

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE MARCH 2010 Edition

Dr. Andrew Seymour
LMC Chairman
Andrew.Seymour@GP-L84026.nhs.uk

Shelina Jetha
LMC Manager
shelina@gloslmc.com

Mike Forster
LMC Lay Secretary
mike@gloslmc.com

Sue O'Sullivan
Administration
sue@gloslmc.com

LMC Website: <http://www.gloslmc.com>

Tel: 01452 310706

Fax: 01452 386503

We are nearly through to the end of another financial year, but a financial year like few others. Although we have not seen soup and bread queues, food riots and heavy-handed policing of civil disturbances, they may yet come. The Government is now specifically asking primary care to make savings – the first time it has done so – and has insisted on the pay award advised by the DDRB be abated by an assumed 1% improvement in efficiencies next year.

TAX CHANGES

Under the Finance Bill 2008-09, from 6 April 2010 you will lose £1 of your personal tax allowance for every £2 you earn above £100K. This means that if a GP earns between £100K and £120K he will notice a drop in take-home pay. The greatest impact comes at a gross income level of £112,950 at which point the effective tax rate on the portion of earnings above £100K will be 60%. You should get proper advice from your accountant, but by way of illustration:

Practice Profit Share	£100,000	£110,000	£120,000	£130,000	£140,000
Tax/NIC/superannuation	£ 45,154	£ 53,010	£ 58,914	£ 64,230	£ 69,544
Take-home pay	£ 54,845	£ 56,990	£ 61,085	£ 65,770	£ 70,455
%age of profit taken home	54.85%	51.81%	50.90%	50.59%	50.33%

For comparison take-home pay in 2009/10 would have been

£ 54,845	£ 58,990	£ 63,675	£ 68,360	£ 73,045
54.85%	53.63%	53.06%	52.59%	52.18%

In addition there is to be a new 50% rate of tax for amounts earned over £150K.

For 2011/12 there may also be an increase in national insurance contributions and restricted tax relief on pension contributions for those with a taxable income greater than £150K. These changes will further restrict take-home pay. Some GPs might consider it worth their while to take on a new partner and reduce their personal hours to three-quarter time; of course this could affect your pension so in all cases you should consult your accountant before making irrevocable steps.

GP PRACTICE PAY

The DDRB recommended an increase in contractual payments to practices of 1.34 per cent, designed to result in no increase to GPs'

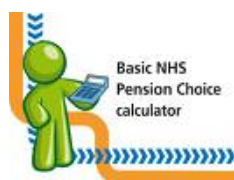


average net income after allowing for movement in their expenses.

In making its recommendations the DDRB indicated that efficiency savings made by GP practices should only be taken into account retrospectively, after

the scale of these savings were shown in earnings and expenses trend data. The Government, for reasons of national economy, has decided to abate the DDRB's recommendations for GPs by applying a prospective efficiency assumption of 1 per cent of contractors' operational costs. This will have the effect of reducing the proposed uplift in the value of contract payments to 0.8 per cent for GP practices. This will almost certainly reduce partners' drawings. No final agreement has yet been reached on how the 0.8% uplift is to be applied

NHS PENSIONS – CHOICE



Every member of the 'current' NHS pension scheme (i.e. those who joined before 1 Apr 08) will have recently received, or will soon be receiving, a pack (either directly or via the practice) from the NHS Pensions Office giving personal financial details and an estimate of pension benefits and asking each member to elect (or not) to transfer to the new NHS Pension Scheme. (Those joining on or after 1 Apr 08 must join the new scheme.) If no decision is made within the 3 months allowed then members in the current scheme will irrevocably stay in the current scheme. This may be no bad thing: it depends on individual circumstances. The LMC is not qualified to give financial advice, and strongly recommends that you seek advice from your accountant and an independent financial adviser. The following figures regarding the current scheme may help you in those discussions:

- The earliest one can now take early retirement is age 55. The full pension is reduced by 4% for every year of retirement before age 60.
- The decision to retire and the decision whether to go on working are not 2 sides of the same coin, as it is possible to retire for 24 hours, work no more than 16 hours a week for the next month, and then work whatever hours you wish, while also taking the pension. If a member decides to work on

beyond age 60 without retiring he gains a further 2% of pension per year. This potential increase should be weighed against the amount of pension he would otherwise be drawing for each of those years had he retired instead, and of course while working he is still making superannuation payments. Had he retired these would be income instead.

