GPs' ancillary staff: pensions

GMSC tells DHSS to honour agreement

National Insurance and superannuation payments paid by GPs for their staff have been reimbursed indirectly to GPs as part of general practice expenses. For several years, however, the General Medical Services Committee has pressed the DHSS for these payments to be reimbursed directly. Last November the chairman of the GMSC told the committee that its negotiators had achieved this change (3 December 1977, p 1494). The DHSS had agreed in principle that from 1 April 1978, when the Government's new occupational pension requirements started, such payments would be reimbursed in full—and not at the 70% level as with ancillary staff salaries. Local medical committees were told of the success in a GMSC circular on 18 November.

At a negotiating meeting with the DHSS on 15 February this year the precise wording of the amendment to the Statement of Fees and Allowances was discussed and the following sentence agreed: "From 1 April 1978 reimbursement will be made of 100% of the employer's National Insurance contribution and of his contribution (if any) to private superannuation schemes in being at 1 April 1978." The amendment was reported to the GMSC's routine meeting on 16 February and included in a circular to LMCs dispatched the next day.

Chairman's comments

The aim of the negotiations, the GMSC was told by its chairman, Dr R A Keable-Elliott, last week, had been to protect the position of those GPs who had already entered into private pension schemes for their staff. But when full information about the new rules had been released on 17 February campaigns had been launched by independent insurance brokers throughout the country to sell new superannuation schemes for ancillary staff. The DHSS had expressed concern about the financial implications of the new agreement and had written to the GMSC on 28 February proposing that only superannuation schemes in being on 1 January 1978 should be accepted for reimbursement. The Department had also said that it would consider exceptionally for reimbursement any case where a doctor was committed to a scheme before the date on which FPCs were advised of the change of date.

Dr Keable-Elliott went on to say that the Department's proposal had been discussed by the GMSC's General Purposes Subcommittee on 2 March, and the chairman had been authorised to negotiate further with the DHSS. Negotiations had been conducted immediately with departmental officials by telephone, and it had been agreed that any private superannuation schemes in being on 6 March would qualify for 100% reimbursement of the employer's contribution. A circular issued to LMCs that day had told them of the change. In telling family practitioner committees of the change in the date and the new wording to be included in the Statement of Fees and Allowances the DHSS had stated that FPCs should ensure that any schemes entered into between 17 February and 6 March were "reasonable" and that if they were in any doubt they should let the Department know.

A separate agreement had been reached in Scotland on 3 March whereby any schemes in being on 15 February would be accepted; those entered into between 15 February and 3 March (5 pm) would be considered individually; and any entered into between 5 pm on 3 March and midnight on 6 March would be limited to 15% of the salary of the ancillary staff concerned.

On 14 March the DHSS had sent a further letter stating that Ministers had decided to make another change, and that only *reasonable* schemes (entered into between 16 February and 6 March) would be accepted. The Department would regard as reasonable only those schemes where the annual contributions were roughly at the same rates as for the NHS superannuation scheme—that is, a total employer/employee contribution of 13·5% if the scheme entered into was non-contributory. The Department had made it clear that the GMSC was being *informed* and not *consulted*.

Replying to a parliamentary question on 13 March (p 795), Mr Roland Moyle had alleged that the profession had agreed that there was no intention to include new schemes and, concluded the chairman, "in the Department's letter on 14 March it is suggested that the GMSC had agreed that the Department could be expected to accept only those schemes which were 'reasonable.' The GMS Committee does not accept either of these allegations."

GMSC's debate

During the debate in the GMSC on 16 March Dr G R Outwin suggested that if criticism was levelled at anyone it should be at the civil servants. Those practitioners who had jumped on the bandwagon had either been unscrupulous or had been led by the nose by business people. What trust could the committee have in the Government in future negotiations if the matter was allowed to go unchallenged, Dr W Keith Davidson asked. Several practitioners had stated that had they been paid properly in the past they would have provided pensions for their ancillary staff. When the opportunity arose to do so GPs had taken it. Dr Davidson urged the committee to do what it could for those doctors who in good faith had entered into an agreement with insurance companies. A protest in the strongest possible terms should be sent to the Secretary of State.

