Information for PMS practices and APMS GPs following publication of Department of Health guidance on non-GMS contracting arrangements for 2006/07 – England only

Background

The guidance is available on the Department of Health website at the following location:

http://www.dh.gov.uk/assetRoot/04/13/16/44/04131644.pdf

This sets out the implications for PMS practices and GPs holding APMS contracts for essential services in light of the recent changes that have been negotiated to the GMS contract for 2006/07. It is intended to support PCTs and SHAs in securing similar arrangements to those agreed for the GMS contract for 2006/07, from local PMS and APMS contracts. It also refers to an accompanying direction (yet to be released) from the Secretary of State that will require PCTs and SHAs to review local contracts and seek to constrain payments made under these in line with the 2006/07 GMS contract.

A joint NAPC and Department of Health statement has also been released in response to this guidance. This is available here: http://www.napc.co.uk/media-view.php?mediaID=80

This GPC guidance note seeks to provide PMS practices and GPs holding APMS contracts for essential services and LMCs with information in light of the Department of Health guidance. Note that although the Department of Health guidance does not apply to PCT Medical Services (PCTMS), there may be implications for these practices. Where applicable, these are set out in this GPC guidance.

Why was the guidance issued?

The guidance was issued following the GMS contract negotiations for 2006-07 and the statement in paragraph 3.31 of the White Paper "Our health, our care, our say: a new direction for community services" that the Government intends to carry out a fundamental review of the financial arrangements of PMS practices.

The GMS negotiations were conducted in a particularly difficult environment. There was considerable pressure not just to limit any future pay awards but to try to secure better value for money from the 2004 GMS contract. The guidance on non-GMS contracting arrangements for 2006/07 indicates the Department of Health's intention to do the same with PMS agreements.

Significantly, however, the GPC has reached agreement that this year's settlement will address the perceived value-for-money issues associated with the original contract and that these will not be revisited in the future.

Briefly, for GMS practices, in return for certain "value-for-money" savings in the Quality and Outcomes Framework (QOF) all four countries have agreed to additional investment in the contract, mainly in the form of directed enhanced services to resource new areas of Government policy. The main changes and how these will impact on PMS practices and GPs holding APMS contracts for essential services is as follows:

- PCTs may try and seek similar agreements for PMS practices and GPs holding APMS contracts for essential services as those that were agreed for GMS practices including no uplift to any existing element of the GMS contract for inflation or cost pressures in 2006/07
- PCTs will be seeking similar efficiency savings from PMS practices and GPs holding APMS contracts for essential services as GMS practices in terms of the QOF

- New DESs for access, choice & booking, practice based commissioning and IT will be offered to PMS practices and GPs holding APMS contracts for essential services
- Revised national QOF will be implemented for PMS practices and GPs holding APMS contracts for essential services where the agreement requires the contractor to use the national QOF. An alternative local QOF is also acceptable where there is no agreement to use the national model. The PMS points deduction will remain at 109 points
- PCTs will want to review their dispensing arrangements with PMS providers to ensure they are in line with the revised GMS agreements
- The implications of the increase in maximum locum reimbursement for maternity, paternity and adoptive leave to £1500 per week from week three of the potential entitlement in GMS practices should be considered for PMS practices and GPs holding APMS contracts for essential services and increased accordingly.
- There is no change to the deduction for GPs opting out of out of hours cover.

The Department of Health guidance was issued in part to ensure that PCTs encourage PMS practices and GPs holding APMS contracts for essential services to engage in the new DESs that assist with the delivery of key areas of Government policy. Furthermore, in the light of evidence from the Technical Steering Committee which oversees GP incomes, there is a disparity between PMS practices earnings and those of their GMS colleagues. The government seem determined to ensure that it is getting value for money from PMS practices and GPs holding APMS contracts for essential services particularly in terms of their use of growth monies.

