Revised October 2007
(Originally issued in July 2005)

# FOCUS ON COMMUNITY HOSPITAL GPs

## GPC guidance for LMCS and GPs

**Background**

This GPC guidance note was originally issued in July 2005. Since its publication the Department of Health has suggested a new direction for community hospitals as outlined in the White Paper '*Our health, our care, our say*: *a new direction for community services'* published in January 2006. The White Paper can be accessed online at the following address:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453

In Scotland, the *'Delivering for Health'* document published by the Scottish Executive in 2005, set out a similar programme of action for the NHS in Scotland:
www.scotland.gov.uk/Publications/2005/11/02102635/26389

On-going discussions within the BMA have also led to changes to GPC policy and strategy on the future development of community services. The main part of the original guidance note remains relevant and where necessary, changes have been made to reflect developments in government and GPC policy on community hospitals. It should be read in conjunction with the GPC discussion document 'Developing community hospitals and services for the future', which can be found online via the following address:
www.bma.org.uk/ap.nsf/Content/Hubcommunityhospitalgps

This guidance:

- recognises the problems facing GPs working in community hospitals;
- sets out the measures that the GPC has taken in order to remedy the situation, including our evidence to the Doctors' and Dentists' Review Body (DDRB) and the negotiated agreement between GPC Wales and Powys Local Health Board (LHB) in 2004[1];
- details the DDRB pay award for 2006-2007;
- provides advice as to what action GPs and LMCs could be taking locally, including conducting local negotiations and offers a model service level agreement (SLA) with different pricing arrangements.

**What are the problems facing community hospital GPs?**

GPs working in community hospitals are employed on a number of different types of contract, with different terms and conditions, and payment methods. There is one common theme however; the remuneration package is generally inadequate and fails to recognise the workload, experience, skills, commitment and clinical responsibility of GPs working in this environment. This has resulted in increasingly low morale, severe and urgent recruitment and retention crisis in community hospitals, which not only affect community hospital services, but also discourage prospective GP partners from applying for vacancies in practices with community hospitals and this in turn affects the capacity and primary care workload of these practices.

Under the GP contract practices can make business-minded decisions by prioritising other work such as specialised enhanced services, in order to preserve practice income and take steps to make further improvements under the Quality and Outcomes Framework (QOF), rather than providing services to the community hospital.

[1] The Powys agreement is uplifted by the same amount/percentage as the annual pay award made to Consultant grade staff in Wales.

Furthermore, under the GP contract GPs can transfer responsibility for out of hours (OOH) primary care work to their PCO. Consequently some GP practices have opted out of their OOH responsibility for the provision of this service, although many GPs are still doing OOH by working for OOH providers. The archived GPC guidance note 'Working in GP and community hospitals', first published in 1992 and updated annually until 2004, provides background information on the different contractual arrangements and employment issues faced by GPs in community hospitals and can be accessed through the following link (log-in required):
http://www.bma.org.uk/ap.nsf/Content/Hub2004archivegeneralpractitioners

Another area of concern is that in many areas, community hospitals are under review, threatened with closure or provision of medical services other than by the local GP practices, face a loss of services or have already been closed down. This development does not only affect GPs and other professional staff working in community hospitals, but also destabilises other local services including GP practices.

In summary, GPs working in community hospitals currently feel undervalued, unrewarded and under threat. A long-term solution for this important group of clinicians has yet to emerge, despite being long overdue and necessary for the retention and recruitment of GPs in community hospitals and for the continuity of quality care in community settings.

**What is the BMA doing to help community hospital GPs?**
In the past, responsibility for GPs working in community hospitals lay with the BMA's consultants committee and later with the BMA's staff and associate specialists committee. In June 2003 the BMA's Annual Representative Meeting resolved that the GPC should assume representational and negotiating responsibility for this group of doctors.

An explanation follows of some of the steps taken by the GPC to achieve improvements, including an overall pay review, for community hospital GPs.

*Review and negotiations*

*England*
After taking over responsibility for this group of doctors, the GPC wrote to the Department of Health to inform them of this new negotiating responsibility and asking for national negotiations for community hospital GPs to commence as a matter of urgency. The GPC requested that issues relating to community hospitals should be considered separately to that of other hospital grades on the basis that the link between GPs working in community hospitals and the clinical assistant pay rate is an historical one, and does not necessarily reflect the work that they do. Consequently, any solution for GPs working in community hospitals need not be dependent upon or even related to solutions for other health professionals.