Dr L Kopelowitz paid a tribute to the chairman for the manner in which he had conducted the negotiations. But he reminded the committee that it was the letter of an agreement that mattered and not the spirit. If the DHSS had made an error in negotiation there was no reason for general practitioners to pull its chestnuts out of the fire. If a doctor received advice from his LMC secretary he accepted it in good faith and acted accordingly. The committee would support the chairman in every endeavour to see that the DHSS honoured agreements into which they had freely entered. Dr R A Keable-Elliott pointed out that the Department was the servant of the Secretary of State. If the latter made a decision over-ruling the officials, there was nothing that the committee or anyone else could do about it.

The committee had to consider carefully how it could negotiate in future with any degree of confidence with those who could be over-ruled by the Secretary of State. That was Dr Gyels Riddle's advice. The chairman had referred to the "spirit" of the agreement, but doctors in the periphery saw only the words,

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Letter to the Secretary of State

In a letter to the Secretary of State on the pension schemes Dr Keable-Elliott stated: "I must point out that those general practitioners who have now made pension arrangements for their staff have acted entirely in the interests of those staff. We understand that the large majority of schemes have already been given prior approval by the Inland Revenue, and should therefore be accepted as reasonable.

"I am concerned that Ministerial intervention in our negotiations was not reported to me personally in a letter either from yourself or from Mr Moyle. I consider that a unilateral alteration of an agreement freely negotiated between our two sides is an extremely serious step, which can only prejudice future negotiations between the GMSC and Departmental officials.

"We would therefore request that you now instruct your officials to revert to the original agreement on this matter. . . ."

will advise or help with the care of the patient in hospital and then follows the patient home, either on the day of discharge or the following day. She meets the community nurse and they decide when the patient should be handed over. She is available to all nurses, in both the hospital and the community, for advice on the care of their patients; she discusses with hospital medical staff and general practitioners the care and progress of the patient and will co-ordinate the work of non-NHS agencies to the benefit of her patient, even, at times, negotiating with employers about the patient's return to work.

This service has been so successful that we are experimenting with other nurses carrying similar responsibilities. The nursing officer with responsibility for general surgery has been running her own (rapidly expanding) gastric follow-up clinic. One of the community nursing officers is responsible for a diabetic clinic and for advising community nurses on the care of diabetic patients who are learning to adjust their own insulin treatment.

Conclusion

Cries about too few nurses and inexperienced nurses predate reorganisation, Salmon, and even the Health Service itself. Even if not the result of the Salmon Report there is no justification for inadequate staffing levels. But concepts of quality are relative: the number of nurses we can afford is part of the larger issues of how much health care the country can afford and the efficient use of resources. Apart from the obvious major priorities there are other, more mundane, ones. For instance, do consultants going on holiday, study leave, etc, consult with their nursing colleagues about the underuse of beds so that nursing staff might be encouraged to take their own annual leave during periods of lower clinical activity? Are nurses ever asked about new consultant appointments? The RCN's Royal Commission evidence[3] stated that "The work of the trained nurse has been affected by an 185% increase in consultants during the past 25 years. Consultant appointments carry a nursing consequence, and the esoteric specialties a heavy consequence."

Medical staff at this hospital find that most matters concerning day-to-day management of their patients can be settled with the ward sister or, if the problem has wider implications, with the nursing officer. The senior nursing officers attend meetings of the relevant cogwheel divisions, and the medical members of the divisions are always more willing to listen to advice from their SNO than from the divisional nursing officer or from me.

Though pay awards have been agreed for nurses and junior doctors, little thought seems to have been given to the revenue consequences—which may be only partly funded. There is insufficient money to employ additional staff to cover the extra statutory holidays. Did anyone realise the effect of the junior doctors' new contract on continuity of care or on medical training? Doctors and nurses have complementary jobs in providing health care and unless both understand each other's aspirations their potential in providing patient care will not be achieved.

References

1 Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*. London, HMSO, 1966.
2 Royal College of Surgeons of England, *Evidence to the Royal Commission on the NHS*, Part 1. London, RCS, 1977.
3 Royal College of Nursing, *Evidence to the Royal Commission on the NHS*. London, RCN, 1977.

