I am pleased to have this opportunity to share with you my future plans. I am retiring in April 2003 having attained full pensionable service. I intend to work in General Practice up until I am 65 (health and social circumstances permitting) .I would prefer to be a Partner rather than a locum , partly, of course, for the financial benefits but also for the team-spirit and continuity which working in one Practice engenders. I had always assumed this would be at Forton Road.

I realise my original offer may have seemed somewhat unfavourable to the Practice but as you know I only had Philip's model to work from. I have re-read your reply many times and considered it thoroughly. I have also had to take into account that what I accept now is for the next 5 years. We have all experienced the shock of seeing a 60 year-old mayor die before enjoying the benefits of retirement and realise that we are all too mortal. I feel I would find the constraints of the model you have devised increasingly unacceptable and feel I must decline them rather than accept and then withdraw.

I have looked at a couple of alternative options and append them together with the original option.

(a) ORIGINAL PROPOSAL(amplified) ¾ Time (19-26 hours patient contact in GMS Regulations 1992) ½ Share.

5 Sessions/week composed of morning surgeries Mon. Tues. & Fri. a.m. followed by calls with day-off on Wed. and full-day on Thurs. This is marginally more than a ½ commitment but would ease the Thursday pm situation.

½ share of other duties i.e weekday on-call duties (approx. alternate Thursdays) , weekend duty, Sat a.ms in (if still operative!), Bank-Holidays, Liq. Nitrogen sessions, Steering-group attendance, share of CHS clinic (if required). This commitment would obviously increase pro rata in absence of a Partner due to illness, maternity or paternity leave

I would be very happy to continue overseeing the CHD National Framework Provision as I am aware these kind of roles will multiply with time.

It can be seen that in terms of time on practice duties this equates with your suggested timetable.

The major differences from your proposals is in my wish to have a set timetable , primarily for my own sake, but also because there is no doubt that the staff find regular duties much easier to work with. I also feel morning working is the only sensible pattern when house-calls are involved and this has been backed up by P/T partners whom I have known. The other difference is ,of course, the lack of Friday pm involvement .

I would wish to attend Practice Meetings but might have to absent myself on a Wednesday if I had alternative plans.

I would plan to use Health-Call to cover OOH totally.

(b) MODIFIED PROPOSAL –still ¾ time.

Same as the above with Friday involvement continuing as at present i.e every fifth Friday would be a full-day ~~duty~~ with alternate Fridays (i.e 1in 10) being a duty-day. This could dove-tail in with the 1 in 10 Sat a.m. duty.

On the weeks I worked Friday as my full-day I would not work the Thursday p.m. (I feel this could be a down-side of this option as I know locum availability next year will be scarcer than this)

(c) HALF-TIME PARTNER (13-16 hours Patient Contact) -share to be determined.

Because of the hours stipulation of this type of post it could only include in-hours duties (9am to 5or6 pm) as outlined in para 1 of option (a).

P2.

One minor issue I would like to mention is that, should I remain a Partner, I would relinquish formulating the rota from April next. There may be a Partner who would take this on but otherwise I feel a staff-member could do it provided we all severely pruned our requests.

My own preference of a future role would be in the order I have listed. There may be other formats you can suggest but I feel there is not too much tinkering which would be possible which would be acceptable to us both.

My final plea is for a rapid response, especially if in the negative, as I will then have to consider the other options open to me with some promptness.