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School of Health and Related Research (ScHARR)
University of Sheffield

Leading Medical Consensus – Local Medical Committees in the 21st Century

Chris Fewtrell and David Martin

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The School of Health and Related Research

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Professor Ron Akehurst
Dean of the School of Health and Related Research

Chapter 1: Background

Introduction

Local Medical Committees (LMCs) are unique. They alone amongst health service institutions have remained largely unchanged in their functions and structure since 1911[6,18]1. Therein lies both their strength and their weakness.

They have been described as *"riding changes in the NHS"* with an outstanding record for continuity of organisation, personnel and policy. The NHS, meanwhile, has been in a constant state of reorganisation for at least the last thirty years with the next change sometimes being planned before the previous one has been implemented. This has resulted in massive discontinuities of management and policy, often leaving the LMC as *"the memory of the NHS"*.

There are a number of organisations that provide support to general practice but, as one practitioner put it, *"LMCs are unique because they are paid for and owned by GPs"*.

However, the increasingly complex and decentralised arrangements for contracting with general practice coupled with the larger number of organisations with which LMCs have to deal means that the status quo is no longer an option. Over the next few years LMCs will need to consider changes in their functions, financing and organisational arrangements.

Against this background surprisingly little is known about the overall pattern of LMCs as a basis for individual LMCs to consider viable policy alternatives.

It is in this context that the School of Health and Related Research at Sheffield University (ScHARR) was commissioned by The LMC Secretaries Network (SECSNET) and the General Practitioner Committee (GPC) of The British Medical Association (BMA) in December 2002 to:

- create a database of present and planned organisational arrangements for LMCs handling a growing workload in a rapidly changing environment;

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[1] Superscript numbers in brackets refer to the bibliography in Appendix B.

- assemble and disseminate a picture of emerging good (and less successful) practice in work with Primary Care Trusts (PCTs) and others;

- gather information about the aspirations, concerns, uncertainties and experiences of a sample of PCTs and Strategic Health Authorities (StHAs) in relation to their LMCs;

- make recommendations about future roles and relationships, and the development and maintenance of successful LMC working.

Demands on LMCs

Local Medical Committees have been recognised by statute in successive NHS Acts as the local professional organisations representing General Medical Practitioners (GPs). The Health Act 1999 extended the LMC role to all GPs whatever their contractual status[11]. LMCs represent the views of GPs to PCTs and StHAs, and to other statutory and voluntary organisations. This is an important role as many GPs appear not to engage with PCTs[19]. They should, and in many cases must, be consulted on a very wide range of structural, financial, human resources, conduct, health and performance issues.

The workload of LMCs is increasing rapidly. The Government's National Health Service (NHS) modernisation programme impacts strongly on general practice and LMCs are (or should be) engaged fully in the change process. The NHS programme brings very challenging workforce issues, with ambitious workforce targets to be achieved against a background of problems with recruitment and retention. It introduces new accountability and performance improvement processes for primary care, including routine appraisal for GPs. The Local Improvement Finance Trust arrangement (LIFT) promises extensive improvements in general practice premises. The number of Personal Medical Services (PMS) practices has grown rapidly, and the new General Medical Services (GMS) contract will make demands on everyone concerned. General practice has new national access targets to meet and a major part to play in implementing National Service Frameworks and other good practice guidance. LMCs have roles to play in representing and supporting general practice through these challenges and opportunities.

Organisational Context

The organisational context in which GPs and their LMCs face these demands has changed quickly too as *Shifting the Balance of Power*[4] is implemented. New primary care entities – Walk In Centres and NHS Direct – have arrived on the scene. PCTs are key players in relation to general practice but in many cases they are new and inexperienced organisations, struggling to match their capacity and capability to the expanding tasks they carry and to develop successful working relationships in their local health communities. StHAs are even newer and it will not be clear for a while how they will fulfil their roles.

Organisationally, *Shifting the Balance of Power* has changed the NHS, and LMCs were invited to redraw their own map to suit local needs and circumstances. As well as establishing new boundaries it is clear that LMCs are becoming more diverse in their management arrangements. In some places there has been little apparent change. In others, sophisticated supra-LMC collaborative arrangements have been set up to cover large geographical areas. The emergence of 'executive' teams has also affected the role of elected LMC members.

Informal evidence has suggested a similar variety in arrangements for and the effectiveness of external work with PCTs and others.

But there has been no systematic body of knowledge about:

- what is being done structurally at the local level to adapt to change;
- how LMCs are developing their capacity and capability;
- how they are working with PCTs, StHAs and others;
- what is working well internally and externally (and less well);
- what plans are in place to respond to continuing change (for example the likelihood of PCT mergers).

Survey Methods

In order to gather factual information and opinions a questionnaire (see Appendix D) was sent to all English LMCs. Follow-ups were made in order to obtain the largest number of responses possible. A significant proportion of respondents were then interviewed personally.

A brief questionnaire was also sent to all English StHAs and PCTs and a small number received a personal interview to clarify key points.

Interviews were conducted with a number of key national organisations including the NHS Confederation, the GPC, SECSNET and the DoH.

In order to test emerging themes two small workshops were then held, the first with LMC Secretaries and the second with GPs with knowledge of LMCs but no vested interest. In addition a survey of relevant literature was undertaken (see Appendix B).

Numbers and responses

Interestingly there appears to be no fully accurate and up to date list of current English LMCs held anywhere nationally, not least because of the health service organisational flux in which LMCs have been operating in recent years.

In our research we have identified 101 English LMCs as listed alphabetically in Appendix E, grouped together where federations or confederations exist. In establishing the number of LMCs it has been necessary to make some assumptions. For example Bedfordshire and Hertfordshire is constitutionally a

single entity with two main subcommittees but because the two counties have considerable autonomy they have been counted as two LMCs. Although Devon also has two main subcommittees reflecting the two previous Health Authorities there is greater consistency of LMC policy across Devon and it is therefore counted as one LMC.

In our research we have had written responses to our survey (see Appendix E) from 87 of the 101. On a purely numerical basis this represents a very satisfying response rate of 86%. However because the majority of the 14 non-respondents were the smaller, poorly resourced LMCs it represents about 90% of GPs if size is taken into account (see Appendix F where we estimate the total number of GPs represented by LMCs).

We were able to interview the Medical Secretary or Chief Executive (and sometimes other senior staff) of 42 LMCs (i.e. around 42% of the total number). This is including supra-LMC organisations (confederations) as the number of LMCs they represent i.e. London 19, Wessex 5 etc. We did interview some of the smaller LMCs as well as the largest. A full list of those responding and interviewed is in Appendix E.

Organisation of report

The report is divided into seven chapters after this introduction:

- in Chapter 2 we describe the range of potential functions of LMCs;
- in Chapter 3 we describe a range of different organisational models for LMCs and the current position in the field;
- in Chapter 4 we describe the current pattern of relationships with PCTs and other key organisations;
- in Chapter 5 we set out the staffing and development position;
- in Chapter 6 we cover the current position and options for the future financing of LMCs;
- in Chapter 7 we consider communications and marketing issues;
- and finally in Chapter 8 we set out some of the possible ways forward for LMCs to consider.

We are aware that the term "LMC" is used commonly to denote either the LMC office and the Secretary/Chief Executive, or the LMC itself as a committee. Rather than be laborious, we use the term to mean either and trust that readers will understand which is intended.

Chapter 2: The functions of LMCs

Variety

No two LMCs are the same in respect of the breadth and depth of the functions undertaken. At one end of the spectrum there are LMCs which provide the minimum core functions of representation and pastoral care to a limited extent. At the other end of the range there are LMCs providing a wide range of optional services on a professional, in-depth basis.

Lockharts Solicitors, in *The Work of the Local Medical Committees in England and Wales*[12], described the functions and duties as:

- administration of the GMS contract;
- the representation of GPs as a whole.

They went on to say that by custom and practice they perform other services: advising on ethical problems, representing GPs to bodies outside the NHS, and maintaining the standing of general practice in the media and with the general public.

By contrast the GPC/BMA 2000 report, *Non-statutory functions of LMCs - guidance for LMCs*[10], described the role as:

- representing core values;
- local representation;
- national representation;
- communication;
- links with other bodies;
- helping individual GPs.

Since this report was published the position has been further complicated by the advent of different employment contracts for GPs such as PMS, expanding the representative role of LMCs.

The position of individual LMCs on this spectrum seems to be determined by a number of factors including:

- the willingness of GPs to fund services;

- local LMC leadership;
- the availability of services from other sources;
- knowledge of the possibilities.

For the purposes of this report we summarise the activities we have encountered using the categories of:

- local representation;
- national representation;
- helping individual GPs;
- communication and marketing;
- other services.

Functions

Local Representation

The LMC represents the views of all local GPs (sometimes interpreted more narrowly as GPs who help fund the LMC) to PCTs, StHAs, other NHS bodies (e.g. Workforce Development Confederations), voluntary groups, local authorities etc. Representation may relate to:

- GPs as professionals;
- GPs as providers of services;
- the commissioning of patient services and policy development;
- ethical issues.

Both PMS and the new GMS contract are practice-based. Although LMCs will not represent them formally, practice managers, nurses and other staff are likely to be of growing interest because supporting a whole practice will in many cases be equivalent to supporting its GPs.

National Representation

The LMC also represents the views of local GPs at the Annual Conference of LMCs, to the GPC and other national bodies.

Helping Individual GPs (the "Pastoral Role")

The LMC provides assistance to individual GPs in dealing with the complexities of working for the NHS both contractually and personally. This may include:

- GP remuneration;
- terms and conditions of service (GMS and PMS);
- the new contract;
- premises;
- complaints including Independent Reviews;
- partnership issues including disputes;

- employment issues for non-principals;
- disputes with PCTs;
- appraisal;
- sickness;
- performance problems.

Communications and marketing

The LMC provides a mechanism to keep local GPs informed of all issues that are relevant to them and to ascertain the views of GPs. This may involve:

- meetings, workshops, roadshows, forums;
- newsletters;
- email, bulletin boards and web sites;
- reports including Annual Reports;
- liaison with other LMCs.

Other Services

Other services might include:

- training;
- buying consortia;
- services for practice managers;
- services for primary care nurses;
- services for other Local Representative Committees (LRCs).

Skills mix

The full list of functions clearly suggests the need for a wide range of experience, training and skills. It is unlikely that this requirement can be met, either in volume or range of skills, as it might have been in the past, by one hard-working individual. It suggests the need for a team of people who can combine to cover the range of demands placed on a modern LMC. We will return to the options available to meet this challenge in Chapter 5.

Facilities required by LMCs (non-staff)

The range of functions described suggests the need for facilities which would include:

- an administrative office (separate from a patient surgery);
- up to date information technology;
- modern office equipment;
- rooms for LMC meetings and smaller meetings with good access and car parking.

Many existing LMCs do not have this basic list of facilities and are therefore hampered in carrying out their full potential role effectively.

Chapter 3: Organisational arrangements

Configurations and Models

The boundaries of LMCs have shown an enviable consistency over time, adapting to the rest of the NHS as necessary but refusing to follow short term fashion, often being able to meet the latest reorganisation coming back to a previous configuration.

Historically the most consistent building blocks for LMCs have been the counties, the cities and, in the case of London and other metropolitan areas, the boroughs. In 1996 LMCs were required to align with Health Authorities but this was achieved with maximum continuity of personnel and structure.

The emergence of PCTs and StHAs leaves the configuration of LMCs to local decision provided that it consists of whole PCTs - even if they are not joined geographically (so far there are no examples of LMCs of this sort but some do cover more than one StHA).

This process of local adaptation has led to a number of different models for LMCs and we will borrow from political theory in order to provide a simple classification[15,17]. This suggests three basic models for describing the relationship between sovereign states:

- the unitary model;
- the confederate model;
- the federal model.