What action can practices expect from PCTs?
This sets the scene that PCTs will be seeking, at the very least, to make amendments to PMS contracts to secure similar changes to those outlined in GMS. This will be in the form of freezing 2005/06 contract prices, adopting the revised national QOF and implementing new arrangements for dispensing doctors. Continued investment however should be made available through the new DESs for patient choice, access, IT and practice based commissioning.

The three key paragraphs from the Department of Health guidance which may provide the opportunity to do this are as follows:

5. It is the Department's intention to issue directions to SHAs and PCTs who have entered into PMS agreements or APMS contracts requiring them to review the financial provisions within all their PMS agreements and APMS contracts at the earliest opportunity with the specific aim of constraining the costs of such agreements/contracts.

6. This document sets out guidance to assist PCTs and SHAs in:
   - **reviewing the financial provisions contained in their existing (or new) PMS and APMS contracts;**
   - **seeking to constrain payments made under these contracts so that future investment from 1st April 2006 is consistent with the changes introduced for contractors providing equivalent services under a General Medical Services (GMS) contract.**

9. If PCTs and SHAs are unable to reach agreement with such contractors, they will need to carefully consider, taking legal advice where necessary, the continuing appropriateness of the existing contract they have with that provider.

The Government's intention would seem to be that PCTs should review PMS contracts to ensure they are providing 'value for money'. It is inevitable that the final balance between actual levels of efficiency and new investment will vary between practices depending on local contract discussions.

For example, PCTs are likely to want to put a freeze on all baseline increases, in line with GMS agreements. However, many PMS practices and GPs holding APMS contracts for essential services will have a clause included for automatic uplift of PMS baselines in line with inflation. It is possible that PCTs will wish to review these arrangements.

What should practices consider in preparation for negotiations?

Growth money

An area that PCTs may wish to investigate is the use of PMS growth monies. Many PMS practices and some GPs holding APMS contracts for essential services were allocated growth monies to expand their services when they first entered PMS or APMS arrangements. This money was intended to be used to employ additional staff, or to improve or restructure services. PMS practices and GPs holding APMS contracts for essential services may now be asked by PCTs to justify the use of this money. Practices would therefore be well advised to consider collecting evidence of how their growth money has been used appropriately.

It should be recognised however that PMS growth monies had relatively little guidance attached to obtaining them at the start. Therefore it does seem unreasonable that practices may now be expected to fully justify what the money has been spent on. The original growth money was primarily to fund doctors or nurse practitioners specifically, however, in April 2004, growth monies were made permanent in the baselines and had new flexibilities over how they could be used.

Some practices may have agreed a plan about how growth money should be spent at the time of opting to move to a PMS contract. If so, it would be worth practices looking over this to ensure that they have kept to their side of the agreement.

Value for money

PCTs may also try to seek a higher level of service from practices, or seek an opportunity to cut the costs of PMS contacts. Some PCTs are insisting that PMS practices and GPs holding APMS contracts for essential services take on additional patients for no extra funding. Others are seeking to claw back money where they do not believe that the practice has provided enough services for patients – providing evidence of services that have been provided will be of paramount importance. For PMS practices and GPs holding APMS contracts for essential services, growth in list size is an issue, especially for the later waves of PMS as allowances for an increase in list size will be largely dependent on local contract and negotiation. This may be an area that the PCT will wish to revisit and for which practices will need to be prepared to demonstrate value for money.

Additionally, paragraph 27 of the Department of Health letter states that '*PMS providers are expected to ensure that they have arrangements in place to ensure that patients receive copies of their clinical letters*'. This is something that is not currently a requirement of GMS practices, PMS practices or GPs holding APMS contracts for essential services (unless their agreements specify otherwise) and is one way in which the Department may feel justified in obtaining greater value for money from PMS contracts. PMS practices and GPs holding APMS contracts for essential services do not have to agree to such arrangements but should consider the merits of doing so when making overall decisions about whether they would be willing to consider changes to their contracts (see following two sections).

