Somerset LMC Newsletter

November 2011

Issue 170

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GP PENSIONS – HOW BIG IS THE THREAT?

Most thinking people accept that there is a need for reform of public sector pensions, but the extent and depth of the changes is worrying to those of us in the public service, albeit, in the case of many GPs, as independent contractors. But what will the changes mean in practice?

It has been suggested that Public Sector pensions currently cost 1.4% of GDP and this would rise to 1.9% if they were not to be reformed: a significant increase, but not quite the matter of life and death that it is sometimes portrayed to be. It also means that it is unfair to cast them as giant Ponzi schemes, for although there is no specific savings pot for NHS pensions, a rolling cost of under 2% of Government budget is perfectly manageable. And it is partly the consequent saving in running costs that allows the NHS scheme to be both generous and efficient. About 21.5% of GPs gross pay goes in superannuation, and private schemes with similar benefits would probably cost nearer 28%.

The proposed changes fall into two groups, those arising from the Hutton report, and the operational changes already in the pipeline. Both may have an impact. High earning doctors will already have fallen into various tax traps, and inflation increases after retirement have now been switched from an RPI to a CPI basis, though we may have to concede that this is fair enough for us as most GPs will own their houses at retirement so housing cost increases do not affect our disposable income. We also do not have to worry about the end of final salary schemes as ours already depends on the actual contributions made, so the painful bit will be the likely hike in contributions. A rise in the top rate for employee contributions from 8.5 to 14.5% is possible, which may make the scheme very close in cost to a private one.

The Government has issued firm assurances that benefits already accrued will not be reduced, and the widespread fears about taxation on the retirement lump sum may be partly assuaged by these. However, as GP incomes stagnate or fall, and pressure for pension reform grows, many doctors getting towards the end of their careers may be tempted to retire, and many of them will not return to NHS work. We risk slicing off the top end of the profession and losing half a generation of skill and experience almost overnight.

But our greatest concern must be the increase in retirement age, initially from 60 to 65, and then, if Lord Hutton has his way, up to the planned state pension age of 67 to 68 for current young workers. Although we may be living longer, and enjoying better health in late middle age, the Government cannot slow the aging process and the technical demands and sheer intensity of modern medical practice make full time working beyond 60 potentially harmful for both doctors and their patients.

Some pension changes may be inevitable, but we must ensure they are proportionate, fair and safe. It is not clear that the current proposals meet these criteria. *For full details on the BMA position on NHS Pension Reform see* www.bma.org.uk/nhspensionreform.

NOROVIRUS

D&V Cases on the Increase in Somerset

There have been warning signs of a rise in the number of likely Norovirus cases in the county which means there is an increased risk of care homes and hospitals being affected. Patients should be advised to stay away from school or work and not to handle food for others until 48 hours after symptoms subside, to maintain scrupulous personal hygiene, including having separate or disposable towels and to wash hands regularly with soap and water (alcohol gels are less effective). They should also avoid visiting friends and relatives in care homes or hospitals as this seems to be a major source of infection. For more information: Link.

PATHWAY NAVIGATOR APP

Referral Information and Decision Aid

The Flexible Healthcare Group plans to release their desktop application to practices early next month. This will contain information for GPs and patients about referral pathways and alternatives. It sits quietly in a corner of your screen until you will it down and inside there will be an evolving and interlocking set of information including, in the first release:

- The current list of low clinical value procedures.
- Flexible Healthcare pathways.
- Advice and Guidance Support.
- Referral forms – downloadable library of all known common referral forms.
- Formulary – current document viewable through searchable menu.

Best of all, it will automatically be updated, so no more rooting around for that obscure referral form and finding it went out of date in 1996!

SELF CERTIFICATION FORMS

Do not have to be provided by GP Practices

Paper versions of the self certification form are now only available under very limited circumstances and GPs have not been able to obtain paper copies for some time. Employees should be advised to obtain one from their employer or to download the single page form from: link.

