



October 2026

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

Dear Colleagues

LLRLMC NEWSLETTER

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

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

OCTOBER PODCAST
CHARLOTTE WOODS, FAHREEN DHANJI AND GRANT INGRAMS
(11 MINUTES)

SUMMARY OF THIS MONTH'S MUST DOS:

- **Continue to engage in Collective action. The actions do not breach the contract or any other requirement but puts your practice in better control. [SEE SECTION 6 FOR MORE INFORMATION.](#)**
- **If you work as a GP in Rutland consider standing for the LMC Board**
- **Consider the scandalous remarks made by the LLR Health Scrutiny Committee, read the LMC's response and consider using the contents for information leaflets/posters for patients, and to engage with your local politicians.**

TOPICS IN THIS NEWSLETTER:

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**The Beatings
Will Continue
Until Morale
Improves.
*Read this
month's final
thoughts.***

If you are not finding the thought of, or practical implementation of, Artificial Intelligence Scribes to be positive but are unsure why, then consider reading this article: [The Silent Consultation — and Nobody's Story: Signal Loss and Displaced Clinical Authorship | Zenodo](#). It was written by Dr A Hassey (GP and Clinical Informaticist) in collaboration with Dr G Ingrams et ors.

1. LMC MEETING – OCTOBER 2026



The LMC Board met on 14 October 2026. Richard Mitchell (RM - Chief executive) was due to attend but was delayed returning from a previous meeting. Gang Xu (Medical Director) attended on behalf of UHL together with representatives from ED.

Dr Xu gave an update regarding UHL and a wide-ranging discussion was held regarding the increasing pressures on ED and possible causes. It was agreed that general practice was not the cause and could be part of the solution if appropriately funded.

The Board discussed various other topics including:

- Contract changes and Collective Action
- LMC Elections
- Advice and Guidance/SPOA
- Ongoing concerns about glaucoma service and prescription of associated drops.
- Review of Pastoral Service
- Board Stability (it was decided that this would be discussed at a separate dedicated meeting).

If you would like more information about what is discussed at Board meetings, please contact the [LMC Office](#), or consider attending as an observer (please contact the [LMC office](#) to advise when you would like to attend).

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2. DISTRICT VALUER AND ASSOCIATED PROBLEMS.

There have been various issues raised by practices about the District Valuer service.

The first is that more than one practice has reported that the District Valuer has proposed a zero increase in valuation for notional rent etc. This is not sustainable, as clearly the costs will have increased over that period.

Even when the District Valuer has proposed an increase, if the practice appeals the ICB decline to pay any increase until, the appeal has been completed which can take up to 2 years. This is inappropriate and the LMC has approached the ICB regarding and requested that the ICB should pay the initially agreed uplift, and a further adjustment payment can be paid if appropriate once the appeal process has completed this, and the ICB have agreed to look into this. If this issue is or has affected your practice, please [contact the LMC](#).

The LMC is also aware that delays in the District Valuer service have also caused problems with proposed extensions and new builds.

TIP FOR PRACTICES ON NOTIONAL RENT. If you own your premises and receive notional rent, then this should be reviewed every 3 years. The LMC recommends that for practices receiving notional rent:

- 1) You check that you have had a triennial review of your rent, and if not, you approach the ICB premises team.
- 2) If your current review is low or zero, and in particular if you have never appealed your Notional Rent valuation before, you consider appealing. There are multiple companies who will arrange an independent valuation and then manage an appeal of the notional rent on behalf of the practice. The normal arrangement is that they charge 1/3rd of any agreed uplift. So, in essence, the practice pays the independent surveyor the increase for one year, and the practice benefits from both the increase for the other 2 years, but also that the 'base rate' has been increased for the next review.

For comments or queries or if your practice has been affected by any issue relating to the District Valuer Service please [email the LMC](#)

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3. NEW LMC BOARD.



Following the conclusion of the recent Board elections, the following are your LMC Board members for the next two years (the current arrangement is that half the Board is reappointed every 2 years, but each individual GP member is elected for a term of 4 years).

You will note that no GP member was nominated to represent Rutland. Please see Section 4 below for the next steps in getting this position filled.

The members elected in the recent election are:

Name	Role / Representation	Status
Dr Rakesh Choudhary	Contractor GP, Leicester City Partner	Elected
Dr Fahreen Dhanji	Leicestershire County, Sessional GP	Elected
Sarah Gibson	Leicestershire County Practice Manager Representative	Elected
Dr Dhianna Hindocha	Resident Doctor Representative	Not Contested (Elected Unopposed)
Dr Neha Popat	Contractor GP, Leicestershire County Partner	Elected
Dr Amit Rastogi	Contractor GP, Leicester City Partner	Elected
Jessica Robinson	Leicester City Practice Manager Representative	Not Contested (Elected Unopposed)
Dr Sakshi Sadhu	Leicestershire County Sessional GP, Newly Qualified GP	Elected

They join the members who had a further term of 2 years to run to form the full Board:

- Dr Grant Ingrams (Contractor GP, Leicester City Partner)
- Dr Nutan Kumari (Leicester City, Sessional GP)
- Dr Shiraz Makda (Contractor GP, Leicestershire County Partner)
- Dr Ebrahim Mulla (Leicester City, Sessional GP, Newly Qualified GP)
- Dr Reema Parwaiz (Contractor GP, Leicestershire County Partner)

If a member would like more information regarding the LMC elections, please contact the Returning Officer, grant.ingrams@llrlmc.co.uk

On behalf of the LLR LMC, we would like to thank all the candidates who stood for election and all GPs and Practice Managers who participated in the voting process.

In line with the constitution, at the November Board meeting elections will be held for Chief Executive, Treasurer, and Chair (the post of Deputy Chief Executive is appointed by the Chief Executive). The posts are elected from existing Board Members for a term of 2 years, although if there is no-one who is willing and has the right knowledge and experience the Board can recruit from outside Board members.

For comments or queries, please [email the LMC](#)
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4. BYELECTION FOR RUTLAND GP MEMBER.

The LMC's constitution specifies the minimum number of GP members from various constituencies to ensure that the Board can represent the views from the whole of LLR General Practice.

The previous GP member who represented Rutland (Dr Adam Crowther) did not stand for re-election and as no other nominations were received from any other GP working in Rutland this position remains vacant.

