BIRMINGHAM LOCAL MEDICAL COMMITTEE

ANNUAL REPORT 2016

67TH ANNUAL REPORT

This is the second report of the 21st Committee of Birmingham LMC since the introduction of the NHS in 1948. 2016 has seen yet further massive change and unprecedented challenges for Birmingham GPs and their practices. During the year the LMCs' constituents sought our advice and support more than ever before, reflecting the huge and diverse problems now facing general practice and the wider NHS.

WORSENING GP CRISIS

The ongoing crisis of GP workload, workforce and funding continued to worsen and reached catastrophic proportions during the year. The LMC dealt with an escalating workload, supporting and advising practices and partnerships, many of which were struggling to deal with various consequences of the inexorably worsening situation. A number of Birmingham practices closed during the year; increasing numbers of others recognised the urgent need to merge or to join of the of city's super partnership organisations or federations in order to help safeguard their viability.

None of the funding promised by NHS England in 2015 as part of its vulnerable practice programme managed to reach any practices during the year, despite the LMC's best endeavours to assist NHS England and the CCGs in this process. A number of other funding streams were promised by NHS England in 2016 as part of its GP Forward View (GPFV) plan to support general practice. Whilst the commitment to this additional investment was most welcome the LMC repeatedly made clear that these various, limited pots of additional non-current funding were not solutions to the severe problems facing general practice, which could only be resolved by massive recurrent increases in core practice funding to enable the necessary increases in GP numbers, practice staffing and capacity.

The GPFV funding streams included that for the resilient practice programme where again the LMC, whilst recognising and making clear that what was available would go nowhere near to resolving the many dire problems facing general practice, engaged with NHS England and the CCGs in order to ensure that those practices in greatest need of urgent support were identified.

As in previous years, it became abundantly clear that the focus of the government and NHS England was not on supporting the safe delivery of general practice during core hours, but of increasing the availability of routine appointments at other times, as well as continuing the massive shift of inadequately funded work out of hospitals and into the community. The LMC was tireless in pointing out to commissioners that such policies were wholly inappropriate and would not resolve the broader issues caused by NHS underfunding and a decade of destructive policies.

CCGs AND CO-COMMISSIONING

As noted above, the LMC worked closely with the three Birmingham CCGs during the year, in order to help ensure that support for practices through the GPFV and other initiatives was maximised and used appropriately. As in the previous year, the LMC maintained good and close working relationships with the three CCGs through attendance at their Primary Care Co-Commissioning Committees and also with regular liaison meetings between the LMC and the CCGs. This ensured that there was early discussion and consultation with the LMC over many policies and initiatives affecting general practice. In particular we were able to input positively into the new policies for the commissioning of procedures of limited clinical value (PLCV) and the new non-urgent patient transport policy. This ensured that the revised policies properly

recognised the perspective of general practice, did not inappropriately add to its workload burden, and, with respect to the PLCV policy, recognised the right of GPs always to be able to refer for a specialist assessment and/or opinion.

Unsurprisingly, and true to form in light of the experience of the last few years, the year brought news of yet another massive upheaval for the commissioning of GP services, with the announcement that Birmingham Cross City and Birmingham South Central CCGs would enter into a "functional merger" with Solihull CCG, to form a single joint commissioning board with a view to a formal merger of the CCGs in 2018.

This news inevitably brought further complications to the landscape of commissioning of general practice in the city, with practices in West Birmingham continuing to have their contracts held by Sandwell and West Birmingham CCG, but with the practices in the rest of Birmingham now set to share a commissioning organisation with Solihull. A "Joint Commissioning Board " was put in place at the end of the year, and the LMC met with its interim chair in order to develop relations and gain clarity over the way that general practice would be commissioned in Birmingham going forward. It was anticipated that an Accountable Officer for these new arrangements would be appointed early in 2017, together with the putting in place of a" Primary Care Co-Commissioning Committee in Common" for the three CCGs. It remained to be seen what benefits, if any, the new commissioning arrangements would bring about for general practice in Birmingham.

