

Sustaining Innovation through New PMS Arrangements

Revised

18th March 2004

Important Notice

Elements of this guidance may be subject to change following further development and consultation on secondary legislation that will underpin the policy intent outlined in this document

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1 Chapter One - Executive Summary

1.1 Introduction

This document sets out guidance for PMS providers, PCTs and SHAs. It explains how Personal Medical Services (PMS) will change from 1st April 2004.

1.2 Purpose of PMS

The piloting of Personal Medical Services (PMS) began in April 1998 as a voluntary option for GPs and other NHS staff to enter locally negotiated contracts as an alternative to the national General Medical Services (GMS) contract. The key aims of PMS when it was introduced were to:

- Provide greater freedom to address the primary care needs of patients.
- Enable flexible and innovative ways of working, encouraging greater skill mix and a team-based approach to managing patient care.
- Address recruitment problems by providing a GP salaried option and supporting an enhanced role for nurses within general practice.
- Tackle issues of under-resourcing by attracting GPs and nurses to previously under doctored areas.

External evaluation of PMS pilots demonstrated that the new arrangements provided greater opportunities for reforming the delivery of primary care.

Over 40% of GPs in England now work under PMS contracts; PMS is here to stay as a viable local contract. PMS will offer choice for GPs and other primary care providers on the contractual arrangements they work under. We also hope that PMS will continue to provide a vehicle to drive local innovation.

1.3 New PMS

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.

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

- **Choice** – to provide a choice for GPs and other primary care providers as to the form of the contract they operate under. A nationally negotiated but locally sensitive and managed GMS contract or a locally agreed and managed PMS contract.
- **Equity and Fairness** – to ensure that similar opportunities exist for patients to benefit from the services they receive from primary care providers whatever the contractual framework they operate under. Likewise, primary care providers should be able to access, fairly, the additional primary care investment that is being made available by the Government. In this way any differences that result are due to the actions and outcomes relating to the manner of delivery and not resources.
- **Value** – Over 40% of GPs have opted for a locally agreed contract. With the demonstrable benefits that have been delivered, it is clear that PMS is a valuable contractual framework. New developments must sustain and enhance these attributes.
- **Decentralisation** – to deregulate wherever possible, enabling further decentralisation and moving decision-making closer to the patient. This will empower clinicians to deliver further benefits to patients.
- **Sustaining Innovation** – PMS has been a powerful vehicle for change in primary care. It should continue to be a test-bed for trying out new ideas, for finding solutions to existing problems and providing opportunities for tackling particular needs or circumstances, particularly for patients who needs may not always be best met through GMS.

The Government expects that these attributes should be reflected within the local negotiations and PMS contracts that will result.

1.4 New benefits from Investment in General Practice

The Government has given a commitment to deliver [£8.1bn] of investment in primary care as part of the Gross Investment Guarantee.

PMS contractors will benefit from this new investment in primary care. There will, however, be some important changes to the financial arrangements [as set out further in Chapter Six]. PMS finances will be managed at PCT level. There will be no centrally held fund for new PMS growth as PCTs overall allocations will in future reflect their fair share of 'growth' monies that was previously held centrally. Instead, PMS schemes will be able to access significant additional funding via the quality framework.

The Health and Social Care (Community Health and Standards) Act 2003 provides for PMS pilot arrangements to become a permanent local alternative primary care contract. Wave 5B was therefore the last "wave" of 'piloting.' After 1 April 2004, those wishing to enter PMS will not be subject to a national deadline and will need to deal directly with their PCT or SHA as appropriate.

Chapter two covers operational issues that relate to establishing PMS as a permanent local alternative contract.

Alongside new investment, PMS GPs will also benefit from the following:

- The ability to opt-out of responsibility for Out-of-Hours provision
- Improved seniority pay
- Improved pension benefits
- New and improved HR policies
- Increased investment in and modifications to IM&T
- More flexible premises arrangements

Details of each of these improvements are covered in Chapter three.