The unitary model

Unitary systems are described thus:

"… sovereignty concentrated in a single, central body…"

"Multiple levels of government are integral to a federation whereas in a unitary system sovereignty resides solely with the centre and, no matter what the extent of decentralisation in practice, the lower levels exist at the pleasure of the centre."

The confederate model

Confederations are described thus:

"...sovereignty is preserved through a process of unanimous decision-making that gives each state a veto, at least over matters of vital national importance."

"In a (confederation) the central authority remains the junior partner and is dominated by the component states."

The federal model

Federalism is described in this way:

"...federalism requires the existence of two distinct levels of government, neither of which is legally or politically subordinate to the other. Its central feature is therefore the concept of shared sovereignty."

Co-operative federalism is explicitly based on the principles of co-operation and interdependence between levels.

Subsidiarity

It may also be useful to borrow the concept of subsidiarity from political theory.

"...the idea that decisions should be taken at the lowest level possible."

"...devolution of decision making from the centre to lower levels."

"...a constitutional principle that defends national sovereignty against the encroachment of supernational bodies."

"...the competence of supernational bodies should be restricted to those actions that cannot be sufficiently achieved by nation states."

A model for describing the relationship between nation states does not transfer perfectly, but it is relevant. Historically all LMCs can be seen as "unitary" bodies based on counties, cities and boroughs. Over time there has been a gradual move across the country towards confederations and, in at least one case, federations (with occasional examples to the contrary of confederations disbanding to unitary bodies - for example Worcester and Hereford). In all groupings the principle of subsidiarity seems to apply. This general trend towards larger groupings has been regardless of the prevailing trend in the rest of the NHS.

The drivers for this seem to be:

- economies of scale;

- the relative shortage of suitably qualified Secretaries/Chief Executives;
- policy encouragement from the GPC and SECSNET;
- increasing demands.

The GPC[9] described factors in choosing a configuration as:

"Local geography, history, communications and health service configuration. The need to provide a locally relevant voice and presence to constituents. The need to appear locally relevant to the PCT executive. The desirability of increasing the professionalism of the management structure and support provided for and by LMCs. The opportunities provided by larger structures in increasing the professionalism of that management and support. That recognition will be required from each and every PCT in the event that the profession decides that it wishes its representational system to relate to multiple PCTs."

Current LMC arrangements

Information on the current position in English LMCs is given in Appendix E.

In reality the degree of integration of LMCs is a constantly shifting continuum and there are a number of links between them at a less formal level than confederation.

Unitary LMCs may have informal linkages with another LMC sharing expertise, support and sometimes training (Cornwall and Devon, Cleveland and County Durham). Some unitary LMCs group specifically to facilitate working with their StHA (The Dales and Wolds, West Yorkshire). (Others regard the StHA as remote and currently irrelevant to the business of the LMC.)

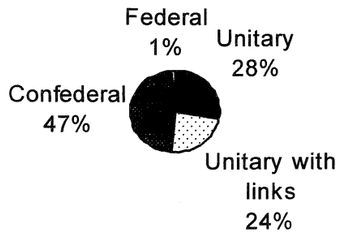
Another form of linkage is the continuation of a previous Regional LMC structure. This is most apparent in the West Midlands where most of the previous members of the regional group still meet regularly to develop policy and provide mutual support. They have a regional budget part-funded by the LMCs, but uniquely there is also funding of around £30,000 pa from the West Midlands PCTs because the allocation was originally made by the West Midlands Regional Medical Committee.

Their star contribution to joint policy making is The Midland Therapeutic and Review Advisory Committee (MTRAC) which, jointly with Keele University, publishes GP-friendly advice on National Institute for Clinical Excellence (NICE) policies, with particular reference to prescribing and shared care.

If we ascribe the 101 LMCs to four categories - unitary, unitary with links to others, confederate, federal - 28 are unitary, 24 unitary with links, 48 confederate and one federal (Devon, in so far as it has recently moved to a single LMC across Devon with a high degree of common policies). Confederal LMCs, by and large, have differing policies for separate LMCs even if they are technically sub-committees (Beds and Herts for instance). A number of

confederations use service level agreements to define the work to be carried out for individual LMCs.

Current LMC Organisation Type



In summary, a 'typical' unitary LMC has all its practitioners governed by a single committee with a high degree of consistency of policy. A 'typical' confederation of LMCs will be characterised by having two or more constituent parts, each of which has a degree of individual autonomy and agree common policy only where there is mutual consent. In this system it is possible for different parts to choose to have different levels of autonomy from the centre and distinctive approaches.

Finally, a typical federal LMC will have two or more constituent parts which have shared power over policy issues with the central governing body, each having primacy on different issues. As power is increasingly centralised in a federal LMC it will eventually translate into a larger unitary body.

Membership and internal organisation of LMCs

Eight LMCs have the whole LMC as the electoral constituency using differing ratios of members to GPs served. In addition London uses single borough constituencies for elections.

One LMC (Wakefield) continues to use pre-1974 local government boundaries for its constituencies.

Ten LMCs report using "localities" (smaller than PCTs, sometimes reflecting former Primary Care Group (PCG) boundaries).

PCT boundaries are increasingly being used as the building block for constituencies (currently 15 of those reporting). These in turn are often being aligned with a sub-committee structure. In Devon there are four sub-committees each covering two PCTs. Whilst PCTs are seen as relevant building blocks by LMCs in many parts of the country they are not regarded as being stable in their current format. The GPC and many LMCs predict amalgamations of current PCTs, often back to the boundaries previously covered by Health Authorities.

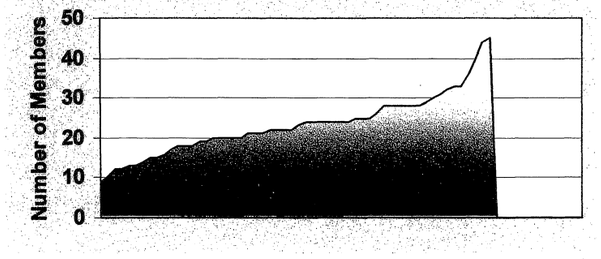
"..at a time when further reconfigurations of primary care organisations, and particularly amalgamations of PCTs, seem inevitable it will enable LMCs to plan for the future on the basis of some stability."

"..many believe the resulting organisations will ultimately cover areas.... broadly similar to existing (as at Jan 2002) health authorities." [9]

This is reflected by PCTs who group together to provide shared services.[20]

The size of LMC as committees varies from 45 members in Kent and 44 in Devon to 9 in North Lincolnshire, 10 in South Staffordshire and 12 in Lincolnshire. Mostly this can be explained by the number of GPs served but nevertheless the ratio of GPs served to LMC members does vary from six GPs per member (Barnsley) to thirty-nine (Lincolnshire).

LMC Committee Size



The number of positions which are unfilled could be regarded as an indicator of the local GPs' interest in the LMC. Some LMCs reported around a half of places unfilled: Dudley 8 of 15; South Staffs 5 of 10; Lincolnshire 6 of 12 and East Yorkshire 7 of 15 - notably all from the group of smallest LMCs. However, some small LMCs reported no vacancies e.g. Bolton. In total, 7 LMCs reported no vacancies including the largest, Kent. However, it has also been pointed out that there is a finite pool of GPs interested in medical politics (in its widest sense) and there is now greater competition because of the need to fill GP Professional Executive Committee (PEC) roles.

The vast majority of LMC members are elected without opposition from other candidates.

PMS GPs

Almost all LMCs do not differentiate between GMS and PMS GPs in elections to the LMC. They rely on the elections to provide a reasonable proportion of each, reflecting the degree of PMS in the area. A few LMCs (e.g. Derbyshire and Warwickshire) have a proportional system to achieve this fair share.

Non-principals

Most LMCs set aside one or two seats for non-principals on their LMC which are filled by election or co-option. There is frequently difficulty both in filling these seats and in getting attendance.

Co-options

Most LMCs use co-option to fill gaps or balance expertise. However there is no obvious pattern in those chosen for co-option. Some of those reported were: PEC chairs, ophthalmic GP, dispensing GP, Director of Public Health (DPH), out-of-hours doctor, child protection, prisons and homeless; clinical tutor, BMA (Warwickshire), private practice (Kent).

Executive Committees and Sub-Committees

The vast majority of LMCs (63 out of 78 reporting) handle their business through an executive committee. In some places this may have a different title - in Cornwall it is called the "cabinet", in Avon it is called the "board". Those that had no executive committees unsurprisingly included mostly small LMCs but some with as many as 24 members reported no formal executive committee (Derbyshire, Doncaster and Sunderland).

The executive committees always include elected/appointed officers of the LMC but vary in size from 3 (in Cleveland, East Yorkshire and North Lincolnshire) to 14 in Devon.

Some executive committees are very active (Barnsley, Coventry and Stockport meet once a week). The norm is between 6 and 12 meetings a year with the executive committees of 12 LMCs meeting on an entirely ad hoc basis as business requires.

A growing trend is for there to be sub-committees (sometimes not formalised) which cover one or sometimes two PCTs (see for example Devon). In these cases it is usual for the chairs of the sub-committees to be members of the executive committee. This in turn is leading to more and more business being done in the sub-committees and the executive committee, with the full LMC only meeting a few times a year.

In some confederations there is a joint executive/management committee (e.g. Beds and Herts, Essex).

Whatever organisational arrangements are employed there is also significant variation in the degree of delegation from the committee structure to the Chief Executive/Secretary.

Chapter 4: Relationships

Relationships with PCTs

One of the core functions of LMCs is the development and maintenance of relationships with the NHS, local government, voluntary groups, national organisations etc. The relationship with the local NHS is by far the most significant and in the current structure of the NHS it is the PCT axis which is crucial, with StHAs as another key, but less important, interface.

In general the need to work with PCTs has put a large extra burden on LMCs as typically there are several PCTs where previously there had been one Health Authority (or FHSA/Family Practitioner Committee (FPC) before that). It is important to note that on average an LMC will need to deal nowadays with over three PCTs and a StHA. There are still one-to-one relationships - for example in Barnsley, Bolton, Coventry, North Lincolnshire and Stockport - but at the other end of the spectrum Kent has nine PCTs and as a confederation Wessex has nineteen. In addition there is the relative immaturity of PCTs struggling to learn their new roles, often hampered by primary care knowledge spread too thinly. Sometimes it will be the LMC that will know the provenance of particular policies and issues rather than NHS management.

Types of Relationship

Relationships can be characterised as competing ("If I win you lose") or collaborative ("If I win you can win too"). These positions have been described as "the zero sum game" and "the non zero sum game"[1]. In the past many Health Authorities and Family Health Service Authorities (FHSAs) before them had developed mature, symbiotic relationships with their LMCs so that they were mutually supportive and dependent on one another. This is now hugely complicated by the number and youthfulness of the relationships, such that many are still in the win/lose mode.

We can classify LMC/PCT relationships into four groups:

- LMC competing; PCT competing
- LMC collaborative; PCT competing
- LMC competing; PCT collaborative
- LMC collaborative; PCT collaborative.

Group one is characterised by stand-off and mutual suspicion. Group two is characterised by a bewildered LMC trying to engage an immature PCT in constructive dialogue. Group three is characterised by a PCT which is frustrated by an LMC that will only engage in negative and destructive

comment on its policies. Group four has LMCs and PCTs with mutual respect, each helping the other to succeed.

A classic example of group four behaviour is demonstrated by PCTs in Cheshire appointing the LMC Chief Executive to chair the new GMS Contract Implementation Group.

Group one behaviour can be exacerbated by underlying financial problems particularly when primary care development is stultified by secondary care overspending.

"(We are) here for the long haul.....our interests coalesce more often than not."

LMCs and PCTs may want to reflect on their local position and what changes may be desirable.

Personal relationships

Although the emergence of PCTs is often seen to have set the LMC/NHS relationship back, it clearly works well in some places, with the personalities and histories of the key senior players on both sides making the difference.

