BMA

# Salaried GPs working under new models of care

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## Overview

The traditional model of general practice is under pressure, as momentum builds to provide integrated care services at scale. Against the backdrop of rising demand and diminishing resources, many practices are left in a vulnerable position, creating an impetus to take forward new ways of working which can be used to help alleviate these pressures. Whilst this environment brings with it a number of threats to salaried GPs working under these models, it equally creates opportunities. With this focus on document, the sessional GPs subcommittee attempts to create a rough guide around these models and flag a number of issues that salaried GPs need to be aware of in order to ensure that the employment offer and their working arrangements are fit for purpose.

## GP networks and federations

More and more practices are beginning to explore entering some sort of collaborative arrangement with other practices in their area. These partnerships come by many names (i.e. federations, networks, alliances etc.) and can be formal or informal entities with a set of common objectives or purposes. There are two main approaches to how GP networks opt to deliver economies 'at scale'. The main difference between them is the extent to which individual practices retain or lose their autonomy, thereby affecting the employment arrangements for salaried GPs employed by these structures.

### Super partnership

Several partnerships merge to form a super partnership covering multiple sites across a wide area. The super partnership operates much like a regular partnership at a larger scale. Usually, a partnership agreement between the partners of the practices is sufficient for a merger to take place, thereby merged practices can hold G/PMS or APMS contracts, but this may eventually be in addition to another structure, e.g. a company limited by shares etc.

### Federations

Similarly, a federation is a group of practices that come together, to share responsibility for a range of functions, which may include developing, providing or subcontracting services, training and education, back office functions, safety and clinical governance.[a] The collaboration may be informal or formalised as a legal entity which can hold contracts. Table 1 provides a list of structures for how a formalised legal entity could look like and what the implications would be for a salaried GP.

a RCGP, *Primary care federations toolkit*, available at http://www.rcgp.org.uk/clinical-and-research/clinical-resources/primary-care-federations-toolkit.aspx

**Table 1. Collaboration structures and contractual implications for employers and employees.**

| Structure | Employer's contract status | Pension status | Model contract status for salaried GP |
|---|---|---|---|
| Super partnership | Can hold G/PMS and APMS | Eligible for NHS Pension Scheme if holding G/PMS/APMS. | Contractually bound to offer terms no less favourable if G/PMS[b].<br><br>Recommended if APMS. |
| Company limited by shares | Can hold G/PMS/APMS in its own right. Member practices retain individual contracts. | Eligible for NHS Pension Scheme if holding G/PMS/ APMS contract. | Contractually bound to offer terms no less favourable if G/PMS. Recommended if APMS. |
| Company limited by guarantee | Only APMS contract in its own right.<br><br>Individual practices retain contracts | Eligible for NHS Pension Scheme as an independent provider if holding APMS. | If employed by the Company limited by guarantee, then model contract recommended.<br><br>If employed by individual practice which holds G/PMS contract, then bound to offer model contract. |
| Limited Liability Partnership (LLP) | Can only hold APMS in its own right, but individual practices retain individual contracts. | Eligible for NHS Pensions Scheme as an independent provider if holding an APMS contract | If employed by the LLP, then model contract recommended.<br><br>If employed by individual practice which holds G/PMS contract, then bound to offer model contract. |
| Community Interest Companies (CICs) | Can hold G/PMS/ APMS contracts in its own right. | Eligible for NHS Pensions Scheme as an independent provider if holding an APMS contract. | Contractually bound to offer terms no less favourable if G/PMS.<br><br>Recommended if APMS. |

Appendix A provides a checklist of questions you should be asking if your practice is considering entering a super partnership or federation.

Further information on the collaborative GP networks and their legal structures can be accessed here.

b Any reference to PMS practices having to offer the model contract refers to practice that have signed the 2015/16 NHS England Standard Personal Medical Services Agreement.

## Five Year Forward View and new models of care

The *Five Year Forward View*, which was published in 2014, set out how the health service needs to change by designing several new models of care which break down the barriers between general practice, hospitals, community services, and social care.

