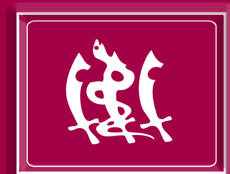
Tempus Fugit

Annual Report 2008/2009

North & South Essex
Local Medical Committees Ltd



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NORTH ESSEX LMC CHAIRMAN'S REPORT - DR GARY SWEENEY

Another year gone! I wish I could feel that we were making progress. Plus ça change, plus c'est la même chose. One thing that does not seem to change is the interfering micromanagement of this Government.

If any of you need some literary Mogadon, try reading the "World Class Commissioning" literature. You will soon conclude that it is a load of "round objects", but do not be complacent. It presents huge potential threats to Primary Care. PCTs are no longer allowed to take the view that Primary Care in its area is not broken and does not require fixing. They must take a formal commissioning approach and scrutinise every nut and bolt of every practice. All contracts are now up for review and renegotiation. In the distant past we have been encouraged to make bids for monies to fund service improvements and investments in staff and infrastructure. The PCTs will have lost all this documentation, but you will be expected to dig it all out to justify your funding. I wonder how many of us will be told that we are underfunded!!?

Extended Hours has come in and settled down. We are proud in North Essex that we managed to negotiate quite acceptable funding for this additional service. Audit by EQUIP suggests that the service is effective and probably good value for money. Do not sit on your laurels though. Many PCTs are now looking to negotiate down the funding for this service. The targets have been reached, the political capital has been gained, and the centre will not care if the whole thing is quietly dropped to save money.

The Clinical DES funding that was supposed to be part of the 2008/9 pay award materialised so late that it was impossible to implement the service changes necessary to realise the funding. What a tacky way to save money.

Pandemic Flu: A great deal of theoretical stuff throughout last year, then a chance to put the planning into practice during this year. Most of you will have opinions about how this has gone. At worst, we will have had a dry run for the real thing. I can't help feeling that the money spent on Tamiflu could have been better used!

There are a number of other issues that I could bang on about but the one issue that I fear will dominate our thinking in the years to come is suspiciously low profile. Be worried. Be very, very worried:

One of the great privileges accorded to the Chair of an LMC is the overview (s)he has of the huge variety of styles of General Practice. It is a living and breathing collection of organisms that works collectively and individually to provide health services for our patients. Like human beings, no two practices are alike. And yet we somehow manage to produce a consistent and remarkably high level of care. Patients seem to like this variety as it gives them a choice of the style of practice that best suits their needs. GPs instinctively understand this, and have always resisted attempts from above to impose a "one size fits all" approach to Primary Care service provision. It does not suit an increasingly centralising Government, that

wants standardisation of all of its services, to have such a variety of ways of achieving the same end. On the one hand it preaches the mantra of "Patient Choice" and on the other it seeks to deny that choice.

It is astonishing therefore to see, in 2008, the Royal College of General Practitioners come up with their proposals for Federations of Practices, and even more unbelievable to see the GPC add their support to these proposals. In my view, and I must stress that is a personal view, this plays into the hands of the Department of Health and goes against the best interests of our patients.

The underlying theme is that practices will be grouped together under a single umbrella management, clinically led by a "Senior GP". The theory is that practices will continue to function as independent entities, whilst taking advantage of the economies of scale that this model undoubtedly affords. There are other potential benefits that must be acknowledged, the most important of which are peer support and a reduction in duplication of effort. Only a fool will fail to recognise that this is the thin end of a very long wedge. They are calling this a "Hub and Spoke" approach, but in a very short time we will see a "Master and Drone" model with increasing homogeneity of Practice. We will drive out the Mavericks and Innovators who thrive in General Practice, and we will be to all intents and purposes a fully salaried service.

I got up on my hind legs at the recent LMC Conference and urged the GPC to ballot its constituents before formally supporting these initiatives, which to my mind are as fundamentally revolutionary as anything we faced in the New Contract. My proposed amendment was dismissed as being "unhelpful". Unhelpful to the DH perhaps, but not to Primary Care in this country.

