Pre-ARM briefing 2019:
Integrated care models and employment rights

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Pre-ARM Briefing 2019: Integrated care models and employment rights

This briefing provides background information on the drive towards better integration of health and care services across the UK and an overview of how this shift might affect doctors’ employment rights.

1. Introduction

All of the UK health services have had varying degrees of integration for some time, but across each of them there is now a renewed focus on providing health and care as a system rather than within fragmented structures.

Integration has the potential to lead to better and more joined-up patient care. In particular, it could help ensure a more joined-up approach for the growing number of people living into old age with multiple long-term conditions, ensuring they receive the best care from a multi-disciplinary team. Integration has the potential to make life easier for doctors too. In an all-member survey carried out by the BMA in 2018, 73 percent of doctors said that organisational barriers between primary and secondary care increase costs and bureaucracy, 60 percent said that those barriers compromised the quality and safety of patient care, and 57 percent said that organisational interests take priority over patient care.

However, while integration is welcome in theory, making it work in practice is more difficult. National attempts to deliver integration have often, particularly in England, failed to properly engage doctors in their development. There is also a lot of uncertainty about what the terms of employment for doctors would be working in these new models that may require mobility between different employers and different care settings. This briefing summarises what is happening across the UK and what this might mean for doctors and their terms and conditions.

2. Key developments in each UK nation

2.1 England

In 2016, England was divided into 44 individual health and care systems – referred to as STPs (Sustainability and Transformation Partnerships). NHS bodies, local authorities, and third sector providers within these areas were tasked with collaboratively planning the future of health and care services in their area. Since then the emphasis has moved from simply planning across the STP area towards co-ordination and delivery of services at a system-wide level. This has led to the development of ICSs (Integrated Care Systems), which are more advanced or ‘mature’ versions of STPs.

ICSs are meant to lead to greater integration without major contractual changes. The ICS model was launched in 2017 and there are currently 14 ICSs in place across the country. NHS England’s Long Term Plan, launched in January, has now set out a formal expectation for every area in England to be covered by an ICS by 2021.

ICSs are about collaboration rather than contractual change. They aim to deliver more co-ordinated care and collaboration between staff and organisations throughout the system. In an ICS, NHS bodies, local authorities, and third sector organisations jointly make strategic decisions about: the use of resources, service design, and population health across their footprint. As a reward for doing so, ICSs receive increased freedoms and powers – including greater control over the finances of their system.

As of February 2019, the 14 ICSs in England are: South Yorkshire and Bassetlaw; Frimley Health and Care; Dorset; Befordshire; Luton and Milton Keynes; Nottinghamshire; Lancashire and South Cumbria; Berkshire West; Buckinghamshire; Greater Manchester (devolution area); Surrey Heartlands (devolution area); Gloucestershire; West Yorkshire and Harrogate; Suffolk and North East Essex; North Cumbria.
To make an ICS work, the individual member organisations sign an alliance agreement, underpinned by a memorandum of understanding. The agreement overlays (but does not replace) regular commissioning processes and contracts. This means that the development of an ICS does not necessarily require major structural or legal change. This also means that, unlike other models of integration, an ICS does not present an increased risk of privatisation as contracts remain with current contract holders and will not need to be formally tendered.

ICSs work on three key levels. At the ‘system’ level, work is focused on partners working together to set strategy, finance, workforce planning, and agree overall levels of integration. At ‘place’ level – normally based around towns within a system - work centres on the planning of localised services and the delivery of secondary and community care. The smallest level – the ‘neighbourhood’ – is based around PCNs (primary care networks), groups of GP practices covering populations of 30,000 – 50,000 people and will heavily involve the use of other professionals in MDTs (multi-disciplinary teams). CCGs will continue to play a major role in these structures; however, the long-term plan announced NHS England’s intention to reduce the number of CCGs to one per ICS footprint.

ICPs involve the merger of providers and integrate care under a single contract

ICPs represent another model of integration and were also introduced in 2017. They evolved from the MCP (multi-specialty community provider) and PACS (primary and acute care systems) models developed in the Five Year Forward View and were previously known as ACOs (Accountable Care Organisations).

