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Contractual issues for GPs

Guidance for GPs

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Chapter 1: Introduction

At a recent meeting, the GPC in consultation with the Small Practice Association (SPA), agreed to produce guidance on best practice and options in relation to a contractor who is an individual medical practitioner and their retirement. This was in response to a primary care trust (PCT) that had developed a blanket policy not to replace single-handed vacancies with single-handed practitioners. Although the guidance is geared towards single-handed GP issues, many of the contractual issues raised in this guidance are relevant to GPs in general. Information on practice mergers and advertising of vacancies is also included.

When a contractor who is an individual medical practitioner resigns, the primary care organisation (PCO) has an obligation to ensure the provision of primary medical services to that former contractor's patients. The PCO could discharge that duty by entering into a contract with existing or new providers, or deliver primary medical services itself.

Whilst the concept of a statutory vacancy has disappeared, the local medical committee (LMC) (or its equivalent) should be consulted about all proposals in relation to the retirement of a single-handed practitioner, greenfield and brownfield sites. It is also good practice for existing, affected patients to be kept informed[1]. Section 11 of the Health and Social Care Act details the duties placed on healthcare organisations in relation to public involvement and consultation.[2]

[1] Paragraph 5: 'Primary Medical Performers Lists Delivering Quality in Primary Care.' Department of Health
[2] www.opsi.gov.uk/acts/acts2001/10015--b.htm

Chapter 2: Succession and notice periods

Under general medical services (GMS), a retiring contractor who is an individual medical practitioner must give three months notice of termination of the contract to the PCO (GMS regulation 108 (3)[3]. Under personal medical services (PMS), there is provision for the contractor to terminate the agreement by serving notice on the other party but in the regulations the notice period required is highly ambiguous.

Retiring doctors are not responsible for securing the succession of the practice but, if the list is dispersed, the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) should not come into play and the retiring GP will have to make the staff redundant as part of the winding up of the business. Further information on TUPE can be found in chapter 5. In most cases, if the list is moved to another contractor the new practice will take on the staff and will then be responsible for any redundancy or merger issues. When a single handed GP retires the length of time to advertise, short list etc. usually means the PCT takes on the practice temporarily (employs the staff, leases the building and employs a locum). This can be an issue for successors because the PCT will put staff on NHS contracts and this may be at a higher rate of pay with issues for TUPE/redundancy for the successor.

Sometimes a contractor who is an individual medical practitioner will wish to take a partner prior to retirement. This can help to ensure that the retiring GP can return to work after retirement where this is desired. Under GMS, this also helps to guarantee succession and will preserve the practice's MPIG.[4] To do this, the PCO first has to agree that the potential partner is suitable, although if he/she is on the performers list and not subject to conditional removal, this should not be a problem.

Under the regulations, a single-handed practitioner proposing to practice in partnership during the existence of the contract must notify the PCT in writing of:

- the name of the person or persons with whom it proposes to practice in partnership
- the date on which the contractor wishes to change its status as a contractor from that of an individual medical practitioner to that of a partnership, which shall be not less than 28 days after the date upon which it has served the notice on the PCO.

Hence, PCOs must have 28 days notice of a new partner. As set out in the regulations, the PCO, if satisfied that the new partner meets the necessary conditions, should give notice in writing to the contractor confirming that the contract shall continue with the partnership entered into by the contract and its partners, from a date that the PCO specifies (this should normally be the date requested by the contractor).

The new partnership can split under the regulations and the new partner retains the contract if that partner is nominated by the other partner. The contractor must notify the PCO in writing at least 28 days in advance of the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner. This notice must be signed by all of the partners and specify:

[3] NHS GMS contracts (Scotland) regulation 96, NHS GMS (Wales) regulation 106, Health and Personal Social Services GMS regulations (Northern Ireland) 100.

[4] New practices are not entitled to an MPIG although it is possible for the PCO to pay an equivalent to the MPIG to a new practice under section 28Y. If practices merge MPIGs merge, if they split and there is a transfer of patients, there is a sharing of the MPIG (SFE 3.15).