Equity between primary medical service providers

LMCs will wish to advise, support and defend levy-paying PMS practices and GPs holding APMS contracts for essential services where there is any suggestion that funding might be unjustifiably removed. Although there is some evidence that PMS practices have higher per patient funding when compared to similar GMS practices, it is necessary to consider the overall services provided, and the workload of individual practices, when making comparisons rather than simply looking at crude £ per patient calculations. This is another potential way for PMS practices and GPs holding APMS contracts for essential services to demonstrate value for money.

Some PCTs are already looking at how list size change generates different amounts of income between GMS and PMS and assessing how they can bridge the gaps with funding inequalities. Practices and LMCs are reminded that, if this does happen, it should be done in an open, transparent and fully consultative way and everyone should understand any new process from the outset. This is especially true if there are likely to be financial losers under new arrangements. It is recognised, however, that both within and between primary medical service providers of essential services there are likely to be historic inequities that practices will need to bear in mind during discussions. PCTMS practices should also note that the case for equity for all primary medical essential services would equally apply.

Making a case

Unless there is an explicit statement set out in the contract to state otherwise, PCTs cannot claw back funding retrospectively. However practices and LMCs should work to ensure that funding is not withdrawn for the future. Taking into account the above paragraphs, it is recommended that a process is put in place that takes into account the following:

- PCT and practice needs to be clear why any use is considered ‘not appropriate’
- PCTs need to give support to state what they would find ‘acceptable’
- There should be adequate notice/change period time for the practice to make the necessary changes, and without any adjustment to funding.
- Changes must be discussed and agreed by both the practice and the PCT.

When considering the above points, and looking at their PMS contracts, practices should identify precisely what was agreed. Practices should be aware that there may be some situations in which they have been unable to provide a particular service due to circumstances beyond their control (for example based on PCTs developing certain initiatives that were never delivered) and that, in this situation, PCTs cannot try to claw this money back.

Can PCTs alter contracts without agreement?

Existing contractual provision is based on an agreement jointly entered into, and changes to those arrangements may only be achieved through proper consultation and negotiation with practices. That means additional efficiencies over and above those currently within the contract agreements can only be achieved with the agreement of the practices concerned. This is set out in the joint NAPC and Department of Health statement of PMS referred to at the beginning of this document and is also covered by schedule 5 part 8 of the National Health Service (Personal Medical Services Agreements) Regulations 2004.

Additionally, there have been reports of PCTs seeking to claw back payments from PMS practices. PMS practices should resist such moves and note that contracts cannot be amended retrospectively unless there is anything specific stated in the contract that would allow for this.

Can existing contracts be terminated if agreements cannot be reached?
Because each PMS contract is negotiated locally, there are likely to many differences between the termination provisions in individual agreements. It is therefore not possible to give universal advice to PMS practices and GPs holding APMS contracts for essential services. However, the GPC legal department has considered this question in the light of the regulations and existing model contracts.

Its view is that the PMS Agreement Regulations 2004 (schedule 5, paragraph 100) are unclear on the subject of termination. These regulations state that either party may terminate the agreement by serving notice in writing but they do not specify the notice period, nor do they specify what, if any, reasons may need to be given for termination. Like the regulations, the majority of PMS agreements replaced after 1 April 2004 also fail to specify a period for termination of the agreement by notice.

It is widely assumed that when PMS became permanent on 1 April 2004, PMS contracts became permanent. GPs should be aware however that there is a possibility that PCTs wishing to terminate PMS contracts without cause may seek to use the regulations to do so. In the event that no clear notice period is set out in any agreement between the practice and the PCT, due to the local nature of contracts, it is not possible to say whether it would suffice for the PCT to issue a reasonable period of notice and then to allow the contract to be terminated without cause. Practices should be aware however that the PCT may well try to terminate without cause on this basis. The GPC would like to know if any PCTs attempt to terminate PMS agreements without cause under these regulations and would be prepared to provide advice to practices in this situation

What can PMS practices do if they think their contract may be terminated?
PMS contractors are potentially vulnerable because of the regulatory provisions which may enable PCTs to terminate PMS agreements on notice (see above). This sets PMS agreements apart from GMS contracts and may give the PCT sufficient leverage over the practice to impose changes.

