GLOUCESTERSHIRE
LOCAL MEDICAL COMMITTEE

ANNUAL REPORT
2018 - 2019

ANNUAL REPORT APRIL 2018 TO MARCH 2019 – CHAIRMAN'S REPORT

What a year it has been!

I took up the post of chair of the LMC in March 2018. Since then there have been many events. Some good news first: the numbers of GPs and Practice Nurses as whole-time-equivalents have gone up over the last year in Gloucestershire. Obviously, this isn't enough but it does perhaps show some small green shoots of recovery after a long chill. This bucks the trend nationally.

Several new practice builds and large improvements have taken place; among them Churchdown, Stow, Kingsway in Gloucester and Bishops Cleeve this year, as well as Culverhay in Wotton and Hadwen in Gloucester last year. After years of little in the way of new builds it is good to see such excellent premises developed. Next year further builds are intended, some well on their way.

The immediate issue on taking on the chair was to decide who should be the General Practice representative on the new Integrated Care System (ICS) Board. After some discussion the unanimous decision among the LMC committee, provider lead GPs and GDoc was for the chair of GDoc to be co-opted onto the LMC and be the representative. Gloucestershire is now one of only 5 ICS second wave groupings in England. As we now know, all areas must become ICSs in rapid time. We are indeed fortunate to have talented GPs such as Dr Jo Bayley to lead us into the new world of integration. Any loss of our GMS status and contract, though, would be a large step too far. We owe it to our profession's future and to our patients to preserve this. Fortunately, not quite too late in the day but near to it, there is some acknowledgement that outsourcing and compulsory APMS contracts are short-termism. Institutional and personal memory are things not to be taken for granted and are vital ingredients for the NHS even though almost, but not quite, impossible to measure.

The year saw a notable piece of research by Professor Pereira Grey. This showed that continuity of care on its own was responsible for lower mortality rates. Whilst of little surprise to most GPs this is a telling study which should help to preserve the principal of continuity of care.

Over the year a number of areas of concern were identified, which we already understood and for which we have been trying to negotiate pathways and funding. Many are related to work that hasn't been commissioned. The pattern is regrettably often the same, where practices pick up the pieces, sometimes rather untrained and often unprepared for the job. Such work includes ear wax removal, monitoring of eating disorder patients with bloods and ECGs, dopplers for leg ulcers (both diagnosis and ongoing monitoring) and, topically, prophylaxis of flu in nursing homes. There are many more. Slowly these are being addressed and resolved. Whether the ICS will provide the catalyst to resolve these difficulties at an earlier stage only time will tell. Flu vaccination among pregnant women is still terribly low, another area where working together could help.

This year I have been privileged to be the representative for the General Practice Committee on the Consultants' Committee. What has been sad is the realisation that the Consultants are in as invidious a position as GPs, with familiar stories – additional hours, pension problems with the annual allowance and lifetime allowance, work related stress and Trusts trying to get as much work as possible from them. It is rare for a Consultant to work beyond 60, as the pension issues effectively mean they are working almost for free. The BMA are lobbying hard on this. Without this change the number of experienced doctors will continue to decline, which after Professor Grey's research must put serious concern over the nation's long-term health.

The Care Quality Commission (CQC) continues to assess practices, and continues to cause distress at times. Almost all our practices are in the 'good' or 'outstanding' area, with only one that was rated as 'inadequate' (now successfully upgraded to 'good'). The effect of these assessments on all practices isn't good; morale is very badly affected at times by the CQC's

reaction to relatively minor misdemeanours. There appears to be no acknowledgement in these assessments of the pressures that practices are under. It really is to practices' great credit that the results have been resoundingly at such a good level.

