

Focus on local implementation of new models of care – GP contractual implications

November 2015



Background

The Five Year Forward View (5YFV) of October 2014 set out several new care models designed to ‘dissolve traditional boundaries’ between general practice, community services, hospitals and social care. Vanguard sites were selected in early 2015 to test these new models of integration, though movement towards more integrated care is already well underway in many parts of England.

The 5YFV proposed creating a number of major new care models. These included two models of care intended to redefine the relationship between primary and secondary care: MCPs (Multispecialty Community Providers) and PACS (Primary and Acute Care Systems).

In April 2015, the GPC published a discussion document for LMCs on these new care models [*General practice and integration: Becoming architects of new care models in England*](#). This set out the GPC’s support in principle for greater integration in the health care system and discussed several possible ways MCP and PACS could evolve, including the possible impact of these new systems on general practices and GP contracting. The publication promoted the potential of an expanded role for GP provider companies/networks in integrated care structures¹ and highlighted the need in any system to protect the most important organisational elements of traditional general practice, namely:

- A registered list system delivering patient-centred continuity of care
- Small-scale direct connections with local communities in the primary care setting, regardless of broader developments in health service organisation
- The continuation of a nationally negotiated core contract for essential services underpinning fair and consistent health service delivery to patients across England regardless of post-code
- General practice led by general practitioners working within broader multi-professional teams
- The freedom of GPs to be independent advocates for their patients

Since the GPC published *General practice and integration*, nationally-supported integration plans in vanguard sites and some non-vanguard areas has moved apace. A number of LMCs are grappling with proposals for major changes to local service commissioning and provision as a result of PACS, ACO² (accountable care organisation) and MCP development. It is becoming increasingly clear that the direction of travel in all models is broadly towards:

¹ The publication outlined a possible model of integrated working, a *collaborative care provider organisation* (CCPO), based on GP networking but retaining a core services contract at individual practice level. This was designed to protect the most important elements of traditional general practice whilst meeting the current policy objectives of the integrated care agenda.

² “The basic concept of an ACO is that a group of providers agrees to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target.”(Kings Fund, March 2014)

- The development of organisations providing or procuring/subcontracting a range of services including primary, community, secondary and possibly social care
- Capitation-based contracts with a single provider and single unified budget for most/all care of a registered population ('natural communities of care').
- Outcomes-based contracts which shift decision making and risk from the commissioner to the provider organisation
- New commissioning structures including joint commissioning (between multiple CCGs or CCGs and other organisations such as local authorities) and split commissioning functions (with only high-level strategic commissioning left with the main commissioner and other decisions devolved to the provider organisation)

NHS England has explicitly encouraged vanguard sites to work creatively to restructure local health economies. Local innovators have the support of NHS England's new care models team which is helping these developments to move incredibly swiftly; many of the new models are intended to be in operation from April 2016.

There is little certainty anywhere about how exactly these reforms will take shape. One of the main areas of uncertainty at the moment is how contracts for core general practice services will fit into the new models and, indeed, whether it will be possible for GPs to maintain a ring-fenced budget for core work. NHS England is working to develop a model contract for MCPs but it is likely that this will be quite basic and that local areas will retain considerable freedom to design contracts and services.

All of these developments have potentially far-reaching implications for GP contracting and service delivery. In some cases, the role of LMCs in safeguarding GP interests will never have been more challenging or more critical.

This short piece of guidance, focusing on GP contracting arrangements has been written as a starting point for LMCs facing local proposals for new models of care.

LMCs and GPC will benefit from sharing experiences. Do keep the GPC and other LMCs updated. If you have a question it is quite possible that someone else will already have found an answer.

Possible options for GP contracting under new models of care

There are a range of contracting options for GPs under the emerging new models of care, several of which are mutually compatible. These are outlined below.

- Core GMS or PMS contracts could remain separate from wider population-based contracts for other health services, with the contract held directly with the commissioner. This is the GPC's preferred option as a nationally negotiated core contract for essential services underpins fair and consistent health service delivery to patients across England. The GMS contract in particular also provides a relatively high level of stability to contract holders as it is not time limited and cannot be terminated unilaterally without cause. This option could

be accompanied by greater use of alliance contracting methods to align incentives across different categories of provider.

- GPs could be shareholders in the new MCP or PACS provider organisation, perhaps through super-partnership arrangements or network membership, both of which can be variously constituted from a legal and financial perspective.
- GPs could be employed by the new provider organisation, either on the salaried model contract or on an alternative type of employment contract, perhaps akin to being employed as a consultant or staff-grade doctor in a community trust.
- Some GPs could be engaged on a self-employed short-term basis, as with locum arrangements.
- Practices could be subcontracted by the lead provider organisation (MCP or PACs) to provide primary care services. These contracts could range from rigidly prescribed contracts with ring-fenced funding (similar to the current national contract) to loosely defined arrangements with income determined heavily by the contractor's financial position or contingent on financial, referral or outcome targets being met.
- A provider organisation could effectively take over the running of a practice/practices creating some form of hybrid employment/subcontracted arrangement. This could include renting premises from the GP partnership, sharing staff etc.