The GPC has also called for a national framework for local negotiations between PCOs and GPs, but this approach received no support on a national level. The Departments of Health have, contrary to assurances received during the nGMS contract negotiations, continued to insist that arrangements for community hospital provision should be reviewed locally, rather than through establishing a framework for national or local negotiations.

It should be noted that in early 2005, Ministers accepted the recommendations made in the NHS Confederation's report 'Pay and terms and conditions of service for non-consultant career grade doctors and doctors working in community hospitals' (November 2004), including the following:

- That the pay scales for GP clinical assistants and hospital practitioners be closed to new entrants;
- That the appropriate contractual model and the level of remuneration for GPs working in secondary care (i.e. a specific SLA with a GMS/PMS practice or a Salaried GP model contract) be determined locally.

With regards to non-GP Clinical Assistants and Health Practitioners, their pay and terms and conditions are covered by the Staff and Associate Specialists (SAS) contract.[2] Further clarification has been sought on the contractual arrangements for GP clinical assistants and hospital practitioners as the current situation remains unclear and unsatisfactory.

*Wales*

While to date no national deals have been reached, there has been some sign of development in Wales. On 15 December 2004, following detailed negotiations between GPC Wales and Powys LHB, an agreement was reached on the payment and terms and conditions for approximately 70 GPs working in 10 community hospitals. It was originally hoped that the Powys agreement would be used as a blue print for national negotiations on community hospitals, but this did not emerge. Instead, this practice-based agreement was used and adopted by some local health boards, but not by others. A summary of the Powys local agreement is set out in appendix A.

*Scotland*

In Scotland, progress and national discussions stalled in 2005 due to ongoing work by the Scottish Executive Health Department to develop a strategy for the future of community hospitals. In the *'Developing Community Hospitals- A Strategy for Scotland'* document published in November 2006, the SEHD made it clear that Health Boards and their Community Health Partnerships were to take the lead in developing community hospitals.

*A call for improvements to pay*

In an attempt to highlight the problems experienced in community hospitals, the GPC has submitted detailed evidence supporting the need for a review of remuneration for GPs working in community hospitals to the Doctors' and Dentists' Review Body (DDRB) in 2005 and again in 2006. The DDRB evidence called for a significant uplift in community hospital GP pay as a matter of urgency, especially in view of the fact that there has been no substantive review of community hospital remuneration by the DDRB since 1979. Our evidence was backed up with results from a 2004 BMA survey of community hospital GPs which showed that:

- morale is low among GPs working in community hospitals;
- these doctors work long hours and the work is disruptive to other business and personal life;

[2] At the time of writing, SAS doctors were waiting to go to ballot on the acceptability of a new contract for SAS grade doctors, which if accepted will be implemented UK-wide.

    - the majority of respondents (86%) at the time of the survey provided 24-hour care for their unit. The remainder provided 10 to 12 hour/day cover with other arrangements in place for OOH;
    - on average these GPs are specially recalled to the hospital 4.3 times a week to attend beds;
    - the vast majority (85%) make or receive calls relating to community hospital work at times when they are not carrying out their normal session. In a week, the number of calls made ranged from 0 to 80, and the number received ranged from 1 to 160;
- a large majority (83%) undertake the work without any clinical supervision from consultants;
- 91% provide specialist care that is usually associated with hospital settings;
- 56% at the time of the survey said that they were planning to withdraw from OOH cover and 6% were planning to withdraw from all community hospital work.

**DDRB pay award 2007-08**

Following the GPC's call for a substantive pay increase for community hospital GPs, the DDRB in its 36th report for 2007-08 yet again concluded that issues relating to GPs working in community hospitals are matters for local negotiation. This recommendation is in line with the Department of Health's strategy and explains why, despite its continued efforts, the GPC has been unable to achieve national negotiations with the Department of Health on these issues.

The DDRB 36th report also drew attention to paragraph 3.63 of the 35th report issued in 2006 which stated that: "If the Health Departments believe that it is important for the whole of the NHS that community hospitals have an integrated role within the NHS, particularly in rural areas, then we would urge all three Departments to maintain strategic oversight of these hospitals and to look for any early warning signs that problems might be developing with service delivery because of funding issues".