The Acute and Community Trusts have both had CQC assessments this year. To their credit they have both increased to a 'good' rating. Concerns over several areas at the Acute Trust continue, most often in the interface between primary and secondary care. We must be on our guard for any shift in work aimed to reduce the recently-found but persistent negative financial balance. The waiting times for many specialties has increased, which has impacted on our own work in practices, as well as upsetting many patients. We welcome Dr Pietroni and say farewell to Dr Sean Elyan after many years as the Acute Trust's Medical Director. The LMC continues to meet with Deborah Lee the Chief Executive and her team. Her open approach has been welcome. We appreciate how hard it is to run such a large organisation on two main sites with such well-proven limited funds.

The LMC have been particularly concerned at the mass reduction of X-ray sessions at the Community Hospitals. This has been due to a shortage of radiographers. It is almost inevitable that there will be some delays in diagnoses as a result. We are reassured that the local politicians are similarly dismayed. Plans are being developed for the medium-term including more recruitment and using less-skilled staff where appropriate.

Capita's running of Primary Care Services England (PCSE) remains a cause for concern with issues still cropping up. Many will wonder how bad it can get before the contract is terminated, but sadly the local apparatus that served practices and patients well has been dismantled. The failure of PCSE to send out many thousands of invites for patients to arrange smears is at a new low.

As the financial year closes, we see both the Long-Term Plan and the New GP contract released. This represents the largest change since the 2004 contract. The extra investment into Networks is very welcome, and the strings attached appear to be less cumbersome than the GP Forward View, which hasn't achieved as much as it could have.

The CCG deserves credit for its foresight in setting up 'clusters' that are now changing to 'networks'. These will be GP-led and will be a big focus of work over future years. All are trying to work out the employment and other legalities and we wait for guidance from the BMA and NHSE soon. The moneys coming in are significant, and should help to improve our workload.

Losing the need for all practice staff to have indemnity cover for clinical negligence is most welcome. However, it is absolutely vital that we continue our MDO payments to cover private work e.g. DVLA reports, performance, GMC and other matters. The cost of defending oneself through the many performance channels is very significant, and should be relatively inexpensive for the MDOs to provide.

The Improved Access (IA) pilots have gone remarkably smoothly and, as we know, the funding is now guaranteed through Networks, though this can be sublet out. Many regret the need for this work, weekends in particular are not too popular with patients either. The ability to set IA up in fast time showed what General Practice is capable of, even with limited additional resources. This fills most with hope for the future of the Network DES model.

Alongside this has been Dr Nigel Watson's partnership review. Many recommendations are incorporated in the New Contract. Others, such as LLPs as well as premises issues, need addressing promptly. Maintaining partnerships as well as networks will be no easy task. Mergers are not necessarily the answer and, if contemplated, then slow careful planning and, if possible, maintaining smaller teams within the merged structure appear to be the best way to help with continuity.

As many will have seen, our new Secretary of State is very keen on information technology. The recent agreement by Birmingham CCGs and NHSE to allow GP at Hand into their area is deeply concerning though. To allow the GP at Hand hosting practice in London to move from under 5,000 patients to over 35,000 in one year would lead many to question how safe quality medicine can be delivered. Our area is developing appropriate online presence via our practice

websites in liaison with the LMC. The new websites look good and may help to divert some demand away, though may attract further demand as a new communication method is started. On-line booking will become the norm for many. The NHS 111 appointment slots for practices are coming. Trials around the country have not been as fearsome as supposed; all appointments have to go through a clinical assessment process. Some of this will save time, such as on-line ordering of medication. On-line submission of asthma and BP reviews may help too. Patient on-line access may also help with the GDPR requests that have been a significant additional work stream for practices this year

Some wins have been achieved over the year. At last the need for signing the District Nurses Drug Administration Charts seems to be nearing its slow end. We have agreed and proposed a flu prophylaxis enhanced service, as well as one being developed for the physical health checks for seriously mentally ill patients. We have negotiated a small, though welcome, pay rise for the enhanced services. We continue a healthy dialogue with the CCG and with GCS and the 2gether Trust, which will be merging in the very near future

After almost 12 years our Lay Secretary is retiring. His work has been of high quality and he has been a rock for the LMCs stability. He started at a time when the LMC had had 3 secretaries in fairly quick succession. As with GPs, Mike Forster has proved that continuity of care works well. We wish him well in his retirement. I will miss his calm unflappable presence, as well as his expert timekeeping. Mostly though he has provided wise counsel to myself, Phil Fielding and Andy Seymour, our immediate past chairs.