Some of the indicators of this kind of relationship are:

- the frequency of personal contact at top level;
- the frequency and quality of liaison meetings;
- the attendance of PCT staff at LMC meetings;
- the involvement of LMC members in PCT business;
- the joint development of policies;
- the sharing of more confidential paperwork.

Personal contact between the Chief Executives of PCTs and LMC Secretaries is very variable and often dependent on historical factors. The rapid turnover in senior NHS managers has clearly set this aspect back, with some relatively inexperienced Chief Executives in post with variable knowledge of and interest in primary care. Equally, those LMC Secretaries with near full time roles in general practice realistically do not have the time to develop these new relationships.

The quality of relationships was described as "excellent" or "co-operative", through "generally positive" or "good with some PCTs", to "no respect for LMC", "limited trust" or "poor".

Attitudes to PCT attendance at LMC meetings range from a welcome with open arms, through 'by invitation only', to an invitation to individual parts of the agenda only. In some cases where the invitation is made attendance can be poor, conveying a lack of interest or other priorities.

This pattern is mirrored in the approach to the distribution and sharing of papers. The sharing of confidential information is particularly indicative of maturity and trust in the relationship.

In our survey LMCs were asked about the involvement of LMCs in policy making with PCTs. There had been widespread involvement of LMCs in the development of policies for violent patients, occupational health, appraisal, out of hour's services and manpower issues.

However, a surprising 53 respondents reported examples of the LMC being inappropriately excluded from policy making. Comments were made such *as "generally peripheralised"* and *"LMC sidelined"*, although *"PCTs need constant reminding"* sounded more like cock-up than conspiracy. The other side of the coin was represented by: *"They are quite inexperienced organisations and tend to come to the LMC for help."*

One reaction of LMCs to the increased burden of dealing with PCTs has been to create one or more posts specifically targeted at developing relationships. Typically called PCT Liaison Officers or similar, there are examples in around half a dozen LMC organisations with a number of others planning to follow suit. These posts are at what might be described as a middle management level and the people appointed are often from practice management or community nursing backgrounds.

Professional Executive Committees

It is, however, with the PECs of PCTs that the relationship with LMCs is thrown into the sharpest relief.

When PCGs existed they were dominated by general practice. In fact the members were often selected by the LMC with many places going to LMC members and LMC secretaries. This phase saw speculation that LMCs would no longer need to represent general practice as they now had a seat at the table of power.

This situation did not last very long, however, as the move to PCTs brought with it the realities of financial pressures and government targets. Now PECs have a much smaller proportion of GP members and some are chaired by nurses or other professionals. Most GPs would no longer regard the PECs as a credible form of representation to replace LMCs.

"PECs have been decimated as far as GPs are concerned."

Nevertheless, the Chair of the PEC, and the other GP members of the PEC, are critical to the relationship between the PCT and the LMC. This is where the different modes of relationship between collaboration and competition are at their keenest.

In some places the PEC Chair was previously a leading light in the LMC (in some the previous Secretary). This can result either in harmonious

relationships or in some cases quite the opposite. (One LMC Secretary described former LMC members who had joined PECs as *"Quislings";* another said they had *"gone native".*)

The different policy positions of LMCs on the relationship between PEC Chairs/members and the LMC can be quite illuminating:

- one group are passive and make no distinctions if LMC members are appointed to the PEC;
- another group regard the roles as incompatible and debar either all GP PEC members or at least Chairs from LMC membership;
- a third group actually co-opt/invite PEC members, or at least Chairs, onto the LMC.

As one PEC Chair put it *"The disadvantages of conflicts of interest between PEC and LMC membership is far outweighed by the advantages to joint working and problem solving."*

Relationships with Strategic Health Authorities

In general the relationships between LMCs and StHAs (with a few notable exceptions) are much less developed, although a large number do have infrequent liaison meetings. This is partly to do with the newness of StHAs and the tight control of their early agendas, tying them to government targets. Secondly, it is also to do with StHAs' interpretation of their role, often seeing the interface with LMCs as primarily the role of their PCTs. Thirdly, it is to do with geographical fit, where traditional LMCs relate to only a part of the StHA which therefore feel more remote.

There are important and growing exceptions to this pattern. There are some StHAs which have adopted a more hands-on approach to primary care and see their relationship with LMCs as more important (for example Trent).

There are also a group of LMCs that see the StHAs as an important focus of decision making which might prove a good use of their time in influencing PCTs in their area. This has led to some grouping of LMCs to the same boundary as the StHA, either in a form of confederation (e.g. Bedfordshire and Hertfordshire, Trent, Essex) or in a looser alliance of unitary LMCs (e.g. West Yorkshire, Greater Manchester). There has also been some synergy with the desire of some LMCs to amalgamate and share services to reap the benefits of economies of scale. Grouping around a StHA provides one solution to this issue. This may have important implications for the LMC agenda.

In a small number of cases the large confederations of LMCs (London, Surrey and Wessex) deal with more than one StHA. In the case of London this is done through one of the five StHAs taking a lead role. This does afford London-wide LMCs considerable policy leverage with its 24 PCTs and greater influence on issues like manpower planning. The relationship with the lead StHA is said to be effective.

Other Local Representative Committees

As well as Local Medical Committees there are also Local Representative Committees in each area for pharmacists, optometrists and dentists[3]. The degree of contact between LRCs is remarkably slight in most areas and is mainly ad hoc when a subject comes up which affects more than one group.

There are a few LMCs which have developed relationships with particular LRCs but this seems in most cases to have been a historical accident rather than an explicit policy. Modes of liaison include exchange of meeting papers, cross representation and occasional joint meetings. Leeds is an exception to the 'historical accident' rule – they hold a quarterly joint LRC meeting.

In Devon they have gone a step further by sharing offices and other services with the Local Pharmaceutical Committee (LPC). Strategically they see the benefits of extending this to the dentists and optometrists as a way of achieving greater economies of scale.

In Cheshire they are starting joint meetings with the LPC to address shared concerns about supermarkets moving into pharmaceutical provision.

Nursing

Given the extent of the shared agenda with community nursing, the almost complete lack of formalised liaison is surprising. The vast majority of LMCs claimed to have either no link at all or ad hoc links when issues arose. Only one example was given of a PCT Director of Nursing attending LMC meetings (Barnsley). A productive linkage may be easier where there is a professional nursing representative committee unrelated to trade union membership.

BMA Regional Offices

In our questionnaire we asked about the relationship with BMA Offices. Given the overlapping roles and common agenda of support for GPs it would be imagined that the relationship would be close and supportive.

The response was very variable in describing the relationship. Of 78 LMC responses 24% said it was very good, 23% good, 9% OK and 44% poor or no contact.

Some descriptions of the BMA Office were not complimentary, *"Who are they?"* and *"useless"* being examples.

The GPC

Some LMCs find the GPC very helpful and some suggest there is a lack of responsiveness. The management of the GPC appears to be very keen to improve its support for LMCs and is well placed to do so. It has organised itself into eight geographical regions with a liaison officer responsible for

designated LMCs. The support for LMCs would be most effective if it were developed in close concert with SECSNET or its successor.

Department of Health

Successive governments over the last 92 years have recognised the value of LMCs and they have again been given a substantial role in the implementation of the new GMS contract[5].

It is clear that if an LMC is sufficiently developed and resourced it can make a massive contribution to the successful implementation of change in primary care. The Department of Health (DoH) should consider how it can be more proactive in the development of LMCs.

Some PCT responses on their relationship with LMCs

"...we have made a conscious effort to ensure the appropriate involvement and consultation with the LMC takes place on a regular basis."

"... the relationship with the LMC has always been excellent and something sustained through many re-organisations of the NHS."

"Generally good. (but) By its very nature the LMC has a specific GP focus which is not necessarily coterminous with the more multi-disciplinary future of primary care practices."

"We appreciate the expertise they bring to our discussions."

"It is helpful to have a very well organised LMC with a strong leadership…. (The) LMC Chief Executive is very effective."

"We see the role of the LMC as representing...the interests of GPs…primarily as providers of services."

"Long standing constructive relationship." (coterminous with old HA and LMC)

"One can always rely on the LMC for a speedy and robust response."

"The forum between LMC and four PCTs and its terms of reference appears very shared."

"There is little doubt in my mind that PEC GPs cannot act as representatives of GPs." (PEC Chair)

"More positive now LMC sees a role for itself post PCGs."

"Involving the LMC very usefully."

"In the current context of change within primary care a strong LMC voice is vital to development as they can provide a coherent and constructive voice for GPs."

"Main difficulty is LMC is reactive and critical…This leads to them being sidelined and consulted when we have to."

"Are they representative of GPs?"

"Our major issue would be that the role of the LMC is recognised as a trade union along with other health unions and is not given a greater or lesser place within the health system."

"...urgently need clarity about the role and functions of LMCs and their relationship with the PEC..."

"...important channel of communication and consultation..."

"Relationship with StHA unclear."

"...consumerism and patient centred care presents the greatest challenge to the LMC..."

"I am pleased to say we have a very good relationship with our local LMC they are very much involved with many aspects of the PCT's work and are consulted on a regular basis..."

"very much at forming stage."

"...not all GPs consider LMC represents their views ...behaviour far outdated."

Chapter 5: Staffing and development issues

Introduction

The staffing supporting individual LMCs is very variable in terms of numbers, remuneration, background, training and experience. However, it should be clearly recognised that even the best staffed LMCs have very few resources when compared to their counterparts in the NHS. It is evident that many LMC staff are hard pressed and working long hours to fulfil a demanding role.

An analysis of current staffing is given in Appendix F. It is often difficult to make direct comparisons of staffing because of the differing titles and levels of remuneration used.

At the minimalist end of the spectrum a number of LMCs operate with just a part time medical secretary (some of whom also work full-time as GPs) and a part time personal assistant/secretary.

("Don't tell them I said so but I would do it for free.")

At the other end, some of the confederations and federations have a full time medical secretary, a senior non-medical manager, middle managers (now often designated as primary care trust liaison staff) and a number of office staff. However, even these are thinly spread when considered against the large number of GPs served.

Nineteen of the respondent LMCs had plans or had recognised the need to increase staffing. Thirteen specifically thought their staffing was adequate for the role they were performing.

The fact that LMC staff are outside the NHS superannuation system is undoubtedly a factor in the recruitment of staff and this is an issue that the DoH might wish to consider.

Chief Officers

As we have noted, the work of LMCs is clearly growing in volume and complexity and this makes it less likely that all the skills required can be embodied personally in the Chief Officer. The Chief Officer therefore has to

secure a range of skills to supplement their own to ensure that the LMC has the capacity to:

- think strategically and scan political and professional trends;
- lead change through other people;
- provide high quality services to general practice;
- deal with complex personal issues;
- negotiate and conciliate;
- collaborate and influence other organisations;
- communicate effectively with a wide range of people;
- manage finances;
- administer committee structure;
- develop officers/staff[2].

Traditionally the Chief Officer (Secretary, Medical Secretary or Chief Executive) of an LMC has been the medical secretary although some LMCs have a long history of a non-medical (often referred to as 'lay') post. There are in the order of 13 LMCs out of 101 in England who are currently served by a non-medical chief officer. This seems mostly to have been determined by historical accident.

Now the trend is to consider the mix of managerial and medical knowledge (and credibility) required and build the team accordingly. What is clear is that many able medical secretaries do not possess managerial skills (or inclination) and in these cases the use of a senior non-medical manager provides a good, and often cost effective, solution (for example Cheshire, Avon).

"Don't talk to me about figures - they make my head ache." (Medical Secretary)

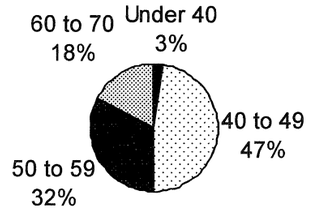
Roughly 50% of respondent LMCs had Chief Officers with role descriptions.