**Options for development**

*Local negotiations and the GPC model service level agreement (SLA)*

The GPC has produced a model SLA that LMCs throughout the UK[3] can use as a benchmark for local negotiations. The model SLA is set out in appendix B and the following gives an overview:

- The SLA is between a practice (or practices) and the PCO. Practices, rather than individual GPs, will hold the contract to provide the SLA to each community hospital;
- It is a rolling three year contract, with an annual review;
- It is for in-hours only – from 08.00 to 18.30 hours Monday to Friday, excluding bank and public holidays. The PCO would be entirely responsible for the provision of OOH cover, and there is no part of the SLA that obligates GPs to act as a "fallback" option should the PCO's OOH arrangements fail. If the practice contractor is willing to provide OOH cover, a separate contract for this work should be negotiated with appropriate funding;
- It contains an admissions policy that describes the type of patient that the community hospital has the resources and capacity to treat;

[3] The GPC is aware of areas across the UK, such as Tayside, where the model SLA has been used as the basis for local negotiations.

- For each community hospital a Clinical Lead will need to be appointed. There is a role specification for this post which is included in the GPC model SLA. An additional payment should be made where one of the practice's GPs is appointed as the Community Hospital Clinical Lead;
- There should be agreed pricing for the SLA. This could be:
- a payment per grouping of beds, as per the Powys arrangement. The Powys deal gives a payment per grouping of 24 beds (plus or minus 15%, so the range is 20 to 28 beds), with the pricing differing depending on whether the practice is responsible for GP-led beds or consultant-led beds, although the payment for consultant-led beds is increased when a GP has an additional qualification in the care of the elderly (e.g. Diploma in Geriatric Medicine);
- a retainer fee plus bed payments;
- a payment per hour based on bed numbers;
  Further details of these payments are set out in appendix C. You will want to consider your current pay and the likely remuneration arising from each of the different pricing suggestions;
- There should also be agreed pricing for seeing or giving advice at a nurse's request to minor injury patients;
- It is recommended that an uplift of 5% is added to all payments annually to recognise internal cover provided by the practice when a partner is away (e.g. sick, maternity or annual leave);
- All payments will qualify under the NHS superannuation scheme;
- Under the model SLA, the practice has to provide the following service to the community hospital:
- a doctor must attend the hospital each day Monday to Friday (excluding bank and public holidays) for appropriate lengths of time according to workload, with a minimum of one multi-disciplinary ward round a week.
- a doctor must be "on call" or available at all times during the in-hours (normally 8 am to 6.30 pm Monday to Friday) if urgent or emergency care is required. This doctor must be available for in-patient admissions, providing cover for the minor injury unit (where applicable). The on-call doctor should ensure that at the end of the working day all patients with specific problems have been pre-notified to the OOH provider following the local arrangement;
- Where a patient is admitted under the care of a named GP, the admitting doctor is responsible for appropriate admission documentation, agreeing a patient's treatment plan and discussing that and the care plan with the nursing staff. The clinical record must be completed and any drug treatment written up;
- A practice may employ other suitably qualified doctors, such as staff grade doctors, to undertake the work. The practice will be responsible for informing the PCO of the GP partners and employees involved in the provision of services.
- Minor injury work should be covered by a separate contract with agreed pricing for seeing or giving advice at a nurse's request to minor injury patients.

The GPC model SLA is based around the Powys deal negotiated by GPC Wales, with some differences to reflect the situation in the rest of the UK.

*Benefits of the model SLA to practice contractors*

The model SLA, if agreed with the suggested pricing, should provide practice contractors with appropriate funding to encourage them to undertake this work.

*Benefits of the model SLA to PCOs*
While the pricing may initially seem high for PCOs, the overall cost should be less than if the PCOs had to employ experienced hospital doctors directly for this work and cover any absences (such as sick, maternity and annual leave). Examples of the cost to PCOs of employing staff grade doctors in community hospitals are set out in appendix C. It should also be noted that staff grade doctors are not clinically autonomous. Under the model SLA, GP practices would be responsible for the provision of service to community hospitals as specified, including covering absences and providing the service from 8.00 am to 6.30 pm on weekdays (except bank and public holidays). The GPC will continue to work with the Health Departments to ensure that appropriate funding is made available to PCOs.

**It would be helpful if details of your locally negotiated agreements could be sent to the GPC office for information.**

***Transfer of responsibility of out of hours***
If you feel that it is not possible for you to continue to undertake work for a community hospital OOH, then you can formally request to opt out. This would take the form of a letter informing the PCO of your desire to alter the current contract.