The constitution requires the LMC to either co-opt someone into the vacancy or to hold a byelection. After a full discussion at the last LMC Board it was agreed that a byelection would be held. This will be open any GP who works in Rutland (Partner, Salaried or Locum). The proposed timetable is:

Wednesday 28th October 2026	Reopened nominations circulated. Click on link to nominate: https://www.surveymonkey.com/r/RutlandGPnoms
Thursday 5th November 2026 (12.00 midday)	Deadline for nominations
Friday 6th November 2026	Voting opens (if required)
Friday 13 th November 2026 (12.00 midday)	Voting closes
Tuesday 17 th November 2026	Returning Officer verification and sign-off
Wednesday 18 th November 2026	Applicants notified of outcome

If you have any question about the election for a GP Rutland Board member please [email the LMC](#)

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5. FAREWELL TO LEAVING BOARD MEMBERS.



Following our recent elections, four Board members have now left the Board. At the October Board meeting a small presentation was given and the following citations read out:

Citation for Departing Board Members

As we say farewell to four valued Board members, I would like to thank **Dr Adam Crowther, Dr Rakesh Desor, Dr Tushar Shamji and Mr Dinesh Vadgama** for their commitment, knowledge, support, and dedication to the work of the LMC.

Dr Adam Crowther joined the Board in 2022 and became LMC Chair in 2024. Your leadership, professionalism and commitment have been instrumental in guiding the LMC over the years. On behalf of the board, we want to thank you for your stewardship, support, and the lasting contribution you have made to the LMC.

Dr Rakesh Desor also joined the Board in 2022 and has certainly waved the flag for GP partners in LLR. You have been a passionate advocate for ophthalmology issues and relentless in pursuing solutions on this topic. We wish you many enjoyable holidays and rounds of golf ahead.

Dr Tushar Shamji joined the Board in 2024, and his kind nature and subtle demeanour has added balance to the board. You have taken the role of representing the LMC at digital meetings and bringing valuable perspectives to the discussions. Whilst your time with us has been short, it has been a pleasure getting to know you. We wish you and your family all the very best as you prepare for an exciting new arrival.

Mr Dinesh Vadgama joined the Board in 2024 as the City Practice Manager representative. Your knowledge, experience and insight from a practice management perspective have been greatly appreciated. Thank you for your support with the Practice Managers Conference and for helping to establish and champion this important Board role for future representatives.

I hope you will join with the Board in giving thanks to all of them for their service, friendship, and commitment to supporting general practice across LLR.

If any practice experiences any further problems, please [email the LMC](#).

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



The LMC hopes that your practice held out on signing and returning the Contract Variation Notice. If any member of staff was put under any pressure by the ICB to sign please [email the LMC](#).

COLLECTIVE ACTIONS – **NO NEW ACTION ADDED FOR OCTOBER**

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 ACTIONS AS BELOW. PLEASE REMEMBER THAT THE BMA RECEIVED KC OPINION THAT NONE OF THE ACTIONS BREACHES THE GP CONTRACT, REGULATIONS OR ANY OTHER REQUIREMENT, AND SO AS PER THE LAST COLLECTIVE ACTIONS CAN BE CONTINUED EVEN AFTER THE CA IS STOPPED.** FULL DETAILS OF THE COLLECTIVE ACTIONS ARE AVAILABLE IN PREVIOUS NEWSLETTERS AND ON THE [BMA WEBSITE](#).

1. GP COLLECTIVE ACTION MAY 2026 – DATA SHARING AGREEMENTS

2. GP COLLECTIVE ACTION JUNE 2026 – MEDICINES OPTIMISATION SOFTWARE

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

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

7. PATIENTS AND SHARPS DISPOSAL

The LMC has received queries from practices about the disposal of sharps boxes provided to patients relating to treatment at home.

This has been highlighted as a national issue, and the BMA has revised its guidance: [GP practice responsibility when disposing of clinical waste](#)

The responsibility lies with local authorities. We have had confirmation from the County Council regarding their process.

Any health professional can refer the patient for the service (Hospital staff, Midwife, District Nurse, or GP etc) and I would suggest that the responsibility should remain with the person who has prescribed the injection.

Patients can also be advised to contact their district council to arrange collection of clinical waste and/or sharps: [Find your district council | Leicestershire County Council](#)

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8. LLR HEALTH SCRUTINY COMMITTEE.



The LMC were advised of scurrilous anti-general practice comments reported in [Leicestershire live](#) about general practice. Their comments were made after gaining ‘facts’ about GPs from anecdotes and the ICB. I have sent the following to the LLR Joint Health Scrutiny Committee, and you may wish to use the contents or forward the whole content to your local councillor(s):

By email: democracy@leics.gov.uk

22 October 2026

Mr J Morgan

Chair, Leicester, Leicestershire, and Rutland Joint Health Scrutiny Committee

County Hall

Glenfield

Leicestershire

LE3 8RA

Dear Mr Morgan

I am writing in response to an article published in Leicestershire Live ([GP 'black hole' fears raised as bosses call on Leicestershire surgeries to step up](#)) which reports 'concerns' raised by your committee at a meeting on 28 September 2026.

I write in my capacity as Chief Executive Office of the Leicester Leicestershire and Rutland Local Medical Committee (LMC). LMCs were initially established by the National Insurance Act 1911 and have continued to be recognised by statute ever since, currently by the NHS Act 2006. LMCs are the only single authoritative and independent representative body of general practice for the area in which they are formally recognised. LMCs have various statutory and contractual duties, most importantly to represent all general practitioners in their designated area.

I was surprised that the article suggests that the meeting took place without any attempt to engage with general practice and I would urge that in the future if your committee were looking to discuss an issue relating to general practice that you contact the LMC for information.

There is indeed a significant ongoing problem with general practice which is having a negative effect on individual patients and the health of the population. However, this is due to decisions being made at ICB and national level and is not the fault of individual practices.

Your committee raised the issue about access being mainly online and subject to triage. This situation is not how general practitioners wish to run their practices but has been foisted on them by the DHSC and NHS England by using imposed unilateral changes to the GP Contract. Whilst the changes seem superficially enticing the effect of the way they have been imposed is making healthcare worse. When the 2025/26 contract was imposed the LMC predicted that the changes would lead to further deterioration in the NHS with worsening health outcomes and increasing pressure on the hospital Emergency Departments ([press release](#)). As you will be aware health outcomes have further deteriorated and there was a step wise increase in ED attendances as we predicted. The LMC further predicts that the unilaterally imposed changes for 2026/27 will make the situation worse, not least because they take even more of the scarce resource of GP time away from the frontline of treating patients. The LMC believes that the DHSC and NHS England are sacrificing quality, continuity, and health outcomes on the altar of so-called access.

