PMS Agreements Framework

Introduction

It is 2 years since a suggested outline PMS agreement was published. This paper is intended to bring PCTs and PMS providers up to speed with current requirements and flexibilities, to be read in conjunction with 'Sustaining Innovation through new PMS arrangements'[i]. It does not cover specialist PMS, which will be the subject of future papers or agreements where the PCT is the provider.

This document is intended as a starting point for considering five elements of Personal Medical Services (PMS) agreements:

1) An outline agreement for consideration by *new* PMS schemes containing references to flexibilities that may well be of interest to existing PMS schemes (Section 1)
2) Details of flexibilities introduced in line with new General Medical Services (nGMS) changes (Section 2)
3) Transitional arrangements for existing PMS schemes (Section 3)
4) Mandatory contract terms as required by the PMS Agreements Regulations 2004 (Section 4)
5) A method for calculating 2004/5 contract price for *existing* PMS schemes (Section 5

There are several issues that have been taken into account, including:

(i) The move to PMS from pilot status to becoming a permanent option and regulations covering this change.
(ii) The introduction of a single PCT performer list covering all medical practitioners performing primary medical services.
(iii) Skill mix freedoms
(iv) New PMS developments
(v) Changes to ensure comparability with GMS developments.

PCTs and PMS providers with existing agreements may be interested in some of the ideas presented in Section 1 but should definitely read sections 2-5. It is not necessary to completely rewrite current agreements, but ALL PMS agreements must have the mandatory contract variations referred to in Section 3 and 4 included in them by the end of September 2004, to comply with the PMS Agreement Regulations (SI/2004/627)[ii]. These changes are required as part of the process of abolishing pilot status and achieving permanence for all PMS schemes. Many current PMS agreements will need little alteration to comply with these stipulations. From April 1 2004, 'Transitional arrangements' will apply with the effect that certain clauses will be assumed to be in place.

When considering variations to existing contracts, the following should be taken into account (Sustaining Innovation…[i]).

"PMS is already very flexible. The Government is committed to increasing the flexibility of PMS further while ensuring that existing arrangements between PCTs and providers are secured. So, as part of mainstream PMS, the financial arrangements already agreed within existing PMS Scheme contracts need not be unpicked. However, this should not preclude discussion and new agreements on specific elements of the contract. Where the PMS provider wishes to change the range, scope or form of services, discussion should be possible without triggering a wholesale restructuring of the contract".

Responsibility for delivery of national priorities and for reaching agreements with PMS providers now rests with PCTs. Therefore many of the quality issues referred to in detail in the previous agreement framework, including those relating to NSFs and access, may well form part of the scheme's quality and incentive arrangements.

N.B. Throughout this document the terms 'provider' and 'contractor' are used interchangeably. This reflects the fact that, although 'contractor' is technically correct, the term 'provider' is still in current use and is better understood.

Section 1: A Framework for PMS agreements

Agreement Summary

The ideas that underpin the national development of the new PMS framework are:

Choice – for GPs and Patients
Equity and Fairness for patients and providers
Value
Decentralisation moving decision making closer to patients
Sustaining Innovation – PMS continue to be a test-bed for trying out new ideas and finding solutions particularly for patients and populations whose needs may not always be best met through GMS.

From the 1st April 2004 all new PMS agreements will need to comply with the requirements of the 2004 PMS Agreements Regulations (a list of these is provided at Section 4). In particular the PMS contractor and the PCT will want to include the following in agreements (some of which are legislative requirements and some recommended provisions):

1. Parties to the Agreement

2. Type of Agreement

3. Start Date and Duration

4. Nature of performers inc subcontracting arrangements

5. Services to be provided

6. Address at which services will be provided

7. Population covered

8. Registration

9. Performance monitoring, reporting and incentives

10. Information for patients

11. Common Standards

12. PCT Support arrangements

13. Dispute resolution

14. Termination

15. Price of Contract

16. Signatories

Details of Scheme

1. Parties to the Agreement

PMS Contractor

Name
Address
Contact Details

Nature of contractor (e.g. PCT, Practice, Qualifying Body)

Where the provider is a qualifying body, both parties will need to satisfy themselves that they meet the contractor conditions in PMS regulations.

and

PCT

Name
Address
Contact details

Eligibility to become a PMS provider
PMS contracts may be entered into with individuals, persons or groups made up from any of the following:
(i) medical practitioners who meet the conditions set out in the new PMS regulations;
(ii) health care professionals (including General Dental Practitioners) who meet the conditions set out in the new PMS regulations;
(iii) NHS employees;
(iv) employees of PMS or PDS providers
(v) individuals providing services under a GMS, GDS, PMS or PDS contract
(vi) PCTs or Local Health Boards (LHB);
(vii) NHS Trusts (including NHS Foundation Trusts).

NHS employee means anyone employed by:
(i) an NHS Trust, NHS Foundation Trust or a Health and Social Services Trust;
(ii) a person providing services under a GMS or GDS contract
(iii) a provider or performer of PMS or PDS

PMS Qualifying Bodies
PMS arrangements can also be reached with a PMS qualifying body. A PMS qualifying body is a company limited by shares, all of which must be legally and beneficially owned by a person who could lawfully enter a PMS contract as an individual or as part of a partnership.

A PMS provider is responsible for ensuring the terms and obligations in the PMS contract and applying to the contractor are fully complied with. Providers do not

have to be performing clinical services under that contract, although many individuals will be fulfilling both roles.

Health Service Body status
State whether a contractor is a Health Service Body or to be covered by a contract at law.