In Scotland, the SEHD has agreed that there should be no reduction in pay if GPs opt out of OOH work in community hospitals, unless they were paid a clearly defined sum for OOH cover. In England we are aware that many PCTs have also relieved community hospital GPs of OOH provision of service for no reduction in pay.

Please note that OOH is 6.30pm to 8am Monday to Friday, at all times during the weekend, and bank and public holidays.

***Withdrawing from community hospital work***
To withdraw from community hospital work is a personal decision and one which GPs should consider carefully. If you find that you need to stop undertaking this work for whatever reason, then the ways in which you can do so will depend on the nature of your contract for this work:

- If you have an employment contract to provide this work then you can resign and serve notice. In some circumstances you might not even be required to serve out that notice period.
- If you have any other type of agreement (i.e. a commercial agreement, any contract of services or an independent contractor agreement), whether it is a long-term or a short-term agreement, there should still be provision to withdraw from that contract on relatively short notice.

We would advise that you examine your contract/agreement in the first instance and to seek individual expert advice where necessary, particularly on when to withdraw from community hospital services to ensure that your best interests are protected. BMA members can contact *askBMA*. **Please also keep your LMC informed.**

***Enhanced services funding***
*Delivering investment in general practice* (2003) makes it clear that community hospital GP work that is currently undertaken must not be funded from the enhanced services funding

floor. Paragraph 2.79 of the document states that the following does not count towards the enhanced services floor:

> "baseline spend on services provided through Trusts or other providers, for example an accident and emergency-based minor injuries service commissioned from an acute trust, or existing services delivered by GPs in community hospitals or as clinical assistants. These baseline services cannot be included for as long as the existing contracts are simply rolled forward."

The only exception is where the level and type of service changes significantly. It will then depend on how the new service differs from the current arrangements as to whether it is suitable to use enhanced services funding. For example, if a new minor injury unit was introduced then, following discussion with the LMC, this could be treated as an enhanced service. However, if the change is only to hours of work then this should continue to be funded from the secondary care budget.

If the PCO is wrongly using enhanced services funding for community hospital work, then please inform your LMC as soon as possible so that appropriate action can be taken.

**APPENDIX A**

**POWYS COMMUNITY HOSPITALS AGREEMENT[4]: GPC SUMMARY (revised October 2007)**

Please note that this is a summary only. For the precise details please see the Powys Service Level Agreement (SLA).

- Practices, rather than individual GPs, will hold the contract to provide the SLA to each community hospital. The SLA will be a rolling 3 year contract, with an annual review.

- The SLA is for in-hours only – from 08.00 to 18.30 hours Monday to Friday (excluding bank and public holidays). While the practices have a 24-hour clinical responsibility for the GP-led beds in the hospital, in the same way that consultants retain 24-hour clinical responsibility for their beds, the PCO is entirely responsible for the provision of out-of-hours (OOH) cover. There is no part of the SLA that obligates GPs to act as a "fallback" option should the PCO's OOH arrangements fail. If after discussion with the PCO the practices wish to provide OOH cover, they may do so under a separately agreed and funded contract.

- The practice will be paid as follows:

  - 10 sessions paid per grouping of 24 beds (plus or minus 15%; so the range is 20 to 28 beds)[5]

    Each session with GP-led beds = £6,840
    Each session with consultant-led beds = £5,771
    Each session with consultant-led beds where the GP has an additional qualification in the care of the elderly (e.g. Diploma in Geriatric Medicine) = £6,840

  A 5% uplift will be added to all sessional payments annually to recognise internal cover provided by the practice when a partner is away (e.g. sick, maternity or annual leave). This means that a:

    GP-led session = £7,181
    Consultant-led session = £6,059

  Therefore a practice responsible for 24 GP-led beds will receive £71,810 a year. A practice responsible for 24 consultant-led beds will receive £60,590 a year, etc.

  - 7 sessions paid (at £6,840 per session) per year for seeing or giving advice at a nurse's request to 2,500 minor injury patients over the year. The number of patients to be covered by the 7 sessions may alter by 15%; so the range is 2,875 to 2,125. [2]

[4] The Powys agreement is uplifted by the same amount/percentage as the annual pay award made to Consultant grade staff in Wales.
[5] Any variation in bed numbers outside of these ranges is for local discussion between the PCO and the practice(s) involved using the main SLA agreement as the basis for this.