One of your committee members, Leicestershire County Council Phil King, made the crass statement that general practices should be hit where it hurts "which is in their pockets" and also suggested that it would be better to 'financially penalise partners' which just demonstrates that he has no idea about the current situation in general practice and has made no attempt to understand the actual situation. I would urge him to meet with the LMC to learn the facts before making any further similar inappropriate suggestions.

General practices are the bedrock of the NHS and continue to provide around 90% of all NHS healthcare for about 8% of the total budget.

As your committee members should be aware 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 a direct correlation between the ratio of GPs to patients and various health outcomes. Starfield's original paper summarised all the relevant published research at the time, which included that outcomes for tonsillectomy and adenoidectomy were better when patients had been referred by a primary-care physician compared to those who had self referred, and that self-referred patients have higher rates of unnecessary interventions. Also she noted a consistent relationship between the availability of primary care physicians

(known as General Practitioners in the UK) and health levels, including improved mortality associated with cancer and heart disease, neonatal mortality and life expectancy. She also provided evidence “that population, mortality and health are directly related to the quality and resourcing of primary care and, conversely, inversely proportional to that of secondary care.”

Unfortunately, despite many governmental and other reports advising that the proportion of health expenditure spent on general practice must increase for health outcomes to improve, for many years the reverse has happened. The Health Service Journal 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. As above, infant mortality is one area where Barbara Starfield demonstrated a direct relationship (between infant mortality rate and ratio of GPs to population).

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.

In real terms General Practices now receive approximately £40 less per patient than in 2019 and during the same period the complexity of patients has increased. This is mainly due to an increasing percentage of elderly patients, and the number surviving with disease. In Lord Ara Darzi’s report he further noted that the percentage of patients with two or more long-term conditions is increasing at an annual rate of 6.1%.

The number of fully qualified general practitioners reduced by 7% during the same period that the number of hospital consultants increased by 48%. But despite this the productivity of hospitals has decreased whereas the productivity of general practices has increased. The number of GP appointments has increased significantly. In 2025, the last fully reported year, the number had increased from 375.7million to 388million per annum. English General Practices are now providing 30 million appointments every month. The average number of general practice appointments per patient per year has increased from 2.5 to 6.8, with no recognition of this increase by additional funding or workforce.

The current funding formula (Carr-Hill) which was developed over twenty years ago is not fit for purpose and does not allocate funding equitably. This has been noted in many separate reports including Lord Ara Darzi’s. The formula means that practices with the highest population health need receive the lowest level of funding. In Leicester, Leicestershire, and Rutland the practices receiving the lowest level of funding per patient are those in inner city Leicester providing services to patients with the highest need. A few years ago, the LLR CCGs and then LLR ICB developed an equity payment scheme which aimed to partially ameliorate this effect by providing additional funding to those practices with populations with highest need but receiving less than average funding via the national distribution formula. This project was recognised nationally, but the ICB has undermined its effectiveness by never increasing the amount in line with inflation and other cost pressures, and then for this year reducing the total budget by a further 10%. During the first two years of the scheme there were demonstrable improvements in the performance of practices receiving the additional funding, including an improvement in overall patient satisfaction.

There has been a steady transfer of uncontracted and unfunded work to general practices. There is a common misconception that general practices are contracted to provide whatever their patients need, but they are contracted and funded via national and local contracts to provide specific

services. If a practice takes on additional uncontracted work, it can only be by using funding that was allocated for another service. Last year the Royal College of General Practitioners undertook research to quantify the amount of unfunded work GPs are expected to do and concluded that the cost is around £500,000 for an average sized general practice.

There has recently been a small increase in the number of fully qualified GPs, but the total remains lower than in 2015. During that period, the number of patients registered at English General Practices has increased by 6.2 million (12. %).

In addition, the recent modest increase in GP numbers has been funded by transferring funds within the General Practice Additional Roles Reimbursement Scheme from other roles to GPs, which means that this increase has been funded using short term funds and at a loss of other clinical staff. This will not lead to the long-term improvement needed to improve quality of care, especially continuity. Continuity of care (i.e. being seen by the same GP for your ongoing health problem) is another factor shown by research repeatedly to be crucial in delivering the best health outcomes most cost effectively.

GP partners are normally the most experienced general practitioners in each general practice. In addition to providing clinical services to patients, they are also responsible for management and development of the practice and for providing the capital needed for general practices to continue. Since 2015 the number of GP Partners has fallen by 6,600 FTE driven by several factors, most notably rising operational costs, financial uncertainty, increased administrative burdens as well as the heightened perceived risks involved in taken on partnership. The result has been that since 2015 1,480 English GP practices have closed or merged, leading to interruption to the healthcare of approximately 6 million patients. So, if your committee really does want to see an improvement in general practice services they should be considering why GP partners cannot be recruited and retained rather than suggesting they should be further punished for providing an overall excellent service in extremely difficult circumstances.

Local General Practice Funding is provided by local contracts between ICBs and general practices. These contracts are more often than not poorly priced, in that what practices are paid to deliver the services is less than what it costs the practice to do. Also, there are some services that the ICB does not commission from any service including ones whether they have a legal obligation to do so leading to 'commissioning gaps' with general practices trying to support patients who cannot access the care that they need.

There are also other additional pressures on general practices that affect the ability to provide a service fit for today include that many GP premises are inadequate for the services practices should be providing.

So, as you can see from the evidence outlined above rather than relying on anecdote and hearsay the decline in provision of general practice services is related to national and local healthcare policy outside of the control of individual general practices. Overall general practices remain the most productive part of the NHS providing 90% of NHS healthcare despite significant workload, workforce and funding pressures and should be congratulated for doing so. Please let us know if you would like any further information.

Yours sincerely



9. PRESCRIBING TIRZEPATIDE/MOUNJARO



The LMC continues to receive concerns about prescribing Tirzepatide (Mounjaro) in general practice. I thank Dr Fahreen Dhanji (General Practitioner, GPC member, and Deputy CEO LLR LMC for drafting our revised guidance as below which includes a letter that practices can provide to patients.

LMC briefing – QOF obesity indicators and tirzepatide.

