Other Document Form

Number 1391

Title EMAIL FROM DR HOLDEN- ASSISTANCE IN MEDICAL INVESTIGATION

(Include source and any document number if relevant)

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Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Receiver

Code A

O/M	SIO

Indexer

Code A

From: Williams, David M
Sent: 06 March 2006 17:53
To: Grocott, David
Cc: Code A
Subject: FW: Assistance in Medical Investigation
Importance: High

Dave..

I have read these documents that pretty much all relate to remuneration formulae for Healthcare staff.. and workloads from a selection of respondent hospitals mainly in the North of the Country..
At this stage I do not believe that they are particularly relevant to this investigation.

DW.

From: Williams, David M
Sent: 10 February 2006 15:29
To: Williams, David M
Subject: FW: Assistance in Medical Investigation
Importance: High

From: Grocott, David
Sent: 12 December 2005 09:37
To: Code A; Williams, David M; Niven, Nigel
Subject: FW: Assistance in Medical Investigation
Importance: High

Gents,

some reading sent to us by Dr Peter Holden GP

Dave Grocott
D/Insp
Int 641-404
Mobile Code A

From: Peter Holden [mailto:Code A
Sent: 11 December 2005 23:46
To: Grocott, David
Subject: Assistance in Medical Investigation
Importance: High

Inspector Grocott

Here are a few documents somewhat repetitive which basically demonstrate the situation in Community

Hospitals a much neglected by managers but much loved and valuable resource in their own locality .

I authored all the documents. The important bits are at the end where the different contractual models are delineated.. For 10 years I chaired the BMA committee responsible for Community Hospitals and for the past 6 years have overseen the professions policy on them. I still work in a Community Hospital and have done so since July 1985
GPs essentially run these places with minimal input from consultants.
Professionally there is nothing wrong with this. The public hugely underestimate the skills and experience of GPs and frankly the consultants opinion is only sought for the narrow clinical problem not the whole patient. GPs who work in Comm. Hosps have never actually left hospital medicine but ARE used to making difficult judgements with an incomplete data set which they do all day every day in General practice unlike colleagues in pure hospital medicine

I will be happy to meet/set aside time for a prolonged phone call.

Peter Holden MB ChB FIMCRCSEd MRCGP DRCOG

Code A

----- Original Message -----
From: dave.grocot Code C
To: Code A
Sent: Friday, December 02, 2005 2:11 PM
Subject: RE: Assistance in Medical Investigation

Dr Holden,

Thanks for the reply. I look forward to hearing from you in the next couple of weeks

Dave Grocott
D/Insp
Int 641-404
Mobile Code A

From: Peter Holden [mailto: Code A
Sent: 01 December 2005 14:44
To: Grocott, David
Subject: Re: Assistance in Medical Investigation

Dear D/Insp Grocott

I believe that I may be able to help you. Personally I have held such a contract since 01 July 1985 and have led for the BMA on the topic of GPs and community hospital work since 1989.
Until Tuesday I am locked into negotiations with HMG and have an exam on Sunday.
May I revert next week please?
I attach my contact details

Peter JP Holden MB ChB FIMCRCSEd MRCGP

----- Original Message -----
From: dave.[Code C]
To: [Code A]
Sent: Thursday, December 01, 2005 2:08 PM
Subject: Assistance in Medical Investigation

Dr Holden,

Can I introduce myself I'm Detective Inspector Dave Grocott from Hampshire Constabulary's Major Crime Team. I'm currently working on a medical based investigation and I need to utilise the services of a suitably qualified expert in the field of General Practitioner (Clinical Assistant).

I am looking for someone who in the first instance can provide a report as to what the role of a GP (CA) is in a small community hospital, primarily in the area of elderly medicine. I'm interested in contracts, job description, expectations, qualifications, line management etc.This is in order to give me a better understanding of what the role is.

It may then follow that I ask for specific work to be undertaken to review or clarify issues in relation to someone performing a similar role here in Hampshire.

I was given your details by John Grenville, he stated that you might be able to help personally or if not you would be the best person to direct me elsewhere. If you feel that you may be able to help please contact me either by email or on the below number. I will then be able to provide some more detail and hopefully arrange a meeting.

Dave Grocott
D/Insp
Int 641-404
Mobile [Code A]

February 2005

GPC

General Practitioners Committee

Focus on community hospital GPs: Interim guidance

BMA

Focus on community hospital GPs: Interim guidance

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.

Draft II

GMSC inquiry into GP workload and Remuneration in Community and General Practitioner Hospitals

In 1988 the former GMSC Hospitals Subcommittee began to question the workload and payment system for General Practitioners working in a GP and Community Hospitals. Anecdotal evidence revealed that there was considerable injustice in the current pay system for such work. This culminated in a position paper (GMS 13 1990-91) which GMSC debated in July 1990 and the Committee resolved to arrange production of this survey. Many of the assertions and suppositions in GMS 13 have been confirmed and it is now safe to say that there is considerable disquiet amongst those GPs involved in such work. It is worth reiterating that such hospitals tend to be in the more rural areas where the only ready source of medical manpower is the local general medical practice. Additionally through historical accident and tradition the local populace expect their local general practitioners to support and work in their local hospital. It is not an option for such general practitioners (who with their families have to live in such (rural) communities) to withdraw from such work which in some cases is a gross exploitation of their professional skills and personal good faith. Such work in many cases is now becoming an officially enforced act of public charity by the doctors concerned with DHA/HB simply using emotional blackmail on those doctors concerned to ensure these units have medical cover.

Neither minor nor major accident services are part of the FHS treasury vote but there is evidence that some GPs are actually having to provide such services as part of rural GMS and this is a trend which must be stopped. The provision of casualty services irrespective of the grade of doctor providing such services are properly a charge on the HCHS treasury vote and not the FPS vote. There are many activities in (rural) general practice which have become part of normal day to day practice but they are not part of General Medical Services and for both financial and service committee procedure reasons such activities must be prescribed and the responsibility for provision and servicing and funding such non GMS services be placed firmly with the DHA/HB or other authorities as appropriate.

Identification of GP and Community Hospitals

The identification of GP and Community hospitals, which tend to be small in size, is difficult because of varying bed classification policies amongst Regional Health Authorities. Many beds masquerade for a variety of reasons as Geriatric, Long stay geriatric, or even General Medical acute beds. Despite considerable reference to usual sources such as the Hospitals and Health Services Yearbook, the Directory of the Association of GP and Community Hospitals and RCGP occasional Paper 43 "Community Hospitals - Preparing for the future", it proved difficult to identify readily the relevant hospitals and so the survey was confined to three regions (Scotland, Trent, South Western) and the help of LMCs enlisted to identify the correct hospitals. This process alone took seven months. The survey was conducted during November/December 1991 with telephone follow up of non responders and further telephone follow up in the manual editing and confirmation of data.

During the latter exercise it became very clear that most general practitioners have no real idea of the mechanisms of payment for GP principals working in hospitals.

Definition as to what constitutes a General Practitioner or Community Hospital

A GP or Community Hospital is one having no resident medical staff where **the first point of contact** for medical cover/advice or attendance either by routine or in an emergency is a local general medical practitioner.

Methods of Payment

There are five possible methods of payment mechanisms for GPs working in GP and Community Hospitals and, because of the Hospital Terms and Conditions of Service which apply to such posts it is important to have an adequate definition of what constitutes a GP or Community Hospital (vide supra).

The five methods are

(1) Clinical Assistant Sessions (CA)
(2) Hospital Practitioner Sessions (HPG)
(3) Bed Fund Arrangements (In Patients)
(4) Casualty Payments
(5) Other (local arrangements)

From enquiries made to the GMSC office it is clear that:-

a) GPs are underpaid for the work done in hospitals
b) GPs do not know how to check that they are being paid properly
c) There is variability in the methods used to calculate relevant pay

Which Method of Payment?

Bed fund, Clinical Assistant or Hospital Practitioner Grade?

The key question is:- Who leads the team? Consultant or GP?

If a consultant leads the team then the payment should only be via clinical assistant sessional payments or preferably hospital practitioner grade payments.

Why?
- The pay is better
- with H.P.G. there is security of tenure
- with C.A. there is still no security of tenure but redundancy pay may be payable in rare circumstances
- **the bed fund assumes that the GP is in control of the beds and orders his work both inside and outside the hospital at his own professional discretion**

Clinical Assistant Sessions (Paragraph 94 appointment Hospital TCS)

- Fixed pay rate £2720 per session per annum (1992 rate)
- No security of tenure

- No entitlement to study leave
- Not related to the number of beds but to the **time** commitment of the job
- Employee status
- Covered by the General Whitley Council regulations
- Do not require manpower approval for establishment of less than 6 sessions
- On one month rolling contract
- Subject to exploitation
- When working as a CA during the fixed routine sessions the first loyalty is to the hospital and NOT the practice. Other arrangements have to be made for practice emergencies.

- Emergency and on call duties should be specified in the contract. Often they are not
- Supposed to be responsible to a NAMED consultant
- Hospital terms and condition of service should apply
- Travel expenses payable under certain conditions
- When working as a CA the doctor cannot have independent charge of the beds

Hospital Practitioner Grade

- Payscale £2690 via 6 increments to £3,620 per session per annum
- Maximum of 5 sessions per week
- Require manpower approval and is a PERSONAL appointment
- Have to be advertised

- 4 years full registration
- Qualifications and experience depend on the post concerned and the attitude of the consultants concerned
- Study leave entitlement 30 days in 3 years
- When working as hpg cannot have independent charge of beds
- First loyalty is to hospital during contracted time NOT the practice
- emergency and on call duties have to be specified in the contract
- Responsible to a NAMED consultant
- Full hospital tcs and gwc rights apply
- Travel expenses payable under certain circumstances
- **Security of tenure**

Clinical Assistant and Hospital Practitioner Grade posts are time sensitive employed grades. The postholder is an employee.

Sessional Calculations for CA/HPG
Average time per week to do the job in hours 1 session
3.5
ie a session is 3½ hours

This includes outpatient clinics, ward rounds, operating sessions, laboratory work, and travelling time from the surgery to hospital and return. Any fraction of a session is rounded up to the nearest integer. The maximum number of sessions payable is 5 per week for HPG, 9 per week for clinical assistant except in calculating casualty payments.

It is reasonably easy to calculate the sessional payments for routine regular work but assessment for providing out of hours cover is difficult with huge variations across the UK. Many GPs are being exploited because there is no justice or logic to the system and there is little doubt that huge amounts of medical cover are being provided at a cut price.

What timescale has to be covered by CA/HPG sessions?

168 hours in a week
48 sessions per week @ £2770 for CA session or £132,960 pa for 8760 hours (365 x 24 = 8760)

or £15 = 18p per hour
Clearly this is grossly unrealistic

Remember average net remuneration for GP's is £40,010 or £4 = 56p per hour (unrealistic also)

What if the beds were not covered by GP's?

The hospital would have to employ as a minimum a SHO or a staff grade doctor.

The out of hours mechanisms of payments for these doctors have increased recently by very large amounts, and their hours of work are soon to be restricted. (see table below)

Working arrangements	**Maximum contracted hours per week**		Maximum continuous day (hours)*	**Minimum period off duty between duty periods (hours)***	**Minimum continuous period off duty (hours)**	**Pay Rate**
	as soon as practicable	by 31.12.94				
Full shift	60	56	14	8	48 + 52 in 28 days	**100% of basic**
Partial Shift	72	64	16	8	48 + 62 in 28 days	**70% of basic**
On-call Rota	83	72 (for hard pressed posts)	32 (56 at weekends)	12	48 + 62 in 21 days	**50% of basic**

* Except when two shifts are worked consecutively

It would therefore be likely that a community hospital would have to be covered by a doctor on an on call rota basis.