A 5% uplift will be added to all minor injury sessional payments annually to recognise internal cover provided by the practice when a partner is away (e.g. sick, maternity or annual leave).
Therefore a practice seeing 2,500 minor injury patients a year will receive £50,267 on top of the annual payment for the GP or consultant-led beds.

- An additional payment of one session at £6,840 (£7,181 with the 5% uplift) where one of the practice's GPs is appointed as the Community Hospital Clinical Lead.

- All payments qualify under the NHS superannuation scheme. The PCO's employer contributions are paid directly by them to the pensions department and are in addition to the amounts mentioned above.

- The SLA will be uplifted by the same percentage as the annual Welsh consultants' pay award.

- GPs involved with the SLA will be appraised using the established NHS GP system.

- The practice has to provide the following service to the community hospital:

    - a doctor must attend the hospital each day Monday to Friday (excluding bank and public holidays). There will be a daily ward round, and wherever possible this should be multi-disciplinary (as a minimum at least one multi-disciplinary ward round a week must be undertaken).
    - A doctor must be "on call" or available at all times during the hours of 08.00 and 18.30. This doctor must be available for in-patient admissions, providing cover for the minor injury unit (where applicable) and to ensure that at the end of the working day all issues have been dealt with and an appropriate hand-over is made to the OOH provider.
    - Where a patient is admitted under the care of a named GP, the admitting doctor is responsible for "clerking in" the patient, agreeing a treatment plan and discussing that and the care plan with the nursing staff. The clinical record must be completed and any drug treatment written up.

- A practice may employ other doctors, such as staff grade doctors, to undertake the work. The practice will be responsible for informing the PCO of the GP partners and employees involved in the provision of services.

- For each community hospital a Clinical Lead will be appointed. There is a role specification for this post.

**APPENDIX B**

**MODEL SERVICE LEVEL AGREEMENT FOR COMMUNITY HOSPITAL GP PRACTICES FOR THE PROVISION OF IN-HOURS MEDICAL COVER AT COMMUNITY HOSPITALS**

Between ----------PCO and Medical Contractor Practices

In respect of ----------Community Hospital

From ---------- to ----------

This service level agreement is made on ----- day of ----------2007

between

1 ----------PCO
Address
Postcode
AND
2----------Medical Contractor Practice
Address
Postcode

This SLA will hereafter be called the Agreement.

The community hospital referred to in this Agreement is the ….. Community Hospital, hereafter called “the Hospital”.

**Introduction**
This Agreement is between the two parties stated above. It relates to the provision of medical cover to patients in the hospital during the specified weekday (Monday to Friday) hours of 8.00 am to 6.30 pm excluding bank and public holidays (and also to agreed services to patients attending the Minor Injuries Unit that cannot be managed by the nursing staff during normal contracted hours – delete if not appropriate).

Where the local out-of-hours provider offers different hours based on local agreement then the hours in the agreement may differ provided all parties agree.

The Agreement replaces the historically contracted service arrangements.

**Duration of Agreement**
The Agreement shall exist for a three year rolling period commencing on the date stated below.

The Agreement shall start on the ----------
Consideration to the further rolling forward of the agreement shall be given annually on the anniversary of the date above.

The period of notice for termination of the Agreement will be six months unless mutually agreed by the parties to the Agreement to be shorter.

**Professional requirements of Community Hospital GP Practice contractors:**

a) Registered medical practitioners with full GMC Registration
b) Eligible for entry on a PCT Performer's List
c) Professional indemnity insurance and/or Crown indemnity
d) Postgraduate medical experience or qualifications relevant to care of the elderly would be an advantage, as would a willingness to undertake relevant training.

The practice will be responsible for informing the PCO of the GP partners and employees involved in the provision of services to the community hospital.

**Hours of Service**
The Hospital shall be provided with the following medical input from the practice contractor:

Cover from 0800 to 1830 hours Monday to Friday excluding bank and public holidays for the care of those patients admitted under in-patient care.

Should the Hospital have a Minor Injury Unit then cover will be provided from 0800 to 1830 hours excluding bank and public holidays for the care of those patients who attend and are assessed by nursing staff as needing to see a doctor or for whom the nurse contacts the doctor for telephone advice.

Where the local out-of-hours provider offers different hours based on local agreement then the hours in the agreement may differ provided all parties agree.

