NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

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

Dear Colleagues

LLRLMC NEWSLETTER

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

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

JULY 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, and consider declining new Shared Care Agreements if you are not being fully funded to provide the service.

TOPICS IN THIS NEWSLETTER:

Following on from last month's newsletter article on fear of flying the LMC has now developed a poster that can be displayed by practices or shared on social media.
Click on this box to download.

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 – JULY 2026

The LMC Board met on 8 July 2026 in the meeting room associated with the new LMC offices.

Dr Gang Xu (Medical Director) attended the meeting on behalf of UHL and gave an update on ongoing issues. One thing he raised was that all the Medical Directors from across England had been summoned at short notice by NHS England to a meeting to be told about the Ockenden Report and what they needed to do about it. This took me back to when I worked for the NHS E and Trust Chief Executives or Chairs were regularly similarly summoned to be given a dressing down (I was often given the job of presenting the data and the differences between trusts. I found the top-down bullying approach to NHS management to be inappropriate and counter productive then and I am shocked that the service has not evolved over the past 30 years to stop this negative culture.

Dr Xu talked through the main points of both the Ockenden and the Amos reports. It was sad to note that there have been many previous reports into maternity services over the years, and the learning never seems to be incorporated into services. A common theme was patients not being respected and not being listened to.

I noted that as a consultant in Public Health working with NHSE, I had been involved in looking into maternity services in the 1990s. This had led to the closure of 2 maternity units that were just too small with too few deliveries for the teams to b able to maintain skills and provide a safe service. Another service had recurrent adverse events that seemed to be related to the consultants all working individually with their own separate views how patients should be managed leading to confusion and inconsistency.

I used the opportunity to again highlight the research (initially by Barbara Starfield but repeated by Brian Jarman) showing a direct correlation between infant mortality and ratio of GPs to population, and that we should therefore not be surprised that the infant mortality rate and ratio of GPs in Leicester City are both the second worst in England. I noted that this was not being raised in discussions but was a factor that could be improved if the ICB decided to prioritise it.

Dr Xu also mentioned that UHL is still undergoing digital change, with the inpatient electronic health record being implemented only 3 weeks before, with problems relating to integration across systems causing unpredicted issues.

Dr Xu also discussed changing referrals to A&G as per national guidance. Board members noted that it was not appropriate for all referrals to be converted to providing Advice without the agreement of the referring GP. It was agreed to discuss this issue further outside of the meeting.

Dr Amit Rastogi (Treasurer) gave an update about the LMC's financial position. Although we have increased services and therefore costs, due to efficiencies like moving to a bigger much improved office space for an overall lower cost, the LMC is still trading with a surplus albeit reduced. We have agreed to move some of the reserve into a higher interest-bearing account which will help fund LMC activities. He also reported on the meeting that we had with our external auditors who were content with our accounts. A full breakdown of the annual accounts is included in each of our annual reports which are all available online. If you would like to know more about LMC finances, please contact us.

The Board had a further discussion about the ongoing issue regarding LPT letters being added and visible to general practices without them being formally sent and therefore processed through the practice's workflow. Although reduced, and now being identified by LPT and action taken, they are still occurring with 225 identified in June 2026. The LMC will continue to press LPT to resolve this ongoing patient safety issue.

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

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2. FIREARMS LICENSING.

In October 2025, a constituent raised an issue with the LMC that there was no defined/dedicated way of informing the police if a patient with a known firearms license developed a relevant new medical problem. If a new relevant problem is coded and the Digital Forearms Marker has been added, then an on-screen reminder should pop-up on the computer screen.

It has taken Charlotte almost a year of constantly contacting and chasing the police, and we have had meetings with them. However, her determination has paid off, and the police has provided a dedicated email address which will be constantly monitored for practices to report concerns.

The dedicated police email address is: mailto:GP.ReportsFirearms@leics.police.uk

If there is immediate risk GPs should consider phoning 999 or 101 if not an absolute emergency.

The LLR LMC guidance is available on our website, and the BMA guidance about all aspects of the firearms licensing process can be read here.

For comments or queries please email the LMC.

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3. MATERNITY SERVICES.

As mentioneed above a spotlight has again been shone on maternity services to try and reduce inconsistences and avoidable poor outcomes for mothers and children. The latest MBRRACE-UK data (2021 to 2023) suggests that maternal mortality has increased by 21% since 2009 to 2011, or 7% excluding deaths relating to COVID-19 infection

In response NHS England is requiring every area to implement a 'Maternal Care Bundle' (MCB).