- the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner
- the name of the medical practitioner with whom the contract will continue, which must be one of the partners.

A partnership constituted with a view to the original single-handed practitioner retiring would therefore need to be in existence for at least 28 days before it reverted to a single-handed practice. It is recommended that advice be sought from LMCs. To help demonstrate that the partnership is genuine and ensure the rights of the new partner on the other's retirement, a written partnership agreement should be entered into. Partners will also wish to ensure that, if they wish to, they will be able to rejoin the partnership after retirement. How this is achieved should be detailed within the agreement.

Legal advice suggests that it is possible that a partner could be taken on for a probationary period where after six months either party could terminate the arrangement if it did not work out. If this is written into the partnership agreement then this could be a safeguard regarding liabilities etc. The probationary partner may be paid a fixed guaranteed sum for the period or a lower share of profit.

The arrangements for PMS are different owing to the ambiguity surrounding notice periods for termination and the fact that contracts are held between the PCO and the individual practitioner rather than between the PCO and partnership. Taking on a new partner would be treated as a variation to the contract and the PCO would be under no obligation to agree this, potentially making securing succession more difficult, although a PMS partner need not be a GP, so long as (s)he belongs to one of the list of persons in the Act and is not disqualified on grounds of suitability.

Although at least one of the partners must be a medical practitioner whose name is included in the GP register, other partners may be:

(i) a medical practitioner
(ii) a health care professional who is engaged in the provision of services under the 1977 Act (including general dental practitioners)
(iii) an NHS Employee
(iv) an employee of a PMS or PDS provider (or equivalent in Scotland or Northern Ireland)
(v) an individual providing services under a GMS, GDS, PMS or PDS contract (or the equivalent in Scotland or Northern Ireland).

Chapter 3: Returning to work after retirement

A common scenario is that a retiring GP wishes to make arrangements to return to work in the same practice after retirement. The best way of ensuring that this happens would normally be to take a partner (as above) before retirement. Any arrangements made with the incoming GP in relation to the return of the retired partner may well be based on trust, but written agreements should be entered into where possible.

To retire, a GP must resign from providing primary medical services.

In 2006, the NHS Pensions Agency removed the requirement for a one month break in service for GPs who wished to return to work after retirement.[5] This provided greater flexibility for those GPs who wished to take their NHS pension and return to work in the NHS.

However, there are still conditions which must be met in order for GPs to receive their NHS pension:

- You must take a break of one day from all NHS posts, and
- If you work more than an aggregate[6] of 16 hours a week in the NHS (any home country or the IOM) in the month following retirement your pension will be suspended until either the age of 70 or the GP works less than 16 hours per week for a month. The NHS Pensions Agency states that the onus is on the GP to prove that this condition has been met.
- A GP retiring before age of 60 will have his pension abated to prevent him earning more than that in the average of the 3 years prior to retirement, or, if appropriate his final salary.

GPs should note that they do not need to come off the Medical Performers List in order to access their NHS pension. They simply have to retire from pensionable employment. We advise doctors that the resignation from a list with a new application may leave a period when it is impossible to work.

[5] NHS Pensions Newsletter – Benefits and retirement: www.nhspa.gov.uk/site/Library/Newsletters/TN2006/TN14-2006.htm

[6] 'On aggregate' is intended to encapsulate those doctors who have several posts, for example they work 8 hours in a practice and 8 hours in a PCO, this would aggregate to 16 hours a week in all NHS positions.

The test is a weekly test and there is NO carry over if the hours are under in any particular week. If the 16 hours are exceeded during the first month then the pension would be suspended until such time as a qualifying break is taken again.

The onus is on the GPs to prove that they have not exceeded the limit.

Chapter 4: Implications of retirement on partnerships

The arrangements for the retirement of single-handed practitioners are discussed in chapter 2. It is a complicated area as any retirement may dissolve the partnership if not catered for in writing. It is important to remember, however, that retirement from the NHS medical contract does not necessarily equate to retirement from the partnership. If the new 24 hour retirement rule is to enable GPs to take retirement to crystallise retirement benefit then start work again, there is no need for the partnership agreement to be affected as long as this is made clear within the agreement.

