NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

August 2025

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

Dear Colleagues

LLRLMC NEWSLETTER

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

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

AUGUST PODCAST (21 MINUTES)

SUMMARY OF IMPORTANT INFORMATION:

- New LMC services for practices: TPP Automate, Mediation, Safeguarding Admin Leads Group
- Treatment of dental problems

Topics in this newsletter:

The single most important action any partnership should take to protect their practice, is to have an up-to-date PARTNERSHIP AGREEMENT. Join our Webinar on 9th September about this and other partnership issues.

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

1. LMC MEETING AUGUST 2025.

The LMC Board met on 9 August 2025. Dr Gang Xu (Deputy MD, UHL) and Mr Marwan Habiba (Consultant Gynaecologist, UHL) attended. We discussed various interface issues between ED and general practice including:

- Unilateral changes made by UHL Pathology Labs to stop mycology cultures for nail infections, and to limit requests for BNP blood tests despite CKS guidance saying GPs should be requesting both.
- Dermatology declining referrals and requesting photographs or asking referral to be changed to A&G request instead.
- Orthopaedics discharging patients after trying to phone them on two occasions.
- TWW clinics sending back significant non-cancer diagnoses to GPs rather than referring on to the appropriate clinic.
- That the published UHL Waiting List data does not compare with patient experience. The data is the 'average wait' and we have requested that UHL also includes the longest waiting time.

The LMC was given a presentation from Kerryjit Kaur from the ICB regarding the proposal of a Single Point of Access for both Health and Social Care. This would involve merging three present SPAs into one with effect from September 2026.

Mr Marwan Habiba gave an update about Gynaecology services. He advised that there is now an almost complete separation of gynaecology from obstetrics with the services running separately with dedicated consultants and teams. He was aware of the concern about long waiting times. These have improved and the longest wait is now 4 months, and they plan to reduce the maximum wait of first outpatient appointment from referral to 6 weeks.

Concerns about the time taken for A&G requests were discussed. There are 4,200 A&G Gynaecology requests each year, many of which are complex. Gynaecology are planning to improve the response time, including by developing some standardised advice for common requests.

Finally concerns regarding gynaecology referral pathways on PRISM were raised. Mr Habiba apologised for the situation and advised that they will be simplifying the pathways.

We are pleased to report that we have now concluded the Resident Doctor (GP Specialist Training) and can announce that Dr Syed Rayyan Ahmed has been elected has been elected by his peers to join the LMC and we look forward to welcoming him soon.

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

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2. NHS HEALTH CHECKS – CONTRACT LEICESTER CITY PRACTICES ONLY.

Due to a change in procurement regulations Local Authorities need to change how they contract with general practices for services. So far we have engaged with Leicester City Council regarding NHS Health Checks, but this will affect all LA contracts in future.

This is due to the NHS Provider Selection Regime (PSR) introduced by regulations under the Health and Care Act 2022.

Under PSR Local Authorities are required to align current contracts to abide by these new statutory regulations. Having considered these against the services provided as part of the NHS Health Check contracts we currently hold with Leicester City GP Practices, Leicester City Council have been able to identify that this will come under Direct Award Process B.

To carry on delivering the NHS Health Check Service, Leicester City Council (Public Health) require all Leicester City GP Practices to engage with and complete this process. For those that do not, unfortunately you will no longer be able to deliver the NHS Health Check Service. Therefore, the City Council would really appreciate your cooperation and engagement throughout this process, in turn, they are happy to support you and your GP Practice as much as possible during this time.

This will be a seven-year agreement, subject to contract.

NEXT STEPS AND ACTION REQUIRED

GP practice will need to register on East Midlands Tenders and the GOV.UK Central Digital Platform which is known as 'onboarding.'

There will be further information and support provided during the first week of September, and drop-in sessions will be available throughout September and October to support the onboarding, contract signing, and countersignature of the new Health Check contracts.

At present we are not aware of how Leicestershire County Council will be implementing this required change. LCC was approached to try and have a joint process, but we have been advised that this is not possible

SUPPORT MEETINGS

There will be an initial engagement meeting:

Title:	Introduction Change in Contract for NHS Health Check (CITY PRACTICES ONLY)
Date:	Tuesday 16th September 2025
Time:	1pm to 3pm
Venue:	Virtual/MS Teams
Speakers:	Gavin Yarnold (LCC) and team
To Book:	Email enquiries@llrlmc.co.uk

There will be drop-in sessions for assistance on completing the contractual information for the three weeks between 29 September and 24 October as below.

Week Commencing 29th September – 3rd October: 09:00-11:00, Monday to Friday
Week Commencing 6th October – 10th October: 11:00-13:00, Monday to Friday
Week Commencing 13th October – 17th October: 13:00-15:00, Monday to Friday
Week Commencing 20th October – 24th October:15:00-17:00, Monday to Friday

These drop-in sessions will include 1:1 technical support and offer help and guidance in completing the required documents. Email enquiries@llrlmc.co.uk for more information, or to book a slot.