PCTs should note that the choice of being or not being a Health Service Body is entirely a matter for the PMS contractor and they should not attempt to force such status, or deny such status, onto a PMS contractor. If providers do not wish to be a Health Service Body, but have a private law contract instead, PCTs should reflect that in the PMS contracts.

Further information on Health Body Status is included in Annex A

2. Type of Agreement

State whether:

PMS

PMS Plus (not equivalent to enhanced services, and PMS schemes are not obliged to use the national models or fee rates).

3. Duration:

Start Date
Review date
Duration (if required):

There will be no national 'waves', so a locally agreed timetable will need to be established. Where a new service or new delivery model is being explored, parties may wish to agree a specific duration.

4. Nature of Performers

The range of potential PMS performers is vast. The following notes are included to clarify two of the most commonly-raised issues in this area and should not in any way be seen as limiting choice to these performer models.

Note on Subcontracting
Since the PMS provider will have the right to subcontract, there will be no need to specify the individual performers. However, PCTs will need to be informed of sub-contracting arrangements, and will want to know:

(a) the name and address of the proposed sub-contractor;
(b) the duration of the proposed sub-contract;
(c) the services to be covered; and
(d) the address of any premises to be used for the provision of services.

Note on Salaried GPs
The structure and flexibility of PMS contracts already facilitate the salaried GP option where this suits the practice and the practitioner. This flexibility will continue. The new GMS salaried doctor model contract need not necessarily apply in PMS. PMS providers will continue to be able to respond to local labour market conditions and will have the freedom to decide to what extent they wish to offer comparable arrangements.

5. Services to be provided

This section will vary according to the nature of the contract.

Existing schemes should take note of the introductory paragraphs – there is no need for existing schemes to rewrite agreements except to include the mandatory variations. Current services will usually be the starting point.

Except where a provider provides essential services (which will have the same definition as in nGMS) there is no necessity to mimic the nGMS contract. For instance, where there is a locally agreed PMS plus contract for a service it does not have to be turned into an 'enhanced service' and there is no obligation to copy national enhanced service arrangements e.g. for homeless. Most schemes will, however, want to take into account the new OOH opt out arrangements and other flexibilities referred to in Section 2.

6. Address at which services will be provided

7. Population

There are various different populations that a PMS scheme might serve including:

- Practice list based
- Specific patient group e.g. disease specific, 'client' group such as homeless
- Wider e.g. for unregistered OOH and drop in centre
- Catchment or practice area where appropriate

8. Patient Registration

'Registration' applies only to patients for whom essential services are being provided. However, the actual patient list of a PMS provider may differ according to the population served. Where, for example, a service is delivered to a particular client group, a different patient list may be required that does not amount to registration.

Where the full responsibilities for registered patients rests with another body such as the PCT, a patient list will usually need to be identified with the PMS Provider, even though they may be taking only partial responsibility.

Many PMS schemes will wish to continue with there current systems of a specific list size change triggering a change in remuneration.

Franchising
Some PMS schemes have explored a franchise option. Under a PMS franchise scheme, patients may for example be registered with the PCT and another organisation might be responsible for delivering the care on their behalf to the patients under a service level agreement.

Various professionals or organisations might be responsible for delivering elements of care and might in turn have their own list associated with the specific service they were providing. They would only be responsible for the elements included in their own agreement with the PCT.

Patient Preference

PMS schemes need to be aware that the principle of choice of practitioner should be addressed, since the patient is no longer registered with a named GP, but with the practice.

Under these arrangements, where the contractor has accepted an application for inclusion in its list of patients, for new patients the scheme should:

- notify them of their right to specify a particular practitioner or class of performer, whether generally or for a particular condition.
- note their wishes
- comply unless there are reasonable grounds for refusing to provide the service (if provided).

9. Quality, reporting, monitoring and incentive arrangements

This section could include

- Quality and incentive arrangements
- Specific incentive schemes e.g.
- Prescribing (particularly where the scheme has taken on a prescribing budget).
- Practice-led commissioning budget and incentives (if taking part in such a scheme)
- Review period

- Review process

- Frequency and nature of reporting including agreed information collected electronically in year and noting that an annual review will be a contractual requirement.

Quality Arrangements and Incentives
Existing PMS schemes will be able to read across from their current contracts. Existing resources will remain in PMS baselines, as agreed. *Where providers and PCTs agree*, this section could be updated to take into account any new shared priorities.

Practice-led commissioning
Practice-led commissioning will promote greater collaboration between providers and PCTs in service development along with greater responsibility on the part of the referrer. Where a PMS provider is entering into an agreement which includes practice-led commissioning, it could look at redesigning care pathways as well as extended prescribing and referral incentive schemes.

PMS schemes continue to have the right to opt for a 'real' prescribing budget. Where PMS providers take on the risk of a real budget and resources are freed through prudent prescribing over and above existing prescribing incentive schemes, practices will want to demonstrate how patient care has benefited from the extra resource. Where budgets are linked to incentives, PCTs will want to ensure associated practice remains of good quality to ensure perverse incentives are not introduced into the system.

Variations from the National Framework
PMS is essentially a local contract. Whilst embarking solely on the national QOF as a vehicle for quality development and delivery may be a first choice for many practices, PCTs should encourage practices to look further and consider developments and variations of the national QOF.

Possible variations are offered below:

- A core from national QOF plus local add-ons
- Fewer indicators for the same disease areas
- Local use of different indicators
- Different interventions for related fields
- A different evidence base
- Use organisational quality frameworks (e.g. QTD)
- Different approaches.

The contract will need to include reference to how agreed data is to be collected (e.g. via MIQUEST), the frequency of feedback and the nature of PCT support. Note that, although QMAS may be used for PMS schemes that opt for a direct

QOF read-across, local payments may still have to be made as part of the contract price. It will still be possible for the practice to consult the central database (QMAS) to monitor its progress.

