

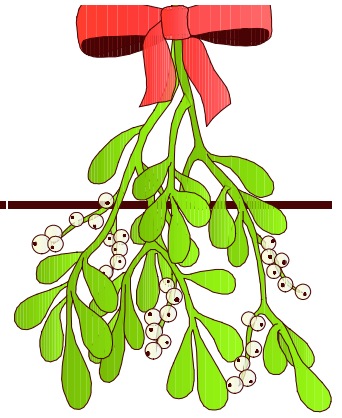
# NORFOLK LOCAL MEDICAL COMMITTEE

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December 2006 Flyer



## So what is going on with pensions, then?

At the recent LMC Secretaries Conference I attended a presentation by the Chair of the BMA Pensions sub-committee, Andrew Dearden, on GP pensions; for a few minutes I really understood the subject. To the best of my recollection the following is true, but anyone making their plans at the moment needs the best possible advice from the BMA or a specialist in GP finance.

Some time soon there will be new pensions arrangements for all public servants, including NHS doctors. The BMA is negotiating the detail and it will still be an excellent scheme. Where the differences from the current scheme are sufficiently attractive those within the current scheme will be able to swap. The main "disadvantage" of the new scheme is likely to be the age from which a full pension may be drawn.

There are likely to be some changes and improvements to the current scheme where improvements developed for the new scheme are affordable.

No one who has already joined the current scheme will be compelled to change to the new scheme and I expect most will decide not to. In the current scheme there will be an increase in the employee's contribution; this has not increased from 6% for more than 20 years - in spite of the increase in life expectancy that it, in effect, has to fund. Dr Dearden assured us that the BMA actuaries have confirmed that this increase is reasonable and that the steps (6.5%, 7.5% and 8.5%) are the least worst way of ensuring that the required benefits will be paid. Another issue that has come in for some criticism is the dynamising factor - until the next re-negotiation it is likely to be the Retail Price Index plus 1.5%. Again Dr Dearden confirmed that the BMA's advisers believed this to be appropriate, especially as practice incomes may remain steady or even fall during the next few years.

The "hot" pension issue is, of course, Lord Warner's decision to try to cap the pension increase resulting from the increased income generated by the New Contract. The GPC is likely to take the matter to the courts.

Under the current GP pension arrangements the increased income of the last three years not only leads to good "pension investment" (this is shorthand for something rather more complex) for each of those three years, but also to a revaluation of all previous years under the dynamising arrangements. If the "Lord Warner cap" is applied the increase is likely to be 48% over five years: April 2003 to March 2008 inclusive (I assume). A simple way of thinking about the implications of this is that for years of service before 2003 it would be as if every year's worth of pension becomes nearly half as much again. For example, a GP who joined the NHS pension scheme in 1983 and has 20 years of service by 2003 would find that the "new contract effect" would be to increase the pension due from those 20 years to what it would have been if he had been contributing for 30 years.

Clearly the new contract has been good for income and pensions. I don't think we should be ashamed of this, we all knew that the new contract was designed to deliver (amongst other good things) increased funding for general practice - both to improve recruitment and to reward improved care. The fact that Lord Warner is considering a cap means that GPs have earned income, and a pension, which could be greater than the (threatened) cap.



Any GP considering retirement at the moment should try to defer their decision at least until after the "cap" issue is settled, or until April 2008.

Is it right to fight the cap? I think it is; if the GPC does not do so it would set a precedent for the government ignoring or reversing anything it does not like in a contract which was properly negotiated and agreed. Indeed, no public servant could feel safe if that sort of precedent is set - which could mean that the GPC may find it has some rather unlikely allies should

there be trouble. Furthermore, it is particularly unfair on GPs who have planned and taken their retirement on the basis of the existing arrangements - the "new contract benefits" should have fed through in their entirety by last April. Also, it appears that the government has got its figures wrong - not correcting for the employer's superannuation - so there must, at the very least, be an argument.

If the government really believes that GPs have benefited from "windfall profits" it could have done other things than attempting to impose a (probably illegal) cap. It could have discussed the matter reasonably to see if there was an acceptable resolution for all parties - GPs are nothing if not pragmatists. I might invest in the future of the NHS by buying "NHS bonds" if they invent them. Of course, to have thought of inventing them the powers that be would have had to believe that the NHS has a future.

SRL, December 2006

## Excessive Prescribing

In the GPC "Focus On ... Excessive Prescribing" guidance it states: "Statements by PCOs indemnifying individual practices against future action by patients who believe that they have been damaged by refusal-to-treat decisions have no legal force and do not provide any protection at all". This is a timely reminder when PCTs may be tempted to try too hard to save on prescribing budgets and give reassurances that are not worth the ephemeral media they are electronically wedded to. Even if there is some evidence in support of not prescribing a drug then who will be there to carry the can in the future? The example the GPC gave upon our enquiry was (and I am not sure if this is a real example from some daft PCT somewhere) NRT - if a patient with lung cancer sues in 10 years time it will be the GP, not the here today, gone tomorrow, PCT director, who gets his month in court. In addition, and as befits a prescribing item, this is probably a generic issue: beware of PCT reassurances on confidentiality, referrals, follow ups ... well, everything really.



## Spineless in the IT Department

As Guardian readers your Secretary and your PEO should understand this story but we are not quite sure that we do. Toward the end of November their favoured paper campaigned on patients' right to privacy and, on Saturday 16<sup>th</sup> December, it reported that the "government has bowed to privacy concerns" and has "conceded that patients should be allowed a veto on information about their medical history being passed from their GP to a national database".

information to the DoH and that this might itself be a breach of confidentiality. The appearance of the article on Saturday rather suggests the first

stage of the campaign is over, so such a warning is, probably, now unnecessary.

