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The current health service reforms, enshrined in the Health and Social Care Act, promise a new way to commission health services by allowing groups of GPs to work with patients and other clinicians in shaping future health care provision for their community. The rhetoric which brought in the reforms was for “like minded” GPs to set up these GP, now Clinical, Commissioning Groups (CCGs) and take control of health spending.

CCGs do not start until April 2013, but many believe that this ideal has already been overtaken by the need for NHS senior management to retain control. It is almost as if they looked at a brand new future with GPs having real power and promptly applied the brakes in order to return control to the establishment within the NHS. This will now be named the NHS Commissioning Board (NHSCB).

Many LMCs have been closely engaged with CCG constitutions and in advising member practices on issues arising from the establishment of these organisations. This is important as the future is far from clear, and if GPs find themselves within CCGs which fail to respect the interests of practices and patients they will require the ability to work with colleagues to protect themselves. We don’t yet know just how strict CCGs, and their Commissioning Board masters, will be in requiring GPs to adhere to their constitutions.

One particular issue has been the selection or election of GPs to the Boards of CCGs. I have never seen so much collective stress and anxiety as has occurred during this process, and it has produced some rather unprofessional infighting and argument among colleagues. We need to be clear on the function of the CCG. It is to commission health care for the community and it is not to represent any particular faction within the NHS, not even GPs. That is the job of the LMC and to mix up the functions will be to invite disaster on all fronts. We have already seen minor forms of confusion where PCTs or others have spoken to CCGs and assumed that this counted as consultation with GPs. This is not the case, and GPs on the new Boards will be failing their patients if they get this wrong.

We will need LMCs to support CCG Board colleagues against top down pressure, but also to challenge them when we feel practices are being disregarded or bullied. We are also about to enter a new world of rationing where practice against practice, or locality against locality, disputes are common. This is where the LMC can act as the independent voice of the profession and facilitate understanding. We live in hope.

I sincerely hope the new NHS works because I am fond of the old girl and will depend on her in my dotage. It will not be easy, but it has a chance if we can communicate clearly with one another, respect one another’s differing roles, and keep patient care at the centre of our aims.

Dr Brian Balmer
SESSIONAL GPs

Just over two years ago we were part-time salaried GPs in different parts of Essex and independently of one another decided to stand as Representatives of Salaried and Sessional GPs on the North and South Essex LMC. Neither of us knew a great deal about our LMC but having completed our GP training around the time of the introduction of the New Contract we had considerable experience of working as salaried doctors in various practices and meeting many other sessional colleagues like ourselves. Kamilla had also worked regularly for the local OOH service and was spurred on by her involvement in sessional GP peer support groups. Lisa was switching to a practice in a different locality and was keen to explore a new opportunity. Neither of us imagined that one year after being elected onto the LMC we would take up the roles of Vice-chairmen. But a doctor’s training is full of steep learning curves, especially in general practice. With the nurturing and encouragement of our respective Chairmen, Dr John Guy and Dr Beverley Davies, as well as considerable support from the North and South Essex CEO Brian Balmer we were willing to rise to the challenge. Over 100 years ago LMCs were given statutory recognition as the representative voice of local doctors and it is vital that LMCs represent all their constituents including the growing number of sessional doctors at this time of radical NHS reform. However, many sessional doctors remain unaware of the work of their LMC and of important decisions that are being taken in their region. Professional isolation is widely recognised as a significant problem for many sessional doctors. Where a partner regularly attends practice meetings and has the support of his or her practice manager and fellow partners, a locum or part-time salaried doctor has no such network. Sadly, there are still some GP principals who espouse the view that a sessional doctor’s role is purely to see patients and that their opinions on other matters are unimportant. From studying the appraisal database in Essex we have ascertained that over 400 GPs work as sessional doctors, which amounts to one third of the work force. At the recent National LMC Conference in Liverpool we learned that in some areas of London 50% of GPs are sessional. It is not just churlish to exclude such a significant and growing part of the workforce but damaging and wasteful to the profession as a whole. At this time of unprecedented change to the NHS and threat to the very survival of general practice, its local delivery and practice management that many sessional doctors do not get exposed to. We both have a much better understanding about our profession as a whole and seek to stand up for sessional colleagues as well our principal colleagues who we also represent in our Vice-chair roles. Lisa has gone onto to become more involved in commissioning and last year was appointed as Chair to the Mid Essex Clinical Commissioning Group, a role she would not have contemplated had she not taken that first step to finding out about her LMC. Alongside Kate Baruva who is Sessional GP representative on the GPC for the Eastern Region, Kamilla helped to lead last year’s Essex Sessional GP Conference which was a successful collaborative project with the North and South Essex LMCs and Anglia Ruskin University. This has proved to be a catalyst for sessional GP networking and an opportunity to raise the profile of sessional GPs and promote peer support groups across the region. Kamilla is now reviewing feedback from the second conference and taken on a new role as Sessional GP Lead and Clinical Advisor to EQUIP (Education and Quality in Primary Care), an educational organisation responsible for organising appraisal for all GPs in Essex, undertaking audits and supporting and providing education and training for all members of the primary care team.