All parties to an agreement considering variations to the National QOF should take account of the relevant section in 'Sustaining Innovation…'[I]. Further papers will be published throughout the year to assist those intending to work towards local variations for inclusion in 2005.

10. Information for Patients

Practice leaflet
Where a provider is responsible for delivering essential services, a practice leaflet must be produced which includes the information listed in Annex B. It should reviewed at least annually and altered to maintain accuracy. Leaflets and updates should be made available to current and prospective patients.

Arrangements for sharing information
Some PMS schemes have already expressed their intention to publish details about their achievements, particularly in relation to the QOF. If providers and PCTS agree, they may wish to discuss how this information is best shared with the PCT in year and more widely with patients.

11. Common Standards

Several elements of the PMS contract will now be covered by regulations and common standards. There will therefore be a need to include appropriate agreement by PMS providers to comply with common standards which will include (where relevant) the following:

- Storage of vaccines
- Infection control
- Notifications of deaths
- Certification
- Prescribing and dispensing
- Registration of gifts
- Patient charges
- OOH quality standards (from April 2004)
- Complaints procedure
- Training of GP registrars
- GP Appraisal and assessment
- Notification of the PCT of changes in partnership
- Obligation to perform services with reasonable care and skill

- Clinical governance
- Insurance and medical indemnity
- Compliance with relevant legislation
- Confidentiality
- Rights of entry
- Co-operation with investigations and inquiries
- Use of accredited IT systems

12. PCT Support arrangements

Ongoing Support and Development

Ways in which PCTs will be able to help provide on-going support and development include through:

- The Department's human resources strategy, Improving Working Lives Standard (www.doh.gov.uk/iwl);

Supporting appraisal of all staff;

Provision of locum support through PCT locum banks;

Partial reimbursement for locum costs, where necessary for maternity, paternity, adoptive leave, sickness leave, or to cover for suspended doctors, or for the prolonged study leave scheme;

Initial development of local sabbatical schemes;

The Directed Enhanced Service for violent patients;

Delivering the NHS childcare strategy;

New pensions flexibility's and;

Support arrangements for practice managers and practice nurses (toolkit and guidance to be published in 2004).

13. Dispute Resolution

Dispute resolution and contract status

The PMS agreement regulations contain comprehensive appeal processes, referred to as dispute resolution. These can cover issues ranging from decisions about contractual sanctions and termination through to matters such as remuneration, list closure, OOH opt-out and individual patient assignment.

Health Service Body Status or Contract at law?
Key points to note about Health Service Body status are included in Annex A.

The relevant dispute resolution procedure is dependent on the nature of the contract held by the PMS provider. The contract might be an NHS contract or an ordinary contract for services.

Pre-contract disputes
If in the course of negotiations intending to lead to a PMS contract the prospective parties are unable to reach agreement on a particular term of the contract (including the contract price), either party may refer the dispute to the SofS who will appoint the FHSAA (SHA) to consider and determine it.

All such disputes will be considered and determined in accordance with the procedure set out in the PMS guidance. Any determination may specify the terms to be included in the proposed contract and may require the PCT to proceed with the contract. However, any determination will not require the proposed contractor to proceed with any PMS contract.

NHS Contracts
If a dispute arises between the parties to this agreement they shall try to resolve the dispute locally in the first instance.

With such a wide-ranging ability to take matters for external adjudication it is vital that local resolution is approached in an open and constructive manner. PCTs and contractors should note that attempts at local resolution are a requirement of the PMS contract regulations. It should involve, where necessary, board level involvement in conciliation meetings and neither side should be afraid to use appropriately skilled and qualified advisers.

At the time of conciliation parties might request the attendance of an appropriate professional representative. Reaching local solutions will make best use of the resources available for the local population and will help to develop a partnership approach between contractor and PCT. If no solution can be found locally it will be open to either party to the dispute to refer a matter to dispute resolution.

Where this has clearly failed, the Secretary of State will appoint the FHSAA (SHA) to determine most disputes. Where, however, it is important to factor local knowledge into the process of adjudication the Strategic Health Authority (or its equivalent) will be appointed. These instances involve disputes over list closure and patient assignments.

Where the Strategic Health Authority (or its equivalent) is to be appointed as adjudicator the Authority must, to preserve its independence, have played no part in the local dispute resolution process.

Non-NHS contracts
Where a practice opts for an ordinary contract at law they will have the option of asking the courts to resolve any resultant contractual disputes. However, it is the intention to provide an optional internal dispute resolution procedure.

As with GMS, PMS contracts which are contracts at law should include a clause that provides for dispute resolution involving binding adjudication by the Secretary of State. The practice therefore will have a choice of routes when there is a difference that cannot be resolved locally; either the courts or binding adjudication.

Where the dispute is referred for adjudication, the dispute would ordinarily be referred to the FHSAA(SHA). In certain circumstances (mentioned above), however, the Strategic Health Authority (or its equivalent) would be asked to adjudicate.

Disputes where the contractor is not an NHS body could be referred to either the FHSAA (SHA) or a competent court. The rules are:

- PCTs may only refer such disputes to the FHSAA (SHA) or the SHA with the written agreement of the contractor;
- the contractor may choose to refer a dispute via the NHS procedures without the PCTs agreement. If the contractor elects to follow the NHS process it should express that choice in writing. Any such dispute should follow the procedure set out for NHS contracts;
- alternatively the contractor can choose to refer it to a competent court;
- if a dispute is referred for NHS consideration the resulting determination will be binding on both parties. There are no two bites of the cherry.