SUSTAINABLITY AND TRANSFORMATION PLANS

The main plank of NHS England's national response to the calamitous funding crisis in the NHS and the implementation of its Five Year Forward View was to order every health economy to develop "sustainability and transformation plans" (STPs). The aim of STPs was to produce far-reaching agreement between all local health providers, commissioners and local authorities on the way forward in order to bridge the enormous projected funding gaps and ensure ongoing safe delivery of services. The formation of STPs in Birmingham took place in the context of a massive local authority deficit and service cuts, the fragmentation of commissioning as detailed above, with West Birmingham being in a different CCG to the new merged Birmingham and Solihull commissioning footprint, and also the news of the planned merger of University Hospital Birmingham and Heart of England Foundation Trust. As a result Birmingham was split across two STPs with the Sandwell and West Birmingham CCG practices being in the Black Country STP whilst the Cross City and South Central practices were in the STP footprint covering the new merged Birmingham and Solihull commissioning body. It was stated however that West Birmingham practices would be "associate members" of the Birmingham and Solihull STP.

It soon became clear that STP plans for the transformation of services were being progressed at great pace with, disgracefully, absolutely no engagement with GP providers or their representatives. In order to help rectify this an alliance of the large GP provider groups in the city (super partnerships and federations) was formed in order to help ensure a unified voice for practices across the city to engage and influence the STP process. The LMC was also strongly represented in the GP provider alliance, along with representation on behalf of those practices not formally aligned to a larger grouping.

The GP provider alliance was eventually successful in gaining representation on the various boards and committees created as part of the STP process, and in particular the LMC was represented on the key community care and general practice work streams. However, whilst this representation was most welcome it was quite clear that the principle direction of travel of the Birmingham and Solihull STP was already well-established prior to any opportunity to be significantly influenced by the LMC or GP providers.

In a nutshell the STP's objective was to plug an estimated £700 million pound funding gap which would arise by 2020/21. This would necessitate a decision not to provide over 400 additional hospital beds which it was believed would otherwise be needed and, needless to say, involved shifting massive amounts of work out of hospital and into the community and general practice.

The intention was to radically transform general practice through working at scale, delivered by a number of hubs servicing geographical populations, rather than being delivered based on practices' registered lists. As noted above, these aspirations were well-advanced prior to any engagement with GP providers, but with little idea within the STP as to how these changes could actually be delivered.

The LMC robustly and repeatedly made it clear that the entire STP agenda was completely undeliverable without the required massive additional resources to ensure, first and foremost, general practice sustainability. Only then could the type of transformation being suggested be properly considered, and of course, only with the full consent and co-operation of general practice. How the STP ambitions will pan out remain to be seen but, at the end of the year, there was precious little evidence to suggest that the required funding would be forthcoming.

MULTI DISCIPLINARY COMMUNITY PARTNERSHIPS

Alongside the STP agenda, NHS England also produced frameworks for its new models for providing integrated care at scale, namely Multi-Specialty Community Partnerships (MCPs) and Primary and Acute Care Systems (PACs). Towards the end of December it then published draft contractual documentation for MCPs. The intention was for general practice to work with community and other organisations to provide extended and integrated general practice and community services potentially also including elements of social care, mental health services and public health. Whilst participation in a MCP would be voluntary for practices, it was quite clear that, due to the appalling crisis affecting the profession, many GPs and practices might be enticed into entering these arrangements if they were seen to offer the only potential solutions to their huge funding, workload and workforce challenges.

The contractual documentation indicated that GP practices could form MCP organisations at three levels, virtual, partially integrated and fully integrated. Joining a fully integrated MCP would require the practice to "suspend" its GMS or PMS contract and, whilst it was suggested that this might be "reactivated" should the practice choose to leave the MCP at a later date, the patients would remain registered with the MCP and would have to actively choose to re-register with the original practice, something which could not be guaranteed. It was evident therefore that any practice choosing to leave its core GMS or PMS contract in order to participate in a fully-integrated MCP was, in effect, permanently forfeiting its existing practice. The LMC issued robust advice to practices about the dangers of going down this path and that they should not in any circumstances be tempted relinquish their core contracts.