We had little idea about the repercussions of putting our names down on the LMC nomination papers in 2010 nor did we anticipate finding such supportive and friendly networks. As we live and work in different areas of Essex it is unlikely that our paths would have crossed had we not joined the LMC; in fact we only met for the first time a year ago as newly appointed Vice-chairs at the LMC Board meeting. Being part-time female salaried doctors each with three small children of similar ages we have a lot of common ground and have been a great source of mutual support. It has been reassuring to share some of the trepidation and concerns we initially felt on joining the LMC and our confidence has grown as a result. We would encourage any sessional doctor who is contemplating standing for a position on his or her LMC to take the plunge.

Dr Kamilla Porter
Dr Lisa Harrod-Rothwell
This article is written from the perspective of the Chair of the Essex Revalidation Steering Group. It draws heavily on the GMC document Good Medical Practice Framework for Appraisal and Revalidation.

We have been fortunate in Essex to have an effective system of GP appraisal which has been running for 9 years. It is important to continue to have an annual appraisal as revalidation will mostly rely on this process.

The LMC has had a major impact in establishing and maintaining an Essex wide approach and its support in this time of transition is very much appreciated. One of the major contributions has been to encourage the whole Essex economy to fund a subscription to the Clarity Appraisal toolkit which is free to all doctors on Essex medical lists at least until March 2015.

I am indebted to my colleagues in EQUIP Sarah Powell and Emily Brown without whom the process in Essex would not have worked. There are many resources to support doctors in Essex on the EQUIP website http://www.essexequip.nhs.uk/content.asp?page_id=110

After a very long gestation Revalidation began, initially for responsible officers, in December 2012. The national plan is for 20% of senior members of the profession to undergo revalidation during 2013/14 and in Essex these doctors have already been notified. In the subsequent 2 years 2014/15 and 2015/16 the great majority of the remaining GPs will be revalidated. EQUIP will be contacting all GPs in Essex over the next few weeks with more information on timing. Once the responsible officer (RO) has determined that the doctor is fit to practise, he or she will make a recommendation for revalidation to the GMC. When this has been approved the doctor will be revalidated for 5 years.

The important message is that this is a very do-able process. We want all doctors who wish to be revalidated to succeed. We all want to be cared for by doctors who remain up to date and concerned to deliver a quality caring service for their patients. You need to be demonstrating this in whatever area you are practising through the evidence you present at your annual appraisal.

The Essex scheme is designed to assist in this process and we would strongly encourage you to work openly and honestly with your appraiser to achieve this end. By doing this it should be possible to identify any gaps in the evidence which can be filled in a timely fashion. The RO will have access to concerns raised through clinical governance / complaints to the PCT. It is important that if any concerns have been raised that you take the opportunity to discuss these at your appraisal and decide on a course of action where appropriate. Insight is a key requirement as far as the GMC is concerned and ‘brushing things under the carpet’ is an unwise strategy.

All appraisals in Essex after 13 December 2012 should be ‘revalidation ready’. This means that six key areas should have been covered:

**Continuing Professional Development**

All the Royal Colleges recommend 50 credits each year or a total of 250 over the 5 year period. The main themes here are to develop a satisfactory system for recording your CPD although this is not a competition to get the greatest number. Much more important is recorded reflection on how the education / learning will influence your practice. You do not need to provide this for all the activity but there should be at least two good examples every year.

**Quality Improvement Activity**

This will most commonly be covered by a full cycle audit i.e. with 2 sets of data collected, but audit is not compulsory. There are components of our work which most of us do – keeping adequate notes, prescribing, writing referral letters, reviewing the outcome of referrals etc which could form the basis of this component.
REVALIDATION - A CHAIRMAN’S VIEW

Significant Events

The expectation is that every doctor will be able to report at least 2 significant events a year over the five year period – these should involve the doctor and be discussed at a meeting for which notes are kept.

Patient Feedback

There is a facility to use the Clarity toolkit either electronically or via paper questionnaires – a minimum of 34 questionnaires is sought. There are other questionnaires but they should relate to patients seen by the individual doctor and not to a whole practice questionnaire.

Colleague Feedback

The Clarity toolkit has an easy to use section – feedback is reported in a non-attributable way once 15 colleagues have responded.

