Title: GENERAL MEDICAL SERVICES PRACTICE VACANCIES - A GUIDE TO GOOD PRACTICE

For Action by: Chief Executives of Local Health Boards

Action required See paragraph(s):

For Information to: Local Health Boards - Medical Directors

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Enclosure(s): Annex 1
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Summary

1. The latest statistical data on the General Practitioner workforce in Wales indicates that 25% or more of GPs in eight of our Local Health Boards are aged 55 years or over. In addition three of our LHBs have 10% or more of their GPs working as single handed practitioners. It is clear therefore that some LHBs carry a moderate to significant risk of GPs opting to retire within the next five years or so and some of these may be from small or single handed practices.

2. Local Health Boards have a statutory duty to ensure the sustained delivery of primary medical services to their resident population. When a practice becomes vacant for whatever reasons the LHB must ensure that primary medical services continue to be provided to those patients by the most effective and efficient means possible having regard to local needs and circumstances.

3. The future vision for healthcare services in Wales is spelled out in Designed for Life. This envisages that “the extended primary care team will be central to the delivery of chronic disease management for the overwhelming majority of patients.” The strategy acknowledges that some GPs will develop specialist skills and that increasingly they may work alongside other health professionals undertaking extended roles. These developments are intended to ensure that high quality primary care can develop and expand, and improve recruitment and retention of general practitioners.

4. Local Health Boards have a crucial role in ensuring that their primary care workforce plans address the short, medium and longer term vision for primary care services and reflect the views of GPs, patients, service users and local populations. They should also ensure that capital/estate, financial and workforce planning is done together so that there is a coherent and transparent local plan. They should support local practice development in ways that enhance overall recruitment and retention for example by enabling practitioners to return to work following a career break.

5. Attached at Annex 1 is a guide to good practice in resolving practitioner vacancies. It outlines the steps to be followed by Local Health Boards in anticipating future vacancies, consideration of the best options for future delivery of services and offers advice on consultation and implementation of the preferred option.

ACTION

6. LHB Chief Executives are asked to note the attached guidance and to ensure that this is disseminated widely throughout the LHB. They should also ensure that the guidance is shared with key stakeholders.

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RESOLVING PRACTICE VACANCIES
A GUIDE TO GOOD PRACTICE

Introduction

1. This guidance provides advice to Local Health Boards (LHBs) on the recruitment of General Practitioners and reminds Local Health Boards of the steps they should follow when considering the future of vacant practices. The overriding concern is to ensure that primary medical services are delivered to a consistently high standard across the whole of Wales.

Strategic Considerations

2. Designed for Life – the ten year strategy for healthcare delivery in Wales (building on Improving Health in Wales) outlines a national vision of healthcare services which broadly suggests that delivery of healthcare services will increasingly be determined by:
   - a patient centred or service user focus to health and social care delivery around the patient pathway rather than along functional lines
   - continued technological change that will alter traditional work roles for example through the use of near patient testing
   - a continued shift in the boundary between primary and secondary care with a greater range of chronic conditions being managed in primary care.

3. Every Local Health Board in Wales has translated that national vision into a local vision that addresses local circumstances. LHB primary care estates’ strategies should outline how primary care premises development will support the realisation of that vision. It follows therefore that each LHB should have a clear “understanding” of the future shape and configuration of primary medical services. In terms of realising their vision LHBs will need to be clear about their intentions where decisions need to be made about the continued provision of primary medical services when a practice (for whatever reason) becomes vacant.

4. The configuration of primary medical services providers is a matter for LHBs to determine having regard to local healthcare needs and having consulted with all relevant stakeholders including the Local Medical Committee. Practices will vary in size according to local circumstances. Where a small or single handed practice is considered appropriate then the LHB will want to ensure that the following is in place:
   - appropriate arrangements for continued professional development of all members of the primary care team
   - effective clinical governance arrangements
   - reasonable, well equipped premises
   - reasonable staffing and infrastructure including IT and manual recording systems
Workforce Planning

5. LHBs should work with contractors locally to ensure that they have a robust primary care workforce plan that takes account of future primary medical services needs. The plan should incorporate realistic projections in terms of future GP numbers; the implications of changing skill mix and where appropriate new roles and new ways of working.

