



Calling all GPs - your LMC needs you!

A message from Dr Diana Hunter, Chair of Cambs LMC

In March 2027, Cambs LMC will be inviting nominations to fill half of its committee seats, which are up for election. This happens every couple of years and is vital to ensuring that the committee continues to reflect the breadth of experience, views and challenges faced by GPs across Cambridgeshire and Peterborough. We are particularly keen to have a diverse range of colleagues represented, including GPs at different stages of their careers and those working in different practice settings and localities, so that the committee truly reflects the profession it serves.



This election is particularly important. When the new committee meets in April 2027, it will elect a new chair, which means finding someone to take over from me. Standing orders limit the Chair of Cambs LMC to two terms of office. While that might seem very black and white, I also believe that now is the right time for a new chair to lead the committee into the 2030s.

My own journey into medical politics was not a traditional one. I found myself in Huntingdon unexpectedly following my husband's appointment as a consultant. Moving to a new area as a doctor can be challenging, and for a while I felt isolated as a GP, not at practice level but within an unfamiliar local system. A fortuitous conversation with a senior colleague at Hunts Doc, the local out of hours cooperative at the time, encouraged me to put myself forward for the LMC.

I am not embarrassed to admit that I had very little idea what an LMC was or what it actually did! I had heard of it while working in London, but with no experience of medical politics, I assumed it was a role for people who loved debating, something which, quite frankly, terrified me.

Fortunately, my colleague reassured me that the committee was made up of local GPs with different skills and experiences, all committed to working together to support and represent GPs across the county. That was something I could get behind.

And so, my LMC journey began, one for which I am immensely grateful.

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I quickly learnt that at committee meetings, my views mattered. In fact, everyone's views mattered. Speaking in front of 24 colleagues initially seemed daunting, but the committee was, and remains, respectful, supportive and genuinely interested in hearing from everyone. I came to realise that while formal debates at conferences have their place, so too do the more measured discussions around the committee table. In a confidential setting, colleagues can speak honestly, challenge each other's thinking and work together to make decisions that have a real impact on local general practice.

I learnt a huge amount, too. When you are sitting in your consulting room as a GP, it is easy to feel isolated. How much you know about the wider challenges facing general practice depends partly on your role within the practice and partly on whether you can keep up with the seemingly endless stream of gateway messages! Being on the LMC opened my eyes to the wider health system and the national issues affecting our profession. It also strengthened my appreciation of the vital role general practice plays in delivering healthcare to our patients.

So, what does being an LMC committee member actually involve?

The committee meets nine times a year, on Thursday afternoons from 3 to 5.30 pm. Most meetings are face to face, as members value the opportunity to get together. Members also receive an honorarium for their time, alongside reimbursement of travel costs.

We provide an induction for new members and pair them with an existing committee member who acts as a mentor. Agendas are circulated the week before each meeting, giving everyone time to read the papers and prepare.

And if you want to become more involved, there are plenty of opportunities to do so. You could attend LMC conferences or even consider joining the LMC board. The board provides oversight and helps shape the committee's strategic direction.

Being part of the LMC is an opportunity to learn, to contribute and to make a difference. You do not need to be an experienced debater or arrive with an encyclopaedic knowledge of medical politics. You simply need to care about general practice and be willing to listen, share your views and work with colleagues to represent our profession.

As my own LMC journey draws to a close, I do so with some sadness, but also with enormous gratitude for all that I have learnt and the colleagues I have worked alongside. Now, I would love to see someone else's journey begin.

Could that be yours?

If this has sparked your interest, please get in touch at office@cambslmc.org. We can put you in touch with one of our committee members for an informal chat about what being part of Cambs LMC involves.

You might be surprised by how much you have to offer, and by how much you stand to gain.