Also retiring in May will be our very long-standing Administrator, Sue O'Sullivan. She has worked tirelessly in the office for more years than almost all GPs locally can remember - 28. As well as her work, her late husband ran the LMC accounts very well indeed behind the scenes.

We will also be saying farewell to our Office Manager, Shelina Jetha. Her work has been excellent and she has kept the LMC finances in good shape. She stood in as Secretary e.g. when Mike holidayed for 10 weeks in 2016.

I am delighted that our new secretary is to be Dr Penelope West. Many will have come across Penny as a GP in the Stroud area. Before this she was a GP in Swindon for many years. Currently she is in her last month as Safeguarding Lead for Gloucestershire Care Services. This may be opportune as both the adult and safeguarding intercollegiate documents have been updated and published this year.

I would like to thank my immediate past Chair, Phil Fielding. He has, without my realising it, prepared the way for a smooth transition. He has done sterling work for the LMC over many years and we are fortunate that he continues in his new role as Treasurer.

I also thank Executive members of the LMC committee and all of you in General Practice. The Exec have been supportive. Many of you have been diligent with bringing issues to our attention. Members of the committee have stepped up to work in different areas including prescribing, enhanced service reviews, IT and PAG work as well as providing support for our colleagues when things go wrong.

Work in General Practice has become increasingly complex and difficult. The health outcomes, very few complaints and excellent patient satisfaction in the annual Ipsos Mori Poll show that despite these big problems General Practice maintains its worth for the health of Gloucestershire and the UK.

I look forward with the new office team to the excitement and challenges that next year will bring.

Chairman Gloucestershire LMC

ANNUAL REPORT - APRIL 2018 TO MARCH 2019– SECRETARY'S REPORT

OVERVIEW

Funding. The national position is that General Practice is still substantially underfunded for the amount of work it has to do. The Doctors and Dentists Review Body (DDRB) recommended a 4% increase in pay for GPs but the government would only implement a 2% rise, and that only in stages. The NHS England Long Term Plan has promised considerable extra funding to Primary Care (not specifically General Practice) so we will see how that will be implemented. Also, the new GMS contract amendments published at the end of January to come into effect on 1st April 2019 are far-reaching and lead to some optimism.

Primary Care Support England (PCSE). Having started with such poor performance, and made scarcely any noticeable improvement, there appears to be a general weariness about complaining – is it worth complaining if nothing happens? The LMC continues to miss the updates we used to receive when GPs joined or left a practice, but at least the levy is paid on time and in full. However, recent liaison with PCSE gave some hope that they are putting their house in order.

Integrated Care Systems (ICS). In February 2018 the CCG revealed that Gloucestershire had been selected to form part of the second wave of ICSs. As part of this there would be a Board comprising the Chief Executives of all the related health and social care organisations. Of course, General Medical Practice (GP) has no Chief Executive. During the year the LMC worked with the CCG and GDoc Ltd (the provider company owned by all the practices in the county) to develop an arrangement whereby a suitable representative of general medical practice could sit on that Board. In brief, the seven Locality Provider Leads were co-opted onto the Board of GDoc and the Chief Executive of GDoc was co-opted, *ex officio*, onto the LMC. Formally, it will then be for the LMC to send a representative to the ICS Board, but in practice it is intended that this should be the Chief Executive of GDoc Ltd, in her capacity as an LMC member.

Recruitment. As has been the case for many years, few people respond to job adverts in general practice. Thankfully the situation in Gloucestershire is less dire than elsewhere in the country, but we must not be complacent; the troubles afflicting general practice affect us all.

Premises.