PARVOVIRUS B19 IN PREGNANCY

Be aware of the current high incidence of this virus

We have been warned that hPVB19 (Slapped Cheek or Fifth disease) is currently circulating at epidemic levels in the county. It has been estimated that more than 1/3 of pregnant women are non-immune, and if infected there is a 30% chance of foetal infection. In epidemics this risk appears to rise and there is a 5-10% foetal loss rate as well as a risk of foetal complications including hydrops – the chance of the latter being variously observed to be between 0 and 12%. Frequent hand washing reduces transmission risk but do consider serological testing. Detailed guidance has been promised shortly.

2009/10 GP EARNINGS & EXPENSES ENQUIRY

The "EEQ" for 2009/10 states that for contractor GPs in the UK, average net profit was;

£100,400 for GMS GPs
(an increase of 1.2% since 2008/09).

£ 97,300 for GMS non-dispensing GPs
(an increase of 1.4% since 2008/09).

£117,000 for GMS dispensing GPs
(an increase of 0.4% since 2008/09).

£115,300 for PMS GPs
(a decrease of 0.8% since 2008/09).

£113,000 for PMS non-dispensing GPs
(a decrease of 0.8% since 2008/09).

£131,100 for PMS dispensing GPs
(a decrease of 0.8% since 2008/09).

£105,700 for all GPMS GPs
(an increase of 0.8% since 2008/09).

£ 58,000 for the average salaried GP
(an increase of 1.2% on 2008/09).

The GPMS expenses to earnings ratio was 59.8% in 2009/10, an increase of a 0.5%.

CONGRATULATIONS!

To Teresa Hull, who has worked at the Mendip Country Practice for 17 years, on winning the UK Dispensing Assistant of the Year Award 2011.

CHANGES TO THE DISABLED PERSONS (BADGES FOR MOTOR VEHICLES) (ENGLAND) REGULATIONS 2000

From April an independent mobility assessment is required

This change means that GPs should not be asked to provide information in support of a Blue Badge application after the end of March 2012. The changes require that "eligibility under the 'permanent and substantial disability' walking criterion (at regulation 4(2)(f) of the Principal Regulations) is confirmed by an independent mobility assessor, unless an applicant's eligibility is self-evident". Link provides more information.

LMC AWARDS FOR 2011

Who has helped you most during the last year?

Last year we asked readers to nominate the organisation or service that had done to most to make the GP's job easier in 2010. That award went to Sophie Jones and her team at SPL for their helpfulness and cheerful good humour. We would like to invite your nominations for this year, sent to harry.yoxall@somersetlmc.nhs.uk by the end of December. The winners will be announced in our January edition.

SMALL ADS ..... SMALL ADS.....

EXPERIENCED GP AVAILABLE

Details: Recently arrived in Somerset, currently based in Wells. Most recently a 9 session partner, experience of salaried GP and University posts as well as OOH, undergraduate and postgraduate teaching, medicolegal work and research. Looking to get back to work after a 6 month break for personal and professional reasons. Initially seeking 4-8 sessions long term locum or salaried position.
Contact: damianmartinsmith@hotmail.com.

SALARIED GP: WINCANTON HEALTH CENTRE

Details: 6 sessions required but happy to consider part time combinations. Salary negotiable according to experience. Informal visits welcome.
Contact: Janet Loe on 01963 435703 or email janet.loe@wincantonhc.nhs.uk. Visit our website www.wincantonhealth.co.uk for more details.

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PARTNER: HENDFORD LODGE MEDICAL CENTRE, YEOVIL

Details: Partner required for 6 sessions. Application pack available at www.hendfordlodge.co.uk.
Contact: Dr Anne Salkeld for informal chat on 01935 470200 or anne.salkeld@hendfordlodgemc.nhs.uk. Closing date 6th January 2012.

SALARIED GP: YEOVIL HEALTH CENTRE

Details: Opportunities for part/full/flexi GPs. Future partnership opportunities in the GP consortium practices for ambitious candidates.
Contact: Daniel Vincent on 01935 709269 for an informal chat, to apply send CV with accompanying letter, referees and details of current salary to Daniel Vincent, Practice Manager, Yeovil Health Centre, 37 Middle Street, Yeovil, BA20 1LS or by email to danielvincent@nhs.net.