14. Termination

The period of notice to terminate is to be agreed mutually between the PMS provider and the PCT and should be specified in the local contract. Six months is the recommended period.

15. The price of the contract

Note Spreadsheet in Section 5 applies to existing contracts

16. Signatories

Section 2

New flexibilities

The Government has committed to carry across into PMS nearly all of the benefits that have been negotiated as part of the new GMS Contract. This is on the principle of equity and fairness. The main areas are:

OOH

PMS providers will have the ability to opt out of responsibility for Out-of-Hours provision unless they are contracted as a specialist PMS out of hours provider.

Unlike GMS, PMS contracts will not automatically include a requirement for providers to obtain written permission to sub-contract their OOH services. However, providers will nevertheless need to inform their PCT when any services have been sub-contracted to another provider and will remain responsible for ensuring that their sub-contractors meet the terms of the contract including (from 2005) the National Quality Standards.

Where PMS providers decide to opt out, reduction in contract prices will reflect list size rather than numbers of doctors. It will be based on a figure of around £6,000 (to be finalised) in 2004/05, for an average individual list size. The existing Out of Hours Development Fund will be increased to support PCTs in funding alternative out-of-hours service provision where necessary.

Increased seniority pay

Seniority

Seniority pay for GPs will increase. The arrangements for this differ in 2003/04 and 2004/05.

2003/04

PCTs have received an increase in PMS allocations of 3.225% to cover the equivalent of the increase in GMS fees and allowances (2.85%) and the new seniority payments. There are two ways to deliver an increase in seniority pay to PMS GPs equivalent to that for GMS GPs. The first is **by agreement with the practice** to uplift the whole contract price by 3.225%. However, such an approach will only benefit more senior GPs if the internal partners agree. The alternative is for PCTs to establish the GP notional seniority entitlement (i.e. what seniority payments would be made if the GP in question had been working under GMS). The next step is to calculate what that same GPs entitlement would be under the new rules for GMS GPs. The PCTs would then:

- apply an increase of 2.85% to the contract price less the notional seniority entitlement;
- add back the notional seniority entitlements under the new rules.

2004/05

The same principle will apply to 2004/05 (and beyond); i.e. either apply an across-the-board uplift to the contract price, or calculate the uplift to the notional seniority component separately.

Human resource improvements and improving working lives

PMS Providers will have the same access to human resource improvements and the PCT will be expected to provide similar support as to its GMS Practices.

These include:

Facilitating the introduction of a new career structure e.g. through:

- skills development.
- special interest development.
- clinical leadership.

Supporting the introduction of protected time for skills development to cover e.g.

- Continuing professional development, appraisal preparation, revalidation, clinical governance, audit, and practice management and development.
- Providing for some or all of the costs of remediation to be paid for by Workforce Development Confederations.

Enabling the widespread employment of salaried GPs where this best suits practice and practitioner preferences

- PMS has supported the option of salaried GPs and there is no obligation to change to use the nGMS salaried contract.

Delivering family-friendly improvements including

- PCTs will consider the specific needs of GPs and their staff when developing local provision, including childcare options that are appropriate to GPs and their staff who are working parents.
- Equal access to maternity, paternity, adoptive and special leave benefits.

Encourage recruitment and retention through national schemes such as:

- Golden hello schemes,
- Sabbatical schemes
- Flexible career schemes and
- Returners' schemes

Supporting practice managers

- Recognising the crucial role practice managers will play in exploiting the benefits of recent developments by encouraging role development through the use of the practice management competency framework which covers strategic issues, the development and delivery of services to patients and practice infrastructure
- Pooling management resources
- Requesting access to practice management expertise through the PCT.

Supporting practice staff

- Practice team development
- Practice-employed nurses supported to participate in clinical
- Supervision, appraisal and to have access to professional advice and continuing professional development and to IM&T
- Nurses to take on new roles
- GP performer list to be extended to other professionals eventually
- Skill mix development
- Team responsibility for quality

Increased investment in and modification to IM&T

IM&T needs and funding

The funding of the IM&T needs of PMS Providers should be reflected in PMS contracts. PCTs should ensure that IM&T resources are made available to support both GMS and PMS schemes.

Funding to support the PMS practices is included within the additional £20m non-recurrent funding for 2003-2004 made available to PCTs in 2003. Similar levels of funding will be available in 2004-05 and 2005-06. This is an entitlement for primary care providers, both GMS and PMS, and therefore not discretionary.

This funding is specifically to support the commitment for PCTs to meet the costs of IT maintenance and minor upgrades for all practices from 1st April 2003, and is in addition to the £50m currently allocated to PCTs each year for this purpose.

The work programme to support the information requirements of PMS practices is being discussed and is expected to be brought into the scope of NPfIT in due course. Meanwhile PCTs should offer similar levels of IT support PMS as to GMS practices. This will be of particular importance if PCTs are making good use of PMS flexibilities; for instance, where a local QOF variation is being developed, requiring local data extraction and analysis.

Premises flexibilities

PMS and GMS practices should have equal access to new premises flexibilities including:

- The payment of a grant to meet mortgage deficit costs, to enable GPs to sell their existing premises and move to appropriate alternative premises
- The payment of a grant to meet mortgage redemption costs
- Allowing PCTs to take an option on land
- Allowing PCTs to continue cost rent payments to GPs who buy premises from a single-handed/two partner practice
- Allowing PCTs to review cost rent payments when GPs re-mortgage to lower interest rates
- Reimbursement of legal and other professional fees for GPs in new premises developed by public-private partnership
- Revised arrangements to pay notional rent in addition to cost rent when premises are modernised or extended
- Abatement of notional rent to pay full notional rent on GP capital invested in premises and abated notional rent for NHS capital equivalent to additional costs for heating, lighting, maintenance etc
- Payment of notional rent to leaseholder GPs who improve their premises
- Extension of the timescale to repay improvement grants to 10 years for owner-occupiers and for renting GPs to re-negotiate the terms of their lease to 15 years
- Allowing PCTs to directly reimburse insurance and utility costs, maintenance and service charges etc
- Introducing periodic (potentially quarterly) reviews of building cost location factors
- Introducing index-linked leases (e.g. RPI-based) to support capital invested in primary care premises better
- A revised premises schedule and a revised commentary
- Issuing a letter on safeguards and security for GPs signing leases with third party developers with the intention that PCTs will be able to have a lease assigned to them temporarily if the departing GP is unable to assign it.

