

Independent Review of the current representative structure of General Practitioners in the UK

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Foreword

The Annual Conference of Representatives of [UK] LMCs in 2021 passed a motion which called “on GPDF to commission a thorough review of the current representative structure [of General Practitioners], particularly seeking the views of LMCs”.

It is GPDF’s role to listen, support and influence on behalf of LMCs and therefore it commissioned an independent review by Ijeoma Omambala QC in order to satisfy this motion.

The views expressed in this Report are not GPDF’s views and are drawn from the consultations with GPs and LMCs which were conducted by the professional organisations who have supported the QC in the preparation of this Review.

There is no doubt that the issues in relation to representation are complex and vary across England, Scotland, and Wales. Therefore, this Report does not seek to propose simple solutions, but rather it suggests options for consideration and further discussion.

It will be for GPs and LMCs to determine any future evolution or change in relation to representation.

Dr Douglas A Moederle-Lumb

Executive Summary

I was selected by GPDF to lead an independent review of the current representative structures of general practitioners in the UK. The Review arose from a motion passed at the Annual Conference of representatives of [UK] LMCs in 2021 and required me to consider the existing structures and to identify potential options for improvement.

The voices of GPs were captured in a number of ways including an online survey and consultations with a range of individuals. I also considered the reports and outcomes of earlier reviews and reports.

The themes which emerged from the evidence I received were familiar and consistent with those earlier reviews and reports.

What emerges from the evidence provided to me is a surprising degree of unanimity across England, Scotland and Wales. The further away GPs were or felt from their representatives, the less satisfied they were with them. On the whole GPs in all countries were fairly satisfied with the support they received from their LMCs.

GPs across all three countries felt that their representation could be improved. GPs in Wales and Scotland were generally more positive about the arrangements in place than those in England. There was a view that England had a particular problem which should be addressed without impacting on arrangements in Scotland and Wales, which were working better.

The evidence also revealed the very real tensions that exist between certain groups of GPs.

The tension that was brought into sharpest relief was that between sessional GPs and

partner GPs which was most notable in England but existed to a lesser extent in Wales and Scotland. Whilst this Review cannot provide any solution to this problem it can offer some options for consideration and it does shine a light on the situation and on the consequences for the profession if it is not addressed.

Many GPs expressed a desire to improve the current system without creating new organisations or additional layers of bureaucracy. There was a real concern that the voices and influence of GPs would be diluted and weakened if this came to pass.

One of the most significant barriers to achieving improvement appeared to me to be a lack of knowledge of how the existing structures operate. Disseminating reliable information in accessible formats to GPs is the first step to empowering GPs to access and engage with the representative structures. That engagement should enable GPs to influence policy and practice issues and to more effectively hold their representatives to account.

The evidence I received was not a call for the wholesale dismantling of existing structures. There was a recognition that, although imperfect, existing structures were capable of working well and could be substantially improved and refreshed. The call was to do things better; to build in systems of accountability. There was a desire for more effective representation and an acknowledgment that this requires effective representatives who are appropriately skilled and resourced and who reflect the populations that they serve. Providing meaningful equality of opportunity was recognised as central to this ambition. There were suggestions for practical reforms to bring this about and to embed good practice.

It is hoped that this Review will contribute to enabling the debate from conference to continue and to be taken forward.

IJEOMA OMAMBALA QC

6 May 2022

Part 1: Introduction

1. GPDF commissioned the Review following a Motion passed at the Annual Conference of Representatives of [UK] LMCs in 2021 which called “on GPDF to commission a thorough review of the current representative structure [of General Practitioners], particularly seeking the views of LMCs”.
2. Following the Motion, GPDF consulted with a number of senior individuals within LMCs and the UK and national GPCs in an to attempt to seek clarity as to the scope of the Review, and in particular whether it should cover representation of GPs in England only or include the other three countries in the UK. There was no consensus from these Consultations and therefore GPDF has instructed that the Review should look at the whole of the UK, given that the Motion was passed at the UK-wide conference. However, Northern Ireland has its own General Practitioners Defence Fund and is in a different situation to the other countries in terms of the relationship that subsists between GPC UK and Northern Ireland GPC. GPDF therefore considered that the representative structures in Northern Ireland did not fall within scope of this Review but I was asked to, and did, look at the representative structures in Northern Ireland. Relevant individuals within those structures were spoken to in order to establish what works well within the Northern Ireland framework, and whether any of the systems or approaches might benefit other parts of the UK. I was not asked and therefore have not considered how structures in Northern Ireland may be revised.
3. Initially it was anticipated that this Review would report to the Annual Conference of Representatives of [UK] LMCs in 2023. However, it was decided by GPDF that in view of the unprecedented pressures on general practice at this time and the need to move

quickly, awaiting a report outcome in 2023 would be detrimental and could result in the matters reported being outdated as a result of the rapidly changing landscape, particularly the move away from CCGs in England to ICSs. Therefore, as requested this Review has been conducted within a timescale which allows GPDF to report its publication by the Annual Conference of Representatives of [UK] LMCs in 2022. This report is not designed to make specific recommendations or to provide a definitive view. Rather, the hope is that it will identify common themes and ideas for change within the profession enabling the debate at conference to continue and be taken forward.

Purpose, scope and expected outcomes of the Review

4. The primary purpose of this Review is to look at the existing structures in England, Scotland and Wales which represent GPs on a national and local basis, and to report on what is working well, what is not working so well, and to identify possible options for improvement.
5. As mentioned above, I was not asked to provide options for improvement in respect of the representation of GPs in Northern Ireland. As a result, references in this report to “all countries” or “all/the national GPCs” refer only to England, Scotland and Wales and the GPCs in respect of those countries (unless indicated otherwise).
6. Specifically, GPDF has commissioned a critical, independent assessment of the functionality and efficiency of the communications between GPs, LMCs, GPC UK, the national GPCs and the Executives, and representation of GPs at a local and national level. I was asked to look at the level of satisfaction with the following issues:
 - 6.1. Representation regarding the current National Contract in each country.