Diana

GP Committee Election

2027

Cambs LMC

Representing • Supporting • Advising



Help shape the future of General Practice



**Support
GPs**



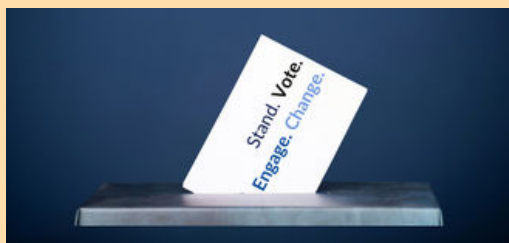
**Tackle
challenges**



**Influence
change**



**Build a
stronger future**



We hold elections every two years and invite all constituent GPs who work within Cambridgeshire and Peterborough to consider standing for election to the Committee



The next election process begins in Spring 2027. We'll start by emailing every constituent GP, inviting them to consider standing for election and joining the diverse range of voices representing the local profession on your Committee.

This is your opportunity to be part of that representative process. By standing for election, you can make a real difference to your colleagues and help shape the future of the profession at a time when strong leadership is vital, both locally and nationally.

Make sure we have your up to date email address

So you don't miss important updates, newsletters and election information

If you know any GP colleagues who haven't heard of us, aren't sure who we are or what we do, or aren't receiving our communications, please encourage them to get in touch. We'd be delighted to hear from them at office@cambslmc.org.

AI FUNCTIONALITY WITHIN ONLINE CONSULTATION AND TRIAGE SYSTEMS

► Advice for Practices

We are aware that some providers of online consultation and triage systems are introducing new AI-enabled functionality, including automatically generated follow-up questions based on information submitted by patients.

For example, Accurx has advised practices that its new Smart Triage Questions functionality is being enabled automatically, unless practices request a delay.

Practices should be able to satisfy themselves that any new functionality is clinically safe, appropriately governed, and consistent with their responsibilities for protecting patient information.

What should practices consider?

- **Clinical safety:** Practices should understand how AI-generated questions are determined, whether they could inadvertently influence subsequent clinical decision-making, and what clinical safety assurance has been undertaken. Supplier clinical safety documentation should inform, but does not replace, appropriate local assessment of risks and workflows.
- **Information governance:** Practices, as data controllers for relevant processing of patient information, should understand what information is being processed, for what purposes, by whom, and under what contractual arrangements. Any material changes may require review of existing data protection impact assessments (DPIAs), privacy information and data processing agreements.
- **Patient choice and transparency:** Patients should be appropriately informed about the use of AI in their care. Practices should consider whether alternative routes for accessing care remain available, particularly for patients who cannot or do not wish to use AI-enabled systems.
- **Local decision-making:** The introduction of new functionality by a commercial supplier should not be assumed to remove the need for appropriate local clinical and information governance assurance. Practices should be able to establish what options exist to defer or disable functionality pending that assurance.

Can practices switch this functionality off?

For Accurx specifically, practices have been notified by email about the introduction of Smart Triage Questions, including a 'delay the switch-on' link. We understand that practice administrators can use this link to request that the functionality is not activated at this stage. One local practice has confirmed that its request was actioned within a few hours.

Practices wishing to defer activation should check their correspondence from Accurx or contact support@accurx.com directly. If the functionality is already active, they should request confirmation of the available options for disabling it.

For other providers, practices should contact their supplier to establish whether AI functionality is optional, how it can be disabled, and what contractual or operational implications may arise.

Our advice

Practices should not feel obliged to adopt new AI-enabled functionality before they are satisfied that appropriate clinical safety, information governance, and operational assurances are in place.

The important principle to remember is that innovation should be introduced transparently, with appropriate assurance and meaningful engagement with the organisations responsible for delivering patient care.

We are happy to receive feedback from practices experiencing difficulties with the introduction of new AI functionality, particularly where they are unable to defer implementation pending appropriate local review.

ICB INVITATION FOR NHS APP AI TRIAGE PILOTS

➤ Advice to Practices considering participation

On Tuesday 13 October via Gateway email PC1116, Central East ICB invited practices, PCNs, and groups of practices to express an interest in participating in NHSE's Intelligent Navigation programme, specifically a pilot of AI-enabled triage through the NHS App and other routes. The deadline for expressions of interest is 28 October 2026.

Cambs LMC welcomes the ICB's commitment to evaluating these technologies properly and welcomes the clarification that expressing an interest will not commit practices to participation. We note that this current invitation relates only to Stage 1. It is self-evident that further clinical safety, financial, and contractual assurances will be necessary before practices are asked to sign an agreement, as we believe there are important reasons for practices to exercise considerable caution here.

