FOCUS ON COMMUNITY HOSPITAL GPs
July 2005

This guidance note replaces and supplements our earlier *Focus on community hospital GPs: interim guidance* which was issued in February 2005.

This guidance:

- recognises the problems facing GPs working in community hospitals
- sets out the measures that the GPC is taking to remedy the situation, including our evidence to the Doctors' and Dentists' Review Body (DDRB) and the recently negotiated Powys agreement by GPC Wales
- details the DDRB pay award for 2005-2006
- provides advice as to what action GPs and LMCs could be taking locally, including conducting local negotiations and offers a model service level agreement 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, as set out in the GPC guidance, "Working in GP and community hospitals" (www.bma.org.uk/ap.nsf/Content/Hubcommunityhospitalgps). There is one common theme to all of these, which is that the remuneration package is inadequate. It fails to recognise their workload, experience, skills, commitment and clinical responsibility. This has resulted in increasingly low morale that, in turn, is leading to a severe and urgent recruitment and retention crisis. These recruitment and retention difficulties 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.

In addition, under the new GP contract GPs can transfer responsibility for out-of-hours primary care work to their PCO. Consequently many GP practices have already opted out of their out-of-hours commitment for their community hospital.

Furthermore, under the new GMS contract there is other work - for example further development under the Quality and Outcomes Framework or providing more specialised enhanced services - that practices can be concentrating on and that are currently far more financially attractive than providing services to the community hospital.

In summary, GPs serving community hospitals currently feel undervalued and unrewarded. A long-term remedy for this must be achieved if this important group of GPs is to be retained and new GPs recruited to enable this vital service to continue. Indeed, with appropriate levels of investment for GP providers, this could still be very cost effective for PCOs.

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 the steps taken and being taken by the GPC to achieve improvements, including an overall pay review, for community hospital GPs.

UK-wide review and negotiations

After we took over responsibility for this group of doctors, the GPC wrote to the Department of Health to inform them of our new negotiating responsibility and asking for national negotiations for community hospital GPs to commence as a matter of urgency. The Department responded that it wished to consider community hospital GPs as part of the Staff and Associate Specialist (SAS) doctors' negotiations, and we set out the reasons against this, which are broadly that:

- a solution for GPs working in community hospitals is required urgently. It cannot wait to be considered as part of the large-scale SAS negotiations, which will take time to set up and conclude
- the issues facing GPs working in community hospitals are separate from those for the other hospital grades. The link between GPs working in community hospitals and the clinical assistant pay rate is an historical one, and does not reflect the work that they do. Any solution for GPs working in community hospitals need not be dependent upon or even related to solutions for the other grades.

The Department, while acknowledging the work carried out by GPs, other doctors and staff in community hospitals, replied that it remained "unconvinced that there is an urgent need to review arrangements nationally".

However, it now appears that NHS Employers (a subsidiary body of the NHS Confederation which represents the service and is mandated by the English Department of Health to negotiate on its behalf) would prefer to decouple the negotiations for these two groups of doctors as it recognises that there are differences between them and that there is an urgent need to resolve community hospital GP issues. Following recent correspondence, the DoH has said that it wants negotiations to be conducted locally. We have written to the DoH on the urgent need for a national framework for negotiations to be agreed and also for adequate funding for PCOs to be made available, in line with the recent proposals by the Doctors' and Dentists' Review Body, and we will continue to push for this.

In the meantime, GPC Wales and Scottish GPC have been discussing this with their respective Health Departments. While to date no national deals have been reached, in December 2004 GPC Wales negotiated a local agreement with Powys Local Health Board (LHB) for community hospital GPs and this will form the starting point for our national and UK negotiations. Further details of the Powys agreement are set out on page 3. In Scotland negotiations are stalled awaiting the formation of the new NHS Scotland employers' organisation which will have to be involved, as well as the Scottish Executive Health Department (SEHD), in the negotiations.

While achieving national and UK negotiations is proving very difficult, you can be assured that we will continue to work to ensure that all GPs receive the necessary improvements to their terms and conditions and pay.