- 6.2. Representation regarding engagement with Governments and NHS bodies.
- 6.3. Representation by GPC England, GPC Scotland, GPC Wales and GPC UK.
- 6.4. Representation of Sessional GPs.
- 6.5. Communication between GPs, LMCs, GPC and the Executive in each of the three countries.
- 6.6. Services and support provided by LMCs to their constituents.
- 6.7. Wellbeing, workload and workforce.
- 6.8. Equality of opportunity.

7. There is a proposal to establish a National Association of LMCs. That proposal is out of the scope of this Review. It is being considered as part of a separate review process. That said, given that this too would form part of the representative framework (if established), the possibility of creating such an association was touched upon throughout the Interview process. I therefore report briefly on the views expressed on this issue, recognising the possibility that it may form part of the broader representation structure in the future.

Part 2: Glossary

Annual Conference of Representatives of [UK] LMCs	An annual conference of representatives of LMCs based in the United Kingdom. There are separate Annual Conferences of LMCs in England, Northern Ireland, Scotland and Wales.
APMS	The APMS framework allows contracts with organisations (e.g., as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services. These generally have more flexibility than GMS or PMS contracts.
ARM	Annual Representative Meeting. The major annual meeting of BMA members. Also known as the RB (Representative Body).
BMA	British Medical Association which is a company limited by guarantee, a professional organisation, medical publisher and the medical profession's trade union. This is separate from GPDF.
BMA Articles	BMA Articles of Association and Bye-Laws.
CCG	Clinical Commissioning Group.
Consultations	Consultations carried out by GPDF in the Summer of 2021 for the purposes of ascertaining the scope of the Motion.
Executive	The team (referred to as the Executive or Negotiators) within each national GPC charged with leading negotiations and representing the views of GPs in their respective country on all matters affecting general practice on behalf of their GPC. Remuneration of the Executive committee members is funded by the BMA partly from the annual grant to the BMA from GPDF.
GMS	General Medical Services (is often the abbreviation used for one of the national standard GP contracts).
GPC Secretariat	Administrative support for GPCs provided by the BMA.
GPC UK	The General Practitioners Committee. A standing Committee of the BMA with national sub-committees in England, Wales and Scotland, referred to collectively as the GPCs.
GPDF	Formerly named the General Practitioners Defence Fund, GPDF is a company limited by guarantee consisting of members who are nominated by LMCs across Great Britain. It is governed by an elected Board of Directors (in addition to three appointed independent directors) and works alongside the BMA (providing funding to LMC conferences/ Executive salaries and GPC honoraria).
GP	General Practitioner (Doctor).

ICS	Integrated Care System.
Interviews	One to one interviews conducted by Penningtons Manches Cooper LLP for the purposes of this Review.
JLRAL	James Law Research Associates Limited. An independent market research company and advisors to GPDF on research and insight. JLRAL also acted as project manager coordinating those involved in this Review.
LMCs	Local Medical Committees. Local representative committees of GPs in England, Wales and Scotland.
Meldrum Reforms	Reforms made following a 2016 report of the GPC Reform Task Group led by Dr Hamish Meldrum, former chairman of GPC UK and the BMA.
Motion	Motion 14 (iii) passed at the Annual Conference of Representatives of [UK] LMCs in 2021.
National Association of LMCs	A proposed new body or bodies that is currently being considered but is outside the scope of this Review.
National Contract	Contracts governing the national provision of medical services to the general public made between the GP contractor and the NHS Commissioning Board in England, the local Health Boards in Scotland and Wales.
National GPCs	National sub-committees of GPC UK in England, Scotland and Wales referred to collectively as the national GPCs.
Performers List	The list on which any GP offering primary care in an NHS setting is required to be registered.
PMS	Personal Medical Services (is often the abbreviation used for one of the national GP contracts).
Principals	National Contract holders.
Review	Review of the Current Representative Structure of General Practitioners in the UK by Ijeoma Omambala QC carried out between March and May 2022.
Romney Report	The 2019 Confidential report by Daphne Romney QC for the BMA which considered allegations of sexism and sexual harassment experienced by BMA members and staff during their work with the GPC.
SchARR Report	A 2003 report from the University of Sheffield School of Health and Related Research titled Leading Medical Consensus – Local Medical Committees in the 21 st Century by Chris Fewtrell and David Martin of November 2003.

Sessional GPs	Salaried, locum and retained GPs.
SHG	Survey Healthcare Global, an independent market research company.
Survey	The survey carried out for the purposes of the Review by SHG in March to April 2022.

Part 3: Methodology

8. This Review has been conducted using a two-stage process. It was considered appropriate to give every GP the opportunity to participate in a consultation to inform this Review. Every LMC was requested to forward an invitation to every GP in their area from the Chair of GPDF (Dr Douglas Moederle-Lumb). A 20-minute online consultation questionnaire (Survey) was prepared by James Law Research Associates Ltd (JLRAL) based on validating or rejecting the views which had been expressed by representatives of LMCs in previous discussions and other forums. Survey Healthcare Global (SHG) managed the hosting and analysis of findings from the GPs/LMCs in England, Scotland and Wales who participated. JLRAL is a specialist market research consultancy which has been working with GPDF for a number of years. SHG is an independent market leader in data collection for healthcare market research. The full detail of results gathered from the Survey are included in the Appendix. Simultaneously, a number of in-depth Interviews were conducted.
9. The Survey was open for a period of 16 days and received 957 responses, which represents around 2% of the GP community. While I am informed by JLRAL that this level of proportionate participation is common in many consultation projects, it was less than hoped for in this Survey. I am conscious that this response rate is not sufficiently high for the responses to be considered as representative of GPs as a whole. However, GPs covered by 94 LMCs (of 125 in total) responded, with 280 responses not identifying the respondent's LMC. A list of the 94 LMCs from which GPs participated is included within the Appendix for information. Not all questions were answered by all who took part as this was a voluntary consultation. It is not clear why a greater number of GPs did not

respond. However, I am grateful to all of those who did take the time to fully engage with this Survey and to those who participated in the Interviews. The data collected provides some indication of core issues and themes within the GP community.