[Out of the hours stated medical cover including for Minor Injuries unit is to be provided under a separate agreement between the PCT and the Provider of the out-of-hours service.]

**Payment options**
The different payment options are set out in appendix C to the GPC guidance.
[Please note that where there is a medical defence organisation surcharge then that needs to be built into the contractor price. A 5% uplift should be added to all payments annually to recognise internal cover provided by the practice when a partner is way (e.g. sick, maternity, annual leave and study leave). The separate remuneration for any Clinical Lead and minor injury work also need to be calculated.]
All payments will qualify under the NHS superannuation scheme.

**Service Outline**
The practice contractors will:

a) provide medical cover as stated ideally by nominated doctors with deputies in periods of leave and sickness

b) work with the wider multidisciplinary team including nursing staff, social services, consultants in elderly care/psycho-geriatricians, community staff and other agencies to the benefit of the inpatients

c) undertake to attend the hospital for appropriate lengths of time according to workload during contracted hours per (Monday to Friday), with a minimum of one multi-disciplinary ward round a week.

d) undertake to be available during the contracted hours if requested if urgent or emergency care is required when the practice on-duty medical contractor is not at the hospital.

**Principal Duties and Responsibilities of Practice Contractor**
Medical Officers will have the following duties and responsibilities for in-patients:

a) to accept appropriate admissions following the PCO admission criteria from district general hospitals and /or the community

b) to examine patients on the day of admission to the hospital where appropriate to do so, recording this and the prescribed medication and treatment in the patients health care records and undertake all appropriate admission documentation. This is to ensure that at the time of admission the patient has had an appropriate clinical examination and relevant documentation completed. Patients transferring from a local DGH must have their drug charts and a treatment plan updated/revalidated prior to transfer so that there is no requirement for the medical officer to attend the patient until the next routine ward round unless new treatment is required. Admission documentation may be undertaken on the next working day after admission

c) the resuscitation status of patients should be recorded following discussion with the patient and their relatives and regularly reviewed as appropriate
d) to contribute to the patients written care and contemporaneous notes ensuring legibility and signed entries for all attendances

e) to work to ensure all necessary investigations and diagnostic tests are carried out with appropriate actions taken in a timely manner

f) to reassess inpatients by history examination and ongoing investigations those inpatients that require clinical monitoring with the hospital staff
g) to support prescribing to the in-patients in line with the PCO Formulary

h) to liaise with the hospital pharmacist about medication reviews

i) to support PCO medication discharge policies – e.g. 28 day post discharge supply of medication as appropriate.

**Communication**

a) To maintain contemporaneous clinical records and to date and sign all entries and prescriptions to allow appropriate coding of discharge information
b) To ensure the patients registered contractor practice when appropriate as well as relatives or carers are informed of any significant changes in the ongoing condition and progress of the patient
c) To liaise two way with the local out-of-hours service provider about inpatients to provide communication and professional continuity of care
d) To participate in the multidisciplinary team care of in- patients to plan patient care and discharge plans
e) To liaise and communicate plans for discharge and referrals of patients to their local GP Contractor Practice by timely discharge letters
f) To arrange for follow up care and treatment as appropriate whilst in hospital
g) To support the PCT in ensuring any patient complaints are responded to within the time requirements of the NHS complaints policy.

**Continual professional development, training and education**

The Community Hospital Practice Contractor medical officers shall:
a) be expected to participate in an annual NHS GP appraisal and personal development planning.
b) attend in protected contracted time mandatory updates and other training as required by the PCO and as set out in the PCO's training policy, e.g. resuscitation updates.
c) utilise professionally the contracted study leave allowance in time prescribed for this post.

**Quality Research and Audit**

Community Hospital Medical Officers should:
a) support clinical governance by ensuring treatment is where ever possible underpinned by research evidence and compliance with NICE and NSF requirements.
b) follow agreed local care pathways and /or protocols.
c) support PCO staff in development of care pathways.
d) undertake and participate in clinical audit and PCO quality initiatives in protected time.
e) comply with PCO policy in ensuring ethical approval for all research projects.

**Health and safety, and risk management**

In order to protect the safety of the public patients and staff, the Community Hospital GP Medical Officer will participate in the PCO risk management programme and the adverse events and complaints system.

**Confidentiality and Data Protection**

The Contractor Practice:

a) must ensure that all persons delivering the service to the Community comply with the Caldicott Guardian requirements and ensure that any matters of a confidential nature are no divulged or made available to un authorised personnel
b) is responsible to ensure all their staff are aware of their obligations in respect of the Data Protection Act and in relation to the Freedom of Information Act 2005.