Although there are a number of senior LMC Chief Officers around retirement age, amongst those who reported their age (n = 40) there was a normal looking distribution.

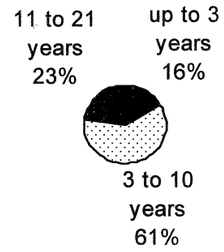
There was also a good spread of experience amongst those who responded to the question about it (n = 43).

[2] *A recent example of the complexity and demanding nature of the Chief Officer role is given in the published job description and person specification for the Chief Executive of Bedfordshire and Hertfordshire LMCs.*

LMC Secretary Age Ranges



LMC Secretaries' Experience



The Chief Officer role is clearly very demanding and can be stressful. In their pastoral role the medical secretary is acting in many ways as the GPs' GP. This begs the question of who is the GPs' GP's GP? We believe there is a vital need to consider the support provided nationally to individuals in this role.

Whatever the skills mix employed, all LMCs need someone with the experience and credibility to carry out the pastoral aspects of the role. It is difficult to imagine this being possible unless the person concerned is qualified as a GP with deep and up to date knowledge of the realities of front line general practice. The jury is out on whether this means a current clinical role (our questionnaire suggested that people's view on this was usually determined by their own position) but it does mean that full time secretaries/chief executives carrying out the pastoral role need to ensure that their knowledge of practical issues in general practice is up to date.

At least one full time Chief Executive has recently said *"I believe now that it is important that the Chief Executive does a session on a regular basis."*

"Their role requires them to be full time but if they have no clinical commitment they lose touch with their constituents."

"Part time means they are more likely to... be feeling the pain of their constituents."

There were 11 full time Chief Officers covering 42 LMCs (3 of whom did some clinical work). There were 40 part time chief officers each covering single LMCs. The lowest recorded commitment was two sessions per week.

Other staff

The classification of staff in LMCs other than the Chief Officer is made difficult by a plethora of titles and rates of pay. ('The Secretary' may be the most senior member of staff, the most junior or somewhere in between.)

Of the 86 LMCs who provided information on staffing 48 (56%) were in some form of grouping with shared staff. If the staff reported (other than medical secretaries) are grouped into senior managers (Chief Executives, Deputy Chief Executives etc.), middle managers (PCT liaison, finance managers etc.) and junior staff (typists, clerical staff), the following picture arises:

- in total there were 16 non-medical senior managers, or about 0.2 per LMC;
- there were 52.7 middle managers reported, or about 0.6 per LMC;
- there were 44 junior staff reported, or about 0.5 per LMC.

There are two major provisos about these figures. Firstly the allocation of staff to categories was crude because of the different titles and roles used and, secondly, the 13 non-respondents were amongst the worst staffed and, had they reported, they would have brought the average down even further.

If we do not make any adjustment for this last point then it means the 'typical' LMC has, in addition to roughly a half time medical secretary, a day a week of senior management, half a middle manager and half a typist or clerical assistant. However this averaging disguises the variety, with many LMCs existing on a few sessions a week from a busy GP (some saying that they are full time GPs) and a part time typist. One LMC Secretary said he did LMC work in his lunch hour and had no staff to support him. At the other end of the spectrum there are the confederations which may have a critical mass of staff to provide a range of skills, cover and support (Londonwide around 22, Wessex around 7.5, Trent around 10).

What is clear is that even the best staffed LMCs have very few staff for the volume and complexity of their role and are dwarfed by the NHS organisations with which they deal.

Training and development.

Training and development for LMC staff is currently ad hoc and patchy. There are a number of LMCs where no staff training or development is apparent and, if the need is recognised at all, then it is squeezed out by time or cost pressures.

At the leading edge, training and development is given a prime position with a few pursuing the nationally recognised and validated Investors In People accreditation.

There are many different facets to the training and development needs identified by LMCs. Those particularly mentioned were negotiating skills, conflict resolution, finance, dealing with the press and strategic thinking.

"There will be a big future role in negotiations...this will require a high level of expertise and I do not feel adequately trained or briefed on the issues concerned with this."

There is a case for recognising the new roles developing in LMCs, in particular PCT liaison, and developing targeted training for them.

The training provided by the GPC and SECSNET has been appreciated but many LMCs struggle to release precious staff time for training days, particularly where significant travel is required. Yet the small numbers of staff involved mean that some specific training activities probably have to be centralised, principally in London.

Some development work – the induction of new arrivals, for example – should be organised locally.

There are only a few examples of appraisal schemes for chief officers or LMC staff (the Farmers Club has an embryonic scheme). Clearly the introduction of appraisal for all LMC officers and staff would provide a major step forward in identifying training and development needs.

The training and induction of Chairmen and members is widely recognised as desirable but there is very little activity in practice. Most LMCs rely on Chairmen learning from their predecessors (risky?) and members learning from their peers on the job. Some, like Devon, provide a role description plus in-house training.

Networking

SECSNET has recently widened its criteria to allow more LMCs to join and this clearly has the potential to provide a support and development network. The 'Farmers Club' provides a useful development forum but is restricted to full time, medically qualified chief officers.

There are a number of other groupings of different levels of formality, from the West Midlands Regional Group to friends who meet for lunch. There is no systematic support and development network available to all.

It is strongly recommended that the SECSNET pilot is reviewed and a network owned and available to all LMCs is evolved or established from scratch as an immediate priority.

Chapter 6: Financial matters

Introduction

In financial issues diversity between LMCs is again apparent with consequent opportunities to learn from each others' experience. In the vast majority of LMCs the Secretary or Chief Executive is the nominated finance officer, how much of this role is subsequently delegated depending on the staff available. Many do not have the choice and do the job themselves. In a few LMCs another LMC member is the Honorary Treasurer and, in an even smaller number, a professional administrator or accountant takes on the role. Further information on financial issues is given in Appendix G.

Levies

LMCs are almost exclusively funded by a levy on their members. This system has a long history which is set out in detail in *The General Practitioners Defence Fund,* and *General Practitioners Defence Fund - History and Purpose*[2,8].

The levy can be "statutory", i.e. a levy that must be paid by all GMS GPs to fund the running costs of the LMC, or "voluntary", i.e. a levy that members may choose to pay. In addition all LMCs are required to raise their share of the GPC's Medical Defence Fund by a voluntary levy. This levy is used by the GPC to fund its committee meetings, honoraria for GPC members, LMC conferences and legal/professional fees. The extent to which this part of the levy is actually paid by individual GPs varies from LMC to LMC and consequently, where support is poor, the GPs who do elect to pay make a disproportionately high contribution. Interestingly one LMC claimed not to collect or pay any voluntary levy at all.

The vast majority of LMCs currently use a statutory levy for their own administrative costs supplemented by a voluntary levy for the GPC (the mixed levy). Around one in eleven LMCs uses a voluntary system for both. It has been an issue of some contention that the statutory levy does not apply to PMS GPs, so they are also covered by voluntary contributions. In most places the majority of PMS GPs have agreed to pay the same contribution they would have done under GMS and this clearly becomes increasingly important where the proportion of PMS GPs is high. (At least one LMC reported they

had 80% PMS coverage.) Non-principal GPs (salaried, registrars, locums etc.) are equally not covered by the statutory levy.

It would make sound policy sense if there were provision to ensure all GPs were covered by the statutory levy, particularly as the number of people covered by alternative employment contracts is growing. Fragmentation of the GPs' local voice is in nobody's interest. This would require legislative changes.

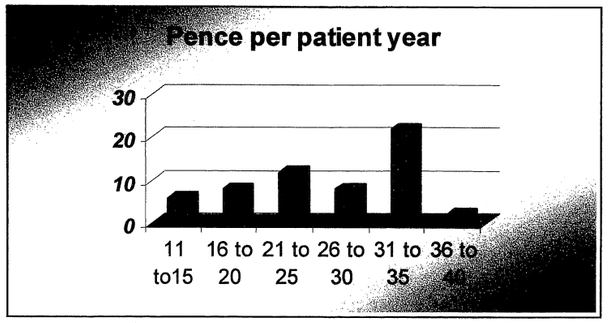
The systems for collecting income for LMCs vary widely, although in all LMCs the PCT or PCT agency collects the statutory levy by deduction at source. In the most favourable circumstances this arrangement has been extended to at least PMS GPs by individual mandates. Clearly the maximisation of GP coverage and deduction at source is an important goal for all LMCs. The administrative cost of collection of levies directly by the LMC (e.g. from non-principals) tends to be very high.

The main method of calculating the levy contribution is to set a level of contribution per patient on a GP's list (capitation). A smaller number of LMCs use a percentage of superannuable income as the method. Some use capitation for the statutory levy and percentage of income for the voluntary component.

No LMCs report applying a practice based levy, although this might become appropriate in view of PMS and the new GMS contract.

LMC levy rates

There were 57 LMCs which reported on their level of capitation for the statutory levy and these ranged from 13.4p (Cheshire South) to 40p (Devon). The average rate for LMCs was 25.5p (unweighted for LMC size). In Devon the cost of the LMC is not regarded as a problem. They estimated that it worked out at about £800 pa per principal (which is a tax allowable expense) - what they described as *"...about a pint of beer a day".*



Eight LMCs reported their levels of statutory levy as a percentage of superannuable income and these ranged from 0.25% (South Staffs) to 1.0% (Derbyshire). The average was 0.55% (unweighted for LMC size).

The position in respect of non-principals varied widely in method, coverage and amount[16]. The methods of calculation included a fixed sum (typically £25 or £50 pa), a sum related to sessions worked in a week, or a sliding scale according to previous year's income (in Bradford and North Yorkshire £55 to £260 pa). In some LMCs the rate of collection from non-principals was very low and the cost of pursuing them probably higher than the amount collected. Non-principals by their nature have a higher turnover and some PCTs use the Data Protection Act as a reason for not passing on details of changes to the LMC.

At least two LMCs (Devon and Liverpool) have taken the policy decision that all non-principals will be provided with LMC services and it is deemed that the principals in their practices are paying for them. A final small group of LMCs use the methodology of a percentage of income of non-principals (Dudley and Essex 0.2%).

A number of LMCs stressed the need for value for money and the reluctance of GPs to see the levy increase. As one GP put it, *"They are particularly reluctant to pay in quiet times when they don't have a problem".*

Budgets

As the size and the services provided vary so do the annual budgets of LMCs. They range from £25,000 pa in Dudley and £35,000 pa in Walsall; through North Lincs £45,000, and Barnsley, Wigan and Oxfordshire between £60,000 and £64,000; to £592,000 in Kent. Most unitary LMCs are dwarfed by the confederations - London (nearly £2 million) and Wessex (£689,000).

If an effort is made to standardise these figures as rates per GP served (GMS, PMS and non-principals) a more complex picture emerges. The range then goes from £145 pa in Dudley and £164 in Oxfordshire to £563 pa in Stockport and £564 pa in Kent - a multiple of well over threefold.

If the overall picture is looked at then 24,812 GPs were covered by a total budget of £9,513,000 giving an average budget per GP of around £383 pa.

Other income

It is also worth mentioning in this chapter other sources of income which may be available to LMCs. They fall into four main categories: investment, sponsorship and advertising, income generation, and financial support or support in kind from the NHS.

Some LMCs collect levies as early as possible and then invest the money in a way that maximises their income.

A number of LMCs use sponsorship for meetings and producing their annual reports. (Devon makes a "profit" from its annual report.) Some refuse to use sponsorship for ethical reasons and clearly, if it is used, then discretion is required.

Income generation might include training courses or facilities offered to other than LMC constituents or a service provided to primary care e.g. a buying consortium such as exists in Northamptonshire.

The NHS may also provide support to LMCs ranging from free meeting space to the financial contribution, reported on page 11, in the West Midlands.