10. Most of the responses to the Survey were received from GPs in England (784) with 140 received from GPs in Scotland and 33 from Wales.

11. The responses received covered GPs with a range of experiences (from fewer than ten years' experience as a GP to over 40 years') and positions (trainees, locums, salaried GPs, fixed share partners, salaried partners and partners). The majority of respondents have been in practice for ten years or more. There was a higher number of responses from partners, which is not proportionately representative of the current GP population with just under half of GPs in England now being Sessional GPs. There was a fairly even split of responses from males and females. Most GP types showed a higher number of male respondents, with a greater number of female respondents among Sessional GPs. A majority of the respondents across England, Scotland and Wales were members of the BMA.

12. Feedback was received by GPDF from two individuals on behalf of their LMCs out of the 125 LMCs who received the Survey. These individuals queried the appropriateness of questions regarding GPs' contentment with representation by LMCs. They felt that the Survey questions were not sufficiently clear and/or that most GPs would not understand the activities of the Annual Conference of Representatives of [UK] LMCs or the decision-making process to be able to answer some of the questions meaningfully. This observation is illustrative of the problems that gave rise to the Motion and of a general

theme that came through in the Interviews and within the Survey responses. This is addressed in the Outcomes and Options sections of this Report. Also raised in the Interviews by a very small minority was a concern that the Survey appeared to be biased against the GPCs. However, the Motion specifically asked GPDF to address representation by the GPCs so its focus on GPCs is unavoidable.

13. I have considered transcripts of Consultations between GPDF and a range of individuals which also addressed the individuals' perspectives and opinions on current representation. In addition, I have considered various earlier reviews and reports including the SchARR Report, the report of the GPC reform task group led by Dr Hamish Meldrum and the Romney Report.

Part 4: Summary of Current Representative Structure

Local Medical Committees

14. Local Medical Committees (LMCs) are independent bodies recognised in statute representing individual GPs and GP practices at a local level. LMCs are independent, elected representative bodies. LMCs in England and Wales are funded by a statutory levy paid by GP practices which varies (I am told, from 15p to £1 per patient per year) and is set by each LMC. Arrangements in Scotland differ. Some LMCs work together in different models to provide joint secretariat. LMCs represent GPs in the geographical area that they cover.

15. LMC members are GPs on the Performers List. They are elected by the GPs in their local area according to the individual LMC's constitution. There are three national Annual Conferences of LMCs which feed into an Annual Conference of Representatives of [UK] LMCs where issues concerning / affecting GPs are debated. Motions passed at the Annual Conferences of LMCs are passed to the relevant GPCs. There is no requirement for GPCs to act on these motions. The LMCs interact with the GPCs, with each other and with other stakeholders. They engage in and are consulted on a wide range of issues as well as providing professional, pastoral and business support to GPs. LMCs should provide a link between GPs in the community and the national GPC in each country.

General Practitioners Committees of the BMA

GPC UK

16. GPC UK is a standing committee of the BMA and its role and membership is defined in the BMA's Articles. It deals with all matters affecting NHS GPs, regardless of BMA membership. GPC UK has sub-committees comprising GPC England, GPC Scotland, GPC Wales, the Sessional GP Committee and the GP Trainees Committee. Although there is a separate sub-committee for Sessional GPs, Sessional GPs are able to, and, many do, also participate in their national GPC sub-committee. This can be in addition to or instead of participation in the Sessional GP Committee.

17. GPC UK meets twice a year. GPC UK consists of:

17.1. Forty three (43) regional seats whose representatives are elected for a 3-year term. Any GP who lives or works in that region and who is a BMA member is eligible to vote and/or stand in regional seat elections;

17.2. Seven (7) seats elected at the Annual Conference of Representatives of [UK] LMCs for a 1-year term, one of whom must never have held membership of the GPC in any capacity. Although all GPs are eligible to stand for election, only Representatives of LMCs may vote in these elections. BMA membership is also required;

17.3. Ten (10) members elected by the Annual Representatives Meeting of the BMA ("ARM") for a 1 year term. Any working GP or LMC officer who is a BMA member can stand for election but only ARM representatives can vote;

17.4. Twenty-three (23) voting seats allocated to the Chair and Deputy Chair of the Annual Conference of Representatives of [UK] LMCs, Chairs of GPC Scotland and GPC Wales, representatives from the Sessional GP Committee and the GP Trainees

Committee and representatives appointed by other groups, for example the Medical Women's Federation, the British Indian Doctors' Association and Doctors in Unite;
and

17.5. A number of non-voting positions.

18. GPC UK is also able to co-opt up to six members from under-represented groups (which, for these purposes, refers to the contract type or classification of the practitioner, not their protected characteristics).

19. All GPC UK members have a seat on their national GPC. The vast majority of GPC UK members work or live in England and are therefore automatically members of GPC England.

20. The Chair of GPC UK is elected by the four chairs of the national GPCs for a period of three years.

National GPCs

21. As above, GPC UK has sub-committees in respect of England, Scotland and Wales which specifically attend to issues affecting each of their respective countries. The Executive teams of these national GPCs conduct the negotiations in relation to GPs' contracts with their respective governments. According to the BMA website, GPC England and GPC Wales meet 4 times a year, and GPC Scotland meets 5 times per year. Any changes to BMA policy or bye-laws must be passed by the Representative Body of the BMA.

22. The Chairs of each national GPC are elected by the members.

23. In England, the Executive is successfully interviewed and appointed by the Chair of GPC England. In Scotland, the Chair nominates individuals to be part of the Executive Team and the GPC members then vote. In Wales, the Executive are elected by the GPC members. In Scotland and Wales, members of the Executive must be members of the GPC, but this is not always the case in England.

24. There is currently no cap on the number of successive terms any individual can serve on the GPCs or the Executive teams. There is a cap on the length of time an individual can serve as a Chair of the GPCs.