If there is no reference in the partnership agreement to the arrangements upon retiring, then once doctors have retired from the partnership, they have, in effect, legally left the partnership and are no longer part of the business until such time they are reinstated. There is no legal requirement that the remaining doctors have to take them back on reapplication although the partnership may not be affected by the retirement of a partner if catered for in the agreement itself. The leaving of a partner could trigger the termination of a PMS agreement as this is a change in the nature of the contract. In this case, agreement should be sought from the PCO well before the anticipated retirement date and the arrangements outlined in writing to prevent problems arising at a later date. In the same way, should the single-handed practitioner not wish to take a partner prior to retirement in order to secure succession, then discussions and agreement with the PCO will be needed so that the contract can be secured upon return. The PCO approach may vary and we recognise that it may be difficult to reach agreement in some areas.

Chapter 5: TUPE, possible scenarios and financial implications

TUPE

If a service is replacing an existing service, it may be affected by the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) which preserve employees' terms and conditions when a business, or part of one, is transferred to a new employer. Generally speaking, staff employed in an existing undertaking will transfer on existing terms of employment, except for pensions, to a new undertaking carrying on the same business. This means that the new employer inherits the contractual terms, rights, powers, duties and liabilities owed by the previous employer to the employee. This will include liability for any wages owed or where there is an unresolved claim regarding, for example discrimination, the new employer will be responsible.

Practices should contact their LMC or the BMA as early as possible for further detailed advice. BMA members should contact askBMA in the first instance. Similarly individual partners who are contemplating moving to employed status post-merger would be advised to seek advice on their contractual position before agreeing to the new contract. The remaining partners can also seek advice regarding the proposed change in the relationship.

The scenarios given below provide an example of what may happen if a single-handed GP retires and details the financial implications of practices taking on new patients:

Scenario 1 – Closure of a practice, then taken over in its entirety by one existing practice

This situation is most likely to occur when a contractor who is an individual medical practitioner retires and the contract is not offered to a replacement contractor who is an individual medical practitioner – who would continue to run the practice as a single-handed practice – but instead to an existing local practice to take over the list in its entirety. The PCO would need to advertise the practice, short-list, interview, then appoint. The appointment could be a direct replacement for the single-handed GP or a practice.

In financial terms this is probably the most advantageous situation, provided the PCO agrees to treat it as a merger of practices as set out under paragraph 3.16 of the 2005 Statement of Financial Entitlements (England) and equivalent in Scotland, Wales and Northern Ireland.

In this case the Minimum Practice Income Guarantee (MPIGs) of the two practices should be added together to give a new MPIG for the enlarged practice. It is likely, however, that the PCO will simply wish to merge the entire patient list with the new practice in a way which does not involve re-registration and in this case there will be no List Turnover Index (LTI) payable.

As part of the negotiation for taking over the list, practices should seek to be compensated for the lack of LTI because there is no doubt that there will be a great deal of extra work in the first year or two.

In some circumstances, however, the PCO will not treat this scenario as a merger, but as the termination of an existing contract with a contractor who is an individual medical practitioner but with no creation of a new contract with the existing practice. In this case there will be no merging of MPIGs and the new practice will not inherit the Correction Factor of the practice which has been taken over. In fact, the Correction Factor would go into the unified budget of the PCO which gives a perverse incentive to PCOs not to treat the takeover as a merger. However, the LTI would apply, giving an enhanced Global Sum in the first year only because the patients would have to be re-

registered. The transfer of a patient list is considered an undertaking and so TUPE would apply as set out above.

Scenario 2 – Closure of a small practice and patients advised to re-register with local practices

There may be circumstances where a small practice is dispersed when a contractor who is an individual medical practitioner retires and a number of other practices, whilst not willing to take on the complete list, see this as an opportunity to increase their own list size and, subsequently, take on some of the displaced patients voluntarily.

In this case the receiving practices must be aware that, as explained earlier in this paper, the new patients will bring an increase to both the global sum and payments for Quality and Outcomes Framework (QOF) and enhanced services, but there will be no additional element for the Correction Factor.