As no junior doctor in the long term can work more than 72 hours per week another 96 hours of cover would have to be found by involving at least 2 other doctors and it is likely that any such doctor would have to cover more than one site when on duty which therefore could involve much travelling, increased response times to clinical emergencies and a general pace of work which could then make the job "hard pressed" and thus cause it to be regraded onto a partial or shift rota basis.

Thus minimum costs to cover a 25-30 bed unit is an SHO on an on call rota basis would involve at least 2 other doctors in the out of hours rota. This would have implications concerning holidays and study leave which could affect at least 18-20 weeks per annum.

The costs of a Senior House Officer (1992 prices)

SHO Basic Salary top of scale £20,585

128 hours pw @ 50% pay rate	£32,936
6 weeks leave/locum (incl week study leave)	£ 6,175
Employers NI (approx)	£ 5,068
Employers superannuation	£ 4,179
	£68,943 per annum
or	£7 = 87p per hour

Before travel, sickness or study leave or any other adversity etc

Staff Grade doctors come more expensive with limitations on their hours of work.

WHAT PRICE "COVER"?

DoH (DHSS) suggested in their various letters regarding CA sessions
1 session for overnight
Plus 2 sessions for weekend
ie 7 sessions or at present pay £19,390 pa
This is a lot better than many people receive now.
But overnight is defined as 1700 - 0900 80 hours pw
Weekend 48 hrs
128 hrs pw or 6656 hr pa
= £2.91 per hr out of hours and what about daytime cover?
Should we be so rigid?
Should we have a "professional" contract but very adequately priced?

BED FUND

WHAT IS THE BED FUND?

Assume it is a "pot" into which all bed fund and casualty payments are paid.
The division of the pot is up to the participating doctors to agree amongst themselves.
It is superannuable - tell the FHSA/HB.

Doctors appointed to the staff of a GP hospital with a bed fund are principals on the local FHSA list. Bed fund payments are simple cash payments to the fund. There is no sick leave, study leave, annual leave or security of tenure. No travel expenses or other payments are made. Doctors paid under the bed fund order their work in connection with those activities paid via the bed fund at their own professional discretion and they are answerable to their peers on the medical staff committee and of course to the courts and the GMC. In simple language bed fund doctors are their own boss. **Bed fund payments are bed occupancy not time dependent**.

BED FUND PAYMENTS - IN PATIENT BEDS

- GP is in control of admission, management, administration and discharge.
- No consultant involvement.

Below 70% bed occupancy of available beds
£ per annum % bed occupancy x 1.2 x Bed fund rate x no of beds

70% or above bed occupancy
£ per annum No of beds x Bed fund rate.

Thus assuming 10 Bed fund beds:

69% occupancy

$10 \times £394 = 80 \times \frac{69}{100} \times 1.2 = £3,269 = 94p$

70% occupancy

$10 \times £394 = 80 = £3,948 = 00p$

Thus a 1% shift in occupancy at the threshold resulting a 1.4% reduction in workload gives a 17.17% reduction in pay.

A 15% drop in occupancy from 70% to 60% delivers a 28% drop in pay and a 15% rise in occupancy delivers no more pay.

The SAGPCH 1988 survey has shown that increased turnover delivers lower bed occupancy.

The GMSC survey has shown average occupancy to be 69%!! **MORE WORK EQUALS LESS PAY**

CASUALTY PAYMENTS

Are part of and paid into the Bed fund.

The clinical assistant pay **rate** is used to calculate the payments **but the payments themselves are nothing to with the clinical assistant grade**

1. SMALL CASUALTY UNITS
   Under 200 new attendances pa £15.85p per new casualty

2. OTHER CASUALTY UNITS (By definition over 200 new attendances pa)

   2 COMPONENTS

   a) retention fee
   b) Attendance dependent payments

   a) Retention Fee
   Mon - Fri 12 hours per day £1470 pa
   7 day 12 hour service £2430 pa
   7 day 24 hour service £4860 pa

   b) Attendance dependant payments
   - Based upon the number of new attendances
   - Pay rate is based upon the clinical assistant pay scale

This seems to be subject to local variation

A common situation is that every seven and ten hundred new attendances generates one clinical assistant session payment to the bed fund or pro rata

- assumes you do not have to see every patient at first attendance but at some stage in the episode
- assumes that the nurse triages and sorts minor problems herself and telephones for sanction, advice or to request immediate attendance by the GP
- the GP has to be prepared to attend **immediately** if requested to do so

If the GP sees every patient on first attendance then the divisor may fall to 200 new attendances per clinical assistant payment.

Another common assumption is that each new patient takes 20 minutes to deal with thus the total number of new attendances per annum divided by three = hours worked. Hours worked divided by 3.5 divided by 52 = sessions per week.

A worked example of the average GP community hospitals 1992 figures

Calculating the bed fund payment for a 23 bedded GP hospital with 69% bed occupancy and a 24 hour casualty seeing 2381 new attendances per annum.

This average hospital will generate the following workload for the GPs.

319 admissions
20 days average stay
624 recalls to the beds per annum
832 hours of routine work to the bed fund beds
1404 special recalls to casualty
312 routine visits to the hospital

Casualty 24 hour service retainer £4860
Attendance fee $\frac{2381}{710}$ x 2770 = £9421=95

£14281=95p

or £6.00 per casualty

In patient beds 23 x bed fund rate (394=80) x $\frac{69}{100}$ x 1.2 £7518=57p

Grand Total £21800=52p

for a total of 2340 visits to the hospital
24 hour total medical cover
832 hours routine work on the wards
Supervision of all the casualties

If this hospital were staffed by the lowest grade of fully registered doctor ie an SHO the staffing costs would be a minimum of £60-70K per annum.

Comments on the survey results

78% of questionnaires issued were returned and 63% of those issued were useable. This is remarkable for a postal survey but not surprising given the comments appended to the survey report forms.

Section A Bed fund in a patient arrangements

Clearly much good work grossly undervalued and underpaid is being performed here. It is especially galling that the active units doing active medicine result in a pay cut for the GP because increased turnover delivers reduced bed occupancy. The actual pay rates are insultingly low taking all factors into account.

Section B In patient Sessional Arrangements

Clearly in comparison to bed fund beds the turnover is lower, the workload and recall rates are lower. The pay rates in both absolute and relative terms vastly better than bed fund especially as ultimate clinical responsibility lies with a consultant. It should be noted that in reality all day to day decisions are taken on the spot by the local GP CA and the input from the consultant varies considerably according to the type of hospital. It is a feature of CA sessional payments that there is no formal mechanism for calculating the number of sessions payable for providing out of hours cover. This state of affairs is totally anomalous in the employer/employee relationship at this type of reward level. The liability and call out rate is high and real and not theoretical as in other walks of life. Departmental guidance is deliberately vague and non committal and is at least 13 years old. This needs revision.

Section C Casualty Arrangements

These payments are almost universally bed fund payments and the method of calculation is subject to local variation. Some GPs are being paid nothing at all for providing casualty services, their local FHSA/HB arguing that "in rural areas such work is part of General Medical Services".

This assertion is wrong, and unacceptable and takes money from the FPS budget rather the HCHS budgets. Casualty work is unpredictable, demanding and highly disruptive to normal practice routine especially post 1990 where many GPs find that despite careful management there is no longer any contingency time in the working day. At £4=24 per casualty (£6=00 in 1992 figures) many GPs would be better off doing nothing after taking expenses such as travelling etc into account.

Comments appended to the survey returns

1. "During 0900-1700 we have to see the casualties in our own treatment room. We do not get paid for this."

2. "There is an ongoing dispute between ourselves and primary care management on this."

3. "In the year to 30 April 1992 (sic) there were 1094 new attendances at our casualty facility. In reality the true figure is up to 20% greater because of under recording. Three full time partners provide continuous on call. The gross remuneration per partner per month is £273.75 in other words the total practice income per year was £9855=00."

4. "At the beginning of 1991 the number of GP sessions was arbitrarily reduced to 10 with approximately the same amount of day work and out of hours cover still being carried out."

5. "We cover casualty 24 hours/day but because the H/C and the Cottage Hospital are on the same site we get only 12 hour coverpayment - the logic being we see them all as GMS services during the day."

6. "Far too long has this aspect of medical care been underestimated. It has relied heavily on doctors "good faith" but I suspect that this will last not too much longer. The pay for this aspect of general practice grossly inadequate for the work and inconvenience involved."

7. Comment from a GP in Southern Scotland who sees 500 new casualties per annum with no payments even though they attend a casualty unit.

   "The NHS receive a service which no other profession in its right mind would do for nothing. The fact that total cover is provided all year round makes the situation even more ludicrous."

8. "Years ago, I should have negotiated a proper contract but never did."

9. "The practice is under increasing pressure from the increased amount of casualty work, particularly during the summer months .... I have estimated that over the year each patient who is seen by a GP in our Cottage Hospital cost xx Health Board £7=05p ... - an enormous sum you will agree!!"

10. "Our perception is that GP Community Hospital work is a good service to the community and that to be done well requires time which is poorly remunerated. Currently it is an unprofitable aspect of the practice in terms of remuneration. It is however an integral part of the community health care as we see it."

11. "Years ago, I should have sought help in getting increased sessions and in grading - must do it now."

12. "Many of my colleagues feel an "administration" sessional fee would be appropriate in addition to payment for clinical responsibility ... Above all we feel grossly underpaid for this work at present."

13. "4 sessions we regard to be inadequate payment for full time cover, all admissions, discharge notes and letters, routine ward work (taking of specimens, arranging investigations, seeing relatives, drug supervision) for a unit of 30 beds. Overall occupied beds 78.82%, 176 admissions, average length of stay 18.8 days."

14. "We feel generally that:-

    i) The unpredictable burden of casualty can at busy times be that "final straw"
    ii) Increasing restrictions upon the nurses actions have increased our number of visits
    iii) It is a local service that is popular and for minor casualties saves people a lot of time. The occasional major casualty has benefited a lot as well therefore. ? better payment for a valuable service."

15. "The beds here have been officially designated as consultant beds. The consultant geriatrician is based in xxx - 94 miles from yyy and he visits once every two weeks. Day care and responsibility rests with the GPs."

16. "Overall - a meagre reward for a pretty open ended commitment for a job well enjoyed, nonetheless, and within a set up that is apart from the reward financially - sensible locally ... This can impose significantly on the ... practice workload and days planning."

17. "Community hospital allows our practice team to expand the delivery of primary care and to expand the scope of primary care. To do this takes a lot of time which we feel is given because of the expansion of primary care - NOT because of the remuneration which is derisory."

18. "Casualty work especially at weekends in the summer constitute a great deal of our workload, for although the attendance figures are an annual and weekly average there is a huge seasonal variation."

19. "The consultant geriatrician visits on a monthly basis but with holidays and adverse weather conditions etc he only appeared 8 times in the last year. We therefore have been admitting assessing and discharging patients as one would in a GP hospital. We would advocate that this unit be redesignated as such. Without the overbearing influence of the consultant geriatrician and CANO we would have made much more use of the beds for other non geriatric cases eg terminal care etc."

20. "For clinical assistants there is no payment for locum cover during holidays and sickness."

This last comment from a manager of a community hospital indicates that managers do not understand the system of payment for clinical assistants.

Summary

The suspicions and assertions of the former Hospitals and now the Hospitals and Special Services Subcommittee as expressed in GMS 13 1990-91 would appear to be substantiated.

Given that (a) Community Trusts will have powers to set local pay rates and (b) the DHAs are moving more people out into "the community" and trying to foist the provision of urgent medical care of patients still actually under the care of consultants onto General Medical Services. (c) Some areas are seeing the development of community hospitals; it is vital that pay and terms of service are just.