The BMA

25. The BMA is a professional association and trade union for doctors, including general practitioners. It is partly funded by membership fees.

The Representative Body

26. The representative body of the BMA is known as the RB. It meets at least once a year at the ARM. It is the BMA's main policy making forum. The ARM also elects representatives to roles and committees and can propose changes to BMA Articles to the BMA's AGM.

27. There are 560 seats available on the RB. BMA members are eligible for election to the RB via their branch of practice or by virtue of their BMA membership.

GPDF

28. GPDF is a company limited by guarantee whose objects include:

28.1. to support and promote the interests of GPs and LMCs;

28.2. to provide funding to the BMA or another relevant organisation for the benefit of LMCs and GPs;

28.3. to fund activities of benefit to LMCs and GPs including the provision of development grants;

28.4. to liaise with other national and governmental bodies in order to further the interests of the LMCs and GPs.¹

29. GPDF characterises its functions as: listening, supporting and influencing. It works with LMCs to strengthen their voices at national representative level. It funds interventions in legal matters that benefit LMCs and the wider GP community. It also funds initiatives that aim to support the effective functioning of all LMCs and of general practice.

30. GPDF is not a statutory body, or a trade union and it does not negotiate with national governments. It is funded by a voluntary levy from GP practices. Its membership consists of nominees from LMCs. Each LMC is entitled to appoint a nominee to be a member of GPDF.

¹ GPDF Articles of Association 25 March 2020 Article 3

Part 5: Outcomes

Representation by LMCs in all countries

33. On the whole, GPs in all countries were fairly satisfied with the support they received from their LMC. On a scale of 1-10, with 1 being “Very Dissatisfied”, 10 being “Very Satisfied” and 5.5 being the “Middle Score”, Scotland reported the highest levels of satisfaction with an average score of 7.1 (from 118 responses), followed by England with an average score of 6.7 (from 637 responses) and then Wales, with an average score of 6.1 (from 25 responses). The factors driving satisfaction with LMCs related to their engagement with local GPs, their responsiveness, good communication and the provision of support. The main reasons for dissatisfaction related to LMCs not being representative and being ineffective in bringing about positive change. LMCs reported that a lack of resources was a barrier to providing effective support to those within their community. Tables provided to me by SHG detailing their analysis of the Survey responses to the follow up question of “*Why do you say that?*” (in reference to the respondents’ reply to “*To what extent are you satisfied with the services and support which are provided to GPs in your area by the Local Medical Committee (or combined LMC organisation)?*”) are set out below:

Table 1: Areas of Satisfaction²

	England N=120	Scotland N=32	Wales N=2
Engaged/responsive/good communication	38.3%	43.8%	50.0%
Supportive/good support/act in interest of GP	32.5%	18.8%	50.0%
Respondent is medical officer/on the LMC	14.2%	15.6%	0.0%
Good/excellent representation/representative	10.0%	15.6%	0.0%
Good/excellent/try hard/do a good job (unspec.)	7.5%	12.5%	0.0%
Knowledgeable/good advice	7.5%	3.1%	0.0%
Understand (local/national/political) issues	6.7%	0.0%	0.0%
Regular feedback/communication	5.8%	9.4%	0.0%
Education/mentoring	5.0%	0.0%	0.0%
Helpful	5.0%	6.3%	0.0%

² Please note: I am informed by JLRAL that the above tables are derived from 'open text' responses to a follow-up question asked to those who indicated they were 'Satisfied' and to those who indicated they were 'Dissatisfied' asking 'why' they were satisfied or dissatisfied. The 'open text' comments have been grouped into themes and statistically analysed to establish the proportion holding each view. It would not be appropriate to interpret that the balance of respondents held an opposite view.

Table 2: Areas of Dissatisfaction³

	England N=67	Scotland N=9	Wales N=2
Not representative	16.4%	33.4%	0.0%
Don't do anything/nothing changes/not effective	14.9%	22.2%	100.0%
LMC is weak/ignored/has 'no teeth'	13.4%	11.1%	0.0%
Communicative/engaged/responsive	13.4%	0.0%	0.0%
Supportive	11.9%	0.0%	0.0%
Don't listen/engage/communicate	10.4%	33.3%	50.0%
Old/retired GPs (should not represent working GPs)/Out of touch	7.5%	11.1%	0.0%
Not supportive/poor support	7.5%	0.0%	0.0%
Approachable/helpful	7.5%	0.0%	0.0%
Put profits first/self-interested	4.5%	0.0%	0.0%

³ Please note: I am informed by JLRL that the above tables are derived from 'open text' responses to a follow-up question asked to those who indicated they were 'Satisfied' and to those who indicated they were 'Dissatisfied' asking 'why' they were satisfied or dissatisfied. The 'open text' comments have been grouped into themes and statistically analysed to establish the proportion holding each view. It would not be appropriate to interpret that the balance of respondents held an opposite view.

Representation by GPC UK and national GPCs

National Contract, Engagement with Governments and Representation

34. Whilst there is greater dissatisfaction in England than in Scotland and Wales, GPs in all nations reported being dissatisfied with:
- 34.1. national representation;
 - 34.2. their current contracts;
 - 34.3. engagement with the NHS;
 - 34.4. engagement with governments; and
 - 34.5. representation by their national GPC.
35. All categories of GP (partners, fixed share partners, salaried partners, Sessional GPs, and GP trainees) in each country expressed similar levels of dissatisfaction. The Survey responses revealed a particular dissatisfaction with representation by the national GPCs amongst rural GPs in general and in Scotland in particular.
36. The average score from responses in England in respect of satisfaction with representation by GPC England was particularly low, at just 3.9 out of 10 (from 713 responses). A major theme running through the Survey, Interviews and Consultations was that there is a disconnect between GPC England and LMCs in England. GPC England was at times described as 'dysfunctional' and plagued with 'infighting'. The Survey results showed dissatisfaction with representation in Scotland and Wales but to a lesser extent. Overall, respondents from England and Scotland did not feel that the Executives followed the wishes of the national GPC membership. Respondents from Wales did feel that the Executive followed the wishes of GPC Wales, but not to a great extent.