**Staff competency**

All community hospital clinical staff (including nursing staff) must be appropriately trained, for example in nursing care and life support.

**Admissions policy**

The following points should be considered when drawing up an admissions policy.

The level of case complexity will determine the input required by the general practitioner. It is important that only admissions which are within the capacity, skills or resources of the community hospital are made. A clear definition is needed of the type of patients that GPs have the time and skills to manage satisfactorily to avoid inappropriate admissions.

Normally only patients aged over 18 years of old may be admitted to a community hospital. With local agreement the minimum age for patients may be lowered to 16 years of age.

Examples of patients that may and may not be suitable for community hospital admission are set out below.

Patients normally suitable for community hospital admission:

- Uncomplicated medical conditions in the elderly– e.g. UTI, chest infection.
- Mild to moderate exacerbation of COPD, not requiring arterial blood gases (ABG) monitoring.
- Uncomplicated rehabilitation / respite assessment.
- Crisis admission; breakdown in care at home package.
- Joint assessment by health and social care.
- Step-down care at low risk level.
  - Post-orthopaedic electives.
  - Post surgery rehabilitation.
  - Stroke rehabilitation.
- Palliative care patients, except those requiring interventional therapy.
- Stabilisation of drug therapies.
- Intravenous antibiotic treatment.

There is an assumption, in the list above, that the community hospital has adequate facilities and staff resources and in particular adequate support from allied health professionals to rehabilitate suitable patients adequately.

Patients not normally suitable for community hospital admission

*(but maybe suitable if the GPs and the allied health professionals have the appropriate resources, including up-to-date skills)*

- Palliative or terminal care requiring interventional therapy i.e. effusion tapping and chemotherapy.
- Step-down care at relatively high dependency e.g. strokes, complex orthopaedics.
- Patients with persistent severe behavioural disturbance.
- Patients requiring regular daily specialist medication review.
- Patients admitted with chest pains.
- Patients with acute cerebrovascular events.
- Patients with metabolic imbalance requiring intravenous fluids and blood monitoring.
- Intravenous therapies, including blood transfusions.
- Alcohol detoxification.

**Clinical Lead**

The Practices will nominate (in discussion with the PCO) a Clinical Lead/Director. The specification for this role is set out below. An additional session paid at an agreed rate will be added to the SLA to recognise this role. This lead would normally be in place for a year at a time, to encourage continuity and development of services within the community hospital. Only one clinical lead will be appointed per community hospital.

*Role specification for a clinical lead/director:*

The General Practitioner Clinical Director for each hospital will have responsibility for providing leadership to the general practitioners who provide services at that hospital. They will be responsible for:

- Ensuring that the admitting doctors comply with the corporate and clinical governance frameworks of the PCO and the policies and procedures of the PCO.
- Working with the practitioners to ensure that only those patients whose needs can be met are admitted to the community hospital. In situations where there is uncertainty the matron, the General Practitioner Clinical Director and if necessary the on call manager should decide. In these circumstances and if necessary the General Practitioner Clinical Director should immediately inform the Medical Director of the PCO or their Deputy of the problem. In some circumstances patients will need to be admitted to other local hospitals or a District General Hospital that can provide the care needed.
- Encouraging participation in the clinical audit process by all of the general practitioners and working closely with the PCO audit lead.
- Ensuring a rota is in place that provides:
  - Cover from 8.00 to 18.30 Monday to Friday for the care of those patients admitted under the care of a named general practitioner, except bank and public holidays.
  - Cover from 8.00 to 18.30 Monday to Friday for the care of those patients who attend the minor injury department and who are assessed by the nursing staff as needing to see a doctor, except bank and public holidays.
  - A doctor presence in each hospital each day (Monday to Friday except bank and public holidays). It is expected that this should be for an

appropriate length of time, e.g. for one session a day (3.75 hours), to reflect the workload within the hospital.

- ♦ A minimum of one multi-disciplinary ward round a week.
- ♦ That an appropriate handover procedure to the out-of-hours providers is in place.

- Involvement in clinical complaints and helping the Medical Director of the PCO to ensure that any remedial action is taken.

