March 2010

Reviewing PMS contractual arrangements

Guidance for PMS practices (England only)

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This guidance note sets out the options available to PMS practices when PCTs seek to change PMS contracts – e.g. when PCTs propose a review of existing contractual terms; when PCTs threaten to terminate the contract; and/or when PCTs offer 'new' contracts.

This is an update of the GPC guidance issued to PMS and APMS contractors providing essential services in April 2006 and March 2007. Whilst this is specifically an England-only document, the principles can be applied to non-GMS contractual options in all four countries.

1. Contract reviews

Practices facing a review of their PMS contract have, at least, four options:

- Seek to retain current contractual status with no changes
- Renegotiate PMS contracts
- Transfer to GMS
- Transfer to a new, locally-negotiated, APMS contract

Further details of each of these options are set out below.

1.1 <u>Seek to retain current contractual status with no changes</u>

A PMS contract cannot be amended, unless it is following a change in the Regulations or a Secretary of State Direction, without the agreement of both parties. This is set out in schedule 5, paragraph 98 of the National Health Service (Personal Medical Services Agreements) Regulations 2004. A practice may therefore refuse to accept any contractual amendments proposed by the PCT (which are not the result of a change in Regulations or a Secretary of State Direction).

However, an outright refusal may leave contracts open to the threat of termination – see section 2 below. Therefore, in the first instance a practice might prefer to seek to convince the PCT that any amendments are unnecessary – and the following are some of the arguments that could be used to counter PCT proposed amendments:

1.1.1 Proposed reduction in PMS growth monies

- Practices are advised to collect evidence of how their growth money has been used appropriately (i.e. to employ additional staff, and/or to improve or restructure services).
- If a practice agreed a plan about how growth money should be spent at the time of opting to move to a PMS contract, they should check to ensure that they have kept to their side of the agreement.
- The letter from the then Secretary of State, John Hutton, to all PMS practices of 15 October 2003 said: "The Government's commitment to 'no unpicking' means that you will be able to retain the baseline funding you receive now, together with any growth monies you have been awarded during the piloting process, as part of your PMS contract price after 1 April 2004. This includes those considering signing PMS contracts shortly. The growth money that has already been agreed will be for you to use flexibly as part of your local agreement. It will no longer be restricted to its current use for GPs and nurse practitioners."

1.1.2 Proposed requirement to do additional work or take on extra patients without extra funding

- Contract holders could provide evidence of their value for money and of the services that they are currently providing.
- Where the PCT suggests that new work is undertaken, check whether it has adequate clinical evidence to demonstrate its value to patients.

1.1.3 Proposed amendment to a superannuation clause

Some PMS practices have a superannuation clause in their contract to allow for full 14% employer superannuation contributions to be paid by the PCT.

- If the PCT seeks to review this clause, PMS practices should seek what is due to them under existing contractual arrangements.

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1.1.4 *Proposed variations to the national QoF*
Practices should be aware that some variations may result in a more demanding framework for the same rewards. Generally variations should be resisted, and the following are points to raise:

- The Department of Health previously recommended a standard deduction of 109 points (the 'offset') from the QoF achievement points of PMS practices from 2005/2006 onwards. This was irrespective of the baseline PMS contract price. The nationally determined offset calculation was agreed because of the difficulties inherent in trying to separate PMS finance out into baseline, non-baseline and growth money. Therefore, any attempt to make further deductions should be resisted.
- Any local variation of QoF for PMS practices (ie. using different qualify specifications and targets) should be evidence-based and at least as good as the QoF standard.
- The software, including that for monitoring the QoF, is specific to the nationally agreed framework. Therefore this is unlikely to recognise variations.
- 'Sustaining Innovation through New PMS Arrangements' (2004) states, "Quality delivery and quality frameworks should be broadly comparable between PMS and GMS. We expect that most PMS quality schemes will show a resemblance in content to the new GMS QoF but there can be differences in delivery and measurement – subject to the same overall points total – to enable movement between schemes" www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4066930

1.2 Renegotiate PMS contracts
This option should have the involvement of LMCs, and it is important that an LMC gets a mandate from all practices (or at least the majority) in the area to act and negotiate with the PCT on behalf of the practices. We suggest that practices and their LMC should proactively approach the PCT to discuss how the negotiation process will take place.

Ultimately, whether practices are willing to accept a review of their contract will largely depend on the extent of the changes proposed. LMCs should be able to provide advice on what are acceptable changes and what are not. The points made above (1.1.1 to 1.1.4) may assist. In addition, it is recommended that a process is put in place that takes into account the following, and with a view to ensure that funding is not withdrawn in the future:

- PCTs and practices need to be clear why any use of funding or services are considered 'not appropriate'
- PCTs need to demonstrate why what they are proposing is 'acceptable'
- Proposals should be well documented (in writing) before any agreements are made
- Changes must be discussed and agreed by both the practice and the PCT
- There must be adequate opportunity for the practice to make any agreed changes, with appropriate funding.

