hours is a key risk factor, rather than exposure to a hypobaric environment (7).
3) Diazepam has been shown to reduce hypoxic drive (8). Since the O2 saturations of a healthy person with a normally functioning hypoxic drive are around 93% at 8000ft (9), those under the influence of diazepam are risk of lower O2 saturations.
4) A paradoxical increase in aggression may be reported by patients taking benzodiazepines (10)(11) and therefore has the potential to put other occupants of the aircraft at risk.
5) The use of benzodiazepines combined with alcohol consumption increases the effective dose (12) and is therefore likely to heighten the risks discussed here. Many (nervous) flyers may consume alcohol in the terminal before boarding and during their flight, despite any advice given to the contrary.
6) Benzodiazepines are contraindicated in phobic states (13).
7) In some countries, such as in the Middle East, it is illegal to import these medications. Therefore, the passenger would need to adopt a different strategy for the journey home or any subsequent stages.

8) Standard medical indemnity does not cover treatment started outside the UK. It could be argued that medication used during journeys starting outside the UK is treatment initiated outside the UK.
9) NICE guidelines advise against using medication for mild and self-limiting mental health disorders; for more severe anxiety-related conditions, benzodiazepines, sedating antihistamines, or antipsychotics should not be prescribed (14). Benzodiazepines are only recommended for short-term use during a crisis in generalised anxiety disorder, such as acute anxiety emergencies (14). In such cases, patients would not be fit to fly, and fear of flying alone is not classified as generalised anxiety disorder.
10) There is a risk of addiction associated with benzodiazepine use (15).
11) There is an increased risk of dementia in benzodiazepine users (16), although it is unclear whether this risk affects only regular users or also occasional users.
12) There are several high-quality fear-of-flying courses available in the UK, which are easily accessible to those who wish to fly & conquer their fear of flying (17)(18).

There is only one scenario in which Dr Hunter suggests you could consider prescribing: when the benefits of undertaking the flight clearly outweigh the risks of prescribing the medication, and the risks can be minimised as much as reasonably possible. For example, this includes medication use in full collaboration with the airline medical department, having a medically trained escort, and liaising with and obtaining clearance from the relevant customs authorities and Medical Defence Organisation.

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For comments or queries please email the LMC.

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10. SEMAGLUTIDE FOR CVD (NICE TA).

NICE have recent issued Technology Appraisal Guidance for prescribing semaglutide for reducing the risk of major cardiovascular events. We have written the following email to the ICB to make it clear that they will need to properly commission this service and not expect general practice to just take on the additional working unfunded:

"Hi All

NICE have recently published Technology Appraisal guidance regarding Semaglutide for reducing the risk of major adverse cardiovascular events: Overview | Semaglutide for reducing the risk of major adverse cardiovascular events in people with cardiovascular disease and overweight or obesity | Guidance | NICE

Further we note that ICBs are required to commission this service by virtue of section 6 of The National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 and that section 8(b) makes it clear that that the ICB will need to allocate funds from its existing budget to do so.

Have the ICB considered who they plan to commission this service from? If you are considering commissioning from general practice, I would kindly remind you of the need to consult with the LMC and suggest that this happens at an early stage.

Best wishes

Grant"

For comments or queries please email the LMC.

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11. PODCASTS.

The LMC continues to develop 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

- **May 2026 LLR LMC Podcast – Conversation between Charlotte Woods, Fahreen Dhanji and Grant Ingrams**
- **April 2026 LLR LMC Podcast – Conversation between Charlotte 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

- **2026-04-23 Employment Law Update (Session 1)**
  - 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

- **2026-04-30 Employment Law Update (Session 2)**
  - 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
- 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

- 2026-05-13 Conference of LMCs UK Motion 5 proposed by Dr Fahreen Dhanji
- 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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12. UPCOMING LMC EVENTS.

Please find below confirmed LMC events. Book early to avoid disappointment as they are often over-subscribed. Where we can we are now recording Webinars, so if you can't remember what was said, or could not attend a session please check in the Podcast section.

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.

RESCHEDULED: MEET THE NEW CQC TEAM AT LLR LMC WEBINAR

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.