A call for improvements to pay in 2005-6

We submitted detailed and compelling evidence to the Doctors' and Dentists' Review Body (DDRB). This called for a significant uplift for 2005-06 to help to prevent a recruitment and retention crisis in the short term. Our evidence was backed up with results from a 2004 BMA survey of community hospital GPs which showed that:

- morale is low
- these doctors work long hours and the work is disruptive to other business and personal life
    - 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 out-of-hours

    - 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% said that they were planning to withdraw from out-of-hours cover and 6% were planning to withdraw from all community hospital work.

The DDRB reported its recommendations in February 2005. Details of the pay award are set out later in this guidance.

Informing MPs

We have submitted evidence to the House of Commons Health Select Committee's inquiry into the potential impact of the GP contract on the provision of out-of-hours services. This stressed the urgent need for a national framework for GPs working in community hospitals in order for these doctors to be able to continue providing out-of-hours and in-hours cover.

Also for a House of Common's debate on GP services in November 2004 the GPC worked with the BMA's Parliamentary Unit to brief MPs on the need for an urgent review for community hospital GPs. Separate, individual MP briefings have also taken place. In addition we are considering, with the Parliamentary Unit, other initiatives for the future.

The Powys local agreement

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. This is a practice-based agreement. A summary of the agreement is set out in appendix A.

DDRB pay award 2005-06

As mentioned earlier, the GPC submitted strong evidence to the Doctors' and Dentists' Review Body (DDRB) for a substantive pay increase for community hospital GPs.

The DDRB 34th report was issued in February 2005 and stated that:

- It was grateful to the BMA for its efforts in undertaking a survey into the quantum and complexity of the work performed by GPs working in community hospitals. However, as it had been provided with no evidence by the Health Departments, it felt that it did not have an agreed basis from which to make a judgement on this.
- Community hospital GPs should receive a cost of living pay increase of 3.225%, in accordance with the general uplift for GPs in 2005-06.
- The remuneration arrangements for community hospital GPs are complex and need updating.
- It hopes a sensible framework can be agreed by the parties within which negotiations can then be conducted locally by PCOs and GPs.
- PCOs should not be expected to bear additional costs without additional funding. It was noted that it was important for the whole of the NHS that community hospitals have an integrated role within the NHS, particularly in rural areas. If PCOs decide that GPs are needed to support these hospitals, but the cost of their services increases as a result of the new GMS contract, PCOs should not be expected to bear the resulting financial brunt.
- It recommended that Ministers give careful consideration to the case for providing appropriate additional funding for PCOs to meet any increased costs for medical staffing cover for community hospitals.

While the pay award for 2005/06 is disappointing, the report does highlight the need for a national framework for local negotiations and the need for additional PCO funding to support community hospitals. These are points that the GPC has highlighted to NHS Employers and the Health Departments.

What are your options?

Local negotiations and the GPC model service level agreement

The GPC has recently produced a model service level agreement that LMCs throughout the UK can use as a benchmark for local negotiations. This is set out at Appendix B. The following gives an overview of our model SLA:

- 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 totally responsible for the provision of out-of-hours cover, and there is no part of the SLA that obligates GPs to act as a "fallback" option should the PCO's out-of-hours arrangements fail. If the practice contractor is willing to provide out-of-hours 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.
- 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 out-of-hours 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.

Please note that community hospital GP work that is currently undertaken must not be funded from the enhanced services funding floor. This is explained further on page 7.

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).

We will be working 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 out of hours, 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 out-of-hours work in community hospitals, unless they were paid a clearly defined sum for out-of-hours cover. In England we are aware that many PCTs have also already relieved community hospital GPs of out-of-hours provision of service for no reduction in pay.

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

Are you considering withdrawing from community hospital work?
To do this 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 how you can do this 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 advise in all instances to consult with your contract/agreement and to seek individual expert advice, particularly on when to withdraw to ensure that your best interests are protected. BMA members can contact their local BMA office. Please also keep your LMC informed.

Ensure that enhanced services funding is not used

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.