The creation of an ICP involves major structural and contractual change, with a single provider taking on a single contract for the majority of health and care services in an area. ICP contracts are tendered for at least ten years and the holder, while responsible for the provision and integration of services, may not deliver all the services itself; it could instead hold sub-contracts with other providers. NHS England expects ICP contracts to be awarded to statutory public bodies, which would likely entail existing NHS trusts merging to form a single provider organisation. Yet, under existing competition law, a private provider would be able to bid for any ICP contract during the procurement process. However, this may change. To support integration, NHS England has now called for legislative change in the NHS Long Term Plan to reverse some of the competition reforms instituted by the 2012 Health and Social Act which, if implemented, would mitigate this issue.

The services covered by an ICP are likely to include secondary care, community care, mental health, public health, social care, and aspects of local authority care provision. The extent to which primary care services are included in an ICP contract will depend on the degree of GP involvement and the model of ICP that commissioners choose to pursue. There are two potential models of an ICP, a ‘fully integrated’ model or a ‘partially integrated’ one. In a fully-integrated ICP all services will be procured in a single contract, including core general practice. A fully integrated ICP would therefore entail radically altering the current model of general practice and would be incompatible with GPs independent contractor status. In a partially integrated ICP, a single contract will cover all ‘in-scope’ services, apart from core general practice. While a partially integrated model would allow GP practices to retain their core contracts, any primary care services outside of that may fall under the scope of the ICP, potentially limiting the services practices can be paid to provide.

The ICP contract has been subject to consultation and, as of the publication of the NHS Long Term Plan, is now available for health and care systems to pursue if they wish to. Dudley is currently the only area actively developing an ICP, with plans to have awarded an ICP contract (to an NHS body) by April 2020, a year later than originally planned by the CCG.

Due to the implications of an ICP contract on general practice and the increased risk of privatisation they currently present, the BMA has been highly critical of the model and opposes its introduction in England.

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b An ICS ‘alliance agreement’ is a single, overarching agreement between commissioners and providers which establishes a common strategy, sets joint goals, and establishes a commitment to collaboration, but does not necessitate any organisational integration.
2.2 Northern Ireland

Starting from an integrated system, Northern Ireland is now moving towards further integration

Integration is not a new innovation in Northern Ireland, where health and social care services have been formally integrated since 1973. However, over time, reforms to this long-standing model have been proposed with a focus on providing care within systems, rather than organisations. In 2011, for example, the Transforming Your Care review identified integrated care as a major principle for change. This led to the creation of ICPs (Integrated Care Partnerships) in 2013, which brought service providers together in 17 different localities to collaboratively design and co-ordinate the delivery of health and social care services.

Subsequently, further reforms to integrated care have been called for. In October 2016, a 10-year approach to transforming the health and social care system in Northern Ireland, Health and Wellbeing 2026: Delivering Together, was launched. The strategy builds on the findings of several reports on health and care from the past 15 years, including Professor Rafael Bengoa’s October 2016 report: Systems, Not Structures - Changing Health and Social Care, that recommend a shift towards more primary and community-based care to best meet the needs of individuals and relieve system pressure.

This has led to proposals to introduce ACSs, the roll out of elective care centres and MDT teams

Health and Wellbeing 2026 focused on the need for clinically-informed reform and service reconfiguration to deliver better health outcomes, improve conditions for frontline staff, and secure the financial sustainability of the health and care system. This included proposals to introduce new local ACSs (Accountable Care Systems). Each ACS would have a shared leadership model, designed to support collective responsibility from providers, and would be bound by agreed quality outcomes and clear budgets. They have been envisaged as a means of enabling flexible, responsive care based on local needs. It is yet to be determined, however, whether the ACS model would replace ICPs – although the BMA has consistently highlighted the need for clarity on this issue.

The availability of comprehensive and reliable data has been recognised as a problem in delivering both system transformation and improvements in population health. Better information gathering, data sharing, and analytics are recognised as requirements to enable better and more accurate population health management.

The roll out of prototype elective care centres for day-case surgery was also announced in late 2018. Five centres are now in place and undertaking treatment of cataracts and varicose veins, with the expectation that they will inform the development of further centres for a wider range of treatments. The Department of Health believe this new way of working will increase productivity, reduce the risk of cancellations and address waiting lists in Northern Ireland. An MDT initiative was also announced by the Department of Health in May 2018 as part of a £15m transformation fund allocated to primary care. MDTs within GP practices are initially being piloted in three of the 17 GP Federations in Northern Ireland (Down, Derry/Londonderry, and West Belfast), providing practice-based physiotherapists, mental health specialists and social workers to better meet local needs. This is in addition to investment in practice-based pharmacists across Northern Ireland.