Remuneration

"We feel people should do it as a service to the profession."

The most significant item of expenditure determining the differing costs of LMCs is their policy towards paying members to attend meetings. This means there is no direct link between the rate of levy and services provided to members.

Some, like the LMC quoted above, steadfastly cling to the concept of unpaid members (see for example Dudley, East Sussex, East Yorkshire, Sunderland and Warwickshire). Some, like Birmingham, do not pay at present but are actively considering introducing payments. At least one just pays travel costs (Leeds). Another group does not pay for LMC meetings but does pay for representing the LMC at other meetings (Liverpool, Sheffield). The majority, and an increasing number, of LMCs do pay (or reimburse) members for attending LMC meetings using a bewildering array of rates and systems.

Some use the same rate as their PCTs use for PEC members (Avon, Devon). Several LMCs use the locum rate per hour and at least one the "GPC rate". The commonest system of payment is per meeting or per session. This shows a clear North/South divide with Gateshead and Tyne at £40, Salford and Trafford at £55, Calderdale and Kirklees at £70, Barnsley at £80, and Wigan at £90; and then Cambridgeshire at £175, both Kent and Wessex LMCs at £150, and both Beds and Hertfordshire and Warwickshire at £120.

Other costs of this kind are the payments or honoraria given to the Chair, Secretary and other appointed officers of the LMC. This may be a fixed rate per annum (Beds and Hertfordshire £5,000 for the Chair, Cornwall £10,000 for the Chair and £5,000 for "cabinet members", Wessex £12,000 each for the five Chairs). Others pay per meeting using rates like two sessions of hospital practitioner (Bucks and Berks), or in North Cumbria they pay the Chair £680 plus travel per meeting.

Although there is no detailed data it is also clear that Chief Executives/Secretaries are paid widely differing amounts even when their hours and the size of LMC(s) is taken into account. The rates currently paid to Chief Executives/Secretaries range from under £15,000 pa to well over

£100,000 pa. There is a need to ensure that in the future they are paid at a rate that attracts the best candidates and reflects the skills required.

Chapter 7: Communications

Introduction

"Practitioners do not open email or visit web sites on a regular basis."

"(LMCs) will need to actively sell themselves in the marketplace to survive."

"We must demonstrate we are a worthwhile organisation, the world does not owe us a living."

As representative bodies LMCs have to communicate effectively to do their job. The key sectors which they must communicate with are:

- all GPs in their area;
- other primary care staff;
- PCTs;
- StHAs;
- other NHS bodies including Trusts;
- other public and voluntary bodies;
- national organisations;
- press and public.

Annual Reports

Some 25 LMCs out of those reporting produced an annual report of some kind. Some of these were a single duplicated sheet of wisdom (usually with a fair sprinkling of ironic humour) from the Secretary or Chairman, directed solely at LMC members. At the other end of the spectrum were the professionally produced glossies aimed at the wider health community. Attitudes to annual reports varied from *'waste of money'* to *'great if we had money or time'* to *'essential tool of communication for a professional LMC'.*

Newsletters

Although newsletters are the most common method of communication with LMC constituents, by no means all produce them and some that do only do so on an occasional basis. The most successful ones seem to employ humour to engage their audience, reflecting a slightly anarchic tone, which

contrasts nicely with the less colourful NHS messages GPs are showered with. A good example is Cornwall where the newsletter is well written and includes the extraordinary musings of "Dr. Basil Bile".

Newsletters are also used as a good way for LMCs to share issues with other LMCs and health service organisations.

Email

Email is increasing in importance as a means of rapid communication with LMC constituents. However, GPs may not always read emails as the proportion of health service related spam increases. Some LMCs have reverted to fax for "urgent" communications.

Web sites

Around half of all LMCs currently have web sites (see Appendix H for web addresses) and several more have them in the planning stage. Some contain interactive sections for GPs to comment or seek information ("Viewpoint" in Cheshire, "Vox Pop" in Devon). The majority of LMCs see web sites as an important part of their future communications strategy. A number of Chief Officers commented on the usefulness of the LMC Secretaries List Server.

Non-principals

LMCs have particular problems in communicating with non-principals. This is partly because of the higher turnover and the fact that non-principals are often part time. Another major issue has been the reluctance of PCTs or their agencies to release information about non-principals because of the provisions of the Data Protection Act. This is of increasing importance to LMCs as nationally non-principals now account for around 25% of the GP workforce (source GPC). There may be particular difficulties in communicating with the growing band of practitioners who are directly employed by PCTs.

Some options which are used by LMCs for engaging with these groups include non-principals groups, dedicated but linked web sites, and relying on the practices where non-principals work, particularly by cultivating the link with practice managers.

Personal contact

Many LMC chief officers and their staff make strenuous efforts to make personal contact with individual GPs. While this is obviously desirable it is severely constrained by the limited LMC time available.

Chapter 8: The way forward for LMCs

Criteria for success

How can an LMC judge if it is successful? Criteria might include:

- being seen as representing all GPs;
- having a secure financial position;
- giving GPs a quality service;
- having PCTs/StHAs recognise the value and expertise of the LMC;
- being recognised as wanting to improve health care for the population;
- being seen as knowledgeable about the whole of the local health community;
- having a reputation as forward looking and adaptable.[3]

The next sections set out some ideas and suggestions about how these criteria might be met, following the main chapter headings of the report.

The Functions of LMCs

Form should follow function. It is essential that purposes and priorities are clear.

- All LMCs should review the functions they are carrying out now and those that they wish to carry out in the future.

- They should identify the skills required for them to carry out the desired functions.

- They should review their facilities in the light of their staffing and their other needs.

Organisational arrangements

- Small unitary LMCs will find it increasingly difficult to carry out their role cost effectively.

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[3] From Dr Judy Gilley.

- Confederations provide economies of scale and pooling of skills whilst retaining local ownership and the potential for more locally based pastoral work.

- There is no single organisational model that can be applied to all as it is necessary to take into account many factors including geography, history and the existing and future shape of the NHS.

- It seems probable that the current shape of the NHS will not last, so LMC organisational arrangements have to be flexible to adapt if necessary to further changes in structure.

- LMCs should review their internal structure of member constituencies. Increasingly, LMCs are built up from constituencies based on geography, often coinciding with PCT boundaries. Lead GPs from these constituencies are often involved in the executive of the LMC.

- Almost all LMCs treat GMS and PMS GPs equally. This approach will become even more important as different forms of arrangement proliferate.

- According to the GPC, non-principals now account for 25% of the national GP workforce. It is therefore essential that all LMCs have in place mechanisms to communicate with non-principals and that they are effectively represented in policy making.

- LMCs should review their policy on co-option as a means of covering all of their constituents and fostering relationships.

Relationships

- In the current NHS organisation PCTs are the most important partners for LMCs. LMCs will be hampered in their role if they do not have an open, constructive and co-operative relationship with their PCTs. LMCs should reflect on their current relationships.

- Considerable patience and goodwill may be required where there are new appointments and relatively new PCT organisations. In places where there is an entrenched relationship problem then external facilitation might be considered.

- In most cases there will need to be regular liaison meetings between PCTs and officers of the LMC. Sometimes it will be possible to meet more than one PCT at a time where issues are reasonably common.

- If staffing resources allow, then PCT liaison posts could be developed to encourage a close working relationship on a more day to day basis. Experience of this exists in a number of LMCs, for example Trent, Devon, Essex and Beds and Herts.

Staffing and development issues

- LMCs should review the numbers and skills of staff needed to carry out the desired roles.

- LMCs should consider whether senior management skills and experience are a requirement for the future.

- They should consider the options available to secure the staffing and skills available including shared posts and part time secondments.

- There is a need to consider the support available on a personal basis to LMC Chief Officers.

- There is a need to review the training and development available for LMC Chief Officers, medical secretaries (pastoral role), other LMC staff, LMC Chairs and LMC members.

- In view of the small numbers involved, specific training should mainly be provided on a national basis although some development work such as the induction of newcomers should be carried out locally.

- The use of appraisal for LMC officers and staff should be encouraged.

- There is a particular need for training around negotiating skills required for implementing the new GMS contract.

- There is a need for training in conflict resolution.

- There is much scope for joint training, particularly with PCTs.

- The DoH should consider how it could provide more proactive support to the development of LMCs.

- It is strongly recommended that the SECSNET pilot is reviewed and a network owned and available to all LMCs is evolved or established from scratch as an immediate priority.

Financial matters

- LMCs need to review the income required to carry out their desired role.

- It seems likely that many LMCs at the lower end of the income range will need to increase their levy if they are to provide a reasonable level of service to their constituents.

- The method of calculation which involves a percentage of constituents' incomes is applicable to all groups of GPs and provides LMCs with a measure of inflation proofing.

- It is important that all collection is made by deduction at source if it is to be cost effective.

- Collecting £25 or even £50 from a small percentage of non-principals is unlikely to be cost effective.

- LMCs should consider a policy of providing services to all non-principals and collecting all money from practices by adjusting the levy on principals. A practice based levy would leave practices to decide whether to pass the cost on and how to apportion it.

- Historically, the levies to support the administration of an LMC and the contribution made to the GPC have been kept separate, often with different systems of calculation. Few GPs understand the complexities of this arrangement and there may be merit in consolidating it into a single sum, leaving the LMC to agree the sum required to support GPC work.

- Whichever levy system is preferred, there appears to be consensus that it should cover all practitioners; that all practitioners should contribute directly or indirectly via the practice; and that the amount paid should have a fair relationship to individual income.

- LMCs should consider whether there is scope for income generation without diverting scarce resources from core business.

- LMCs should review their policies for remunerating members and officers of the LMC. This is generally one of the highest forms of expenditure for LMCs. The few LMCs who do not pay will probably have to budget to do so in the future.

- It is possible that some PCTs will be willing to support LMCs with staff or facilities where they see mutual benefit, for example the smooth introduction of the new contract.

Communications

- LMCs should consider producing an annual report if they do not already do so.

- Annual Reports can be used to communicate the role of the LMC to the wider health community. Sponsorship and advertising can be used to defray the costs.

- Concise, well written and appropriately humorous newsletters available in hard copy and electronically are essential for communicating with constituents and the wider health community.

- GPs and the NHS are increasingly relying on electronic communication. LMCs will undoubtedly require web sites with the facility for GP interactive comment. There are many good examples in operation (see Appendix H) and it is not necessary to start from scratch.

- Simple communications aids often work best. One suggestion made was the production of a small card, issued to all practitioners, with key contact details for their LMC.

In conclusion

It is widely acknowledged that general practice is the cornerstone of the NHS. However, because of its history of contractor status and tradition of independence, general practice is perhaps the most precariously supported element of the health service.

LMCs are a vital element in securing a healthy and well motivated workforce in general practice. But the demands on them are increasing, with more organisations to deal with and major new initiatives, including the new contract, to deal with. Their work is complex and exacting. They themselves must look afresh at their roles and priorities, and consider how they can become or remain "fit for purpose". Health service organisations and the relevant national bodies should recognise that effective LMCs are in everyone's interests and continue to support them as they address new challenges.

Appendix A: About the authors

Chris Fewtrell BSc (Econ) MSocSci FHSM

Chris has worked in all facets of health services management including the management of both community and acute services. He was Chief Executive of North Derbyshire Health Authority between 1991 and 2000 where he had a special interest in the development of primary care. He has also worked with a number of university departments including a spell as a Research Fellow at the University of Birmingham. He has contributed to policy development and published, particularly in the field of management development. Currently he is contributing as a Research Associate to ScHARR.

David Martin BA DipAppPsych PhD CPsychol AFBPsS

David worked as a clinical psychologist with young offenders at the Department of Health's Youth Treatment Centre in Brentwood. He was Assistant Director of Social Services in North Yorkshire and Deputy Director in West Glamorgan, then General Manager of Bradford Family Health Services Authority and Assistant Regional General Manager at Yorkshire Health. After a period as a Director at Trent RHA, managing the RHA/Regional Office transition, he joined Sheffield University's School of Health and Related Research in 1996.