If you have any questions, please contact the LMC.

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3. NHS 10 YEAR PLAN.

Implementation of the 10 Year Plan continues very slowly.

At present it is still unclear what bits will be implemented and within what timescale.

This is happening against a background of a significant reduction in the capacity and funding of the ICB (which now has to achieve a further 50% reduction on top of the previously imposed 30% cut to running costs). With no available specific funding for this proposed transformation, it will be down to providers, including general practices to provide the resources needed.

The LMC will continue to engage with other local providers, the ICB and the developing Primary Care collaborative on the development of Neighbourhood Health services and implementation of the 10 year plan.

The BMA has recently updated their summary and response to the 10 year plan. Due to serious concerns that the BMA has regarding the proposed changes there will be a Special Representative Meeting on Sunday 14th September. I will be attending on behalf of Leicester, Leicestershire and Rutland – please email me with your views and what you feel needs to be raised.

For any comments or queries click here.

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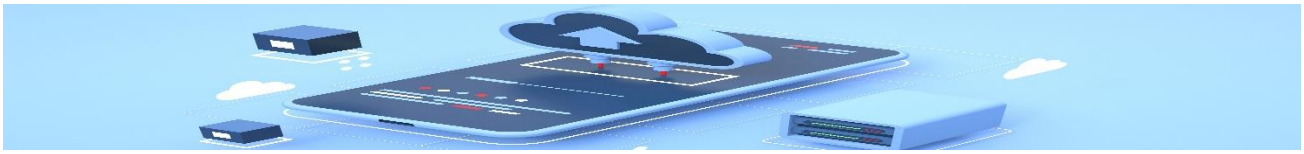
4. BACK OFFICE NUMBER.



The "LLR GP Newsletter – Week Commencing Monday 18th August 2025" stated that Every "GP practice should have a designated 'back-office number'."

The LMC has challenged the ICB regarding this as it is not a contractual requirement, and the ICB have advised that the section had been published without the knowledge or agreement of the CCIO.

Practices can consider providing this, and we understand that some cloud-based telephony services can provide a bypass (e.g. by dialling an additional number once through to the practice) at no additional cost, and practices may consider discussing this with their telephony provider. The LMC has been discussing how the ICB could support this approach.

The ICB advise that they will be releasing guidance imminently regarding the proposal for a back door number for cloud-based telephone systems which they are naming 'Dial 9 for Clinicians.'

For comments or queries please email the LMC.

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5. COMMUNITY BASED SERVICES.

The LMC has been chasing the ICB regarding an uplift to the Community Based Services (CBS) costs for 2025/26 in view of inflation and other costs pressures like employers National Insurance.

After chasing we have now been advised that the ICB has decided **NOT TO PAY ANY UPLIFT**.

The LMC have raised with the ICB contracting team and senior management that this is unacceptable. The LMC negotiated the costings at actual cost with no leeway in good faith with the understanding that they would be uplifted annually at an appropriate rate.

The ICB will be distributing the revised CBS contract for 2025/6 soon (a third of the way into the contractual year!), and practices will need to decide whether they wish to continue providing the services or not. If your practice wishes to opt out the contract requires a three month notice period.

For comments or queries please email the LMC.

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6. TREATMENT OF DENTAL PROBLEMS.

A common query from practices is whether they can or should provide treatment to a patient with a dental problem.

Treating patients with dental problems is not a GP responsibility, even if a patient is not registered with a dentist because:

1. GPs are not trained to deal with dental issues, and
2. Dental treatment is not a contractual requirement.
3. There is a legal restriction on who can provide dental care.

If a patient presents with a toothache or other dental issue they should be advised to contact their local dentist or NHS 111 if their usual dental surgery is closed or they are not registered with a dentist.

The Dentists Act 1984 bars anyone who is not a registered dentists or dental care practitioner from practicing dentistry which is defined as "*to include the performance of any such operation and the giving of any such treatment, advice or attendance as is usually performed or given by dentists; and any person who performs any operation or gives any treatment, advice or attendance on or to any person as preparatory to or for the purpose of or in connection with the fitting, insertion or fixing of dentures, artificial teeth or other dental appliances shall be deemed to have practised dentistry within the meaning of this Act*."

There is a caveat that allows registered medical professionals to carry out a medical task **for which they are qualified to do so**.

So, for the majority (if not all) GPs it would be unlawful for them to provide any treatment for a patient with a dental problem, and "*shall be liable on summary conviction to a fine not exceeding the fifth level on the standard scale*."

This would not apply to resuscitation of a collapsed patient or assessment of a patient with systemic symptoms

BMA guidance states that:
"GPs should not attempt to manage a condition requiring dental skills unless they have the appropriate training and expertise. Both the civil courts and the GMC require doctors to have appropriate skills for any treatment they offer."