Given the local nature of the contract, the arrangements for these improvements may differ from those in GMS. Our aim has been to ensure that additional flexibility has been built into PMS that will allow PCTs and PMS providers to sustain innovation and to reflect local population and patient needs. For example, PMS providers *can* (but need not) differ from GMS providers in the application of the Quality Framework (details of which are in Chapter Four)

1.5 New Opportunities

PMS has always been a driver of innovation. In the future, we will be promoting further innovation through

- Development of Specialist PMS
- Practice-led Commissioning

Further details on Specialist PMS is contained in Chapter Five. Guidance on Practice Led Commissioning within PMS will be issued in January 2004.

2 Chapter Two – Operational Issues

Action Points for PCTs to Note

- PMS is to be a permanent option for the provision of primary care services from the 1st of April 2004;
- It is for PCTs (or SHA where the PCT is the provider) and the primary care provider to agree a PMS contract. That contract should be clear about funding, services to be delivered and arrangements for quality improvements;
- There will be no further central allocations to cover preparatory costs for PMS. It is now a matter of local discretion for PCTs;
- PCTs can agree to vary all contracts from 1st April 2004 (except where they themselves are the PMS provider) in line with a locally agreed process;
- Notice of termination is to be agreed mutually between the PCT and the PMS provider (recommendation of six months);
- PCTs should establish a local resolution procedure agreed with PMS stakeholder groups.

Action Points for PMS Practices to Note

- To enter into a NHS contract the PMS practice will need to have health service body status;
- To obtain health body status, the provider(s) will need to notify the PCT in writing of that intention;
- There is no longer any requirement to apply for PMS status through a national process to the Secretary of State. From 1st April it will be a matter for local contractual negotiation with the PCT;
- PMS providers will be expected to have a complaints procedure in place that adheres to the NHS complaints procedure.

2.1 Permanence and New PMS Operating Arrangements

This chapter covers:

- A. Permanence
- B. Roles and Responsibilities
- C. Contracts
- D. Movement between GMS and PMS
- E. List Closures and Patient Assignments

Each is considered in turn:

A. Permanence

2.2 Commissioning Primary Care

From April 2003, 75% of the total NHS budget has been devolved to PCTs. The allocation of GMS and PMS resources in January will increase this further. By controlling NHS resources and through effective commissioning, PCTs can now seek to deliver patient centred care for their particular local populations. New primary care contracts provide a significant step forward in supporting this. In many cases PCTs will use new GMS and PMS to deliver a primary medical service through local GP practices. However, they may also want to look at the use of other arrangements such as the existing and new PMS schemes, PMS PLUS, Specialist PMS, or PCT medical services to deliver a specific type of care to a specific population.

In all cases it will be for the PCT and the primary care provider to agree a contract that is clear about funding, services to be delivered and arrangements for quality improvements. The contract must include provisions for effective clinical governance arrangements to ensure and safeguard high standards of care.

Where new services are to be delivered, the PCT would take the same approach as it would when commissioning secondary care from NHS Trusts, i.e. ensuring that the provider was able to deliver within a robust accountability agreement.

In a PMS relationship, the contract is agreed between the provider and the PCT and determined by local negotiation. It will be for the two parties to decide upon the length of the contract and any review or break clause arrangements to be included.

2.3 Permanence

The Health and Social Care (Community Health and Standards) Act 2003 provides for the abolition of PMS pilot schemes. It also amends sections 28C to 28EE of the 1977 Act to bring them up to date in preparation for PMS “permanence.”

It is the Government’s intention to introduce the “permanent” provisions from 1st April 2004 which will replace PMS pilot scheme provisions.

Transitional arrangements will be put in place to ensure that existing PMS schemes can continue to provide the same services to the same patients under the permanent provisions, if this reflects the wishes of the PMS provider. We anticipate, however, that new benefits relating to OOHs and new quality schemes will mean that current PMS providers and PCTs will wish to discuss their contracts and agree, where appropriate, contract variations.

B. Roles and Responsibilities

PMS is most successful where there is a real partnership between the provider and the PCT. Each has a role in the successful delivery of PMS. Strategic Health Authorities also have an important role to play.