Review of Complaints and Compliments

Both aspects are important – we are all human and will get things wrong – the important thing is to acknowledge the problem and seek ways to prevent recurrence. The annual appraisal is an ideal time to get independent feedback. You should also produce the summary of your last appraisal and have information about your last PDP.

The GMC requirements are straightforward. We should be reflecting on our professional practice and approach and show we are up to date. We should reflect on supporting information we submit to appraisal and whether this covers all the areas above and fairly represents our work. We should all continue to identify areas where we could improve / develop – none of us is perfect and complacency that we have no need to do this suggests it may be time to retire.

The GMC document highlights the 4 domains which form the framework and in the bullet points I have identified some key points on the basis of my recent experience.

Knowledge Skills and Performance

- Maintain performance
- Keep knowledge and skills about your current work up to date
- Take part in and respond constructively to outcome of quality improvement activities
- Prescribe drugs or treatment including repeat prescriptions safely and effectively
- Make and/or review records at the same time as the event or as soon as possible afterwards

Safety and Quality

- Contribute to and comply with systems to protect patient safety
- Co-operate with legitimate requests for information from those responsible for monitoring the public health
- Report adverse drug reactions
- Respond to risks to safety
- Safeguarding vulnerable patients
- Take action where a colleague’s conduct, performance or health may be putting patients at risk

- Protect patients and colleagues from any risk posed by your own health and seek independent medical advice

Communication Partnership and Teamwork

- Communicate effectively
- Work constructively with colleagues
- Establish and maintain partnerships with patients

Maintaining Trust

- Show respect for patients
- Treat patients and colleagues fairly and without discrimination
- Act with honesty and integrity

These are self-explanatory but in recent practice visits I have encountered significant gaps. I am happy to try to help if any of this needs clarification.

John Guy
December 2012
Dear Colleagues,

I am writing to you at a time of significant changes both within the NHS with the imminent Clinical Commissioning Groups (CCGs), and within our profession with the start of Revalidation. We have all seen and survived many re-organisations of the NHS over the years, but never before has any re-organisation depended so much on the skills, enthusiasm and goodwill of our profession as does the change to CCGs. Yet at the same time, the Health Minister has chosen to withdraw from longstanding negotiations with our GPC negotiators over changes to our Contract and instead seek to IMPOSE unilateral Contract changes on us, with the threat of significant loss of income and/or resources developed over the years to improve and enhance patient-care. Then there’s the on-going threat to our pensions.

The establishment of CCGs fundamentally differs from previous GP commissioning initiatives. All GPs and their practices have to be signed-up to what is effectively a corporate agenda, and one in which an element of each practice’s resources may in future be linked to the overall performance of their CCG. It is essential that all individual member-practices ensure that their CCG commissioning decisions adequately reflect their patients’ needs and their own referral practices and intentions.

North and South Essex LMCs have been very active on behalf of our constituent GPs throughout 2011-2012 in many matters but especially issues regarding the development of the Essex CCGs. Chief Executive Dr Brian Balmer, Deputy Chief Executive Andrew Bradshaw, and Cathy Pedder have worked tirelessly representing the best interests of the GPs of Essex, ably supported by the skills of Annette and Sarah in the LMC office at Hatfield Peverel. The LMC office has produced a number of excellent documents on the development of CCGs, and I commend to you the excellent “Clinical Commissioning Survival Guide” – a survival guide for GPs and their practices on the establishment of CCGs in Essex, published in May 2012. Further information on this and other LMC documents regarding the establishment of CCGs in Essex is available from the LMC Office.

I thoroughly recommend the LMC newsletter, produced and circulated to all GP practices, and the LMC website, containing much useful information. Please encourage your colleagues to read the Newsletter and to contact the office or their local LMC representative if they have any issues they want brought to our attention.

It was in this way that South Essex LMC has been able to pursue with the local hospitals the recurrent problem of failure to provide 28 day prescriptions and also difficulties regarding hospital discharge letters requesting GPs to follow-up results of investigations that they should not be expected to interpret to patients, and the risk of important results or requests “slipping through the net”.

South Essex LMC is fortunate in having several sessional GPs among both its elected and co-opted members and our Deputy Chairman, Dr Kamilla Porter, once again organised an excellent Essex Sessional GP Conference in October this year and was commended for her organisational abilities by the combined North & South Essex LMCs. Hopefully, Kamilla can be prevailed upon to organise another Sessional GP Conference next year. Please look out for details on the LMC website or in the Newsletter!