26 Oct 2026 ·

Tirzepatide is licensed as a drug in the UK, and so general practices can prescribe it if they wish to do so. However, as the work associated with commencing, titrating, and monitoring is not insignificant and general practices are neither contracted nor properly funded to provide this service we urge practices to consider the below carefully before deciding whether to prescribe. Finally, we remind practices that the ICB has a legal obligation to commission and fund a service to provide Mounjaro but at present they have not commissioned any service in apparent breach of their legal duty.

NHS England are still erroneously claiming that practices are funded to provide this service via the Quality and Outcome Framework (QoF). The LMC view is that QoF is a voluntary incentivisation scheme and therefore is neither appropriate for commissioning a service, nor does QOF ever fund clinical activity. The LLR LMC therefore advises practices that QOF indicator OB005 (the tirzepatide pathway) is inadequately funded, and that practices are entitled to decline it. Practices that decline may simply not pursue the points. OB004 (weight management referral) does not require prescribing, and practices can continue to deliver it.

The two indicators

	OB004	OB005
Points	5	13
Threshold	10–30%	50–80%
Patients	Adults with BMI ≥ 30 (≥ 27.5 for South NICE TA1026 priority cohorts: currently BMI ≥ 35 Asian, Chinese, other Asian, Middle (≥ 32.5 for the groups above) plus at least 4 of Eastern, Black African, or African-type 2 diabetes, hypertension, sleep apnoea, Caribbean backgrounds)	dyslipidaemia, cardiovascular disease
What is needed	Referral to a weight management programme within 90 days of the BMI of reading	Coded shared decision-making discussion, offer of medication, and referral to behavioural support (BSOP) within 12 months
Needs prescribing?	No	Yes
LMC view	Achievable; continue	Not adequately funded; practices may decline

LMC advice to practices

QOF is voluntary. OB005 does not make tirzepatide prescribing a contractual requirement, and its place on the formulary is not a direction to prescribe. The OB005 payment does not cover the cost of delivering this pathway safely, so practices should not assume QOF income will fund the work.

If your practice chooses not to deliver OB005:

- Record the decision and reasons at practice level, for example capacity, safety, training, and lack of commissioned support.
- Do not pursue the OB005 points. There is no penalty beyond the lost income.
- The most recent [Dataset and Business Rules v51](#), includes the ability to exception-report patients (Personal Care Adjustment) for "Service unavailable" The SNOMED CT Code: is 999037061000230108 "Weight management service unavailable codes". At present this code is not available on SystmOne. In the interim we recommend that practices consider using

SNOMED CT Code “Weight Management service not available: 1326221000000105. It is possible that towards the end of the financial year TPP may have updated SystmOne with the right codes, but if your practice has consistently used the code that we advise, you can easily carry out a bulk change of the code if necessary. We have raised this issue nationally via the GPC.

- Use the LMC template letter to explain this to patients who ask about tirzepatide, and direct access queries to the ICB.

For all practices:

- Continue OB004: record BMI and refer to a weight management programme within 90 days, coding the referral, decline, or exception.
- Use patient-level Personal Care Adjustments (exceptions) where they apply: declined, unsuitable for the obesity medication pathway, contraindication to tirzepatide, previous bariatric surgery, or no response to two coded invitations.

If your practice chooses to deliver OB005, make sure you have the clinical capacity, training, monitoring systems, and governance in place first. All patients prescribed tirzepatide should be referred to wraparound behavioural support.

ICB position and LMC action

The LMC asked LLR ICB to commission a funded local service for tirzepatide prescribing and monitoring. The ICB declined, on the basis that QOF funds this work. The LMC disagrees, and further notes that as this is a NICDE Technology Appraisal the ICB has a legal obligation to commission and fund a service.

Under the NICE TA1026 funding variation, ICBs are required to fund tirzepatide for eligible cohorts. NHS England guidance requires "a defined approach to access" in every ICB and offers four delivery models, of which general practice is only one. Where practices do not deliver OB005, the duty to provide access stays with the ICB.

The LMC has written to the ICB asking it to:

1. confirm how patients at practices not delivering OB005 will access tirzepatide and wraparound care.
2. reconsider commissioning a properly funded local service.
3. confirm where practices should direct patient enquiries.

We are also raising the issue with GPC England. We will update practices when we receive a response.

Resources

- LMC template patient letter: weight-loss injections (tirzepatide) – [link to be added]
- For questions about this briefing, contact the LMC at [LMC email]

Sources

- [NHS England – QOF guidance 2026/27](#)
- [NICE TA1026 – Implementation and funding variation](#)
- [NHS England – Interim commissioning guidance for TA1026](#)
- [Primary Care IT – OB005 business rules summary](#)
- [Primary Care IT – Understanding QOF exclusions and personalised care](#)
- [Datasets and Business Rules v51](#)

SUGGESTED PATIENT LETTER

Patient letter – weight-loss injections (tirzepatide)

26 Oct 2026 ·

For practices: replace the text in square brackets before sending. This can also be shortened for SMS or a website notice.

[Practice name and address]

[Date]

Dear [Patient name],

Weight-loss injections (tirzepatide / Mounjaro)

Thank you for asking about weight-loss injections. We know managing your weight can be hard, and we want to help you get the right support.

Our practice does not currently prescribe tirzepatide for weight loss. This is not a decision about you or your health. Starting and monitoring this medicine safely needs regular appointments, checks, and follow-up support. GP practices in Leicester, Leicestershire and Rutland have not been given the funding or resources to provide this service safely.

NHS Leicester, Leicestershire, and Rutland Integrated Care Board (the ICB) is responsible for making sure eligible patients can access this treatment locally. At the moment, it is being offered in stages to people with the highest health needs first, so not everyone with a high BMI is eligible yet.

What you can do

- **Weight management support:** we can refer you to a free NHS weight management programme. Please contact the practice if you would like a referral.
- **Questions about access to tirzepatide or to complain about the lack of service:** please contact the ICB.
 - **Address:** NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB), Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB
 - **Phone number:** 01604 476777 – Monday to Friday 8:30am to 4:00pm
 - **Email:** llricb-llr.enquiries@nhs.net
- **Your other health conditions:** we will keep supporting you with these as usual.

A note on buying weight-loss medicines online.

If you are thinking of buying weight-loss injections privately, please only use a registered UK pharmacy or provider. Medicines bought from unregulated websites or social media may be fake or unsafe. Tell us if you start any weight-loss medicine, so we can keep your records up to date and check it is safe with your other medicines.

Yours sincerely,

[Name] [Role] On behalf of [Practice name]

”

Please [let the LMC know if you have any further questions or concerns about this](#).