This has 5 elements:

- Element 1: Venous thromboembolism
- Element 2: Pre-hospital and acute care
- Element 3: Epilepsy in pregnancy
- Element 4: Maternal mental health
- Element 5: Obstetric haemorrhage

I attended a face to face meeting with representatives from all Trusts in the East Midlands in the Secret Garden at Glenfield Hospital. Fortunately there were a couple of other GPs present but it was mainly full of managers who from time to time mentioned general practice as being best positioned to take on some of the work. I made it clear repeatedly that except for essential services as defined in the regulations, general practice has not been commissioned to provide ante-natal services since 2004.

In addition it was stated that general practices should be using the national Maternity Early Warning Score (MEWS). I asked whether, similar to NEWS, the score had been validated in general practice or not. No one knew the answer but a quick Google search found that general practices are not required to use MEWS and that the MCB made it very clear that MEWS was 'out of acope' for general practice.

All in all a useful day in repeatedly declining the dumping of uncontracted and unfunded work onto general practice.

For comments or queries please email the LMC.
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4. FIBROMYALGIA

One of our Board members recently found out indirectly that the UHL Rheumatology Department have decided that they will no longer accept any referrals relating to the diagnosis or management of Fibromyalgia Syndrome (FMS). In reaching this view they were relying on guidelines written by the Royal College of Physicians (click here). We have discussed it within the LLR LMC Board and with other GPs more widely who do not believe that this is appropriate on the grounds that it is both a further unfunded and non-contracted dump of workload onto general practice as well as being clinically inappropriate.

The UHL rheumatology department selectively quotes from the guidelines which state "The diagnosis of FMS should be made by any clinician adequately experienced to make this diagnosis" and that "The responsibility for the diagnosis of FMS has moved away from the domain of a medical subspecialist."

I have responded to point out that the full second quote is "The responsibility for the diagnosis of FMS has moved away from the domain of a medical subspecialist except in cases of uncertainty" and that the document also includes the statement "In case of uncertainty referral to a specialist with experience in diagnosing fibromyalgia (usually a pain specialist or a rheumatologist) is recommended for clarification of the diagnosis."

Rheumatology also claimed that the guidelines were endorsed by the RCGP, but I have checked this, and it untrue. The RCGP have replied that they have never and do not currently endorse these guidelines.

I asked other LMCs what was happening in their areas. Most (but not all) reported that in their areas rheumatology was planning to also decline any FMS related referrals. For these areas where this change had already taking place I had almost immediate responses from two different areas of two separate clinical cases where patients had already come to harm due to this change resulting in avoidable joint damage as although the patients were presumed to have FMS one was later found to have psoriatic arthritis and the other rheumatoid arthritis.

I would recommend that unless you feel confident in the diagnosis and management of FMS that you continue to refer patients with possible FMS to rheumatology but that you may wish to include in the referral that you do not have any GP in your practice adequately experienced to make the diagnosis and/or that the diagnosis is uncertain. If you have any referral declined, please use the TCS process but also let the LMC know.

The LMC has been asked by Dr Leslie Borrill (GP) to forward on a request to complete a survey about FMS. I have completed and took 2-3 minutes to complete.

"Dear Colleagues,

I'm forwarding a request from Loughborough University regarding a research project on perceptions of fibromyalgia. They have already gathered significant insight from patient communities and are now seeking the specific perspective of GPs and reception staff to ensure a balanced view.

As someone who sees the daily friction and communication gaps around this condition, I believe their goal, to improve dialogue between patients and surgeries, is vital. The survey takes approximately **five minutes**, and it would be incredibly valuable to have our local clinical and administrative voices represented.

Could you please circulate the link below to any GPs or receptionists in your practice who might have a spare moment?

🔗 **Survey Link:** https://loughboroughssehs.eu.qualtrics.com/jfe/form/SV_dmaAf71GKbVwSO2.

Thank you for supporting this effort to better understand and manage fibromyalgia in our area.

Leslie"

5. UHL GALA AWARDS EVENING.

Once again UHL has kindly offered to host an award for general practice at their evening extravaganza award ceremony on the evening of Friday 3rd October at Athena Leicester, Queen St, LE1 1QD.

Nominations can be made by any general practitioner, practice or other manager, member of practice staff, or patient. The award will be to recognise the "GP who has made the greatest positive impact on General Practice in LLR in the last year." THIS AWARD IS OPEN TO ANY GENERAL PRACTITIONER PERFORMER WORKING IN LLR.

The nominator will need to provide a supporting statement of up to 300 words, which should indicate how the nominee has fulfilled one or more of the following criteria:

- **Provided leadership to general practice.**
- **Developed new service(s)**
- **Supported the development of general practice.**
- **Supported diversity, inclusivity, and/or health equality.**

Nominators should include specific example(s) of how the nominee has achieved one or more criteria, and what impact it has had.