Participation in the virtual and partially integrated levels of MCP also entailed currently unquantifiable risks and implications for practices, as these would require them to sign alliance or integration agreements placing burdens on them as providers which were considerably over and above current contractual obligations. Above all it was clear that being part of an MCP at any level would, for the first time, impose responsibility and accountability for staying within wholly inadequate budgets onto GPs and practices as providers rather than holding only indirect responsibility as commissioners. This represented an absolutely fundamental change in the work of and responsibilities of GPs. With so many questions still to be answered the LMC issued whatever guidance it could to practices and also requested further national guidance from the GPC, including legal opinion on the implications of MCP membership. This was still awaited as the year came to a close.

PRIMARY CARE SUPPORT SERVICES PRIVATISATION

The LMC noted in its 2015 annual report the catalogue of problems that had been caused by the cuts to and reorganisation of primary care support services. We also suggested that problems were likely to get even worse in 2016 following the news that the service was to be completely privatised and that NHS England had awarded Capita the national contract to provide primary care support.

Dire as the LMC's warnings had been, the full extent of the problems caused by Capita's wholly incompetent handling of primary care support services was beyond even our worst nightmare. Practices spent the entire year having to deal with the fall out of the many problems caused across the entire breadth of primary care support functions including the delivery of medical records, patient registration and removals (including, crucially, incompetent processes for violent patient removals which put the public at risk), payments, the delivery of vital supplies including prescription stationery, needles and syringes, performers list management, pension contributions and just about every element of primary care support function. To compound matters, Capita's communication with practices was truly appalling, with phone calls and emails invariably unanswered and absent responses to both queries and complaints.

This complete and utter shambles of a primary care support service proved to be one of the major areas of LMC work throughout the year. As well as doing our best to deal with specific practice problems as they arose and were notified to us, the LMC was proactive in requesting that practices report all problems which were then directly taken up by the LMC not just locally but with escalation of all issues to the highest level nationally at Capita, NHS England and the GPC. A number of meetings took place between the LMC and key Capita and NHS England personnel.

Much of the work supporting practices dealing with these primary care support issues was shouldered by Wendy Loveridge, the LMC's new Practice Support and Liaison Manager and we are extremely grateful for her sterling efforts on behalf of our constituents. Whilst the LMC was, to some extent, successful in resolving a number of specific practice issues with primary care support services, it was clear throughout the year that there was no improvement in Capita's performance and it remained an organisation completely incapable of delivering on its multi-million pound contract. The LMC made it clear that NHS England bore ultimate responsibility and accountability both for awarding Capita this massive contract and then for failing to properly hold it to account and ensure that vital primary care support services were properly delivered. It remained to be seen whether the New Year would bring any improvement to this appalling mess.

CARE QUALITY COMMISSION

It was no surprise that continuing to help and support practices with issues related to CQC remained a considerable focus of LMC activity during the year. CQC's programme of practice inspections and its wholly unfit for purpose system of quality ratings continued and the majority of Birmingham's practices had been inspected and received an official rating by the year's end.

The LMC provided considerable advice and support to GPs and practices both before and after their inspections. This work included help with registration issues, providing much guidance to practices once they had received their draft QCQ reports, assistance with completing factual accuracy returns and providing evidence to submit with these, advice on formal challenges to ratings and help with putting in formal complaints about CQC's inspection teams' attitudes and actions, with a number of practices reporting that, disgracefully, GPs and practice staff had been reduced to tears by members of inspection teams.

It was inevitable, bearing in mind the context of the difficult circumstances and lack of funding they were operating under, as well as the complete unfitness for purpose of CQC's regulation of general practice, that a number of Birmingham practices received requires improvement or inadequate ratings during the year. These practices received more intensive guidance and support from the LMC, in conjunction with their CCGs and with the Royal College of General Practitioners support programme. It was hardly surprising that as a result of some of this activity wider issues related to practice vulnerability, sustainability and viability came to light and there was no doubt that CQC's practice ratings were more a symptom of the challenging circumstances, lack of investment and many other difficulties facing practices rather than indicating that poor quality care was the fundamental underlying issue.

As a result of this the LMC spent a considerable amount of time helping these practices to consider the issues of their practice sustainability and longer-term strategic direction in addition to dealing with the immediate crises related to their CQC ratings.