Date: Monday 29th June 2026
Time: 12.00 – 1.00pm

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 an 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.

To reserve a space, please email: **enquiries@llrlmc.co.uk**

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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13. 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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14. 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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15. FINAL THOUGHTS

A NEW BROOM

Unless you have been living under a rock you will know that we have a new broom - a new Secretary of State for Health and Social Care – Mr James Murray. This is the 20th SoS for health (and social care) during my career. Many of the previous encumbants I had met, knew, or at least had heard of them, but the current reincarnation is completely unknown to me.

Following my usual pattern I wanted to start with a quote and found a few that may be relevant to this situation:

- A new broom can sweep the floor, but an old broom knows where the dirt is.
- A new broom sweeps clean, but an old broom knows the corners.
- A broom is drearily sweeping up the broken pieces of yesterday's life.
- I think we are all frightened a little bit when a new broom starts to sweep.

First we need to consider Mr Wes Streeting's Legacy. If you believe the hype from Mr Keir Starmer (Prime Minister) he single handedly turned around the NHS, saying that "The NHS is back on its feet."

But what is the real legacy? First that despite commissioning and being involved in various reviews he failed to act on the findings. They all stated that general practice is on it's knees – being asked to do too much for too little, that there needs to be a significant increase in the proportion of NHS funds spent on general practice, that there needs to be investment in improving general ptractice premises whilst at the same time noting that general practice was the most productive and demonstrated the best financial controls.

So has there been a significant increase in general practice core funding – no. What he did was to impose contract changes that required much additional work for less than adequate funds, and continued the ongoing situation with continuity and quality being sacrificed on the altar of access.

He also introduced a 10 Year NHS Plan that has good ambitions but provides no vision of how this can be achieved. Indeed the proposals for change within it are likely to make things worse rather than better. He decimated local management, and put national management in disarray by announcing the dissolution of NHS England with no plan as to how the crucial functions will be delivered leaving the NHS with minimal capacity to carry out the proposed transformation even if anyone had an idea what is needed.

So his real legacy is that the health of the nation has continued to decline with a further reduction in life expectancy and the UK now being considered to be the sickman of Europe (newsletters passim). This effect has become very stark locally with the situation in Leicester City. In line with international research that demonstrates a linear relationship between infant mortality and ratio of GPs to the population, both of these now the second worse in England in Leicester City.

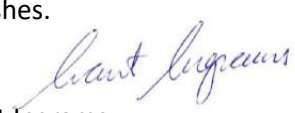
So is the new broom going to sweep out the old debris and leave the NHS sparkling? Well, the vibes so far are not good.

Mr James Murray has written to all NHS troops to provide insipration and succour to NHS workers. If you have not read it, it can be read here. I do not think that this is going to enter the list of greatest letters, or even the list of most inspirational letters. Make up your own mind, but I think it lacks leadership or vision. It does not give any idea what is going to happen next, and reads like a letter

trying to maintain a degree of calm whilst he and the administration are trying to work out what on earth they are going to do next.

In addition there is the new NHS Workforce Plan, a chance to make sure that we will have a workforce fit for the future. It replaces the 2023 plan which envisaged replacing much of the fully trained clinical workforce with physicians associates and other 'enhanced' and 'advanced roles.' Following negative feedback and experience regarding this direction of travel (not least the Leng review) this has been replaced with another whizzo idea which I predict will prove just as unworkable. The new Workforce Plan envisages that we will need significantly fewer clincial staff as they will be replaced by Artificial Intelligence (I kid you not). Whilst as a informaticist I have always been an advocate for embracing new technology, due to the current limitations which are unlikely to be overcome in the medium to long term future, a Star Trek like Emergency Medical Hologram actually able to replace a doctor remains science fiction and to put this in an official workforce plan does make you wonder what the authors were sniffing.

Best wishes.



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P.S. As a footnote, I have been open in this month's podcast about my health which unfortunately will continue to decline. Whilst I still have the energy I promise I will continue to fight to protect and promote general practice with every fibre of my being. I apologise if at times this means you have to wait a bit longer for replies to queries, and this is the reason why this newsletter is later than usual.