Appendix B: Bibliography

1 Brembs, B. (1996) *Chaos, Cheating and Co-operation: Potential Solutions to the Prisoner's Dilemma.*

2 Chisholm, J. (2002) *General Practitioners Defence Fund - History and Purpose.*

3 Department of Health (1996) *HSG(96)9: Local Representative Committees.*

4 Department of Health (2001) *Shifting the Balance of Power.*

5 The NHS Confederation and the BMA (2003) *The New GMS Contract.*

6 Ellis, N. (1975) The General Medical Services Committee and Local Medical Committees. *Journal of the Society of Administrators of Family Practitioner Services.*

7 General Medical Services Committee/BMA (1997) *GP Involvement in the Work of Health Authorities: Improving the Quality and Effectiveness of GP Advice.*

8 General Practitioners Committee/BMA (2002) *The General Practitioners Defence Fund.*

9 General Practitioners Committee/BMA (2002) *The NHS Reform and Healthcare Professions Bill and Local Medical Committees in England: Guidance for LMCs.*

10 General Practitioners Committee/BMA (2000) *Non-statutory Functions of LMCs: Guidance for LMCs.*

11 General Practitioners Committee/BMA (2000) *Implications of the Health Act 1999 for LMCs: Guidance for LMCs.*

12 Lockharts Solicitors (1999) *The Work of the Local Medical Committees in England and Wales.*

13 General Practitioners Committee/BMA (2000) *Non-principals and Local Medical Committees in England and Wales.*

14 General Practitioners Committee/BMA (2000) *LMC Representation of General Practitioners: Guidance for LMCs in England.*

15 Hague, R. and Harrop, M. (2001) *Comparative Government and Politics.*

16 Harvey, P. (1999) *Guidance from the Secretary of the National Association of Non Principals.*

17 Heywood, A. (2000) *Key Concepts in Politics.*

18 Orr, J. E. K. (1998) *The Role of the Local Medical Committee 1911-2011.*

19 Regen, E. (2002) *Driving Seat or Back Seat? GPs' Views on and Involvement in Primary Care Groups and Trusts.* University of Birmingham, HSMC.

20 Smith, J., Ham, C., Knight, T. (1998) *Joined Up Solutions? Determining the Functions and Possible Support Arrangements for Primary Care Groups.* The University of Birmingham HSMC and Birmingham LMC.

Appendix C: Glossary of abbreviations

BMA	British Medical Association
DoH	Department of Health
DPH	Director of Public Health
FHSA	Family Health Service Authority
FPC	Family Practitioner Committee
GMC	General Medical Council
GMS	General Medical Services
GP	General Medical Practitioner
GPC	General Practitioner Committee of BMA
LIFT	Local Improvement Finance Trust
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LRC	Local Representative Committee
MTRAC	Midland Therapeutic Review and Advisory Committee
NICE	National Institute for Clinical Excellence
NANP	National Association of Non-Principals
NHS	National Health Service
PCG	Primary Care Group
PCT	Primary Care Trust
PEC	Professional Executive Committee
PMS	Personal Medical Services
RCGP	Royal College of General Practitioners
SECSNET	(LMC) Secretaries Network
ScHARR	School of Health and Related Research at Sheffield University
StHA	Strategic Health Authority

Appendix D: Research Methodology

Survey letter and questionnaire

Dear (LMC Chief Officer)

The Future Development of Local Medical Committees

Following the decision of The Conference of LMC Secretaries, we have been commissioned by the national network of LMC Secretaries/Chief Executives (SECSNET) and the General Practitioner Committee of the BMA to study the future development of LMCs. The results of this project will be reported back to the Conference of LMC Secretaries this autumn.

Our project aims to:

- Create a database of present and planned organisational arrangements for LMCs handling a growing workload in a rapidly changing environment.
- Assemble and disseminate a picture of emerging good (and less successful) practice in LMC work in this changing context.
- Gather information about the aspirations, concerns, uncertainties and experiences of LMCs in relation to their PCTs/StHAs.
- Make recommendations about future roles and relationships, and the development and maintenance of successful LMC working.

From the information gathered we intend to produce a report which will be of real practical relevance to the successful future of LMCs.

The attached document sets out a series of questions which may assist you in your response. Most can be answered quite simply but we will understand if you do not wish to respond to all questions. We also appreciate that not all the questions will fit the many varied circumstances of individual LMCs. If you consider there are important issues we have omitted please include them in your reply.

In addition we would be very grateful to receive from you your most recent annual report and any relevant policy papers.

Our intention is to review the information from LMCs in March so we would appreciate your response by the end of February.

Responses can be made by post, using the enclosed freepost label, by email to "l.a.hall@sheffield.ac.uk" or by telephone on 0114 222 0718.

We may wish to follow up your response either by telephone or with a face to face interview which I hope you would find acceptable.

Thank you very much for your help and please do not hesitate to contact me if you would like further information.

Yours sincerely,

Chris Fewtrell

Christopher Fewtrell
Research Associate

University of Sheffield - School of Health and Related Research
The Future Development of Local Medical Committees

You can either fill in this as a 'hardcopy' document or obtain it electronically in Word format from "l.a.hall@sheffield.ac.uk".

Name of LMC (or LMCs if federated).....
Contact person.....
Tel:.....
Address.....
.....
.....
Email:..... Web Site:.....

Not all questions will fit the situation of all LMCs . Please adapt your response to your circumstances and to tell us what <u>you</u> think is important for the future development of LMCs.

	Organisational issues	
1.	What PCTs/StHAs does the LMC currently relate to?	
2.	What number of GPs (main plus supplementary lists) are served by the LMC?	
3.	On what electoral constituencies is the LMC built?	
4.	How many members are there on the LMC?	
5.	How many LMC members places are unfilled?	
6.	How many LMC constituencies were uncontested at the last election?	
7.	Is the LMC grouped with others?	
8.	If so, for what purpose(s)?	
9.	Is there an Executive Committee of the LMC?	
10.	What is the membership of the Executive Committee?	
11.	What is the frequency of meetings of the LMC?	
12.	What is the frequency of meetings of the Executive Committee?	

13.	Who attends LMC meetings from PCT/StHA (all or part)?	
14.	Who attends LMC Meetings from Hospital Trusts (all or part)?	
15.	What key PCT/StHA bodies have LMC representation?	
16.	Are LMC agendas prioritised and if so how?	
17.	How are PMS GPs represented?	
18.	How are non-principals represented?	
19.	Are there any co-opted GPs and if so for what purpose?	
20.	What changes are already planned to the current organisation of the LMC?	
21.	What further changes do you envisage might be desirable in the next 12 months or so?	
22.	What are the key relationships with PCT/StHA Executives and how would these be characterised?	
23.	Are you working to any organisational quality standards, eg Investors in People?	
24.	Are there any other organisational issues that you think we should consider?	
	Financial Issues	
1.	Do you have a designated finance officer/treasurer?	
2.	Is your levy statutory, voluntary or both?	
3.	How is your levy collected?	
4.	How is your levy calculated?	
5.	What is the rate of levy per patient per annum?	
6.	What is the levy contribution from non-principals?	
7.	What is your total budget?	
	Staffing Issues	
1.	Does the LMC Sec/CE have a role description? (if so please attach)	
2.	Do you have any views about remuneration of LMC Secs/CEs?	
3.	Do you have any views about whether LMC Secs/CEs should be full time or part time?	
4.	What is your current local situation?(F/T or P/T)	
5.	Does the Sec/CE do any clinical work and is this important?	
6.	What is the age of the current LMC Sec/CE?	
7.	How many years in post?	
8.	What other staff does the LMC have (numbers and roles)?	
9.	In what way should these other LMC staff roles and numbers change?	
10.	Do you have any views on the selection and training of LMC Chairs?	
11.	Do you have any advice or views about LMC Member training?	
12.	What are the current/future arrangements for the payment of	

	LMC members?	
	Communications	
1.	What are the main communication links with the StHA?	
2.	What are the main communication links with PCTs?	
3.	What are the main LMC links to pharmacists, dentists and optometrists?	
4.	What are the main LMC links with Community Nursing?	
5.	Do you have any advice or views about the relationship with GPs who are sceptical of, or disinterested in, the role of the LMC?	
6.	What access does the LMC have to PCT papers?	
7.	What is the distribution of LMC papers?	
8.	What are the LMC arrangements for communicating with non-principals (eg locums, registrars, assistants and retainers)?	
9.	Do you have any views or examples of good practice in respect of communication methods eg newsletters, web sites, GP forums?	
10.	How would you describe your relationship with the BMA Office?	
11.	What are the main changes you would like to see in linkages to	

	other health organisations?	
	General	
1.	What are the main policy issues facing your LMC over the next twelve months?	
2.	Are you able to supply a recent annual report with your response?	
3.	Do you have an example of the LMC being effectively engaged in the development of local policy?	
4.	Do you have an example of the LMC being inappropriately excluded from local policy making?	
5.	Do you have any other views or advice on the future roles of LMCs?	

Thank you for your help in contributing to the project on the future development of LMCs.

Appendix E: LMC organisational data

LMC	Written Response	Inter view	No of PCTs	PCT Responses	Strategic Health Authority	Organisation Type
Avon LMC	Yes	Yes	5	BN,BSW,	Avon, Gloucs & Wilts	unitary
Barking & Havering LMC	Yes		2	Havering, Barking & Dagenham	Essex	unitary
Barnsley LMC	Yes		1		South Yorks	unitary
Bedfordshire & Hertfordshire LMCs			[11]		Beds & Herts	
Bedfordshire LMC	Yes	Yes	5	Luton, Beds Heartlands,	Beds & Herts	confed
Hertfordshire LMC	Yes	Yes	6	St Albans & Harpenden,	Beds & Herts	confed
Berkshire & Buckinghamshire LMCs			[10]		Thames Valley	
Berkshire LMC	Yes		6	Reading, Wokingham,	Thames Valley	confed
Buckinghamshire LMC	Yes		4		Thames Valley	confed
Bradford & North Yorks LMCs			[8]		2	
Bradford LMC	Yes	Yes	4		West Yorks StHA	confed
North Yorks LMC	Yes	Yes	4	Selby & York,	N&E Yorks & N Lincs	confed
Birmingham LMC	Yes	Yes	4	South Birmingham,	Birmingham and Black Country	unitary
Bolton LMC	Yes		1		Greater Manchester	unitary
Calderdale & Kirklees LMC	Yes		4	S Huddersfield,	West Yorks	unitary
Cambridgeshire LMC	Yes		6	E Cambs, N&S Peterborough.	Norfolk, Suffolk & Cambs	unitary
Cheshire LMCs			[6]		Cheshire and Merseyside	
Cheshire North LMC	Yes	Yes	2	Halton	Cheshire and Merseyside	confed
Cheshire South LMC	Yes	Yes	4		Cheshire and Merseyside	confed
Cleveland LMC	Yes		4		Co Durham & Tees Valley	unitary
Cornwall & Isles of Scilly LMC	Yes	Yes	3		South West Peninsular	unitary

