

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 (DDRDB) and the recently negotiated Powys agreement by GPC Wales
- details the DDRDB 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 Commons' 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.

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-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 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.

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 -----2005

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 away (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 not divulged or made available to unauthorised 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 age 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 ie 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:

- Regular meetings with the matron and will support the matron in developing and providing high quality patient care and achieving agreed PCO performance targets.
- The Hospital Operational Team meetings which is a monthly meeting attended by all those who are involved managerially in the hospital.
- Meeting with the Medical Director quarterly and alerting the Medical Director if any issues arise relating to clinical competence, inadequate staffing or equipment levels.
- 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.
- 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:

- Encouraging a culture of multidisciplinary care
- Encouraging that patients are admitted and treated to agreed clinical protocols
- Discussing regularly with the pharmacist prescribing practice and appropriate NICE guidance awareness
- 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.
- 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

Pricing options for the SLA:

- a payment per grouping of beds, as per the Powys agreement (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 £67,200 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:

- £24.62 per hour or
- £2,400 per bed for 20 beds, to £3,360 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:

- A retainer of £19,200 plus £2,000 per bed or
- A retainer of £13,200 plus £2,250 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 an amount that reflects the practice admission activity over the previous year.

Cost to the PCO of employing staff grade doctors

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 - £48,700

Staff grade doctor on the maximum scale for the grade - £72,600

	Basic salary	To work 13 sessions	Annual leave	Study leave	Employer NI costs	Employer superannuation	Total
SG lowest pay band	£30,808	£36,409.45	£3,500.91	£1,400.37	£3,059.23	£4,313.12	£48,683.08
SG highest pay band	£43,871	£51,847.55	£5,982.41	£1,994.14	£6,636.49	£6,141.94	£72,602.53

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.