I strongly believe that our grassroots has a right to a voice in this debate. Our silence will be taken as assent, and I urge you all to send your views into the LMC offices, so that we can forward them to the centre.

Time to sign off for another year which I expect to be dominated by the effects of the "Credit Crunch". I urge PCTs to spread the pain and not to just go for the soft targets such as Primary Care, Mental Health and Community Care.

I would like to thank Dr John Guy for his unstinting support in his role as Vice Chair. We should all be grateful for the enormous amount of valuable work undertaken on our behalf by Dr Brian Balmer and his team in the LMC office, and I thank them all very sincerely on behalf of all of you.

'It is a living and breathing collection of organisms that works collectively and individually to provide health services for our patients. Like human beings, no two practices are alike'

SOUTH ESSEX LMC CHAIRMAN'S REPORT - DR MIKE SAAD

My Dear Colleagues,

Last year, when I wrote my annual report, I was very optimistic that the Deptartment of Health (DH), Strategic Health Authority (SHA) and Primary Care Trust (PCT), would have had their act together by now, but unfortunately, the onslaught has not stopped; they are determined to change/destroy Primary Care with or without us. The DH, I can understand their motive, privatisation through the `back door', but what I can not understand is that the SHA and PCT do not seem to realise that if primary care is destroyed, their roles would be severely curtailed. This is a very bold statement to make, but please bear with me whilst I try and justify it.

Firstly, let's look at Practice Based Commissioning (PBC). It is four years now that we have been dilly dallying with PBC but DH guidelines have only been cherry picked by the PCT, so that we do not have control. It should really be renamed `PCT based commissioning'. In certain PCTs they are very keen to re-organise the groups into bigger groups, for easier domination and control, they would not listen to reason or logic, even though we have pointed out to them that they have no rights to impose it. In one of our PCTs the only group that has saved any money is a medium size group. If PCTs were any good at commissioning why try to transfer it to practices.

Balanced Score Cards: again the PCT does have the right to ensure that we adhere to our contracts, but to actually produce pages and pages of `mumbo-jumbos' that have no place in our contracts is crazy. The bad news is that they want to inspect us every three months,. It beggers belief that we would actually have any time to see patients. It is ok for PCTs, as every time they have a new target they employ a new Project Manager, we do not have such luxuries. The LMC has written to every practice informing them of what's in their contracts and what's not, and what you should do if you are unhappy.

PMS practices: beware your contracts are being redesigned, and as usual they will probably be altered unilaterally. Please ensure you read, understand, and verify it before you sign it. Also ensure that anything new in it attracts new resources. Do not allow things like Choose and Book to enter the contracts without new resources, it is voluntary. The Growth Money is the stick the PCT have, but it was meant for a specific purpose, and you should insist on it remaining if it supports a specific service.

I hope all those who feel that the Patient Survey was skewed against them have already appealed over PE7 and PE8. In some PCTs, the appeal hearings are about to start. Again, the LMC has produced information on

what you need to produce at the appeal. However, we promise we shall continue to try to work with PCTs to attain a more reasonable approach.

I would like to thank all my colleagues for their continued participation in combating swine flu. The DH believes that the actual battle has not started as yet, so if you have not `buddied up' with another practice, please ensure you do so as soon as possible. Make sure you produce a business case of how you plan to work together.

What does my crystal ball hold for the future?

- Well, the battle between Salaried and Principals is just starting. My advice would be to treat your colleagues as you would expect to be treated, fairly.

- Out of hours (OOHs), I am quietly certain that both the DH and PCTs would like to pass this poisoned chalice back to us. Let's hope our Negotiators don't let us down.

- Pharmacists, becoming more proactive in disease management, over-riding our scripts, our dispensing colleagues being hit in the pocket, etc, etc. We have to ensure that Patient safety is guaranteed.

- Micro-management and increasing numbers of managers seems to be the norm these days. These will be hugely costly to patients, especially in Primary Care, as there is only one NHS pot.