6. LHBs should also have in place a recruitment and retention plan that outlines how the recruitment and retention of GPs and other practice staff complements and supports the future delivery of high quality primary medical services. These plans should outline how Recruitment and Retention monies included in LHB Administered funds might be utilised to support recruitment and retention, e.g. support for retainer, returner schemes.

7. A crucial element of workforce planning is the need for LHBs to maintain an effective dialogue with its independent contractor population. This will mean that age profile is monitored, future retirements are anticipated and a clear strategy exists to maintain, replace or re-provide services in the event of a vacancy. LHBs are strongly urged to maintain an ongoing dialogue with the Local Medical Committee so that any such difficulties are anticipated and managed. It may also be beneficial to seek the advice of the Head of Contractor Services at the NHS Wales Business Services Centre.

Vacant Practices – Consideration of Options

8. Where a practice becomes vacant the LHB will want to determine the best option for sustaining services to the practice population. Every circumstance needs to be considered on its particular individual merits, but in general terms, if the list is less than 1000 patients then the LHB may need to consider whether that list should be dispersed. Where the LHB considers that retaining a small or single handed practice would be appropriate then the vacancy should be advertised.

9. Unless the circumstances are straightforward the LHB should convene a panel to undertake a detailed option appraisal to determine a way forward. The LHB will chair and administer the panel but any LHB officers participating in the option appraisal should not normally be involved in the final determination of the matter by the LHB. The panel will make recommendations to the LHB who will make the final decision.

10. Membership of the panel should include as many relevant stakeholders as is practicable. It will be for the LHB to determine the membership of the option appraisal panel. However it should consider including:
   • GP Board member
   • Board lay member
   • CHC member and/or a patient group representative
   • Local Medical Committee representative
   • local authority officer
doctors from neighbouring practices
• practice nurse
• local Pharmacy representative
• Contractor Services Advisor.

In some circumstances the panel may wish to seek the views of local councillors, the local Assembly Member and/or Member of Parliament.

11. In the majority of cases it is anticipated that the options available to the LHB will be:
• advertisement of the vacant practice
• direct management of the practice by the LHB using salaried GPs
• management by another practice under GMS or by another practice /provider under APMS arrangements
• closure of the practice and dispersal of the list to neighbouring practice/s

More detail on these together with other possible solutions appears below from paragraph 13 onwards.

12. The following indicators will be helpful in determining the preferred option:
• Viability of patient list and potential for growth of the local population
• Age profile of list and geographical spread
• Doctor/patient ratio in the area
• Proximity, capacity, financial consequences upon and willingness of neighbouring practices to absorb extra patients.
• Particular local needs e.g. ethnic groups, need for women doctors etc.
• Availability and condition of surgery premises
• Specific social considerations that may suggest a list should be kept intact e.g. relatively deprived area, rural isolated community, poor public transport infrastructure
• Preference of local residents

Advertising the vacant practice

13. The LHB should advertise locally and nationally for expressions of interest to run the practice as a GMS practice. The advertisement should provide as much information as possible but in particular should seek to market the local area. Interested applicants should be provided with an information pack that includes:
• A general description of the practice to include premises layout, equipment, staffing, enhanced services, etc
• Full description of services currently provided from the practice and opportunities for further developments
• Financial profile of the practice
• Structure of primary medical services in the area and future plans
• Arrangements for protected learning, continued professional development, and appraisal
• Information on housing, schools and local amenities
• Any financial incentives that may be available to the successful applicant e.g. relocation grant
• Named LHB contact for further discussion

Recruiting Salaried Doctors to run the practice temporarily

14. In order to sustain services while permanent solutions are being pursued the LHB may advertise for salaried doctors to work under the direction of the LHB in running the practice. LHBs are unlikely to view direct management of a practice as part of their core business. However on occasions it may prove necessary to assume management of a practice in order to prevent the disruption or collapse of existing services. This should be viewed as a temporary measure and separate from direct management under LHBMS whereby the LHB takes a strategic decision to provide primary medical services (see 17 below).