Vast amounts of skilled experienced medical cover are being provided by fully trained GP principals at rock bottom prices and in some cases when all factors are taken into account at a loss to the GP himself. Professor Nick Bosanquet has already warned Community Hospital Managers that their medical staffing costs are unrealistically low when speaking at the AGPCH Symposium in Tewkesbury in 1991. It is pertinent to note that to employ the lowest, least experienced fully registered medical practitioner ie a SHO would cost at least £70000 per annum at todays costs for 24 hour cover, 365 days per annum.

The Way Forward

We need to discuss with CCSC this report as the negotiation of Terms and Conditions of Service and pay rates for Bed fund, Clinical Assistantship etc are in their purview. Many GPs find this anachronistic and unacceptable.

We should seek joint or sole negotiating rights for GPs working in GP and community hospitals according to the definition above.

Given the new era of Trusts our recommendations and/or negotiations should be to produce a "floor" to payments leaving room for local negotiation above this floor.

We must make the bed fund payments truly work sensitive. At present they are actually the reverse! Perhaps we should be paid per day on a sliding scale according to how long the patient has been in hospital.

Action is needed quickly, we should be aiming for evidence to the 1994 Review Body Report.

P J P Holden 27.8.92

Source Documents

HOSPITAL TERMS AND CONDITIONS OF SERVICE

Relevant paragraphs
87-94 with references to para 61, 63, 71 to 75 and 287

OTHER IMPORTANT OFFICIAL SOURCE DOCUMENTS
(ENGLAND & WALES)

HC(PC)(79)5 Pay and Conditions General Practitioners Working in hospitals
HC(79)16 The Hospital Practitioner Grade

Scottish Equivalents are

1975 (PCS) 66 Hospital Practitioner Grades
1979 PCS 45 Pay and Conditions of Service. GP's working in hospital

OTHER OFFICIAL LETTERS

Mostly letters concerning the mechanisms of calculation of number of (clinical assistant) sessions to pay for "cover" out of hours.

November 1970 DHSS letter to BMA ref B/M43/3

November 1976 DHSS letter to BMA dated 4/11/76 No reference number
February 1977 DHSS letter to Cornwall and Isles of Scilly HA ref B(3)/M43/31
October 1977 DHSS letter to BMA ref B/M43/34-23
September 1979 Letter from DHSS ref B/M43/34 to Calderdale AHA

PAYMENTS TO GPS FOR HOSPITAL, CASUALTY AND OTHER WORK - THE NEED FOR A SURVEY?

The Hospitals Subcommittee has had a series of enquiries, usually from doctors practising outside the conurbations, concerning appropriate pay rates for performing non GMS work which falls within the orbit of the NHS such as Bed Fund work, GP Casualty, work both in formal GP casualty units and in their own surgeries and other work connected with GP and Community Hospitals, and Care Units. With the new NHS and Community Care Acts it is possible that the new DHAs as purchasers rather than providers of care may attempt even more disadvantageous local payment arrangements for general practitioners providing services to such units.

There is evidence that some DHAs are attempting to convert payments to GPs from clinical assistant sessions to bed fund calculated payments yet the beds remain firmly under the clinical control of a consultant. Thre is an increasing amount of evidence of a huge disparity in payments to GPs for ostensibly for the same work in different districts because of the lack of any guidance as to how to calculate payments for the often considerable time spent (up to 168 hours per week) providing "cover" to beds not under bed fund arrangements, notionally under a consultant, but de facto under the day to day care and responsibility of general practitioners. There are particular problems in districts where new community hospitals and units are being established requiring medical cover. Because of he geographical isolation of such units often the only medical manpower available for them are the local GPs. The initial workload can only be guessed at, and when the payment is found inadequate, the challenge is two fold. firstly, to cite the non existant mechanism for calculating how much money for how much work. Secondly, avoiding the increasing threat of local newspaper publicity of the "doctors feeling for wallets threatens local hospital" variety from the administrators. In some areas, such as parts of Scotland, the viability of GP partnerships continuing at present size can depend crucially on income from the local community hospital. It is difficult to demonstrate with brevity the increasing impact that community hospitals, GP hospitals, GP casualty units, bed fund beds, care units etc are having on the already hectic pressurised general practitioner workload. It must be recognised that particularly outside the conurbations, general practitioner involvement in community hospitals, bed fund activity, casualty work etc are not an optional activity but part of usual general practitioner activity and are perceived as such by the local population.

TYPES OF WORK CAUSING CONCERN AT PRESENT

a) Bed fund work.
b) GP casualty work - particularly in dedicated units.
c) Clinical assistantship analogue sessions paid for work undertaken in GP hospitals, community hospitals, care units, etc., not remunerated under bed fund arrangements, where the medical cover is provided mainly or exclusively by the local general practitioners.
d) Traditional clinical assistantships/HPG working in DGH type environments.

AREAS OF CONCERN

i) Absolute pay rates!
ii) Method of calculation of how much work for how much pay especially the vexed question of payment for "cover".

iii) Indiscriminate ad hoc usage of the clinical assistant scale arrangements for paying GPs for non GMS work in Type C work *vide supra).
iv) Absolute level of bed fund payment.
v) Amount paid per casualty seen in GP minor casualty units bearing in mind the disruption such work generates.

PROPOSED AREAS OF ENQUIRY

Work falling into types A, B, and C are intimately bound up with general practice workload although not part of general medical services, needs reviewing.

Work falling into type D is not within the remit of GMSC although a watching brief ought to be maintained through the GMSC/CCSC Liaison Committee. We should NOT attempt to survey this group.

THE NEED FOR A SURVEY

The Hospitals Subcommittee has discussed payments and methods of calculating payments for bed fund, casualty and other work in GP community hospitals and care units on several occasions in the past few years. The qualitative nature of the problem has bene recognised but progress has been hampered by the lack of quantitive data. Recent events have forced GPs to cost/benefit analyse their work and a steady series of questions are being sent in; almost all concerning "the rate for the job" in work connected with GP Hospital environments.

A disturbing suggestion has recently been sent in for comment: that the GP casualty should now only operate 12 hours per day thus allowing participating GPs to claim night visit fees, immediately necessary treatment, emergency treatment fees etc. Consider the consequences on average net remuneration if these became widespread. Imagine the benefits to cash limited DHAs encouraging this kind of "opt out", shifting costs from their budget on to Family Practitioner Services budgets. It would seem the appropriate time for the GMSC to attempt quantitative assessment to head off any groundswell activity which could gather momentum and affect the average net income.

CONSEQUENCES OF SURVEY

a) How many to survey? - may need ERU advice to get statistically significant number of responses to get an administratively manageable response to analyse.

b) How are papers distributed? - via `M' Circular to LMC secretaries to distribute?

c) Office consequences - Processing of returns? - manpower? - time? - money? Members of Hospitals Subcommittee to analyse batches of return??

d) Confusion and overload - must not have GPs confusing this survey with the workload survey presently being conducted.

SUMMARY

- From various sources there is dissatisfaction on the pay rates for GP Hospital work. The dissatisfaction seems to be spreading.
- The Hospitals Subcommittee and the GMSC are aware of the nature but not of the size of the problem.
- Further analysis and progress on the problem will require quantitative evidence.

- Some help has been offered in gathering data on the problem by the Association of GP Community Hospitals but a) their coverage will be limited and b) this politically should be our own operation.
- There are logistical and resource implications in a survey but from a political and negotiating point of view, data is required and a balance ought to be found between a survey we can afford and manage and our need for hard facts to deal with the problem.
- Draft questionnaires are attached.

P J P Holden (9/7/90)

PS Wef 19/7/90 for Hospitals Subcommittee read Hospitals and Special Services Subcommittee.

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P J P Holden (9/7/90)

PS Wef 19/7/90 for Hospitals Subcommittee read Hospitals and Special Services Subcommittee.

REQUEST FOR INFORMATION ON PAYMENTS TO GPs UNDER THE BED FUND ARRANGEMENTS

Name of hospital:

DHA/Health board area:

A GP BEDS

Number of bed fund beds:

Number of participating GPs:

Amount paid to GPs for bed fund work during 1989/90:

Number of admissions/discharge pa:

Average length of stay: days

Bed occupance: %

Approx hourly commitment/per week to the hospital for attending the GP beds:

"covering" :

Specially called in :

Routine work :

B MINIOR CASUALTY UNITS

How many new attendances pa? (1989/90 figures)

How many follow-up attendances pa? (1989/90 figures)

Is it open: *12 hrs per day Mon-Fri/12 hrs per day 7 days per week/open continuously?

How many GPs service the Department?

In total, how much were GPs paid for the casualty work?

How is the payment calculated?

What % of casualties have to be attended personally at first attendance?

How many hours per week on average do follow-up clinics take?

How many call-outs per week (either from home or surgery) does the casualty unit generate?

C

What proportion of total practice time does bed-funded GP hospital activity absorb?

What proportion of total practice income does bed-funded GP hospital activity produce?

Would closure or reduction of facilities at your GP hospital with the consequent loss of practice income affect the viability of your partnership continuing at its present size?

YES/NO*
(* delete as appropriate)

Please write any further comments overleaf.

Thank you for your co-operation.

Please return the form by:

To: Hospitals Subcommittee
General Practitioners Committee
British Medical Association
BMA House
Tavistock Square
London
WC1H 9JP

REQUEST FOR INFORMATION ON CLINICAL ASSISTANT OR HOSPITAL PRACTITIONER GRADE PAYMENTS

MADE TO GENERAL PRACTITIONERS UDNERTAKING DUTIES IN:

COMMUNITY HOSPITALS

(Please photocopy this form and complete one form for each post held)

Name of hospital:

DHA/health board area:

Specialty:

Grade: HPG/clinical assistant:

Number of sessions paid:

Number of years in post:

Number of hours of fixed weekly commitment (eg ward rounds routine clerking etc):

Number of hours on call "covering" the unit outside Mon-Fri 0900-1700:

Number of out-of-hours
(between 1700-0900 + all day Sat/Sun) hours worked on average?

How much clinical freedom and direct clinical control from the responsible consultant do you have?

How is the payment calculated?

Would loss, or reduction of clinical assistant sessions at your GP/community hospital with the consequent loss of practice income affect the viability of your partnership continuing at its present size? YES/NO*

De fact, are you the medical practitioner in day-to-day charge? YES/NO*

Are you first on-call for your unit in the community hospital? YES/NO*

How many beds do you cover?

What is the number of admissions/discharges per annum?

What is the percentage occupancy of the beds?

What is the average length of stay?

Is there any restriction as to the time of day your unit accepts admissions? YES/NO*

Are admissions acute? YES/NO*

Are acute admissions planned or unplanned? YES/NO*

Please write any further comments overleaf.

Thank you for your co-operation.

Please return this form by:

To: Hospitals Subcommittee
General Practitioners Committee
British Medical Association
BMA House
Tavistock Square
London
WC1H 9JP

GPC ENQUIRY INTO THE WORKLOAD AND PAY OF GPs WORKING IN COMMUNITY AND GP HOSPITALS

Economic Research Unit

July 1992

1. INTRODUCTION AND RESPONSE

1.1 The survey took the form of a postal questionnaire (Appendix 1) sent to GP/community hospitals in two English regions (South West, Trent) and in Scotland. A total of 165 questionnaires was mailed of which 128 (78%) were returned. Of these, 24 either had no data or were otherwise unusable. The remaining 104 questionnaires (63% of total) were input to the survey analysis program. The data were manually edited where appropriate. The response rate by region/country is shown in Table 1.1 below.