Our advice is that practices should not feel under any pressure to volunteer for this pilot at this stage. We would recommend waiting until the outstanding clinical safety, contractual, financial, and operational questions have been satisfactorily resolved before considering participation.

Why are we advising caution?

Clinical safety and accountability. The proposed technology is intended to influence how patients are assessed and directed to care, potentially including advice to self-manage without further clinical assessment.

While the supplier will be required to provide regulatory and clinical safety assurances, participating practices will also have responsibilities for assessing the safety of deployment within their own services.

The ICB has acknowledged that this is a substantial piece of work and intends to offer support. Nevertheless, practices will need to understand the clinical risks they are accepting, how errors will be identified, and where responsibility and liability will sit if patients go on to experience harm.

Financial and workforce implications. The costs of the technology itself will be met centrally, but the funding available to practices for implementation, training, clinical governance, evaluation, and ongoing operational work has not yet been agreed.

Participation is likely to create considerable additional demands on already stretched clinical and managerial teams. Practices should be cautious about taking on new responsibilities without clarity about the resources required to discharge them safely.

There are unanswered questions about the longer-term consequences for general practice funding and workforce capacity if the technology is subsequently adopted more widely.

Patient access and inequalities. The NHS App is currently available in English only. Although telephone and receptionist-supported alternatives are proposed, the effectiveness and accessibility of these arrangements are yet to be launched.

The evaluation must establish whether the technology works safely and equitably for the full range of patients served by general practice, including those who face language, disability, or digital access barriers.

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Workload and wider system capacity. AI-assisted navigation may change where patients are directed, but it cannot create additional clinical capacity in services that are already under pressure.

Practices will need assurance that their registered patients directed elsewhere will access the services recommended; that unsuccessful navigation will not create additional work for general practice; and that existing contractual responsibilities beyond 08:00-18:30 will not inadvertently be extended to 24/7 - as is suggested in later phases.

The ICB has confirmed that securing the participation of other providers will be its responsibility, which we welcome.

The purpose and consequences of the evaluation. A properly conducted pilot should establish whether the technology is safe, effective, equitable, and cost-effective - including whether it genuinely reduces overall workload rather than simply transferring activity or risk between providers.

It should also establish the impact on continuity of care, patient outcomes, and the costs of delivering such services.

We would be concerned if assumptions about future efficiency savings or reductions in general practice resources were made before these questions had been answered.

What should practices do?

We recognise that some practices may be interested in contributing to the development and evaluation of new technology. The ICB has confirmed that submitting an expression of interest is not binding, and individual practices are free to explore the proposal.

Nevertheless, our recommendation is that practices should consider carefully whether becoming an early test site is an appropriate use of their limited clinical and managerial capacity at this stage, particularly when key aspects of the funding, clinical governance, and liability arrangements remain unknown.

Practices should not enter into a site agreement without first obtaining appropriate advice and satisfying themselves that the risks, responsibilities, and resources are fully understood.

For practices interested in supporting the evaluation, the ICB is also seeking comparator sites which would contribute to the evidence base without implementing new technology. This may provide an alternative worth exploring, subject to appropriate arrangements for funding and data collection.

The separate remote blood pressure monitoring pilot should be considered on its own merits and does not carry an identical set of considerations.

The LMC's position:

We are keen to work constructively with the ICB to ensure that innovation in general practice is evidence-based, clinically safe, appropriately funded, and designed around the needs of patients and practices. We appreciate the ICB's engagement with concerns we have raised, and its willingness to involve the LMC in agreeing the evaluation framework.

However, it is precisely because this technology remains under evaluation that we believe practices should remain cautious about volunteering to deploy it, before the outstanding assurances are available.

Our role is to help practices make informed decisions about the responsibilities and risks they are being invited to accept. We will continue to engage with the ICB on behalf of practices and review our advice as further information becomes available. Practices considering participation are encouraged to contact the LMC office before entering into any agreement.

Update for Practices

You may have seen the recent ICB briefing about the planned rollout of DELPPHI, the population health management (PHM) data and analytics system. We have received a number of queries from practices, so we wanted to clarify the current position.