- PDP and Revalidation, nobody really knows what format this is going to take as yet. The LMC and Equip have jointly produced a Handbook for GPs based on the RCGP guidance. Our thanks go to Dr John Guy and Andrew Bradshaw for undertaking the bulk of this work. I suspect, however, the final process will be different.

I would like to take this opportunity to thank my Vice Chair – Dr P.K. Singh, my Chief Executive, Dr Brian Balmer, Andrew Bradshaw, Cathy Pedder, Sarah Bell and Annette Finer for their continued support and dedication. Our LMC would not function without the hard work these people continually put in.

Finally, I would like to thank you all, and wish you the best for the future. Remember, we are the most cost effective arm of the NHS, and our Patients are our greatest asset.

CHIEF EXECUTIVE'S REPORT - DR BRIAN BALMER

Primary Care is about Partnerships and Patients, it is not a Cattle Market.

I am very proud of the work that is done in primary care across Essex by dedicated clinicians, managers and support staff. It is clear that their efforts are appreciated by patients and the public at large, despite some ill-judged assaults from politicians and some sections of the national press.

General practice remains the cornerstone of the NHS and our ability to manage demand within a rapidly changing environment is central to the survival of a tax-based service. It is my belief that the partnership model of general practice delivers such efficiencies better than the alternatives.

Thriving partnerships are innovative, adaptable businesses which can therefore move rapidly to provide the service under a host of often unstable conditions. It is partnerships which have delivered the service under the new "GMS/PMS" contract. The Government, instead of taking some credit for this and praising general practice, decided that GPs had "over-performed" and focused on trying to reduce the investment into the contract.

I believe this was both a political mistake and a fundamental misunderstanding of how best to both stabilise gains in the quality of care given to patients, and to build on such achievements by increasing the quantity and range of services in primary care. In attacking traditional partnerships and flaunting unproven theories about competition and markets, the Government has attempted to undermine general practice and therefore the NHS as a whole.

The very idea that healthcare in the UK can be devalued to the level of market economies is an insult to patients and has no economic or long term political credibility. A tax funded system cannot afford over capacity and therefore in a competitive arena the commissioning of services has to be rigged to encourage new contracts, and no apparent thought is given to the effect on patients of the destabilisation of primary care. The argument that competition, and "choice", always improves services is simplistic and patronising. If you choose to send your children to a different school every month that may be utilising the choice option within the market, but it does nothing for quality and long term benefits.

We should protect and preserve our partnerships and, although there are genuine threats from current DH policies, we should not lose our nerve and imagine that the values of British general practice will be so easily surrendered.

More threatening to the long term survival of general practice is the short term attitude which seeks to employ GPs when the long term needs of patients are a clear practice succession plan and the ability to attract new partners. This is the challenge from within our own ranks and it is this attitude which could do the most damage to our shared futures. The UK is training more doctors than ever before and there is an apparent over-supply of GPs in some areas. This will not last, and if the general practice community fails to offer our new GPs the full range of contractual opportunities, including potential partnership, we will alienate this workforce and create a dangerous situation.

Partnerships depend on intelligent adults working with a common purpose towards agreed goals, but such a model can only succeed within a regulated framework. The Partnership Agreement is the key to resolving unknown or unexpected threats and challenges. Partnerships without an up to date agreement are at risk from both within and without, as a "partnership at will" is an unstable signatory to an NHS contract with a PCT. The LMC office can give advice on a range of experienced lawyers who can assist practices in this area.

If we don't support and preserve traditional general practice, future generations will judge us harshly.

I would like to thank the Committees and the Board of Essex LMCs Limited for their support during the past year. Finally, we would have achieved nothing without the dedication and hard work of Andrew, Cathy, Sarah and Annette. I hope they know how much I depend on and appreciate their efforts and encouragement.

'General practice remains the cornerstone of the NHS and our ability to manage demand within a rapidly changing environment is central to the survival of a tax-based service.'

ESSEX PRACTICE MANAGER CONFERENCE 2009

The LMCs held a second Annual Practice Manager Conference on 10th February at the Ivy Hill Hotel in Margaretting. Despite roads closed due to flooding and consequent terrible traffic problems that morning (including the A12 at Margaretting), 60 Practice Managers (out of 72 delegates) braved the awful conditions and made it to the event. We were also pleased to welcome colleagues from Wessex LMCs, Cambridgeshire LMC and a Practice Manager from Suffolk.