Improvements to pension benefits

There is no general distinction between PMS and GMS practices for pension purposes. General Practitioners have been included in the NHS Pension Scheme since it was established in 1948. They automatically become members unless they decide not to join. As with other scheme members, their personal contribution is based on 6% of their pensionable pay, and the Primary Care Organisation which acts as their employer contributes an amount equal to 14% of their pensionable pay.

A sum representing a reasonable approximation of employer, employee and any AVC payments will be retained at PCT level and paid to the NHS Pensions Agency monthly. At the end of the year the practice will produce a certificate of NHS profits in a specified form. Once this has been agreed with the PCT, it will be forwarded to the NHS Pensions Agency with any balance of payments.

'Sustaining Innovation…[i]' contains details (paras 3.4 to 3.7) of new pension flexibilities, including calculation of pensions where a practitioner has worked as an independent contractor in general practice and as an employee of a Trust.

Admission of non-GP Partners to the NHS Pension Scheme
Non-GP contractors in PMS are entitled to join the scheme (i.e. signatories to the agreement)**.** They are admitted on a whole time officer basis so that their eventual benefits are assessed on the basis of final year salary. Their contributions are assessed on profit share.

Directed Enhanced Services

There are six DESs:

(vi) Childhood immunisations (target payments);
(vii) Influenza immunisation for those aged 65 and over in addition to those under 65 in at-risk groups
(viii) Minor surgery;
(ix) Access;
(x) Services to support staff dealing with violent patients;
(xi) Quality information preparation for supporting better use of patient records.

Specifications are available at:
http://www.doh.gov.uk/gmscontract/supportingdocs.htm#2

PCTs will have a duty to commission the Directed Enhanced Services listed above. The quality information preparation DES will apply equally to PMS practices with registered patients given. Access payments will also be extended to PMS, as will the requirement for PCTs to commission flu immunisation for the under- 65s at risk for the first time.

Minor surgery will be a matter for local agreement in PMS, given the commitment not to unpick current contract prices and its treatment as a combination of additional, directed enhanced and nationally enhanced services.

Support arrangements for violent patients are more straightforward given PCTs may only commission these from a few providers at most. Some PMS schemes are already leading the way in providing services expressly for violent or difficult patients.

The adoption of National Enhanced Services and use of Local Enhanced Services will be entirely a matter for local specification and agreement in PMS.

Section 3

Transitional Arrangements

From the 1st April 2004 all existing PMS pilot schemes will be treated as permanent agreements made under section 28C of the National Health Service Act 1977. As such they will need to be varied to comply with the requirements of PMS Agreements Regulations 2004 (listed in Section 4 below).

It is not expected however that all agreements will be varied on the 1st April and the following transitional arrangements (implemented by the General Medical Services and Personal Medical Services Transitional and Consequential Provisions Order 2004) will be put in place to effect the move from pilots to permanence:

1. From the 1st April all existing PMS agreements will be deemed to have been varied to include the ability to opt out of Out of Hours services, variation of the contract by agreement and termination of the agreement by the PCT on fitness grounds.

2. PMS contractors and PCTs will have a six months transitional period to agree the other necessary variations to bring agreements in line with the regulations.

3. During the transitional period it will not be possible to vary agreements contrary to the PMS Agreement Regulations

4. Agreed variations can be made at any point during the six month period and can be made either in a piecemeal fashion, as and when agreement on particular provisions has been reached or as one variation which includes all the necessary provisions

If after the six month period providers and PCTs have been unable to agree variations PCTs must unilaterally vary the terms of the agreement to ensure it complies with the PMS Agreements Regulations

Section 4

Mandatory Contract Terms as required by the PMS Agreements Regulations 2004

The following is a list of the terms required to be included in all PMS contracts made under the PMS Agreements Regulations 2004. All new contracts agreed on or after 1st April must include these terms. Unless otherwise indicated all existing agreements must be varied in accordance with these provisions as set out in Section 3 above. All references in bold are to the PMS Agreements Regulations 2004 (available atwww.legislation.hmso.gov.uk/si/si2004/20040627.htm).
The Transitional Order is still in draft form and references to it may be subject to change.