Practices in Hertfordshire are already familiar with DELPPHI, while BLMK and Cambridgeshire & Peterborough are being asked to adopt the system anew, as part of a single ICB approach to PHM.

The LMC recognises the potential benefits of having a consistent PHM system across our area. Used effectively, it will not only help identify population health needs, but support service improvement through identifying and inform the development of more joined-up care.

However, before practices are asked to formally participate, we are working with the ICB on three important areas:

1. Information governance

Practices will need to enter into a new Data Sharing Agreement. The LMC has reviewed the draft documentation and provided feedback to the ICB. Discussions are continuing to ensure that the appropriate governance arrangements are in place and that practices have clarity about what they are being asked to agree to.

2. Support for onboarding

Hertfordshire practices have received support with the introduction of DELPPHI. We are discussing equivalent support and funding arrangements for Cambridgeshire & Peterborough practices, including assistance with the initial implementation and data flows.

3. Funding for additional work

PHM may identify groups of patients who could benefit from proactive care, reviews, coding, care planning or referral into other services. Where this generates activity beyond existing contractual responsibilities, there needs to be a clear agreement about how that work will be commissioned and resourced.

We support the principle of using better data to improve patient care and to support the development of neighbourhood-based services. Our role is to ensure that this is implemented in a way that works for practices and does not result in additional unfunded workload.

What does this mean for practices now?

There is currently no expectation for Cambridgeshire & Peterborough practices to make changes or formally commit to DELPPHI.

The LMC will continue discussions with the ICB and will update practices once the outstanding issues have been satisfactorily addressed and there is a clear position on next steps.

We will keep you informed as the rollout develops.

DIGITAL CONSENT FOR VACCINATION PROGRAMMES

► Templates for General Practice's that use Accurx

Digital Consent Templates for Vaccination Programmes

Below is a suite of digital consent templates for use within Accurx, covering flu, COVID-19, childhood flu, shingles and RSV (for non-pregnant adults). These templates were developed by Avon LMC and are shared with thanks.

These templates are provided as a resource only. Practices are responsible for reviewing the content, ensuring local requirements and governance arrangements are met, and determining whether it is appropriate for their patient population. Practices are welcome to adapt the templates as required. Any digital consent process should be supported by a local policy or practice protocol.

Key considerations

- Consent is a process, not a one-off event. Patients should have the opportunity to ask questions or request further discussion before making a decision.
- Patients should be provided with information about the risks and benefits of vaccination to support informed consent.
- Digital consent may not be suitable for all patients, including those with limited digital literacy, language barriers, low literacy, capacity concerns, or those requiring information in accessible formats.
- Alternative methods of obtaining consent should remain available where appropriate.

Prescriber responsibilities

Where vaccines are administered under a Patient Specific Direction (PSD), prescribers should have visibility of the recorded consent and be satisfied that:

- the patient has received appropriate information and can make an informed decision
- consent is informed and voluntary
- the patient is eligible for vaccination
- there are no contraindications or precautions to vaccination

The assessment of suitability and consent process should be completed before the PSD is signed. Prescribers remain professionally and legally accountable for the prescribing decision and the delegation of vaccine administration.

A note on implied consent

We are aware that some practices are sending vaccine information via Accurx and advising that attendance for vaccination will be taken as consent. We would not advocate this approach.

Attendance alone does not provide clear evidence that a patient has read, understood, and considered the risks and benefits of vaccination. A documented consent response provides a more robust record of informed consent and supports the prescriber in making an informed prescribing decision before signing a PSD.

Accurx Links for Digital Consent Templates

Children's flu: <https://web accurx.com/import/bybthvauus>

Adult flu: <https://web accurx.com/import/sdvuyjn8cq>

RSV: <https://web accurx.com/import/x8mtfb7c66>

Covid: <https://web accurx.com/import/59ktrvuszs>

Shingles: <https://web accurx.com/import/zh3g877ps8>

Importing the templates

We hope these templates support practices in developing safe, effective, and patient-centred digital consent processes. The process for importing questionnaires is straightforward. Guidance is available [here](#)

Further information

Further Information regarding assessment and consent for immunisation under a PSD can be found [here](#).

