NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

August 2026
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
GRANT INGRAMS
(12 MINUTES)

SUMMARY OF THIS MONTH'S MUST DOS:

- **Collective action is continuing with a new area for August and DO NOT SIGN THE CONTRACT VARIATION NOTICE**. SEE SECTION 6 FOR MORE INFORMATION.
- **Consider using the video by Dr Adam Juanja (CEO of the Consortium of Lancashire and Cumbria Local Medical Committees) to inform patients about List Cleansing.**
- **Consider what changes/training you need to make in practice in line with NHS England Guidance about preventing staff from unlawfully accessing patient records.**

TOPICS IN THIS NEWSLETTER:

As predicted a report from HSSIB has found that mandated Advice and Guidance, has already led to 30 incidences of harm/near misses. Contact the LMC if you have a referral inappropriately downgraded

NHS ENGLAND HAS ISSUED GUIDANCE ABOUT HOW TO PRVENT STAFF HAVING UNLAWFUL ACCESS TO PATIENT RECORDS. PLEASE CONSIDER WHAT CHANGES YOU MAY NEEDTO MAKE TO PRACTICE POLICIES/PROCEDURES AND UPDATING YOUR STAFF.

1. LMC MEETING – AUGUST 2026

The LMC Board met on 12 August 2026 in the meeting room associated with the new LMC offices.

Drs Ginny Lee, Paul Smith and Cathy Lea attended on behalf of the UHL pathology department. They apologised for the repeated problems there have been within the pathology department with processing blood samples. They advised that over the past year the number of samples being processed per month had increased from 4.5million to 5.5million per year. These additional samples are coming from inpatient, outpatient and general practices equally. They advised that they had recruited additional staff to improve their capacity to be able to process samples in a timely manner.

One option they are considering is whether to include an additional option of requesting creatinine without potassium. This would allow monitoring of renal function without the risk of a rejected sample due to the potassium not being able to be analysed due to the age of the sample. Your LLMC Board thought that this may be beneficial for GPs, who would retain the option of requesting full U&Es including potassium if needed for an individual patient.

Lee Walker (Deputy Medical Director, and clinical lead for Urgent and Emergency Care) attended the meeting on behalf of the UHL executive team and gave an update on ongoing issues. He provided an update. Ambulance handover times have improved considerably with UHL's performance within the top 6/7 of midland Trusts. The handover time has reduced on average for an hour to around half an hour. He also reported that Same Day Emergency Care (SDEC) service has improved with a 16% increase in patients seen in the SDEC service. The CQC rating has improved.

Dr Walker advised that there had been a 7% higher increase in ED attendance than predicted. He reported that most of these are low acuity and asked whether the Board felt that this may be related to the change in GP Contract. We advised that the LMC had predicted that the 2025/26 contract changes would reduce the GP time practices would have available for appointments so that this change was predictable. We further advised that our assessment of the 2026/27 contract changes which have not yet had a full impact, but that we predict they will further increase the amount of GP time taken away from clinical work, so to expect the number of attendances to increase further. However, it was advised by the board and agreed by Dr Walker that the increase was not due to the fault of general practice but to health policy including imposed contractual chnages.

Dr Walker advised that UHL is now using AI (Ambient Voice Technology) in OPD to generate patient letters. He was keen to explore the LMC's view of AI. I reported the risks and limitations in using AVT for clinical work and generating electronic records, but that if it was replacing the use of dictation then it was likely to improve the quality. We discussed the importance in ensuring that all the appropriate information is included, and Dr Parwaiz advised of the importance that the letters include medication details, including what medication the specialist believes the patient should be taking already as well as any changes.

We finally had a discussion with Dr Walker about Advice and Guidance, and regarding that the reply should include the name and designation of who had written it. This meeting was before the publication of the HSSIB report into potential and actual patient harm associated with A&G.

Another GP Registrar attended this month to observe the LMC Board 'in action' together was a GP who was considering whether to put themselves forward for election to the board. 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. NHS ENGLAND OBESITY QOF FAQS.