Whilst it was disappointing that the DH Communications Manager for Choice & Long Term Conditions failed to present, Chris Locke, Nottingham LMC CEO picked up the mantle and stepped into the first slot of the day. Chris shared details of the Trent LMCs Buying Group, which Essex LMCs Ltd joined in January 2009. His presentation was informative and was followed by a Q&A session.

We were pleased to welcome Shanee Baker, (BMA Law) to the conference. Shanee gave an informative presentation, focussing on Partnership Agreements and Partnership Splits – acrimonious splits as well as amicable. She covered the many aspects that GMS and PMS practices need to consider and in particular highlighted the need to have a robust and current Partnership Agreement in place, confirming that practices who don't have this are subject to the Partnership Act 1890! The importance of resolving acrimonious splits was emphasised and the consequences of not doing so were highlighted e.g. the PCT could remove the contract from existing parties and put it out to tender.

A lively session followed lunch with Darius Feringo (Law for Business Corporation) who gave an update on Employment Law. There was plenty of interaction and audience participation and Managers were encouraged to ask questions about current Employment Law issues they faced.

The next presentation from Helen Dowling of Exceptional Thinking focussed on Customer Service. Her message was important in terms of sustaining and maintaining general practice for the future and the shift to a patient driven service focus.

The final speaker of the day was Nigel Grinstead of About Health Ltd. Those of you who have attended previous events with Nigel will not be surprised to hear that he was as interesting as ever. He emphasised the significant Provider opportunities and the various options available when setting up a Provider Company. Nigel also talked about opportunities available under "Any Willing Provider" model, which PCTs can use

to commission services without going through the tendering process.

Feedback from the day was extremely positive and, given the terrible journeys that some had endured, the atmosphere was very relaxed. An overwhelming majority of delegates rated the conference on the whole as “Excellent”.

This event is definitely now a firm fixture in the LMCs’ calendar and we look forward to seeing even more of you at next year’s Practice Manager Conference, which is scheduled for 9th February 2010.

Below are a selection of quotes from the Evaluation forms received on the day:

‘Shame about the weather! However, well worth the three hour car journey. Speakers excellent as usual. Good content to conference agenda. Look forward to next conference.’

Practice Manager - Tendring

‘Again a very enjoyable conference, good speakers, well worth listening to. Nice to catch up with PMs from other areas and exchange news, views and Ideas.....’

Practice Manager - Chelmsford

‘First PM Conference. As a new PM I found it informative and enjoyable. Will definitely attend next year.....’

Practice Manager - BBW

LMC SURVEY OF CONSTITUENT PRACTICES

A big thank you to all practices who completed and returned the survey sent out early in 2009. The survey was the first time that the LMCs had sought feedback in this way and the 50% response rate from practices was encouraging.

LMCs are established in statute to represent and protect the interests of all GPs working in the NHS. The two LMCs in Essex are funded entirely by local GPs and it is therefore essential to provide a service that is valued by practices.

The views of practices obtained as part of this exercise were recognised as being crucial in ensuring that the work undertaken by the LMCs on behalf of constituents remains relevant and helpful.

A range of issues were raised by practices. These were summarised in a report which was considered by the two LMCs at their meetings in May. A copy of this report can be downloaded from the LMCs' website at www.essexlmc.org.uk. An Action Plan was agreed by the two Committees, the key parts of which are as follows:-

Communication

The LMC office would continue to use a variety of forms of communication with practices.

- There would be an increased reliance on E-Mail correspondence for urgent issues.
- A link will be sent to all practices each time a significant update is posted on the website.
- Practices will be encouraged to use the website via the quarterly newsletter.
- Minutes of Part One of LMC meetings will be made available on the website.