Scenario 3 – Closure of a small practice and patients allocated to other local practices

PCOs have a legal responsibility to provide primary medical services to the population of their area. There is evidence that where a small practice has closed, some PCOs are seeking to discharge this responsibility by assigning (allocating) large cohorts of displaced patients onto the lists of other local practices.

This is the worst possible scenario as practices are forced to take on an increased number of patients with which they may well be unable to cope in terms of workload, space and so forth. It is unlikely that the extra global sum and QOF income will be sufficient to fund extra clinical staff, even if there is space for them to work in, and the per capita increase income will not be pro rata with existing income.

It is essential that practices in areas where this might happen take as much preventative action as possible before they suddenly find themselves the unwilling recipients of a large number of extra patients. They should do so in conjunction with their LMC. Making the issue public and getting the support of the existing patients of the practice (who will not wish to see their service deteriorate) will be helpful.

Practices may need to consider carefully the pros and cons of formally closing their lists. It is recognised that practices are often reluctant to do this as the process of list closure is complex. Additionally, there may be some disadvantage to the practice in that they are unlikely to be invited to provide any further enhanced services. However, practices should not have to accept a large influx of forced allocations without adequate funding. If LMCs take this stand, PCOs will be forced to resource practices appropriately or make different arrangements to disperse patients. Practices and LMCs should work together to ensure that the situation is resolved as best as possible for each practice in the area. Practices are also reminded of their right to refuse to register new patients provided it has reasonable and non-discriminatory grounds for doing so as detailed in the following guidance: www.bma.org.uk/ap.nsf/Content/focuspatientreg0404.

LMCs should consider identifying the contractors who are individual medical practitioners in their area and who are approaching retirement to seek their cooperation in developing a strategy for the future of the practice and its patients. A contractor who is an individual medical practitioner can recruit a partner prior to retirement to ensure the continuation of the existing contract. However, the additional administrative burden and the cost to the GP would need to be weighed up. Provisions of how to do this are set out under part 25 of the standard GMS contract.

In some cases, when a group of GPs has taken over a vacant practice list, the PCO has established a local enhanced service (LES) – to assist the practice in note summarisation, appointing health care assistants etc – to help practices to facilitate the movement of patients. However, this is not an avenue that we recommend because it funds new patients in a different way to existing ones, therefore complicating the process.

Chapter 6: Practice mergers

When a contractor who is an individual medical practitioner wishes to take a partner prior to retirement, the PCO must be informed. Similarly GMS and alternative provider medical services (APMS) practices must inform PCOs of proposed mergers because it is the practice that holds the contract. PMS practices do not need to do this as the contract is held between the PCO and the individual GPs although they will usually wish to do so as the agreement is likely to be framed in a way which requires, or at least implies, that the provision will be in a particular framework. The PCO may have the ability to prevent changes if it feels it will affect patient care, or its financial stability. Once merged, it should be possible for the GPs to do a combination of PMS, APMS and GMS work, though GMS doctors will need to amend the PMS agreement and sign up to it.

The priority for most merging practices will be to preserve the contract. Practices are therefore probably best advised to merge in the first instance by forming a partnership. If the practices then want to operate under PMS terms and conditions they will need to seek a variation to the existing PMS contract. This shouldn't be necessary if they wish to continue to carry out business under a GMS contract. Once the practices have merged and preserved the contract they should be able to make changes to the way the practices are staffed and run by informing the PCO of changes regarding changes to contract holders etc.

This guidance note does not cover the financial implications of practice mergers though GMS practices should refer to paragraph 3.16 – 3.19 of the 2006 Statement of Financial Entitlements (England), and equivalents in Scotland, Wales and Northern Ireland, which covers entitlements to payments in respect of essential services in practice mergers. Any mergers involving PMS and APMS practices will need to refer to their locally-negotiated contracts to determine financial entitlements. Any merger will also require some negotiation locally about continuation of service provision and funding for the services provided once the merger has taken place.

Any disputes in relation to practice mergers can be referred to the Family Health Services Appeals Unit (FHSLA) if necessary.

Example
A PMS practice has been approached by a GMS practice which would like the PMS practice to take them over and make the GPs in the GMS practice salaried.