If a GP chooses to treat a patient for dental problems, they should be aware of their legal and contractual obligations.

If refusing to treat a patient for a dental issue, BMA guidance (September 2020) states:

- Before refusing to treat a patient asking for emergency dental treatment, a GP must ascertain that the condition requires only dental treatment. Primary care teams must put themselves in a position to judge the nature of the patient's condition by undertaking reasonable enquiries, and where appropriate a clinical assessment.
- Having established an apparent dental problem, GPs or practice teams should signpost to a dentist or local emergency service or if they feel necessary refer a patient to secondary care for any further assessment and treatment.
- Everyone in the practice team must do their best to ensure the patient doesn't need the attention of a GP when signposting.
- If the patient has no usual dentist, or there is no response from the usual dentist, the patient should contact the local NHS 111 service.
- Patients presenting with signs of spreading infection or systemic involvement of a dental infection should be referred immediately to secondary care for appropriate surgical management. Signs and symptoms of this may include diffuse or severe facial swelling, trismus, dysphagia, fever or malaise.
- The GP's obligation to refer is set out in the GMS and PMS regulations

For comments or queries please email the LMC.

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7. GMS/PMS CONTRACTUAL CHANGES 2025/26.

There are some significant changes to the PMS/GMS contracts which should come into force from 1 October 2025 (dependent upon whether the practice has been sent a contract variation notice). You can preview the GMS Contract Variation Notice here which was published 21 August 2025.

ACCESS
Following the letter of 28 February 2025 about agreed changes to the GP Contract in 2025/26, NHS England has sent a reminder to GP practices of three key requirements taking effect from 1 October 2025. These are:

- online consultation tools must be switched on for the duration of core hours
- You and Your General Practice must be on practice websites

- GP Connect Access Record (HTML and Structured) and Update Record must be enabled within GP Practice clinical systems.

I note that The Contract Variation Notice appears to overstep the mark in terms of opening hours.

The NHS E letter setting out the Contract Changes for 2025/6 states:

> "We want patients to contact their practice, by phone, online or by walking in, and for people to have an equitable experience across these access modes. This will be a key intervention in the government's ambition to end the 8am scramble. From 1 October 2025 practices will be required to keep their online consultation tool open for the duration of core hours for non-urgent appointment requests, medication queries and admin requests."

The wording states that only the ONLINE CONSULTATION TOOL will be required to be kept open for the duration of core hours.

However, the Contract Variation Notice states:

"7.5.1 The Contractor must take steps to ensure that all of the following means of contacting the Contractor are available for patients throughout core hours:

(a) by attending the Contractor's practice premises;
(b) by telephone;
(c) and through the practice's online consultation tool within the meaning give in sub-clause 16.5ZD.2."

The existing General Medical Services Regulation 20 states: "A contract must also … contain a term which requires the contractor to provide … essential services, … at such times, within core hours, as are appropriate to meet the reasonable needs of patients." This means that the regulations will now be internally inconsistent.

I have written to the GPC E for clarification

I have significant concerns regarding the contract change which I realise will cause considerable problems for many practices, particularly:

1) Practices' right to subcontract services – will it no longer be possible to close early, half days and lunchtimes, and subcontract to another service?
2) Ability to close for a half day training session?
3) Practices operating from multiple sites – will they have to keep every one open?

Once there is clarity I will provide this.

ONLINE CONSULTATION TOOL (OCT)

There is also the concern that the requirement to keep the **Online Consultations Tool** (OCT) available throughout core hours could prove to be unsafe and increase workload for practices. Although the requirement is to provide OCT only for administrative queries, it is likely that some patients will still try and use to contact for an urgent/emergency clinical request.

An OCT should allow a patient or their appropriate representative to "seek advice or information related to the patient's health or make a clinical or administrative request." There is no requirement for the practice to respond immediately.

GP CONNECT (UPDATE RECORD)

From October 2025, registered pharmacy professionals will have access to patient records via GP Connect (Update Record).

Other NHS providers and private providers (where patients have provided explicit consent) will be limited to read only access for the purposes of direct patient care.

At present there is no further information regarding which other providers will be involved. The LMC has significant concerns regarding this in particular due to the recent debacles of: other parties misusing writing to SystmOne and not communicating properly; pharmacies sending erroneous pregnancy codes via CPCS; and the Joy App erroneously misidentifying who has added information to the patient record. These are the errors discovered, but there may be others. Each of these is reducing the integrity of the electronic patient record, increasing practice workload, and potentially affecting patient safety.

Together with other proposed changes practices are being put at increasing risk of action regarding breach of confidentiality. Whilst Trusts have access to both Clinical Negligence Scheme for Trusts (CNST) for clinical negligence claims and the Liabilities to Third Parties Scheme (LTPS) for non-clinical claims, at present general practices only have access to a national scheme for clinical negligence (CNSGP).

