

## New models for delivering care

### Practical implications for doctors

Guidance for consultants, general practitioners, junior doctors and SAS doctors

---

#### Introduction

This series of briefings is designed to help members understand the different models of care that are emerging in the NHS in England, their associated contractual and payment models and the practical implications for doctors.

Providers of acute, community and primary care tend to operate separately at present. But increasing emphasis on new, integrated models of care across the sectors, and greater networking within sectors, has the potential to change the provider landscape over time. Be informed.



## Practical implications for doctors

### Guidance for consultants, general practitioners, junior doctors and SAS doctors

NHS England's scale of ambition regarding new care models is for 50% of the population to be covered by an MCP (multispecialty community provider) or PACS (primary and acute care systems) by 2020. All areas have set out how they are planning to implement these models in local STPs (sustainability and transformation plans). However, the actual scale of change that we will see across the country is still unknown. It will almost certainly vary from area to area and over time, and depend upon the specific model or arrangements put in place. See our accompanying [briefing](#) for more information about the models.

#### Contracts and employment

If your employer or GP practice is part of a site testing a new care model (MCP or PACS in particular) or has plans to develop one, this may affect your contract/employment.

#### Consultants, junior doctors and SAS doctors

Traditionally, the majority of consultants, SAS doctors and junior doctors are employed by an NHS trust and undertake the majority of their work for their main employer, usually in the hospital setting. With the five year forward view's ambition to break down traditional divisions between primary, secondary and community care, an increasing number of doctors could be employed by different organisations to provide services in a different way.

There are a number of ways in which you could be engaged to undertake services on behalf of one of the newly-emerging providers of care. The main potential changes are listed here and set out in further detail below.

- No change to current job plan, employer or contract
- Change to job plan to facilitate a shift in where you see/treat patients
- Direct employment by the new organisation, including transfers following an organisational merger
- New private practice arrangements with the new or lead organisation
- New 'chambers' arrangements where you and others contract with the new or lead organisation as a single entity, in addition to or instead of your existing employment contract

#### Changes to your job plan

Depending on the model that develops in your area, it is possible that your existing job plan or work schedule could be amended to reflect a different way of working. For example, you may agree to work one PA (programmed activity) a week for another employer at a different site run by your NHS employer. Alternatively, your NHS employer might arrange for you to spend one PA a week working for another organisation which has won a contract to provide care. This type of change to your working pattern could be agreed through the job planning process without the need for any substantial change to your contract. Further information on job planning is available [here](#).

#### Direct employment

You could be employed by the new organisation directly. Contracts are likely to vary between providers, and it is likely that you could be offered a contract that is not the national 2003 consultant contract, 2008 specialty doctor contract, or 2002 or 2016 junior doctor contract. In such circumstances, it is vital that you establish the differences between the contract you are offered and the nationally agreed contracts. The terms may be better or worse, but it is extremely important that you understand what you are signing up to in advance. We would strongly recommend that you contact the [BMA's contract checking service](#), which is free for BMA members, to assist with this process.

External organisations, or new organisations formed by mergers, may take on the provision of a service previously provided by your employer, and which you have been employed to undertake. In these circumstances TUPE (Transfer of Undertakings (Protection of Employment) Regulations) may apply, in which case your contract of employment would be transferred to the new organisation. This usually 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. Please see Annex 1 for a general guide to the TUPE process.

### **Private practice arrangement**

It may be that you have the opportunity to undertake sessions for one of the new organisations as an individual on a private basis. Please be aware that any arrangement must be in line with the [code of conduct for private practice](#) and the [BMA's advice on private practice for consultants and SAS doctors](#).

### **Alternative methods of employment, eg the chambers model**

If there is appetite amongst your colleagues, you may find that locally you are able to explore other ways of being contracted to undertake work for one of the emerging care providers, for example via the chambers model. Under this model, you and other involved parties could work together to provide services for one of the new organisations, under a contract as a single entity ie as the chambers.