Two of the models outlined were MCPs (multispecialty community providers) and PACS (primary and acute care systems). These are population based models of care, built upon the GP registered lists of the practices involved covering a population of circa 50,000 to 100,000. However, it is expected they will vary in size dependent upon local agreement. MCPs seek to integrate primary and community services, but can also include moving some hospital services into the community, or employing hospital doctors to work in the community.

PACS will include NHS list-based GP and hospital services, together with mental health, community care services, and potentially public health or social care. As such, NHS England would expect PACS to cover the same population footprint as the Trust(s) involved. You can read information on MCPs and PACS here.

## ACO and ACS

Fully formed MCPs and PACS are examples of an ACO (accountable care organisation), where a single organisation is contracted to provide agreed services to a defined population. The ACO may sub-contract some services, but they are ultimately responsible for the cost and quality of care for their population within an agreed budget. Existing providers, therefore, may be employed directly by the ACO, or may potentially be merged. Advanced ACOs would cover the majority of the health and care services, including public health.

In October 2015, the Government announced its intention to create a new 'voluntary' contract to be used by GPs and other providers in England, in order to provide 'at scale' general practice and integrated services as described above. The latest updated version of a draft MCP contract was published in August 2017, and has been adapted to be usable for all types of ACOs. The contract is aimed at providers who wish to provide integrated care 'at scale' over populations of at least 50,000 patients.

At the same time, NHS England also mandated health and care systems in England, divided into 44 areas, or footprints, to come together and develop an STP (sustainability and transformation plan). These are five year, umbrella plans, detailing how different providers in local areas will work in partnership to implement the five year forward view. NHS England expect that these STPs will evolve into ACS (accountable care systems).

ACS involve local NHS organisations, potentially in partnership with local authorities, working together as an integrated system. The ACS has collective responsibility for resources and population health in their area, rather than a single organisation holding the contract as in an ACO. In time, it is expected that some ACS may establish an ACO. In both ACS and ACOs the traditional division between commissioners and providers is blurring.

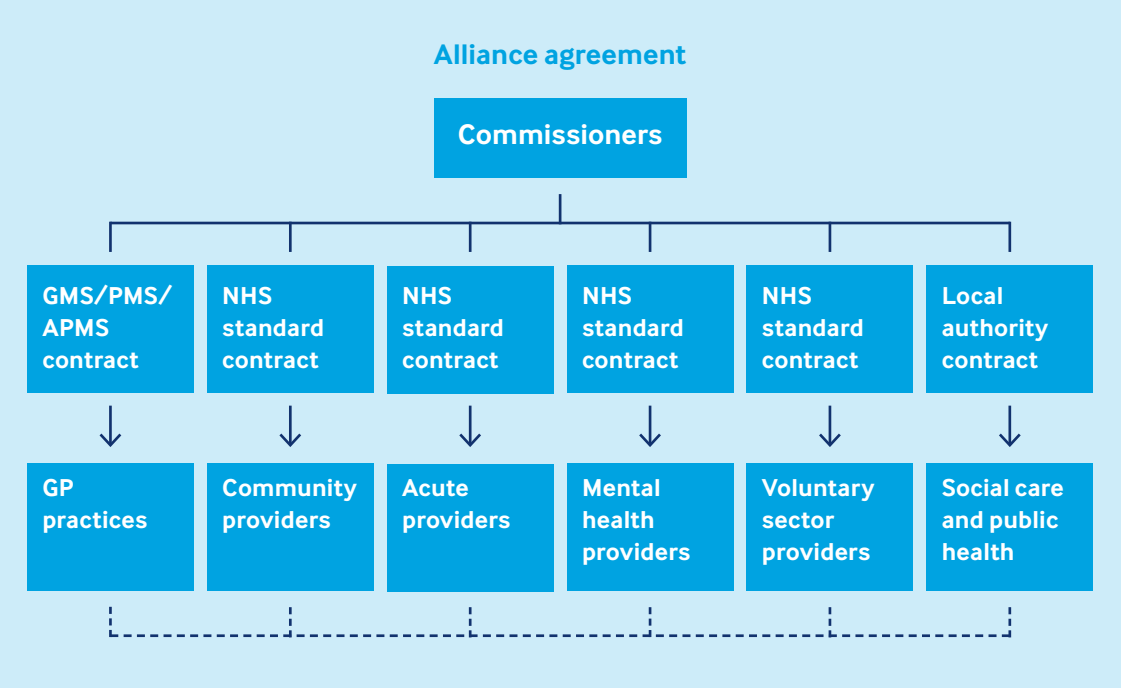
NHS England's contractual frameworks outline 3 different paths for ACO development:
- Virtual
- Partially integrated
- Fully integrated