15. In seeking to recruit salaried doctors under these temporary arrangements the LHB should consider the possibility that doctors recruited, if they prove effective, could be part of the longer term solution. Therefore their recruitment campaign should be designed with this in mind. Ideally the LHB should supply an information pack that provides the main details of the practice (as indicated above) together with a job description, person specification and an outline of the terms and conditions of employment, including salary range. It should also include information on the LHB’s longer term plans for the practice. LHBs should be mindful that to attract high quality candidates they may need to consider offering a range of benefits as part of the employment package e.g. flexible working, childcare support or a voucher scheme, academic/research links, protected learning time, mentorship for professional development.

16. Some LHBs in Wales already run salaried doctor schemes and LHBs will want to consider the benefits of working collaboratively with neighbouring LHBs in this regard.

LHB Medical Services (LHBMS)

17. LHBs have a statutory duty to secure the provision of primary medical services to “the extent that they consider it necessary to meet all reasonable requirements” of their resident populations. Aside from awarding a GMS contract the LHB may decide to provide primary medical services itself under the Local Health Board Medical Services Directions 2006.

Alternative Provider Medical Services (APMS)

18. The Welsh Assembly Government’s preferred policy is to ensure delivery of primary medical services via GMS contracts. However where a LHB is unable to secure a contract with a GMS provider then it may determine that the best option would be to commission the services from an
alternative provider. Such arrangements must be in line with the Alternative Provider Medical Services Directions 2006. The LHB may enter into an APMS contract with any individual or organisation that meets the provider conditions set out in the Directions. This will include the private and independent sectors, voluntary sector, not-for-profit organisations, NHS Trusts, other LHBs, or existing GMS practices. The LHB must ensure that it has transparent processes in place for securing a contractor in order to encourage competition.

19. Whilst LHBs will need to take account of their Standing Financial Instructions consideration of alternative providers need not automatically involve a formal tender exercise. If LHBs preferred to use another approach (e.g. inviting existing independent contractor providers to put forward proposals in response to a service specification) this would be regarded as acceptable procurement practice within the NHS. LHBs must ensure that they secure a service that delivers clinically safe primary medical care and represents good value for money.

Dispersal or Re-assignment of the Patient List

20. This section should be read in conjunction with Part 2, Schedule 6 of the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 (as amended) – (“the regulations”). These regulations deal with the assignment of patients by LHBs to contractors having “open” or “closed” lists.

21. A decision to disperse or reassign patients is normally an option of last resort. Prior to taking such a decision the LHB is advised to consult with neighbouring practices and the LMC. LHBs will be fully aware that practice closures can be extremely sensitive issues and they would be well advised to seek the involvement of democratically elected local representatives as early as possible in the process.

22. Where a LHB has no alternative other than to disperse or re-assign the patients then the following steps should be followed:
   a. The LHB should discuss with neighbouring practices the feasibility of a measured dispersal of all affected patients to named practices. These discussions should include an accurate assessment of the likely impact on the receiving practice(s). The vacant practice will require interim support to redirect patients to their new practice. The receiving practice(s) will probably need transitional support e.g. temporary additional staff, registration clinics, transport and storage of patients’ notes, help with inputting new patients onto receiving practices’ systems etc. The LHB should also ensure that patients notes are transferred with the minimum of delay to minimise inconvenience to patients.
   b. The LHB should write to every patient (or in the case of those aged under 16 to their parent/guardian) giving full details of the contractor in their area to whom they are being allocated. Details should include names of doctors, details of services provided, opening times and a
contact name for any further queries. Consideration should also be
given to housebound or disabled patients who may need to be
visited at home so that they can have the new arrangements
explained to them.