One way to do this is as follows:

The PMS and GMS contracts can join in partnership, effectively merging their practices. Partnerships can hold more than one type of contract so this should not be a problem. However all partners should be aware of the changes in their liability; partners will be jointly and severally liable for the GMS contract, but the liability for the PMS contract will be determined by the individual agreement.

The GMS practice will need to inform the PCO of the changes to its partnership as the contract is held with the practice (PMS agreements are held by individual GPs). By starting the takeover as a merger, the practices will help to preserve both contracts.

Once the practices are merged they can begin to make changes to their organisation. If the GMS doctors wish to become salaried, those involved can split from the other partners, nominating them as successors to the contract. If agreed by the PCO (which it should be unless the PCO believes the

action will harm patient care) the contract will continue and the contractors can employ the old partners as salaried GPs.

If the two practices want to move to operating only under the PMS contract, the GPs should talk to the PCO and seek a variation in the existing PMS contract to allow the GMS GPs to become part of the contract. Eventually the GMS practice should be able to resign its GMS contract.

Chapter 7: Advertising and tendering the practice vacancy

Where practice vacancies arise, there is no longer a nationally-set procedure for the steps that the PCO must follow with regard to advertising and this has led to considerable variation process between PCOs. Some believe that European Union (EU) treaty obligations of transparency and fairness in tendering processes indicate that tenders should be advertised at least as widely as there is likely to be an interest in providing the service. Advice to PCOs seems to vary. They have been advised by the NHS Confederation to tailor advertisements to the value of the contract available,[7] but the NHS Purchasing and Supply Agency recommends that contracts should be advertised in at least one local and one national publication to reduce the risk of legal challenges and ensure competition.

The paucity of explicit tendering requirements and the mixed advice to PCOs indicates that advertising processes will vary. This variety may be formalised by individual PCOs standing orders that may set out procedures for procurement. Some PCOs may, for example, be directed to use the Official Journal of the European Union to advertise major contracts, while other PCOs may only advertise contracts locally.

The Department of Health document *Delivering Investment in General Practice: Implementing the new GMS contract* (2003) sets out certain guidelines for PCOs filling vacancies in general practice. For 'greenfield' sites (new surgeries that cover essential services as a result of significant increases in population) PCOs are expected to invite bids from existing general medical services (GMS) and personal medical services (PMS) contractors and are not expected to progress to inviting bids from alternative providers unless there is no interest from GMS and PMS contractors, or if those contractors do not satisfy the criteria set out in the specification. For 'brownfield' sites (pre-existing surgeries that were but are no longer delivering essential services, for example in the event of a single-handed GP retiring, or essential services in areas of historic under-provision), PCOs have the option of inviting interest from existing primary medical services contractors, employing a GP using the primary care trust medical services (PCTMS) route, or advertising the vacancy and entering into a GMS, PMS or APMS contract. In all cases the PCT should consult with the LMC as stated in *Delivering Investment In General Practice*.

[7] The NHS Confederation (2005) Alternative providers of medical services: a contracting guide for primary care trusts. London: NHS Confederation.

Chapter 8: Further reading

APMS: www.bma.org.uk/ap.nsf/Content/apms0406?OpenDocument&Highlight=2,apms.

This guidance provides a factual background on APMS and suggests ways in which GPs can best harness this new contracting route in the interests of their patients and primary care. It offers guidance on tendering for APMS contracts, working for APMS providers and contracting care through this route. Throughout the document it also highlights areas where inequities may arise and suggests ways GPs and their local medical committees (LMCs) can work to ensure a level playing field between different types of provider.

APMS: www.bma.org.uk/ap.nsf/Content/pmscontracts.

This guidance details the advertising and appeals process in relation to the APMS process.

Retirement:
www.bma.org.uk/ap.nsf/Content/genprac05~retment?OpenDocument&Highlight=2,retirement.

This guidance provides information on membership of the scheme, early retirement, pensions and dynamisation.

Holding Primary Medical Services contracts: www.bma.org.uk/ap.nsf/Content/pmcontracts.