TABLE 1.1 - RESPONSE RATE

	MAILED	RETURNED	USABLE	% EFFECTIVE RESPONSE
Scotland	121	92	76	63
Trent	24	20	14	58
S Western	20	16	14	70
ALL	165	128	104	63

1.2 Of the 104 responses in the effective sample, 35 covered GP hospitals, 14 community hospitals and 32 a combination of both. The full response by type of hospital is set out in Table 1.2 below.

TABLE 1.2 - RESPONDENTS BY TYPE OF HOSPITAL

	NUMBER	%
GP	35	34
Community	14	14
Combined	32	31
Other	20	19
No reply	2	2
TOTAL	104	100

1.3 The questionnaire sought details of admissions, hours of work and remuneration, using the financial year 1990/91 as a statistical base. Questions were divided into three sections covering respectively bed fund arrangements, sessional arrangements and casualty units. Table 1.3 overleaf shows response by service provided. No respondents combined in-patient (sessional) work with casualty work alone.

TABLE 1.3 - RESPONSE BY TYPE OF SERVICE PROVIDED

SERVICE	RESPONDENTS
Bed fund only	10
Bed fund plus IP (sessional)	3
Bed fund plus casualty	44
Bed fund plus IP (sessional) and casualty	19
IP (sessional) only	26

Casualty only	2
	104

ANALYSIS

2. (A) IN-PATIENT FACILITIES: BED FUND ARRANGEMENTS

2.1 The average GP/community hospital has 23 beds remunerated under the bed fund arrangements. The most common number was 9 beds cited by 5 respondents; the smallest number of beds was 4, the greatest 96. The full distribution is set out in Table 2.1 below. The beds were serviced on average by 11 general practitioners (see Table 2.2 below).

TABLE 2.1 - DISTRIBUTION OF BED FUND BEDS

BEDS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 10	12	16
10 - 19	27	35
20 - 29	19	25
30 - 49	12	16
50 and over	6	8
TOTAL REPLYING	76	

TABLE 2.2 - GPs PARTICIPATING IN BED FUND

GPs	NUMBER OF HOSPITALS	% OF TOTAL
Less than 10	45	60
10 - 19	20	27
20 - 29	7	9
30 - 49	2	3
50 and over	1	1
TOTAL REPLYING	75	

2.2 On average there were 319 admissions to these beds in 1990/91 and length of stay averaged 27 days. If 7 units, which contained a number of very long stay patients are excluded, average length of stay drops to 20 days (Table 2.3).

2.3 General practitioners spend on average 16 hours a week servicing these beds and are specially recalled to attend the beds twelve times in a typical week (Tables 2.4 and 2.5). Average total remuneration for the provision of medical care under the bed fund arrangements was £7,800 in 1990/91 in those hospitals sampled.

TABLE 2.3 - DISTRIBUTIONO F AVERAGE LENGTH OF STAY (BED FUND BEDS)

DAYS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 10	4	6
10 - 19	17	24
20 - 29	24	34
30 - 49	15	21
50 and over	11	15
TOTAL REPLYING	71	

TABLE 2.4 - HOURS SPEND ON ROUTINE* WORK (BED FUND BEDS ONLY)

HOURS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 10	23	32
10 - 19	22	31
20 - 29	14	20
30 and over	12	17
TOTAL REPLYING	71	

* ie scheduled or planned work.

TABLE 2.5 - WEEKLY RECALLS ** TO BED FUND BEDS

RECALLS PER WEEK	NUMBER OF HOSITALS	% OF TOTAL
Less than 5	20	28
5 - 9	18	26
10 - 19	18	26
20 - 29	9	13
20 and over	6	8
TOTAL REPLYING	71	

** Returns to patients outside normal scheduled or planned attendances.

TABLE 2.6 - TOTAL AMOUNTS PAID TO PARTICIPATING GPs DURING 1990/91

AMOUNT PAID	NUMBER OF HOSITALS	% OF TOTAL
Less than £2,500	4	6
£2,500 - £3,499	9	13
£3,500 - £4,999	10	14
£5,000 - £7,499	24	34
£7,500 - £9,999	9	13
£10,000 and over	15	21
TOTAL REPLYING	71	

2.4 GPs participating in the bed fund arrangements received on average £322 per bed per year. The prevailing standard rate per bed during 1990/91 was £335.90. 20% of respondents were paid either £335 or £336 per bed, according to the survey and in all, 31% received between £330 and £340 per bed. 20 respondents appeared to have been paid less than £300 per bed and 17 more than £350 per bed. Participating GPs spend on average, a little under one hour per week per bed, representing just over 2 hours per GP per week. The recall rate per bed averages 34 per annum and a substantial number of respondents are recalled over 40 times to each bed per year. The effective payment per day per case under the bed fund arrangements is £1.64.

3. (B) IN-PATIENT FACILITIES: SESSIONAL ARRANGEMENTS

3.1 Some community hospitals contain beds which are under the care and control of a named consultant. Such hospitals are usually some distance from the main district general hospital and these beds are managed on a day to day basis by local general practitioners paid sessionally. The average consultant-led unit in a community hospital has a little under 60 beds (mode = 12) covered by 3 general practitioners. Admissions during 1990/91 averaged 186. In addition 5 units reported day case admissions averaging 341 per annum.

TABLE 3.1 - DISTRIBUTION OF BEDS (SESSIONALLY PAID)

BEDS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 20	16	33
20 - 49	12	25
50 - 99	10	21
100 and over	10	21
TOTAL REPLYING	48	

TABLE 3.2 - GPs PARTICIPATING IN SESSIONAL WORK

GPs	NUMBER OF HOSPITALS	% OF TOTAL
1	16	33
2	11	23
3	6	12
4	5	10
5	3	6
More than 5	7	15
TOTAL REPLYING	48	

TABLE 3.3 - ADMISSIONS DURING 1990/91 (SESSIONAL BEDS)

ADMISSIONS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 50	17	43
50 - 199	12	31
200 and over	10	26
TOTAL REPLYIING	39	

TABLE 3.4 - LENGTH OF STAY (SESSIONAL BEDS)

DAYS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 10	4	12
10 - 49	9	26
50 - 99	5	15
100 and over	16	47
TOTAL REPLYING	34	

3.2 The data in this section are affected by the presence of a small number of large hospitals whose inclusion is inappropriate. Hereafter the data are presented excluding these hospitals. Complete data are at Appendix 3.

3.3 Routine ward work for these beds occupies on average 8 hours per week for participating GPs and they are recalled some four times per week to these beds (Table 3.5).

3.4 Average payment per bed under the sessional arrangements represented some £356. Total bed cover hours average 10,084 and the amount paid per bed cover hour represents £1.98. Sessional payments per bed for **routine** work average £240 per annum and total sessional payments for such work, £7,533. The implicit hourly rate for routine work is £24.80.

TABLE 3.5 - RECALLS PER WEEK TO SESSIONAL BEDS

RECALLS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 5	25	56
5 - 9	13	29
10 and over	7	15
TOTAL REPLYING	45	

3.5 Typically GPs are on-call for 45 doctor hours inside the hours 9 to 5 and for 138 doctor hours outside these hours. Total payments to GPs (routine plus on-call) averaged £11,899 in 1990/91 for the groups of doctors concerned.

4. (C) CASUALTY UNITS

4.1 Many GP/community hospitals also have casualty units staffed by general practitioners. Again, such units are frequently a considerable distance from a major district general hospital. They

enable patients to be treated close to their (frequently rural) homes. Whilst it is possible for such units to be open on a restricted basis eg 12 hours per day, the most common arrangement is for the unit to be open continuously. Indeed, of 65 respondents who answered this question, 61 indicated that their casualty unit was open continuously.

4.2 The average casualty unit saw 2,381 patients during 1990/91. The full distribution is shown in Table 4.1 below.

TABLE 4.1 - NEW CASUALTY ATTENDANCES DURING 1990/91

	NUMBER OF HOSPITALS	% OF TOTAL
Less than 1,000	14	24
1,000 - 2,999	30	51
3,000 - 4,999	8	13
5,000 and over	7	12
TOTAL REPLYING	59	

4.3 Three-quarters of these patients are seen by a doctor at first attendance and 80% at some stage in connection with the casualty attendance. In the case of 13 units patients always saw a doctor at first attendance and in 21 units patients always saw a doctor at some stage.

TABLE 4.2 - PERCENTAGE OF CASUALTIES ATTENDED BY A DOCTOR AT:

PERCENT	FIRST ATTENDANCE	SOME STAGE
Less than 20	4	2
20 - 39	4	5
40 - 59	9	4
60 - 79	8	7
80 - 99	25	23
100	13	21
TOTAL REPLYING	63	62

4.4 Recalls to casualty units average 27 per week.

TABLE 4.3 - RECALLS PER WEEK TO CASUALTY UNIT

RECALLS	NUMBER OF HOSPITALS	% OF TOTAL
Less than 10	6	12
10 - 19	17	35
20 - 49	28	58
50 and over	7	15
TOTAL REPLYING	48	

4.5 Average total payments to GPs for casualty work were £15,980 during 1990/91. The distribution of total amounts paid out for casualty work is shown in Table 4.4 below.

TABLE 4.4 - TOTAL AMOUNT PAID IN 1990/91 FOR CASUALTY WORK

	NUMBER OF HOSPITALS	% OF TOTAL
Less than £5,000	4	6
£5,000 - £9,999	25	40
£10,000 - £14,999	10	16
£15,000 - £24,999	13	21
£25,000 and over	10	16
TOTAL REPLYING	62	

4.6 Over half of those involved in casualty work (35 respondents) were paid for this work by the 24 hour cover retainer arrangements. The implicit rate of payment per casualty was £7.29 (£4.24 excluding retainer). The average number of "sessions" paid for on top of the retainer payment for those providing 24 hour cover is 4½.

APPENDICES

APPENDIX 1 - QUESTIONNAIRE

GPC INQUIRY INTO GP WORKLOAD AND REMUENRATION IN COMMUNITY AND GENRAL PRACTITIONER HOSPITALS

Name of hospital: ..... hospname: .....

District health authority: .....

Type of hospital:

		tick one
-	community hospital	❒
-	GP hospital	❒
-	combined community - GP hospital	❒
-	other (please specify)	❒

This survey is divided into sections as follows:

Section A:	Inpatient facilities - Bed fund arrangements
Section B:	Inpatient facilities - Sessional arrangements
Section C:	Casualty units

Please complete ALL sections relevant to your hospital. Return your completed questionnaire, using the SAE provided, by 6 December 1991.

Please note that throughout the questionnaire, the year 1990/91 means 1.4.90 - 31.3.91.

IF THIS QUESTIONNAIRE IS NOT RELEVANT TO YOUR HOSPITAL PLEASE COMPLETE THE INFORMATION AT THE TOP OF THIS PAGE AND RETURN IT IN THE SAE PROVIDED. THANK YOU

SECTION A: INPATIENT FACILITIES: BED FUND ARRANGEMENTS

Answer questions A1 to A8 below only if the hospital contains beds for which GPs are remunerated under the BED FUND arrangement.

Exclude any payments for casualty, anaesthetic or maternity work.

A1	Number of bed fund beds	.....
A2	Number of participating GPs	.....
A3	Total number of admissions to the beds during 1990/91 requiring overnight stay	.....
A4	Average length of stay (in days) per patient	.....
A5	Total number of day case admissions during 1990/91	.....

Please answer items A6 to A8 below in aggregate terms for all participating GPs, NOT in terms of individual GPs.

A6	Total amount paid to participating GPs for bed fund work during 1990/91 (excluding payments for casualty, anaesthetic and maternity work)	£.....
A7	In a typical week, how many hours in total do participating GPs spend on routine work attending the GP beds? (excluding casualty, anaesthetic and maternity work)	.....
A8	In a typical week how many times in total are participating GPs specially recalled to hospital to attend the beds?	.....