Key:

*- provisions apply only to agreements providing essential services
^ - provisions do not apply to PCT providers

1) That it is(n't) an NHS contract **(reg 10)**

2) The services to be provided **(reg 11(1)(a))**

3) The premises on which services are to be provided **(Reg 11(1)(b) & 11(2))**

4) To whom the services are to be provided **(Reg 11(1)©)**

5) ***Practice area **(Reg 11(1)(d))**

6) ***Whether the registered list is open or closed and details of closure (**NB** PCT contractors **must** have open lists) **(Reg 11(1)(e) & 11(4))**

7) That the contractor must issue free of charge a certificate listed in Schedule 2 of the PMS regulations to a patient **(reg 12 and Schedule 2)**

8) That the relevant body will make payments to the contractor under the agreement promptly and in accordance with both the agreement and any other terms on which the payment is made. **(Regs 13 & 14)**

9) That the contractor shall not demand or accept a fee or other remuneration from any of its patient (except where schedule 3 of the regs applies), but may charge a person if it has reasonable doubts as to that person's claim to be entitled to services from it **(Reg 15 and Schedule 3)**

10) The agreement must make suitable provision for arrangements on termination of the agreement including the consequences (financial or otherwise) **(Reg 17)**

11) ***The contractor must provide the services it is required to provide at such time, within core hours, as are appropriate to meet the reasonable needs of patients and have arrangements in place for its patients to access such services throughout core hours in case of emergency **(Sch 5 para 1)**

12) The premises in which services are to be provided must be suitable for delivery and meet the reasonable needs of patients **(Sch 5 para 2)**

13) ***That a contractor shall take steps to ensure that a patient who has not made an appointment and presents himself during at the premises in normal hours for essential services should be provided with those services unless it is more appropriate that he is referred elsewhere or he is given an appointment **(Sch 5 para 3)**

14) If a patient requires attendance and, in the reasonable opinion of the contractor, it would be inappropriate for them to go to the premises the contractor will provide services to him either at the patient's home, or some other place. **(Sch 5 para 4)**

15) Where a contractor provides services (except those services which must comply with the OOHs quality standards) to a patient not on its list it shall prepare and send a clinical report to the relevant body (except where the relevant body is an SHA) of the treatment it gave **(Sch 5 para 5)**

16) That vaccines are stored as per manufacturer's instructions in fridges with a maximum/minimum thermometer and that readings are taken on each working day **(sch 5 para 6)**

17) The contractor shall ensure it has appropriate arrangements for infection control and decontamination **(sch 5para 7)**

18) ***A contractor who does not provide to its patients a particular service shall co-operate as far as is reasonable co-operate with any person responsible for the provision of that service and reasonable efforts are made to ensure a patient who contacts the contractor in the OOHs period is informed of how to get services **(sch 5 para 10)**

19) A contractor who ceases to provide to its patients a particular service shall comply with any reasonable request for information from the relevant body or any person who is likely to be providing those services to those patients in the future. **(Sch 5 para 11)**

20) *Procedures for accepting or refusing to accept patients on a contractors registered list or a temporary resident **(Sch 5 paras 13 - 16)**

21) *Patient preference of practitioner **(Sch 5 para 17)**

22) *Removals of patients from a list of patients **(Sch 5 paras 18 - 26)**

23) Termination of responsibility for unregistered patients **(Sch 5 para 27)**

24) *^List closure **(Sch 5 paras 28 - 30 except para 30 (6) - (8))**

25) *^Assignments to lists of patients (where lists are open and closed) **(Sch 5 paras 31- 36 except paras 34 (5) - (9) and 35(5) - (17))**

26) Requirements as to prescribing **(Sch 5 paras 37 - 38)**

27) Repeatable prescribing services **(Sch 5 paras 39 - 40)**

28) Restrictions on prescribing by medical practitioners and supplementary prescribers **(Sch 5 paras 41 - 42)**

29) Bulk prescribing **(Sch 5 para 43)**

30) Excessive prescribing **(Sch 5 para 44)**

31) *^ Provision of dispensing services **(Sch 5 paras 46 - 48 and 50)**

32) Provision of dispensing services by PCT contractors **(Sch 5 paras 49 and 50)**

33) Provisions of drugs, medicines or appliances for immediate treatment or personal administration **(Sch 5 para 52)**

34) No medical practitioner shall perform services under the agreement unless he is on, and not suspend from, a medical performers list held by a PCT and not suspended from the medical register (interim or otherwise) except where the practitioner is employed by a NHS (foundation) Trust (or DA equivalent), provisionally registered or a registrar in his first two months of training. Any conditions on registration must be complied with **(Sch 5 para 53)**

35) No Health Care professional shall perform services under the contract unless he is appropriately registered with (and not suspended from) his relevant professional body. Any conditions on registration must be complied with. **(Sch 5 paras 54 - 56)**

36) Conditions for employment and engagement **(Sch 5 paras 57 - 60)**

37) Contractor must ensure that any health care professional performing or assisting in the performance of clinical services under the contract shall have reasonable opportunities to undertake training with a view to maintaining competence and that there are arrangements in place for maintaining and updating his skills and knowledge. **(Sch 5 paras 61 - 62)**

38) Arrangements for GP registrars **(Sch 5 paras 63)**

39) Drs with provisional registration (a contractor shall not reduce the hours of other staff assisting in the performance of medical services when one is employed) **(Sch 5 para 64)**

40) ^Independent nurse and supplementary prescribers **(Sch 5 para 65)**

41) Signing of documents **(Sch 5 para 66)**

42) Level of skill **(Sch 5 para 67)**

43) The contractor must ensure that any medical practitioner performing services under the agreement participates in the appraisal system provided by the PCT and co-operates with assessments by the NCAA **(Sch 5 para 68)**

44) Sub-contracting of clinical matters **(Sch 5 para 69)**

45) Patient records - requirements for keeping of records (**NB** the bulk of this applies only to contractors providing essential services) **(Sch 5 para 70)**

46) Confidentiality of personal data **(Sch 5 para 71)**

47) *Contractor's leaflet **(Sch 5 para 72 and Sch 10)**

48) Provision of information and rights of entry and inspection **(Sch 5 para 73 - 74 & 83 - 85)**

49) ^Inquiries about prescriptions and referrals **(Sch 5 para 75)**

50) *Reports to a medical officer **(Sch 5 para 76)**

51) Annual review **(Sch 5 para 77)**

52) Notifications **(Sch 5 paras 78 - 82)**

53) Complaints procedure **(Sch 5 paras 86 - 92)**

54) Dispute resolution **(Sch 5 paras 93 and 95 - 97 except paras 95 (5) - (14) and 96)**