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10. CONSENT FOR VACCINATION.



There have been various concerns raised about how to gain valid consent in general practice for vaccinations, when the vaccinator is not a registered health professional. Dr Fahreen Dhanji (General Practitioner, GPC Member and Deputy CEO LLR LMC) has written the following guidance:

If you have any comments or queries about this guidance, please [contact the LMC](#).

Consent for Vaccinations in General Practice

Guidance for Leicester, Leicestershire, and Rutland (LLR) Practices

Document owner: LLR LMC

Review date: October 2027

National resources last checked: 19 October 2026.

1. Introduction

Obtaining valid informed consent is an essential part of every vaccination programme. Practices must ensure that patients receive appropriate information, have an opportunity to ask questions and make a voluntary, informed decision before vaccination.

The UK Health Security Agency (UKHSA) Green Book, Chapter 2, sets out the principles of consent for immunisation, including consent for children and young people and people who may lack capacity.

The legal mechanism used to authorise vaccine administration determines which healthcare professionals may undertake the assessment, obtain consent, and administer the vaccine. These arrangements include Patient Specific Directions (PSDs), Patient Group Directions (PGDs), Vaccine Group Directions (VGDs), and other applicable legal mechanisms.

This guidance explains how practices can obtain and document consent, use digital consent tools and ensure that healthcare support workers (HCSWs) undertake vaccination activities within the applicable legal framework.

Key national reference: [UKHSA Green Book — Chapter 2: Consent](#)

2. Key principles of informed consent

Consent is a process, not simply a signature, a completed questionnaire or attendance at a vaccination appointment.

Practices should ensure that:

- Patients receive appropriate information about the proposed vaccine, including its benefits, material risks, and relevant considerations.
- Patients have an opportunity to ask questions and request further discussion.
- Consent is informed, voluntary and obtained from a person with the relevant capacity or lawful authority.
- The patient's decision is documented appropriately in the clinical record.
- Patients are given the opportunity to change their mind or withdraw consent before vaccination.
- Consent is reconsidered where circumstances change or new concerns arise.
- Information is provided in an accessible format appropriate to the patient's needs.

Consent for one vaccine should not automatically be assumed to cover another vaccine or a subsequent dose where a new decision is required.

Useful resources

- [UKHSA Green Book — Chapter 2: Consent](#)
- [UKHSA Green Book — full collection](#)

3. Who can obtain consent for vaccination?

The healthcare professional responsible for obtaining informed consent must be authorised to undertake that activity under the relevant legal framework and must have the necessary knowledge, training, and competence.

3.1 Patient Specific Direction (PSD)

A PSD is a written instruction from an authorised prescriber for a named individual to receive a specified medicine or vaccine.

Where vaccination is undertaken under a PSD, the prescriber must be satisfied that the required individual clinical assessment has been completed, that vaccination is suitable and that valid informed consent has been obtained through an appropriate process. The PSD must be issued before administration.

An HCSW administering a vaccine under a PSD cannot independently undertake the informed-consent process required of the prescriber. The consent process must be undertaken by an appropriately registered healthcare professional.

Informed consent may be obtained before the vaccination appointment, provided the process is appropriate and the patient's decision is adequately documented. The patient's continued agreement should be checked as appropriate at the point of vaccination.

Supporting resource: [Assessment and Consent for Immunisation under a PSD](#)

3.2 Patient Group Direction (PGD)

A PGD permits specified registered healthcare professionals to supply and/or administer a medicine to eligible patients who meet the direction's criteria.

The activities specified in a PGD must be undertaken by the authorised registered healthcare professional. PGD activities cannot simply be delegated to an HCSW.

Practices must ensure that the relevant PGD is current, applicable to the vaccination programme and properly authorised for use.

3.3 Vaccine Group Direction (VGD)

VGDs provide a legal mechanism for vaccination within specified NHS vaccination programmes.

Only the registered healthcare professionals permitted by the applicable legislation and named in the VGD may undertake the assessment and obtain informed consent.

Where the VGD permits it, subsequent activities such as vaccine preparation, administration and record keeping may be delegated to appropriately trained and competent registered or non-registered practitioners.

The VGD must be followed precisely. Practices must not assume that every activity can be delegated or that the arrangements are identical across vaccination programmes.

3.4 Other legal mechanisms

Practices must establish the correct legal mechanism for the vaccine and programme concerned rather than assuming that one mechanism applies to every vaccination.

National guidance

- [UKHSA — Immunisation PGD and VGD templates](#)
- [NHS Specialist Pharmacy Service — UKHSA PGD resources](#)
- [Legal Mechanisms for Vaccine Administration and the Principle of Delegation](#)

4. Obtaining consent in advance of vaccination

Informed consent can be obtained by an appropriately authorised healthcare professional before a vaccination clinic. This can support efficient delivery of seasonal vaccination programmes and allow the required clinical assessment to take place before the patient attends.

A practice may send vaccine information and a digital questionnaire through AccuRx, enabling the patient to review the information and record their decision.

The practice must have a clear process to ensure that the response is reviewed by the appropriate healthcare professional and that any required clinical assessment is completed before the relevant legal authority for vaccination is issued.

Consent obtained in advance does not remove the need to address questions, changes in circumstances or concerns arising at the appointment.

If a patient withdraws consent, expresses uncertainty, or raises an unresolved concern, vaccination must not proceed until the matter has been appropriately addressed.

5. Digital consent using AccuRx

Avon LMC has developed a suite of digital consent templates for use within AccuRx. These cover adult influenza, childhood influenza, COVID-19, shingles, and RSV vaccination for eligible adults who are not pregnant.

LLR has reviewed the AccuRx questionnaires and is incorporating them into this guidance as practical resources for practices.

Practices remain responsible for ensuring that the questionnaire used is suitable for their patient population and consistent with current programme requirements, vaccine product information, and local governance arrangements.

5.1 Direct links to AccuRx templates

Vaccination programme

Adult influenza

Childhood influenza

COVID-19

Shingles

RSV — eligible adults who are not pregnant

AccuRx consent questionnaire

[Open adult flu template](#)

[Open childhood flu template](#)

[Open COVID-19 template](#)

[Open shingles template](#)

[Open RSV template](#)

The RSV template listed above is for the adult programme described by Avon LMC. Practices must use the appropriate arrangements for pregnant patients and must not assume that this template covers pregnancy vaccination.