The ICB recently circulated a document entitled "**2026/27 Quality and Outcomes Framework (QOF) Obesity Indicators Frequently Asked Questions." This document is inaccurate, misleading and the LMC view incompetent. GPs are contractually required to have regard to NHS England guidance, but this does not mean following the contents slavishly. In this case your LMC recommends that you read the LMC's view and approach the NHS England guidance accordingly.**

We have formally replied to NHS England to explain the errors in their 'FAQs' which renders their document incompetent as below:

"17 August 2026 To: NHS England Contracts Team: england.gpcontracts@nhs.net

Dear Sir/madam
RE: ***2026/27 Quality and Outcomes Framework (QOF) Obesity Indicators Frequently Asked Questions***

I am writing to raise our significant concerns regarding the above document which you have circulated which is causing significant distress to general practices.

I am writing as Chief Executive of Leicester, Leicestershire and Rutland Local Medical Committee. As you will be aware LMCs were first established by the National Insurance Act 1911 and continued by other legislation most recently the NHS Act 2006. LMCs have various functions outlined in legislation and guidance but the main role is to represent all performers of primary medical services within their agreed area. We represent and support circa 700 general practitioners working across 126 practices providing services to 1.2 million registered patients.

For clarity I will cover two major areas first (Background to QoF, and the Responsibility of Commissioning Technology Appraisals) and then respond to each of the FAQs individually.

Background to the Quality and Outcome Framework

The Quality and Outcome Framework (QOF) is a voluntary incentive scheme that general practices can chose to participate with or not. The funding never was designed to pay for the actually clinical activity, which can easily be demonstrated, either on the grounds that it would be inappropriate for the services to be provided in general practice (e.g. echocardiograms to diagnose heart failure) or the amount per clinical episode is so small as to make it non-sensical to consider it appropriate funding.

I am fully appraised of the purpose of the QOF as I was involved in its development as a member of the GPC and as a member of the GPC's IT Subcommittee, including being deputy chair and then chair. I was also co-deputy chair and then co-chair of the Joint GP IT Committee.

On a general basis it is important that general practices are not expected to provide unfunded or underfunded services. As you are aware since Barbara Starfield's seminal paper in 1994 - the findings of which have been repeated in subsequent multiple national and international research - showed that the higher the ratio of a nation's health budget that is spent on primary medical services (i.e. general practice in the UK) the better the health outcomes for the best cost effectiveness. In addition, there is direct correlation between the ratio of GPs to patients and various health outcomes.

Unfortunately, despite many government and other reports advising that the proportion of health expenditure spent on general practice must increase for health outcomes to improve, in reality for many years the reverse has happened. The HSJ recently reported that the proportion is now at the lowest for at least the last decade. It cannot be unrelated that life expectancy and health outcomes is now falling behind other countries. It is also unlikely to be unrelated that locally in Leicester City there is now the second worst infant mortality rate and the second worst ratio of GPs to patients in England. Infant mortality is one area where Barbara Starfield demonstrated a direct relationship (between infant mortality rate and ratio of GPs to population) in her 1994 published research.

As Lord Ara Darzi concluded in his 2024 Independent Investigation of the NHS in England that 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.' Patients with the highest healthcare need are the most affected meaning that this increases health inequalities.

So, decisions to try and force general practices to further provide additional services without appropriate funding increases this negative effect on the health of the population.

Responsibility for Commissioning NICE Technology Appraisals

Your document correctly identifies the NICE document on Tirzepatide as being a Technology Appraisal. As you will be aware ICBs have a legal requirement to commission services to implement NICE Technology Appraisals by virtue of section 6 of The National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 and that section 8(b) makes it clear that that ICBs need to allocate funds from its existing budget to do so.

I would also make the additional comment that NHS England Guidance and GMC requirements are very clear that general practitioners as registered medical practitioners must not prescribe drugs unless they have sufficient knowledge and competence to do so. Your document assumes that the whole of general practice will suddenly achieve this overnight which is foolish and could put patients at risk.

To respond to each of your 'FAQs' individually:

1. What do the OB004 and OB005 indicators cover?

This is straight forward and we make no comment.