2.4 The Role of the SHA

SHAs have a strategic improvement and performance management role within the local health community. They are responsible for ensuring that PCTs deliver health services to their local population in line with an agreed Local Delivery Plan. This in turn should reflect local population needs.

SHAs also have specific roles in PMS with regard to the following:

- As the commissioning agent where the PCT is the PMS provider;
- Ensuring the effective operation of quality schemes in PMS;
- The operation of closed list procedures.

2.5 The Role of the PCT

PCTs will continue to operate as the commissioning agent to negotiate GMS or PMS contracts in a way that best suits the needs of their patients. PCTs may also provide services directly.

PCTs roles include:

- Securing the provision of PMS;
- Evaluating proposals for new schemes;
- Funding and supporting PMS contracts;
- Managing (where applicable and appropriate) transfers between GMS and PMS;
- Providing information to patients on PMS practices.

2.6 The Role of the Provider

PMS providers are required to meet the commitments set out in their contracts. We expect that PCTs/SHAs and providers will operate in a supportive and developmental climate. The high trust, low monitoring approach adopted in GMS should be carried forward into PMS.

Provider roles include:

- Provision of services as described in contracts;
- Provision of information to patients on services available.

C. Contracts (PMS providers etc)

This section looks at the rules around providing PMS, the process for developing new PMS proposals and detailed aspects of contracting.

2.7 Who can be a PMS Provider?

There are specific rules relating to who can be a PMS provider. GPs, nurses, dentists and other healthcare professionals, staff employed by the NHS or employed by a practice, NHS Trusts, NHS Foundation Trusts and PCTs, can all be providers, as long as they meet specific requirements.

Annex (A, B, C, and D) sets out these requirements in much more detail.

2.8 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. Further details can be found at Annex (D).

2.9 NHS Contracts and Health Service Body Status

Section 28E of the 1977 Act makes provision for PMS providers to be considered as health service bodies for the purposes of entering into PMS contracts. In turn, 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. For a PMS contract to be considered as an NHS contract potential providers will need to be a health service body for the purposes of entering into the PMS contract. Most of the current PMS schemes have opted for health service body status.

Entering into a 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.

The PMS provider(s) must give written notice to the PCT if it wishes to become a health service body for these purposes. Health service body status would then commence 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. Health service body status in respect of other NHS contracts will cease on the termination of those contracts;
- 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.

2.10 Preparing PMS Proposals

Future local applications to **enter** PMS contractual arrangements will be for local determination. PCTs are encouraged to adopt flexible local processes for applications. There will be **no requirement** to submit applications to a national time scale nor to seek the approval of the Secretary of State.

New applications to enter a PMS local contract should involve **local consultation**. This might include the LMC, Patients Forum and other relevant local bodies such as the Local Authority, especially where they might directly relate to, or impact on, local government services.

2.11 Submissions

All submissions are to be sent to the relevant PCT as the commissioning body (or SHA where the PCT will be the provider) in a timetable negotiated locally. PCTs (and each SHA) therefore need to immediately determine arrangements for handling any local PMS application submitted that could begin from 1st April 2004.

2.12 Preparatory costs for preparing a future PMS proposal

Under piloting, resources were made available to PCTs to help cover the costs involved in preparing for PMS pilot status. As PMS schemes will now become a permanent feature to contract locally for primary care services, there will be no further central allocations to cover these costs. It is a matter for local discretion within each PCT to decide if any future new PMS applications will receive support to develop their proposal.

When preparing PMS proposals PCTs and practices may wish to access nationally supported networks through the MA and NPDT. Details are available at <http://www.doh.gov.uk/pmsdevelopment/>
<http://www.modernnhs.nhs.uk/home/>

2.13 Proposals

In order to assist the contracting arrangements, proposals might include the following information:

- Names and addresses of all the parties to the proposed contract;
- In the case of a partnership, the names of the partners (whether or not it is a limited partnership) and if so, the status of each partner as a general or limited partner;
- The aims and objectives of the scheme and the services to be provided;
- The patients to whom those services are to be provided;
- The address(es) of the premises to be used by the contractor;
- The area of the practice in which residents will be entitled to register for provision of services (if appropriate);
- Whether the scheme is to be PMS, PMS Plus, specialist PMS and/or engaged in practice led commissioning;
- Whether the contract is to be an NHS contract.