GPC England has formally raised with NHS England that before further IT schemes and changes are introduced increasing liability, general practices should also be covered for data protection claims. My own view is that GPs should have access to a scheme that covers all of the same areas that LTPS does for NHS Trusts, which covers claims relating to:

- Employers' and public liability from NHS staff, patients and members of the public
- Human Rights Act
- Data Protection Act
- Defective Premises Act
- Defamation, unlawful detention
- Professional negligence claims

YOU AND YOUR GENERAL PRACTICE (YYGP) (PATIENTS' CHARTER)

From 1 October 2025, practices must have a link to the YYGP document from their website.

NHS England has published guidance for GP practices to support the implementation of You and Your General Practice.

Your practice may find it help to include a caveat on their website like the below:

> NOTICE TO PATIENTS
> Please note the practice will provide services as per 'You and Your General Practice' except when unable to do so due to:
> - lack of capacity
> - closure due to staff training (half day each month)
> - unforeseen events
> - failure of NHS supplied software
> - unable to assure a safe service

For comments or queries please email the LMC.

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8. TRAINING AND DEVELOPMENT.

The LMC is concerned that the ICB in their haste to meet financial targets are axing Training and Development programme for General Practice. We believe that this is short sighted and not in the best interest of patient care. It demonstrates a lack of commitment to support general practice and the personal development of GPs and all their staff.

We are particularly concerned that some of the funding used for the programme was from education budget freed up after the transfer from the Red Book to the (then) new GMS Contract in 2004.

The LMC has formally written to the ICB and have met with them to raise our concerns and the negative impact this disinvestment will have on practices. The ICB have advised that they plan to continue to defund this area regardless.

The LMC is now considering what additional support that we could provide practices once this has been enacted, and we welcome any thoughts, ideas or comments about what this could include.

For comments or queries please email the LMC.

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9. TPP AUTOMATE FOR SYSTMONE.

The LMC Board has agreed to commission local support for practices wishing to use the Auto-Reviewing tool provided by TPP for SystmOne. To learn more about this new tool click here.

This Tool will free up administrative and clinical time for all practices as results which are completely normal will be filed automatically with no human intervention.

Practices who wish to participate will be provided with an easy to follow guide how to set it up and pre-designed 'rules' to work with results provided by the UHL laboratory. Every time UHL change their ranges etc revised rules will be issued.

To express an interest for your practice in participating please email the LMC.

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10. REMOTE VERIFICATION OF DEATH.

We have updated our guidance about **Remote Verification of Death** (RVOD). This can be downloaded here and has the support of both local senior coroners.

RVOD can be done by any appropriate adult, as long as they are comfortable in doing it.

There is a form to act as guidance on PRISM.

To support GPs in deciding whether a death is expected or not for both the RVOD process and when considering whether a death should be referred to a coroner this definition has been agreed with both Senior Coroners in LLR (L Pinder and Prof C Mason).

EXPECTED DEATH. There is no legal definition of expected death, and this definition is provided in context of this guidance only. An Expected Death is any death where due to a known disease process or advanced age (over 80 years old), the attending doctor believes from their own experience or observations from others that the death could have been foreseen (even if not on that specific day or time). In essence it is any death that was not unexpected.

For comments or queries please email the LMC.

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11. GENERAL PRACTICE ESTATES AND PREMISES.

The LMC works closely with the ICB estates/premises team.

There are three current schemes to provide funding for developments.

- Business as Usual (BAU)
- Utilisation and Modernisation Fund (UMF)
- Section 106/CIL

BAU funding provides a limited resource to the ICB on an ongoing basis for practice premises developments.

UMF was announced during the 2024 spending review. It has provided £102million across England for 2025/26 with a promises that there will be additional tranches of money over a 5 year period.

Section 106/CIL. This funding is provided by developers and can be used to develop/expand general practice to deliver services to the new builds.

All Premises funding is provided in accordance with The National Health Service (General Medical Services - Premises Costs) Directions 2024, and practices need to develop a Project Initiation Document (PID).

If your practice has a current or upcoming requirement for premises development please contact the ICB team for their help and advice by email: llricb-llr.strategyandplanningteam@nhs.net

The current ICB Strategy & Planning Directorate team is:

- Lorna Simpson – Head of Strategy Estates
- Louise Robinson – Estates Programme Manager
- Kelly Contina – Estates Project Officer
- Laura Ward – Programme Support Officer

The LMC arranged a webinar on premises issues in July 2025. If you were unable to attend a recording can be found at: 2025-07-30 LLR LMC Understanding Notional Rent Reviews & Improving property Webinar

For comments or queries please email the LMC.

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12. FREEDOM TO SPEAK UP (FTSU) - UPDATE.