2. Why is OB004 funded through QOF rather than a per-referral payment?

As per our information above it is inappropriate and misleading to advise that this service is funded through QOF. This section misses the facts that QOF was never designed to and does not fund activity as well as the ICB has a legal obligation to commission and fund a service to deliver a technology appraisal. This FAQ is therefore misleading.

3. What type of services count for OB004?

The only comment that we make is that in our, and other areas, the ICB currently does not commission a Tier 2 Weight Management service.

4. What happens if no suitable weight management service is available?

We fully agree that if no service is available then practices should consider applying a Personalised Care Adjustment.

5. How should differences in locally commissioned service specifications across ICBs be managed?

In this FAQ we only regret that you do not include the only body formed by statute and that independently represents general practitioners should be engaged (i.e. LMCs).

6. Has OB005 replaced locally commissioned tirzepatide obesity medication pathways?

You state that "OB005 provides a nationally consistent framework for incentivising general practice activity relating to the identification, assessment, prescribing and ongoing management of eligible patients" however this is inaccurate. Putting aside as above the crucial point that QOF does not fund activity, as QOF is a voluntary activity that practices will divert different levels of resources in achieving or decide not to participate with at all, it is eminently not 'nationally consistent.' Indeed, your proposed approach results in the opposite position, which will further increase health inequalities.

You are wrongly conflating the correct description of 'incentivisation' with payment for activity.

7. What behavioural wraparound support services count for OB005?

We welcome the clarification that the NHS BSOP is available to all patients referred from general practice but are concerned that this service only purports to be targeted at reducing diabetes risk which is inappropriate as many patients may be obese with a low risk of diabetes compared with other complications of obesity. This service should be recommissioned to specify that they support the reduction of risk for all complications of obesity.

In addition, if a patient is purchasing tirzepatide privately, should general practices:

- *a) Accept that any wrap around service provided by the private provider is appropriate?*
- *b) Refer the patient to NHS BSOP?*
- *c) If you believe that the patient does not fulfil the criteria for referral to NHS BSOP to support a Personalised Care Adjustment as they therefore cannot access an acceptable wraparound support service?*

Finally, we find your final paragraph nonsensical. If the purpose of your process is to increase the percentage of eligible patients being treated with tirzepatide it is incomprehensible that you do not allow patients receiving tirzepatide via a Tier 3 Specialist service to count towards the target. This is out with the normal approach to QOF. In addition, it leaves practices with such patients in a difficult position. Please clarify whether general practices should either:

a) *Cancel all further treatment by the specialist service, and then, if there is no local commissioned service, advise the patient that they can no longer access treatment with tirzepatide unless they pay privately?*
b) *Or, if the patient wishes to continue to have tirzepatide to add a Personalised Care Adjustment?*

I would suggest that if you asked a member of the general public about your approach, they would likely to find it bonkers and to represent bureaucracy for the sake of it.

8. The NICE guidance for type 2 diabetes recommends that patients with atherosclerotic cardiovascular disease are prescribed semaglutide. There is an overlap in eligibility between NICE diabetes and obesity guidance. How should GPs manage these patients?

Thank you for accepting that in this complex scenario a Personalised Care Adjustment can be applied which would appear to be the obvious action to take.

9. How does OB005 interact with locally commissioned tirzepatide services?
For the reasons that we rehearse above this FAQ is inappropriate, incorrect, and would further add to reducing the health of the nation if accepted, and increase health inequalities

To be clear again, QOF does not pay for activity, ICBs have a legal obligation to commission and fund this as a NICE technology appraisal, and therefore on both these grounds we require you to correct this FAQ.

9. Which SNOMED CT codes should practices record to evidence the required activity for QOF Indicator OB005??
I am unclear why you are including such a small subset of the SNOMED CT codes needed for the QOF indicators, and in particular why you have not included the various Personalised Care Adjustment Codes.

Summary
In summary our view is that your document contains so many errors/inaccuracies and wrong assertions as to make it pointless. We are particularly astonished that it condones: ICBs' disregard of legislation in not commissioning a NICE Technology Appraisal and suggests that general practices undertake non-commissioned and unfunded work having a further negative pressure on the health of the nation and increasing health inequalities. We will therefore be advising our practices accordingly.