5.2 Digital consent is not suitable for everyone.

Some patients may be unable or unwilling to use digital consent because of limited digital literacy, lack of access to technology, language barriers, difficulties understanding written information, capacity concerns, or a preference to discuss vaccination with a healthcare professional.

Practices must retain suitable alternative methods, including discussion with an appropriate healthcare professional and accessible written information where required.

5.3 Attendance does not constitute sufficient evidence of informed consent.

Practices should not send vaccine information through AccuRx and treat attendance at the appointment as consent.

Attendance alone does not establish that a patient has read, understood, and considered the information or made an informed decision.

A recorded consent response provides a more robust record of the patient's decision. However, a digital response does not automatically establish that consent is valid in every circumstance. The healthcare professional must consider the patient's understanding, voluntariness, capacity where relevant, and any questions or concerns.

A non-response must never be treated as consent.

6. Prescriber responsibilities and clinical assessment

Where a PSD is used, the prescriber remains professionally and legally accountable for the prescribing decision.

Before issuing a PSD, the prescriber must be satisfied that:

- The patient is eligible for vaccination or has been appropriately assessed for vaccination outside the criteria of a relevant PGD or VGD.
- The required individual clinical assessment has been completed.
- Relevant contraindications, precautions, allergies, and other clinical considerations have been assessed.
- The patient has received appropriate information and has had the opportunity to ask questions.
- Valid informed consent has been obtained and appropriately documented.
- The vaccine and administration arrangements are appropriate for the individual patient.

A questionnaire or screening response may support this process but cannot replace the required clinical assessment.

Where vaccination is delivered under a PGD or VGD, the assessment and consent responsibilities specified by the relevant direction must be followed. Practices must not automatically apply the PSD process to a different legal mechanism.

The relevant legal authority must be in place before the vaccine is administered.

7. Processing consent responses in AccuRx

Practices should have a documented process for reviewing and acting on digital consent responses in sufficient time before the vaccination appointment.

The process should cover:

- **Consent given** ensuring the response is recorded and available to the appropriate healthcare professional.
- **Consent declined:** recording the decision and ensuring the patient is not vaccinated unless a valid new decision is subsequently made.
- **No response:** arranging appropriate follow-up where required; non-response must not be treated as consent.
- **Incomplete or unclear responses:** seeking clarification before proceeding.
- **Requests for further information:** arranging discussion with an appropriately qualified healthcare professional.
- **Clinical concerns:** ensuring the appropriate assessment is completed before vaccination.
- **Changes at the appointment:** checking for new concerns, changes in relevant circumstances or withdrawal of consent.

The practice should identify who is responsible for reviewing responses, completing the assessment, issuing any required PSD, and ensuring that the appropriate legal mechanism is followed.

7.1 Processing vaccination consent responses

[Open Avon LMC's Processing Vaccination Consent Responses in AccuRx guide](#)

7.2 Importing and sharing custom questionnaires.

[AccuRx — How to share questionnaires with colleagues](#)

8. Children, young people, and adults who may lack capacity

Consent arrangements must reflect the relevant legal framework and the circumstances of the individual patient.

For children and young people, practices should consider parental responsibility, the competence of the child or young person to make the decision, their views, and the applicable guidance on disagreement between those with parental responsibility.

For adults who may lack capacity to make the specific vaccination decision, practices must follow the Mental Capacity Act 2005 where applicable, including the requirements for decision-specific capacity assessment and best-interests decision-making.

A relative or carer does not automatically have authority to consent on behalf of an adult who lacks capacity. Any applicable legal authority must be established.

Reference: [UKHSA Green Book — Chapter 2: Consent](#)

9. Local practice policies and governance

Practices using digital consent or delegating vaccination activities should maintain a local policy or protocol appropriate to their arrangements.

This should specify:

- The legal mechanism used for each vaccination programme.
- The roles and responsibilities of prescribers, registered healthcare professionals and HCSWs.
- Who sends and reviews digital questionnaires.
- How consent responses and clinical assessments are documented.
- How eligibility, contraindications and precautions are assessed.
- How incomplete responses, refusals and requests for discussion are managed.
- How consent is checked at the appointment and withdrawal of consent is handled.
- What alternative arrangements are available for patients unable to use digital methods.
- How staff training, competence and authorisation are maintained.
- How relevant directions and supporting records are retained.
- How the process is reviewed and audited.

Practices should ensure that staff undertake only those activities permitted by the applicable legal mechanism and their training, competence, and authorisation.

10. Current national vaccination documents

The following resources were checked against published UKHSA and NHS England resources on 19 October 2026. Practices should confirm that the linked document remains current and appropriately authorised before use.

10.1 Influenza vaccination — 2026–27

- [National influenza programme guidance for healthcare practitioners](#)
- [Influenza vaccine PGD — inactivated and live attenuated vaccines](#)
- [Influenza vaccine VGD — inactivated and live attenuated vaccines](#)

The published PGD and VGD versions checked were valid from 1 September 2026 to 31 March 2027. Practices should check the current published versions and applicable authorisation arrangements before use.

10.2 COVID-19 vaccination — autumn 2026 and spring 2027

- [COVID-19 vaccine PGD and VGD — individuals aged 5 years and over](#)

The published PGD version 5.0 and VGD version 2.0 checked were valid from 1 October 2026 to 1 February 2027. Practices must check for updated or replacement directions before the expiry date and follow their local procedures for accessing the authorised documents.

10.3 RSV vaccination

- [RSV vaccine VGD template](#)
- [UKHSA Green Book — full collection](#)

The RSV VGD published in July 2026 supports the national programme for pregnant women from 28 weeks of pregnancy and specified older-adult groups. The published validity period checked was 1 September 2026 to 31 August 2029.

Practices must check the current programme criteria and direction before use.

10.4 Shingles vaccination

- [UKHSA — Shingrix PGD template](#)

The published version 3 checked was valid from 1 September 2025 to 31 August 2028 and covers the specified immunocompromised population. It must not be assumed to cover every patient eligible for shingles vaccination.

Practices must identify the applicable current legal mechanism for the individual patient's programme and eligibility group.

10.5 General immunisation resources

- [UKHSA — Immunisation PGD and VGD templates](#)
- [UKHSA Green Book — full collection](#)
- [NHS Specialist Pharmacy Service — UKHSA PGD templates](#)

11. Keeping this guidance current

National vaccination programmes, legal directions, and eligibility criteria can change during the year. Practices should check the latest UKHSA and NHS England publications, the relevant Green Book chapter, the vaccine's Summary of Product Characteristics and the applicable authorised direction before using these resources.