PTO

SECTION B: INPATIENT FACILITIES: SESSIONAL ARRANGEMENTS

Answer questions B1 to B11 below only if the hospital contains bed serviced by GPs who are remunerated for this work by sessional payments.

Exclude any payments for casualty, anaesthetic or maternity work.

B1 How many beds are serviced by GPs who receive sessional payments for this work? .....

B2 How many GPs participate in this work? .....

B3 Total number of admissions to the beds during 1990/91 requiring an overnight stay .....

B4 Average length of stay (in days) per patient .....

B5 Total number of day cases admitted to the beds during 1990/91 .....

Please answer items B6 to B11 below in aggregate terms, for all participating GPs, NOT in terms of individual GPs.

B6 In a typical week, how many hours in total do participating GPs spend on routine ward work? .....

B7 In a typical week, how many times in total are participating GPs specially recalled to hospital to attend the beds? .....

B8 How many sessions per week were paid to participating GPs in 1990/91 four routine work such as ward rounds, clerking etc **(Do not include sessions paid for providing cover)** .....

PTO

SECTION C: CASUALTY UNITS

C1 How many GPs service the casualty unit? .....

C2 Is the unit open: tick one box

- continuously? ❒
- 12 hours per day Mon-Fri? ❒
- 12 hours per day 7 days a week? ❒
- other (please specify) ❒

.....

C3 During the year 1990/91 how many <u>new</u> attendances were there? .....

C4 What percentage of casualties have to be attended by a doctor at <u>first</u> attendance? ..... %

C5 In all, what percentage of patients do you estimate are, at some stage, seen by a GP in connection with their casualty attendance? ..... %

C6 In a typical week, how many times in total do GPs have to be specially recalled to the casualty unit to attend a casualty? .....

C7 On what basis are GPs remunerated for their work at the casualty unit? tick whichever apply

- retainer payment for 24 hour cover ❒
- retainer payment for 12 hour cover ❒
- retainer payment for 12 hour cover Mon-Fri ❒
- a sessional payment per nhd ❒
- sessional payment per given number of casualties (if Yes, enter number here .....) ❒
- other (please specify) ..... ❒

C8 In the year 1990/91 how much in total was paid to GPs for the casualty work? (Exclude payments for GP beds under bed fund arrangements or payments for anaesthetic or maternity work). £.....

PTO

PLEASE USE THIS SHEET FOR ANY COMMENTS YOU WISH TO MAKE

Questionnaire completed by:

Name .....

Position .....

Telephone no .....

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE WHICH SHOULD BE RETURNED TO THE GENERAL PRACTITIONERS COMMITTEE BY **FRIDAY 6 DECEMBER** USING THE ENCLOSED SAE.

ALL INFORMATION PROVIDED WILL BE TREATED IN THE STRICTEST CONNFIDENCE AND MADE AVAILABLE ONLY IN AN AGGREGATED FORM.

APPENDIX 2 - RATES OF PAY IN FORCE DURING 1990/91

Clinical assistant session	£2,353.75 per year
Bed fund payment	£335.90 per bed per year
Casualty rates:	
Retainer - 24 hour cover	£4,133.75 per year
Retainer - 12 hour cover	£2,066.25 per year
Retainer - 12 weekday cover	£1,473.75 per year
Rate per casualty (small units only <200 new attendances per annum. No retainer paid)	£13.48

The DDRB award was phased during 1990/91 so the above figures are derived thus:

Pay rate effective 1/4/90 - 31/12/90 x 75%

plus

Pay rate effective 1/1/91 - 31/3/91 x 25%

APPENDIX 3 - DETAILED ANALAYSES

A: BED FUND ARRANGEMENTS

ADMISSIONS PER BED

Base	104	
No reply/not asked	30	
Under 10	19	Average: 15
10 to 20	41	
21 to 30	12	
Over 30	2	

PAYMENT PER BED

Base	104	
No reply/Not asked	33	
Less than £300	20	
£300 to £334	13	Average: £322
£335 or £336	14	
£336 to £350	7	
Over £350	17	

HOURS PER WEEK PER BED

Base	104	
No reply/Not asked	33	
Less than one	45	Average: 0.9
One to two	23	
Two to three	2	
Three and over	1	

HOURS PER WEEK PER GMP

Base	104	
No reply/Not asked	34	
Less than one	18	Average: 2.2
One to two	14	
Two to three	20	
Three and over	18	

BED OCCUPANCY

Base	104	
No reply/Not asked	34	
Less than 10%	1	
10% to 50%	14	Average: 69%
51% to 60%	11	
61% to 70%	12	
71% to 80%	14	
Over 80%	18	

AVERAGE DAILY OCCUPIED BEDS

Base	104	
No reply/Not asked	34	
Less than 10	25	Average: 15
10 to 20	33	
21 to 50	10	
Over 51	2	

AMOUNT PER ADMISSION

Base	104	
No reply/Not asked	34	
Less than £10	7	
£10 to £20	22	Average: £48.50
£21 to £50	29	
£51 to £100	6	
Over £100	6	

AMOUNT PER DAY PER CASE

Base	104	
No reply/Not asked	34	
Less than £1	14	Average: £1.64
£1 to £2	29	
Over £2	23	

RECALL RATE PER BED PER YEAR

Base	104	
No reply/Not asked	33	
Less than 10	17	
10 to 20	18	Average: 34
21 to 30	8	
31 to 40	8	
Over 40	20	

B: SESSIONAL ARRANGEMENTS

AMOUNT PER BED

Base	104	
No reply/Not asked	59	
Less than £200	18	Average: £319
£200 to £300	10	
£301 to £400	4	
Over £400	13	

BED COVER HOURS

Base	104	
No reply/Not asked	56	
Less than 5,000	19	
5,001 to 10,000	11	Average: 13,744
10,001 to 20,000	9	
20,001 to 40,000	5	
Over 40,000	4	

AMOUNT PER BED COVER HOUR

Base	104	
No reply/Not asked	59	
Less than £1	16	
£1 to £2	14	Average: £1.81
£2 to £3	7	
£3 or more	8	

PAYMENT PER BED (ROUTINE SESSIONS)

Base	104	
No reply/Not asked	68	
Less than £100	7	
£100 to £200	10	Average: £250
£201 to £300	8	
More than £300	11	

ROUTINE SESSIONS - TOTAL PAYMENTS

Base	104	
No reply/Not asked	68	
£2,000 to £12,000	26	Average: £11,574
£12,001 to £24,000	7	
More than £24,001	3	

ROUTINE HOURS PER YEAR

Base	104	
No reply/Not asked	56	
Less than 500	31	Average: 483
500 to 1,000	10	
Over 1,000	7	

RATE PER ROUTINE HOUR

Base	104	
No reply/Not asked	68	
Less than £10	3	Average: £29.83
£10 to £20	17	
£21 to £50	12	
Over £50	4	

NUMBER OF PATIENTS

Base	104	
No reply/Not asked	0	
Less than 100	87	Average: 225
100 to 500	11	
501 to 1,000	3	
Over 1,000	3	

PATIENTS PER BED

Base	104	
No reply/Not asked	64	
Less than 5	27	Average: 6
5 to 10	8	
11 to 20	3	
20 and over	2	

BED OCCUPANCY RATE

Base	104	
No reply/Not asked	72	
Less than 10%	2	
10% to 20%	9	Average: 48%
21% to 50%	10	
51% to 70%	6	
Over 70%	5	

C: CASUALTY UNITS

BASIS OF REMUNERATION

Base	104
No reply/Not asked	40
Retainer (24 hour cover)	35
Retainer (12 hour cover)	4
Retainer (12 hour weekday cover)	0
Sessional payment expressed per notional half day	14
Sessional payment expressed per number of casualties	25
Other	11

RATE PER CASUALTY (INCLUDING RETAINER)

Base	104	
No reply/Not asked	48	
Less than £3	6	
£3 to £5	14	Average: £7.29
£5 to £7	11	
£7 to £10	13	
£10 to £20	12	

RATE PER CASUALTY (EXLUDING RETAINER)

Base	104	
No reply/Not asked	52	
Less than £3	15	
£3 to £5	18	Average: £4.24
£5 to £7	13	
£7 to £10	5	
Over £10	1	

APPENDIX 4 - RESPONDENTS BY DISTRICT/HEALTH BOARD

Base	104
Barnsley	0
Bassetlaw	0
Central Notts	0
Doncaster	0
Leicestershire	3
North Derbyshire	5
North Lincolnshire	1
Nottingham	0
Rotherham	0
Sheffield	0
South Derbyshire	4
South Lincolnshire	1
Bristol and Weston	1
Cheltenham and District	1
Cornwall and Isles of Scilly	1
Exeter	0
Frenchay	0
Gloucester	3
North Devon	1
Plymouth	1
Somerset	1
Southmead	0
Torbay	5
Argyll and Clyde	8
Ayrshire and Arran	4
Borders	5
Dumfries and Galloway	6
Fife	5
Forth Valley	1
Grampian	15
Greater Glasgow	7
Highland	9
Lanarkshire	3
Lothian	2
Orkney	2
Shetland	2
Tayside	5
Western Isles	2

July 2001

GPC

General Practitioners Committee

Working in GP and community hospitals

Guidance for GPs

BMA

2001/2002 Edition

Where to obtain advice and assistance

Many GPs are experiencing problems with their part time hospital contracts. BMA local regional offices can offer expert advice and assistance to members on these matters. The BMA's General Practitioners Committee has prepared this guidance which includes a model contract for GPs providing hospital services.

Many GPs and practices do some hospital work, usually in a local GP or community hospital. The contracts under which they work are varied and many include informal understandings which reflect long standing working arrangements. In the past many contractual matters have been seriously neglected and GPs have often virtually given their services to the local community. However, in recent years, GPs have expressed increasing dissatisfaction with their contractual arrangements and some practices have sought to improve these; having seen the NHS embrace the market philosophy they themselves are less willing to let their goodwill be exploited by it.

Defining a GP or community hospital

A hospital without contractually residence medical staff in which the first point of contract for medical care and advice -whether routine or emergency - is a local GP or GP practice.

Important BMA advice

The BMA has advised its members to exercise great caution in the present NHS climate before taking any steps to initiate changes to their existing contractual arrangements. Many GPs in these hospital posts have little security of tenure, particularly if they work only one or two sessions per week. Local NHS management's response to a practice's proposals to change and improve contractual arrangements may be quite different from what is anticipated; in some circumstances they may decide to reduce services in response to a demand for increased pay. In particular, GPs need to know that NHS Trusts can choose to offer local contracts which differ from nationally negotiated agreements and do not contain the same safeguards in respect of job security or annual pay reviews.

GPs should obtain expert advice and assistance from their local BMA office before raising any proposal with local hospital management. Otherwise they could find themselves taking unwittingly a precipitous or irrevocable step which prejudices their long term position. In NHS Trusts GPs should also contact the local negotiating committee (LNC) which negotiates with Trust management on behalf of medical staff. (For more details about LNCs, please see appendix I.)

How GPs are paid for hospital work

Pay rates for the following grades may be found at appendix II.

Clinical assistant grade

Even though the term 'clinical assistant' is not found anywhere in the hospital medical staff terms and conditions of service, the grade is nevertheless covered by the appointment procedures specified in

paragraph 94 of these, and also NHS General Whitley Council agreements. When working as a clinical assistant a GP is responsible to a specific named, consultant and carries an overriding commitment to the hospital service rather than general practice. Thus GPs need to make arrangements to cover their practice obligations during these periods.

Under paragraph 61 of the hospital terms and conditions of service a notional half day (ie session) is defined as 3½ hours, including travelling time.