The closing date for nominations is 31ST July 2026. The LMC with UHL will arrange shortlisting, and the three shortlisted nominees will be invited to attend the award ceremony with their nominator where the winner will be announced and presented with an award on Friday 2 October at a Gala Dinner at Athena in Leicester.

This is a great opportunity to celebrate a colleague whose great work has gone unrecognised

Click here to nominate a GP.

My view is that we do not recognise and highlight the excellent work done by GPs and their teams enough, which is why I asked UHL for us to be part of their award ceremony and why I started the annual LMC awards.

For comments or queries please email the LMC.
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6. CONTRACT IMPOSITION FOR 2026/27 AND COLLECTIVE ACTION.

FIRST IMPORTANT: AS OF YET THERE HAS STILL BEEN NO CHANGE IN CONTRACT FOR ANY PRACTICE (REGARDLESS OF THE RECENT ERRONEOUS NHS BULLETINS). 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. The secondary legislation to update the regulations have now been laid in parliament: The National Health Service (General Medical Services Contracts and Personal Medical Services Agreements) (Amendment) Regulations 2026. These regulations state that they come into force by 15th June 2026, but MPs and Lords had until 6th July to make objections to it but as far as I am aware there were no objections made. The parliamentary legislation website makes it clear that the NHS (GMS Contracts) Regulations 2015 have still NOT been updated with the changes in the amendments regulations.

Once the regulations have been updated NHS England/DHSC will then need to issue a Contract Variation Notice. The change in practice's contracts will only occur after they have either signed the notice, or a period of 14 days has passed since they were issued with it.

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 ACTIONS – *NEW ACTION ADDED*

The BMA remains in dispute with the government regarding the proposed contract changes for 2026/7. **THE LMC STRONGLY ADVISES PRACTICES to PARTICIPATE IN THE BMA COLLECTIVE ACTION**.

There are currently two quite straight forward parts to the Collective Action. If you have any concerns or there is any other reason why your practice has decided not to participate in collective action, please let the LMC know so we can feed this back. **The GPC intends to add an additional Collective Action each month.** The more practices join in the greater the pressure there will be on NHS E/DHSC and the more likely that the contract changes will be overturned.

In addition to the Collective Action the GPC is encouraging GPs to contact their MP to highlight the problems that the 26/27 contract will cause. They have provided a quick and straightforward online tool that you can use to do this: Email your MP about the future of general practice

1. GP COLLECTIVE ACTION MAY 2026 – DATA SHARING AGREEMENTS

We are aware that some practices are unsure what benefit this action may bring. At present it is still in the 'information gathering' stage, with a view that at some point the BMA will be advising practices to disable some sharing, or not to sign up to new sharing. You will recall the almost instantaneous and massive effect we achieved when local practices turned off sharing with LPT which resulted in a solution being found for a patient safety issue which was also putting practices at risk within days when we had been told for 8 years previously no solution could be found.

Like our local action about sharing, this action has the capacity to 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. The ICB has recently sent a DSA for a process to switch inhalers – practices could consider declining this, on the grounds of being part of collective action (on grounds of DSA and medication switch).

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

2. GP COLLECTIVE ACTION JUNE 2026 – MEDICINES OPTIMISATION SOFTWARE

GPC E 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.*

The LMC has considered how this year's MOF may be affected if practices stop using Optimize Software. There is no requirement as part of MOF or otherwise for practices to use the Optimize Software.

The LMC view is that this year's MOF is unviable with the cost of delivering the requirements likely to be more to practices than the funding available.

The only part of MOF which may be affected by turning off Optimize is reducing OTC prescribing. If your practice decides to keep Optimize turned on due to this, please encourage clinicians that for suggested changes which are not related to this goal, they should ignore changes on the basis of cost alone, but should prescribe the medication and formulation as they believe is on the best interest of the patient in front of them.

3.GP COLLECTIVE ACTION JULY 2026 – DECLINE UNFUNDED OR UNDERFUNDED SHARED CARE AGREEMENTS.

I hope that practices will connect with this collective action.

Dr Reema Parwaiz (LLR LMC Board Member and Medicines lead has written this explanation which has been circulated to practices and is as below. In addition, Dr Parwaiz has written a patient facing letter and letter that can be sent to the ICB when declining a shared care agreement due to Collective Action. These can be downloaded from this webpage: https://www.llrlmc.co.uk/guidance/supportive-documents-to-help-practices-with-declining-shared-care-agreements/

"Dear Colleague,

As part of the LMC collective action programme for July 2026, practices are being asked to review their approach to Shared Care Arrangements.