## Virtual

Providers of services would enter into an 'alliance agreement' with the commissioning bodies, which would overlay (but not replace) regular commissioning processes, setting out an agreement to achieve greater integration of these services (e.g. shared managing of resources, governance arrangements, risk sharing agreements, operational delivery of services). The services themselves would remain governed by the regular commissioning procedures and contracts, and in this way, the virtual model is effectively an ACS rather than an ACO.

NHS England have produced a template Alliance Agreement for use by commissioners but this could be adapted based on individual provider or population needs. The agreement is owned by the providers and commissioners within it.

**Diagrammatical representation of the virtual model:**



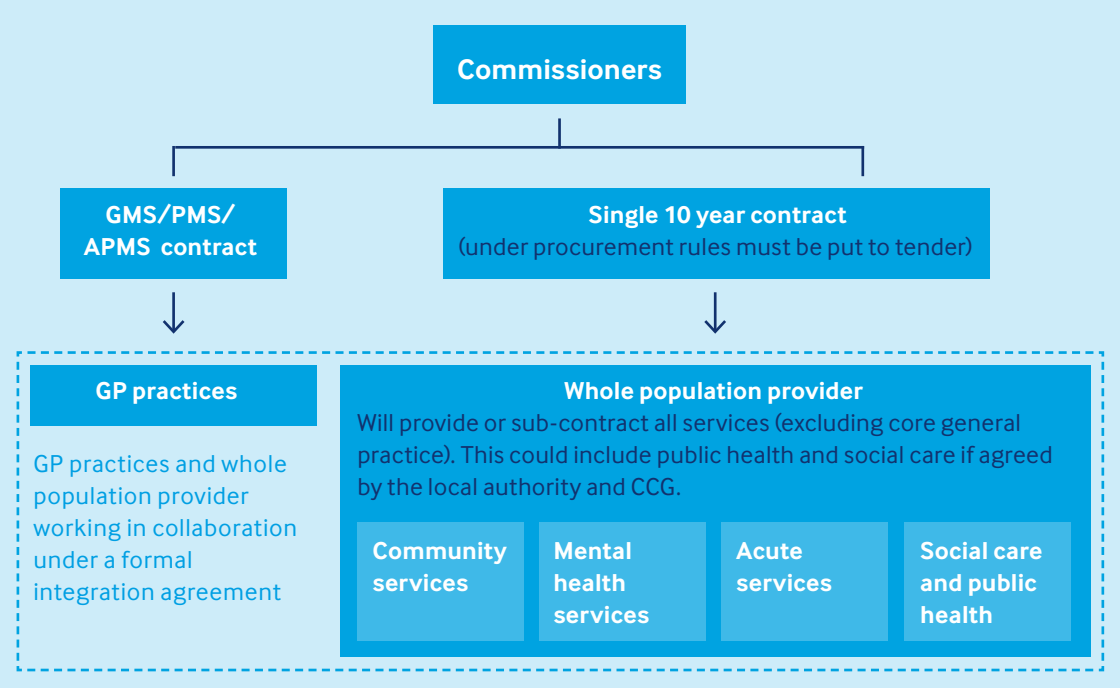
## Partially integrated

This model would provide a single contract for everything included in care provision (primary, secondary, community, mental health, public health, social care and aspects of local authority care provision) apart from core general practice. This would form a 'whole population provider' which holds a single contract with the commissioner, and holds agreements with the GP practices in the area to form the overall ACO. The whole population provider could be a new organisation or an existing organisation which would take the lead role. It would be responsible for the provision of services but may not necessarily deliver all the services itself but could instead hold subcontracts with other providers.