LMC	Written Response	Inter view	No of PCTs	PCT Responses	Strategic Health Authority	Organisation Type
County Durham LMC	No		6	Durham & Chester le St,	Co Durham & Tees Valley	unitary
Coventry LMC	Yes		1		Coventry,Warwicks,Worcs,Hereford	unitary
Devon LMC	Yes	Yes	8	Torbay,	South West Peninsular	fed/unitary
Doncaster LMC	Yes		3	Doncaster W.	South Yorks	unitary
Dudley LMC	Yes		2		Birmingham and Black Country	unitary
East Sussex LMC	Yes		5		Surrey and Sussex	unitary
E, NW & S Lancs & Morecambe Bay LMCs			[12]		Cumbria & Lancashire	
East Lancs LMC	Yes		3	Burnley,	Cumbria & Lancashire	confed
Morecambe Bay LMC	Yes		1		Cumbria & Lancashire	confed
North West Lancs LMC	Yes		4	Blackpool,	Cumbria & Lancashire	confed
South Lancs LMC	Yes		2	West Lancs	Cumbria & Lancashire	confed
East Yorkshire LMC	Yes		2		Cumbria & Lancashire	unitary
Essex LMCs			[13]		Essex	
North Essex LMC	Yes		8		Essex	confed
South Essex LMC	Yes		5	Castle / Rochford, Basildon	Essex	confed
Gateshead & South Tyne LMC	Yes		2	S Tyneside,	Northumberland & Tyne & Wear	unitary
Gloucestershire LMC	Yes	Yes	3	W Gloucs,	Avon,Gloucs & Wilts	unitary
Herefordshire LMC	No		1		Waricks,Worcs,Hereford	unitary
Kent LMCs	Yes		9		Kent	unitary
Leeds LMC	Yes		4	E, S & W Leeds	West Yorks	confed
Leicestershire and Rutland LMC	Yes		6	S Leics, Leicester West	Leicestershire & Northamptonshire	unitary
Liverpool LMC	Yes	Yes	3		Cheshire and Merseyside	unitary

LMC	Written Response	Inter view	No of PCTs	PCT Responses	Strategic Health Authority	Organisation Type
Londonwide LMCs, Confederation of			[24]		5x London	
Barnet LMC	Yes	Yes	1		North Central London	confed
Bexley LMC	Yes	Yes	1	Bexley	SE London	confed
Brent LMC	Yes	Yes	1		NW London	confed
Bromley LMC	Yes	Yes	1		SE London	confed
Camden and Islington LMC	Yes	Yes	2		North Central London	confed
City and East London LMC	Yes	Yes	3		NE London	confed
Ealing,Hammersmith& Hounslow LMC	Yes	Yes	3	Hounslow	NW London	confed
Enfield LMC	Yes	Yes	1		North Central London	confed
Greenwich LMC	Yes	Yes	1		SE London	confed
Haringey LMC	Yes	Yes	1		North Central London	confed
Harrow LMC	Yes	Yes	1		NW London	confed
Hillingdon LMC	Yes	Yes	1		NW London	confed
Kensington and Chelsea LMC	Yes	Yes	1		NW London	confed
Lambeth LMC	Yes	Yes	1		SE London	confed
Lewisham LMC	Yes	Yes	1		SE London	confed
Merton andSutton LMC	Yes	Yes	1		SW London	confed
Southwark LMC	Yes	Yes	1		SE London	confed
Wandsworth LMC	Yes	Yes	1		SW London	confed
Westminster LMC	Yes	Yes	1		NW London	confed
Manchester LMC	No		5		Greater Manchester	unitary
Newcastle & North Tyneside LMC	Yes		2	Newcastle	Northumberland & Tyne & Wear	unitary
Norfolk LMC	No		6	Broadlands	Norfolk, Suffolk & Cambs	unitary

LMC	Written Response	Inter view	No of PCTs	PCT Responses	Strategic Health Authority	Organisation Type
North Cumbria LMC	Yes		3		Cumbria & Lancashire	unitary
North Staffordshire LMC	Yes		4	Staffs Moorlands,	Shropshire & Staffordshire	unitary
Northamptonshire LMC	Yes		3	Northampton,	Leicestershire & Northamptonshire	unitary
Northern Lincolnshire LMC	Yes		1	NE Lincs,	N&EYorks & N Lincs	unitary
Northumberland LMC	No		1		Northumberland & Tyne & Wear	unitary
Oxfordshire LMC	Yes	Yes	5		Thames Valley	unitary
Redbridge & Waltham Forest LMC	No		3	Redbridge,	NE London	unitary
Rochdale & Bury LMC	Yes		2		Greater Manchester	unitary
Rotherham LMC	No		1		South Yorks	unitary
Salford & Trafford LMC	Yes		3	Salford	Greater Manchester	unitary
Sandwell LMC	No		1		Birmingham and Black Country	unitary
Sefton LMC	No		2		Cheshire and Merseyside	unitary
Sheffield LMC	Yes		4	Sheffield West,	South Yorks	unitary
Shropshire LMC	Yes		2	Shropshire,	Shropshire & Staffordshire	unitary
Solihull LMC	No		1		Birmingham and Black Country	unitary
Somerset LMC	Yes		4		Somerset and Dorset	unitary
South Staffordshire LMC	Yes		4		Shropshire & Staffordshire	unitary
St Helens & Knowsley LMC	No		2		Cheshire and Merseyside	unitary
Stockport LMC	Yes		1		Greater Manchester	unitary
Suffolk LMC	Yes		5		Norfolk,Suffolk & Cambs	unitary
Sunderland LMC	Yes		1		Northumberland & Tyne & Wear	unitary
Surrey LMCs			[12]		SW London and Surrey/Sussex	
Croydon LMC	Yes		1	Croydon	SW London	confed
Kingston and Richmond LMC	Yes		2	Kingston	SW London	confed
East Surrey LMC	Yes		3		Surrey/Sussex	confed
West Surrey LMC	Yes		2		Surrey/Sussex	confed
West Sussex LMC	Yes		4		Surrey/Sussex	confed
Trent LMCs			[19]		Trent	
Derbyshire LMCs	Yes	Yes	8	Erewash,	Trent	confed
Nottinghamshire LMC	Yes	Yes	8	Broxtowe & Hucknall, Mansfield, Gedling	Trent	confed
Lincolnshire LMC	Yes	Yes	3		Trent	confed
Wakefield LMC	Yes		2		West Yorks	confed
Walsall LMC	Yes		1		Birmingham & Black Country	unitary
Warwickshire LMC	Yes		3		Waricks, Worcs, Hereford	unitary
Wessex LMCs			[19]		2	
Dorset LMC	Yes	Yes	5	SW Dorset,	Somerset and Dorset	confed
Isle of Wight, Portsmouth and SE Hants LMC	Yes	Yes	4		Hampshire & Isle of Wight	confed
NE Hants LMC	Yes	Yes	2		Hampshire & Isle of Wight	confed
W Hants LMC	Yes	Yes	4	Southampton,	Hampshire & Isle of Wight	confed
Wiltshire LMC	Yes	Yes	4	Swindon,	Avon, Gloucs & Wilts	confed
West Pennine LMC	No		2		Greater Manchester	unitary
Wigan LMC	Yes		2		Greater Manchester	unitary
Wirral LMC	No		2		Cheshire and Merseyside	unitary
Wolverhampton LMC	No		1		Birmingham and Black Country	unitary
Worcestershire LMC	Yes	Yes	3		Waricks, Worcs, Hereford	unitary

Appendix F: LMC GP and staffing data

LMC	Practitioners LMC Estimate	Practitioners DOH Sept 2002	Non-Principals	LMC size	GPs per Member	Secretary/ Chief Executive	Senior	Middle	Junior
Avon LMC	860	745	230	33	26	FT			1
Barking & Havering LMC		200							
Barnsley LMC	112	125	inc	18	6	PT			0.5
Bedfordshire & Hertfordshire LMCs	[1110]	[1024]	inc		22	FT	1	2	2.5
Bedfordshire LMC		488		25		shared	shared	shared	shared
Hertfordshire LMC		536		25		shared	shared	shared	shared
Berkshire & Buckinghamshire LMCs	[1135]	[1002]				FT		2	2
Berkshire LMC	582	531	157	28	21	shared		shared	shared
Buckinghamshire LMCs	553	471	146	21	26	shared		shared	shared
Bradford & North Yorks LMCs	[908]	[921]						1	1
Bradford LMC	382	345	inc	22	17	PT		shared	shared
North Yorks LMC	526	576	inc	31	17	PT		shared	shared
Birmingham LMC	802	678	inc	33	24	PT		1	0.5
Bolton LMC	180	169	inc	13	14	PT		2	0.5
Calderdale & Kirklees LMC	250	348	inc	30	8	PT		1	1
Cambridgeshire LMC	432	488	inc			P/T9xsessions		1	1
Cheshire LMCs	[722]	[674]				FT	1	1	1
Cheshire North LMC	197	191	inc	18	11	PT	shared	shared	shared
Cheshire South LMC	525	483	inc	26	20	PT	shared	shared	shared
Cleveland LMC	400	333	inc	28	14	PT		0.5	1
Cornwall & Isles of Scilly LMC	427	371	inc	22	19	PT		0.2	1

LMC	Practitioners LMC Estimate	Practitioners DOH Sept 2002	Non-Principals	LMC size	GPs per Member	Secretary/ Chief Executive	Senior	Middle	Junior
County Durham LMC		372							
Coventry LMC	183	186	inc	28	7	PT			1
Devon LMC	943	835	inc	44	21	FT	1	2	2
Doncaster LMC	222	164	inc	24	9	PT			1
Dudley LMC	172	189	inc	15	11	PT			1
East Sussex LMC	564	482	144	40	14				1.7
E, NW & S Lancs & Morcambe Bay LMCs	[973]	[984]					3	3	1
East Lancs LMC	332	294	inc	12	28	PT	shared	shared	shared
Morecambe Bay	180	223	inc	19	9	PT	shared	shared	shared
North West Lancs LMC	250	284	inc	19	13	PT	shared	shared	shared
South Lancs LMC	211	183	inc	21	10	PT	shared	shared	shared
East Yorkshire LMC	368	330	48	15	25	Max PT		1	1
Essex LMCs	[817]	[815]				FT	1	1	0.5
North Essex LMC	470	464		32	15	shared	shared	shared	shared
South Essex LMC	347	351		23	15	shared	shared	shared	shared
Gateshead & South Tyne LMC	198	223		20	10	PT 2xSessions		0.5	
Gloucestershire LMC	490	419	150	24	20	PT			0.5
Herefordshire LMC		137							
Kent LMCs	1050	936	200	45	23	PT		2	0.5
Leeds LMC	530	483	inc	36	15	PT		1	1
Leicestershire and Rutland LMC	540	580	inc	22	25	PT	1		1
Liverpool LMC	330	305	80	28	12	PT			1

LMC	Practitioners LMC Estimate	Practitioners DOH Sept 2002	Non-Principals	LMC size	GPs per Member	Secretary/ Chief Executive	Senior	Middle	Junior
Londonwide LMCs, Confederation of	4100	[3821]	inc	1/10 or 1/14 GPs	[12]	2xFT3xPT	4	10	2.5
Barnet LMC		220				shared	shared	shared	shared
Bexley LMC		111				shared	shared	shared	shared
Brent LMC		200				shared	shared	shared	shared
Bromley LMC		177				shared	shared	shared	shared
Camden and Islington LMC		289				shared	shared	shared	shared
City and East London LMC		754				shared	shared	shared	shared
Ealing, Hammersmith and Hounslow LMC		430				shared	shared	shared	shared
Enfield LMC		155				shared	shared	shared	shared
Greenwich LMC		131				shared	shared	shared	shared
Haringey LMC		167				shared	shared	shared	shared
Harrow LMC		125				shared	shared	shared	shared
Hillingdon LMC		149				shared	shared	shared	shared
Kensington and Chelsea LMC		136				shared	shared	shared	shared
Lambeth LMC		202				shared	shared	shared	shared
Lewisham LMC		152				shared	shared	shared	shared
Merton andSutton LMC		216				shared	shared	shared	shared
Southwark LMC		149				shared	shared	shared	shared
Wandsworth LMC		189				shared	shared	shared	shared
Westminster LMC		135				shared	shared	shared	shared
Manchester LMC		508							
Newcastle & North Tyneside LMC	302	324							