2.14 Approval

The PCT or SHA (where the PCT will be providing PMS) will consider all proposals. They may then approve; or approve with modifications; or reject them. The potential provider should be notified, with reasons, of the commissioner's decision.

As part of their consideration PCTs should assess how new schemes will contribute to the PCT wide primary care strategy.

Before entering into a contract the PCT should ensure that any potential PMS provider confirms that it satisfies the conditions given at Annex (A, B, C, and D). PCTs will need to consider what information (if any) they require to support this statement. They may wish to bear in mind that much information should already have been provided to them in response to enquiries made under the performers' list regulations.

2.15 Variations to PMS Contracts

The PCT can agree to vary all contracts (except where they themselves are the PMS provider). PCTs will therefore need to agree processes and mechanisms to handle any application to vary a local PMS contract from 1st April 2004. Each SHA should similarly establish arrangements for handling PCT provider contract variations. All contract variations will need to be funded from within the PCTs overall allocation, including the PMS component of the primary care allocations being made in January.

For further details on contract variations see Annex (B).

2.16 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. We recommend this period to be 6 months. For further details relating to termination see Annex (C).

2.17 Contracting for PMS PLUS

PMS Plus contracts are variations to the core PMS contract which support new service development in primary care. The opportunities for providing such services within PMS Plus arrangements may include specialist care, new diagnostic procedures, services aimed at a particular population with specific needs, e.g. the homeless, or wider community care. There are few limits to PMS Plus, as long as services are appropriately funded and clinical governance arrangements are in place.

2.18 Enhanced Services

In addition to the flexibility inherent in PMS Plus, there are duties on PCTs to develop enhanced services in primary care. These include:

- Guaranteed spend on the local floor. From 1st April 2004, PCTs will be required to spend a guaranteed sum on enhanced services. Plans must be agreed by the PEC and will be monitored locally and nationally by the TSC. LMCs will have a role in ensuring that the monitoring of spend is undertaken against agreed definitions. The TSC will report on whether enhanced services commitments, which form part of the GIG, are being honoured;
- Commissioning Directed Enhanced Services (DESs).

2.19 Direct Enhanced Services

There are six DESs:

- (i) Childhood immunisations (target payments);

- (ii) Influenza immunisation for those aged 65 and over in addition to those under 65 in at-risk groups;
- (iii) Minor surgery;
- (iv) Access;
- (v) Services to support staff dealing with violent patients;
- (vi) 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 we will be introducing new quality related funding in PMS. 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.

2.20 Patients of 75 and Over

Where PMS practices have significant numbers of elderly patients registered with them, PCTs will wish to ensure that contracts reflect a similar duty to that in GMS in respect of patients aged 75 or over (see p.27 point (iv) 1st 2 sentences only of the GMS Guidance).

2.21 Sub-contracting in PMS

PMS providers are able to enter into a sub-contracting arrangement subject to any restrictions agreed in the contract.

In doing so, the provider must ensure that the sub-contractor is both suitably qualified and competent to provide the specified services.

PMS providers should inform their PCT when any services have been sub-contracted to another provider.

2.22 Contract Dispute Resolution Procedures

2.22.1 Procedures

There will be occasions where the parties or potential parties to a PMS contract are unable to agree on issues such as price or services to be provided. In such cases the parties could make use of NHS dispute resolution procedures (see Annex H). However, it is expected that most disputes can be resolved as part of the normal contractual relationship. Use of the dispute resolution procedures represents a failure of that relationship and should be avoided where possible.

2.23 Local Resolution Procedure

PCTs should establish in discussion with PMS stakeholder groups, or their representatives, clear local processes and arrangements for the internal resolution of PMS contract disputes.

Before taking disputes to the FHSAA it would be advisable for the parties to make every reasonable effort to communicate and co-operate with each other in an attempt to resolve matters before considering referring the dispute to the resolution procedure. Practices or PCTs may wish to involve appropriate LRCs, SHAs or other representatives in such circumstances.