NEW DHSC/NHSE ACCESS METRICS

► Check your Appointment Mapping

From 1 April 2026, two new metrics were introduced to monitor general practice access: clinically urgent patients dealt with on the same day, and non-clinically urgent patients seen within 7 and 14 days. For most practices, this is about getting the coding right, rather than doing more work.

Practices should review their appointment mapping to ensure clinically urgent appointments are coded as General Consultation – Acute, routine appointments as General Consultation – Routine, and care home appointments as Care Home Visit, where appropriate. Planned appointments should use suitable codes that do not distort routine access figures.

GP practices are contractually required, from 1 April to deal with all requests they identify as clinically urgent on the same day. This does not mean every patient must have an appointment; an appropriate response could include an appointment, advice, signposting to another service or communication about next steps.

For NHS England's same-day access monitoring, relevant appointments should be coded as General Consultation – Acute. Its planning framework sets a 90% measure for clinically urgent patients to be seen on the same day by March 2027. This is not a contractual target, and any target for 2027/28 remains subject to confirmation.

Practices should also check that their clinical triage activity is mapped appropriately, particularly where triage staff also consult with patients or resolve queries.

[Our full guidance](#), with thanks to Beds & Herts LMCs for shared resources, explains how the metrics are calculated and provides practical advice on reviewing appointment mapping.

SAFEGUARDING UPDATE

► Information Sharing Duty and GP2GP Restrictions

New statutory guidance clarifies GPs' duty to share relevant information to safeguard children, without requiring consent where the duty applies. Practices should ensure information is shared promptly and securely through the appropriate channels.

Separately, practices are reminded to restrict safeguarding, domestic abuse and MARAC information from online patient access. These restrictions do not currently transfer automatically through GP2GP, so practices should check and reapply them when patients register.

Cambs LMC recognises the additional workload this creates and is seeking clarification on potential technical solutions. Practices are encouraged to share any challenges they experience.

Read the full [Cambs LMC guidance on safeguarding information sharing duty](#).



▶ Member tags

We have a thriving WhatsApp community on The Link [click to join](#) which any local GP is welcome to join. In line with GDPR, local performers' list updates are not automatically shared with the LMC, so we need to take steps to ensure our electoral roll/distribution lists are as complete as they can be.

We also appreciate that many of us are anonymous to each other on The Link and it would feel safer for all colleagues if we know the identity of those posting. We would therefore like to invite you to create a member tag on your group profile with your name and role/practice.

We may need to take steps to remove any accounts without an identifier at a future point, to ensure all members are visible and part of our Cambridgeshire and Peterborough community.

How to Add a Member Tag

1. Open The Link WhatsApp group chat
2. Tap the group name at the top to open 'Group Info'
3. Scroll down to the member list to your name
4. Tap Add member tag
5. Type your title (maximum 30 characters; no emojis, checkmarks, or links)
6. Tap Save

Your member tag is unique to each individual WhatsApp group, so how you present your name and role will be unique to The Link *ie Victoria Smith, Village Practice or Raj Kumar, Locum GP as opposed to e.g. a parents WhatsApp group at your child's school, where your member tag may be e.g. Tom Jones, Dad to Leila 7B.*

TIRZEPATIDE (MOUNJARO®) AND QOF OBESITY INDICATORS

▶ Key considerations for Practices

The introduction of QOF obesity indicators OB004 and OB005 has important implications for general practice, particularly regarding workload, funding and the long-term responsibilities associated with prescribing tirzepatide (Mounjaro®).

OB004 focuses on identifying patients living with obesity, recording BMI and referring them to weight management services. This is generally considered achievable within existing practice resources.

OB005, worth 13 QOF points, involves shared decision-making with eligible patients, offering appropriate pharmacotherapy, referral to behavioural support and ongoing clinical monitoring. Practices should carefully assess whether the workload and resources required can be delivered safely and sustainably within the available funding.

Practices should also consider the longer-term commitment: patients started on treatment may require ongoing prescribing and monitoring beyond the current QOF year, while future funding is not guaranteed.