The publication and expiry dates listed above reflect the official resources checked on 19 October 2026. They should be rechecked whenever this LLR guidance is reviewed.

Suggested review frequency: at least annually and whenever a material change occurs to national consent guidance, vaccination programmes, or the legal mechanisms for vaccine administration.

Acknowledgement

LLR LMC acknowledges and thanks **Avon LMC** for generously sharing its digital vaccination consent resources and practical guidance. With permission, this guidance incorporates and adapts material from Avon LMC's work, including its AccuRx consent templates and supporting resources.

We are grateful to Avon LMC for sharing its work and supporting the development of practical resources to help general practices deliver safe, effective, and patient-centred vaccination services.

Important note: This guidance is intended to support local practice processes and does not replace national guidance, the applicable legal direction or professional judgement. Practices remain responsible for ensuring that their arrangements comply with current legislation, national programme requirements, professional standards, and local governance arrangements.

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11. FINANCIAL RESILIENCE – SURVEY FOR GENERAL PRACTICE.



The [Cameron Fund](#) is the GPs' own charity. They support GPs and their families in times of financial crisis. As well as providing financial support, one of their charitable aims is the prevention of financial hardship.

Working with the Cameron Fund and [Plexus Support Services](#), [PG Mutual](#) have developed a Financial Resilience Health Check to improve the financial resilience of GPs.

In addition to helping the person completing the survey, anonymised results will be shared with the Cameron Fund to enable them to identify trends, what help could be needed in the future and what prevention measures might assist.

Please consider completing the survey in the link below. A good response will give The Cameron Fund a better picture of future need.

<https://pgmutual.involve.me/financial-resilience-health-checker>

Thank you on behalf of the Cameron Fund for your help (DOI I am a member of the charitable fund).

If you have any comments about this, please [contact the LMC](#).

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12. FREEDOM TO SPEAK UP (FTSU) GUARDIANS – IMPORTANT UPDATE.



Practices will be aware that LLR LMC has been offering a Freedom to Speak Up (FTSU) Guardian service to practices that have chosen to sign up to the scheme across Leicester, Leicestershire, and Rutland. We would like to highlight a recent change: the National Guardian's Office (NGO) has now been disbanded, with its functions transferring into NHS England. However, having a Freedom to Speak Up process remains a requirement within the Care Quality Commission (CQC) Well-Led framework. As a result, LLR LMC will continue to provide this service for participating practices.

Please download the updated [FTSU Policy](#) for your records. The main changes relate to the informal escalation process, and we would encourage practices to review the policy and consider adopting the updated arrangements - [Freedom to Speak Up - Leicester, Leicestershire, and Rutland Local Medical Committee](#)

If your practice is not currently signed up to the LLR LMC FTSU service and you would like further information, please contact us and we will be happy to provide details of the support available.

If you have any comments about this, please [contact the LMC](#).

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13. UHL GALA AWARDS EVENING.



As previously announced the UHL Gala Awards Evening went ahead on 5th October.

This included a prize for the GP who had made the biggest positive impact over the previous year. I was honoured to attend as one of the shortlisted GPs, and the overall winner was announced on the evening as **Professor Vinay Gupta** who I hope you will join me in congratulating for being the well-deserved overall winning of the award.

The Nomination for Professor Gupta was:

"I am delighted to nominate Professor Gupta in recognition of his outstanding leadership, innovation, and commitment to improving patient care across our PCN and the wider city. His work has had a transformative impact on primary care, benefiting patients, clinicians, and the healthcare system as a whole. Professor Gupta has been the driving force behind the development of our care home service, providing the vision and sustained leadership needed to establish and grow this vital service for care home residents and housebound patients. Through proactive and coordinated care, he has helped ensure that some of our most vulnerable patients receive timely support, reducing reliance on emergency and out-of-hours services while improving continuity of care. The impact of this work is

significant and measurable. Under his leadership, our PCN has achieved the lowest number of referrals to DHU for home visits across Leicester. This has reduced pressure on urgent care services, improved patient outcomes, and demonstrated the value of strong clinical leadership in delivering system-wide change. In addition, Professor Gupta leads our Training Academy, playing a key role in developing the next generation of GPs and healthcare professionals. His commitment to education, mentoring, and workforce development helps maintain high standards of clinical practice and supports the future sustainability of primary care. He also leads our highly successful Urgent Care Service, which provides medical cover across the city during Protected Learning Time afternoons. This innovative service ensures patients continue to have access to safe and effective urgent care while practices undertake essential staff training. Professor Gupta's achievements demonstrate exceptional leadership across patient care, workforce development, education, and service innovation. His lasting contribution to patients, colleagues, and the wider health system makes him a truly deserving recipient of this award."

The winner was:



14. GP EMPLOYMENT REIMBURSEMENT SCHEME - UPDATE.

This scheme has been changed many times already since its introduction, The BMA's UpToDate guidance can be [found here](#).

The LMC's main concern was that this was using short term funding for what is a long-term requirement. However, NHS England has now stated that the funding for the scheme will remain within the core GP contract recurrently beyond 2026/27. We hope that for once NHS England keeps to their word.

About the scheme

The 2026/27 GMS contract brought into place a new SFE based reimbursement scheme to support practices in hiring additional GPs, with the aim of increasing capacity within general practice. This was introduced in May 2026, operating retrospectively from 1 April. Since then, several changes have

been made, most recently expanding eligible roles that can be claimed under the scheme, expanding the period for which roles can be claimed, and allowing the transfer of funding between practices. This guidance provides an overview of the current scheme, along with a summary of the changes since it was first introduced in May.

See [NHS England's full guidance](#) for the scheme.

What can be claimed?

Under the scheme practice can claim up to £4.57 per patient, with list size taken from the practice adjusted population per practice on 1 January in the preceding financial year. The funding can be used for:

- the employment of a new salaried GP (or a contribution towards the cost of a new GP). Although practices can only claim funding from 1 April 2026 until 31 March 2027, new GPs employed by practices between 24 February 2026 and 31 March
- extra sessions from existing salaried GPs within the practice.
- additional sessions delivered by GP locums from 1 October 2026 to 31 March 2027. Practices may claim reimbursement for eligible locum sessions delivered by any GP. This can include existing GPs within the practice (salaried, partners or locums) if they invoice as a locum and the sessions meet the requirements of the scheme.
- salaried GPs where the post was previously funded (and the funding has stopped - or will stop) through either the PCN Capacity and Access Payment or the PCN Test Sites program.