2.24 Pre-contract Disputes

Prior to entering into a PMS contract, the potential PMS provider will prepare a proposal for consideration by the PCT. The PCT has the option to accept the proposal, reject it or ask for further information before making a final decision to enter into a contract. It is possible that the potential PMS provider may seek to challenge the decision of the PCT in the event of a rejection or indeed the request for further information. In this case the potential provider can use pre-contract dispute resolution procedure.

2.25 Contract Dispute

Once a PMS contract has been agreed, the parties may at a later stage have a disagreement about matters such as a change in the services to be delivered.

Details of pre-contract disputes, dispute resolution, NHS disputes and non-NHS disputes are outlined in Annex (H).

2.26 Complaints

PMS schemes will be expected to carry on with their existing complaints procedures and deal with any complaints reasonably related to the provision of PMS under their contract. The scheme will have to make patients aware of the complaints procedure, the roles of PCT and other bodies and their right to assistance in making complaints, for example the PCT's Patients Advice and

Liaison Service (PALS) or the independent complaints advocacy service (ICAS). Details of this service are available at www.doh.gov.uk/complaints.

The NHS complaints procedure is in the process of being reformed and the new process will be implemented from 1 June 2004. New regulations will replace the legislation governing the current complaints procedure and guidance will be issued prior to implementation.

D. Movement between GMS and PMS

Under piloting, when a medical practitioner entered into a PMS pilot arrangement, the PCT was required to remove that practitioner from the PCT medical list. However, the practitioner usually retained a preferential right to return to the list if they subsequently withdrew from PMS arrangements. In effect this allowed a GP who entered a PMS pilot to leave and return to a GMS arrangement.

With the introduction of the new GMS contract and the “permanent” arrangements for PMS, the existing right of individual PMS GPs to return to GMS will end. A new right for the whole PMS contract to transfer to a GMS contract will replace it. Similarly, GMS contractors may also seek to enter into a local PMS contract in line with local procedures, should they so wish.

Where a PMS provider seeks to transfer to GMS, the PCT will be required to offer that provider a GMS contract, so long as it meets all the provider conditions laid down in the GMS contract regulations. A PMS practice that wishes to revert to a GMS contract does not have entitlement to an MPIG. However, where a PCT wishes to exercise its discretion a calculation of MPIG can be achieved using the arrangements set out at para 6.12. This discretion can be exercised at the time of a practice moving back to GMS arrangements.

Where existing PMS schemes have received growth, the reasons for receiving it should be examined – it may still be entirely legitimate for the provider to receive it within its GMS allocation or under a locally enhanced service agreement. Any growth that is not transferred is retained by the PCT for investment in primary care. This is covered in detail later.

F. List Closures and Assignments

2.27 Patient Access to Care

As in GMS, we expect new arrangements to be in place to manage list closures and patient assignments. The clear principles will be that:

- Patients and PCTs will need greater clarity on whether lists are open or closed;
- Closed list procedures will include an appeal mechanism for practices and PCTs;

- The arrangements will ensure that practice workload is managed effectively and that patient access is protected.

2.28 Processes

Detailed guidance will be available in the New Year.

3 Chapter Three – New Flexibilities

Action Points for PCTs to note

- All PMS contracts agreed before 1st January 2005 are required to provide for Out-of-Hours services except where PCT agrees to a written request from the provider not to directly provide this service;
- Existing arrangements for transferring Out-of-Hours liabilities to other accredited out of hours providers will continue until 31st December 2004;
- Human Resource guidance aimed at primary care with examples of good practice will be produced in spring 2004;
- IM&T funding should be reflected in the PMS contract;
- PCTs are required to agree information requests from PMS providers on Interim Aspiration Utility by the 16th of January 2004;
- PCTs need to agree premises flexibilities funding and support arrangements as soon as possible.

Action Points for PMS providers to note

- To opt out of Out-of-Hours services, PMS providers must submit a written notice to the PCT. The PCT has nine months to reach a decision;
- PMS providers must ensure patients are informed how to obtain out of hours services;
- PMS providers should take action now to prepare for using the agreed quality framework.