55) ^ Dispute resolution non-NHS contracts **(Sch 5 para 94 and 97and possibly 95 - 96)**

56) Variation, termination and sanctions (including agreed notice period and sanctions). (**NB** variation by agreement covered in Article 58(2) of the transitional order, termination on fitness grounds by Article 59(6) of the same order.) **(Sch 5 paras 98 - 111)**

57) A contractor must have a system of clinical governance in place **(Sch 5 para 112)**

58) Insurance - clinical and public liability **(Sch 5 paras 113 - 114)**

59) Compliance with legislation and guidance **(Sch 5 para 115)**

60) Third party rights **(Sch 5 para 116)**

61) Register of gifts **(Sch 5 para 117)**

62) *Opt outs of out of hours **(Reg 16 and Sch 4)** (**NB** Opt out and transitional provisions are deemed to be included in agreements under Article 59(4), (5), (7)&(8)of the Transitional Order)

63) *Out of hours transitional provisions **(Reg 20, Sch 4 and Sch 6)** ((**NB** Opt out and transitional provisions are deemed to be included in agreements under Article 59(4), (5) , (7)&(8)of the Transitional Order)

64) Criteria for out of hours **(Sch 5 para 8)**

65) Standards for out of hours services **(Sch 5 para 9)**

Section 5

Calculating a Contract price for 2004/5 for existing schemes

Contract Price

1.1 Enter the agreed 03/04 contract price for this practice

2003/04	2004-05
£00.00	£00.00

1.2 Enter the latest estimate of the unadjusted registered practice list

No. of Patients:	0000
Practice list relative to national average:	0000

1.3 Enter the percentage increase or decrease in unadjusted registered list size you think has occurred since April 03:

1.4. Will the practice opt-out of OOH services in 2004/05?*

If yes, enter no, of months opted out for (April=12, May=11 etc):	0000
Opt out Price:	£00.00

1.5 Will the contractor receive any payments for pneumococcal and 'flu, not included in the 2003/04 contract price above?

If yes, enter the total anticipated payments in 2004/05	£00.00

Estimated Contract Price, 2004/05	**£00.00**

Golden Hellos and other Recruitment and Retention payments outside the contract price

(Exclude all items that are to be delivered as part of the contract price.)

2.1 Do any GPs in the Practice receive Golden Hello payments?

If yes, estimate for each year and enter the total annual payments the Practice will receive.

If no, enter 0 £00.00

* Golden Hello payments are a lump sum payment, but you may wish to simulate further payments if you expect new staff.

Golden Hello payments	**2004/05**	**£00.00**

Out-Of-Hours

(Exclude all items that are to be delivered as part of the contract price)

3.1 Enter any income - not included in the contract price - that the practice will receive for out-of-hours services

	2004/05	£00.00
Total out-of-hours		**£00.00**

Enhanced Services

(Exclude all items that are to be delivered as part of the contract price.

4.1 Directed Enhanced Services

(a) Quality Information Preparation

Enter the payments to be made to the practice for the QuIP scheme

	2004/05:	£00.00

(b) Improved Access Scheme

Implementation Payments	2004/05:	£00.00
The Practice IAS Reward Payments	2004/05:	£00.00

4.2 Other Enhanced Services

Enter the anticipated payments under other Directed Enhanced Schemes, National Enhanced Schemes, and Local Enhanced Schemes in 2004/05
- enter the name of the scheme and expected payment

Name of scheme	Payment in 2004/05
	£00.00
	£00.00
	£00.00
Total other ES payments	**2004/05: £00.00**

Total estimated payments from enhanced services

2004/05: £00.00

5. Quality

If the contractor is intending to follow the national quality and outcome framework, complete 5.1 only.

If the contractor is intending to follow a local quality scheme, complete 5.2 only.

Quality payments are shown at step 5.3.

5.1 If using the national scheme

Using the Interim Aspiration Utility, enter the total expected points you expect to achieve for each domain.

	Your practice	Maximum available
Clinical	000	550
Organisational	000	184
Additional	00	36
Patient experience	000	100
Holistic care payments	000	100
Quality practice payments	00	30
Access bonus	00	50
Total quality points* -174	0000	1050

* includes a 174 point offset, as explained in the recent PMS guidance

5.2 If using a local scheme

If you are using a locally arranged quality scheme, enter the anticipated points you expect to achieve in 2004/05:

000

a 174 point offset will automatically be deducted, as explained in PMS guidance

5.3 Quality Payments

Estimated total quality payment 2004/05

quality prep	£00.00
aspiration	£00.00
rewards	£00.00
Total 04/05	£00.00

6 Premises

Exclude all items that are delivered as part of the contract price.

6.1 Enter the total anticipated practice payments for premises in 2004/05, not included in the contract price.

Total premises payments	**Total 04/05**	**£00.00**

IM&T

Exclude all items that are delivered as part of the contract price.