Investing in the workforce is a priority in Northern Ireland, with effective workforce engagement recognised as being a key component to successful long-term transformation.

2.3 Scotland

Closer joint working between health and social care has been a Scottish Government priority for the past 15 years. The focus of the integrated model in Scotland is on prevention, early intervention and supported self-management through high quality, seamless service provision.
Having established a legislative framework for integration, the focus is now on better, local care

In 2014, the Public Bodies (Joint Working) (Scotland) Act moved this further forward, providing the legislative framework for the integration of health and social care service in Scotland. This led to the creation of joint Health and Social Care Partnerships (HSCPs) across Scotland, with the aim of providing an integrated health and social care service nationwide.

Most recently, the Scottish Government published its Health and Social Care Delivery Plan in December 2016. This established a range of priorities for integration, as well as goals to support the improvement of health and care provision, within an overarching aim of supporting the people of Scotland to live longer, healthier lives at home or in homely settings, with person-centred and high-quality care.

This included a focus on strengthening general practice, with a commitment to increase spending on primary and GP services by £500m per year by 2021, as well as investment in the expansion of the primary care workforce – including recruiting more GPs and increasing access to pharmacists in GP practices. Increased capacity planning for adult social care has also been prioritised, with early work including reform of the National Care Home Contract, a focus on social care workforce issues, and new models of home-based care and support. This is part of a wider shift towards more aligned workforce planning across health and social care, at national, regional and local levels.

Alongside this, there has been a key shift to planning care at a regional level

In addition, there has been a key shift to the regional planning of services, involving the development of RDPs (Regional Delivery Plans) for three NHS Scotland regions – East, West, and North. This is intended to enable better local planning and delivery of services based on the needs of particular regions. By 2020, the Scottish Government also aims to have joint public health partnerships in place between NHS Scotland, local authorities, and others to set national public health priorities and drive forward local, regional and national action to address the issues – the intention is to ‘mainstream’ a joined-up approach to public health at a local level.

The Scottish Government recognises that in the long term, a fundamental change in how health funding is allocated in Scotland is required, if the aim of shifting the balance to primary and community care while supporting service redesign in secondary care is to be achieved. A short-term priority is to create more capacity in general practice, but workload reductions are yet to be realised.

2.4 Wales

There are plans for health and social care becoming more integrated

The drive towards health and social care integration in Wales has recently gathered pace. In January 2018, a Parliamentary Review of Health and Social Care in Wales published its final report – A Revolution from Within: Transforming Health and Care in Wales. The report recommended one seamless system for Wales, whilst recognising that health and social care in Wales are separately planned and funded.

In October 2018, NHS Wales published a plan in response to the report: A Healthier Wales: Our Plan for Health and Social Care. This sets out a long-term future vision of a whole system approach to health and social care, with greater emphasis on preventing illness and supporting people to manage their own health and wellbeing throughout their lives.

A National Transformation Programme has also been established, with responsibility for delivering and reporting on progress towards the various commitments in the plan, with a focus on early impact in 2019-2021. This Programme is being led by the Director General of Health and Social Services and is supported by a National Transformation Board. Delivery of the plan will also be supported by a £100m transformation fund, which is intended to support the development of new models of health and social care provision.
New models of provision are being developed, supported by new regulatory processes, new funding pathways and better planning across the health and social care workforce. Specific examples of integration in development include the strengthening of RPBs (Regional Partnership Boards, established by the Social Services and Well-being (Wales) Act 2014), which bring together health boards, local authorities and third sector providers to act as drivers of change at a local level, and to provide strategic oversight and coordination. Primary care clusters are also continuing to develop models of seamless partnership working. There are 64 clusters across Wales, comprising neighbouring GP practices and partner organisations providing services for 30,000 to 50,000 people. £68 million in capital funding will be invested in new health and care centres across Wales too, with the aim of encouraging initial transformation.

Regulatory processes are also changing to support system-wide working. Under the plan, the Healthcare Inspectorate Wales and the Care Inspectorate Wales will jointly examine the progress of new local models of health and social care to establish their effectiveness. To support integrated performance management and accountability, it is proposed that by 2020 there will be a single national outcomes framework for health and social care aligned to the Quadruple Aim, and joint inspection, pooled budgets and joint commissioning.