It could include primary care services that fall outside of core general practice (including QOF, DESs and local provision of primary care). Whilst GP practices may still hold their GMS/PMS contracts, any primary care services beyond that which fall under the scope of the ACO may either be delivered by the practice or join the 'whole population provider'.

The whole population provider (i.e. the ACO contract holder) would be required to integrate the services they provide directly with the core primary medical services in that area and agree with the GP practices in the area how that will occur using an 'integration agreement'.

**Diagrammatical representation of the partially integrated model:**

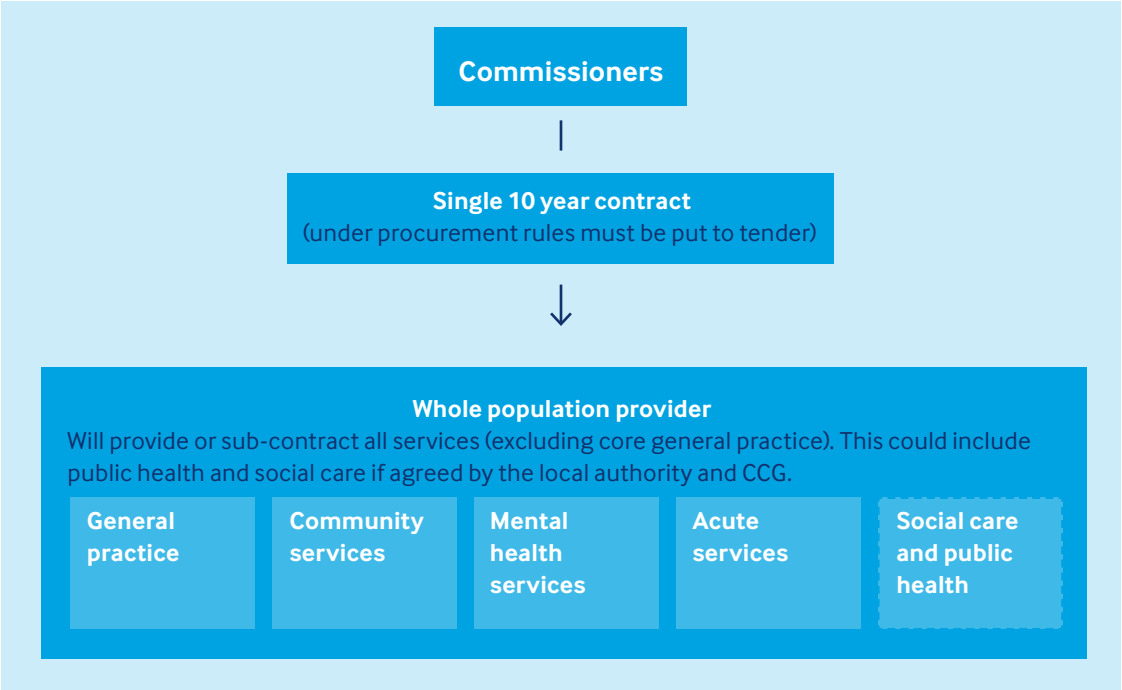


### Fully integrated

This will see all services procured in a single contract between the commissioners and a single legal entity. This organisation would be responsible for the provision and integration of all care services; it could deliver all services directly, or could sub-contract for services to be delivered by other providers. The overall contract would run for a limited period of 10-15 years, and include a break period every 2 years, to allow for evaluation of the development of the ACO and the services provided under the contract.

Provision has been made within this model for GP practices to suspend their GMS/PMS/APMS contracts (for an agreed amount of time), which may later be reactivated. GPs can reactivate their G/PMS contracts at two year intervals or at the termination or expiry of the ACO contract. This is likely to affect salaried GPs, but there are limits as to what can be nationally guaranteed and a number of practicalities would need to be worked out locally. As a general rule, GPs reactivating their contracts would need to show that staff roles move back to the practice as a result of reactivation at which point staff could TUPE back.[c]

**Diagrammatical representation of the fully integrated model:**




## Further collaborative arrangements

The BMA is clear that structural and contractual integration should not become the main focus of any new model of care, as this alone does not guarantee more joined up services or quality of care for patients. Indeed, there are examples of care models already in operation that facilitate integrated services, which build on current contractual models.

c NHS England (2017) *GP participation in a Multispecialty Community Provider*, available at https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-5_A.pdf

# Contractual implications for salaried GPs

If your employer or GP practice is part of a site testing a new model of care or has plans to develop one, this may affect your contract of employment.