LEAD GP & GP VACANCY: ST GEORGE'S & WORLE MEDICAL PRACTICES

Details: Flexible working possible. Part time applicants considered. Salary up to £95,000, Relocation package may be available.
Contact: Claire Kattner, HR Manager mallinghealthrecruitment@nhs.net with CV and covering letter. To arrange an informal discussion contact Practice Business Manager Steve Edwards on 01934 516789/07748 988926. Visit www.mallinghealth.co.uk. Closing date 1st December 2011.

SALARIED NURSE PRACTITIONER: PENN HILL SURGERY, YEOVIL

Details: Up to 6 sessions available from 2012.
Contact: Len Chapman for applications or informal chat on 01935 470816 or len.chapman@pennhillsurgery.nhs.uk by 30th December.

LETTER TO THE EDITOR

Dear Editor

GP Returners: A Detailed Statement from the Severn Deanery School of Primary Care
The Severn School of Primary Care feels it is important to state the position in more detail regarding the return to work of doctors who have been absent from NHS Primary Care for significant periods of time. The management of Medical Performers Lists (MPLs) by PCTs has been criticised since the Ubani case. PCTs are therefore particularly keen to ensure that doctors admitted to their MPLs are competent (as, indeed, should any self respecting doctor).

The Returner Scheme was initiated nearly 10 years ago, although it was initially left open to interpretation as to what a "returner" is. In order to assist PCTs in their management of MPLs, following national discussions, we have shared our experiences. After about 2 years away from clinical general practice, there is good evidence that the skills and competence of a doctor tends to atrophy significantly - with the majority (about 80%) then needing some additional re-training. The main predictors relate to time away from practice, and the efforts that the practitioner has made to stay up to date with UK general practice.

Deaneries recommend therefore to PCTs that if a doctor has not worked within the NHS for 2 years, then PCTs should ask for a Competency assessment, although the actual decision remains with the PCT.

The first move for a doctor returning to work in this country is to approach the PCT of where they will be intending to live, in order to make an application to join their MPL. Our experience is that usually PCTs ask for a formal assessment of competence and any re-training needed is completed within a year.

The assessment itself consists of a written application, a structured interview and an assessment of the doctors' knowledge (an MCQ) and clinical skills (OSCE). The MCQ and OSCE occur 4 times a year and are managed by the London Deanery. The dates are publicised well in advance. The structured interview is carried out by the local Deanery usually within a few days of the OSCE, and a decision on a recommendation is made to the PCT within a day or 2 of that interview. The application, interview and objective assessments are carried out at Deanery expense. The test and cut scores are set according to best international practice.

The completion of this application process results in a decision that may have one of 4 outcomes;

1. The doctor's skills and knowledge are adequately retained and the Deanery will recommend that the doctor is competent to return to NHS GP. PCTs are usually prompt about responding to this.
2. If there are remaining uncertainties about skills or about whether the doctor has enough recent knowledge of NHS structure and function, the Deanery recommends a short period of assessment and re-induction. This usually takes 6-8 weeks and will involve an attachment to a local training practice. The training is provided by the Deanery at its expense, though no salary is currently payable to the returning doctor. (Funding for the Returner Scheme was withdrawn centrally by the DoH in 2006).
3. The application process may deem that the doctor's knowledge and skills have atrophied sufficiently that a full 6 month (or part time equivalent) return to work programme is warranted. Again, this will be an attachment to a local training practice at Deanery expense, though without a salary being payable to the returning doctor.
4. The doctor's skills are so far off the required competence that full retraining is required.

All this information is available on the Deanery website:
primarycare.severndeanery.org/information for gp retainersreturners/inductionrefresher (returner) scheme

Information for doctors intending to work abroad has been somewhat sparse in the past which is why the deanery has taken the decision to publicise details of the process. The equivalent in the devolved UK administrations is different - as in so many other areas of medicine and the law. Further information or queries about this can be made to the Associate Postgraduate Dean for the I&R scheme, Jim Morison, email jim.morison@southwest.nhs.uk.

Jim Morison (Associate Postgraduate Dean) **Prof Bill Irish (Director of GP Education)**

Somerset Local Medical Committee, Crown Medical Centre, Venture Way, Taunton TA2 8QY

Tel No: 01823 331428 Fax No: 01823 338561 E-mail: lmcoffice@somersetlmc.nhs.uk
LMC Website: http://www.somersetlmc.co.uk