We look forward to receiving your reply."

If you have any comments, concerns, or inappropriate pressure by any organisation regarding these QoF indicators, please contact the LMC.

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3. NEIGHBOURHOOD SERVICES.

Despite change in Prime Minister and Secretary of State for Health (Yvette Cooper), the Titanic-esque 10 year plan with Neighbourhood providers continues towards the inevitable iceberg.

The ever decreasingly relevant NHS England has now decided to undertake a consultation regarding the Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) models.

The BMA has produced guidance to assist GPs/practices to input into the consultation, summarising the options outlined in the consultation and outlining key issues that they may wish to consider.

Read more about the BMA's view of neighbourhood providers and the consultation here

The BMA are aware that in many areas practices may be feeling under pressure to agree to neighbourhood working models. Practices do not have to, and should not be pressured to, sign up to local neighbourhood proposals, especially as such proposals are still under national consultation. If you feel under any such pressure please contact the BMA, and also the LMC.

My view remains that neighbourhood services will never deliver any substantial improvement, particularly as they have the ability to further redirect more funding away from core general practice which will have further negative effect on health outcomes. Reading the proposals it again assumes that there is benefit in reducing commissioning of primary care to a transactional basis, which does not work in healthcare.

One day I hope that we will have national political leaders who can read and understand the copius research about how to develop a health service to deliver the biggest health outcomes benefits for the best cost efficiencies and who then develop a national plan to implement it. In the meantime, I will be resigned to continue to try and teach Percy my pet pig to fly.

For comments or queries please email the LMC.
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4. ADVICE & GUIDANCE / SINGLE POINT OF ACCESS.

This continues to cause problems for GPs, in particular when specialist services downgrade a referral to Advice and Guidance, despite the fact that the only clinician in the position to be able to decide the needs of an individual patient is the GP who has carried out a clinical assessment and agreed the management plan with the patient.

NHS England's view of the 2026/27 contract changes regarding A&G is "Practices will be required to use Advice and Guidance prior to or in place of a planned care referral where clinically appropriate and to follow locally agreed referral pathways, including single point of access models once introduced. Advice and Guidance has shown clear value in supporting timely specialist input, reducing unnecessary referrals and ensuring patients receive timely care in the most appropriate setting."

As we forewarned, referrals are being inappropriately downgraded to A&G with Pulse Today recently finding this happening in about 25% of cases in a survey.

We further warned that there was potential for patient harm, and again this has been found to be happening with a recent HSSIB report recording 30 cases of near misses/actual harm.

This further gives weight to a requirement that A&G should have a DCB0160 in place from the ICB's CSO and we are pursuing this. In the interim I suggest that every practice consider adding A&G to their risk registers.

5. UHL GALA AWARDS EVENING.

Nominations for this award closed on 31st July and 10 GPs were nominated from across LLR.

UHL have shortlisted three, and we should congratulate everyone who was nominated and the three shortlisted:

- Prof Vinay Gupta
- Dr Grant Ingrams
- Dr Kirk Moore

This was the first year that I was eligible to be nominated for the award although in previous years I had been nominated regardless although the nominations were set aside.

The winner will be announced at the Gala Event on 3rd October.

Please remember that there will be another chance to nominate people (not just GPs) working in general practice to receive an award at our LMC AGM in Spring 2027, so please be thinking about colleagues who deserve their work to be recognised.

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

Practices should now have received a Contract Variation Notice from the ICB. As before **WE RECOMMEND THAT YOU DO NOT SIGN AND/OR RETURN THE VARIATION**. The profession remains in dispute about these imposed changes which will not benefit general practices or our patients. If you do not sign, they still become a contractual requirement after 14 days, but it provides feedback to the ICB and NHS England that you will only be working to the changes under duress.

The most disastrous part of the contract which is likely to lead to further increase in attendances at ED and risk of patient harm is the requirement that practices cannot cap the number of online requests daily.

First, we would note that this will inevitably lead to a diversion of clinical time away from patient contract to triaging the online requests the clinical significance if which is likely to be low or very low.