If your employer retains their G/PMS contract, then they are contractually bound to offer 'terms no less favourable' than the model contract for salaried GPs. However, if the employer is not a holder of a GMS, or PMS contract that has signed the 2015/16 agreement, then it is possible that you will be offered a contract that is not based on the nationally agreed terms and conditions of service. In such cases it is extremely important to understand what you are signing up to in advance and we would strongly recommend to contact the BMA's contract checking service, which is free for BMA members, to assist with the process.

Under the 'virtual' and the 'partially integrated' models, practices retain their G/PMS contracts and are therefore required to offer terms no less favourable than the model contract. There is no explicit mention of what employment models should be utilised within a fully integrated ACO, however GMS and PMS contracts would be suspended so it is anticipated that all GPs (whether previously contractors or salaried) would be employed by the ACO. The latest draft of the ACO contract states that the contract Directions will include a requirement that the contracts of all GPs employed within an ACO must meet the minimum terms and conditions set out by the BMA model contract for salaried GPs.

The model contract for salaried GPs represents good employment practice and it is advised that a salaried GP should never accept anything less than these minimum TCS. It is equally important that there is contractual parity among all doctors employed under a new model of care.

The minimum key provisions of the model contract that a salaried GP should be looking for when employed under any employer are:

## Continuity of service

The BMA's legal view is that paragraph 1.7 of the model salaried GP contract means that for the purposes of calculating contractual maternity pay, periods of NHS employment include all periods of employment within the NHS, including previous service as a GP principal/provider, salaried GP and/or locum. If you are a salaried GP employed under New Models of Care you need to ensure that the start date of your continuous NHS employment covers all your previous NHS services (provided that there was no break).

The BMA's handbook for salaried GPs provides further information about what constitutes continuous NHS service.

## Job plans

The job plan is the document that translates expectations of employee and employer into a working schedule. It ensures that the post delivers its aims and the requirements of the contract of employment are met. A job plan should be developed collaboratively between the employer and the salaried GP as soon as possible (ideally before the salaried GP starts work). It should be reviewed annually or when there are any significant changes proposed to the work pattern by either party. Changes should only be made by mutual agreement.

The BMA's handbook for salaried GPs includes example job plans and diaries that can be used by employers and salaried GPs in any setting.

### Continuing professional development

Full-time salaried GPs employed under the model contract are entitled to at least 4 hours per week on an annualised basis of protected time for professional development. This is adjusted on a pro rata basis for part time employees. CPD time should be used according to the educational needs of the salaried GP, as specified by their NHS appraisal and PDP (personal development plan).

### Sick/maternity/adoption leave and pay

The model contract offers enhanced protection and benefits regarding annual leave and maternity/sick/adoption leave and pay. Specifically:

- **Annual leave**: The model salaried GP contract provides a full-time salaried GP with 30 working days leave per year, which includes the statutory provisions
- **Maternity leave and pay**: A salaried GP employed under the model contract is entitled to 12 months of maternity leave and, provided they have 12 months of continuous NHS service, they are entitled to contractual maternity pay
- **Sick leave**: The model salaried GP contract provides improved sick leave benefits, in line with hospital doctors

Further information on the model contract entitlements can be accessed here.

### Pay uplift

Under the Model contract a salaried GP's salary must be uplifted annually at least in line with the DDRB recommended increase.

## TUPE

If you are employed by a practice that is merging with other providers/practices to develop a new organisation (e.g. your practice becomes part of a fully integrated model), the new organisation would take responsibility for providing the services your employing practice used to provide. In such cases, TUPE (Transfer of Undertakings (Protection of Employment) Regulations) would normally apply and your contract of employment would be transferred to the new organisation. This usually also covers independent sector organisations, such as social enterprises or limited companies. If you are informed that your contract of employment may be transferred to a new provider, you should seek advice from the BMA immediately.

