FOCUS ON…….

PRACTICE STAFF UNDER THE NEW CONTRACT

Introduction

The new GMS contract raises issues and opportunities in relation to practice staff that practices will need to consider. These include:

- The move to practice-based funding
- Practice-based contracts
- The capacity to provide enhanced services
- Quality initiatives and practice management

This guidance aims to provide you with some background to the issues that you will need to be thinking about and supply some answers to problems that may arise.

Practice Staff Funding

Current GMS practice staff funding involves:

- Application and approval for practice staff reimbursement by the PCO
- Approximately 70% reimbursement of practice staff salaries by PCO plus employers' national insurance and superannuation contributions, and relevant training. In Scotland, practices do not apply for reimbursement but are allocated an ancillary staff budget, largely but not solely, based on historical reimbursed payments.
- The shortfall in reimbursement is made up from other GMS income and, in some cases, money for local development schemes or staff are transferred to another PCO community or secondary care budget
- Many practices have historically been allocated a lower staff budget than they might otherwise have received, as they have had PCO-employed nurses/health visitors assisting with the provision of GMS work in their practices.

Under the new GMS contract staff funding allows:

- The majority of staff costs, including employers' national insurance contributions and superannuation, to be incorporated into the global sum/global sum equivalent.
- Relevant staff costs to be built into enhanced services funding
- Aspiration payments for the quality and outcomes framework to be used to employ staff where this is necessary to deliver the standards aspired to.
- Practices to have complete freedom to decide on the configuration of staff they need to provide their services
- Most staff training costs to be the responsibility of the practice except where, either for historical reasons or contractually – for example, IT training – it is PCO-provided.

Because the funding of practice staff shall cease to be a discrete reimbursable entity in the practice budget it is essential that all practices consider their staffing needs in relation to the new contract. They will need to bear in mind the income these individuals will help to generate and balance this against their salaries, national insurance and superannuation contributions, and training and development needs.

Where practices have historically had **PCO-employed nurses** and health visitors assist with the provision of GMS in their practice then the assumption should be that this relationship should continue for the provision of essential and additional services or that the global sum should be uplifted appropriately where it is agreed that practices take over responsibility for these staff.

Practice-based contracts

Although the introduction of the new GMS contract will demand an amendment to partnership agreements to take into account a practice rather than doctor-based contract, your rights and duties as an employer will not alter in relation to your current practice staff. If you are a sole practitioner, and your employees' contracts name you as their employer, you will need to amend those contracts to show the practice as the employer. You must give your employees written notification of this change to their contracts and explain that this makes no difference to any other terms of the contract.

There are new opportunities with the new contract for practice staff. For the first time in GMS it will be possible to have non-clinical or nurse partners in the practice. Some practices may wish to offer their practice managers a partnership under the new contract. This can be a way of ensuring continued service, encouraging dedication and incentivising performance. If you are considering non-GP partners in your practice you will want to work through all the financial and legal implications. Equally a practice manager, nurse practitioner or other member of staff who might take on a partnership will need to consider what it means for them to be a partner and not an employee.

The capacity to provide enhanced services

Many of the enhanced services are likely to involve the participation of clinical and/or non-clinical practice staff in their delivery. It is likely that some of these duties will be incorporated in to your current staff members' duties. Before you make any variations to an employee's contract you must seek the employee's consent for the variation, negotiating and agreeing the changes with them. It is also prudent to keep employees aware of possible forthcoming changes.

Other enhanced services may require you to take on new staff (e.g. a phlebotomist if you are commissioned for anti-coagulant monitoring, a practice nurse for intra-uterine device fitting or extended minor surgery). Where enhanced services require the employment of new staff, or altering the existing contract of current staff, then we would advise that a clause is put into that contract tying the job or duties to the enhanced service contract which will need to be reviewed if you fail to secure or lose the relevant enhanced service.

The use of short or fixed-term contracts for enhanced services will not diminish your obligations to your employees, but will allow you to make the member of staff redundant should you lose the enhanced service contract in the shorter term. However, it may not be appropriate to consider redundancy where the new duties only form a small element of an employee's post. Further, there is a process for making employees redundant which must be carefully followed. Contact your local BMA office for advice before making a member of staff redundant.

Some practices are currently supported in their work by **PCO-employed nurses**. It is important to be aware that staff costs were built into the pricing of both directed enhanced services and national enhanced services. However, where PCO-employed staff were already providing a service – for instance, assisting with childhood vaccinations and immunisations – as the payment for this work has not changed but simply been re-named, there is no justification for changing the funding arrangements. There may, however, be legitimate circumstances where PCOs wish to charge practices for the use of their staff. Depending on the degree of reciprocity involved (i.e. a GP practice allows PCO health staff to work from their building rent-free) then this could be negotiated at local level.

If a practice is negotiating the provision of a local enhanced service then they will need to ensure that full staff costs are built into the price they negotiate.

In Scotland PCOs have historically employed treatment-room nurses who work in GP health centres. This was traditionally an incentive to encourage the move into better premises. There are also treatment-room nurses in Northern Ireland. The provision of treatment-room nurses meant practices did not need to seek additional funding when it was available to employ additional nursing staff, and as a result have smaller staff budgets than they otherwise would have had. Treatment-room nurses have played a vital role in the provision of essential services. We do not believe that PCOs would have a right to charge for the use of treatment-room nurses and it could destabilise services to withdraw them from practices.

Quality initiative and practice management

The introduction of the quality and outcomes framework, with its organisational markers as well as clinical markers, will mean that the role of your practice manager will be even more important in the process of managing clinical data and organising your surgery.