As part of the 10 year strategy the National Guardian's Office (NGO) is being closed, with the Freedom to Speak Up Guardian role and its functions being absorbed into NHS England. It is unclear what will happen to the functions once NHS England is also disbanded. A statement by the NGO can be found here.

In the meantime, **the LMC gives full assurance that we will continue to provide a FTSU service** as part of our practice offer funded via the levy.

If your practice has not yet signed up to the LMC FTSU service and wishes to do so, please email: enquiries@llrlmc.co.uk. Details of the LMC service can be found here.

For comments or queries please email the LMC.

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13. MEDIATION.

The LMC has trained and accredited five LMC Board members in line with the Civil Mediation Council (CMC) so we are please to confirm that can offer a formal Mediation service.

WHAT IS MEDIATION?

Mediation is a way to mend relationships when there is a disagreement.
It is held by a 'mediator' (neutral person). The mediator is impartial. This means they do not take sides. They're there to help everyone involved find a solution they can all agree to.

Mediation is not about judging who was right or wrong in the past. It looks at how to agree on working together in the future

.

Mediation is a quick way to resolve disagreement at work. It is also:

- less formal
- flexible
- voluntary
- confidential
- usually not legally binding

HOW MEDIATION CAN HELP

Mediation helps to mend relationships within practices by:

- finding solutions that everyone agrees to
- improving communication
- allowing everyone involved to have control of what's finally agreed

There are many benefits of mediation. For example, it can help to:

- reduce stress
- prevent a practice from closing
- avoid more formal processes, such as court proceedings
- avoid paying high costs, for example, legal costs

Mediation outcomes are decided by everyone involved and can be flexible. Outcomes might include:

- an acknowledgement of each party's views
- a commitment to change behaviour
- a commitment to regularly review the agreement reached
- an agreement to review policies and procedures
- an agreement to share work more fairly and provide more responsibility
- an agreement to improved transparency

A voluntary and confidential process

- If you do not want to take part in mediation, you do not have to.
- Mediation is voluntary and confidential. The mediator will agree with everyone involved what information can be shared outside the mediation and how. If you do not reach an agreement, anything that's been said during the mediation must be kept confidential and cannot be used in future procedures.

WHEN MEDIATION CAN BE USED

Mediation can be used to resolve disagreements around relationships at work including within a partnership.

For example, you can use mediation to resolve:

- bullying and harassment
- communication problems
- personality clashes
- relationship breakdowns

HOW TO ACCESS LMC MEDIATION

If you have a situation within your practice/partnership where you feel formal mediation may help, please contact the LMC.

For comments or queries please email the LMC.

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14. SAFEGUARDING ADMINISTRATIVE LEADS.

Many practices are identifying a Safeguarding Administration Lead.

These are crucial roles to support Safeguarding processes within practices.

The LMC has identified a need for support for this developing role and is therefore supporting the development of a dedicated group where Safeguarding Admin Leads can ask questions, share experiences and be given support.

The group will include Dr Amit Rastogi (LMC Board Member and ICB Safeguarding Lead) who can help with more 'technical' questions, and be maintained by the LMC.

A number of Safeguarding Admin Leads have joined this group already. The LMC has held an initial meeting of this group with positive feedback. Please check if your practice Safeguarding Admin Lead is a member of the group. If they are not please ask them to consider joining by contacting enquiries@llrlmc.co.uk

For comments or queries please email the LMC.

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15. OPENSAFELY.

NHS England issued a Data Provision Notice (DPN) in July 2025 which requires GP Practices to provide the OpenSAFELY Data Analytics Service.

This has the support of the Joint GP IT Committee, which is co-chaired by GPC and RCGP, who are encouraging practices to accept the DPN as soon as possible.

The OpenSAFELY COVID-19 Service was established under the COVID-19 Public Health Directions 20201 (**COVID-19 Public Health Directions**) in June 2023 and provides a secure analytics service for users, approved by or on behalf of NHS England, to run queries on pseudonymised patient data held by GP practices and NHS England (**GP and NHS England pseudonymised patient data**) for COVID-19 Purposes.

Learning from the OpenSAFELY COVID-19 Service (the **COVID-19 Service**), it has been decided that an additional service should be developed and tested on a pilot basis to enable GP and NHS England pseudonymised patient data to be accessed through the OpenSAFELY platform for further secondary uses purposes (**Pilot**).

The purpose of the Pilot is to establish a secure analytics service using the OpenSAFELY platform (**the Service**), for users approved by or on behalf of NHS England (**Approved Users**), to run queries on GP and NHS England pseudonymised patient data for the purposes of the Pilot as set out below.