The main purpose of TUPE is to protect the terms and conditions of employees who are employed in a business that is being transferred, so that their contracts of employment are not terminated or changed. The effect is that the new employer steps into the shoes of the old employer, and continuity of service and any other rights are all preserved.

There is a requirement under the Regulations for the old employer to give the new employer certain information about the employees who transfer and the Regulations make it automatically unfair for the old or the new employer to dismiss an employee because of the transfer, unless an economic, technical or organisational reason can be shown that entails changes in the workforce.

However, even if TUPE does apply you may still consider that your position has been compromised, for example, your place of work may change to somewhere that is not convenient, and there are certain circumstances under which your new employer is entitled to introduce changes to your TCS following a TUPE transfer. You can seek advice from the BMA should this situation arise at support@bma.org.uk and 0300 123 1233.

Following a TUPE transfer, independent sector providers are not obliged to implement nationally negotiated contractual changes thereafter. Similarly, there is no obligation for them to offer nationally negotiated contracts to employees joining after the initial transfer. If you are employed in a new organisation you are still entitled to BMA representation.

For more information on TUPE please access here.

## Pension implications

Access to the NHS Pension Scheme depends on the set up of the employing organisation, so you should ensure that as a salaried GP you will not lose access to the NHS Pension Scheme because of a move to a new model of care. Salaried GPs are able to access the NHS Pension Scheme through their employer, which would likely be a practice, NHS Body, or Independent Provider (assuming IP status in the NHS Pension Scheme has been applied for under the 2014 Regulations).

Under a virtual or partially integrated ACO the current primary care contracting arrangements remain the same and therefore access to the NHS Pension Scheme should not change for salaried GPs. Similarly, the ACO contract has been recognised as an eligible contract under the NHS Pension Scheme Regulations, and consequently GPs employed in fully integrated models are allowed access to the NHS Pension Scheme, regardless of whether the employer is an NHS or a non-NHS organisation.[d]

Through work with vanguards, NHSE has identified NHS Pension Scheme access as a potential barrier to the development of and engagement with new models of care. Therefore, NHSE is working with the Department of Health and the NHS BSA (NHS Business Services Authority) to address these issues, based on the principal that where existing pensionable activity is being delivered by the same teams, but potentially through different organisation or contractual forms, access to the NHS Pension Scheme should be maintained.

In any case, salaried GPs who are intending to work under a new model of care are advised to contact the BMA pensions department to check whether they will be able to access the NHS Pension Scheme.

## Indemnity

All GPs (GP contractors, locum GPs and salaried GPs employed by practices) need to ensure they have adequate and appropriate insurance and indemnity. In most cases this will be provided through an individual membership arrangement with an MDO (medical defence organisation).

If the nature and extent of your work remains the same, following a move to being employed by a new model of care/federation, your individual indemnity arrangements are unlikely to be affected. However, if your employment by a new model of care/federation has changed the nature of your work, e.g. working in unscheduled care, then you should contact your MDO as this could potentially alter your indemnity arrangements. NHS England advises[e] that in virtual and partially integrated organisations, where the practice remains a separate entity to the organisation, GPs should not generally make any changes to the way in which they purchase their clinical indemnity. It is important, however, that GPs entering into these arrangements speak with their indemnity provider about any changes to their ways of working to ensure that they still have adequate cover.

In a fully integrated organisation, all employees will be covered by the organisation's indemnity, which means that both GPs and practice staff moving to the new organisation (whether an NHS or non-NHS body) as employees will have the cost of their cover paid for, or reimbursed, by the employing organisation. However, it is important to note that personal indemnity arrangements are still required.

When moving between insurance/indemnity provider it is essential that GPs establish if they are required to pay individual 'run off' costs to cover continued protection linked to the period prior to joining the ACO. As with doctors working in secondary care, GPs will continue to need, and may have to pay for, personal indemnity arrangements to cover them for any activity that takes place outside the ACO. All GPs should ensure they also have professional indemnity arrangements to cover for medico-legal issues arising from clinical practice, such as Ombudsman's investigation, a complaint to the GMC or a professional disciplinary or criminal investigation.

d NHS England (2017) *GP participation in a Multispecialty Community Provider*, available at https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-5_A.pdf
e NHS England (2017) *GP participation in a Multispecialty Community Provider*, available at https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-5_A.pdf

## Risks

GPs should always have adequate and appropriate protection for all their work and will be accountable for their patient interactions regardless of the setting. However, with the development of new models of care and the integration of different teams it can be difficult to attribute responsibility. It is important that both the employing organisation and the healthcare professionals delivering the care are clear on where responsibility lies and that have the appropriate indemnity cover.