GPC UK

37. In relation to GPC UK specifically, there was an overwhelming view that its focus was too Anglo-centric, with debates at GPC UK meetings thought to illustrate this imbalance.

There was said to be little or no time to focus on issues of concern to the other countries.

This led to a questioning of the role, purpose and value of the GPC UK.

38. Survey respondents and Interview participants considered that national contract negotiations and discussions should be addressed at the respective national GPC meetings. There was a consensus from a significant number of participants in this Review that GPC UK's membership should be reduced and its focus re-directed towards education, training and knowledge sharing between countries. I understand that a GPC UK Task Force has looked at these issues in detail, however, reforms, or indeed, any other changes, have yet to be agreed.

Representation by GPC England

39. I have included the following section regarding representation by GPC England specifically due to a number of common problems identified in the Consultations, Interviews and Survey. That is not to say that no criticism was levied at representation by the GPCs of Scotland and Wales. The Survey results in particular demonstrated that representation by GPC Scotland and GPC Wales could be improved (which is addressed in other sections below). Survey respondents in Scotland and Wales may recognise some of the problems as being ones that they too raised in their response (in addition to others). However, the core issue within the English structure, being a perceived

disconnect between the representative bodies, did not come through in the Interviews regarding Scotland and Wales.

Representation by GPC England: relationship with LMCs

40. There was a strong feeling of disconnect between LMCs and GPC England specifically.

The charge was often that neither GPC England, the BMA, nor the Executive team gave sufficient weight to motions passed at the Annual Conference of Representatives of [UK] LMCs. There was no effective mechanism for ensuring that the views of grass roots GPs were heard and taken into account in developing policy and devising negotiating strategies.

41. The Survey also identified a number of other reasons behind a perceived disconnect between GPC England and LMCs: -

41.1. Representatives on GPC England do not always have an effective connection to an LMC;

41.2. Representatives are insufficiently resourced so that they are unable to report back to LMCs effectively;

41.3. Poor communication generally and a lack of feedback from GPC England representatives to LMCs; and

41.4. Not all LMC members are aware of and/or engage with the process for voting for GPC UK and GPC England members.

42. There is a view that many GPC representatives simply 'represent themselves' and their own interests rather than those of their LMCs and that representatives from the LMC

Conference are largely self-selected. This was a theme both in the Interviews and in the Survey responses.

Representation by GPC England: elections to GPC England and composition of the Executive

43. Contributors to this Review also spoke of a feeling that elections to GPC England are run by an 'old boys' network' with many seats on GPC viewed as seats belonging to a particular individual. This results in seats not being contested so that the same individual is elected term after term, without challenge, sometimes with a very low level of support. Anecdotal and other evidence suggests a degree of disengagement from the electorate on the part of GPC England representatives. I have seen comments that this results in blocking access to fresh ideas and personnel. The result is that representatives are less diverse and fail to reflect the demographics of the profession and their supposed constituencies.

44. As to the change from election of the Executive of GPC England to appointment of the Executive by the Chair which resulted from the Meldrum Reforms, contributors expressed the view that this change should be reversed as the current process is undemocratic. Opposing views supported the current appointment process emphasising the importance of the Chair having synergy with the Executive. It was felt that this can be achieved by the Chair selecting her or his team.

45. The current appointment process militates against a transparent evidence-based process which provides equality of opportunity to eligible candidates. It is also not consistent with current equality, diversity and inclusion best practice.

46. Issues were also raised around communication between the Executive and GPC England with the Executive accused of being too “secretive”. Contributors have commented that GPC England has no real influence over the Executive and that GPC England is informed of decisions on matters as a ‘fait accompli’ with no scope or opportunity to consult members or LMCs or to affect outcomes.

47. A number of contributors also observed that more resources are needed to support the Executive. There was also criticism of the level and quality of support provided by the BMA Secretariat in recent times.

Representation of Sessional GPs

48. There appear to be conflicting views on whether representative structures in England and Scotland benefit Principals or Sessional GPs. Where Sessional GPs do, or should, sit within these representative structures was identified as one of the core issues to be ‘bottomed out’ by the profession. The issue did not figure as prominently in responses from Wales.

49. One view is that Sessional GPs, who are not NHS contract holders, should not be involved in contractual negotiations. The contrary view is that the future of the profession depends on Sessional GPs who make up a significant proportion of all GPs and just under half of GPs in England. Their terms and conditions are important, and they should be proportionately represented on GPC UK and the national GPCs. If fair representation is not achieved, Sessional GPs will, it is said, eventually break away and demand that they receive proper funding in their own right for new structures.

50. I am told that there are approximately 20 Sessional GPs on GPC UK. Of these, some are retired Principals. The claim is that, as a result, they do not truly represent the voice of the typical or 'career' Sessional GP. It was reported in Interviews that the Sessional GP Committee receives £70,000 in funding, whereas GPC England receives £2 million and yet fails to provide adequate representation for Sessional GPs. These figures have not been verified. Similar data was not available for Scotland and Wales.

Communication between GPCs and LMCs

51. BMA ListServers are a common means of communication for LMCs and members of the GPCs. They are variously accessible to other stakeholders and individuals within the BMA. Some updates to LMCs are posted on an LMC ListServer. Some contributors to this Review have noted that useful updates and other materials are difficult to find on the LMC ListServer and can get lost among other comments. Some contributors also commented on the sometimes abusive, disrespectful and/or unpleasant language used by some GPs to speak to one another on the ListServers. This was an issue highlighted in the Romney Report. Rude, bullying and disrespectful communication on the ListServers clearly acts as a disincentive to participation in LMCs in general. In addition, it has the potential to contribute to the marginalisation of women, BAME and other minority voices within LMCs and GPCs. Ensuring appropriate communications on LMC ListServers is one way to encourage engagement with the structures that are supposed to represent all GPs' interests.