As if the problems caused by CQC for practices were not bad enough, the unsurprising outcome of CQC's sham "consultation" on massive rises in practice registration fees predictably ignored the many concerns raised and CQC instigated a massive rise in practice fees in April 2016. Furthermore the consultation outcome was that the totality of the huge proposed CQC fee rise would be phased in over just two rather than four years, with the expectation therefore that another massive rise would take place in April 2017. Sure enough, at the end of the year, CQC launched another sham consultation on the proposal to raise practice fees by a further 75% in April 2017. The nature of CQC's fee-setting process meant that the smallest practices would bear a far greater burden of fee rises, as would those practices whose list sizes were close to the arbitrary thresholds set by CQC for cliff-edge fee increases.

The LMC formally responded to the consultation, as well as encouraging its constituent practices to do so. The knowledge of CQC's track record of listening to concerns raised by respondents to its consultations did not however engender much optimism and it was only to be hoped that GPC might have some success nationally, as part of ongoing contract negotiations, in obtaining additional reimbursement for fee rises.

PREMISES ISSUES

The problems encountered by practices working in NHS Premises, both LIFT buildings managed by Community Health Partnership (CHP) landlords and Health Centres managed by NHS Property Services (NHSPS) continued unabated and remained stubbornly unresolved as the year concluded. Both landlords continued to treat their GP tenants disgracefully, sending them invoices for grossly inflated and unjustified rises in service charges having no legal basis and threatening tenants with court action if these invoices were not paid. The LMC was active in offering support to affected practices and robustly challenging CHP and NHSPS over their behaviours. We advised practices to inform CHP and NHSPS that they were disputing the level of service charges and, until the matter was sorted, would not pay anything above historical charges that they agreed were appropriate.

The level of some of the service charge increases being demanded were staggering, and if practices were to have to pay them, would put their viability in jeopardy. The LMC raised awareness of the severity of the problem with the three CCGs, in order to ensure that they too supported their member practices insofar was possible. This resulted in the three CCGs embarking on a process of engaging external specialists to carry out work to determine appropriate and reasonable service charge costs for these premises. As of the end of the year the outcome of this work was as yet unclear. The LMC obtained commitment from the CCGs that they would look to support practices with their increased service charge costs should the outcome of the exercise still leave them having to pay considerably increased charges. It remains to be seen the extent to which this matter will be resolved going into 2017.

SAFEGUARDING ISSUES AND COLLABORATIVE ARRANGEMENTS

As always, matters concerning child safeguarding occupied the LMC considerably during the year. One particular issue related to a clear gap in fit for purpose services for school-aged children who were no longer the responsibility of the health visiting service. Safeguarding concerns for school aged children which social services did not consider met their threshold for statutory intervention were bounced back to referring practices with a suggestion that they be referred to school nursing services to take the lead in co-ordinating case enquiries and meetings. This was clearly not a task which school nursing was either able or willing to take on, leaving a situation where GPs had virtually no support in ensuring that the concerns were managed appropriately. The LMC had a number of meetings with CCG and Local Authority safeguarding personnel in order to attempt to resolve an extremely serious issue. Unfortunately, despite a recognition by safeguarding leaders that there was a problem which required resolution, this had not been achieved by the end of the year. This is an area on which the LMC will continue to remain vigilant.

Another safeguarding-related issue on which the LMC was active during the year related to the request for practices to co-operate with serious case reviews where a child death had occurred, in particular to supply copies of patient notes. Whilst the legal basis for these requests was clear, the communications being sent to practices about this were far from ideal, and in particular, where it was felt that in those very few cases where there might be sufficient justification for releasing records without consent, the request letters to GPs simply did not supply sufficient information to put them in a position to make a decision that breach of confidentiality was justified.

Again meetings were held with safeguarding leads in an attempt to resolve the matter, and agreement was reached that communications with practices would be revised in order to make them fit for purpose. There is every hope that this work would be satisfactorily concluded in early 2017.

One very positive result over a safeguarding –related matter followed a meeting that took place with Birmingham City Council's new head of safeguarding in order to discuss issues related to requests with unacceptable timescales from social workers to GPs for attendance at case conferences and/or provision of reports, as well as the thorny old problems concerning the arrangement for payment of fees under the collaborative arrangements by means of using the appropriate medical fee claim form. The meeting was extremely constructive and resulted in the head of safeguarding sending a very helpful communication to all local authority staff on these issues, which was shared with the LMC and forwarded to practices.