Programme of Events

It was agreed that the following evening seminars should be arranged:-

- Partnership Agreements/Disputes
  Shanee Baker, BMA Law
- Pensions
  Andrew Dearden, BMA Pensions
- World Class Commissioning
  Gary Belfield, Department of Health

A conference for Practice Managers will be organised for February 2010. A preliminary meeting has already been held between LMC and PCT officers to discuss the possibility of arranging a workshop, followed by a series of master classes, on tendering for contracts.

System of Dedicated Members

The survey indicated a high level of support for the

implementation of a dedicated member system. Members will continue to represent all GPs within their constituency, but under this system will be allocated specific practices for whom they will be the first point of contact.

The intention is this will be done on a geographical basis. The allocation of members will be agreed by the two Committees and details circulated to practices later in the year.

Work with Smaller Practices

A number of potential new areas of work relating to issues effecting smaller practices were identified. It was agreed that future work should be undertaken with representatives of smaller practices to ascertain whether or not to arrange a specific all Essex event.

Practices will recall that all completed surveys were entered into a Prize Draw with the winning practice receiving a case of wine (funded by means of income generation not LMC levy!).

Congratulations go to Dr Naeem & Partners whose name was drawn out of the hat.

In Picture: Dr Naeem, Dr Watts and Dr Brian Balmer

‘LMCs are established in statute to represent and protect the interests of all GPs working in the NHS. The two LMCs in Essex are funded entirely by local GPs and it is therefore essential to provide a service that is valued by practices’

PARTNERSHIP AGREEMENTS/DISPUTES - SHANEE BAKER

PARTNERSHIP AGREEMENTS – FRIEND OR FOE?

Most people who have attended the seminars I have previously given on this topic would certainly say "Friend" when looking at the title of this piece – however, most of the problems encountered in partnership issues are not usually because partners don't have an agreement, but because they have an agreement that is defective. The supposed "Friend" therefore may not be a friend at all.

Back in 2003/04, GP contracts were renegotiated and the implementation of new GMS and PMS resulted in the introduction of new concepts and principles. While GPs assist PCTs in fulfilling their statutory duties under the NHS Act 2006, it never enters their minds that the relationships they have with colleagues can be so fraught with intrigue that understanding the rules sometimes feels like walking through a proverbial minefield.

In advising practitioners to get a partnership agreement, I have in the past received a variety of retorts and I feel that in fairness, I ought to publish them with my responses:-

1. Already got one thanks.

   All well and good, but unless the agreement was post 2003 and aligned with either GMS or PMS Regulations, then it would be hardly worth the paper it was written on. Any partnership agreement MUST operate in conjunction with current GMS or PMS agreements. A pile of yellowed and aging scraps of legal-ease, written pre-2003, stuffed unceremoniously into a drawer and never read, let alone updated, just won't do.

2. This is just some greedy lawyer wanting to make more money out of us.

   Agreements are never cheap as they are ultimately drafted by lawyers who, let's face it, make a living out of complex legislation. However, some of us do from time to time, exhibit some human qualities and two years ago introduced an up to date partnership contract with the potential to have it tailor made to any GMS/PMS practice at a fixed fee of £1500. This fee has not changed in two years and a full time barrister has been employed by the BMA to administer to practices that either want a new agreement, or want an existing one reviewed and updated. This is a good deal. (Contact Neal Hooper, Barrister Tel: 020 7 383 6128)

3. We can't be bothered as we all get on marvellously and never have any disputes.

   No one gets married with the intention of getting a divorce and so it is with all partnerships of whatever nature. You all get on until you don't and its only then that everyone starts scrabbling about either looking for the (now disintegrated) old document they put together years ago or are told, with etched looks of horror on their faces, that they are subject to the Partnership Act 1890.

   The fact is that the Partnership Act 1890 is wholly inadequate for filling in where a practice fails to have a partnership agreement in place. It is a general piece of legislation that basically dictates the rules of any commercial partnership and was never designed with medical partnerships in mind, let alone GMS and PMS. It contains such clauses as dissolution on notice which results in not only all the financial consequences of termination, but also poses a

very real risk of loss of medical contract.