7.1 Enter the total income received for IT items in	2002/03	£00.00
	2004/05	£00.00

7.2 Enter additional revenue requirements to ensure 100% reimbursement for IT items

Total it payments	**2004/05**	**£00.00**

Summary Sheet 2004/05

1) Contract Price*	£00.00
2) Quality	£00.00
3) OOH	£00.00
4) Enhanced primary care services	£00.00
5) Premises	£00.00
6) IM&T	£00.00
7) Other PCT administered funds	£00.00
TOTAL	**£00.00**

Notes on Spreadsheet

1) Further modifications of the spreadsheet to include greater detail beneath the broad headings will be included soon.
2) Note that 'contract price' is equivalent to current baseline, including staffing, growth and seniority (where not claimed using the alternative arrangements). Since contracts are locally derived, baselines may well differ across practices. However, all elements comprising the 2003/04 baseline should be included except where they are covered by headings 2-7 above.
3) Only out of hours is specifically referred to as an 'opt out' in the PMS regulations. Where providers wish to consider reducing their service provision in a similar fashion to GMS opt-outs, the GMS 'price' should be used as the benchmark.
4) Where local schemes covering list sizes are in place including 'trigger points', the starting point should be specified with a note indicating resource attached to triggers.
5) 'Other PCT administered funds' include pharmaceutical budget (where not included in current baseline), PMS Plus (which do not need to conform to enhanced services descriptions), and other local incentive scheme resources.
6) Where a local QOF scheme is developed, a note should be included detailing incentives and triggers.
7) Agreed regular payments based on the final contract price should be specified.

Annex A

NHS Contracts and Health Service Body Status

PMS contractors will have Health Service Body status unless they choose to opt for a contract at law. Most of the current PMS schemes have Health Service Body status. This allows the PMS contract to be considered as an NHS contract. An NHS contract is an arrangement between one Health Service Body and another for the provision of goods and services. Examples of health service bodies include Strategic Health Authorities, PCTs, NHS Trusts and Special Health Authorities.

Entering into an NHS contract brings advantages to both contractor and PCT - bureaucracy is kept to a minimum but security is retained for contractors. Any disputes about the terms of a NHS contract may be resolved through the NHS disputes procedure thereby avoiding time consuming and costly recourse to the courts (although access to the NHS disputes resolution process should be available for providers that do not have health body status).

If the PMS provider(s) do not wish to be considered as a Health Service Body they must give written notice to the PCT to that effect. Otherwise Health Service Body status will commence automatically from the date of the contract.

PCTs should note that the choice of being or not being a Health Service Body is entirely a matter for the PMS provider and they should not attempt to force such status, or deny such status, onto a PMS provider. If providers do not wish to become a Health Service Body, but have a private law contract instead, PCTs should reflect that in the PMS contracts they offer to practices/providers.

Key points to note about Health Service Body status are:

If a PMS provider becomes a Health Service Body, it may enter into other NHS contracts with another Health Service Body;

- Becoming a Health Service Body does not affect other contracts the provider may have entered into before Health Service Body status takes effect. If for any reason the PMS contract is terminated, the contractor stops being a Health Service Body, unless it already holds a separate NHS contract in which case it continues to be a Health Service Body for the purposes of that contract.

Contractors can at any time seek to vary their contract to remove or include provision that it is to be considered a Health Service Body. Any variation in respect of Health Service Body status will need to be set out in writing and signed by both parties.

Annex B

Information to be included in a contractor's leaflet

A contractor's leaflet shall include:

1. The name of the party or parties comprising the contractor.

2. In the case of an agreement where a qualifying body is a party:

(a) the names of the directors, the company secretary and the shareholders of that body; and

(b) the address of that body's registered office.

3. The full name of each person performing services under the agreement.

4. In the case of each health care professional performing services under the agreement, his professional qualifications.

5. Whether the contractor undertakes the teaching or training of health care professionals or persons intending to become health care professionals.

6. Where the contractor provides essential services its practice area, by reference to a sketch diagram, plan or postcode.

7. The address of each of the contractor's premises.

8. The contractor's telephone and fax number and the address of its website (if any).

9. Whether the contractor's premises have suitable access for disabled patients and, if not, the alternative arrangements for providing services to such patients.

10. How to register as a patient.

11. The right of patients to express a preference of practitioner in accordance with paragraph 17 of Schedule 5 and the means of expressing such a preference.

12. The services available under the agreement.

13. The opening hours of the contractor's premises and the method of obtaining access to services throughout the core hours.

14. The criteria for home visits and the method of obtaining such a visit.

15. The arrangements for services in the out of hours period (whether or not provided by the contractor) and how the patient may access such services.

16. Where the contractor is other than a Primary Care Trust, if the services referred to in paragraph 15 are not provided by the contractor, the fact that the relevant body referred to in paragraph 26 is responsible for commissioning the services.

17. The name and address of any local walk-in centre.

18. The telephone number of NHS Direct and details of NHS Direct online.

19. The method by which patients are to obtain repeat prescriptions.

20. If the contractor offers repeatable prescribing services, the arrangements for providing such services.

21. If the contractor is a dispensing contractor, the arrangements for dispensing prescriptions.

22. How patients may make a complaint or comment on the provision of services.

23. The rights and responsibilities of the patient, including keeping appointments.

24. The action that may be taken where a patient is violent or abusive to a party to the agreement who is an individual, any member of the contractor's staff or other persons present on the contractor's premises or in the place where treatment is provided under the agreement.

25. Details of who has access to patient information (including information from which the identity of the individual can be ascertained) and the patient's rights in relation to disclosure of such information.

26. The name, address and telephone number of the relevant body with which the contractor is a party to the agreement.

27. The fact that details of primary medical services in the area may be obtained from the relevant Primary Care Trust.

References

[i] *Sustaining innovation through PMS development (2003)* Department of Health.
Web link:
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PersonalMedicalServicesPilots/PersonalMedicalServicesPilotsArticle/fs/en?CONTENT_ID=4066887&chk=QbnUj4

[ii] *The National Health Service (Personal Medical Services Agreements) Regulations 2004 Statutory Instrument 2004 No. 627 The Stationery Office*
Web link:
http://www.legislation.hmso.gov.uk/si/si2004/20040627.htm