New models of care and GP choice

It is unclear to what extent individual practices will be given a choice in contracting arrangements under new models of care. GMS contractors will probably, as ever, have more choice in contractual movement than PMS contractors. It is likely that certain choices will exist in all cases at individual level – such as whether to become salaried for example or continue to work as an independent contractor of some sort. However to build population-based provider organisations across local health economies it is also likely that LMCs and GPs will be asked to consider moving en masse to new arrangements. This could include proposals to move away from GMS and PMS contracting arrangements to new local probably time-limited APMS contracts. This would ultimately be a matter for local decision making but GPs should be fully informed and involved in any change. CCGs are membership organisations and can be held to account by members if they do not feel that adequate consultation is taking place or if they believe proposals are not likely to work. LMCs must ensure that all proposals have been fully explored and should be very cautious about moving away from the relative security of national contracting arrangements.

Questions to ask of local proposals

Below is an initial list of questions LMCs may wish to ask if new care models are being developed locally. Please inform the GPC of any more that could usefully be added to this list.

Consultation

- Has there been sufficient LMC, clinical engagement and patient involvement in the proposals?

GP contracts

- Are GPs being given a choice about new models of care and their own working arrangements within this?
- Will GPs be employees, shareholders or sub-contracted independent practitioners? Or a combination of these options?
- Will GPs remain on current GMS/PMS contracts or move to new contract types? Are GPs aware of their choices and risks/benefits of moving from current GMS/PMS arrangements?
- Are any (sub) contracts with GP practices time-limited under the new model? This is the most likely scenario. Is there any legal right of return to GMS and how could this work if a whole area has moved to a new contractual arrangement?
- What are the implications of any proposed sub-contract to GP income? To what extent is income protected/dependent on meeting targets?
- How will negotiations around GP contracting be conducted? Who is involved? What role will the LMC play?
- Has the BMA been made aware of any planned changes to doctors' contracts/working arrangements?

Risk and reward

- Are GPs being asked for any up-front capital investment in the new structures?
- What level of risk, if any will the GP network/super-practice/individual practice or GP be exposed to under the plans if, for example, the new organisation will bear the risk of service utilisation or failing to meet quality standards?
- Is GP income directly related to commissioning spend under a unified budget? If so, how will probity and patient trust be maintained to avoid accusations of conflicts of interest?
- What will happen to any surpluses? Will they be reinvested or shared between shareholders?
- Will the organisation be able to deal with the risk of high-cost events?
- Who bears the risk of high-cost prescribing and treatment?
- Will there be any limits or floor placed on GP income?
- How will contract values be uplifted?
- Will there be recognised union arrangements?

Working arrangements

- What new career and working opportunities will the new model offer GPs? What opportunities exist for portfolio working? Are any new or extended roles for doctors being created?
- How/will the proposals impact upon doctors' training?
- What is the relationship between the proposals and the relevant LETB (Local Education and Training Board)?
- Will any salaried contracts conform to/exceed the standards set out in the GMS model contract?
- To what extent will the new organisations support sustainability of general practice eg through shared staff, resilience building etc
- How will conflicts of interest, whether real or perceived, be dealt with in the new structures?

- Has the BMA been made aware of any planned changes to or new roles for doctors?

Investment in general practice

- Is expenditure on general practice ring-fenced or protected or will it be fully merged with other types of care?
- Is the health care budget separate from that of social care?
- Who controls decisions under the new structure – GP organisations, a Foundation Trust, a company?

Practice staffing

- What implications will there be for practice staff? Will practices gain additional staff hours through the new arrangements or will existing staff be shared with others or contracted back to the new organisation?
- Will the new organisation fund backfill for staff working on behalf of the wider organisation?
- Note - A new provider organisation may technically be part of the independent sector, for example, in the form of a social enterprise or limited company. Staff transfers from the NHS to the independent sector will usually be covered by TUPE (Transfer of Undertakings (Protection of Employment) Regulations). This means that staff transfer to the new employer on their existing NHS contract and terms and conditions. However, independent-sector providers are not obliged to implement nationally-negotiated contractual changes thereafter. Nor are they obliged to offer NHS terms and conditions to employees joining after the initial transfer. The BMA would seek national and/or local recognition with any new, independent sector providers, but this would not be guaranteed.

Premises

- Where practices are not to be subcontracted but directly run or employed by the MCP/PACS/ACO, what will happen to the premises and mortgage? These could be taken on by the new organisation but consider the difficulties in reversing such a decision. The new organisation may also wish to rent GP-owned premises.

Medical indemnity

- Are there any implications for GP indemnity? Depending on the employment arrangements the position regarding NHS indemnity will vary. NHS England is considering how indemnity will work in the new provider organisations. As a general rule, when undertaking work for any organisation beyond or instead of a current role, GPs should contact their defence society or other insurer for confirmation as to whether or not the work you are planning to undertake is covered.

Other considerations

- Will any new organisation be an independent-sector or NHS employer?
- Are there any implications for NHS pension eligibility? Be careful here. NHS England is working to find solutions to support new organisations. Current rules may not be so flexible eg at the moment staff employed by subcontractors can't access the scheme
- Where GPs are shareholders in the lead provider, what are the implications for the doctor-patient relationship, (perceived) conflicts of interest etc?

- Is QOF being replaced by an alternative scheme? What are the implications for return to existing contractual arrangements? What are the benefits/drawbacks of such a scheme?
- What say will practices have on who they must register/treat? What are the arrangements for unregistered payments, practice boundaries etc?
- Has any new contract been legally scrutinised for policy changes on traditionally contentious issues including record-sharing, patient charging, gagging clauses and registration etc

For more information about the Five Year Forward View and new care models, visit the BMA website www.bma.org.uk/5yfv