- NHS Property Services Ltd (PropCo). The impasse over the NHS Property Services' proposed lease has continued. None of our ten affected practices have signed up as they are still waiting for a credible explanation of the invoices they have been receiving and an acceptable form of lease to be negotiated nationally.
- New builds. The programme of new builds and renovations continues to accommodate the new housing estates being built.
- Practice Closures. Again, none this year, unlike elsewhere in the country.

Practice mergers. Through a series of mergers, we now have 75 practices in the county.

- The Park Surgery in Cirencester and the Lechlade Medical Practice merged to form the Upper Thames Medical Group.
- St Peter's Road Surgery and the Avenue Surgery merged to form the Cirencester Health Group.
- Romney House Surgery in Tetbury was taken over by the Phoenix Surgery in Cirencester and they will formally merge in April 2019.
- The Alney Practice (the merged Cheltenham Road and College Yard & Highnam Surgery) in Gloucester City brought forward the closure of the College Yard branch surgery from April 2019 to 1st November 2018 because of an unexpected illness in a senior partner and difficulties of recruitment.

- As planned, the three practices in the Aspen Centre and the Saintbridge surgery in Gloucester City merged to form the Aspen Medical Practice.

Practice Take-Overs. The Church Street practice in Tewkesbury now runs the Crescent Bakery and West Cheltenham Medical Practice (formerly known as Springbank). They have recently added the Marybrook Surgery in Berkeley under a short-term APMS contract, following the collapse of that partnership.

THE LMC

LMC Elections. The new Executive Committee formed in March 2018, led by Dr Tom Yerburgh. Dr Phil Fielding stepped down from his long-standing Chairman's role to become our Treasurer. Dr Bob Hodges was elected as Vice Chairman. Dr Roz Bounds and Dr Jethro Hubbard make up the rest of the Executive. The next election period will be in 2020.

New LMC Secretary. Mike Forster, our long-serving LMC Lay Secretary stood down with effect from 31st March 2019. Our new Medical Secretary, in post from 1st April 2019, is Dr Penelope West.

LMC Offices Staffing. Our long-serving (28 years) Office Assistant, Sue O'Sullivan and our Office Manager, Shelina Jetha, have both decided that they need to retire or change career direction in the next two months.

LMC Membership. We have held a two-year vacancy in Gloucester City and have a new vacancy in Cheltenham (Dr Mike Skene moving out of the county) so we could formally reduce the membership for those constituencies from four to three, so reducing the size of the constituency-based membership from 18 to 16. However, the overall size of the committee is now 17 because of the co-option of Dr Jo Bayley, Chief Executive of GDoc Ltd, as explained above.

Support to GPs.

- GP Safe House website. Still in use, but needs to be more widely advertised. The LMC Office now has direct access to the usage figures. The brains behind the site, Dr Roger Crabtree, unfortunately died during this period. Discussions are continuing on how this, and the similar sites in other LMC areas, are to be maintained.
- Personal support. There has been a continued need for senior LMC members to help and support our constituents. This year the costs of this work slightly exceeded our budgeted figure, but that could not be helped.

Budgetary issues.

- The LMC Rate is the amount of money paid, without superannuation, to GPs doing LMC work. This year it stood at £88 an hour. In setting the rate annually at our March meeting the LMC has to balance opposing considerations: the LMC needs to provide adequate remuneration to senior GPs to get involved with the LMC, especially as other organisations are seeking the same people; on the other hand, we must always provide value for money.
- GPDF has confirmed that for 2019/20 they will not be raising the 'voluntary' levy beyond the current 6p per patient.
- The change from a full-time lay secretary to a part-time medical secretary, together with the changes in the support she will need, have implications for the LMC budget.

Office management. The office moved from holding its filing system on a local server to using Office 365 – a 'cloud-based' system that enables office staff to access their computer easily when away from the office. This has proved very useful.

NATIONAL ISSUES

General Practice Defence Fund (GPDF). The GP Defence Fund has been reorganised, with GPC members no longer on the Board, thus avoiding the suspicions of conflicts of interest that might

otherwise have taken root. Dr Phil Fielding is this LMC's representative at their shareholder meetings. We look forward to seeing the GPDF provide closer support to LMCs.