While we believe that the right of patients to confidentiality is important, I am hoping that the paper's item on what will happen next is wrong or that the words "and the necessary extra resources will, of course, be provided" have been omitted in error. It says: "Under (the suggested) scheme, GPs will ask every patient to give their explicit consent for a summary of their record to be put on the national database. They would be given a few weeks to review the summary and call for corrections or amendments to be made before they consented to the upload."

**Christmas Appeal**

On the front page of Saturday's excellent Guardian (hey - I wonder if they would give the Flyer a plug in return) and next to the article referred to above, is an advert for Terry Pratchett's Hogfather. Your Secretary and your PEO are also Terry Pratchett fans but (sob) neither has Sky. If anyone out there has the technology then a burned DVD (for private use only, of course) would be much appreciated.

**Pay (through the nose) Beds**

A warning for your patients who want private treatment but who prefer to support their local university hospital rather than the opposition: it may cost more than you think.

A constituent has advised the LMC that a patient wanting a hip replacement found the rates for an amenity bed at the Norfolk and Norwich looked very favourable compared with BUPA. Alas "extras" - not "luxuries" because they included both pre-operative assessment and post-operative physiotherapy - reversed the value for money equation.

I assume such a patient would have a right for post-op NHS physiotherapy if it could be arranged - though in the present climate who knows? If the PCT tries to impose rigid thresholds it might want evidence that patients operated upon privately would have been eligible for NHS treatment. Organising an NHS pre-operative assessment would probably be even more problematic. Anyway: caveat emptor. Make sure your patients read the small print - so I guess they may really need your help if they are going in to have their eyes done.

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**Referral of Patients with Polycythaemia**

For those of you who refer patients to the James Paget Hospital Haematology Department - Dr Sadullah, with input from the Waveney GP Alliance, has published guidance and flow charts to assist GPs to decide upon appropriate referrals. We understand these will be circulated to all practices but a copy is held in the LMC office if you cannot track one down.

**Norfolk Subfertility Plenary Group**

Dr Beryl Duncan would like some help with representing the voice of general practice on this group. If you are interested in this field of medicine and would like to contribute to the future of subfertility treatment for Norfolk patients (particularly if you live in the central cluster area) please contact the LMC office.

**Nurse Practitioner Referrals to the JPH**

We understand that Dr Neil Statter (PCT Director of Clinical Governance) has agreed a protocol for Nurse Practitioners referring to the JPH. If practices wish their NPs to take on this role they should agree the protocol (copy available from the JPH CG office) and also advise Dr Statter.

**Thanks to the constituent who rang in with the latest idiot request - a model agency contacted him to enquire whether a 15 month old was "fit to work"!  
Now if that had been Caprice.....**

working will be extended to carers.

This will have an impact on GPs as employers. A carer will be defined as an employee who is or expects to be caring for an adult who:

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*Merry Christmas - is it possible?*  
*Nobody is on call if they don't want to be. Families can be together. Statins will allow unrestricted flavoursome fat feeding and alcohol will keep the turn around process away from the conscious parts of the brain. The Ghost of Christmas past will be dynamised for the benefit of the future Christmas ghosts. The Ghost of Christmas present has the Doctor Who Christmas special to look forward to. All is right with the world. Of course a merry Christmas is possible.*  
*And a Happy New Year?*  
*Come off it! Not a PCTing chance.*



**Carers' right to request flexible working**

The government has recently announced that from 6th April 2007 the right to request flexible

- ▶ is married to, or the partner of or civil partner of the employee; or
- ▶ is a near relative of the employee; or
- ▶ falls into neither category but lives at the same address as the employee

The Department of Trade and Industry intends to publish further guidance on flexible working for carers in the near future

**Norfolk LMC's 2006 Charitable Contributions**

At its November meeting the Committee approved the following donations to medical charities:

- ▶ £1,100 to the Cameron Fund
- ▶ £1,100 to the Royal Medical Benevolent Fund
- ▶ £250 to The Sick Doctors Trust

**In the bleak midwinter ....**

We held off publishing this Flyer so we could bring you the up to the minute/hot off the press news from the Norfolk PCT/LMC summit scheduled for the afternoon of 19th December 2006. We almost needn't have bothered. The meeting had been arranged no less than three weeks previously, so you would have thought that the paperwork necessary to ensure a productive couple of hours would have been with the LMC in good time. PCT memories were jogged a week prior to the meeting and the information requested at the latest before the weekend. The best promise we could extract was that it would arrive by Monday, the day before the meeting. The LMC is keen to do everything it can to make progress in this difficult time for the PCT, so planned to make the best of this, but Monday came and went without anything arriving. The LMC was seconds away from pulling the plug on Tuesday morning so that busy GPs were not dragged to a pointless meeting.

The PCT had, apparently, suffered two separate system failures: first - letters to the LMC which were ready to be sent on Monday ended up in good time on the desktop of the right PCT officer,

but after she had left to work elsewhere; second - an attachment that would have given the LMC something to chew on over the weekend mysteriously separated itself from the email. The LMC accepted the profuse apologies of the PCT and a meeting of sorts took place. There is not really much to report but we are still talking - which you may, or may not, think is a good thing. Norfolk PCT is certainly accident prone and failing to engage the LMC and GPs in general (we hear the same story from PBC groups). We hope that is due to new organisation chaos. The alternative is that the PCT has made a decision not to bother talking to GPs, but simply to try and impose its finance driven schemes upon us.

Whichever is the case, given the financial climate in which the PCT is operating, we will have to make some very hard decisions in 2007 if we want to protect our practices, our service and our patients.

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