From 1 July 2026, practices are asked to:
1. Decline any new Shared Care Arrangements that are not supported by a locally commissioned formal agreement, adequate resourcing and clear clinical responsibilities.
2. Review existing Shared Care Arrangements to ensure they remain safe, appropriately commissioned, and supported by up-to-date protocols.
Practices are asked to:
3. Reject new requests for Shared Care Arrangements if inappropriately resourced
4. Ensure a formal agreement is in place before agreeing to prescribe and monitor
5. Ensure provider responsibilities are clear: GP handles prescribing and routine monitoring; specialist retains diagnosis and complex management
6. Maintain communication with secondary care provider(s) and escalate concerns to ICB promptly.
7. Follow prescribing governance and safety requirements.

Position within LLR
Within LLR, Shared Care is currently funded through the Clinical Board Scheme (CBS), with practices receiving:
· £40 per patient for a new Shared Care arrangement.
· £85 per patient for ongoing Shared Care management.

We recognise that many practices rely on this income stream and that Shared Care arrangements often support patients receiving important treatment closer to home. However, we would encourage practices to carefully consider the true resource implications of delivering these services and whether the current funding adequately reflects the workload involved.

When reviewing whether participation remains financially and operationally viable, practices may wish to consider:

- *The significant time pharmacy teams spend reviewing and processing requests.*
- *Reviewing blood test results and monitoring requirements.*
- *Managing recall systems and ensuring monitoring is completed within required timescales.*
- *The volume of monitoring invitations that are declined, ignored or require repeated follow-up.*

- *Administrative time spent contacting patients, arranging appointments and chasing non-attenders.*
- *Liaison with secondary care services when information is incomplete or clarification is required.*
- *Delays in receiving clinic letters, monitoring plans or specialist recommendations.*
- *Managing medicine supply issues, dose changes and safety alerts.*
- *Governance, documentation and auditing requirements.*
- *The difficulty and delays that can be encountered when patients need to be referred back to specialist services due to monitoring failures, adverse effects or clinical concerns.*
- *Clinical and medicolegal responsibility carried by practices when monitoring and prescribing ongoing specialist medicines.*
- *The lack of uplift in this service despite increased staffing costs.*

Practices should ensure that any Shared Care arrangements they continue to support are appropriately commissioned, adequately funded, clinically safe and represent a sustainable use of practice resources.

We want to also reiterate the statement by Stephen Kinnock MP (Minister of Health)which was in our September 2025 newsletter: 2025-09-LMC-Newsletter-September.pdf

"Also, in a recorded answer to a question raised by Kim Leadbetter MP, Stephen Kinnock MP (Minister of State for Health and Social Care) replied (3 September 2025):

"Shared care within the NHS refers to an arrangement whereby a specialist doctor formally transfers responsibility for all or some aspects of their patient's care, such as prescription of medication, over to the patient's general practitioner (GP). The General Medical Council (GMC) has issued guidance on prescribing and managing medicines, which helps GPs decide whether to accept shared care responsibilities. The GMC has made it clear that GPs cannot be compelled to enter into a shared care agreement. GP practices may decline such requests on clinical or capacity grounds. If a shared care arrangement cannot be put in place after the treatment has been initiated, the responsibility for continued prescribing falls upon the specialist clinician. This applies to both NHS and private medical care." Stephen Kinnock MP (Minister of State for Health and Social Care)"

Any questions, please don't hesitate contact on the email below.

Kind regards,
Dr Reema Parwaiz
LLR LMC Board Member (Medicines lead)
reema.parwaiz@llrlmc.co.uk "

I have contacted UHL and LPT to prewarn that they are likely to see an increase in decline in taking over Shared Care Agreements, so their clinicians will need to continue to prescribe this medication, whilst at the same time highlighting that this is only a problem due to the ICB not contracting with general practices appropriately. If the contract for SCAs covered the cost of providing the service, it would be out of scope for collective action.

The message I sent was:

"Dear All

As you are probably aware the BMA is in formal dispute with the government regarding another imposed round of contract changes. Last year we predicted that the changes would cause more harm than good, and there was a significant 5% increase in ED attendances by patients with low acuity problems that could probably have been dealt with in general practice if there was the capacity.

I predict the changes for 2026/27 will have a similar unintended consequence. This will be mainly due to a requirement for practices to keep open and respond to non-urgent messages from patients throughout core hours. Although many of these requests are non-clinical and others repeated (not uncommon for one patient to send 6+ requests in one day), it means that more GP time will have to be diverted away from seeing patients to triaging these messages.