Second although the contract changes say that it will increase capacity by providing funds through introducing the GP reimbursement scheme and altering the rules for employing GPs via ARRS, both are short term fixes. As neither (unlike if the funding had been added to core funding) are guaranteed to still be present by the end of this financial year, let alone in the future, they will not result in practices being able to invest in the additional permanent GPs that are needed to cope with the increased workload and to start the process of providing continuity of care crucial to improving health outcomes.

The LMC has also made it clear to the ICB that as the contract also requires practices to comply with other relevant legislation, as this includes health and safety regulations, practices will have a legal requirement to turn off the online requests if it becomes impossible for practices to be able to otherwise continue to provide a service safe for patients and/or staff.

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 FOR AUGUST*

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 now four 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. Dr Clare Bannon, the new GPC chair has made it clear that **The GPC intends to continue to escalate Collective Action** (Click here for short YouTube video by Dr

Clare Bannon about Collective Action)). 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

You may also like to use this patient facing video created by Dr Adam Juanja, CEO of the Consortium of Lancashire and Cumbria Local Medical Committees regarding list cleansing.

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 "

4.GP COLLECTIVE ACTION AUGUST 2026 – RAISING PUBLIC AWARENESS OF THE CHALLENGES FACING GENERAL PRACTICE.

From 1 August, the focus is on raising public awareness of the challenges facing general practice. Practices are encouraged to share patient information materials (display animations, posters and leaflets), signpost patients to the GPs on your side campaign webpage and public petition, and help build understanding of why investment and contractual reform are needed to protect safe, sustainable GP services. We encourage practices to contact your local MP using the 'Write to your MP' tool to explain how underfunding is affecting patient care and the sustainability of your practice.

Display these animations in your practice

Shorter animations (YouTube links):

- **Sign our petition, take action to protect patient care (horizontal)**
- **Sign the petition, take action to protect patient care (9x16 vertical version)**
- **Worried about the future of your GP practice? (horizontal)**
- **Worried about the future of your GP practice? (9x16 vertical version)**

Shorter animations (downloadable):

- Access the downloads via our **folder** and add password: k0D1dyrRP2F0

Longer animation:

- **GPs under pressure – sign the petition**

Longer animation (downloadable):

- Access the downloads via our **folder** and add password: 1V44Rd5RjXXD

Download posters for your practice

- **Patient care is our priority (PDF)**
- **Your GP is overwhelmed (PDF)**
- **The clock is ticking on patient care (PDF)**
- **Are you losing your GP? (PDF)**
- **Your medical records. Your rights (PDF)**
- **Worried about the future of your GP practice? Sign the petition (PDF)**

Order leaflets for your practice

Our patient leaflet is available in English and nine other languages: Arabic, Bengali, Gujarati, Polish, Portuguese, Punjabi, Romanian, Spanish and Urdu. The translations have been completed by professional translators.

You can order printed copies of the leaflets in the languages and quantities you need via the BMA Hub.

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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 NOMINATIONS ARE NOW BEING ACEPTED FOR THESE POSITIONS UNTIL 5pm WEDNESDAY 2ND SEPTEMBER. To complete a self-nomination form, please complete the following link: https://www.surveymonkey.com/r/26LMCGPboardnominations**

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 working mainly for one or more levy paying practices 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 are 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 SEPTEMBER 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. GENERAL PRACTICE STAFF SURVEY.

The LMC office has received many queries about this survey.

NHS England announced that they would make it a requirement for both practice and ARRS staff to complete this survey as we forewarned in our February newsletter. This is specified in the PCN DES contract for 2026/7, and in the GP contract variation notice. It is therefore now contractual for practices to participate in this.

The deadline for submissions is 11.59pm Tuesday 1st September.

The staff list submission portal is available here:
https://bit.ly/GPSS26StaffListPortal

There is more information on participating on the NHS Staff Survey website, and guidance is incorporated into the portal itself.
https://www.nhsstaffsurveys.com/2026-nhs-general-practice-staff-survey/

There is also a video which provides an overview of the new process. It's available here: https://www.youtube.com/watch?v=XkwHIXc9SCA

For comments or queries please email the LMC.