In addition, if a PCT proposes reducing future funding for the core contract, a practice could consider withdrawing from providing services that are over and above the PMS contractual terms. For guidance on this, please see the GPC guidance, *Safeguarding Patient Services – Maintaining cost-effectiveness at:* www.bma.org.uk/images/safeguarding_tcm41-147089.pdf

Please note that a PCT may offer to terminate the old contract in return for a new (and varied) contract. This should be resisted as there are potential dangers to the practice with this approach – e.g. there is the risk that the PCT might not offer the new contract.

1.3 Transfer to GMS
This requires the local negotiation of fair and equitable rules for the transfer to GMS from PMS. In particular, it also requires the entitlement of PMS practices to the equivalent of a Minimum Practice Income Guarantee (MPIG) and clear guidance on how to deal fairly with the issue of growth monies. This is not a simple procedure, and an MPIG may be more difficult to calculate the longer the PMS contract has been in operation.

The GPC has made repeated attempts to convince the government that to negotiate a national agreement would be in their best interests, but the government has been unwilling to consider this. It

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also seems unlikely that the government will agree to national protection of PMS practices' income at their current baseline rate, including growth monies, particularly as the PMS reviews are generally seeking to make financial savings for PCTs.

1.3.1 Negotiating 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 effectively a practice decision (part 6, Regulation 19 of the PMS Agreements Regulations) – although in theory individual contractors could seek individual GMS agreements. If there is no GP member of the practice, there is no right to a GMS contract unless a GP is brought into to the PMS contract.

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 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. The full content of the John Hutton letter can be found at:
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Advancedletters/DH_4079438

Practices that can demonstrate that they have invested growth money in services will make it more difficult for their PCT to remove the funding.

Although each practice is different, PMS baselines can generally be thought of as the equivalent as a GMS practice's global sum plus MPIG – although there may be other elements included in a PMS baseline such as seniority and target payments, etc. When negotiating on the issue of MPIG and the future of growth funding, LMCs and practices should consider the following funding streams, and the services provided with the money, to ensure fair transfer of resources:

- PMS baseline
- rents and rates
- growth money
- enhanced services
- impact of the QOF points reduction

Under section 96 of the NHS Act 2006 it is possible for a PCT to provide assistance or support to any PMS contractors when a negotiated element to compensate for the absence of MPIG has been agreed. There is some further guidance on this in section 6.12 of 'Sustaining Innovation through New PMS Arrangements':www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4066930

Separate GPC guidance is being prepared on calculating an MPIG equivalent on return to GMS.

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1.4 Transfer to a new, locally-negotiated, APMS contract

This is similar to option 1.3. In addition LMCs would need to be well informed and would require buy-in of APMS from practices. It would open up the services being provided by the practice to the patient population for tender with no guarantee that the PMS practice would be awarded the contract. There is also no guarantee that similar problems would not arise in the near future when APMS ceases to be the government's preferred option. It is also important to determine the level of funding that would be available. Those considering this option should carefully check the bidding terms to ensure that the agreement will be negotiable for the practice, and also that the wording of the final agreement is suitable. The GPC's guidance on APMS is available at:
www.bma.org.uk/employmentandcontracts/independent_contractors/service_provision/apms0406.jsp

2. When PMS practices face termination of their contracts

2.1 When can a PMS contract be terminated?

A PMS contract may be terminated with cause. This is when a term of the contract has been breached.

The Regulations state that a PMS contract may also be terminated by the PCT without cause (ie. when the practice is not in breach of a contractual term) provided that the PCT gives the practice at least six months notice (or a longer notice period if contractually agreed between the parties). However, there was a case (Crouch v South Birmingham PCT) concerning the wording of the termination clauses in a Personal Dental Services (PDS) contract. In that case it was held that the PCT did not have a free standing right to terminate without cause. This judgment has never been legally tested for PMS. If your practice is being threatened with termination or is terminated without cause please immediately contact your LMC and, if you a BMA member, the BMA (email: support@bma.org.uk; telephone: 0300 123 1233).

A PMS contract can also be terminated by the practice without cause by giving at least six months notice of its wish to terminate (or a longer notice period if agreed between the parties).

2.2 Can existing contracts be terminated if review agreements cannot be reached?

Each PMS contract is negotiated locally and hence there are likely to be many differences between the termination provisions in individual agreements. Because of this it is not possible to give universal advice to PMS practices. However, the BMA's legal department has considered the general issue of termination in the light of the regulations and existing model contracts and the following information is provided. For BMA members, the BMA provides individual expert advice on such contractual issues.

GPs should be aware that there is a possibility that PCTs wishing to terminate PMS contracts without cause may seek to use the Regulations to do so. Under the current Regulations (schedule 5, paragraph 100 of the NHS (PMS Agreements) Regulations 2004 as amended), a PCT may terminate a contract provided that they give at least six months notice (or longer if a longer notice period has been agreed between the parties).

PCTs may use this as a threat to coerce practices into accepting a review of their PMS contract.