The Service, and the purpose of running the queries and obtaining the aggregate outputs is limited to the following purposes:

- clinical audit
- service evaluation
- health surveillance
- research
- health and social care policy, planning and commissioning purposes and public health purposes, where agreed on a project specific basis by or on behalf of:
    - the Deputy Director of Data Policy on behalf of the Department of Health and Social Care, and
    - the Chief Data & Analytics Officer on behalf of NHS England, and

    - a nominated representative of each of the Royal College of General Practitioners and the British Medical Association on behalf of the Joint GP IT Committee.
- evaluation of the Service.

The Service is designed to keep patient data confidential: Approved Users write analysis code away from the patient data and test it on dummy data; the Service then automates the running of code (the **Queries**) to generate intermediate pseudonymised patient level data sets specifically tailored to the needs of the project (**Intermediate Outputs**). Further Queries are run to generate aggregated outputs (**the Aggregated Outputs**) and logs to help identify and fix errors in the analysis code (**Error Logs**).

Approved Users only have access to the Aggregated Outputs and Error Logs generated by their Query. Aggregated Outputs are released outside the GP System Suppliers' secure environment only after disclosure controls have been applied within the GP System Suppliers' secure environment and the results reviewed and cleared by trained output-checkers. All actions in the Service are logged in public, in real-time and all Queries are logged and published.

More information can be found on NHS England Website.

In addition the RCGP has produced guidance which can be accessed here which includes:

- Template Data Protection Impact Assessment (DPIA)
- Guidance on updating Privacy Notice (NHS England Website)
- How to activate OpenSAFELY from within SystmOne and EMIS.

NHS England provide further FAQs regarding OpenSAFELY on a webpage which also covers other frequently asked questions and answers to common information governance queries.

For comments or queries please email the LMC.

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16. MOUNJARO/TIRZEPATIDE (WEIGHT LOSS).

The ICB has still not agreed a process for NHS prescribing of Mounjaro (tirzepatide) for weight loss. The criteria remain the same – BMI >40 with at least 4 comorbidities (see June Newsletter).

The original proposal was that triage and initiation would be done by the Tier 3 Hospital service and follow up within general practice. The ICB are now discussing with the LMC a proposal to offer the whole service to general practices. Once we have more detail, we will let you know.

The implementation of the NHS service for weight loss is therefore being put back again until at least the end of 2025.

In the interim we have updated our information sheet for patients/to display on websites and in reception areas, which can be downloaded from the LMC Website.

For comments or queries please email the LMC.

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17. SHARED CARE AGREEMENTS.

The LMC has become more concerned regarding the local process for deciding which drugs should come under a Shared Care Agreement and the RAG rating.

At times it is clear that secondary care colleagues are proposing certain drugs to come under a shared care agreement or to have their RAG rating reduced, as a process to reduce the workload pressure on their department without considering the effect on general practice and whether GPs can prescribe in line with NHS England, BMA, and GMC guidance.

Shared care prescribing is a non-core voluntary activity that can be declined by the GP practice for any reason, including:

- Inadequate capacity within the practice
- Inadequate competency about the specialist medication, despite training. The GMC requires a GP to prescribe based on a proposal or recommendation by a colleague only *"within the limits of [their] competence and that [they] have enough information to safely proceed."*
- Lack of assurance to provide the ongoing specialist support required for shared care.
- Medication is for an off licence use and not for a commonly recognised indication.
- Additional work outside of essential services (see below for definition) is adequately contracted for and funded. NHS England states *"GPs would only be obliged to provide treatment consistent with current contract requirements."*

Any refusal should be consistent and framed by a set of principles, so it is not discriminatory to specific patient groups. Practices should have policy covering shared care requests, as a separate policy or as part of another policy.

NHS England notes that *"Legal responsibility for prescribing lies with the doctor or health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence."*

> **(1) Essential services** are defined as those "required for the management of … registered patients and temporary residents who are, or believe themselves to be
>
> (a) ill, with conditions from which recovery is generally expected;
> (b) terminally ill; or
> (c) suffering from chronic disease,
>
> which are delivered in **the manner determined by the contractor's practice** in discussion with the patient."

The LMC has developed a **POSITION STATEMENT** which we have shared with the ICB and we will use to assess any new proposal for Shared Care arrangements, and to also review the existing ones. The LMC view can be found on our website and includes a template letter for patients and our full position statement.

For comments or queries please email the LMC.

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18. JOY APP – SYSTMONE ISSUE.

An issue has been raised regarding the JOY Case Management Service and SystmOne. It does not affect JoyConnect.

They noticed that when a third party is using the JOY App, the way it writebacks into the SystmOne electronic patient record means that it appears to have been entered by a member of the practice team and also shows that the member of the practice team was logged on at the time of entry (even when they were not). This appears to be due to an issue within SystmOne.

We have raised this with the ICB, who are working with the LMC and Joy to solve it. In the interim the ICB has made the decision to suspend the Case Management part of the JOY App.

The LMC is concerned that the way the information is presented to patients looking at their own record will cause confusion, possibly increase practice workload dealing with queries, and could potentially result in complaints or other action.