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9. LLR INTERNATIONAL MEDICAL GRADUATE PROGRAMME.

The LMC has been asked to circulate this invitation by the LLR Training Hub.

LLR TH International Medical Graduate Programme

Dear All

I am writing to introduce myself and my colleague Dr Ade Arikawe, we are Clinical Leads for the Leicester, Leicestershire and Rutland Training Hub and we are excited to provide further information on the **LLR's International Medical Graduate (IMG) Programme.** This programme is targeted at IMGs in training and those early career IMG GPs who are within their first 2 years of practice post CCT.

Here are further details on what the programme entails and how to register:

Induction date:

We have arranged an Induction session on **Wednesday 16th September 2026** at Loros Education Centre from 5.00pm – 7.00pm.

Eligibility:

International Medical Graduates who are ST1,2 or 3 and post-CCT IMG GPs who are within their first 2 years post-qualification.

Programme Duration:

6 months with a view to extending to 1 year subject to funding.

Format: this is a 4-pillar programme including:

1. Peer support and community connectivity.
2. Mentorship with an experienced IMG GP mentor (targeted to newly qualified IMG GPs within their first 6 months of practice and to include four 1-hour sessions over a 6-month period, offered on a first come first served basis).
3. A bespoke, free-to-attend CPD programme of clinical and non-clinical topics https://www.llrtraininghub.co.uk/events-calendar
4. Advice on local employment opportunities and visa application

The programme is supported by our "**Life in LLR"** app which is now active and regularly updated, **click here** to access and register.

If you are interested in joining this programme, please complete our registration form

If you are a GP trainee at any stage of training, especially if you are due to CCT imminently OR a recently qualified GP within your first 2 years post CCT, please do reach out to us via the following email addresses:

lisa.elliott18@nhs.net
aderik2001@gmail.com
pngreen@doctors.org.uk

Feel free to access the "**Life in LLR"** app via the link above which also has registration details for our induction programme and access the resources that we have available to date.

We very much look forward to meeting you and supporting you through your transition from GP trainee through to working as a fully qualified General Practitioner in Leicester, Leicestershire and Rutland.

Best wishes

Phil

Dr Phil Green
MB CHB FRCGP DRCOG DFFP
Clinical Lead – GP Fellowship Programme, Leicester Leicestershire and Rutland Training Hub

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

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10. MEDICINES UPDATE / INAPPROPRIATE REQUESTS.

Dr Reema Parwaiz (LLR LMC BOARD MEMBER AND LMC MEDICINES LEAD, has written the following update:

As part of our recent LMC Board meeting on 12th August 2026, we discussed a recurring issue that continues to create significant concern for general practice. This relates to situations where prescribing has historically been undertaken by GPs, but where the ICB and secondary care services are now seeking to introduce guidance or governance frameworks retrospectively, effectively transferring additional review, monitoring and clinical responsibilities into primary care.

From both a GP and LMC perspective, we do not believe that many of these reviews sit appropriately within the expertise, capacity or commissioning arrangements of general practice. We are concerned that the introduction of such guidance may create an expectation that GPs should undertake work that has neither been properly commissioned nor adequately resourced.

Two recent examples demonstrate this concern:

1. Antipsychotic prescribing in patients with dementia

NICE guidance recognises that antipsychotics should only be used in limited circumstances, are often prescribed outside their licensed indications, and require regular review, monitoring and consideration of non-pharmacological interventions, including behavioural support plans.

In practice, GPs are frequently asked to continue prescribing these medicines without access to the specialist support, expertise or infrastructure needed to undertake comprehensive reviews. While there are undoubtedly historic patients for whom prescribing has transferred into primary care over time, we do not believe that creating local guidance simply to legitimise or facilitate this transfer is appropriate. There is a real risk that such guidance could be interpreted as an expectation that GPs should routinely prescribe and monitor these medicines, when this was never the intention of existing arrangements.