Representation by the BMA

52. Respondents in England and Wales felt that the BMA was conflicted in negotiations because it is representing GPs who are employers and GPs who are employees. It was felt that the BMA was also conflicted in representing GPs as a collective and NHS employed doctors. This was not a view shared by respondents in Scotland, although they did not report strongly held views on this issue.

Role of GPDF

53. Most respondents surveyed were unfamiliar with the activities funded by GPDF. The highest awareness was in relation to funding legal matters and initiatives supporting LMCs. Most GPs thought that this was an appropriate use of GPDF funds. Most GPs also considered that it was appropriate for the GPDF to provide grants to top-up GPC honoraria payments, the Executive teams payments, the LMC ListServer, and the GPC Secretariat, and to strengthen the voice of LMCs and GPs at a national level. In fact, GPDF does not fund the LMC ListServer or the GPC Secretariat. There were some suggestions that GPDF accumulated funds should be reduced and the funds deployed to provide additional assistance and support, both to improve the effectiveness of representation and the wellbeing of grassroots GPs.

Workforce, workloads and well-being

54. GPs in all categories across all nations surveyed felt that representation in relation to workforce levels, workloads and well-being, has been ineffective, with England scoring the lowest satisfaction ratings on this issue.

Equality

55. In England and Wales respondents did not feel that representation in relation to equal opportunities had been effective. Those in Scotland did feel that representation on equal opportunities had been effective, but not to a great extent.

56. Some of the respondents indicated a need to address equality and diversity on national and UK GPCs. In relation to GPC England, specific comments included that there was “a gender bias towards men”, and that “young women are seen to be encouraged but do not get anywhere”. In relation to Scotland, comments focussed on the under-representation of women with one respondent referring to the BMA committee as being “made up of older men who meet together to play golf”. Several respondents suggested that aspirational targets alone do not work to ensure diversity and representation and mooted quotas on GPCs for individuals with protected characteristics. This was recommended in the Romney Report for a time restricted period of 10 years, in the hope that organisational cultures and therefore the balance of representation would by then change.

Areas for improvement

57. Perhaps unsurprisingly, a majority of respondents across all nations believed that GP representation could be improved (69% in England, 65% in Scotland and 63% in Wales). This sentiment was strongest in England. A relatively high number of respondents said they did not know whether representation could be improved (18% in both England and Scotland, and 33% in Wales). This could point to a lack of understanding of the systems of representation which exist and/or a lack of engagement, which is addressed later in

this report. Equally, it could reflect a disenchantment with the current representative structures.

58. GPC members in the three countries had a more positive view of representation by GPC on the whole, with most being satisfied with representation, but still believing that representation could be improved.

59. The top ten areas identified for improvement are contained in Table 3.

Table 3: Top 10 areas for improvement in representation by national and UK GPC⁴

	England (n=413)	Scotland (n=62)	Wales (n=15)
More/better engagement/representation with local/grass-roots GPs	20.6%	17.7%	26.7%
Improve PR/(social) media coverage	15.0%	12.9%	6.7%
Better/tougher (contract) negotiation	10.2%	8.1%	20.0%
More transparency/clarity of role/representation	8.5%	6.5%	13.3%
More/better communication	8.5%	16.1%	13.3%
Improve workload/reduce pressure	8.5%	4.8%	6.7%
Need to be taken seriously/listened to by Government/NHS/higher bodies	8.5%	4.8%	0.0%
All/more GPs/types of practitioners should vote/be represented/involved	8.2%	8.1%	6.7%
Different/better representation for partners vs. salaried GPs	7.5%	8.1%	6.7%

⁴ Please note: I am informed by JLRAL that the above table is derived from 'open text' responses to a follow-up question asked to those who indicated they considered there were areas for improvement regarding representation. The 'open text' comments have been grouped into themes and statistically analysed to establish the proportion holding each view. It would not be appropriate to interpret that the balance of respondents held an opposite view.

Hold more/regular meetings/Q&A sessions/surveys/ballots/referendums	6.8%	0.0%	0.0%
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60. In addition, there were some suggestions for improvement which endorsed the proposal to create a National Association of LMCs to: support LMCs, help the LMCs to standardise practices within them (including for example offering model constitutions which limited the number of terms in office of LMC Chairs with model policies and pro forma accounts). Most of those respondents who expressed support for a National Association of LMCs emphasised that it should not act as a competing body to GPC England or the BMA.

61. There were also voices which argued against a National Association of LMCs, on the basis that it would be divisive and cause greater confusion.

Part 6: Options

Representation by GPCs and the Executives, and Communication with LMCs and Grass-roots GPs

62. Communication and representation in Scotland and Wales appeared to be regarded as significantly better than in England (although even in these nations the level of communication was still criticised). The better communication in Scotland and Wales was said to be due to there being a representative from every LMC on the national GPC which created a strong bond between LMCs and their national GPC. In turn, this meant that there was a direct line of communication between the two bodies. This system was said to work well.

England

63. A summary of the main GPC England issues identified in the responses received were that:

- GPC England representatives often did not have a connection to an LMC or if they did, they tended to only report back to “their” LMC;
- Poor communication between GPC England and LMCs / grass-roots GPs generally;
- a lack of democracy and engagement in the voting process due to the persistence of an “old boy’s network” in GPC England, which also had the effect of protected characteristic groups being underrepresented.

These are not new issues and have been identified in prior reports.

Representation

OPTION 1: LMCs Working Together Within the Current Structure and Voting Systems

64. While the system in Scotland, Wales and Northern Ireland cannot be replicated exactly in England due to the number of LMCs in England, there is the opportunity for representatives of LMCs in England to hold a majority of the seats on GPC UK (under its current structure and membership composition), and therefore be co-opted on to GPC England and so be able to make changes from within.