PUBLIC HEALTH AND VACCINATION ISSUES

During the year it transpired that NHS England Public Health had engaged a private company, Health Intelligence (HI) to operate a new data extraction service to share practice child immunisation data with the community trust. NHS England initially intended to introduce this by "piloting" in a number of Birmingham practices with supposedly "significant waiting lists" for childhood vaccinations and went about this without prior consultation, explanation or warning to the practices concerned, also without notifying the LMC, and by sending them an email giving just two days' notice to sign up to a complex data sharing agreement (DSA) produced by HI. As well as this lack of communication and the ridiculously short timescale being wholly unacceptable, needless to say the data sharing agreement itself was completely unfit for purpose and would have put practices, as data controllers, at considerable risk.

Happily LMC intervention successfully halted the process, allowing for the acceptability of the proposal and the production of an acceptable DSA to be properly considered. The LMC arranged for the DSA to be vetted by the BMA Ethics Department and subsequently by expert independent legal opinion in order to ensure that the document was revised in order to provide a legally sound basis for data sharing and that there would be no other risks to practices in participating. Furthermore the LMC was successful in obtaining reimbursement for the full cost of the legal opinion jointly by NHS England and the General Practitioners Defence Fund, so that there was no direct cost to LMC statutory/administrative levies paid by our GPs.

The Pharmacy Influenza Vaccination Scheme, which had been rolled out nationally by NHS England in 2015/6 was, unsurprisingly, continued over the 2016/7 winter season. The various inevitable adverse consequences of this continued to be experienced by many practices and the LMC once more collated evidence of these problems in order to feed these back to both NHS England and the GPC, as well as liaising regularly with the Local Pharmaceutical Committee to discuss the reported inappropriate behaviour by some pharmacists in relation to the scheme and attempt to mitigate the damage so caused.

With the national recommendation that morbidly obese patients should be vaccinated against flu, but in the absence of this being funded through the DES, the LMC lobbied the three Birmingham CCGs to request that they commission these additional flu vaccinations from practices. Sadly all three Birmingham CCGs refused to commission this work.

The LMC was consulted by Crime Reduction Initiative (CRI), the substance abuse lead provider for the city, on a new contract for practices to provide substance abuse services. The LMC made a number of suggestions on the proposed new contract which were incorporated into the revision. It was noted however that despite these improvements the new service specification still placed considerable burdens on practices than did the previous contract, yet this was to be delivered with no increase in funding. It was also noted that there would be a very high chance that a subsequent contract, due in two years' time, would both require even more work but also be even less well funded as a result of inevitable cuts in local authority funding. The LMC advised practices accordingly about this.

A number of practices raised major concerns with the LMC in respect of communications they received from Public Health England following their patients being tested positive for Hepatitis B. These letters to practices suggested that they were responsible not just for managing their Hepatitis B positive patients, but for contact tracing and screening of all their household and sexual contacts. Clearly this was wholly inappropriate, particularly bearing in mind that some of these patients would not even be registered with the practice. The LMC immediately took up the matter with Public Health England, NHS England and the CCGs and agreement was reached that communications to practices would be revised, making it clear that GPs were not responsible for any contract tracing, nor was it their contractual responsibility to screen or carry out initial vaccinations on asymptomatic contacts.

Whilst it was made clear and agreed that sexual contacts should be managed through sexual health services and not by general practice there remained the issue that there was no service currently commissioned to screen and carry out initial Hepatitis B vaccination of asymptomatic household contacts presenting to their GP and the LMC made representations to the CCGs and NHS England to ensure that this work was commissioned. As the year ended work to achieve a resolution to this issue was still ongoing.

GPC AND NATIONAL MEDICO-POLITICS

A special conference of local medical committees took place in January, following pressure from a number of LMCs, including Birmingham, to hold such an event to recognise the extent of the crisis in general practice. The key motion which was passed at the conference called on GPC to ensure that should negotiations with government for a rescue package for general practice not to be concluded successfully within six months then further actions must be taken. The outcome of this was the GPC document entitled "Urgent Prescription for General Practice" (UPGP), detailing the measures, including additional investment, it believed should be taken, in order to deal with the massive crisis facing the profession.