c. Patients should be advised that if they do not wish to be allocated to
that particular practice then they should notify the LHB in writing
within 14 days. The LHB should ensure it advises that it will provide
assistance if requested to any such patients who fail to secure
alternative arrangements, so that they may be re-assigned.

d. Where a measured dispersal of patients to named practices cannot
be agreed then LHBs have power under “the regulations” to assign
patients to a new contractor whose list of patients is “open.” The use
of this power should preferably be avoided but if it has to be used,
the LHB should recognise the implications for the receiving practice
and provide appropriate support.

e. In certain specified circumstances, a LHB may present a proposal to
assign patients to a contractor whose list of patients is “closed” to an
assessment panel who may determine that the LHB can assign
patients to that contractor as per “the regulations.” Where an
assessment panel makes such a determination the contractor may
refer the matter to the Assembly for a review of the determination.
Where the LHB assigns patients to a contractor having a closed list
then it must enter into discussions with that contractor regarding
additional support the LHB can offer the contractor and the LHB will
use its best endeavours to provide such support. A practice with a
closed list by definition has already signalled that its workload is at
the limit. Assessment panels should be mindful therefore of the
added pressure an assignment of patients would bring with a risk of
destabilising services further.

f. The LHB should seek the advice of the Head of Contractor Services
to agree roles and responsibilities for handling the actual dispersal or
assignment of patients.

**Communication and Consultation**

23. The LHB should develop a comprehensive communication plan to
support their deliberations around the future of the affected practice. This
should include a clear indication of the timescales involved in agreeing
and implementing the new arrangements.

24. The LHB will want to ensure that all affected patients are aware of the
departure of their GP(s) at the earliest possible opportunity. They should
be advised of the steps the LHB intends to take to determine the future
delivery of primary medical services to patients as well as a description
of how current services will be maintained in the interim period.
25. As soon as the LHB becomes aware of the vacating of a practice it should contact all neighbouring practices for preliminary discussion about the likely implications. The Local Medical Committee should also be notified as soon as possible of the vacant practice and their views sought about the way forward.

26. Where the LHB decides to undertake an option appraisal it will need to ensure that relevant stakeholders are consulted on the range of options considered together with the rationale for recommending the preferred option. The consultation process should be robust and transparent and follow the guidance contained in WHC (2004) 84 – “SHAPING HEALTH SERVICES LOCALLY – Guidance for Involving and Consulting on Changes to Health Services.”

27. Unless it is impractical to do so a public meeting should be held so that patients can address any concerns or queries to the LHB and the LHB in turn can enhance public understanding of the preferred option.

28. LHBs should establish a properly staffed telephone helpline so that patients can raise any queries concerning the new arrangements.

29. In addition to letters to affected patients and a public meeting LHBs should consider other appropriate means of communication e.g. posters, leaflets, newspaper articles, briefing for local community leaders.

30. It is important that the LHB maintains effective dialogue with the doctor(s) from the vacating practice.

Review and Reflection

31. Once the decision has been implemented and the “new” services are up and running then the LHB should reflect on the way it managed the changing circumstances to learn lessons for the future. The views of the Local Medical Committee, the CHC and a patient group representative should be sought on the processes adopted by the LHB.

32. The LHB should undertake a further survey of patients a reasonable time after the implementation of the new arrangements to assess the impact on patients and the local community.

Useful References

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 – Statutory Instrument 2004 No 478 (W.48)

Designed for Life, Creating world class Health and Social Care for Wales in the 21st Century, May 2005

Report on Research into Recruitment and Retention of GPs in Wales, Office of the Chief Medical Officer, March 2005
Primary Care Workforce Development, Dr Jane Harrison, Office of the Chief Medical Officer and Ian Jones, Primary Care Division, June 2005

The Local Health Board Medical Services Directions 2006, National Assembly for Wales (2006/11)

The Alternative Provider Medical Services Directions 2006, National Assembly for Wales (2006/10)

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