- They have already commissioned and delivered consolidated updates of the various regulations covering most aspects of general practice work.
- It may be that they will support a practice if a test case is brought to settle what 'excessive' means when seeking an exception to the Data Protection Act 'no fee' rule for SARs.

LMC Conferences. The English LMC Conference was held in London and the UK LMC Conference in Belfast. Note that another motion calling for co-payments was defeated but by a much narrower margin than in former years. It proved hard to distinguish those motions that were properly of only English concern and those that should be considered nationally. In the end we submitted everything to the English conference whose agenda committee recommended which should be taken to the UK LMC Conference.

GPC. Avon and Gloucestershire are now represented on the GPC by our Chairman, Dr Tom Yerburgh. He is well placed to ensure that our voices are heard in the right quarters. He is also the GPC representative to the consultants committee and deputy policy lead for clinical and prescribing at GPC.

General Data Protection Regulation (GDPR). The new EU regulation was brought into UK law by the Data Protection Act 2018 in May. A probably unintended consequence is that practices are no longer able, with few exceptions, to charge for supplying copies of the medical record. Surely Parliament never envisaged the burden that copying such huge records for free would place on practices? At least the new contract has put money into the Global Sum to cover this.

General Practice Forward View (GPFV) funding streams. These continue to flow. One particular stream was to train a small band of practice managers to provide support and review meetings to their peers. After a slow start these meetings are now taking place.

REGIONAL ISSUES

The South West Regional LMCs continue to meet quarterly for exchange of views.

LOCAL ISSUES – OF LONG STANDING

Earwax removal. The enhanced service granted last year has not been repeated. 'Self-care' is now the order of the day but the CCG recognises that sometimes microsuction will be required where irrigation fails.

Leg Ulcers. The service introduced in 2016-17 run by Gloucestershire Care Services continues but where the patient is unable to access the service the CCG does pay practices to provide the treatment. However, there are instances where the demand and costs involved exceed the remuneration available.

Blood-taking in the Community. The CCG has started the process of harmonising phlebotomy across the county but it will be a slow process as the current arrangements have developed differently in different areas over many years and are well-entrenched.

LOCAL ISSUES – NEW IN THIS REPORTING PERIOD

Acute Trust. The LMC maintained that it was illogical for diabetic patients not to receive foot checks when attending an outpatient diabetic appointment. This was agreed.

Services and commissioning.

- The Primary Care Offer (PCO). This compendium enhanced service was introduced largely without negotiation with the LMC. However, one of our members was involved (as a GP rather than as an LMC representative) in its drafting.
- Inflationary uplift for enhanced services. It took many months of negotiating but the CCG has now agreed to a 1% inflationary uplift backdated to April 2018. The rates had

been frozen for three years so this is only a partial success, but it was all that the CCG could afford.

- Continence assessments. Continence assessments pre-treatment are agreed not to be core work for GP practices.
- Tamiflu as a prophylactic in care homes. After some negotiation terms were agreed. (Remuneration of £30 per patient but £150 per hour if more than 5 patients have to be treated. If many more have to be treated then a pro rata increase to the remuneration would be appropriate.) That said, the clinical effectiveness of using Tamiflu as a prophylactic is debatable.
- Minor Operations Enhanced Service. Practices will now be able to refer their patients to neighbouring practices for minor operations.
- Flu vaccinations of housebound patients and pregnant women. The LMC insisted that district nurses should let the practice know when they had vaccinated a housebound patient. The LMC persuaded the CCG to look into the vaccination of pregnant women by community midwives.
- Mental Health Issues. At the LMC's urging:
    - Adult ADHD. The CCG agreed to commission an adult ADHD service – previously an ADHD child ceased to receive care at the age of 18. While such children could be expected to 'grow out of it' they might not necessarily have done so by their 18th birthday.
    - ECGs and blood tests for Eating disorders. The CCG and 2Gether have agreed that this is not appropriate for GPs to assess and so a service is being set up to deliver this.