DISPUTES UNDER GMS/PMS

When a dispute escalates into major conflict where neither side feel they can back down, the parties can either resort to the PCT, LMC, BMA OR they can refer to their partnership agreement.

The rule of thumb is never get the PCT involved if you can possibly help it – try extremely hard to resolve the dispute internally. This is where the partnership agreement can help – there are certain issues that you can cater for in the agreement whereby you can clearly state principles of management and behaviour of partners, and apply them well before the matter becomes aggravated.

Example 1 - you can cater for what happens if a partner is suspended in terms of locum payments. Decide whether an application will be made via the SFE or via the Determination of the Secretary of State – clearly the latter is more favourable in some instances, but any financial advantage will be lost if the partners are unclear what they should do and how they should act.

Example 2 - partners are jointly and severally liable to the public for any liabilities incurred by the partnership, but internally individual partners can be made to indemnify the other partners for any losses incurred by breach of agreement or negligence.

Example 3 – cater within the agreement for major business decisions – if your partnership wants to engage in APMS work or take on variations to existing agreements what will you do if one partner disagrees? This could pose a problem if the majority want to make progress.

Example 4 – cater for termination provisions for leaving partners – state clearly and unequivocally what they are entitled to in terms of legal costs or costs of second valuations.

Under GMS, the contract is with the contractor (that is, the group of partners) – if one leaves, it doesn't necessarily cause a problem if there is no dispute, but if there is a non-amicable split in the partnership which is not resolved the duty will ultimately be on the practice to inform the PCT, who will be forced to terminate the entire contract.
The rules are similar for PMS, though the contract is regarded as being with the individuals of the practice rather than the partnership. A falling out which is unresolved may result in a loss of medical contract.

The process of obtaining an up to date agreement isn't difficult, it isn't necessarily costly, but the failure to get one can be devastating upon any partnership. It can be time consuming in answering the questionnaire, which assists the lawyer in drafting tailor made clauses, but most of it is standard – but more to the point it is entirely worth doing.

Remember many partnership issues can also be dealt with by your LMC.

Shanee Baker
Senior Legal Counsel General Practitioner's Committee
Barrister, LLB(Hons), LLM

PRIORITIES 2009/2010

Medical Revalidation

Explore with EQUIP the possibility of jointly producing a Handbook for GPs on Medical Revalidation. Ensure any Handbook acts as a useful point of reference and contains a list of suggested preparatory actions for GPs.

Succession Planning

Work with PCTs in South Essex on succession planning issues affecting small practices. Discuss in more detail with PCTs the possibility of incentivising practices to put in place formal succession planning arrangements.

Forum for Doctors

Undertake discussions with Medical Directors of local hospital trusts with a view to establishing a forum for doctors. The forum would provide an opportunity for doctors working in primary and secondary care to share ideas, discuss concerns and identify future areas for joint working.

Seminars for Practices

Arrange a series of seminars on areas highlighted in the survey of constituent practices. Areas identified by practices as a priority include Partnership Agreements, Pensions and World Class Commissioning.

Essex LMCs Ltd Buying Group

Consolidate the LMCs' involvement as part of the national LMC Buying Group Federation. Continue to make available information on the increasing range of deals that have been negotiated to enable practices to benefit from discounted goods and services.

LMC Conference

Arrange a conference for all Essex GPs in early 2010. The aim of the conference will be to update GPs on current contractual negotiations and any other important issues likely to affect general practice.

System of Dedicated Members

Introduce a “Dedicated Member” system for practices. Under this scheme LMC representatives will be allocated a number of practices for whom they will act as a first point of contact for advice, etc.

PMS Practices

Continue to promote the interests of all PMS practices. Provide detailed advice for practices in preparation for formal reviews of PMS contracts by PCTs. Ensure LMC involvement in establishing principles that will underpin local review processes.

LMC Membership

Continue to promote the role and benefits of LMC membership. Produce a Handbook for LMC members. Undertake an advertising/recruitment campaign in advance of the constituency elections to be held in March 2010.