2.3 What can PMS practices do if they think their contract may be terminated?

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 (provided that the notice period is for at least six months), 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 could 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 section 1.3 above).

Practices are reminded that they may invoke the dispute resolution procedures in their agreement, as some 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 NHSLA's Family Health Services Appeal Unit (FHSAU) in Harrogate. If a practice holds a private law contract i.e. it

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has not elected to be treated as a health service body for the purpose of the contract, 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.

2.4 What should PMS practices do if a termination notice is served?

If practices do not wish to accept a termination, they should refrain from signing an acceptance of termination letter when asked by the PCT. They should also seek advice from their LMC, and it is worthwhile requesting an extension to the termination notice from the PCT to allow more time for negotiation. Similarly, if the PCT offers an extension, then this should be acknowledged and accepted.

The practice can also invoke the dispute resolution procedures as noted in section 2.3 above. This must be commenced while the contract is still in force. However, the FHSAU can only consider the legalities of the individual contract and whether it allows this type of termination.

If termination does occur, PMS practices retain the right, prior to the termination being effected, to a GMS contract under the PMS Regulations – see section 1.3 above.

3. Role of LMCs

PMS is a local contract and the role of the LMC is a particularly vital one in such cases. There is also considerable potential benefit to PMS practices if they act together, under the guidance of the LMC, rather than allowing themselves to be picked off, individually, by the PCT. LMCs can support PMS practices by advising practices on the options available to them and helping them make the best decision. One way is to assist with negotiations locally with the PCT to agree an acceptable contract deal if this is agreed as the most appropriate way forward. LMCs should be able to provide advice on what are acceptable changes and what are not. This needs to be a local decision and may vary from practice to practice in an area. In general it may be reasonable to look at fringe issues to avoid the risk to the core contract. It is of course possible that some practices will wish to make the move back to GMS if that is deemed a better long term option and the LMC could also assist with these negotiations. If a threat of termination is issued, this is likely to alarm and distress practices in the area and both LMCs and the GPC should offer support in this situation.

As a starting point, LMC should consider the following actions. Many of these are already currently being undertaken by LMCs:

- Provide support to practices in difficulty with their contract
- Offer assistance with negotiating with the PCT and SHA
- Offer to act collectively on behalf of practices if appropriate
- Provide a realistic view on when to accept a wise agreement with the PCT
- Advice on alternative contractual options

Most LMCs provide these services as matter of course to GMS practices and should offer the same level of service to levy-paying PMS practices, as well as considering what, if any, support they can offer non-levy paying practices. LMCs may have to create additional resources to do this since this work may not have previously been included in their budgets. The GPC is aware that threats of mass termination of PMS contracts have been withdrawn in some areas following LMC involvement so it may also be valuable for LMCs to share experiences with each other. A further consideration is that PCTs will not want to be shown up as destabilising practices so involvement with the local press, patient groups, local councillors or MPs could be an option – see sections 4 and 5 below.

It is also important to ensure that all GPs, both GMS and PMS, unite on this issue, particularly on the issue of destabilisation of health care to patients in the local area, as this will not allow PCTs the opportunity to divide and rule GPs in the area.

4. Consulting with patients

If termination notices are issued, or if PMS contracts are the subject of renegotiation, the LMC should emphasise the threat to patient care that the PCT's approach is or will cause. Where significant changes to patient services are planned, the PCT must consult under the National Health Service Act 2006. Part 12, section 242 of the 2006 Act states:

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(2) Each body to which this section applies must make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, involved in and consulted on:

(a) the planning of the provision of those services,

(b) the development and consideration of proposals for changes in the way those services are provided, and

(c) decisions to be made by that body affecting the operation of those services.

If the PCT fails to do this, then the LMC might wish to bring this to the attention of the public using local media. Please contact the BMA's press office for guidance/support.

The PCT's lack of consultation may also be rectified via a Judicial Review because the PCT will be in breach of its statutory duty.

5. Parliamentary and press action

When faced with proposed funding cuts and/or terminations, LMCs may wish to canvass support from local MPs and counsellors. The following provides some advice on how this can be achieved:

- Call the MPs office and explain the problems. The issues surrounding the PMS contract negotiations may be too complicated to explain by telephone and best saved for a face-to-face meeting.
- Point out the implications that any cuts will have on patient care. It is best to give specific examples of services the practice will have to reduce or cut if funding is withdrawn.
- Tell the MP that you have a petition and the number of people who have signed it so far. You may wish to mention any awareness raising sessions to the MP and your plans for local media work. The MP may want to get involved and do some additional media work with you.
- Ask the MP for a face-to-face meeting as soon as possible to discuss the proposed changes.
- Prepare a briefing paper on the changes to the PMS contracts, which you can send to the MP and to other MPs in the area whose constituents may be patients at your or nearby practices. You could ask the MPs to write to the Chief Executive of the PCT.
- Contact he BMA's parliamentary unit for details of MPs.
- Raise the same issues with local councillors and other local groups with influence.

The BMA's press office can also assist LMCs who would like to achieve press coverage locally.

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