Yet again the changes do nothing to deliver the long-term increase in general practitioners needed to improve health care and health outcomes, and in particular partners who are needed to provide the capital which keeps general practices afloat. National and international evidence shows that the more a country invests in primary care medical services the better health outcomes are for lower costs. Contrary to this, report after report commissioned by this government or written during that time, and indeed previously, has highlighted the gradual reduction In the percentage of NHS funding allocated to general practice and that this must be reversed – as Lord Ara Darzi concluded when considering that the amount spent in general practice is going in the wrong direction 'In the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.' This is not helped by the fact that despite a lot of work a few years ago to increase funding for locally commissioned services to a level that actually covered the cost of delivering them, as the ICB has refused to give any uplift to cover inflation and other costs, the ICB is once again knowingly expecting general practices to provide services for less than actual cost. In addition, the health equity payment which was the only local intervention to try and adjust the inverse care law locally has also been undermined with no inflationary increase for several years and now a further 10% reduction in the total fund for 2026/27.

The result is that practices have less funding to employ general practitioners with the biggest effect being felt in the areas with greatest need. Leicester City has the highest health need, but the second lowest ratio of GPs to population and unless local and national contracting improves this is likely to deteriorate further.

At present, the BMA are not suggesting any strike or stopping clinical services but are arranging Collective Actions with a new one being added each month. The first two were understanding what Data Sharing Agreements were in place and to consider declining any new DSA which was not mandatory/contractual and the second was to ignore medicines 'optimisation' software and for GPs to prescribe what medication and formulation they believe would be the best based on their clinical assessment for the patient in front of them.

The latest additional Collective Action which commenced on 1 July 2026 is for practices to decline new shared care agreements which are not adequately funded. As you may know the LMC's view is that the amount paid for SCAs did not cover the actual cost of delivering the service when it was commenced by the ICB a few years ago, and since then there has been zero increase for inflation and other costs making it even less adequate.

It is therefore likely that unless the ICB agrees to increase the funding to cover the actual costs (please note that unlike in normal contracting GPs are not looking for a profit margin, but just purely that practices and in particular GP partners are not expected to subsidise NHS care), then practices will be declining more SCAs for this reason. The ICB has declined to discuss this at present.

The BMA sought KC legal advice which confirmed this action to be lawful, and that it does not breach the GP contract or any other requirement. In addition, Mr Stephen Kinnock MP (Minister for Health and Social Care) in response to a formal written question made it clear that GPs can decline shared care agreement on clinical or capacity grounds. If practices are not receiving adequate funding, then de facto they will not have the capacity to provide the service.

I was recently provided with the outcome of an audit regarding why SCAs are currently declined in LLR and was surprised that in at least 50% of cases they were declined because the secondary care

physician had not complied with the agreed basic requirements that they should meet before asking a GP to take over prescribing.

I apologise for the length of this email, but in essence just wanted to give you a warning and the background as to why GPs are likely to be declining more SCAs so that you can warn your clinicians that they are likely to need to continue prescribing medications long term to their patients.

Please let me know if it would be helpful to have a further conversation about this.

Best wishes

Grant"

CHANGE IN GPC EXECUTIVE TEAM

There has been a change in the GPC Executive team who are now:

Dr Clare Bannon	**Dr Manu Agrawal**	**Dr Shan Hussain**	**Dr David Wrigley**
GPC England chair	GPCE deputy chair	GPCE deputy chair	GPCE deputy chair

The LMC team and me have had interactions with all 4 for many years. They have already reaffirmed their commitment to the dispute with the government and the Collective Action approach. We wish them all the best as they take over leadership of the GP profession at this very difficult time.

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7. ELECTIONS TO THE LMC BOARD

Half of the Leicester, Leicestershire and Rutland Local Medical Committee governing body (Board) will be soon coming to the end of its 4-year electoral term. We will be looking for committed and motivated GPs who have a natural interest to play an active part in supporting colleagues in general practice. **PLEASE NOTE THAT THIS IS FOR ADVNACE INFORMATION ONLY, AND THE ELECTION IS NOT OPEN FOR NOMINATIONS YET.**

The LMC governing body elects half the board 2 years, rather than the whole board every 4 years to ensure continuity. **Once elected each GP board member will serve a 4-year term.**

The Constitution of the Leicester, Leicestershire and Rutland Local Medical Committee (LLR LMC) sets out the number of Committee members who may be elected to its Governing Body. Click here for the current version.

Committee members are required to abide by the committee's Code of Conduct and Conflict of Interest Policy which is based on the 7 Nolan principles of public office.