### **General practitioners**

The main potential changes to contracts and employment for GPs are summarised below. For more detailed information please see the BMA's [Focus on the MCP contract](#) (which will also largely be relevant to the PACS contract, due to be published in 2017).

- No change (no new care model being implemented in your area)
- No change (no new care model being implemented in your area), but practices may establish or strengthen collaborative relationships (eg in the form of federations or super-practices)
- New overarching 'alliance agreement' between the MCP/PACS partners, in addition to practices' core (GMS/PMS/APMS) contracts (virtually integrated model)
- New MCP/PACS contract, in addition to practices' core contracts (partially integrated model)
- Single contract held by the MCP/PACS leading to the loss of practices' individual core contracts (fully integrated model), under which:
  - new organisation subcontracts general practice provision to individual practices or super-practices; OR
  - new organisation runs local practices directly, either as individual units or as super-practices; OR
  - new organisation employs GPs to provide primary care; OR
  - new organisation uses a combination of these approaches.

It is important to note that the contractual options outlined above are voluntary. NHS England have also proposed that practices giving up their core contracts under the fully integrated model will have a right to return to their original contract, should they wish to, at an agreed point in time every two years. However, in reality, there are a number of issues which put into doubt the practicality of doing so. For example, the right of return does not apply to local enhanced services and practice premises may have changed hands. Practices should ensure they are fully informed before making any decisions, and should not feel pressured into doing so.

For individual GPs, the implications will vary according to your current employment status, the option chosen by your practice and (in reality) the option chosen by practices in your locality. Current GP partners could retain their partnership, continue it as part of the new MCP/PACS organisation, or become sessional GPs. Current sessional GPs could continue working on a salaried or locum basis at their existing practice(s) or a new practice or organisation. There may also be opportunities to become a GP partner. Sessional GPs, who are permanently employed by a practice that gives up its core contract, could be transferred to a new organisation; in this case TUPE may apply. Please see Annex 1 for a general guide to the TUPE process. In any case, GPs employed within an MCP need to be clear about their role and terms of employment.

### **Pension implications**

The Department of Health and NHS England are working closely with the administrator of the NHS Pension Scheme, based on the general principle that: where existing pensionable activity is being delivered by the same teams, but potentially through different organisational or contractual forms, access to the NHS Pension Scheme should be maintained. You may, however, wish to speak to the [BMA Pensions Department](#) prior to accepting any new contract with a provider.

Rules are being amended to allow income derived from a MCP/PACS contract to be pensionable. GPs moving to become employed in a new MCP/PACS organisation will therefore have access to the NHS Pension Scheme on the same terms as other employees. This will be the case no matter whether the organisation is a public or independent sector entity.

There is also an in principle agreement to allow access to the NHS Pension Scheme as a sub-contractor when an NHS Standard or MCP Sub-contract is used. These changes, however, are not yet in place and are subject to public consultation in 2017.

### Workforce

All areas will be developing local workforce strategies as part of the STP process; sites that have been piloting the new care models should be further ahead in their thinking.

### New professional roles

It is likely that many areas will introduce new or extended roles for doctors and other health professionals. Examples include 'generalist' consultants (or 'hospitalists'), physician associates, advanced clinical practitioners, care navigators and community care practitioners. NHS England and Health Education England will support this process by producing 'common skill descriptors and job descriptions'.

### Workforce redesign

Organisations will need to design an effective integrated workforce that builds on existing professional roles, skills mix, leadership and working arrangements. As multi-professional teams develop and cross-system collaboration replaces traditional ways of working there are likely to be both cultural and practical implications that will need to be addressed locally.