- A tax free lump sum of 3 times the pension comes automatically on retirement. One can commute some of the pension to increase that figure to 5 times the annual pension. If one expects to live for less than 12 years from retirement it may well be better to take the cash. How optimistic are you?
- The new scheme does benefit those who work much longer – but you have to work until at least age 63 to get a better pension than you would have had at age 60 under the current scheme. Remember also to ask for a state pension estimate and for a pension estimate from any private pension you may be contributing to.

SUMMARY CARE RECORD

The Summary Care Record (SCR) is a scheme implementing Prime Minister Tony Blair's vision in 1997 that doctors treating a patient away from home should be able to access what they need of his medical record to treat him safely and effectively. The scheme has been piloted. NHS Connecting for Health has proceeded with a wider roll out prior to the publication of the independent evaluation of the SCR pilot and therefore without publicised evidence of the impact of changes to the Public Information Programme and the consent model. The expedited roll out has also happened without consultation with the BMA.

In view of the number of patients who have already been sent information about the SCR, many of whom may wish to have a SCR and may also benefit from having a SCR, the GPC and BMA are not advising GP practices to boycott the SCR, which has potential benefits. The decision to have a SCR should rest with patients. Patients need to be fully aware and thus their implied consent can be deemed valid. The BMA have urged the minister to evaluate the

implementation and impact of the SCR in the areas that have proceeded with Public Information Programmes before rolling SCR out any further.

In view of this, GP practices play an important role in raising awareness of SCR, including patients' rights to opt out of having a SCR. It is important that any information provided to patients is balanced and empowers them to make an informed decision. It is essential that patients who wish to opt-out have the opportunity to do so. There is also a 'consent-to-view' procedure by which the patient (unless incapable) must give permission to those treating him before they can access his SCR.

At present the SCR is not being rolled out in this county, and indeed the BMA has requested the government not to do so until its concerns have been met. Eventually, when it is rolled out here, you should attend locally organised events so that you are informed about roll-out of the SCR in this area. You then have the following options:

- You can decide, as a practice, to be involved. The PCT should provide training and support. Prior to being involved you and the PCT need to be assured that your data are of an appropriate quality for sharing outside of your practice. This would have formed part of component 2 of the IM&T DES. Practices which have not been accredited under the DES should seek advice from the LMC and PCT before agreeing to upload patient data. Further information on data quality is available at: www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/dq
- Your practice can decline to be involved at this stage - if you decide not to be involved it is still important that you understand what the SCR is and that any patient requests to opt out are recorded.

From the start of roll-out in this county you should make opt-out forms available in your practice.

You can access the GPC's full advice on this subject at

http://www.bma.org.uk/images/scrguidance_tcm41-195486.pdf

CfH QUESTIONNAIRE - UPDATE

Many of you have taken the necessary 10 minutes to complete the NHS Connecting for Health (NHS CfH) survey into the quality of the service provided by GP system suppliers. The deadline for completion had been 5 p.m. on **5th March but has now been extended to 31 March**. If you thought you had missed the deadline, take heart – you can still inform NHS CfH about your experience with the GP IT service and so drive discussions with GP Systems of Choice (GPSoC) suppliers and co-ordinate NHS CfH Service Management activities in line with what is most important to users of the GP IT systems. To complete the survey, please click on the link below:

<http://www.survey.connectingforhealth.nhs.uk/gpsystem>

All responses are confidential, unless you choose to submit your e-mail address.

PATIENT SURVEY RESULTS Q1-Q3

The results become more statistically meaningful as you get closer to the year end. The practice results for the first three quarters of the year, which you can find at:

http://www.gp-patient.co.uk/results/practice/GLOUCESTERSHIRE_PCT.aspx

show you how you are doing so far in percentage terms against the PCT, Region and National results.

CHLAMYDIA SCREENINGS

There has been a steady and predictable increase in the number of recorded chlamydia screenings since April 2009. If any practice considers that its reported screenings are significantly less than those it has actually carried out, please report this to the PCT.

PMS REVIEW



The PCT and the LMC have been negotiating for a year to find an acceptable scheme under which PMS practices could decide whether to go over to GMS or adopt a common PMS contract, with a readjustment of the growth

money funding to achieve a more equitable arrangement between all the practices involved. The deadline has been reached, and 26 of our 30 PMS practices have decided to go over to nGMS contracts; the remaining 4 PMS practices will be moving to a common, county-wide PMS contract once its terms have been negotiated.

REFERRALS TO MENTAL HEALTH NURSES

There is no regulation that a referral from a practice to a mental health nurse has to be on any particular form. Whatever means of communication is agreed between you is acceptable

PRACTICE PREMISES

The GPC has issued a lengthy but useful guide about practice premises. A summary of the main points is attached.