65. The main ways to access a seat on GPC UK for GPs associated with an LMC are via:

65.1. Regional elections – 43 seats (although of this, 5 will be outside of England) – any working GP who lives or works in that region and who is a BMA member can stand and vote;

65.2. Annual Conference of Representatives of [UK] LMCs – 7 seats – LMC Conference representatives can nominate and vote (BMA membership is also required); and

65.3. ARM – 10 members - any GP who is a BMA member can stand, only ARM representatives can vote.

66. There is therefore the potential for LMCs to put forward representatives for 60 of the 82 voting seats on GPC UK. At present only 38 of these possible 60 seats are held by GPs associated with an LMC. If LMCs put forward candidates for these seats and encouraged their GP constituents to vote, LMCs could command a majority influence over GPC.

67. I recognise that achieving greater LMC representation on GPC is not a quick or easy process. It will require a concerted effort to identify and target the required number of

seats that are open for re-election each year. Information and relevant materials will then need to be devised and shared with eligible GP candidates and GP voters to encourage and assist them in standing and voting in elections.

68. Many GPs are deterred from presenting themselves as candidates for election by the perceived workload, lack of resources, support and funding available to enable them to undertake the role effectively. However, it is certainly possible to increase the representation of LMCs on GPC England, particularly if additional resources (including funding) were made available to the GPs elected to the role. If LMCs work together to reach this objective, success is more likely.

69. If LMCs are able to work together to hold a majority of seats on GPC England, motions can be passed to effect changes to its structure.

70. More LMC representatives on GPC England is likely to reduce communication issues between GPC England and the LMCs. However, as there are not sufficient seats for every LMC, this may result in LMCs from some regions holding more seats than others and lead to GPs within some (potentially very wide) areas still lacking effective GPC representation. LMCs working together to form regional alliances or coalitions and presenting a single joint candidate for election may help to mitigate this difficulty (see below).

71. The structure above is focussed on GPC England. In Scotland and particularly Wales, there appears to be less call for such an option because the coordination between the LMCs and their national GPC elections are more closely aligned.

OPTION 2: Reform of the Current Structure and Voting – Geographical LMC Representation System

72. An alternative to address the representation and communication issues could be to redefine all current routes to GPC UK (to remove membership through the ARM for example), or to abolish the link to GPC England through GPC UK and to define a separate route to membership of GPC England specifically. The latter may be preferred as the membership composition of GPC England is simpler to revise. Either way, seats could instead be allocated through the creation of a geographical representation system, whereby each seat on GPC England (or GPC UK if the co-option is retained) represents LMCs in a particular region. England would need to be divided into regions and every LMC within each region would be encouraged to put forward a candidate for election by GPs working in that region. Such a system would more closely reflect the systems in Scotland, Wales and Northern Ireland which are said to work better. Consideration could also be given to multi-member constituencies (that is, geographical areas having more than 1 representative) with the aim of enhancing diversity and reducing the workload of representatives.

73. In order for a geographical representation system to operate effectively, a minimum standard of communication would need to be drawn up for GPC England members, to include communications/updates to be issued at set points in time and attendance at meetings with the LMCs that the GPC England member represents. For this to be possible, there would need to be sufficient administrative support and funding available as the new and more formalised representative role would be a time-consuming role

requiring the individual to take time away from practice (even with the widespread adoption of digital meeting technologies such as zoom).

OPTION 3: Reform of the current structure and voting – geographical constituency-based GP representation system

74. An alternative and, perhaps, more radical model to address the perceived disconnect between GPs and GPC England would involve all members of GPC England being directly elected. This representation model would see candidates not being linked to or nominated by a particular LMC or cluster of LMCs but instead being elected by the GPs in a particular geographical area, without that relationship being mediated via an LMC. Directly elected GPC England members would be free to choose whether and how to engage with the LMCs in the area they represent. They would be directly accountable to their constituent GPs whose expectations and priorities they could ascertain with greater immediacy. Such a model might encourage a greater degree of proactivity and innovation from representatives. It might also encourage greater engagement and participation from all ‘grassroots GPs’ particularly under-represented groups and support a more diverse and inclusive pool of representatives. Within this option, there could be a system of recall if the elected representative cannot justify their contribution to constituents annually. This might be seen as the most directly democratic option.

75. Such a model implies greater professionalisation of the representative function than has been present in this area to date. It would necessarily bring with it the need for better use of resources. It might also include the need for more funding for representation.

Implementation

76. Implementation of a geographical representation system for England would need the approval of GPC UK. There are various ways in which this could be achieved. Motions could be passed at the Annual England LMC Conference (although GPC is not mandated to consider motions passed by LMCs at the Conference and so any motions passed may be ineffective). Alternatively, LMCs can work together (as outlined above) to put forward representatives to GPC elections and command a majority on GPC to effect changes to the representation system.
77. To avoid a situation occurring whereby the same individuals are elected term after term, a cap on the number of years' service could be implemented. This would enable new people with new ideas to play a role and enable greater diversity and inclusion. A cap of 12 years was proposed in the Romney Report. In many organisations that would be considered too long a period of service without a break. There is a balance to be struck between retaining experience and encouraging new ideas.
78. The options above could be coupled with a focus on regional multi-member constituencies. These might produce several benefits. Properly implemented multi-member constituencies might bring clearer and more transparent lines of responsibility and accountability to and from GPC England. This would in turn enhance the effectiveness of the GPC England Executive. A better regional constituency focus in GPC England will also assist it to function more effectively. If there was an appetite to make tangible progress more quickly, multi-member constituencies, could devise positive action programmes to encourage under-represented groups. These might include

specific training and development opportunities for candidates from under-represented groups as well as specific promoting aimed at to those under-represented groups.

Raising Awareness

79. A theme running through the survey responses was a lack of understanding of the representative structures that do exist; what they do, how to become a representative and how to go about advocating for changes. This information gap is likely to exacerbate the feelings of powerlessness and disengagement within the electorate which have been observed in this and other studies.

80. It seems that grass-roots GPs would benefit from being provided with information in an easily digestible format which explains how the representative structures operate, how GPs can become involved and demystify the election processes. This material could be designed to include and encourage greater GP involvement especially from those GPs who share protected characteristics. This information could be produced by LMCs themselves (with appropriate support and resourcing) or by the BMA together with GPDF and distributed via LMCs to the GPs they represent. A more pro-active option would be to launch a campaign on a range of platforms, including via LMCs aimed at providing this information and encouraging more GPs to step forward and represent their peers at LMC and GPC level. The Survey results commented on how roadshows were very effective at engaging GPs.