### Leadership

NHS Improvement published a [national framework for leadership development](#) that aims 'to equip and encourage people in NHS-funded roles to deliver continuous improvement in local health and care systems and gain pride and joy from their work'. The framework guides leaders at all levels to develop a critical set of improvement and leadership capabilities including:

- **Systems leadership skills** for leaders improving local health and care systems, whether through sustainability and transformation plans, vanguards, or other new care models.
- **Improvement skills** for staff at all levels in their operational performance, staff satisfaction and quality outcomes.
- **Compassionate, inclusive leadership skills** that create just, learning cultures where improvement methods can engage colleagues, patients and carers, deliver cumulative performance improvements, and make health and care organisations great places to work.
- **Talent management** to fill current senior vacancies and future leadership pipelines.

### Clinical engagement

It is essential that new care models engage the workforce in a meaningful way so that doctors and staff at all levels feel that they have been involved. There needs to be a commitment to full consultation with clinicians, patients and the public on any proposed changes as early as possible. This is particularly important as there is no legal or clinical accountability within the STP process.

### Appraisal and revalidation

All doctors are required to have an annual appraisal and be revalidated every five years, and you must ensure that any work that you undertake for a different organisation can be evaluated for these purposes. The BMA, in conjunction with the Independent Healthcare Forum, has produced [guidance](#) on this for doctors engaged partly or exclusively in the independent sector.

### Medical indemnity

In a fully integrated MCP/PACS (one that includes core general medical services) GPs and practice staff will also have their indemnity cover paid for or reimbursed. GPs should check with their previous indemnifier, however, to see if they are required to pay individual 'run off costs to provide continued protection for the period prior to joining the MCP'. As with doctors working in secondary care, some GPs may need to continue to pay for personal indemnity arrangements to cover them for any activity not linked to the provision of services on behalf of the MCP – whether they do will depend on the particular indemnity policy covering the MCP. For more information see our guidance on [NHS medical indemnity](#).

In a virtual or partially integrated MCP/PACS, GPs would not generally make any changes to the way in which their clinical indemnity is purchased. Similarly, where a practice continues in its current form as a sub-contractor to an MCP, it will likely continue on existing indemnity arrangements.

NHS England and the Department of Health will work with the NHS Litigation Authority to provide information to potential MCP providers on their options of securing and providing cover. The type of clinical negligence indemnity options available for the MCP will depend on its organisational form, but the type of cover – provided by the clinical negligence scheme for trusts (CNST), medical defence organisations or insurance brokers/providers – will not impact on the obligation for all employees to be covered.

### Reconfiguration and provider sustainability

One aim of the MCP and PACS models is to shift patient care from acute to community settings, where appropriate. This is something that almost all areas will have considered as part of the STP (sustainability and transformation plan) process, and more detailed plans for service reconfiguration are likely to emerge on the back of this process. The scale and focus of these plans will vary by area, but many will be looking to develop one or more new models of care.

Shifting care into the community could impact upon the sustainability of some partners within the MCP/PACS, or other neighbouring providers. In time, the volume of care delivered by a particular provider, and therefore the level of income they receive, may decrease, and they may not be able to reduce costs proportionately.

NHS England and NHS Improvement have also designed a new integrated support and assurance process. It is designed to safeguard the sustainability of the local healthcare system and ensure that providers are able to take on the risks associated with the proposed MCP/PACS contract.

While some disruption and destabilisation is inevitable as new integrated provider models emerge, this should be carefully planned and monitored by commissioners and providers to ensure that there are no major unintended consequences for doctors, other NHS staff and patients alike.

### Structural and cultural change

For the new care models to work, there will need to be significant changes in the culture and relationships within and between partners delivering the model. If structural integration – where partners merge to form a new organisation – becomes the main or only focus, evidence suggests that this will be insufficient to achieve better coordination and integration of services.<sup>1</sup> Furthermore, the available evidence does not support any one organisational form (eg social enterprise, staff-owned mutual, limited company etc) over another in terms of performance in the NHS.<sup>2</sup>

### Further information and advice

We have produced a range of briefings which explain the new care models in more detail, including the evidence base behind them and the contractual and payment models that will support them. You can find these briefings on the [BMA website](#). We have also produced specific guidance on the [draft MCP contract](#).