The Joy App is an NHS approved service that connects people with local services.

As soon as we have further clarity, we will let practices know.

For comments or queries please email the LMC.

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19. PODCASTS.

The LMC is developing a library of Podcasts.

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

Featured Podcast

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

Monthly Podcasts

- 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 2025 LLR LMC Podcast

Recordings of Webinars

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

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

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20. UPCOMING LMC EVENTS.

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

Please note some webinars are recorded – see list in 'Podcasts' section.

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

Succession Planning & Partnership Change Webinar

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

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

Managing partnership change

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

Succession planning and property

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

Target Audience: GP and other Partners, Practice Managers, anyone considering partnership.

Date:	Tuesday 9h September 2025
Venue:	Remote by MS Teams
Time:	1.00 – 2.00pm
Speakers:	**Rebecca Reynard** Director of Agency and Sales, GP Surveyors

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

Tuesday 16th September 2025, 2pm to 2pm
Introduction to Change in Contract for NHS Health Check
(CITY PRACTICES ONLY)

This webinar has been arranged by Leicester City Council (Public Health) to support practices in the change in contract for NHS Health Checks required by new procurement regulations.

Target Audience:	Practice Managers and interested GPs
Date:	Tuesday 16th September 2025
Time:	2pm to 3pm
Venue:	Virtual/MS Teams
Speakers:	Gavin Yarnold (LCC) and team
To Book:	Email enquiries@llrlmc.co.uk

Thursday 9th October 2025, 1pm to 2pm
What a GP needs to know about their pension

This webinar will be delivered by Chase De Vere and will look at supporting GPs on pensions, the session will include an overview of the NHS Pension, Death in service and sick pay implications and how to create an effective financial safety net as well as Retirement Planning

- **Target Audience:** GPs (and Practice Managers interested in attending).
- **Date:** Thursday 9th October 2025
- **Venue:** Remote by MS Teams
- **Time:** 1.00 – 2.00pm
- **Speakers:** **To be confirmed**

More details to follow in due course, **but to book a space, please confirm by emailing us at enquiries@llrlmc.co.uk**

Tuesday 18th November 2025, 1pm to 3pm
Understanding practice accounts and Income sources for General Practices (additional date added due to demand)

We recognise that practice accounts can often be complex and difficult to navigate, but as a GP partner this is a key area to have a sound understanding of when running a GP practice. As an LMC we are often surprised at the lack of understanding within the profession. As a result, we are pleased to confirm that the LMC will be hosting another face-to-face event on this very popular topic.

- **Target Audience:** GP Partners (new to partnership or wishing to have a refresher) and Practice Finance leads
- **Date:** Tuesday 18th November 2025
- **Venue:** Hilton Leicester, Junction 21 approach, Leicester, LE19 1WQ

- **Time:** 1.00pm – 3.00pm (lunch from 12.30)
- **Speakers:** **Glyn Rawlings**

The session is open to all LLR GP Partners (new to partnership or wishing to have a refresher) and well as Practice Finance leads but **capacity is limited, so please book early** to confirm and maximum of 2 spaces per practice.

Areas covered:

- Global sum and how its calculated
- List sizes , raw , weighted and adjusted
- Opt outs
- Quality and Outcome Framework – its domains and indicators
- How QOF is calculated
- Primary Care Networks and their funding streams
- Other Financial entitlements and reimbursements.
- Directed Enhanced Services
- Local schemes
- PPA claims
- Practice accounts, how they are put together.
- Partners pensions
- Salaried versus Partner – key differences

We have a capacity of 50 for this event and it will be a first come first served basis and last few spaces remaining, To book a space, please confirm by emailing enquiries@llrlmc.co.uk

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21. ADVERTISE YOUR JOB VACANCIES FREE WITH THE LMC.

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

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

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

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

To advertise please email the LMC.

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

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22. AVAILABLE TO WORK

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

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

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

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

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

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23. FINAL THOUGHTS

Shroud-Waving

Definition: **Noun**
shroud-waving (*uncountable*)
(*derogatory*) Arguing against a proposed policy on the grounds that it will result in deaths.

Etymology: The earliest known use of the word *shroud-waving* is in the 1960s. OED's earliest evidence for *shroud-waving* is from 1967, in the writing of P. L. Nokes[1].

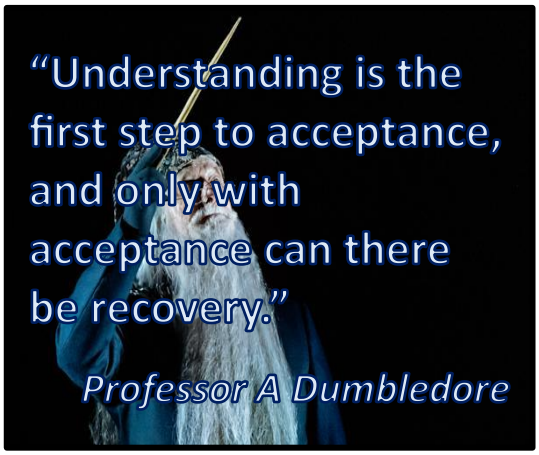
There have been many occasions whilst representing doctors and general practice I have been accused of shroud-waving.