"Training Passports". The LMC were able to get 'Mandatory Training Passports' retitled to reflect the fact that there is no such thing as mandatory training for GPs in general medical practice.

LIAISON WITH OTHER ORGANISATIONS

Private organisations referring through GPs to secondary care. The CCG was quick to respond to LMC concerns that private consultants and opticians were referring the patient to their GP rather than direct to secondary care.

Coroner's Office. We continue to work towards a system whereby GPs can be provided with the necessary forms to certify death (which are meant to be provided 'free of charge') without their having to pay for the postage – a minor matter, but irritating.

District Valuer assessments. These seem to be very slow at times. One practice in particular had not had an up to date valuation for 4 years which was preventing the new partner from signing the partnership agreement. We have made representations to GPC regarding this.

Gloucestershire County Council Public Health Department. It was suggested that GP practices should trace contacts of patients testing positive for chlamydia. The LMC rejected this. Public Heath had agreed with us that it isn't appropriate but then sent out a letter clearly stating that GPs are responsible for tracing contacts – more work required here!

INFORMATION MANAGEMENT AND TECHNOLOGY

Acute Trust's new TrakCare IT system. TrakCare was introduced in December 2016 and has been giving problems ever since. The recovery programme is still on-going. Suggestions from the LMC that practices should be compensated for the extra work TrakCare had caused them were rebuffed. The particular area of GP concern is the voluminous irrelevance of much of the discharge summaries and the difficulty of finding the relevant information in them.

Joining up your Information (JUYI). Is still not fully in service.

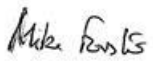
Paper-referrals switch-off. Thanks to very close and continuous liaison between the LMC, the Trust and the CCG, and with good communications to all practices the switch-off of paper first

referrals to consultant-led outpatient appointments was successfully launched on 4th June 2018. The number of paper referrals has now dropped to a mere trickle. The process has been held up as an exemplar to other areas.

SUMMARY

General practice is about to face major change in the NHS. Existing organisations are being shaken; new ones are being introduced. Practice teams will grow to relieve the personal pressure on GPs.

The LMC has existed for more than 100 years and still has a useful role to play. But it will need to adapt itself to the new circumstances if it is not to be side-lined.



M J D FORSTER
Lay Secretary

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

ACCOUNTS' REPORT

FOR THE YEAR ENDED 31ST DECEMBER 2018

We have prepared the annexed accounts from the books and records of the Gloucestershire Local Medical Committee, and from the information and explanations supplied by the LMC Manager and approved by the Treasurer.

We have not carried out an audit.

L Beaven

Griffiths Marshall
Beaumont House
172 Southgate Street
Gloucester
GL1 2EZ

February 2019

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE
RECEIPTS AND PAYMENTS ACCOUNT FOR YEAR ENDING 1ST DECEMBER 2018

			2018		2017
		Voluntary (£)	Statutory (£)	Total (£)	(£)
EXPENDITURE					
Donations	Royal Medical Benevolent Fund				-
	Cameron Fund				-
	General Medical Defence Fund	45,800		45,800	
Retirement gift		308		308	49
Secretary's remuneration			67,963	67,963	64,772
Secretary's expenses			948	948	1,042
Catering		2,117		2,117	2,279
Accountancy fees			1,920	1,920	1,920
Bank charges and interest			84	84	59
Locum fees & mileage expenses			127,955	127,955	134,291
Training & Support			11,497	11,497	12,667
GP Safehouse, training & Pastoral	*7,365*				
NHSE PM Appraisal training	*4,132*				
Clerical assistance and office expenses			57,758	57,758	57,570
Sue Salary	*11,820*				
Shelina salary	*38,624*				
Other office running costs	*7,194*				
Corporation Tax			284	284	283
Office rent etc			11,682	11,682	11,672
		48,225	280,091	328,316	316,604
INCOME					
Voluntary Levy		38,000		38,000	38,000
Statutory levy			273,000	273,000	247,000
Training income			5,185	5,185	-
Other income	Taxable		1,799	1,799	1,689
	Council recharge		357	357	-
	Conference costs		860	860	-
		38,000	281,201	319,201	286,689
SURPLUS / (DEFICIT)		(10,225)	1,110	(9,115)	(29,915)
CASH AT BANK AS AT 1ST JANUARY 2018		39,921	42,497	82,418	112,333
CASH AT BANK AS AT 31ST DECEMBER 2018		29,696	43,607	73,303	82,418