Prescribing must be undertaken by appropriately trained clinicians, in line with eligibility criteria and current guidance, with appropriate behavioural support, shared decision-making and monitoring.

What should practices do?

Practices are encouraged to assess the clinical, financial and operational implications, consider future sustainability and document their decision. QOF participation is voluntary, and a reasoned decision not to pursue OB005 is not a breach of contract. Cambs LMC recognises that practices may reach different decisions based on their local circumstances.

Read the full [Cambs LMC guidance on Tirzepatide QOF guidance](#) on our main [weight management medication in primary care](#) webpage.

Important changes to the GP Reimbursement Scheme

Following negotiations with NHSE and DHSC, BMA is pleased to advise you that the [GP Reimbursement Scheme](#), first introduced as part of the 26/27 GMS contract changes, has been updated. From October 1st practices are able to claim for locum sessions under the scheme, which means that any GP (salaried GP, locum or partner) can provide additional sessions and invoice on a locum basis where appropriate. There are some requirements to fulfil for these claims, and these are explained further in our refreshed guidance linked below.

[The updated SFE](#) also provides additional flexibility around transitional claims and the transfer of unspent funding, which should help practices make full use of the funding available, and other changes around claim amounts and periods. If your ICB is being difficult about claims, please let BMA know at info.gpc@bma.org.uk. [Read the BMA Focus on guidance on the 26/27 GP reimbursement scheme](#)

Single Point of Access and Advice and Guidance

NHSE has published new guidance ([technical guidance](#), [implementation guidance](#)) on developing and implementing Single Point of Access (SPoA) for referrals into specialist care. Importantly, this now states that SPoA proposals must be developed with the relevant LMCs and local GPs, with clear escalation routes for disagreement, uncertainty, delayed or unclear responses, or safety concerns, and that that SPoA does not override GP clinical judgement/right to refer.

Whilst this is welcome, GPCE are still pushing for a pause in implementation of SPoA and A&G pathways following the patient safety concerns raised in the report published by the [HSSIB](#) in August and the consequent ongoing external review commissioned by NHS England.

FP69 national list validation funding

Practices continue to experience an unprecedented acceleration in patient list cleansing, which is becoming one of the most significant financial and operational challenges facing general practice this year. In this financial year it is expected that around 2,000,000 patients will be de-registered as they are not patients residing in the practice area and have moved elsewhere. BMA continues to liaise with NHSE around this process and seek improvements to the way it is being applied.

Following discussions, BMA formally wrote to NHS England to confirm urgent meetings to discuss and agree the reinvestment of funding released through the patient list validation programme during 2026/27. Given the scale of the pressures facing General Practice as we approach winter, and the financially de-stabilising effect list validation will have had on some practices, BMA believes it should be paused now ahead of winter, until we know what is going to happen with the funding. Read the [PCSE guidance on FP69 process](#) and [PCSE FAQs on FP69](#)

MMRV

NHSE has advised that, due to issues with IT systems, in November and December 2026, automated CQRS payments will apply only where children are aged 5 or under when vaccinated. Practices vaccinating eligible children aged 6 during this period must make a manual CQRS adjustment. NHSE will provide further information via the primary care bulletin and CQRS before November.

Childhood immunisation indicators

Practices will be able to earn QOF points for these indicators by improving against their average over the previous 2 years and **will receive whichever points allocation is higher of** either their points based on existing achievement thresholds, or their points awarded on a sliding scale for improvement from their baseline.



Show support for the NHS People Promise and join us for our Building Belonging EDI Discovery Week (19-23 October) with virtual lunch and learn sessions, videos and additional resources, we'll explore how equality, diversity and inclusion help patients and staff feel they belong and thrive. Hear lived experiences, discover practical approaches, and gain valuable insights to take back to your workplace. [Click here](#) to find out more.

Also coming up we've got 2 engaging and informative events facilitated by the LGBT Foundation, find out more and [book here](#).

➤➤➤ ARTIFICIAL INTELLIGENCE (AI): LUNCH & LEARN

Join our quick lunchtime session on Wednesday 21 October, (1.00-2.00pm) to find out the basics of AI: • AI for Everyday Tasks • The Power of Simple AI Tools • AI Chatbots & Effective Prompting • AI Software Examples • Why AI Matters for You. [Click here](#) to book.