Practices should first check their own contracts to note whether any notice period for termination has been included. If no notice period is included, the practice is in a far stronger negotiating position. Unfortunately, if a notice clause is included, which provides for termination on a specified number of months notice, the PCT may be able to terminate using the stated time period.

Practices in this position would have to balance the possible disadvantages of accepting contract variations against the risk of the PCT attempting to unilaterally terminate the contract. The GPC would hope that mutually acceptable compromises should be achievable through negotiation, with the assistance of the LMC. If they are not, the contractor may wish to exercise its right to return to GMS (see below).

Practices are reminded that they may invoke the dispute resolution procedures in their agreement, as most PMS practices will be recognised as NHS bodies for the purpose of the agreement. This includes the opportunity to have local resolution but if this is unsuccessful practices may appeal to the FHSAU in Harrogate. If a practice holds a private law contract i.e. it has not elected to become a health service body, it can choose to use either the NHS dispute procedure or use the Courts in relation to any particular dispute. Practices can, at any stage, opt to become, or cease to be, a health service body, by requesting a variation of their contract with the PCT.

Movement between PMS to GMS contract
Before 1 April 2004, individual doctors had a right of return to GMS. Under the PMS Agreements Regulations, this right now applies to contractors, rather than individual doctors.

Return to GMS is therefore now a practice decision (see part 6, Regulation 19).

The contractor must notify the PCT that it wants to enter into a GMS contract three months before the date on which it wants the GMS contract to take effect. The notice to the PCT must specify the date on which the contractor wants to terminate the PMS agreement, the names of the persons with whom the contractor wishes the PCT to enter into a GMS contract and to confirm that those persons meet the relevant conditions (as set out in Regulations 4 and 5 of the GMS Contracts Regulations).

There is no agreed formal mechanism for determining the financial position of PMS practices and GPs holding APMS contracts for essential services who wish to enter into a GMS contract. Whilst these practices have no statutory right to a Minimum Practice Income Guarantee (the income protection guarantee that GMS practices had on transfer from the old to new GMS contract), John Hutton's October 2003 letter to PMS GPs stated:

"A PMS pilot practice could make a strong and robust case for having an MPIG from 1 April in discussion with the PCT. The practice would be expected to provide the data which could be assessed by the PCT using:

- the local data on payments for Global Sum Equivalent (GSE) items that they may have available for the pilot; this might include some or all of growth monies relating to contract variations forming part of the practice's Global Sum Equivalent
- a national average calculation (if the supporting data are not robust enough to do the calculation) based on PMS earnings and GSE".

There is no automatic entitlement to retain growth monies on movement to GMS. However, the Hutton letter stressed that this should be allowed "where a practice provides evidence that some growth should form part of the GSE". If the growth money is retained, the PCO may use it for the benefit of patients across GMS and PMS practices.

There is some further guidance on this in section 6.12 of 'Sustaining Innovation through New PMS Arrangements.'

Although PCTMS practices do not have the right the return to GMS, the GPC expects that GMS GPs who went into a PCT run PMS practices and are now PCTMS should be treated fairly and should have the opportunity to re-take over their practice if desired.

Further information requested

The GPC will be monitoring the situation with regard to non-GMS contracting arrangements for 2006/07. Therefore we would be grateful if LMCs and practices could provide information on the following two points.

- If any PCTs attempt to terminate PMS agreements without cause under the PMS regulations.
- How many, and to what level, PCTs are trying to negotiate alternative (less advantageous) contract terms with PMS practices and GPs holding APMS contracts for essential services.