2. Antipsychotic prescribing for behavioural symptoms in patients with learning disabilities

This applies to both adults and children and often involves highly specialised prescribing outside licensed indications. These are complex clinical decisions that typically require specialist assessment, ongoing review and expert oversight.

It is important to remember that prescribers are under no obligation to prescribe medicines that they do not feel competent to initiate, monitor or continue safely. The fact that a patient has historically received a medicine in primary care does not automatically mean that primary care should assume ongoing responsibility for specialist reviews, monitoring requirements or future prescribing decisions.

LMC concerns

Our primary concern is that these proposals place unrealistic expectations on general practice. It is simply not practical to expect every GP, practice pharmacist and prescribing clinician to identify, review and monitor all patients who may fall within these categories, particularly where specialist expertise is required.

For example, if guidance states that a Structured Medication Review (SMR) should occur every six months, this creates an implied responsibility for primary care. However, in reality, these reviews are frequently not undertaken by the initiating specialist service, and responsibility gradually defaults to general practice without any additional resource, funding or governance arrangements.

The Board's view was therefore that we cannot support guidance that effectively transfers specialist responsibilities into primary care through the back door, particularly where:

- The work has not been appropriately commissioned.
- The required expertise sits primarily within specialist services.
- There is no additional funding or resource to support delivery.
- Governance and lines of accountability remain unclear.
- Compliance with the proposed pathway is unlikely to be achievable in routine practice.

As the NHS moves towards greater national standardisation and the potential development of a single national formulary, there remains considerable uncertainty regarding future responsibilities. Until clear national arrangements, appropriate commissioning and adequate resourcing are in place, the LMC does not believe it is reasonable for general practice to accept additional prescribing and monitoring responsibilities for these specialist areas.

Ultimately, our position is that patient safety is best served when prescribing responsibilities remain with the clinicians and services that have the expertise, capacity and governance arrangements necessary to manage these complex treatments safely.

Dr Reema Parwaiz (She/Her)
GP Board Member - Leicester, Leicestershire and Rutland LMC
If you have any comments about 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

- August 2026 LLR LMC Podcast Grant Ingrams flying solo
- 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

- 2026-07-31 Video for Patients about List Cleansing by Dr Adam Juanja
- 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.

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

The Emporer's New Clothes

When Hans Christian Andersen first published his short story 'The Emporer's New Clothes'in 1837, I bet he did not realise how closely this would resemble our current 10 year health plan 189 years later.

As in the story we had a seemingly vain Secretary of State for Health being persuaded to publish and implement a health plan which when you stand back and look at it has no substance.

The plan is the eighth major attempt to achieve the needed NHS shift from secondary to primary care, none of which has had a soupcon of success in delivering this worthy aim. The government's own assessment is hardly rosy indicating many risks, and includes some warnings like "This complexity creates a high risk that the plan's ambition cannot be matched in delivery and implementation and results in insufficient pace of change" and that previous examples referred to have taken 4 to 6 years to see any improvement, and the improvements were lost once the additional funding was withdrawn. On this occasion the 10YP is being implemented when the NHS is already under extreme pressure and with no additional funding.

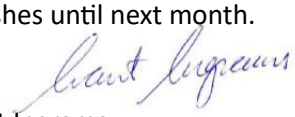
After 8 failed attempts as any ful kno just renaming the policy, dusting it off, and giving it a new look will make not a jot of difference and as sure as eggs is eggs this is just another titanic heading serenly towards the iceberg. The 10YP really does not have any clothes.

In the Hans Christian Andersen story it is an innocent child that blurts out the emporer's new clothes do not actually exist.

I wonder which senior NHS/DHSC official(s) will have the courage and integrity to reply to NHS England's 10YP consultation pointing out that it has not been woven out of invisible thread, but has no substance what so ever. SNP and MHP are just two new three letter initialisms with no ability to lead to the amount and consistency of change needed.

Andy Burnham (Prime Minister) you have previous experience regarding the NHS, but together with Yvetter Cooper (Secretary if State for Health and Social Care this week) you need to listen to the growing Siren Calls, and recognise that the 10YP has no clothes and abandon it before you are made to look as foolish as the emperor in the story.

Best wishes until next month.



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