Shortly after this NHS England produced its own document the" General Practice Forward View" (GPFV) recognising at last that there was a crisis, belatedly admitting the underfunding that had taken place for many years and putting forward its own proposals for investment and initiative to support general practice. It was clear however that the various piecemeal measures in the GPFV, and the additional investment offered therein, were a woefully inadequate response which simply did not recognise the scale of the catastrophe engulfing general practice, and would go nowhere near to providing the solutions required.

The usual annual UK conference of Local Medical Committees took place in May. Birmingham LMC was allocated five representatives to the conference with Dr Sam Dawlatly, Dr Gavin Ralston, Dr Bill Strange, Dr Aamir Syed and Dr Martin Wilkinson selected by the committee to represent Birmingham. In addition LMC

secretary Dr Robert Morley and LMC members Dr Fay Wilson and Dr Pooja Arora attended the conference in their roles as members of GPC.

Three motions were submitted by Birmingham for consideration for inclusion in the conference agenda:

This conference believes that a strong and sustainable independent contractor model of general practice is essential but now only viable through partnership working at scale and calls on GPC to robustly champion extended partnership models as a means to ensure the survival of GP-led general practice.

This conference believes that a doubling of funding is now the minimum required to save general practice and calls on GPC to negotiate this as part of the Special Conference rescue package, in order to ensure both an appropriate increase in global sum together with contractual changes to deliver additional explicit funding for

i) each GP partner
ii) extended partnership models
iii) direct reimbursement of all employed clinical and support staff, CQC registration fees and medical indemnity costs
iv) extending the scope of direct premises reimbursements

This conference calls on GPC to publicly advise every practice that in order to continue to safely provide essential services to currently registered patients they must now consider contractual measures to reduce workload, including, as a priority, declining to register new patients whilst formally applying for practice list closure.

Sadly none of these motions was chosen for debate by the conference agenda committee.

A key motion passed at the conference called for the government to accept the urgent prescription document in full and that if it did not do so the profession would be surveyed on its willingness to take industrial action (by means which would not breach contracts or statute) and on its willingness to submit undated resignations. The LMC's position on this was that whilst the UPGP went a little further than the GPFV, even in the likely event that the urgent prescription demands were met in full, the additional funding it called for was still nowhere near adequate to address the catastrophic crisis facing the profession.

Subsequent discussions between GPC and NHS England led to an agreement by the latter to continue discussions with GPC over the demands in its UPGP document which were not covered in the GPFV. As a result of this the GPC's position was that the requirements of the conference motion had been met, a matter however with which Birmingham LMC did not concur.

The action which the GPC did take in respect of the conference motion was a survey of the profession at the end of the year over the problems that GPs and practices were currently facing and to canvas views on what actions practices might take to resolve them. Sadly only about 5000 GPs responded to the survey and of note the survey omitted the key question as called for in the conference motion, in respect of willingness to submit undated resignations. Overall the results of the survey were not particularly enlightening and did not appear to suggest a clear way forward for the profession.

2017 brought significant reforms with changes to the structure of the GPC as a result of pressure from LMCs to ensure that voluntary levies paid over by them to the General Practitioners Defence Fund (GPDF) which provided the majority of GPCs' funding, were put to the best possible use in order to further the interests of GPs nationally, and to make GPC and GPDF more accountable to LMCs and their constituents.

One of these changes led to the decision to expand the membership of GPDF to ensure it included a nominee member of every LMC as opposed to comprising solely of GPC members. This would lead to LMC nominees forming the majority of the GPDF's members. Birmingham LMC nominated its chairman Dr Bill

Strange to be its member of GPDF. Other changes included in the reform programme established a GPC England to meet regularly, as opposed to the previous situation where GPC UK held regular meetings but GPC England existed in virtual form only.