The General Practitioner Clinical Director for each hospital will be part of the hospital management process and so will take part in:

- o Regular meetings with the matron and will support the matron in developing and providing high quality patient care and achieving agreed PCO performance targets.
- o The Hospital Operational Team meetings which is a monthly meeting attended by all those who are involved managerially in the hospital.
- o Meeting with the Medical Director quarterly and alerting the Medical Director if any issues arise relating to clinical competence, inadequate staffing or equipment levels.
- o Working closely with all other doctors who work in the hospital and in partnership with them establishing a medical staff committee. This committee will be represented on the PCO Medical Staff Committee.
- o Discussions on service change/redesign where appropriate.

The General Practitioner Clinical Director for each hospital will be expected to encourage and champion high quality evidence based care including:

- o Encouraging a culture of multidisciplinary care
- o Encouraging that patients are admitted and treated to agreed clinical protocols
- o Discussing regularly with the pharmacist prescribing practice and appropriate NICE guidance awareness
- o Encouraging that notes are completed and any changes to the treatment and/or care plan are documented (within one working day in cases of telephone advice to nursing staff) and discussed with the nursing staff.
- o Identifying any CPD needs of the admitting doctors.

The Medical Director will work with the practices involved to appoint the Clinical Lead/Director.

**Minor Injury Unit SLA**

The Practice Contractor GP Medical Officer should provide support and advice to the nurse practitioners as requested with regard to the patients attending the MIU for immediate

assessment and treatment during the hours of 0800 to 1830 hours Monday to Friday excluding bank and public holidays within an agreed range of response times.

The support may include the provision of verbal telephone advice and instructions, but NOT to take 999 calls unless the paramedic crew have formally and directly discussed the case with the responsible on-call contractor doctor.

**APPENDIX C**

**PRICING OPTIONS [revised October 2007]**

Pricing options for the SLA:

- a payment per grouping of beds, as per the Powys agreement[6] (see appendix A)
- a payment per hour based on bed numbers
- a retainer fee plus bed payments.

Available evidence suggests that the average community hospital has around 20 GP beds.

Under the Powys agreement, a practice would receive £71,810 per year for looking after 20-28 GP-led beds or consultant-led beds where the GP has a qualification in the care of the elderly during in-hours (08.00 to 18.30 Monday to Friday, excluding bank and public holidays). This equates to:

- £27.03 per hour (Based on 253 days of 10.5 hours) or
- £3,591 per bed for 20 beds, to £2,565 per bed for 28 beds

If one wished to ensure a reasonable income for practices covering a small number of beds in order to encourage practices to do this work, it could be recast as, for example (assuming 24 beds):

- A retainer of £20,570 plus £2,135 per bed or
- A retainer of £14,090 plus £2,405 per bed

Where a community hospital has several practices with admission rights they may wish to develop and agree a local formula that divides the income pool on the basis of a retainer plus and amount that reflects the practice admission activity over the previous year.

Cost to the PCO of employing staff grade doctors[7]

The alternative to the PCO is to employ staff grade doctors. As the following calculations show this is a costly option, and also leaves the PCO with responsibility for finding suitable cover when the staff grade doctor is on leave, including study, sick or maternity leave. Based on the salary of a staff grade doctor working 13 sessions a week, and taking account of the cost of annual and study leave cover plus employer's national insurance and superannuation contributions, the costs to the PCO are:

Staff grade doctor on the minimum scale for the grade - £59,560
Staff grade doctor on the maximum scale for the grade - £84,350

| | Basic salary | To work 13 sessions | Annual leave [8] | Study leave [9] | Employer NI costs | Employer superannuation | Total |
|---|---|---|---|---|---|---|---|
| SG lowest pay | £32,547 | £42,311 | £5,956 | £1,985 | £4,748 | £4,557 | £59,556 |

[6] The Powys agreement is uplifted by the same amount/percentage as the annual pay award made to Consultant grade staff in Wales.
[7] At present, 10 x 4 hour sessions equate to a full time staff grade post.
[8] Cover is based on 6 weeks annual leave.
[9] Cover is based on 2 weeks study leave

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| band | | | | | | | |
| SG highest pay band | £45,924 | £59,701 | £8,435 | £2,812 | £6,974 | £6,429 | £84,351 |

These prices do not include the costs involved in covering sick and maternity leave. They also do not include provision for any discretionary points or for the cost of consultant supervision. These costs need to be taken into account when comparing the cost of a single staff grade doctor to a GP practice (and possibly multi-practice) SLA contract.