LMC	Practitioners LMC Estimate	Practitioners DOH Sept 2002	Non-Principals	LMC size	GPs per Member	Secretary/ Chief Executive	Senior	Middle	Junior
North Cumbria LMC	210	237	inc	14	15	PT			
North Staffordshire LMC	240	255	inc	20	12	PT			0.5
Northamptonshire LMC	320	339	inc	28	11	PT	1	3	
Northern Lincolnshire LMC	195	189	34	9	22	maxPT		1	1
Northumberland LMC		253							
Oxfordshire LMC	390*	{392*] 473	inc	20	19	PT	0	0	0
Redbridge & Waltham Forest LMC		266							
Rochdale & Bury LMC	213	187	inc			PT2to3 sessions			2
Rotherham LMC		151							
Salford & Trafford LMC	235	264	inc	29	8	PT2xsessions		0.5	0.25
Sandwell LMC		131							
Sefton LMC		183							
Sheffield LMC	390	390	35	24	16	PT3xsessions		1	1
Shropshire LMC	350	285	inc			PT2to3 sessions			0.5
Solihull LMC		136							
Somerset LMC	500	388	inc	20	25	PT		1	0.5
South Staffordshire LMC	280	345	inc	10	28	PT		1	
St Helens & Knowsley LMC		205							
Stockport LMC	160	192	inc	18	9	PT		1	1
Suffolk LMC	480	454	inc						0.5
Sunderland LMC	165	170	2	24	7			1	
Surrey LMCs	1700	[1558]	inc 300		15	FT	1	1	1.5
Croydon LMC		205		22		shared	shared	shared	shared

LMC	Practitioners LMC Estimate	Practitioners DOH Sept 2002	Non-Principals	LMC size	GPs per Member	Secretary/Chief Executive	Senior	Middle	Junior
Kingston and Richmond		315		25		shared	shared	shared	shared
East Surrey LMC		357		16		shared	shared	shared	shared
West Surrey LMC		250		21		shared	shared	shared	shared
West Sussex LMC		431		28		shared	shared	shared	shared
Trent LMCs	[1736]	[1607]				FT	1		
Derbyshire LMCs	600	599	inc	24	25	PT	shared	2	1
Nottinghamshire LMC	670	628	120	24	28	PT	shared	3	2
Lincolnshire LMC	466	380	126	12	39	PT	shared	1	1
Wakefield LMC	234	231	29	17	14			0.5	0.33
Walsall LMC	162	136				PT		1	
Warwickshire LMC	390	319	110	24	16	PT		1	
Wessex LMCs	[2402]	[2224]		1:17 to 1:26 GPs	[22]	FT+1.5PT		2	3
Dorset LMC	635	551				shared	shared	shared	shared
Isle of Wight, Portsmouth and SE Hants LMC	472	422				shared	shared	shared	shared
NE Hants LMC	257	247				shared	shared	shared	shared
W Hants LMC	531	501				shared	shared	shared	shared
Wiltshire LMC	507	403				shared	shared	shared	shared
West Pennine LMC		232							
Wigan LMC	147	151	inc	13	11	PT			1
Wirral LMC		226							
Wolverhampton LMC		193							
Worcestershire LMC	306*	[305*] 360	inc	20	15	PT		0.5	

*Principals only

Appendix G: LMC financial data

LMC	Levy Calculation	Levy per patient per year	Levy Non-principals	Budget £ 000s	£ per GP pa
Avon LMC	Patient List	20p	£25	250	290
Barking & Havering LMC					
Barnsley LMC	Patient List	25p	£50	60	536
Bedfordshire & Hertfordshire LMCs	Patient List	26p	£45	470	423
Bedfordshire LMC					
Hertfordshire LMC					
Berkshire & Buckinghamshire LMCs					
Berkshire LMC	Patient List	26p	£25 per session/week for year	160	275
Buckinghamshire LMCs	Patient List	26p	£25 per session/week for year	143	259
Bradford & North Yorks LMCs					
Bradford LMC	Patient List + vol @% income	32p plus 4.5p vol	£55 to £260 by income	162	424
North Yorks LMC	Patient List	36p plus 6p vol	£55 to £260 by income	277	527
Birmingham LMC	% superannuable income	15p plus 6p vol	sliding scale based on income	209	261
Bolton LMC	Patient List		£80	90	500
Calderdale & Kirklees LMC					
Cambridgeshire LMC	Patient List	24.0p		210	486
Cheshire LMCs					
Cheshire North LMC	Patient List	24.0p plus 3.6p vol	£26	72	363
Cheshire South LMC	Patient List	23.2p plus 4.2p vol	£26	94	
Cleveland LMC	% superannuable income		£25	128	320
Cornwall & Isles of Scilly LMC			None	156	365

LMC	Levy Calculation	Levy per patient per year	Levy Non-principals	Budget £ 000s	£ per GP pa
County Durham LMC					
Coventry LMC	Patient List		£50	74	404
Devon LMC	Patient List	40p	£25 to £100	350	371
Doncaster LMC	Patient List + vol @% income	23p	£50	64	288
Dudley LMC	Patient List + vol @% income		% income	25	145
East Sussex LMC	Patient List + vol @% income	22.5p +up to £400	£50	192	340
E, NW & S Lancs & Morcambe Bay LMCs					
East Lancs LMC	Patient List		£50		
Morecambe Bay LMC	Patient List	29p	£50		
North West Lancs LMC	Patient List		£50		
South Lancs LMC	Patient List		£50		
East Yorkshire LMC	% superannuable income	13.64p	£25	80	217
Essex LMCs				387	
North Essex LMC	Patient List	22.69p	0.2% income		
South Essex LMC	Patient List	23.5p	0.2% income		
Gateshead & South Tyne LMC			n/a		
Gloucestershire LMC	Patient List	26p	£25	147	300
Herefordshire LMC					
Kent LMCs	% superannuable income	32p plus 5p vol	£25 under review	592	564
Leeds LMC			stepped by last year salary	140	264
Leicestershire and Rutland LMC	% superannuable income	0.5% raising to 0.75%	£50	261	483

LMC	Levy Calculation	Levy per patient per year	Levy Non-principals	Budget £ 000s	£ per GP pa
Liverpool LMC	Patient List	0.98% capitation fee	None	85	258
Londonwide LMCs, Confederation of	Patient List	31p	£25	1,987	487
Barnet LMC	Patient List	31p			
Bexley LMC	Patient List	31p			
Brent LMC	Patient List	31p			
Bromley LMC	Patient List	31p			
Camden and Islington LMC	Patient List	31p			
City and East London LMC	Patient List	31p			
Ealing, Hammersmith and Hounslow LMC	Patient List	31p			
Enfield LMC	Patient List	31p			
Greenwich LMC	Patient List	31p			
Haringey LMC	Patient List	31p			
Harrow LMC	Patient List	31p			
Hillingdon LMC	Patient List	31p			
Kensington and Chelsea LMC	Patient List	31p			
Lambeth LMC	Patient List	31p			
Lewisham LMC	Patient List	31p			
Merton and Sutton LMC	Patient List	31p			
Southwark LMC	Patient List	31p			
Wandsworth LMC	Patient List	31p			
Westminster LMC	Patient List	31p			
Manchester LMC					
Newcastle & North Tyneside LMC					
Norfolk LMC					

LMC	Levy Calculation	Levy per patient per year	Levy Non-principals	Budget £ 000s	£ per GP pa
North Cumbria LMC	Patient List		£25 for three years		
North Staffordshire LMC	% superannuable income	26p	£25		
Northamptonshire LMC	Patient List + vol @% income	19p	some practice contribution	100	313
Northern Lincolnshire LMC	% superannuable income	13.64p	£25	45	231
Northumberland LMC					
Oxfordshire LMC	Patient List	15p	£10	64	164
Redbridge & Waltham Forest LMC					
Rochdale & Bury LMC	Patient List	24p plus 5p vol		120	563
Rotherham LMC					
Salford & Trafford LMC	Patient List	14.9p plus 5p vol	£25	80	340
Sandwell LMC					
Sefton LMC					
Sheffield LMC	Patient List	24p plus 6p vol	£50	160	421
Shropshire LMC		13p			
Solihull LMC					
Somerset LMC	Patient List	25p	£25	125	250
South Staffordshire LMC	% superannuable income	26p	£50		
St Helens & Knowsley LMC					
Stockport LMC	% superannuable income	30p	None	90	563
Suffolk LMC	% superannuable income			170	354
Sunderland LMC	% superannuable income		None		
Surrey LMCs	Patient List + vol @% income	Between 17.2 and 20p	None-under review	450	5x265
Croydon LMC					

LMC	Levy Calculation	Levy per patient per year	Levy Non-principals	Budget £ 000s	£ per GP pa
Kingston and Richmond LMC					
East Surrey LMC					
West Surrey LMC					
West Sussex LMC					
Trent LMCs					
Derbyshire LMCs	% superannuable income		1% superannuable income		
Nottinghamshire LMC	% superannuable income		£200 for full time-pro rata	250	373
Lincolnshire LMC	% superannuable income		none agreed		
Wakefield LMC	Patient List	17.2p plus 4.5p vol	nil	75	321
Walsall LMC	% superannuable income	0.0316% per pat pa		35	216
Warwickshire LMC	Patient List	32p	£50	150	384
Wessex LMCs	Patient List	21.5p	sliding scale up to £175	689	287
Dorset LMC					
Isle of Wight, Portsmouth and SE Hants					
NE Hants LMC					
W Hants LMC					
Wiltshire LMC					
West Pennine LMC					
Wigan LMC		0.0405% per pat pa/PMS £300pa		50	340
Wirral LMC					
Wolverhampton LMC					
Worcestershire LMC	% superannuable income		£25	84	275

Appendix H: LMC web sites known to ScHARR

LMC	Web site
Avon LMC	www.avonlmc.co.uk
Bedfordshire & Hertfordshire LMCs	www.bedshertslmcs.org.uk
Berkshire & Buckinghamshire LMCs	www.bblmc.co.uk
Birmingham LMC	www.wmrlmcfsnet.co.uk
Bradford & North Yorks LMCs	www.nyblmcs.demon.co.uk
Calderdale & Kirklees LMC	www.calderdale-primarycare.co.uk
Cheshire LMCs	www.cheshirelmcs.org.uk
Cornwall & Isles of Scilly LMC	www.kernow-lmc.co.uk
Coventry LMC	www.wmrlmcfsnet.co.uk
Devon LMC	www.devonlmc.org
Dudley LMC	www.wmrlmcfsnet.co.uk
Gloucestershire LMC	www.gloslmc.com
Herefordshire LMC	www.wmrlmcfsnet.co.uk
Kent LMCs	www.kentlmc.org
Leeds LMC	www.leedslmc.org
Londonwide LMCs, Confederation of	www.lmc.org.uk
Manchester LMC	www.manchesterlmc.co.uk
North Staffordshire LMC	www.wmrlmcfsnet.co.uk
Northamptonshire LMC	www.pcnn.northamtonshire.nhs.uk/ genprac/LMC
Sandwell LMC	www.wmrlmcfsnet.co.uk
Shropshire LMC	www.wmrlmcfsnet.co.uk
Solihull LMC	www.wmrlmcfsnet.co.uk
Somerset LMC	www.somersetlmc@demon.co.uk
South Staffordshire LMC	www.southstaffslmc.co.uk
Stockport LMC	www.stockport-lmc.org.uk
Surrey LMCs	www.lmcs.info
Trent LMCs	www.trentlmcs.org.uk
Walsall LMC	www.wmrlmcfsnet.co.uk
Warwickshire LMC	www.wmrlmcfsnet.co.uk
Wessex LMCs	www.lmclive.co.uk
Wolverhampton LMC	www.wmrlmcfsnet.co.uk
Worcestershire LMC	www.wmrlmcfsnet.co.uk