Since 1988 the maximum number of notional half days for which a clinical assistant may be contracted is five unless the doctor is an unrestricted GP principal where the maximum is nine. Special rules apply to clinical assistant sessions for casualty work. Clinical assistant posts are normally 12 month fixed term contracts and renewed annually. Any emergency and on call duties should be explicitly stated in the contract.

Table I

Key features of the clinical assistant grade

- travel expenses payable under certain conditions
- limited security of tenure
- study leave at employer's discretion
- pay is not related to number of beds but to time commitment of job
- employee status
- no independent clinical responsibility
- no incremental pay scale.

Hospital practitioner grade

Applicants to posts in this grade must be GP principals with:

- at least two years full time (or equivalent) hospital experience in a relevant specialty

or

- a relevant specialist diploma and five years' experience as a clinical assistant

or

- other equivalent experience.

Each post has to be advertised and its commitment cannot exceed 5 sessions per week. The qualifications and experience required of a postholder obviously depend on the post and the views of local consultants. Hospital practitioners do not have independent clinical responsibility and should be responsible to a consultant. Hospital doctors' terms and conditions of service apply.

Table II

Key features of the hospital practitioner grade

- study leave entitlement of 30 days in 3 years (pro rata)
- emergency and on call duties should be specified in the contract
- hospital terms and conditions of service apply
- travel expenses paid in some circumstances
- security of tenure
- incremental pay scale
- no independent responsibility.

The hospital practitioner grade was introduced by health circular HC(79)16 and its annexes and is further updated by HSG(93)50. This is reproduced at appendix III.

Staff fund arrangements

A staff fund is based on a local GP or community hospital and is made up of bed fund payments for inpatient work and, where appropriate casualty payments. The distribution of payments from this fund is agreed among the local participating doctors attached to the hospital. Payment from the fund is superannuable. Only GPs on the local FHSA list are appointed to the staff of a GP hospital under the bed fund arrangement, and they are free to organise for themselves how the work is undertaken. As independent clinicians they are accountable to their peers on the hospital's medical staff committee. The calculation of bed fund payments for inpatient GP beds are based on bed occupancy, not the time spent on the work.

Casualty Payments

Casualty payments are paid into the bed fund and form part of it. The clinical assistant scale is used to calculate the size of these payments, but the payments as such are not connected to that grade. There are two kinds of payments: a retention fee and also a fee which reflects the number of patient attendances. The attendance based payments reflect the number of new patient attendances and the clinical assistant scale is normally used to calculate the rate, though this may vary locally. Typically every seven hundred new attendances draws one clinical assistant session payment into the bed fund. Although the arrangements for casualty payments do not require a GP to necessarily see all patients when they first attend, each patient is usually seen by a doctor at some stage. A nurse may treat minor problems, seeking advice and assistance from a GP as necessary. However, a GP must be available to attend immediately if required.

Retention fees as recommended by the Review Body are currently:

	from 1/4/2001
Monday-Friday 12 hours per day	£2,320.00
7 day, 12 hour service	£3,260.00
7 day 24 hour service	£6,520.00

Table III

Key features of bed fund arrangement

- independent clinical responsibility - no consultant supervision
- doctor controls admission, management, administration and discharge
- no sick leave
- no study leave
- no annual leave
- no security of tenure
- no travel and other expenses
- very poorly paid.

See appendix IV for health circular HC(PC)(79)5 and its annexes which established the staff fund arrangements.

Appendix V contains a suggested updated draft letter of appointment to the general practitioner medical staff of a community hospital (bed fund arrangements) to replace annex B HC(PC)(79)5.

The content of the contract

The contract should state to which consultant the GP is clinically responsible if applicable. If supervised by a consultant, the post should be graded normally as either clinical assistant or hospital practitioner; the latter may be preferred because it has greater security of tenure and is higher paid. Contracts for both grades should specify hours of work; it should be noted that although it is comparatively simple to calculate sessional payments for routine work it is usually more difficult to do so for out-of-hours work.

The hours during which casualty work is to be covered must be clearly specified; some GPs with surgeries on the same site as a GP hospital have found that between 9 am and 5 pm they receive no pay for casualty work because health authorities mistakenly consider it to be part of general medical services. **CASUALTY WORK IS NOT PART OF GENERAL MEDICAL SERVICES.**

Contract checklist:

Does the contract include?

- name of employing authority
- date of employment commences and any previous employment which may count towards continuity
- place of work
- job description
- hours of work
- superannuation

- remuneration
- annual leave
- study leave
- maternity leave
- sick leave
- a definition of clinical responsibility
- substitution and deputising arrangements
- medical indemnity
- period of notice of termination
- disciplinary procedure
- grievance procedure
- reference to the terms and conditions of service for hospital medical and dental staff, as appropriate.

GPC December 1993
(Revised July 1999)
(Re-revised April 2000)
(Re-revised June 2000)
(Re-revised July 2001)

APPENDIX I

Local negotiating committees (LNCs) - general points

Membership

- **preferably LNCs should be elected by and from the BMA members working in the trust**
- **some LNCs may be elected by all doctors (possibly through the medical staff committee) and may include non-members**
- **should include representatives of all categories of career grade staff and of junior doctors**
- **GPs in part time community and GP hospital posts should be represented on LNCs in all NHS trusts. These representatives should be nominated by local medical committees.**

BMA policy on recognition in NHS trusts

- **A local negotiating committee (LNC) for every NHS Trust**
- **All LNCs should be formally accredited by the BMA**
- **Criteria for accreditation by the BMA**
- **majority of LNC members are BMA members**
- **arrangement for election of LNC members to represent all categories of doctors employed by the trust**

Benefits of BMA accreditation

- **rights and protection under TU law**
- **expert advice and assistance from BMA staff**
- **negotiating training**
- **secretarial support**

Clinical assistants

- LNCs are advised to seek more advantageous terms for clinical assistants than are available under national agreements. These include incremental pay scales and security of tenure.
- Trusts are not at liberty to exceed the notional half day maximum agreements.
- LNCs should ensure that the following items are addressed in any contracts between trust and clinical assistants.
    - freedom of speech

- national pay review system (DDRB)
- separate disciplinary procedures
- NHS pension scheme
- performance related pay
- job evaluation schemes
- fixed term and rolling contracts
- study leave, although the terms of service make no provision for study leave for clinical assistants, it should be emphasised to trusts that study leave should be granted to all doctors to ensure quality of are.

Hospital practitioner grade

- LNCs should ensure that the points above are also included in HPG contracts.

Non consultant career grade posts invented by trusts

The government has decided that one of the freedoms available to trusts, as part of their right to set their own terms of service, is that of deciding the titles of their career grade staff. This does not mean, however, that manpower approval can be bypassed, although a post may be renamed.

The practice of "inventing" posts may lead to confusion and may also lead to attempts by trusts to circumvent agreements by which the trust is bound. This position creates problems in collecting manpower statistics and may imply a competence not possessed by the postholder.

Superficially many of these invented grades may look attractive however they often lack many of the safeguards built into more conventional arrangements.

LNCs should therefore make every effort to dissuade their trust from adopting such a practice. LNCs should also be extremely vigilant in ensuring that potentially exploitative contracts are not issued to doctors, particularly those in the non-consultant career grades who are especially vulnerable. No doctor in any grade should be expected to work excessively long hours and reasonable rates for out of hours work should apply.

APPENDIX II

Pay rates 2001/2002

In any negotiations with trusts, it has to be emphasised that doctors employed permanently in hospitals do not have to meet the costs of other on-going overheads as GPs do whether they are in their surgery or not.

GPs only saleable commodities are their time and expertise. Payment should therefore take into account this professional time as well as ongoing overheads.

The Treasury no longer publishes a general schedule of fees for doctors providing non-NHS clinical services to government departments and agencies. The last published rates were produced in 1993; this schedule recommended GPs be paid on a basis of £65 per hour for work conducted in surgery. Work outside of surgery was paid at half of this rate, ie £32.50 per hour.

Based upon the intervening DDRB awards since 1993, the fees for GPs undertaking work both inside and outside surgery for government departments would be £87 and £43.50 per hour, pro rata, respectively.

Pay rates

Clinical Assistant Sessions	From 1/4/2001	
annual payment per weekly notional half day	£3,710.00	
maximum annual payment (normally)	£32,130.00	(1/4/2000)
where the number of hours contracted per week is not more than 2		
payment for 1 hour or less	£987.50	
payment for more than 1 hour but not more than 2 hours	£1,975.00	
Hospital practitioner sessions		
Rate per notional half day.	£81.00*	
Staff fund		
payment for each eligible bed per year	£529.05 (abated if bed occupancy is below 70%)	

* **Note:** this is the rate as a **locum**. The standard scale is £3,625 to £4,855 per annum per nhd a week.

Casualty payments - Retainer fees

higher rate (7 day 24 hour service)	£6,520.00
lower rate (7 day 12 hour service)	£3,260.00
12 hours per day Monday-Friday	£2,320.00

Casualty payment - Attendance fees

- subject to local variation but based on an analogue derived from the clinical assistant grade.

Sessional Fees			From 1/7/2001
a	Consultant or specialist work		
	i	Full session (2 hours)	£101.40
	ii	Short session (1 hour)	£65.70
	iii	School ophthalmic work (session of not less 3 hours)	£110.55
	iv	Vasectomy session (full session) (3 hours)	£167.85
b	Clinical refraction work (full session) (2 hours)		£74.45
c	Dental anaesthetic work, where the practitioner has a recognised qualification in anaesthetics (full session) (2 hours)		£74.45
d	Other medical work		
	i	Full session (3 hours)	£64.65
	ii	Short session (1 hour)	£41.65
	iii	Vasectomy session (full session) (3 hours)	£103.10

Note: (1) The staffing cost to a health authority for one senior house officer providing 40 hours of routine work per week and covering 128 hours per week out of hours, involving other doctors on a rota, is in excess of approximately £140,000 per annum. The figure is likely to be larger when the new junior doctors out of hours deal is concluded. The staffing cost for staff grade cover are approximately £200 000 per annum. This is based upon 168 divided by 40 which is equal to the workforce requirement, plus an addition for annual leave, study leave, employers' national insurance and employers' pension contribution.

APPENDIX V

2001/2002 Edition

DRAFT LETTER OF APPOINTMENT TO THE GENERAL PRACTITIONER MEDICAL STAFF OF A COMMUNITY HOSPITAL (BED FUND ARRANGEMENTS)

Insert:

Name and address of employing trust

Date

Dear

1. I am instructed by the [insert name of trust] NHS Trust to write to confirm your appointment to the general practitioner medical staff of hospital.

2. As a member of the staff of this hospital, you will take full clinical responsibility for the patients under your care.

3. You will be entitled to admit patients to the general practitioner beds of the hospital in accordance with arrangements to be agreed among the general practitioner medical staff of the hospital.

4. You will be responsible for attending patients who have been admitted to the hospital by the appropriate consultant during his or her absence, under arrangements agreed between the consultant and the general practitioner medical staff of the hospital.

5. You will [also]* be responsible, together with the other general practitioner medical staff, and in accordance with arrangements made between yourselves, for providing a casualty service [at all times]* [between the hours of and on the following days ...]*, in order to provide such treatment as is necessary and appropriate to any casualty patient who attends the hospital during those hours. The casualty service (including its facilities, equipment and drugs) should not be used inappropriately to provide general medical services.

Local guidelines drawn up by the GP staff committee will define the proper use of casualty services; in general they should not treat conditions of a kind normally treated by GPs in their surgeries.

If patients present at casualty inappropriately during normal working hours they should be normally directed to their GP's surgery.

