February 2005

GPC

General Practitioners Committee

Focus on community hospital GPs: Interim guidance

BMA

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This *Focus on* guidance note recognises the problems facing GPs working in community hospitals, sets out the measures that the BMA's General Practitioners Committee is taking to remedy the situation, including the recently negotiated Powys (Wales) agreement, and provides advice as to what action GPs and LMCs could be taking locally. Additional and detailed guidance on conducting possible local negotiations will be produced in the near future.

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/Hubprovidinggpservices). 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
The GPC initially wrote to the Department of Health to inform them that the GPC had taken over responsibility within the BMA for these doctors and asking for national negotiations 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. In responding, we set out the reasons for separate UK-wide negotiations, 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. We have written to NHS Employers and the English Department of Health about this, and are awaiting a reply.

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. Details of the Powys agreement are set out below. 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.

Improvements to pay in 2005-6
We have submitted detailed and compelling evidence to the Doctors' and Dentists' Review Body (DDRB). This calls for a significant uplift for 2005-06 to help to prevent a recruitment and retention crisis in the short term. Our evidence is backed up with results from a 2004 BMA survey of community hospital GPs which shows 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 will report its recommendations in February 2005.

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 appended.

What are your options?
Local negotiations?
At this stage we do not recommend that any long-term local "deals" (i.e. amendments to contracts, other than opting out of out-of-hours responsibility) are agreed. While awaiting agreement on UK-wide or national arrangements, we will shortly be producing more detailed guidance in the form of a national benchmark for local negotiations. We suggest that LMCs and practices await this before signing any long-term local deals. Short-term deals could be agreed with the proviso that in the event that any GPC national framework or agreement is put in place, then that short term agreement can either be (1) terminated with very short notice or (2) amended to bring into line with any GPC national benchmark or agreement.

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 makes it clear that community hospital GP work that is currently undertaken must not be funded from enhanced services monies.

The only exception is where the level and type of service changes. It will then depend on how 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 PCT 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.

GPC next steps
The GPC is currently awaiting the DDRB's report on community hospital GPs' pay, and also continues to press for UK-wide negotiations for this important group of doctors.

In the meantime, we are working on producing additional detailed guidance on possible local negotiations which we hope to publish in the near future.

This particular guidance note will be reviewed by 31 March 2005.

Appendix

Powys community hospitals agreement: Summary

Please note that this is a summary only. For the precise details please see the Powys SLA.

- Practices, rather than individual GPs, will hold the contract to provide the Service Level Agreement (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 totally responsible for the provision of out-of-hours cover. 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 practices wish, and after discussion between the practice and PCO, the practice may agree to provide out-of-hours cover 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)*
    Each session with GP-led beds = £6400
    Each session with consultant-led beds = £5400
    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) = £6400

  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 = £6720
  Consultant-led session = £5670

  Therefore a practice responsible for 24 GP-led beds will receive £67,200 a year. A practice responsible for 24 consultant-led beds will receive £56,700 a year, etc.

  - 7 sessions paid (at £6,400 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 2875 to 2125.*

  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 £47,040 on top of the annual payment for the GP or consultant-led beds.

  - An additional payment of one session at £6,400 (£6720 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.

*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.

- 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-displinary (as a minimum at least one multi-discplinary 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 out-of-hours 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.