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Ancillary staff *continued*

which were perfectly clear in the circulars from the GMSC and the Medical Insurance Agency. The practitioners who had acted in the way they had were not irresponsible—they had acted within the confines of an agreement which had been freely made. The negotiators and the GMSC had acted honourably in the matter. Dr Riddle thought that the whole matter was a case of maladministration. Was it a case for the Ombudsman? If the committee did not take a hard line they would be in serious trouble with the Annual Conference. "We must not be seen to be creatures of the Department."

Two classes of GPs

Dr Michael Wilson pointed out that however many GPs concluded reasonable schemes before 6 March, there would be two classes of practitioner after 1 April—those who had managed to get a reasonable scheme in before 6 March and those who had not. One thing was certain: those who had not would want the GMSC to negotiate direct reimbursement for reasonable schemes after 1 April. Ancillary staff would gain from the scheme, not the doctors, Dr Mervyn Goodman told the committee. But if anybody were to suffer, it was the general practitioner, and that must be made clear to the public: family doctors had been given certain information and because they thought of the welfare of their staff they had taken out policies. Then the Department had reneged.

When the matter had been debated at the General Purposes Subcommittee, Dr B L Alexander reported, the question of a limiting percentage had been raised. At that time the DHSS had not been prepared to negotiate a percentage figure. All it had been concerned with was existing schemes up to the cut-off point. In his view, those schemes entered into before the cut-off point should be honoured. The reasonable scheme proposed by the MIA had provided for two-thirds salary on retirement and conformed with the Inland Revenue rules. The DHSS was trying very hard to wreck it.

Dr J S Noble was disturbed to hear words such as "unscrupulous" and "irresponsible" relating to a group of people who had worked so loyally and frequently at low pay. An opportunity had arisen to give something to ancillary staff, which was long overdue, and it had been carried out in accordance with the Inland Revenue's rules.

The chairman of the Scottish GMSC, Dr Joan K Sutherland, pointed out the differences in the Scottish agreement and urged the committee not to be too militant. The Government had stated that where schemes had been entered into in good faith and were reasonable they could be taken up individually. There was no reason to suppose that they would not be met in full.

Dr Keable-Elliott made it clear that he attached absolutely no blame to any general practitioner who had negotiated a scheme on the clear understanding that had been given by the Department. The fault lay with the DHSS. It was true that the spirit of the agreement that had been entered into on 16 February was for the reasonable protection of people who had existing schemes: but if the DHSS had written down, as it had done, that that meant total reimbursement until 1 April, and then when it had had an opportunity to alter it subsequently had made yet another agreement saying that total repayment would be up to 6 March, clearly the fault must be the Department's. He had every sympathy with GPs who had suffered personal loss for trying to protect their staff. But the Secretary of State had intervened and the committee had to be reasonably circumspect in making the best of what was a bad job.

ARM and craft conferences

The dates of the craft conferences and the ARM 1978 are as follows:

Saturday, 24 June: Junior Hospital Staff Conference.

Monday, 26 June: Conference of Medical Academic Representatives.

Monday, 26 and Tuesday, 27 June: Hospital Medical Staffs Conference.

Wednesday, 28 and Thursday, 29 June: Annual Conference of Representatives of Local Medical Committees.

Saturday, 1 July: Conference of Community Medicine.

Tuesday, 11 to Friday, 14 July: Annual Representative Meeting.

Some dates given in the programme for the ARM (18 March, p 731) were incorrect.

Press conference

After the debate Dr Keable-Elliott held a press conference. The dispute, he said, had not only put a great many GPs who had taken out private schemes on behalf of their staff in a position whereby they stood to lose considerable sums of money but it also meant that GPs' ancillary staff would in many instances not receive an equitable pension. "I have, therefore," Dr Keable-Elliot continued, "written to the Secretary of State asking him to tell his officials to revert to the original agreement. I am telling him of the background to the case and that we understand that the large majority of schemes have already been given prior approval by the Inland Revenue and should therefore be accepted as reasonable. Failure to do so will inevitably result in the deterioration of relationships between ourselves and Ministers." He added that he was concerned that this intervention by a Minister in the GMSC's negotiations with the Department had not been reported to him personally in a letter from either Mr Ennals or Mr Moyle.

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