Funding pathways will also be altered. By the end of 2019, a method of tracking how resources are allocated across the whole system in Wales will be developed, including through pooled budgeting arrangements. A review of capital and estates investment will also be carried out over the same timescale, to identify future need and the full range of assets that can be used to drive service change, taking into account the longer-term shift towards primary and community care.

In respect of workforce, by the end of 2019 a new Workforce Strategy for Health and Social Care in Wales is expected to be developed. This will include planning for new workforce models, strengthening prevention, supporting diversification across the wider workforce, and aligning recruitment across the health and social care sectors. A new organisation, HEIW (Health Education and Improvement Wales) became operational in October 2018 and is responsible for the development of the entire health workforce, include strategic planning. In an effort to improve communication between care sectors, a Welsh Health Circular issued in May 2018 established a set of All Wales Standards for Communication between Primary and Secondary Care, with the approval of the BMA Welsh Council.

3. Implications of these changes for members

Integration has the power to break down barriers between services, improve patient care, and promote collaboration over competition. Therefore, efforts to improve integration across the UK could, if done well, present real opportunities for doctors.

Integration could help doctors to work collaboratively, beyond traditional roles.

The focus on providing care within systems, rather than individual organisations, should create greater opportunities for doctors to work together across traditional boundaries and build stronger relationships. The chance for GPs to work in A&E departments or consultants to work in the community, as well as the use of MDTs, will allow doctors from primary and secondary care to collaborate more closely and communicate more effectively. Similarly, the development of PCNs (Primary Care Networks), GP clusters and other models of general practice at-scale will see GPs working across a wider local network and practices supporting each other more formally, with the aim of improving practice resilience and overcoming workforce challenges.

c The quadruple aim is a commitment to:
1. Improve the experience and quality of care for individuals and families
2. Improve population health and wellbeing through a focus on prevention
3. Enhance the wellbeing, capability and engagement of the health and social care workforce
4. Achieve better value from health and social care funding by reducing the per capita cost of healthcare
Doctors could take a lead on transforming their health and care system(s)
The integration agenda may also present opportunities for doctors to take a lead in changing their local health and care systems and in designing new services and care pathways for patients. For example, NHS England has stressed the need for clinical leadership within emerging ICSs and has called for greater engagement of doctors in transformation programmes.

Patient care can benefit from effective integration, if given proper time and funding
If based on proper clinical leadership and given funding and time to develop, integration can also have significant advantages for patient care, particularly for patients with long-term conditions. If services can be better co-ordinated and joined-up there are genuine opportunities to ensure that patients receive the right care in the right service, to improve outcomes and, thereby, hopefully reduce pressure on beds, A&E departments, GP practices, and doctors themselves.

Doctors’ terms and conditions could be affected by integration and system-working, as staff are expected work across wider areas and multiple sites
System working does have wider implications for clinicians, however, particularly if existing structures are subject to change. Doctors are likely to be increasingly expected to work across multiple sites or, in cases of service reconfiguration, face changes to their place of work or employer. In these cases, it is essential that doctors’ pay and conditions are protected. The staff portability and employment rights section of this briefing addresses these issues in greater detail.

So, if any of the efforts currently underway across the UK are to succeed, there are several key criteria they must meet. Any efforts to integrate the health and care system must:

1. only be pursued with demonstrable engagement with frontline clinicians and the public and must allow local stakeholders to meaningfully and constructively challenge their plans
2. be given proper funding and time to develop, with patient care and the integration of services prioritised ahead of financial imperatives and savings
3. protect the partnership model of general practice and GPs’ independent contractor status
4. ensure the pay and conditions of all NHS staff are fully protected
5. be operated by NHS bodies, free from competition and privatisation

Currently not all of the models being proposed across the UK meet these criteria. One example of this is the ICP model in England. However, other models and approaches do not present the same risks and, providing they adhere to the above criteria, are potentially compatible with BMA policy.

4. Staff portability and employment rights
The shift toward system-wide working and workforce planning may significantly change the way doctors work. The co-ordination of care across wider areas will increasingly involve doctors working across multiple sites and as part of multi-disciplinary teams, including GPs working in A&E departments and consultants working in the community. In theory, this could give doctors from all branches of practice the chance to work in different environments and more closely with colleagues across primary and secondary care, something which has been identified as way to improve patient care by our members.

