

EXECUTIVE COUNCIL

CONFIDENTIAL

Title of Report: Issues relating to the recruitment of GPs and a CMO

Paper No: 249/11

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Report of: Director of Health and Education

1.0 Purpose

This paper advises Honourable Members of issues that KEMH have had in recruiting Medical Officers (GPs) and a Chief Medical Officer (CMO) over the past 2 to 3 years. The paper then goes on to explain the requirement, the problems, what has been done and options available to address this problem.

2.0 Recommendations

2.1 The Director is recommending that FIG should in the short-term:

- (a) not follow the UK market trends and pay exorbitant GP salaries
- (b) re-advertise for a CMO and also long-term GPs with the 'registered with the GMC' re-worded to be '*registered with GMC or equivalent national body*'.
- (c) seek independent specialist advice regarding the suitability of potential candidates as applicants are received.
- (d) monitor very closely the clinical competence of any non-GMC registered practitioners and their ability to follow the clinical protocols and standards (this may entail focussed external audit).
- (e) investigate any potential impact on insurance prior to appointment of non-GMC registered individuals.

3.0 Summary of Financial Implication

None

4.0 Background

- 4.1** In the past KEMH have primarily recruited GPs who are registered with the General Medical Council (GMC) and we have specified that they have, as well as appropriate GP skills, acute medicine and obstetrics experience. Historically initial GP training encompassed both acute medicine and obstetrics, however, these specialisms have not been taught for many years. It should be recognised that the teaching of these skills also encapsulated 6 months experience in each discipline. The GPs that received this training are now beginning to approach retirement age and are therefore become increasingly difficult to source.
- 4.2** Due to our geographical location, the size of the Population At Risk (PAR), the size of the health services and associated staff numbers and skills, ensuring that the GPs had acute medicine and obstetrics experiences was (and still is) deemed essential. It may be useful to note that to run a successful District General Hospital (KEMH) in the UK the minimum PAR is usually 150-170K.
- 4.3** The current GP establishment is as follows:

Post	Date current contract expires	Grade
CMO	Removed	A2 (£76k-£91k)
Medical Officer	Removed	A1 (£61k-£75k)
Medical Officer	Removed	A1 (£61k-£75k)
Medical Officer	Removed	A1 (£61k-£75k)

- 4.4** Whilst recruiting GPs has been a challenge for a number of years, this issue has become particularly acute since January 2010, from which point we have had to rely on a large number of locum GPs to cover the staffing requirements.

The following table summarises the expenses incurred due to not be able to recruit GPs on longer-term (3 year) contracts:

	Jan 2010 - Sep 2011	
	CMO Recruitment	GP Recruitment
Agency Fees	£18,000	£25,000
Advertising	£8,400	£13,500
Travel & Subsistence	£5,500	£9,800
Premium paid for locum staff compared to budgeted contracts:	n/a*	£54,200
Total:	£31,900	£102,500
Grand Total:	£134,400	

It should be noted that these additional costs are those that exceed what was

budgeted if the establishment was full. These costs could have been higher but for Island Health Services acting up as CMO on occasion at no additional charge to FIG.

5.0 Current Situation

5.1 Of the 4 F/T GP lines the Director would be content if one of the lines were covered by locum GPs, ideally rotating at a minimum of 4 monthly. This rotation brings new ideas into the clinical team and allows for the useful challenging of clinical practices and systems.

5.2 However, conversely and more importantly, we also need to have the other 3 posts filled by GPs who work a 2 or 3 year contract period (potentially longer if we have the right person for the job and for the FIs). This allows for the team to work as a team. It also allows for the individuals to develop essential skills that the FIs need (Civil Aviation skills for FIGAS, Public Health skills to meet legislative requirements, Occupational Health skills for FIG and the private sector and an array of technical skills that are essential for the hospital to run; obstetrics, ultrasonography, endoscopy/gastroscopy, specialist knowledge in diabetes, asthma, dermatology, acute medicine and intensive care etc).

5.3 Our troubles in recruiting are considered to relate to a number of factors, which include:

1. geographical isolation
2. salary
3. on-call commitment
4. potential lack of recent (if any) acute medicine and obstetric experience
5. increased clinical risks
6. the current situation within the UK related to the demise of Primary Care Trusts and the development of GP fund holding consortia (whether they will be able to get a job in the UK on their return)
7. concern about CPD and clinical appraisal requirements
8. loss of pension and clinical seniority

5.4 The following are brief comments outlining these issues in a bit more depth:

- ❖ Geographical isolation – there is little we can do about that but recognise its implications to clinical decision making. The GPs have to be very confident in their clinical skills and decision making capabilities and they need to accept the inherent logistic challenges. We are working towards a telemedicine link that may help to reduce some of these concerns.
- ❖ Salary - A salary review of the GPs is intended within the next 12 months. Whilst we have managed to get GPs for short periods a longer