The first was in the early 1990s when (well before I moved to LLR) I was accused of shroud-waving by an eminent University Hospital with a world wide reputation because of having the audacity to suggest that their insistence Resident Doctors must work well in excess of 84 hours per week and work 80 hours non stop over weekends, often without a break, was harmful to patients and doctors. There was plenty of evidence available at this time that working such hours led to increased errors and was harmful to the mental health of doctors (the maximum allowable contacted hours in the national terms & conditions of service was 72 at the time). They argued that they could not run a service if Resident Doctors only worked 72 hours per week.

[1] Professional Task in Welfare Practice P. L. Nokes 1967. "Doctors are able to indulge in a practice that is known in hospital planning as 'shroud waving', the habit of pointing out the disasters that will ensue if they do not get their own way"

More recently I have been accused of shroud-waving following comments I have made to the press, in meetings, and in articles in this newsletter.

Contrary to this, doctors have a GMC Professional Duty to raise concerns "If patients are at risk because of inadequate premises, equipment or other resources, policies or systems …"



The Public Interest Disclosure Act 1998 (PIDA) protects workers when they disclose information about wrongdoing, including if it involved a risk to the health and safty of any person.

It is against this background that I believe we all have a **duty to point out to anyone who will listen that previous government poicies have led to harm to the health of the public and that the policies of the current government will not improve the situation**.

There is evidence from a huge catalog of research that increasing the amount that a health system invests in general practice leads to better health outcomes for lower costs. The first paper I read on this was by Barbara Starfield in 1994, and it is still a seminal work and worth a read. This summarised relevant research at the time, which included that outcomes for tonsillectomy and adenoidectomy were better when patients had been referred by a primary-care physician compared to those who had self referred, and that self-referred patients have higher rates of unnecessary interventions. Also she noted a consistent relationship between the availability of primary care physicians and health levels, including improved mortality associated with cancer and heart disease, neonatal mortality and life expectancy. She also provided evidence "that population, mortality and health are directly related to the quality and resourcing of primary care and, conversely, inversely proportional to that of secondary care."

In 2020 the OECD published a paper entitled 'Realising the Potential of Primary Health Care.' This concluded that "strong primary health care has all the potential to improve health outcomes for people across socio-economic levels and to reduce the unecessary use of more expensive specialist services," and that "primary health care plays a key role for health systems to deliver more and better services."

Professor Brian Jarman provided evidence that the death rate of patients in hospital is more related to the number of GPs working around that hospital than the number of doctors within it.

Also continuity of care between a patient and a GP/Primary care physician is associated with reduced mortality, hospital admissions, emergency department visits and costs in the health system.

Since 2011 the previous constant increase in life expectancy slowed. It then decreased significantly during the Covid Pandemic, and has not fully recovered since. During the same period life expectancy continues to be lower for people living in more deprived areas, with a a widening of inequalities of health in England.

Neonatal death rate has also been affected, which since 2013-15 has increased from 2.7 to 3.0 per 1,000 live births.

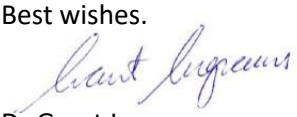
There have been many hypotheses about why the health of the nation has deteriorated. ***The answer appears very clear – there is a direct link to the fact that over the 14 year period of previous governments the amount of the shrinking NHS pie invested into general practice reduced significantly from around 11% to 6%, which has resulted in the reduction in the health of the nation.***

So what about the 10 year plan? Although this superficially appears to move funding from secondary to primary care, it will not achieve this. None of the proposals lead to direct increased investment into core primary care – which in England is called general practice. Indeed it talks much about closing 'poor performing' practices with the service potentially being passed to secondary care providers. The proposal of IHMOs (newsletter passim) will in effect hand the whole of secondary and primary care budgets to secondary care.

In addition, the swathing cuts to ICBs will mean that there will not be sufficient management to provide the support that practices need to effectively serve the needs of their patients. The low regard that the system holds for general practice, can be seen that when penny pinching one of the first areas to be completely cut is the Training and Development budget for general practice. As above this is a short sighted decision. The ICB has also decided not to give any uplift for local contracts (CBS) meaning that they are knowingly are expecting practices to subsidise the cost of these services. As this affects practices in deprived areas more, health inequalities is also likely to widen further.

For as long as I can I will continue to shroud-wave when appropriate, pointing out that local and national policies are harming the health of our patients and the wider public.

Best wishes.



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