Communication

81. A standard of communication outlined above regarding all GPC England (including GPC Executive) activities affecting the profession would help to resolve the issues of transparency and accountability which have been identified.

82. Communication issues could be addressed via minimum standards of communication being set by GPC England. A requirement for greater visibility and dissemination of information could be introduced. It has been suggested that meetings, newsletters and briefings are effective sources of information which could be circulated or made available (not only to members of GPC England but beyond this to LMCs and GPs themselves). Details of the achievements, objectives and progress of GPC England and the Executive could be published or posted on websites with the opportunity for in-person updates (through clinics and roadshows) from time to time. LMCs can influence any such minimum communication requirements devised by GPC England by putting forward candidates for election to GPC England and encouraging GPs to vote, as discussed above. Consideration would then need to be given as to how these minimum requirements can be facilitated and resourced.

Equality

83. Designated seats for doctors with different contractual arrangements (for example, Sessional GPs) and protected characteristic groups on GPC England have been suggested by some respondents (and was a recommendation in the Romney Report). However, this will be difficult to operate in practice with a geographical representation system unless larger regions with multi-member constituencies are used. This is an option which could be explored. A minimum requirement that the representation provided reflects the

demographics of the local area should be considered with reserved places for particular under-represented groups and with powers of co-option.

84. An alternative to this approach is to allow representation which is proportionate to the GP population demographic to happen organically over time. There has been criticism that this simply will not happen. However, a change in the way in which seats are allocated to GPC England and a concerted promotional effort on the part of LMCs to their GP constituents will assist this process. LMCs could also ensure their own constitutions encourage diversity and/or set aside seats for under-represented groups in their own organisations, which should then flow into GPC England.

85. In any event, developing appropriate role profiles and asking candidates to identify the skills, knowledge and experience they bring to a role would increase transparency and accountability in the recruitment and selection processes. It would also facilitate succession planning and enable appropriately qualified and balanced teams to be put together to undertake particular tasks or projects.

Scotland

Representation and Communication

86. The core themes for improvement from the respondents from Scotland were better communication from GPC Scotland, and better representation of and engagement with grass-roots GPs, particularly in rural areas. It is important to bear in mind (as discussed above) that due to the small sample size of the data, the responses cannot be said to be fully representative of all GPs in Scotland.

87. Communication proposals identified in relation to England above could apply equally in Scotland. The flaws identified and potential means of improvement are not applicable to England alone.

Wales

Representation and Communication

88. The core themes for improvement from the respondents from Wales were better contract negotiation, and better representation of and engagement with grass-roots GPs. As with the Scottish data, due to the small sample size of the data, the responses cannot be said to be fully representative of all GPs in Wales.

89. Again, options for improved communication referred to in relation to England could apply equally to Wales.

GPC UK

90. A common theme in the responses received from all nations is that the GPC UK is too England-focussed and is used to debate English issues of no relevance to the devolved nations who each have their own contract and negotiating rights with the governments. There is significant consensus that it would be helpful for membership of GPC UK to be reduced and for its role to become a forum for the Chairs and Deputy Chairs of the nations to meet and discuss issues affecting all nations such as workforce, workloads and well-being, educational matters; and to share learning and knowledge. Similar changes have been proposed by the GPC UK Task Force.

91. If these changes are implemented, it is likely that GPC England would require a greater number of meetings to cover all agenda items. This would require additional funding. One possibility is to meet these costs by reallocating some of the budget from GPC UK to GPC England (as a streamlining of the agenda and reduction in the number of representatives attending GPC UK meetings should reduce costs). This would require agreement among GPC UK representatives (who I understand are mostly GPC England representatives) and the opening a dialogue with the BMA and the GPDF. There have been many comments that “turkeys will not vote for Christmas” which I take to mean that representatives with a seat on GPC UK will not vote to give up or abolish that seat and the income that it brings. However, as I have set out below, the seats on GPC England revolve on either a one or three session basis, and the English LMCs hold the power to make changes to the representatives on GPC England.

Workforce, workloads and well-being

92. There are clearly major issues with high workloads, a lack of workforce, low morale and well-being, which are inter-connected, and which have been exacerbated by the global Covid-19 pandemic. These issues exist across all nations (but are reported to be worse in England). They are not confined to GPs; they are prevalent across the entire NHS.

93. It is recognised that the problems with workload and well-being often flow from the workforce issue, which should be taken up by the national GPCs or GPC UK within the BMA and by the Executives in the next round of contract negotiations with the governments. I understand that it is also being addressed by the BMA and the GPDF in the ‘Rebuild General Practice’ joint campaign aimed at highlighting the issues linked to

workforce, including recruitment and retention of GPs, GPs wellbeing and the concerns of GPs in relation to patient safety.

94. It may also be helpful for either the BMA, GPDF or a group or sub-committee of LMCs to review and enhance existing support mechanisms for GP well-being, such as support helplines, workshops focussing on stress reduction and mindfulness practices, and general health and nutrition.

95. Some of the changes discussed above such as an entirely geographical / constituency representation system providing a link from grass-roots GP constituents to national GPCs may also help GPs to find their voice and be better supported in the profession.

Representation of GPs by LMCs

96. Generally, the GPs surveyed were satisfied with representation, services and support provided by LMCs, although LMCs themselves indicated that they had insufficient resources and funding to be able to provide the level of support they would like to.

97. Despite this general level of satisfaction, there were some suggestions for improvement, including:

97.1. limited terms for the LMC Chair;

97.2. a national association of LMCs (out of scope of this Review);

97.3. model constitutions, standardised policies, financial statements (accounts) and reports across LMCs which would in particular support smaller or under-funded LMCs; and

97.4. a service quality trademark (similar to a Kitemark for instance) for LMCs, including diversity targets.