Another change led to the members of the GPC England executive team (formerly GPC negotiators) being appointed through a robust recruitment process rather than being elected by the GPC membership. Appointment to the GPC England executive team was also opened up for the first time to candidates who might not be current members of GPC. This change led to the happy outcome of senior Birmingham GP partner, Birmingham Cross City CCG chairman and long-standing LMC member Dr Gavin Ralston being appointed to a position on the GPC England executive. This achievement represented a tremendous feather in the cap of both Gavin, and also of Birmingham LMC, and carried on the fine tradition of influence by Birmingham LMC at the heart of national GP medico -politics. Well done Gavin!

Further influence on the GPC was maintained by the LMC with Dr Fay Wilson and Dr Pooja Arora being re-elected to GPC membership, whilst LMC executive secretary Dr Robert Morley also continued as the GPC regional representative for Birmingham and Solihull and, as part of the GPC reforms, was appointed as GPC Policy Lead for both contracts and regulation. Dr Morley was also re-elected as a director of the General Practitioners Defence Fund.

INTERNAL LMC MATTERS

The year brought some significant changes to the LMC office structuring, when Esther Lewis our PA and Administrative Assistant left the fold for pastures new. We are extremely grateful to Esther for all her hard work and great help during her time with the LMC. Esther's leaving however gave us the opportunity to reassess our office staffing and consider the need to develop the services offered to our constituents and provide additional support to the executive secretary in helping and advising practices.

As a result of this we were delighted that Wendy Loveridge, our longstanding practice manager adviser, joined our team in the new substantive post of Practice Support and Liaison Manager. The benefits of this were seen immediately through our being able to improve the LMC's responsiveness and capacity in dealing with practice queries and in providing a great deal of expert advice and, in particular, support related to the numerous problems detailed above caused by Capita's hapless performance over primary care support services.

In addition LMC chairman Dr Bill Strange further settled into his new executive role supporting the secretary so all in all, believe that the year brought a considerably improved package of help and advice for practices in return for their levies, which throughout the year remained at a historically low level of approximately 25 pence per patient, something which we hope you still considered to represent fantastic value for money.

Inevitably however the developments within our staffing as well as other costs meant that a review of our future statutory/administrative levy was unavoidable and we informed practices at the end of the year that this would have to be the case for 2017. Our communication of this to practices though led to us receiving a number of comments of positive feedback and, happily no negative ones!

We can also report that a number of practices just outside Birmingham but with patients within the city requested a switch to representation from their current LMC to Birmingham LMC. These transfers were progressed with the full consent of the other LMCs involved. Taking additional practices on board will, at least to a small extent, mitigate any rise in levy from individual practices and, moreover, we feel is a glowing testament to the work of Birmingham LMC.

A further initiative in 2016 was initiated by Birmingham LMC member and engagement champion Dr Pooja Arora. This was a series of podcast question and answer sessions between the LMC chairman and secretary covering key areas of significance for general practice and we hope these have been found to be a helpful new resource for GPs and practices. These were then uploaded onto YouTube. It is anticipated that these

podcasts will continue going forwards into 2017 as the LMC is belatedly carried into the digital and social media era! 2016 also saw the launch of the LMC's Twitter account.

OBITUARIES

It is with great sadness that we report the loss of three former Birmingham LMC members in 2016, Dr Donald Calderwood, Dr Guy Houghton and Dr Victor Rao. All three of them were tremendous servants to their patients, to general practice in the city and to the LMC. Our condolences to their families, friends and former colleagues.

CONCLUSION

First and foremost as always our thanks go out to our brilliant office staff Julie Mason and Wendy Loveridge for all their hard work and commitment serving the GPs and practices of Birmingham. Thanks too to all our LMC members for their contributions in representing their colleagues.

We are grateful to the leaders and officers of the three Birmingham CCGs with whom we worked in close partnership throughout the year in the common cause of supporting, sustaining and developing general practice in the city. Our thanks are also due to the various other organisations within our health economy with whom we have engaged during 2016 on our increasingly busy and complex agenda.

It goes without saying that our greatest thanks are reserved to all Birmingham's GPs, practice managers and practice staff who, in the most difficult of circumstances, have continued their sterling efforts caring for their patients. Your ongoing support for and appreciation of the activities of the LMC is most humbling and rewarding.

Dr Bill Strange
CHAIRMAN

Dr Robert Morley
EXECUTIVE SECRETARY

On behalf of the members of Birmingham LMC