MEDICAL DIRECTOR NHS GLOS

On 15 Mar 10 the Medical Director for NHS Gloucestershire, Dr Jonathan Steel, resigned. We do not yet know the name of his successor.

MAX'S MUSINGS

I have decided to give up eating the second piece of chocolate for Lent. You may jeer, but have you ever tried to eat only one piece of chocolate? It is extraordinarily hard, especially if you

are used, as I am, to devouring a bar at a sitting. But I am being good. So far I have not succumbed to the temptation of eating the second piece. I confess that I did wonder the other night, whether if I ate the third piece but left the second alone, that would be all right, but I managed to quell that temptation also. I can see that we shall



still be looking at mountains of chocolates left over from Christmas

when we start opening our Easter eggs. I shall then eat many of our grandchildren's chocolate eggs to save their teeth. 'How noble of him!' I hear you cry. 'Is there nothing he will not do for his relatives?'

Now I read in the newspapers the excellent news that red wine really is good for you in that your chances of getting fatter, if female, are reduced if you have regular moderate amounts of the stuff. It may also be true for men, but they were not being studied this time, and if they had been I hope the scientists would not have included me in the study; my figure might have skewed their figures.

And finally:

- 'At the present time the Department of Health does not believe that there is any justification for waving any of the employment check safeguards currently in place.'
[And what good would waving them around do anyway? Ed.]
- 'The patient refused autopsy.'
- 'Overheard outside hospital: "Ah yes. He is well; quite well. Unconscious, but well."'

This newsletter was prepared by Mike Forster, LMC Lay Secretary, & the LMC Office



GLOUCESTERSHIRE LMC DOCUMENT SUMMARY

<u>Document Title:</u> The Future of GP Practice Premises - 2001 (Rev Mar 2010)	
<u>Document Originator:</u> GPC	<u>Document Date:</u> March 2010
<u>Download Full Doc from:</u> http://www.bma.org.uk/employmentandcontracts/independent_contractors/practice_premises/pracpremises1104.jsp	<u>Date of Summary:</u> 10 March 2010
<u>Document Summary written by:</u> Mike Forster	
<i>N.B. This summary was correct when issued. Its accuracy cannot be guaranteed in the long term, since policies and organisations change. Although every effort will be made to ensure that it is updated the Reader is urged to exercise caution if the document at the time of reading is more than a year old.</i>	
<u>Bottom Line:</u> This is a really complex subject; this summary can give you headline points but if you need to get involved in premises replacement or modification you need to download and read the main document for the detail. The PCT needs to understand that by encouraging GPs to take on the risk of owning premises it is divesting itself of that risk, and more cheaply than by use of LIFT.	

The following are headline points only from the paper; there is a mass of useful discussion backing them up which should be read.

- Grouping practices into large, shared premises can be more expensive for practices because of the increased service charges.
- PFI and LIFT are also very expensive for the PCT. Cost-rent was cheaper.
- A long lease and short-term APMS contract creates risks to the lessee.
- There is less confidence now in property holding its value – thus increasing risk.
- Fewer GPs now stay in one practice for the whole of their career, so may not wish to risk investment in premises.
- PCTs have high staff turnover, and may lack estates expertise, so may be less well suited to carry out long-term projects. For instance, a project may short-sightedly 'save money' by buying insufficient land to cater for enough car-parking and to allow room for expansion later.
- Short-term plans are more risky, so require higher profit margins to cover that risk.
- Much clinical work could be transferred to primary care if only it had the space.
- For many reasons it is hardest to develop in areas where the need is greatest.
- GPs are disadvantaged by not having the means or the time to carry out preliminary searches and appraisals of potential development schemes. The GPC thinks PCTs should help by funding preliminary work.
- More private finance is likely to be made available if a PCT takes the head lease and sublets to many practices (not all necessarily medical).
- PFI can work in low value areas rather better than by sale and lease-back.
- LIFT has drawbacks. It costs PCTs a lot in the long term and is only a good investment opportunity for GPs if there is a ready market for its shares.
- In high-land-value areas approval procedures and financial commitment needs to be much faster and more efficient, otherwise opportunities will be missed. A well-funded development strategy is needed.
- Consolidation of practices into one set of buildings is not so sensible in rural areas, although grouping a GP practice with other services (e.g. a library, local authority offices etc) may provide useful economies of scale and give access to other, non-NHS funding.