6. The basis for payment will be on a point scoring basis; the points having a locally agreed monetary value. The points will be accrued as follows:

(a) For ward work (paragraph 3 and 4) you will be paid on the following basis:

Day of admission/readmission	-	50 points
Days 2-7	-	20 points per day
Days 8-15	-	5 points per day
Days 16-20	-	3 points per day
Day 21 & thereafter	-	1 point per day.

Points should be valued at not less than the present bed fund payment.

The BMA recommendation for 2000/2001 is that each point value should be ,1.42. All payments are subject to annual review on a no prejudice basis.

(b) For casualty work (paragraph 5), arrangements will be made to pay additional sums into the bed fund in recognition of general practitioners' availability and provision of casualty work and will consist of a retainer fee and attendance based fee. These are calculated as follows .... (insert here local method of calculation).

7. The appointment will be subject to paragraphs 87-93 of the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales), and such of the General Whitley Council Conditions of Service as apply to hospital medical and dental staff, both as amended from time to time. Copies of these documents can be obtained from ....

In Scotland the paragraphs are 87-93 of the Terms and Conditions of Service of Hospital Medical and Dental Staff (Scotland).

8. The post is superannuable under the provisions of the NHS Superannuation Regulations provided you are superannuable as a practitioner under that scheme and are contracted out of the state pension scheme. Copies of the current Regulations and the guide to these may be obtained from ....

9. This appointment will continue while you remain a principal in general practice in the locality of the hospital, unless it is previously terminated by the Trust. In that event, you will be given 3 months' notice of the termination of the appointment, though this shall be without prejudice to the Trust's right to suspend your rights of practice in the hospital if it considers that this is essential in the interests of the patients of the hospital. Where suspension is considered appropriate, you may appeal against that decision by using the agreed local grievance procedure.

10. You may resign this appointment by giving one month's notice, which should be sent to .....; you should also inform your colleagues so that they can adjust their arrangements as necessary.

11. The Trust agrees that, in addition to any arrangements made between the medical staff of the hospital for covering each others' absences, a doctor may act as your deputy in respect of this appointment if his/her name has been notified to this Trust *(or to the Health Authority in accordance with paragraph 21 or 24 of schedule II of the NHS (General Medical Services regulations 1992) and he/she is a member of a recognised medical defence organisation.

In Scotland the paragraphs are 18(7) and 18(10) and (11) of Schedule I of the NHS (General Medical Services) (Scotland) Regulations 1995.

12. You are required to be fully registered with the General Medical Council, and be a member of a recognised medical defence organisation.

13. The locally agreed procedure for settling differences between you and the Trust shall be invoked where the difference relates to a matter concerning your conditions of service as set out in this letter.

14. In matters of general conduct you will be subject to locally agreed protocols on disciplinary and dismissal procedures. Questions and complaints arising from your practice in the hospital do not fall under the jurisdiction of the Service Committee procedures of the Health Authority.

15. You agree to participate in the work of the Hospital GP Staff Committee which consists of all the GPs working at the hospital.

16. If you agree to accept the appointment on the terms specified above, please sign the form of acceptance at the foot of this page and return to ..... A second signed copy of this letter is attached, which you should also sign, and retain for your future reference.

Yours faithfully

Signature .....

On behalf of .....

[ ]*: A square bracket followed by an asterisk indicates "delete as necessary"

PLEASE DO NOT DETACH

I hereby [accept]* [confirm my acceptance of]* the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it.

Signature Date

This offer, and acceptance of it, shall together constitute a contract between the parties.

December 1993 (revised June 2000)

This document was produced by the GPC, BMA House, Tavistock Square, London WC1H 9JP.

Dr. P.J.P. Holden

Curriculum Vitae

PJP Holden MB ChB FIMCRCSEd MRCGP DRCOG

Registered Address and Correspondence Address:

Code A

Telephone
Facsimile
Mobile
Email

Code A

Name: Peter John Pashley Holden

Nationality: British subject and U.K. resident

Date of Birth: **Code A**

Place of Birth: Sheffield, United Kingdom

Awards and honours

Membership, Royal College of General Practitioners under ordinance 4(2)	2005
The Queen's Golden Jubilee Medal	2002
The BASICS Award	2000

Current Professional Posts

Full time General Practitioner Principal, Drs. PJP Holden, CA Chamberlain, AD Sinnott, RC Emmerson, Imperial Road Surgery, Matlock DE4 3NL and its predecessors since 01 July 1985

Part Time Medical Aircrew Lincolnshire & Nottinghamshire Air Ambulance since 04 February 1998

Part Time Clinical Assistant Accident & Emergency, Geriatrics
Whitworth Hospital Matlock since 01 July 1985

Qualifications - Statutory

Enhanced Criminal Records Bureau Disclosure check number 001088867413	26/11/2004
Joint Certificate of Postgraduate Training for General Practice (JCPTGP)	01/08/1983
General Medical Council Full Registration number 2480804	01/08/1980
Provisional Registration with General Medical Council	18/06/1979

Qualifications - Degrees and Diplomas

M.R.C.G.P. 19/11/2005
(Membership of the Royal College of General Practitioners -By Award under 4(2))

F.I.M.C.R.C.S.Ed 04/06/2001
(Fellowship in Immediate Medical Care, Royal College of Surgeons of Edinburgh - By examination)

Dip.IMCRCSEd. 17/09/1991
(Diploma in Immediate Medical Care, Royal College of Surgeons of Edinburgh - By examination)

D.R.C.O.G. 01/11/1984
(Diploma of the Royal College of Obstetricians and Gynaecologists, London)

M.B., Ch.B. 14/06/1979
(Bachelor of Medicine, Bachelor of Surgery, University of Sheffield June 1979)

Qualifications - Certificates and Listings

Major Incident Medical Management and Support

Provider certificate	1996
Instructor candidate	1996

Advanced Life Support

Provider certificate since	1992
Instructor since (re-verified 04/12/2005)	2000

Advanced Trauma Life Support
Provider certificate since 1990
Instructor since (due for re-verification) 2000

Minor Surgery List 1990
Child Health Surveillance List 1990

Obstetric Lists of Derbyshire, Sheffield, Rotherham, Barnsley and Nottinghamshire 1983

Family Planning Certificate 1983

S.12 Mental Health Act 1983 Approved doctor 2002

Education

Shrewsbury School 1969-1973
10 O levels, 3 A levels
Poor Oarsman, lousy ball game player
School "First" for services to C.C.F. and Stage Management 1971
Cadet Warrant Officer Combined Cadet Force 1972
Gliding A & B Licence 1973
Represented the U.K. on the R.A.F. International Air Cadet Exchange to U.S.A. 1973

Gap year 1973-1974

Clerical Officer, Inland Revenue H.M. Inspector of Taxes Chesterfield No.1 District 6 months
General Factotum and Workshop Assistant Cestradent- McKesson Ltd building anaesthetic machines and installing medical gas pipeline systems 8 months

University of Sheffield 1974-1979
Selected for the Yorkshire Universities Air Squadron 1974
Elective Period in Anaesthesia 1977
Elective Period in Forensic Medicine and Pathology 1978
Treasurer Sheffield University Medical Students Society 1977-1978

Skills and achievements (- generic- outside the ordinary practice of medicine)

A proven track record of

- Professional leadership and representation at the highest levels of government
- Negotiating at the highest levels of government
- Presentational skills
- Managing change at practice, committee and entire profession level
- Team Leadership at practice, committee and entire profession level
- Team motivation
- Working with all types of press and media often at very short notice on difficult topics
- Educating other professionals
- Financial, operational, and executive management of businesses both large and small
- Defining analysing and overseeing substantial budgets
- Operating a charity
- Working with health budgets both large and small
- Adjudication skills
- Interpretation of regulations and the law
- Time management and prioritisation of effort against tight and immoveable deadlines
- Working with and instructing other (non-healthcare) professionals
- Making finely balanced political decisions against a tight deadline or incomplete data set
- Leading a multi-disciplinary practice team of autonomous professionals

Achievements

- Represented the profession before the Doctors and Dentists Pay Review Body
- Represented the profession before the Armed Forces Pay Review Body
- Been interrogated by House of Commons Select Committees on three occasions
- Led the representation of the profession and secured agreements on their behalf with other government departments, government agencies and commercial organisations
- Led the representation of the profession before the Master of the Rolls (The President of the Civil Division of the High Court)
- Led the representation of profession in negotiations and discussions with the Office of Fair Trading, Her Majesty's Customs and Excise and Inland Revenue

Work History

Previous Professional posts held

Full time Principal, Imperial Road Surgery, Matlock DE4 3NL **01/07/1985 ongoing**

Drs. **P.J.P. Holden**, C.A.Chamberlain, A.D. Sinnott, R.C. Emmerson and C.G.Aiton,	01/11/2002-03/03/2003
Drs. **P.J.P. Holden**, C.A.Chamberlain, A.D. Sinnott, and R.C. Emmerson,	01/07/2001-31/10/2002
Drs. J.F. Macfarlane, **P.J.P. Holden**, C.A.Chamberlain, A.D. Sinnott and R.C. Emmerson,	01/10/1991-30/06/2001
Drs. C.G. Orme, J.F. Macfarlane, **P.J.P. Holden**, C.A.Chamberlain and A.D. Sinnott,	01/10/1989-30/09/1991
Drs. J.S Holden (no relation), C.G. Orme, J.F. Macfarlane, **P.J.P. Holden** and C.A.Chamberlain,	01/10/1987-30/09/1989
Drs. J.S Holden (no relation), C.G. Orme, J.F. Macfarlane and **P.J.P. Holden**,	01/07/1985-30/09/1987

Deputy Doctor, Healthcall plc Sheffield, Barnsley and Rotherham 01/08/1983-31/08/1996

Locum and Freelance General Practitioner **01/08/1983-30/06/1985**

Dr TJD McConnell, Staveley
Drs M.T.F. Griffiths and P.L. Davies, Renishaw
Drs. D. Ryan, S.K.T.Neofytou, Clay Cross
Drs AK & G Sharma and PS Crowther Chesterfield
Drs J.S. Holden, (no relation) CG. Orme, J.F. Macfarlane and D.S. Holden (no relation)
Dr T.F. Hebblethwaite, Ilkeston
Drs. Green, Ashton, Baker Sheffield 12
Dr. H.M. Halle, Sheffield 2

Senior House Officer, General Psychiatry (My old VTS post) for an aggregate of 9 months)
Deputy Doctor, Chesterfield and Mansfield Emergency Doctor Service

Chesterfield General Practice Vocational Training Scheme **01/08/1980-31/07/1983**

General Practice trainee, Dr W. Allan, Eckington Health Centre, Sheffield S31 9BD	01/02/1983-31/07/1983
Senior House Officer, Accident & Emergency Medicine, Chesterfield Royal Hospital, Mr. M.M. Alam	01/08/1982-31/01/1983
Senior House Officer, Obstetrics and Gynaecology, Rotherham, Doncaster Gate Hospital, Mr. K.J. Anderton	01/02/1982-31/07/1982
General Practice trainee, Dr W. Allan, Eckington Health Centre, Sheffield S31 9BD	01/10/1981-31/01/1982
Senior House Officer, General Medicine, Walton Hospital Chesterfield, Gastroenterology and Respiratory diseases Drs. D.R. Lewis, M.J. Grundman	01/05/1981-31/10/1981
Senior House Officer, General Psychiatry, Walton Hospital, Chesterfield, Dr A.R. Sabet	01/10/1980-30/04/1981
General Practice trainee, Dr W. Allan, Eckington Health Centre, Sheffield S31 9BD	01/08/1980-30/09/1980