TO THE TRUSTEES OF THE
GLOUCESTERSHIRE MEDICAL BENEVOLENT TRUST

FOR THE YEAR ENDED 31ST DECEMBER 2018

We have independently examined the accounts of the Trust as set out on pages 2 to 3 as required by the Charities Act 2011.

The Trust has elected both to prepare the accounts on the receipts and payments basis and to subject its accounts to independent examination rather than audit.

Our responsibilities are to:

- Identify whether or not proper accounting records have been kept;
- Check that the Trust accounts agree with the account records;
- Look for possible significant errors in the accounts;
- Check that the accounts have been properly prepared in accordance with the Charities Act 1993 insofar as these apply to the receipts and payments basis.

Where matters arise from this examination that give cause for concern it is our duty to report it.

Our report:
No matters have arisen during the course of our examination where we have to give an adverse report.

L BEAVEN
GRIFFITHS MARSHALL
Chartered Accountants

Beaumont House
172 Southgate Street
Gloucester
GL1 2EZ

February 2019

GLOUCESTERSHIRE MEDICAL BENEVOLENT TRUST

RECEIPTS AND PAYMENTS ACCOUNT

FOR THE YEAR ENDED 31ST DECEMBER 2018

	2018	2017
	£	£
INCOME		
Dividends received	119	112
Bank interest received	5	6
	124	118
EXPENDITURE		
Accountancy fees	-	-
	£	£
NET RECEIPTS FOR THE YEAR	124	118

GLOUCESTERSHIRE MEDICAL BENEVOLENT TRUST

BALANCE SHEET

31ST DECEMBER 2018

	2018	2017
	£	£
ACCUMULATED FUNDS		
Balance as at 1st January 2018	12,016	11,898
Net receipts for the year	124	118
	£	£
Balance at 31st December 2018	12,140	12,016

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE
ATTENDANCE BY ELECTED/CO-OPTED MEMBERS*
AT MEETINGS APRIL 2018 – MARCH 2019

NAME:	POSSIBLE:	ACTUAL:
DR. S ALVIS	6	5
DR P BAKER*	6	5
DR H BAXTER	6	4
DR J BAYLEY	4	3
DR. K BHARGAVA	6	4
DR. R BOUNDS	6	5
DR M CHADA	6	5
DR. P FIELDING	6	6
DR L HALDEN *	6	4
DR R HODGES	6	6
DR. J HUBBARD	6	6
DR B LEES*	6	4
DR. C MORTON	6	2
DR. J ROPNER	6	5
DR R RUTTER	6	6
DR M SKENE *(resigned 13.09.2018)*	4	4
DR V TIFFNEY	6	6
DR. T YERBURGH	6	5
RICHARD MARSHALL+ *(resigned 14.03.2019)*	5	5
DR. T YERBURGH: AS REP TO GPC MEETINGS	7	7

+ Practice Manager Rep

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE
MEMBERSHIP AS AT 31ST MARCH 2019

Constituency and Elected Members

North Cotswolds:

DR. C MORTON	Mann Cottage Surgery, Moreton in Marsh

South Cotswolds

DR. V TIFFNEY + *(co-opted (13.07.2017)*	The Avenue Surgery, Cirencester

Cheltenham Bishops Cleeve & Winchcombe:

DR. P FIELDING	Royal Well Surgery, St. Paul's Medical Centre,
DR B LEES + (*co-opted 10.05.2018)*	Leckhampton Surgery, Cheltenham
DR J ROPNER	Berkeley Place Surgery, 11 High Street,
Cheltenham	
DR M SKENE *(resigned 13.09.2018)*	Underwood Surgery, 139 St George's Rd,
Cheltenham	