The Committee shall consist of no less than 11 elected members, and half of the current governing body seats are up for renewal (**6 seats**)

To comply with the LLR LMC constitution, the governing board is seeking to elect the following categories from the vacant seats:

- 3 contractor GPs (*Levy paying GP member & named on the GMS, PMS or APMS contract)
- 1 newly qualified GP (first 5 years of completing CCT)

- 1 GP who works in a Leicester City Practice
- 2 GPs who work in a Leicestershire County Practice
- 1 GP who works in a Rutland Practice

Please note that an elected member may fulfil more than one role – e.g. one elected GP may work in a Leicestershire County Practice, may also be a contractor, and may also be within 5 years of completing CCT.

All GPs in a substantive post working in a levy paying practice in Leicester, Leicestershire & Rutland that are on the performers list are eligible to put forward a self-nomination application.

The following documents have been attached for your reference:

- Committee member role description
- LLR LMC constitution
- LLR LMC code of conduct & Conflict of Interest policy

The LMC will also be running the same process but separately for the two practice manager board positions and the GP registrar position (will be done in collaboration with the TPDs)

ELECTION TIMETABLE

If we receive more nominations than we have available positions, the LMC will conduct elections for the vacant seats within the governing body. All LLR levy paying members will get the opportunity to vote, which will be an online voting system, and further details will be available in due course.

- Wednesday **19th August 2026**: Election pack details is sent to all LLR LMC constituents
- Wednesday **2nd September 2026**: Deadline for completion of nomination forms to be submitted (5.00pm)
- Wednesday **9th September 2026**: Voting opens for LLR constituents
- Wednesday **23rd September 2026**: Voting closes (5.00pm)
- Thursday **24th September 2026**: Returning officer to verify the votes and sign off election results
- Friday **25th September 2026**: All applicants are notified of outcome.
- Wednesday **14th October 2026**: Newly elected board members will be invited to attend the LMC board meeting in a shadowing role

ONCE THE ELECTION IS LIVE AN ONLINE NOMINATION FORM WILL BE MADE AVAILABLE AND DETAILS SENT TO EVERY GP ON THE LMC DISTRIBUTION LIST.

IF YOU ARE CONSIDERING NOMINATING YOURSELF AND HAVE NOT BEEN INVOLVED WITH AN LMC BEFORE I STRONGLY ADVISE THAT YOU REQUEST TO OBSERVE AT THE AUGUST LMC MEETING. If you would like an informal conversation about this role, please contact Dr Grant Ingrams, LMC Chief Executive – grant.ingrams@llrmc.co.uk

For comments or queries please email the LMC.

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8. CYP TIER 3 WEIGHT SERVICE.

In October 2025 the ICB announced that it was ceasing to commission a Children and Young People's (C&YP) Tier 3 Weight Management Service. The LMC felt that this was inappropriate and would increase health inequalities.

As part of this, the ICB wrote advising that they expect general practices to screen obese children for co-morbidities and if found refer to the appropriate speciality.

The LMC view is that although it would be reasonable if an obese child presents unwell for a GP to consider whether this may be due to a co-morbidity, if the child presents due to obesity and is otherwise well, then screening for co-morbidities is not an essential service and represents a transfer of unfunded work from secondary to primary care.

If a child presents to you with obesity but is otherwise well, you should advise that the ICB is currently not commissioning any NHS service to help. You may also wish to suggest that the patient's parents/guardians complain to the ICB and/or raise it with their MP. If you are still concerned about the child, then refer to general paediatrics.

I sent the following to the ICB:

"Re: CLOSURE OF C&YP TIER 3 WEIGHT MANAGEMENT SERVICE
"Practices have raised concerns about this, and the expectation that practices should now screen for co-morbidities.

If an obese child presents unwell at a general practice, then it would be reasonable to consider whether the cause of the ill health is due to a co-morbidity and to investigate appropriately.

However, if the child presents with Obesity and is otherwise well screening for co-morbidities would not come under essential services.

General practice is not an all you can eat buffet and transfer of unfunded and uncontracted workload from secondary to primary care is causing significant pressures on general practice which has the knock-on effect of reducing practices capacity to provide the primary medical care service that has the biggest effect in improving healthcare for the best cost.

As I am sure you are aware general practices are receiving about £40 per patient on average less than in 2019, and there is still an inequality of funding with practices in LLR providing services for patients with the highest need receiving the least funding per patient. Also, there has been significant transfer of unfunded work from secondary to primary care which the RCGP has recently calculated costs an average practice £500,000 per year which is funding that they cannot then use for providing essential services.