15. 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

- [October 2026 LLR LMC Podcast – Conversation between Charlotte Woods, Fahreen Dhanji and Grant Ingrams](#)
- [September 2026 LLR LMC Podcast – Conversation between Charlotte Woods, Fahreen Dhanji and Grant Ingrams](#)
- [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](#)
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- [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

- [2026-10-15 IGPR Webinar](#). If you have any questions following the webinar or would like to arrange a separate Teams meeting to discuss iGPR further, Kevin James would be happy to assist. His contact details are: **Kevin James**, Sales Manager / Senior Product Consultant, Email: kevin.james@igpr.co.uk, Website: [iGPR](#)
- [2026-09-10 LMC pensions webinar with Chase De Vere](#)
 - How to estimate the level of income you may need in retirement—and whether you're on track.
 - The key features of the NHS Pension Scheme
 - Options such as partial retirement and “retire and return.”
 - How your NHS Pension fits alongside other pensions and investments
 - What the McCloud judgment could mean for your retirement planning
 - Considerations for drawing benefits in a tax-efficient way
 - Family and dependant benefits before and after retirement
 - Your questions, answered during a live Q&A
- [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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16. 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](#).

MAXIMISING NHS PREMISES REIMBURSEMENT FOR GP PRACTICES WEBINAR – THURSDAY 26TH NOVEMBER 2026

THIS SESSION WILL FOCUS ON NOTIONAL RENT REIMBURSEMENT AND EXPLAIN WHY MANY GP PRACTICES MAY BE SIGNIFICANTLY UNDER-REIMBURSED BY THE NHS.

THE WEBINAR WILL COVER:

- **HOW NOTIONAL RENT REVIEWS WORK**
- **COMMON CAUSES OF UNDERFUNDING**
- **THE IMPACT OF SURGERY IMPROVEMENTS AND EXTENSIONS**
- **REVIEW TIMESCALES**
- **PRACTICAL STEPS PRACTICES CAN TAKE TO MAXIMISE THEIR PREMISES REIMBURSEMENT**
- **THE PRESENTATION IS INTENDED TO GIVE PRACTICES A CLEARER UNDERSTANDING OF HOW TO PROTECT AND ENHANCE AN IMPORTANT SOURCE OF PRACTICE INCOME.**

DETAILS OF THE WEBINAR:

- **DATE: THURSDAY 26TH NOVEMBER 2026**
- **TIME: 1.00-2.00PM**
- **LOCATION: MICROSOFT TEAMS**

THE WEBINAR WILL BE DELIVERED BY WILL ELLIS FROM BWH SURVEYORS AND TO RESERVE A PLACE, PLEASE EMAIL US AT ENQUIRIES@LLRLMC.CO.UK

TOP TIPS FOR GP PRACTICE PREMISES WEBINAR – THURSDAY 3RD DECEMBER 2026

THIS PRACTICAL AND INFORMATIVE SESSION WILL COVER KEY PREMISES-RELATED ISSUES CURRENTLY AFFECTING GP PRACTICES, INCLUDING:

- **THE 2024 PREMISES COSTS DIRECTIONS CHANGES**
- **NOTIONAL RENT REVIEWS**
- **GP SURGERY LEASES**
- **WAYS TO MAXIMISE RENTAL REIMBURSEMENT AND PREMISES VALUE**
- **COMMON PITFALLS AND IMPORTANT DEADLINES**
- **PRACTICAL ACTIONS PRACTICES CAN TAKE TO IMPROVE THEIR PREMISES POSITION AND FINANCIAL RESILIENCE**

DETAILS OF THE WEBINAR:

- **DATE: THURSDAY 3RD DECEMBER 2026**
- **TIME: 1.00-2.00PM**
- **LOCATION: MICROSOFT TEAMS**

THE WEBINAR WILL BE DELIVERED BY WILL ELLIS FROM BWH SURVEYORS.

AN UP-TO-DATE LIST OF ALL UPCOMING LMC TRAINING AND EVENTS IS AVAILABLE ON THE LMC WEBSITE.

SOME WEBINARS ARE RECORDED – SEE THE FULL LIST IN OUR ‘PODCASTS’ SECTION.

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17. 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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18. 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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19. FINAL THOUGHTS

The beatings will continue until morale improves

Anon – mid 20th Century

This appears so apt to the current position of general practice.

Over and over again the LMC has tried to educate NHS managers, politicians and QUANGOs of the power that General Practice can have to deliver the most cost effective and productive health-outcomes for the NHS.

A report by the Health Select Committee at the end of the last conservative government, with the review that Labour commissioned from Lord Ara Darzi in the early days of their government and together with extensive national and internal research and other independent reports all conclude that the current problem with the NHS and the health of the UK population is due to lack of investment into general practice services.

So why are we still not seeing the necessary support and investment being made into general practice?

As we have explored previously, if you apply Occam's Razor to the situation, the only conclusion you can reach is that the DHSC and NHS England hate general practice. There is no other logical conclusion. The reasons behind this are more difficult to fathom but I believe that it is related to them believing their own negative rhetoric about GPs and their frustration that they cannot instruct GPs precisely how to work like they can directly employed NHS workers, although their yearly imposition of changes increasing micromanagement by way of the contract comes close.

I have also noted previously that the NHS always has been and continues to be modelled on a top down bullying culture. Again the continuation of this culture belies the evidence that this management approach results in reduced morale and reduced productivity.

So although depressing it was not surprising that the [Joint LLR Health Scrutiny Committee](#) felt that it was reasonable to castigate GPs and in particular partners based on just anecdotal and ICB-provided evidence. The short-sightedness and sheer stupidity of their proposal to 'fine' partners of what they consider poorly performing practices is breath-taking. I have responded to their committee but so far have not received a reply. Please feel free to use the contents of my letter as well as the tools [provided by the BMA](#) to inform your patients, as well as in any communication with local councillors and MPs. If you receive any reply wanting to discuss the situation in greater depth, the LMC can support a meeting in your area, or if you prefer can arrange to meet them independently of your practice (although our previous experience is that we see a better response if a local practice is involved).

Best wishes until next month, and continue to be kind to each other as the Road to Damascus appears to continue to have a diversion in place for NHS England and local and national politicians.



Dr Grant Ingrams
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