To help us monitor developments and shape our support for members, we are using our networks to gather intelligence locally. If you are involved in an area developing a new model of care we would like to hear from you: [contact us](#).

Alternatively you can use the [regional integration map](#) on the BMA website or speak to a BMA regional services coordinator to find out more about what is happening in your area:

North West England	Tbc	<a href="mailto:inbox.northwestcentre@bma.org.uk">inbox.northwestcentre@bma.org.uk</a>	0151 702 8419
North East, Yorkshire & Humberside	Ursula Ross	<a href="mailto:uross@bma.org.uk">uross@bma.org.uk</a>	0113 261 8302
East Midlands	Jim Stringer	<a href="mailto:jstringer@bma.org.uk">jstringer@bma.org.uk</a>	0113 261 8300
West Midlands	Alan Roberts	<a href="mailto:aroberts@bma.org.uk">aroberts@bma.org.uk</a>	0151 702 8408
East of England	Nigel Mason	<a href="mailto:nmason@bma.org.uk">nmason@bma.org.uk</a>	0208 655 8805
London	Andrew Barton	<a href="mailto:abarton@bma.org.uk">abarton@bma.org.uk</a>	0208 655 8863
South East Coast/South Central	Hugh Townsend	<a href="mailto:htownsend@bma.org.uk">htownsend@bma.org.uk</a>	0208 655 8804
South West	Sean Cusack	<a href="mailto:scusack@bma.org.uk">scusack@bma.org.uk</a>	0117 945 3101

For advice about your contract or employment status, BMA members can call 0300 123 1233 or email [support@bma.org.uk](mailto:support@bma.org.uk).

### References

- 1 Ham C (2010). *Clinical and service integration: the route to improved outcomes*. The King's Fund.
- 2 Bramwell D (2014). *Moving Services out of hospital: Joining up General Practise and community services?* London School of Hygiene and Tropical Research, University of Manchester and the Centre for Health Services Studies at the University of Kent.

## Annex 1: TUPE

External organisations, or new organisations formed by mergers, may take on the provision of a service which has previously been provided by your employer, and which you have been employed to undertake. In these circumstances, it is possible that TUPE (Transfer of Undertakings (Protection of Employment) Regulations) would apply and your contract of employment would be transferred to the new organisation, but clearly this will depend on the specifics of the situation.

If you are informed that your contract of employment may be transferred to a new provider, you should seek advice from the BMA immediately. Please see the following general points as a guide to the process.

### What is TUPE?

TUPE is a piece of legislation which protects employees' terms and conditions of employment when a business or function is transferred from one organisation to another. If TUPE applies to a particular transfer, employees of the previous organisation automatically become employees of the new employer on the same terms and conditions. It is as if their employment contracts had originally been made with the new employer. Their continuity of service and any other rights are all preserved.

Both old and new employers are required to inform and, if appropriate, consult with recognised trade unions or elected employee representatives (if there is no recognised union) in relation to any of their own employees who may be affected directly or indirectly by the transfer.

### What are the limits of TUPE protection?

When TUPE applies it will protect the terms and conditions of employment of the transferring employees. Given the legal complexities, it is not always clear when TUPE does and does not apply. If you are informed that your contract of employment may be transferred to a new provider, you should seek advice from the BMA immediately.

Even when TUPE does apply there are some respects in which an employee may still consider that their position has been compromised, for example their place of work may change, potentially to somewhere that is not convenient for the employee. There are certain circumstances under which a new employer is entitled to introduce changes to employees' terms and conditions following a TUPE transfer. The BMA can advise on this situation should it arise.

An employee also does not necessarily have the entitlement to the same occupational pension following a TUPE transfer – however the employee should be given an at least broadly comparable pension when they are transferring to another public sector organisation.

Following a TUPE transfer 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.