The practice management competency framework was produced to encourage practice management development and indicate the wide range of skills that practices will need to have access to, to run their practices at maximum efficiency. Different practices will be able to do this by a variety of means depending on their size. Some practices may have a single practice manager who encompasses most of these skills, others may have a practice manager who can access other colleagues (either in other GP practices or via the PCO) to help them in the variety of areas of their work.

The practice management competency framework is a guide for individual and practice development and should not be taken in any way as obligatory. It is an opportunity for practices to develop their staff over time with a view to the long term and the on-going needs of a quality-based, IT-dependent contract.

Advice on specific employment issues in relation to staff can be obtained by BMA members from local BMA offices.

Questions and Answers

- **Will MPIG practices receive sufficient baseline funds for staff that take into account the rising costs of employment?**

The global sum equivalent (MPIG) will be calculated based on the various quarters agreed (last three quarters of 2002-2003 and first quarter of 2003/04) and this will then be uplifted to April 2004 levels. It will include an additional amount for partners' superannuation, staff superannuation and increased national insurance.

- **Will the global sum payments take into account the increase in employee superannuation (14%)?**

To date none of the global sum calculations have been adjusted for the increase in superannuation. However when the final April 2004 calculations are made, an additional amount to cover these costs will be added to the global sum and MPIG amounts, in addition to the 2004-2005 uplift.

- **I have a member of staff whose work I am unhappy with. Would it be valid to dismiss him/her as they do not have the skills required for the new contract?**

Employees are protected by employment law. You should think carefully about the reasons why you want to get rid of a member of staff. The procedure for dealing with inadequate job performance should be quite separate to any decisions to make a member of staff redundant. If you are unhappy with a member of staff's performance, you should discuss ways of improving performance with the employee, and if there is no improvement, consider taking action against the employee for misconduct and/or lack of capability under the Practice disciplinary policy. The end of this process may result in alleviation of the problem, or the fair dismissal of the member of staff.

If you need fewer employees, or employees with different skills, then you may be in a redundancy situation. You would need to notify and consult potentially affected employees about any proposed redundancies. You would have to successfully prove that the job roles had ceased, or significantly changed, and that the member of staff truly lacked the skills to do the remaining or new job. You would also need to consider whether there was suitable alternative employment available within the practice, before you could make a member of staff redundant. Would your decision stand up in an employment tribunal? It may be better to consider developing your staff where necessary and encouraging them to take up new opportunities. We recommend that you seek advice from your local BMA office before making a member of staff redundant.

- **Will our practice have to pay for all practice staff training or will the PCO still be involved in this?**

Much of your staff's professional development will be your responsibility. However, PCOs should provide IT training to all practices. The Department of Health has made a commitment to the IT needs of the new contract and many practices may need extra training to bring them up to date with the demands of the Q&O framework.

In Scotland, in many areas, the training element of the Ancillary Staff Budget has been top sliced by PCOs, and not passed directly to practices. This funding stream is therefore not in the GS or GSE and either needs to be added or the PCO should retain responsibility for the funding of staff training.

- **PCO-employed community nurses help us with a number of tasks in our practice. Will we be charged for all of these next year?**

It will depend on the service provided. If PCO community nurses help you provide essential or additional services, then it is reasonable to expect them to continue in that role. This is because staff costs have been built into the global sum (used to supply essential and additional services) but many practices were historically paid in kind by using PCO nurses rather than receiving adequate staff funding directly. Where this money has not been transferred into the global sum it is reasonable that the nurses should continue to help provide the service.

This is also the case for treatment room nurses in Scotland and Northern Ireland.

Enhanced services benchmarked pricing includes staff costs. Under these circumstances, the PCO may wish to charge you for their use. However, in the case of childhood vaccinations and immunisations and influenza immunisations, there has been no change to the overall level of payments and, therefore, there should be no change to the staff funding or provision arrangements. Moreover, where PCO-employed nurses are attending a patient to provide a non-contractual service (e.g. wound dressing) then this is not something that the PCO can charge the practice for as it falls within their community provisions. Furthermore, practices have often reciprocated by giving community staff 'free' accommodation in their premises. If the PCO were to request charges from the practice for their staff it would be perfectly reasonable for the practice to ask for appropriate charges for accommodating PCO staff.

- **The new contract documentation says funding will be held at PCO level for maternity, paternity and adoptive leave of practice staff – are there any clear guidelines on this yet? What about sick leave?**

Arrangements for staff maternity, paternity, adoptive and sick leave are a matter for the employer, subject to statutory requirement. There will be discretionary PCO-administered funding for staff sick leave, maternity, paternity and adoptive leave. This remains as it was under the Red Book and you can apply for it. We are encouraging LMCs to discuss these arrangements with their PCOs.

- **I would like to develop my staff through training but the costs seem prohibitive?**

Although most staff training costs are within the global sum, there are some kinds of staff development that will still be funded directly through the NHS via the Workforce Development Confederations or their equivalent. For instance, training a nurse in independent or supplementary prescribing could involve funding from a Workforce Development Confederation for the university based training course. This would leave the practice with the less onerous task of funding the mentoring and study time release. It will be important to investigate all possible avenues of funding.

We are aware that, at present, many PCOs have top-sliced practice staff funds to provide training for them. Practices need to ensure that when determining their global sum/global sum equivalent this money is mapped over into their practice's funds.

Other useful BMA resources:

General practice staff (non-medical) Framework: For a written contract of employment
General practice staff (non-medical) Specimen: Handbook of terms and conditions of service
GP Business FAQ – Employment of ancillary staff