Yet, this could also mean that doctors’ places and patterns of work may change significantly. Passporting systems may need to be introduced to allow doctors to work throughout sites across the whole system. In addition, where mergers do take place contracts may be transferred to other Trusts via TUPE (Transfer of Undertakings (Protection of Employment) Regulations). It is essential that doctors are fully and meaningfully consulted in any of these processes, and that their conditions of employment are protected.
A number of different options for staff portability may be proposed by employing organisations, including the following:

**Joint employment**
A doctor can be employed by two separate organisations at the same time provided there is nothing in their contract with the first employer which would prevent them from agreeing the second employer’s terms of employment. In this arrangement the doctor has two contracts of employment and the two employment relationships continue in parallel with each other. A good example of this is the nationally agreed Honorary Consultant Contract (England) which allows for clinical academic consultants to have joint employment.

Joint employment may be a more suitable arrangement where the doctor will be working for the second employer for an indefinite period and the nature of the engagement between the doctor and the second organisation has the characteristics of a standalone employment contract.

**Secondment**
Secondment refers to an agreement between an employer and a second organisation (referred to as the host) for a worker (or group of workers) to be assigned to the host for a limited period. The employer and the host usually intend for the worker(s) to return to work for the employer at the end of the secondment period. Workers can also be seconded to work in different parts of the same organisation. The reasons for a secondment may include:
- the chance for an employee to gain new skills and experience;
- applying existing skills or experience in a different part of the organisation;
- preserving specific employee benefits with the original employer, such as membership of a pension or share option scheme;
- building links with other organisations;
- providing staff cover for short-term projects or short-term absences;
- avoiding redundancies;
- charitable purposes (where the secondment is to a voluntary organisation).

Secondments require an agreement between the employer and the host which clarifies the legal rights and responsibilities in the relationship. Where the secondment is to an entirely separate organisation, the employer and the host are likely to need a detailed secondment agreement that is clear on how the secondment works with the employee’s existing terms of employment.

**License to attend**
A license to attend gives a worker permission to attend another organisation’s premises. Licenses to attend in the context of employment will only usually be suitable in very limited circumstances, for example where the placement is very short term and or where the worker has very limited functions to perform that do not interact in any complex or risk-related way with the employer’s normal operations.

**Honorary contracts**
Honorary contracts are used when an individual is employed by an organisation and is then asked or expected to work at another organisation either temporarily or for part of the working week. Traditionally, honorary contracts have been used to allow clinical consultants from one organisation (including universities) to access another NHS organisation’s facilities in order to see patients or to allow research to be conducted. An honorary contract is not intended to result in any payment obligations between the individual and the host employer, though there will be between the employer and the host and the precise arrangements for meeting on-call or out of hours costs can vary. It is usual and sensible to ask the individual to respect the specific policies and procedures of the Host. In the case of a clinical academic arrangements should be put in place for the joint management and appraisal of the individuals concerned. The host would also be expected to assist with the appraisal and revalidation of other doctors working for it under honorary contracts. As honorary contracts are commonly used for clinical attachments, clinical indemnity provisions will usually be included. The termination of honorary contracts should be done in discussion with the employing organisation.
It is vital that where any of the above arrangements are proposed they are agreed in consultation with the doctors affected and their trade union representatives, and that they are completely clear as to where legal employment responsibilities lie. A wide range of related issues such as arrangements for travel to other worksites, data transfers, indemnity, pre-employment checks and IT access for example will need to be considered as part of these arrangements.

There are a range of existing portability arrangements in place for doctors, in particular to allow trainees to rotate frequently between different employers for training placements and for medical academics to split their work between NHS and university employers. Such existing arrangements should not be superseded or amended by new portability plans for all staff, and it is important that the unique working patterns and contractual arrangements for doctors are protected.

5. Issues to consider

This briefing has highlighted key developments in the drive to integrate health and care across the UK, with the goal of informing members ahead of the 2019 Annual Representative Meeting. There are a number of issues the representative body may wish to consider when drafting motions:

– What forms of integration or system-working do doctors want to see?
– How should clinicians be engaged in the planning and delivery of models of integration?
– What legislative changes would make models of integration more appropriate?
– What should BMA policy on staff portability and working across systems be?
– Which, if any, options for portability between different employers would work best for doctors, and which may pose risks?

When submitting any motions representatives may want to bear in mind that:

– Approaches to integration vary between UK nations and UK-wide policies may need to reflect this
– In England, that there are key differences between ICSs and ICPs