➤➤➤ GP & ACP EDUCATION: ADULT MENTAL HEALTH SERVICES

On **Wednesday 11 November 2026** (7.00-8.30pm), Dr Emma Tiffin will be providing an update on the Cambridgeshire ADULT mental health service offer and how to access these services. This will include both NHS and voluntary sector services and local resources that can be used by primary care to support and advise patients with mental health needs. Please [click here](#) to book.

➤➤➤ PRIDE IN PRACTICE

There's still time this year for practices to take advantage of a funded place on the LGBT Foundation's Pride in Practice programme. The 12-month programme provides training, an accredited award as well as ongoing support and resources. [Click here](#) for more information and how to apply.

➤➤➤ TRANSFORMING TOGETHER THROUGH LEADERSHIP

Are you ready to lead change rather than simply respond to it? Join our leadership journey through three interconnected modules exploring personal strengths, system pressures and evolving landscapes, participants will apply learning to lead meaningful action. Build your leadership influence and drive change across integrated neighbourhood health. Applications close 22/10, [click here](#) to find out more and register your interest.

➤➤➤ ARRS GP SUPPORT & DEVELOPMENT PROGRAMME

This programme offers access to education, mentoring and peer support for GPs within their first 5 years of practice who are employed under the Additional Roles Reimbursement Scheme (ARRS) in Cambridgeshire and Peterborough practices. [Click here](#) for more info.

➤➤➤ COACHING AND MENTORING

CPTH offers Coaching and Mentoring, a key professional development tool, for GPs and a variety of other general practice roles. [Find out more here](#).

➤➤➤ COMING SOON!

Our brand-new podcast series, **Coffee Room Curriculum**, is hosted by GPs Kate, Laura and Annete, with inspiring guests who share stories, insights, and honest conversations from across general practice. Keep an eye on our socials and website for the official launch and details on how to listen and watch. Are you looking to deepen your understanding of frailty? We'll shortly be launching a new **MDT Frailty Peer Learning Programme** facilitated by a GP with a specialist interest in frailty and experience in community geriatrics. More details in November's newsletter.

Support and Signposting

Representing

Supporting

Advising

Cambs LMC is always here to represent, support and advise GPs and their practice teams in a safe, confidential space if you are struggling or in distress. We actively encourage you to reach out to us.

Visit our **website** for more information or snap the QR code:



Vacancies in General Practice



We advertise any roles in General Practice on our website: <https://cambslmc.org/jobs/>.

This remains a free service to our constituent practices in Cambridgeshire & Peterborough.

To advertise a vacancy in your practice, please email us the details, including the closing date and any supporting documents in to office@cambslmc.org.

Practices seeking GP Locums - We continue to forward any GP Locum availability you might have to our locum mailing list. When sending requests to office@cambslmc.org to forward on.

Please remember to include a short synopsis of your practice in your requests i.e. where you are, what clinical system you use and relevant contact information.



Email
office@cambslmc.org
to receive our updates

BMA Wellbeing

View BMA wellbeing support services page here:

<https://www.bma.org.uk/advice-and-support/your-wellbeing>

A range of wellbeing and support services are available to doctors, and we encourage anybody who is feeling under strain to seek support, such as the BMA's [counselling and peer support services](#), [NHS practitioner health service](#) and non-medical support services such as [Samaritans](#). The organisation [Doctors in Distress](#) also provides mental health support for health workers in the UK. We have produced a [poster with 10 top tips](#) to help support the wellbeing of you and your colleagues.

The [Cameron Fund](#) supports GPs and their families in times of financial need and the [RCGP](#) also has information on GP wellbeing support.

Visit the BMA's [wellbeing support services page](#) or call **0330 123 1245** for wellbeing support.



CQC Guidance

Guidance for GPs
Youtube
GP Mythbusters

PCSE Guidance

Guidance Pages
Monthly Updates
Youtube

Contact us:

email: office@cambslmc.org
website: www.cambslmc.org