Additionally, as practices entering new collaborative arrangements might decide to suspend the G/PMS contracts and/or form new organisations altogether, salaried GPs employed under such models might not be protected by the requirement to be offered the model contract. In such cases, it is important that salaried GPs request to be offered at least terms that are no less favourable than the model contract for salaried GPs.

As salaried GPs will be employed alongside doctors from different care settings (i.e. secondary care), they need to ensure that they are not contractually disadvantaged and that the employment and pay offer is equal.

Finally, salaried GPs working under new models of care have raised concerns that often continuity of care is lost. Continuity of care is a bedrock of general practice and it is important that the principle is maintained under these new ways of working.

## Workforce benefits

New models of care have the potential to offer new and flexible options for salaried GPs and other clinicians working under such arrangements. Such innovative employment opportunities could facilitate portfolio careers for salaried GPs and could increase the flexibility of working hours, contributing to a better work life balance.  What is more, there is the potential for salaried GPs to get more actively involved in decision making and/or leadership roles.

Additionally, some GPs employed under new models of care have told us that they benefit from working as part of a multispecialty healthcare team and feel they have a chance to develop their skills by maintaining contact with specialists.

Finally, these new working arrangements and the expansion of the primary care team not only ensures that the needs of the local population are met and that care is provided in the most appropriate setting, but frees up GPs from administrative burdens. This allows for longer appointments and more time to see patients with complex needs and comorbidities.

# Appendix A

Things to look at as a salaried GP working under a super partnership or a federation (please note this is not an exhaustive list):

If your practice is considering entering/joining a super partnership or federation, you should clarify:

- Is the new organisation holding G/PMS contract?
- Will I be employed by the new organisation or the practice?
- Will TUPE apply?
- Are there plans for the organisation to become an ACO and eventually an ACS?
- How will the following responsibilities previously provided by the GP contractor be provided in the new at scale organisation: supervision of staff, development of clinical protocols, responsibility for QOF, complaints, SEA (significant event audit), CQC etc?
- Will all salaried GPs be expected to have some of these?
- Will salaried GPs be able to negotiate which they take on and be recompensed with time and salaried recognition?
- Which of these roles will be delivered remotely by clinicians working away from site of work?
- How will the job plan be developed (tailored to each local team or standardised across the organisation)?
- How will compliance with contracted hours be monitored and pay (or time in lieu) for extra contractual duties claimed?
- Will the move involve any increased responsibilities for extended access (evening and weekends) and will this be optional? How will it be remunerated and organised?
- How will staff performance be managed? Who will carry the performance reviews?
- How and by whom will pay and job plans be reviewed?
- Will there be opportunities for flexible working arrangements to take into account, for example, caring responsibilities?
- Under what circumstances will I be asked to work across different sites?
- What arrangements will be in place to cover the work of colleagues who are absent on sick and maternity leave? Are there cover arrangements in place to cover absence due to annual leave?
- Will the travel costs be covered?
- Will there be a salaried doctor's pool for locum bank working?
- Will the transfer impact on any of my out of practice roles (with other organisations, e.g. education, commissioning, medical politics, specialist roles etc.)?
- How will salaried GPs and other employees be able to influence the organisation (consultative participation/Voice)?
- Will the organisation have any training roles and if so what responsibility and opportunities will the salaried GPs have in these?
- What will be the process of requesting annual leave and CPD? Will this be for determination within each site or managed at scale? Will it be more rigid/bureaucratic or more flexible that current arrangements?
- What resources will the new organisation have to support education and CPD?
- Will the new organisation be providing indemnity directly? If so, will it be:
  - A) occurrence or claims based
  - B) adaptable to accommodate outside portfolios
- Will the new organisation be reimbursing costs of indemnity take out by the individual salaried GP?

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