- ❖ The on-call commitment though is onerous and is now distinctly at odds with current UK GP practice. The financial rewards for that commitment have been highlighted as being insignificant; this will be tied into the intended GP salary review.
- ❖ We need multi-skilled GPs. The potential lack of recent (if any) acute medicine and obstetric experience is a much greater area of concern. For the foreseeable future these essential requirements will remain. In the medium term the Director is aiming to move obstetrics away from a GP responsibility to become the responsibility of the Registered Midwives. This has in principle the support of the GPs, the Consultant in Obstetrics, the Nursing and Midwifery Council and is in line with general practice changes in the UK and the role of Consultant Midwives and the Midwives themselves. This process will be articulated more fully in due course however, it must be recognised that due to the training requirement it will take at least 2 years to reach this point. It must also be recognised that obstetrics has a major financial impact that ranges from the increased insurance cover to potential damages of serious clinical errors (potential costs of up £5-7m per case in the UK). It also has an impact on the skills and tools required for effective clinical decision making (human skills, laboratory equipment, ultrasound skills etc).
- ❖ The Director is in little doubt, although it is difficult to prove, that the current situation in the UK with the demise of the Primary Care Trusts and the increased responsibilities associated with GP fund-holding consortia have their part to play. It is suspected that GPs in UK are reluctant to leave their practices for long as they may fear that they will not easily obtain another appointment on their return to the UK.
- ❖ FIG have always provided the CPD and other associated training to meet the FI requirements and have facilitated the essential need for professional appraisal and therefore any concerns an individual may have during recruitment can be easily dealt with.
- ❖ GPs in UK obtain their seniority by extending their competency range and by obtaining the associated years of experience; their pensions are an important part of their employment portfolio. If they leave the UK and work abroad their pension and clinical seniority can suffer and therefore they may, in real terms, attract financial penalty. One potential way to address this could be for the FCO to seek a dispensation from the DoH that allows GPs working in the Overseas Territories to retain their pro rata pension and clinical seniority. The

potential FCO/DoH agreement needs to be explored further with the FCO in due course.

6.0 Recruitment Update

Section removed

7.0 Proposed Actions for Consideration

7.1 Remove mandatory GMC Registration

It is important to note that one of the essential criteria for the GPs and CMO is that they are registered with the General Medical Council (GMC) in the UK. As the UK recruiting is so expensive and in considerable turmoil, careful consideration needs to be given as to whether the registration with the GMC as essential criteria is withdrawn (the wording in the job description would be amended to be “GMC registration *or equivalent*”). The key issues around this are:

- GMC registration ensures clinical competency via standardised initial and continual professional training and associated annual appraisals.
- Our FIG insurance scheme recognises that our doctors are all registered with the GMC.
- Equally importantly all the GPs/CMO work to similar clinical standards and are able to compliment their skills and experiences and work as a clinical team.
- The model of care and their clinical focus is clearly the patient and their decision making is based on what is best for the patient; the costs of which are about 9.5% GDP in UK and 6.5% GDP for the FIs.
- They also have similar experiences in working to common clinical standards and protocols and are also able to have a common clinical management understanding to their clinical colleagues and specialists, both visiting and to whom they refer patients in UK.
- This picture should be noted as contrasting sharply with clinical practices in North and South America where there is no national clinical governance systems in place, where medicine is practiced as an income-generating business and where healthcare costs are about 17% GDP.

If we withdraw the GMC registration requirement it would undoubtedly broaden the potential recruiting pool. Doctors from Australia, New Zealand, Holland, Denmark, South Africa etc may therefore be attracted to the appointments. There are substantial risks associated with broadening the recruitment pool, not least to clinical standards and ways of working as an integrated team. However, to an extent, some of these risks can be mitigated by seeking independent professional advice of the suitability of candidates

and by ensuring that all clinicians work to common standards and protocols that are based on internationally recognised criteria. Independent advice of this type can be sort at relatively low cost and this risk is deemed to be manageable.

7.2 Remove Obs/Gynae as an essential requirement to extent possible

8.0 Insurance Implications

Advice on the potential insurance implications on FIG and KEMH were sought and the responses were as follows:

Medical Protection Society (provide GP-specific insurance)

They responded as follows:

We would be happy to accept applications for membership for work in the Falkland Islands from doctors of any nationality.

Obviously we cannot guarantee that all doctors membership will be approved as this depends on the individual doctors application and case history etc but acceptance into membership is not dependant on their nationality or where they are registered.

Therefore this is not seen as a major stumbling block, as KEMH would not be recommending a GP for appointment if they were not trained to a standard that also satisfied the MPS.

Marsh Insurers (provide Medical Malpractice Insurance to KEMH)

Marsh confirmed that as long as the appointed person is on the roster with their home authority then there will be no impact on the premiums paid by FIG.

9.0 Financial Implications

There are no financial implications arising from this paper.

All establishment and recruitment costs relating to filling the GP lines have been budgeted for 2011/12 and future years.

10.0 Legal Implications

The current Health Ordinance will allow the appointment of non-GMC registered clinicians under one of two circumstances:

- (1) If the individual's recognition is capable of recognised as equivalent to GMC registration.

OR

- (2) If the Governor, acting in Executive Council, issues an order allowing the appointment of a non-GMC registered clinician.

This second circumstance has happened twice in the recent years, allowing for the appointment of New Zealand and New Jersey (US) registered clinicians.

If Honourable Members agree to the proposal then an order would be issued for the specific country of which any clinician is being recruited from (after the proper recruitment and due diligence process).

11.0 Human Resources Implications

There are no HR issues arising directly from this paper. The normal FIG recruitment process will continue to be followed.