Pre registration posts **01/08/1979-31/07/1980**

House Surgeon, General Surgery, Barnsley District General Hospital, Mr. R.T. Waddington	01/02/1980-31/07/1980
House Physician, General Medicine, Respiratory Diseases, Lodge Moor Hospital, Sheffield, Drs R.H. Townshend & P.B. Anderson.	01/11/1979-31/01/1980
House Physician, General Medicine, Infectious Diseases, Paediatrics, Lodge Moor Hospital Sheffield, Drs P.J. Moroney & B.A.M. Smith	01/08/1979-31/10/1979
Informal attachment Forensic Medicine & Pathology, Professor Alan Usher, University of Sheffield	14/06/1979-31/07/1979

BMA National

Professional Fees Committee (Chairman 1997-2006)		1994-2006
Private Practice Committee		1995-2006
Medico- Legal Committee		2002-2006
Finance Committee		2000-2006
Council, Elected Member	for Trent Region	1990-2006
BMA Council nominee to the Council of The Institute of Advanced Motorists		1994-2006
Armed Forces Committee		2004-2006
Remuneration Committee		2000-2005
Member, Advisory Board, National Association of Air Ambulance Services		2001-2003
Organisation Committee	1982 -1991,1992 -1998,	1999-2002
CCSC Accident & Emergency Subcommittee		1989-1999
Central Consultants and Specialists Committee		1989-1999
Joint Board of Professional Management BMA/Healthcall (Chairman 1992-1994)		1990-1994
Conference of Honorary Secretaries (Chairman 1987)		1984-1992
Junior Members Forum		1981-1991
Annual Representative Meeting representative		1982-2006

BMA Regional and Local

Member	1979-2006
Place of Work Accredited Representative	1980-2006
BMA Chesterfield Division, Honorary Secretary	1982-1994
BMA Trent Regional Council (Honorary Secretary 1982-84)	1981-2006
Trent Regional Hospital Junior Staff Committee (Chairman 1982-1983)	1980-1985

Derbyshire Local Medical Committee

Member	1980-2008

Elected member Derbyshire Dales	1986-2008
Ex officio as a sitting GPC member	1982-1985
Elected Member for GP trainees	1980-1982

Treasurer 1990-2008

Doctors "Friend" 1985-2008

Trent RHA Specialty Advisory Committee, Accident & Emergency Medicine 1990-1995

Member, North Derbyshire General Practice Advisory Committee 1988-1990

Deputising Service Subcommittee Derbyshire FPC 1986-1990

Deputising Service Liaison Officer 1987-1989

Member, North Derbyshire Hospital Medical Advisory Committee 1982-1987

Member, North Derbyshire District Medical Committee 1982-1985

General Practitioners Committee - formerly GMSC

Negotiating Team 1999-2008

(negotiated the new GMS2 contract and parallel changes for PMS)

Deputy Treasurer GPDF 1995-2007

Member, Elected 1987-2006

North Derbyshire and Nottinghamshire	1997-2006
Trent region	1990-1997
By Annual meeting	1988-1990
By Conference LMCs	1987-1988
By Trainees	1981-1985

Director Rural Practice Compensation Fund Ltd 1992-1997

GPC/RCGP Liaison Committee 1999-2008

GPC/CCSC Liaison Committee 1989-2008

Statutes and Regulations 1995-1999

Rural Practice Subcommittee 1992-1999

Hospitals and Special Services Committee (Chairman 1989-1999) 1987-1999

General Purposes Subcommittee 1991-1999

Salaried Service Working Group		1990-1992
NHS Review Working Group		1990-1991
Alternative Strategies Working Group		1989-1991
Trainees Sub (Chairman 1982-1984)		1980-1985
Statutes and Regulations	1982-1984,	1992-1999

Government and Departmental Appointments

Member, FHSAA Appeal Panel, appointed by The Lord Chancellor	2002-2007
Member, Advisory Committee, Cabinet Office Regulatory Impact Unit	2000-2006
External Advisor, The Health Service Ombudsman	1999-2006
Member, Misuse of Drugs Act, Professional Panels and Tribunals	1992-2007
Member, Poisons Board, Home Office	1986-2002
Member, Minister's Panel of Medical Practitioners, NHS tribunal (MAC)	1983-2002
Member, Driver Licensing Panel, DVLA	1986-2002
Examining Medical Officer, DHSS and latterly DWP	1988-2000
Member, FHSA Appeal Unit	1993-1997
Deputy Police Surgeon, Derbyshire Constabulary	1985-1988
Member, Training Allowances Advisory Committee, DHSS	1984-1985
Member, Advisory Committee on General Practice, CPME	1984-1985
Member, Advisory Committee on General Practice, CPME	1981-1983

BASICS - The British Association for Immediate Care

Honorary Secretary		2000-2006
Honorary Treasurer		1994-2000
Joint Management Board *Journal of Pre Hospital Immediate Care*		1997-2001
Chairman	1998-1999,	2000-2001
Executive Council		1992-2006

Accredited Course Director	1997-2007
Course Tutor Cambridge Immediate Care Course	1990-2007
Examiner BASICS/RCSEd PreHospital Emergency Care Certificate (PHEC)	1993-2007
Chairman, BASICS Education Ltd	1997-2006
Curriculum Contributor	
and founding faculty BASICS/RCSEd. PreHospital Emergency Care Certificate	1993-2006
The BASICS Award	2000
East Midlands Immediate Care Scheme Steering then Management Committee	2001-2006

RCGP

Associate Member	1980-2006
Trent Regional GP trainees committee	1981-1984
Trainee representative, Trent Regional Faculty Board	1981-1984
Member, organising committee 1981 National GP Trainee Conference	1980-1981

Other

Board member, The General Practice Finance Corporation Ltd	
A subsidiary of Norwich Union the trading name of Aviva plc	1999-2006
Incident Response Team Royal Air Force Waddington International Airshow	1995-2005
Chief Medical Officer, Trackrod International Motor Rally	1992-2006
Senior Medical Officer The Motor Sports Association (Formerly the RAC MSA)	1984-2006
Mobile Incident Response Physician, Farnborough International Airshow	2000
Accredited Motorsports Rescue Crew Member Race & Rally	1986-2000
Medical Assessor, Motorsports Association Rescue Crew Licensing Scheme	1986-1996

Learned Societies

European Resuscitation Council, Member	1992-2006

Founding Associate Fellow, Faculty of Accident & Emergency Medicine	1993-2006
Founding member, Faculty of Pre-Hospital Care, RCSEd.	1996-2006
British Association for Emergency Medicine, Full Member	1993-2006
Resuscitation Council UK, Associate Member	1999-2006
South Yorkshire Medico-Legal Society	1979-1997

Articles and Publications (since 1990)

Improvising in an Emergency N ENGL J MED (2005) 353:6 541-543

The Doctors and Dentists Pay Review Body - a historical review 2005 revision. General Practitioners Committee British Medical Association London 2005

A guide for General Practitioners working in Community Hospitals. (Co author 2005 major revision) General Practitioners Committee British Medial Association London 2005

Chapter author *The Insider's guide to the new GP Contract* Eds. Cross J., Fradd S.O., Radcliffe Medical Press, Oxford 2004.

Filling the therapeutic vacuum Emergency Services Times London 2002

A review of the type of calls undertaken by the Lincolnshire and Nottinghamshire Air Ambulance and their impact on the choice of a new airframe. 2001. FIMCRCSEd. Dissertation.

Chapter author, *Pre-Hospital Medicine, the principles and practice of Immediate Care,* Eds. Greaves I, Porter KM, Arnold, London 1999

Chapters in *Emergency care a textbook for Paramedics,* Eds. Greaves I, Hodgetts TJ and Porter KM, Arnold, London 1997

Chapter Author *Handbook of Immediate Care* Eds. Greaves and Porter, W.B Saunders London 1995

The Doctors and Dentists Pay Review Body - a historical review. General Medical Services Committee, British Medical Association. London 1995.

Contributing Author *Immediate Care Schemes.* British Medical Association, Board of Science and Education London 1993. ISBN 0727908189

A survey of workload and remuneration of General Practitioners working in Community Hospitals General Medical Services Committee, British Medical Association. London 1993.

A guide for General Practitioners working in Community Hospitals. (Annually revised from 1993 to 2004) General Medical Services Committee, British Medical Association. London

Chapter author BASICS/RCSEd. PreHospital Emergency Care Certificate Course manual 1993-2002 (triennially revised)

Author and Collator on Child Health Surveillance, Minor surgery and Changing doctors *GMSC Survival Guide to 1990 Contract.* General Medical Services Committee, British Medical Association. London 1990

Pre 1990

Patient poaching and advertising of GP services
Violence towards staff and GPs
Series of articles on being a GP deputy and a freelance GP
Article on partnership agreements
Article on GP Training
Working paper on GP Maternity services in the Trent Region
Working papers on GP training 1982 to 1985

Presentations and Media Skills

Audio Interview New England Journal of Medicine 11 August 2005
Over 30 interviews all forms of worldwide media in the wake of the 7th July attacks

Your Contract Your Future Framework Agreement for the new GMS Contract 2002.
Presented at over 20 locations

The New GMS Contract the Final Agreement Presented at over 20 Locations 2003.

Multiple presentations for GPC since 1999 approximately 2 per month on various GP topics

Multiple presentations both professional and lay on Immediate Care and the Air Ambulance service since 1988

Almost weekly newspaper interviews. Regular radio interviews. Spasmodic television interviews often at short notice on complex or controversial topics over the past 15 years.

Courses and Conferences

Item	Start Date	End Date	Comments
In House Practice Quality and Educational Service Time (QUEST)	2001	Ongoing	0.5 days per month includes regular audits
In House Practice Partnership meetings	1985	Ongoing	2 hours p.w. Management and informal audit
BASICS Education	1989	Ongoing	Tutor, Examiner, Course director, 3 courses pa to 1999 and 1 course pa thereafter
BASICS Annual Conference every year since 1992	1992	Ongoing	Attendee, Practical session Tutor, and Lecturer
Rural practice Conference Institute of Rural Health, Gregynog	1992	Ongoing	3 day annual couse Attendee, Practical session Tutor, and Lecturer
Full PGEA allowance earned	1990	2004	30 hours minimum pa. I had over 200 hours in hand at the end
Medical Incident Officers Training Course Nottingham East Midlands Airport Practical	2004	2004	1 day
Medical Incident Officers Training Course Nottingham East Midlands Airport Theoretical	2004	2004	1 day
ALS Provider Course Cambridge	2000	2000	3 days inc exam
ATLS Instructors Course	2000	2000	3 days inc exam
Advanced Presentation Skills, Press radio, television and media skills	1999	1999	1 day repeated every two years
Computer Users Course BMA , basic, Powerpoint, Word, Excel, Lotus Notes, Internet,email	1999	1999	3 days aggregate
MIMMS Instructors Course	1997	1997	3 days
MIMMS Providers Course	1996	1996	3 days inc exam
Adult education, teaching and Presentation skills Course, BASICS Education	1995	1995	2 days
ATLS Providers Course Cambridge	1995	1995	3 days inc exam
ALS Provider Course Colchester	1994	1994	3 days inc exam
Medical Incident officers course	1994	1994	2 days
Adult education, teaching and Presentation skills Course, BASICS Education	1993	1993	2 days
Presentation Skills, Press radio, television and media skills	1993	1993	1 day
ACLS Course Norwich	1992	1992	3 days inc exam
ATLS Providers Course Newcastle upon Tyne	1990	1990	3 days inc exam
Cambridge Immediate Medical Care Course	1989	1989	5 days
Industrial Relations employment law POWAR training Course	1989	1989	1 day
Media Training Day BMA	1989	1989	1 day
Edinburgh Immediate Medical Care Course	1988	1988	5 days
Introductory course Forensic Medicine Nottingham City Hospital	1985	1986	10 days lectures?
DRCOG course Gateshead	1983	1983	5 days