Sessional/Salaried GPs

Review LMCs' role as the representative body of sessional/salaried GPs. Explore ways of improving links/communication with sessional/salaried GPs. Continue to promote the services offered by the LMCs together with the benefits and opportunities of LMC representation.

ESSEX LMCs LTD BUYING GROUP

Under the umbrella of the LMC Buying Group Federation, Essex LMCs Ltd Buying Group was introduced to practices in November 2008 with details of the Buying Group flu vaccine offers for 2009/10.

The group was set up with the assistance of colleagues in the Trent LMCs' Buying Group, established in Nottinghamshire in 1998, which successfully negotiated discounts on flu and travel vaccines for many years, and from early 2000 on stationery and consumables. In 2006, the Trent LMCs Buying Group began working with procurement experts, Burns Associates, undertaking more detailed research and monitoring of deals negotiated. Since 2008 membership has expanded and now comprises practices in 11 LMCs across the country.

The sole purpose of the buying group is to save practices money by negotiating discounts on goods and services which practices regularly use. There is no obligation on practices to take up any of the negotiated deals although the more business they obtain the keener will be their desire to keep the business and the better the prices they offer us in the future.

The discounted goods and services that have been available to practices this year include:

- Flu Vaccines
- Medical Consumables
- Office Stationery and furniture
- Medical equipment calibration and testing and electrical PAT testing
- Insurance products
- Gas, electricity and telephone discount negotiation
- Car Purchase and leasing.

In July the Federation's website www.lmcbuyinggroups.co.uk was launched and practices can access information about the increasing range of deals on which we have been able to secure discounts on goods and services practices regularly buy. All practices were provided with a user name and password to access the site.

The LMC hopes this additional service has been of value to practices so far and our thanks go to Chris Locke, Chief Negotiator, Trent LMCs Buying Group for his support and hard work in being able to offer this additional service to Essex practices.

'The sole purpose of the buying group is to save practices money by negotiating discounts on goods and services which practices regularly use'

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SALARIED & SESSIONAL GP REPRESENTATIVES

Three Vacancies

REPRESENTATIVE OF GP REGISTRARS

Vacancy

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REPRESENTATIVE OF GP REGISTRARS

Vacancy

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ACCOUNTS - 2008/2009

2007/08		2008/09	2007/08		2008/09
£		£	£		£
528,194.79	Statutory Levy	474,196.94	368,461.08	Salaries/NI/Pensions/Car Ins	384,094.88
14,829.71	Bank Interest	12,000.37	25,611.60	Rent/Rates/Service Charge	25,819.33
37,264.00	Levy PCT employed doctors	22,165.00	6,284.88	Telephone/Mobile Phones	2,627.43
163.18	Ballot Fees	0.00	4,322.50	Postage	2,969.84
0.00	Lecture Receipts	190.00	10,308.62	Photocopier/Stationery/Printing	8,422.39
26,174.20	Pharmaceutical Sponsorship	20,035.00	15,114.70	Office Equipment & Maintenance	4,679.93
400.00	Inland Revenue Incentive	100.00	902.63	Office /Fire Insurances	924.41
			108.18	Bank Charges	0.00
			2,334.57	Information Technology	2,933.09
			2532.33	Accountancy Fees	2,190.30
			2439.03	Legal and Professional Fees	0.00
			637.33	Subscriptions	639.00
			1,837.89	Premises Expenses	2,093.45
			1,144.30	Vehicle insurances	0.00
			18,283.18	Sponsored events	17,103.84
			1,895.55	Training costs	3,048.12
			1,183.95	Meeting Expenses	1,789.26
			9,335.52	Travelling Expenses	8,908.26
			5,448.38	Conference Expenses	3,625.65
			14,498.00	Chairmen's Honoraria/Expenses	14,854.00
			27,320.00	Members' Payments	27,072.50
			1,014.60	Corporation Tax	2,963.00
		528,687.31	521,018.82		516,758.68
	Receipts from LMC			Payments to LMC Ltd	
	Excess of payments over receipts	3,848.97	86,007.06	Excess of receipts over payments	15,777.60
607,025.88		**532,536.28**	**607,025.88**		**532,536.28**

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