Lord Ara Darzi concluded when considering that the amount of NHS funding allocated to general practice continues to decrease despite repeated recognition that it must increase of health outcomes are to be improved, said: 'In the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.'

We will be advising our constituents regarding this issue, and I hope that you will look into this, send out an amendment, and avoid further deliberate or unintended transfer of unfunded workload to general practices."

For comments or queries please email the LMC.

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9. LIST CLEANSING.

Last month I reported that in other areas of England there had been 'aggressive' list cleansing with significant amounts of patients being removed from registered lists leading to:

- Significant reduction in funding
- Many patients being inappropriately removed who believed that they are still registered and receiving care from a practice.
- Reduction in care for some patients, not least due to a break in their continuity of care.

Since then, the GPC has communicated with DHSC and NHS England about the issue and the intended/unintended consequences.

The response has been a letter from the increasingly inconsequential Dr Amanda Doyle (see newsletters passim) which seeks not to apologise, not to recognise the negative impact it is having, but to explain it away as a good and important thing to do. This is yet another example pointing to the fact that NHS England just hates general practices.

We have also had the first practice report that they have been significantly affected. They have had 300 patients deducted of who they believe 150 are still resident at the same address and receiving care from their practice. Any system which is wring 50% of the time is incompetent. This has resulted in the practice having to devote many hours of admin, managerial and clinical time in sorting it out.

Please let the LMC know if your practice is affected.

Please let the LMC know if you have any further questions or concerns about this.

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10. SODIUM VALPROATE AND ANNUAL RISK ACKNOWLEDGEMENT FORM.

The LMC has recently been asked about who is responsible for the Annual Risk Acknowledgement Form (RAF) for female patients of childbearing potential on Sodium Valproate, particularly in the circumstance that the patient has been discharged by secondary care. We are aware that this is an area that the CQC will look at during assessments.

The MHRA advise that the RAF should be used at initiation and annual review of all girls and women of childbearing potential on valproate medicines. Also, male patients under the age of 55 should have a RAF completed when they are commenced on Sodium Valproate.

The RAF clearly states that it needs to be signed by the 'specialist prescriber' and countersigned by the 'specialist.' This therefore is clearly a specialist responsibility.

The ICB's Medicines Optimisation Team sent a letter attached to an email on 11 July 2025 that included the advice that practices should "create a list of female neurology patients with an outstanding PPP and RAF for UHL including patients who have been discharged … and share the list … {with} their … specialist at UHL" with similar advice for patients who have been commenced on sodium valproate by a Mental Health specialist.

If you have any problem with this, please contact 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

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

- 2026-06-29 CQC Webinar
  - Copy of the presentation
  - Return to Good inspections – CQC Quality Statements mentioned in the presentation
- **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 05-27-Greatest Hits Radio interview about health in hot and sunny weather
- 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.

UNDERSTANDING PRACTICE CONTRACTUAL RESPONSIBILITIES AROUND IMMUNISATIONS & TRAVEL: MYTH OR REALITY?

- DATE: THURSDAY 30 JULY 2026
- TIME: 1:00PM – 2:00PM
- LOCATION: MICROSOFT TEAMS

Designed to provide clarity on practice contractual responsibilities relating to immunisations and travel services, including myth-busting common misconceptions and practical guidance to support day-to-day decision-making**.**

COMPLAINTS EVENT

- DATE: TUESDAY 11 AUGUST 2026
- TIME: 1:00PM – 4:00PM (LUNCH FROM12.30)
- VENUE: LEICESTER MARRIOTT HOTEL

Following the success of previous complaints events, which were consistently fully booked and very well received, we are delighted to welcome back, Lee Bennett and Cathie Cunnington for another session for LLR practices.

This practical and engaging event will provide valuable learning and discussion around complaints handling, responding effectively to concerns, and managing challenging situations in primary care.

This event will largely repeat the previous sessions, so if you have attended a previous session, you might not find it something new. However, if you would like a refresher, you are welcome to attend or another member of the team is welcome.

SAFEGUARDING NETWORKING ADMIN LEAD WEBINAR

- DATE: MONDAY 24 AUGUST 2026
- TIME: 1:00PM – 2:00PM
- LOCATION: MICROSOFT TEAMS
- AUDIENCE: FOR SAFEGUARDING ADMIN LEADS

A networking and learning session for safeguarding admin leads, providing opportunities for peer support, shared learning and discussion around the administrative aspects of safeguarding within general practice.