Kind Regards,

Beverley Davies
Chairman of South Essex LMC
### RECEIPTS & PAYMENTS FOR THE YEAR ENDED 31st MARCH 2012

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<th>Category</th>
<th>2010/11</th>
<th>2011/12</th>
<th>% Change</th>
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<td>Bank Interest</td>
<td>£527.74</td>
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<td>Ballot Fees</td>
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<td>Lecture Receipts</td>
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<td>£8,220.15</td>
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<tr>
<td>Pharmaceutical Sponsorship</td>
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<tr>
<td>Insurance Claims</td>
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<td>£1,899.96</td>
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<td>Insurance Claims</td>
<td>£1,899.96</td>
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**Total Receipts:** £684,940.67

**Total Payments:** £630,085.11

**Excess of receipts over payments:** £74,855.56
## LIST OF MEMBERS 2012-13 - NORTH

**CHELMSFORD**
- Dr C Dann
- Dr J Guy - Chairman
- Dr E Wood

**COLCHESTER**
- Dr HM Chowhan
- Dr M Hargreaves
- Dr H James
- Dr R Wright

**EPPING FOREST**
- Dr D Dabas
- Dr P Kandasamy
- Dr H Taylor - Vice - Chairman

**HARLOW**
- Dr A Ipakchi
- Dr C Panikht

**MALDON**
- Dr J Hodgkinson
- Dr P McAllister

**TENDRING**
- Dr J Guille
- Dr B Mediavilla-Gomez
- Dr N Roper
- Dr G Sweeney

**UTTLESFORD**
- Dr S Basra
- Dr S Machale

**WITHAM**
- Dr R Grew
- Dr R Melamed
- Dr D Oliver
- Dr D Wijekoon

**BRAINTREE & HALSTEAD**
- Dr L Harrod-Rothwell (Mid Essex)
- Dr J Wier (North East Essex)

**SALARIED/SESSIONAL**
- Dr L Harrod-Rothwell (Mid Essex)
- Dr J Wier (North East Essex)

**OMP**
- Dr V Rao

**CO-OPTED**
- Col N Strowbridge
- Dr V Verma

## LIST OF MEMBERS 2012-13 - SOUTH

**BASILDON**
- Dr V Sharma
- Dr D Singh
- Dr D Staunton

**BILLERICAY BRENTWOOD & WICKFORD**
- Dr T Aung
- Dr MJ Hunt

**SALARIED/SESSIONAL**
- Dr J Brown (South West Essex)
- Dr K Porter (South East Essex) - Vice Chairman

**CASTLE POINT & ROCHFORD**
- Dr G Kittle
- Dr D Nanda
- Dr MA Saad
- Dr DS Taylor
- Dr K Waiwaiku

**SOUTHEND**
- Dr K Chaturvedi
- Dr P Chisnell
- Dr B Davies - Chairman
- Dr N Kumar
- Dr H Siddique

**THURROCK**
- Dr A Deshpande
- Dr PJ Patel
- Dr R Raja

**OMP**
- Dr V Rao

**CO-OPTED**
- Dr K Barusya
- Dr T McCarthy
PRIORITIES 2012/13

Model CCG Constitution
In conjunction with BMA Law produce a model CCG Constitution for use by practices and CCGs in Essex. Its primary aim will be to ensure that the new commissioning arrangements are designed in a way that properly engages practices and facilitates two-way accountability between member practices and the CCG.

Clinical Commissioning Survival Guide
Publication of a Survival Guide which will act as a source of advice to help GPs safely navigate what will be a much more complex operating environment. The Guide will aim to build on existing national guidance together with the local safeguards developed by the LMCs in Essex.

Sessional/Salaried GPs
Review the 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 of LMC representation.

Relationship with Practices
Ensure that the LMCs remain fit for purpose in representing the interests of GPs on all relevant issues. Obtain feedback from practices on the effectiveness of the LMCs and their future role. Investigate the possibility of agreeing priorities and a future work programme with practices.

Liaison Meetings with CCGs
Establish a programme of clinical meetings between representatives of CCGs and the LMCs. These meetings will provide an opportunity for clinicians to discuss concerns, share ideas and explore any future areas for co-operation and/or joint working.

Information for Practices
Continue to provide practices with timely, relevant information on all matters relating to future changes to GMS and PMS contractual arrangements. Update the LMCs’ Website and Management Information System. Produce regular Newsletters and briefings for practices on current issues of interest.

Dispute Resolution in CCGs
Support informal resolution as a means of developing and sustaining a partnership approach between practices and between practices and CCGs. Ensure that arrangements are in place to enable the LMCs to act as an honest broker as envisaged in the CCGs’ Dispute Resolution Procedures.

New Medication/Investigations – Template for Practices
Produce a number of template letters for use by constituent practices on occasions when they receive medication or follow-up requests that, in their opinion, are the responsibility of secondary care.