Forest of Dean:

DR H BAXTER	Newent Doctors Practice, Holts Health Centre
DR R BOUNDS	Lydney Health Centre, Lydney

Gloucester City:

DR R HODGES	Aspen Medical Practice, Aspen Centre, Gloucester
DR M CHADA	Quedgeley Medical Centre, Olympus Park,
Quedgeley	
DR L HALDEN+ *(co-opted 10.05.2017)*	Hucclecote Surgery,5 Brookfield Road

Stroud:

DR. R RUTTER	Stroud Valleys Family Practice
DR. T YERBURGH	Acorn Practice, May Lane Surgery, Dursley
DR. S ALVIS	Cam & Uley Family Practice, 42 The Street
DR. K BHARGAVA	Beeches Green Surgery, Stroud

Tewkesbury:

DR P BAKER+ *(co-opted 10.05.2018)*	Church Street Medical, Tewkesbury

Non-Principal Rep:
DR. J HUBBARD

Trainee Representative:
DR. M MCVEIGH

Officers of the Committee:

CHAIRMAN:	DR. T YERBURGH
VICE CHAIRMAN:	DR. R HODGES
TREASURER:	DR. P FIELDING
EXECUTIVE OFFICER	DR. R BOUNDS
EXECUTIVE OFFICER:	DR J HUBBARD
LMC LAY SECRETARY:	MR M FORSTER *(outgoing* 31.03.2019)
LMC MEDICAL SECRETARY:	DR P WEST *(appointed 01.04.2019)*

Practice Manager Representative
MR R MARSHALL +

Acute Trust Representative
PROF M PIETRONI

2gether NHSFT Representative
DR A UPPAL

Elected Conference Representatives:
DR R BOUNDS
DR. B LEES
DR T YERBURGH

GPC Representative
DR. T YERBURGH

+Co-opted member

LMC MEMBER REPRESENTATION TO COMMITTEES
2018 / 2019

GPC Regional Representative

Dr T Yerburgh

Annual Conference Representatives 2018/19

Dr B Lees
Dr R Bounds
Dr P Fielding
Dr T Yerburgh * (unelected)

Gloucestershire Dispensing Quality Scheme

Member: **Dr K Bhargava**

Gloucestershire Medicines Meeting Committee

Member: **Dr K Bhargava**

Gloucestershire Controlled Drugs Local Intelligence (GDLIN)

Member: **Dr S Alvis**

Maternity

Member: **Vacancy**

Local Enhanced Services Review Group

Member: **Dr S Alvis**

Dementia/Community Care

Member: **Dr R Hodges**

Out of Hours

Member: **Dr J Ropner**

TRUSTS

NHS 111 Clinical Governance Trust

Member: **Dr J Ropner**

LMC WORKING PARTIES & ADVICE

LMC Executive Committee

Members: **Dr R Bounds**, **Dr P Fielding**, **Dr R Hodges**, **Dr J Hubbard**, **Dr T Yerburgh**

LMC Pastoral Support

Dr R Bounds
Dr P Fielding
Dr J Linsell
Dr T Yerburgh

PROFESSIONAL LIAISON

Acute Trust

Members: **Dr P Fielding**, **Dr R Bounds**, **Dr R Hodges**, **Dr J Hubbard**, **Dr T Yerburgh**

Winfield Hospital Medical Advisory Committee

Member: **Vacancy**

Gloucester Medical Staff Committee

Member: **Dr J Hubbard**

PAG (Performance Advisory Group) (Area Team)

Member: **Dr L Halden**

GDoc Limited

Member: **Dr P Fielding**, **Dr J Bayley**

GPFV (General Practice Forward View)

Members: **Dr P Fielding**, **Dr R Hodges**, **Dr T Yerburgh**

South West Regional LMCs

Members: **Dr T Yerburgh plus one Exec**

IM&T Meetings

Member: **Dr J Hubbard**