NHS PENSION & RETIREMENT PLANNING WEBINAR FOR GPS

- DATE: THURSDAY 10 SEPTEMBER 2026
- TIME: 1:00PM - 2.00PM
- LOCATION: MICROSOFT TEAMS

Hosted by the LMC and delivered by Chase De Vere, this free webinar will provide practical guidance on nhs pensions, retirement options, tax considerations, the McCloud judgment, and retirement planning.

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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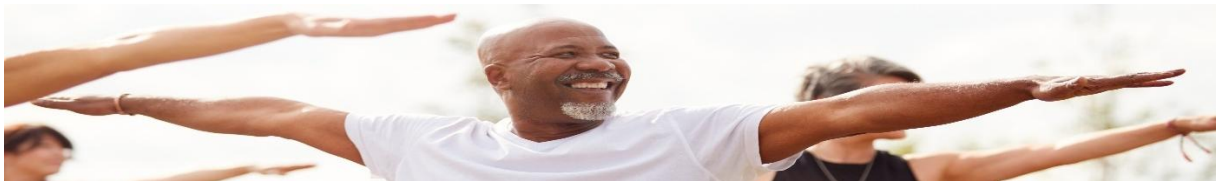
14. AVAILABLE TO WORK



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

"I believe the children are our future
Teach them well and let them lead the way"

Whitney Houston had it right. I was recently talking to a GP colleague who had noted an increase in the number of children being brought to the GP with quite simple medical problems. An old Nigerian saying is that it takes a village to bring up a child. But nowadays the wider familiy group has broken down and whereas in the past grandparents would be at hand to provide simple advice this support structure often no longer exists. Of course this is not universal and I am regularly asked to advise on health issues of our five grandchildren, and I am positive that many other medical colleagues similarly provide this service to those we love.

But as a country, what are we doing for our future, our children? Well overall the evidence is not good, and we are failing them.

In section 3 I note the problems with maternity services throughout England, including LLR and how maternal and infant mortality rates have risen rather than improved. So we are not giving the future generations even a safe start to their lives.

But how do they do following this start? Not good at all. A report published this month by the Royal College of Paediatrics and Child Health (RCPCH) warn:
"The UK is raising one of the unhealthiest generations in decades."

The report highlights some worrying numbers:

- In England, about 1 in 5 children haven't received both doses of the MMR vaccine by the age of five.
- More than one in three children leave primary school overweight or obese.
- One in five, aged between eight and sixteen, has a probable mental health disorder.
- Children in the poorest areas are four times more likely to die from asthma.
- Infant mortality in the most deprived communities is more than double the rate in the wealthiest.

A seprate report by Unicef ranks the UK 21st out of 36 for overall child wellbeing, 27th for mental health and joint second from bottom for teenage life satisfaction.

As I have mentioned in previous newsletters the health of a nation, including of children, depends on the ratio of primary care physicians (GPs in UK) to the population, including a straight line relationship with infant mortality.

So what is being done to address this? As far as I can see minimal if anything.

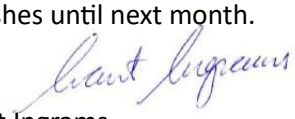
Nationally the centre hates general practice (see newsletters passim) and it would appear that they would prefer to do anything other than invest in the most productive,financially prudent, cost effective part of the NHS with the greatest power to improve health outcomes.

Locally there is a similar approach with the ICB now knowingly contracting with general practices for services for less than they cost to provide. The ICB is also positively undermining their only policy that had the potential to reduce health inequalities for children as well as adults by not keeping the Health Equity payment in line with inflation, and then this year to take the counterintuitive decision to reduce it by 10%. Finally as per section 8 of this newsletter the ICB have decided to decomission the Children's and Young Persons Tier 3 Weight Management service, and as a double whammy the ICB expect general practices to take up some of this workload unfunded thereby further exacerbating the ability of general practice to provide the services they should, and as this will affect deprived populations the most, it will further increase health inequalities.

Most people I talk to hope that they will leave a legacy of improving the world around them or wider afield. But unless national and local health policies improve, our generation will be leaving a legacy of a world much worse off.

Lord Ara Darzi concluded in his Independent Investigation of the NHS in England when reflecting that the amount of NHS funding allocated to general practice continues to decrease despite repeated recognition that it must increase if health outcomes are to be improved, said: 'In the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.' I hope that the new Prime Minister and their new Secretary of State for Health and Social Care, whoever that may be, will be able to look beyond the national ingrained hatred of general practice by NHS managers and act on the massive amount of evidence and increase the investment in core general practice, but I won't hold my breath. But if they do they will be awarded with a significant turaround in the NHS and health of the nation, with benfits likely to be measurable within 2 years.

Best wishes until next month.



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