3.1 Introduction

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:

- A. The ability to opt out of responsibility for Out-of-Hours provision
- B. Increased seniority pay
- C. Improved changes to pension benefits
- D. Human Resource improvements
- E. Increased investment in and modification to IM&T

F. Premises flexibilities

Full details of these arrangements can be found within the relevant sections of the Comprehensive Guide to GMS. This chapter provides a summary of the changes as they relate to PMS. In particular it highlights those aspects where there is not necessarily a direct read across each area is covered in turn.

A. OUT-OF-HOURS SERVICES (OOH)

3.2 Definition and Responsibility

Until 1 January 2005, all PMS contracts under which essential services are provided must include mandatory Out-of-Hours (OOH) services, unless or until:

- the PCT has agreed to the provider's request not to include these services in the contract prior to the contract being signed;
- the provider exercises its right to opt-out of OOH services (see below);
- the PCT and the provider otherwise agree that the provider can stop providing OOH services.

If a provider is required to provide mandatory OOH services it must provide essential services throughout the out-of-hours period, which for this purpose means before 8.00am and after 6.30pm on weekdays and all day on weekends and public holidays.

This does not mean that the provider must provide the same level of service as it provides during normal hours. It must meet the urgent needs of patients which cannot safely be deferred, but in deciding what service to provide it is allowed to consider whether the patient could reasonably be expected to wait until core hours to obtain the service.

Contracts with PMS providers who do not have to provide mandatory OOH services, or who have previously opted-out, may still include OOH services by local agreement. The terms on which they do so are for agreement between the parties.

3.3 Opting-Out

Providers (other than specialist PMS providers of OOH services) will be able to opt-out of providing mandatory OOH services. The procedure for this is explained in the GMS contract guidance. Broadly speaking, PCTs will have a maximum of nine months (or until 1 January 2005 if later) to implement an opt-out by finding an alternative provider. Opt-outs can only be refused or further delayed in exceptional circumstances and with SHA approval. Contract prices for providers who opt-out should be reduced according to a fixed tariff.

Contracts will require providers who opt-out of (or otherwise do not provide) OOH services for their registered patients to co-operate with the providers who do, and to comply with reasonable requests for information from those providers and the PCT.

3.3 Quality, Sub-Contracting and Transfers

From 1st January 2005 individual PMS contractors providing OOH services themselves, rather than through a deputising service or private sector organisation, must meet the national quality standards for OOH services. These standards are available at <http://www.doh.gov.uk/pricare/ooquality.pdf>. They should be reflected in the contract.

Following agreement of the GMS contract, we have pledged to review these standards. PMS providers will be made aware of any changes in due course.

Along with other OOHs providers, Specialist PMS providers set up to deliver OOH services will be expected to meet these standards from 1st April 2004.

Unlike GMS, PMS contracts will not automatically include a requirement for providers to obtain written permission to sub-contract their OOH services, but providers will remain responsible for ensuring that their sub-contractors meet the terms of the contract including (from 2005) the National Quality Standards. PMS providers will nevertheless need to inform their PCT when any services have been sub-contracted to another provider. PCTs will need to ensure that they are in a position to take action should sub-contractors be unable to deliver services of the required quality.

Until 31 December 2004, PMS providers who are required to provide mandatory OOH services will continue to be able to transfer their responsibilities to accredited OOH providers, e.g. GP co-operatives, with their PCT's permission, largely as per the existing regulations.¹ PCTs will therefore need to maintain their current arrangements for accrediting OOH providers. Further details are given in the GMS contract guidance.

3.4 Patient Information

Contractors **MUST** ensure their patients are told how to get OOH services. Whether or not they provide OOH services themselves, all providers must include in their practice leaflets information about how patients can obtain OOH services. Providers who do not provide their own services will be required, in addition, to take steps to ensure that patients who contact them during the OOH period are given information about how to obtain OOH services.

¹ The NHS (Out of Hours Provision of Personal Medical Services and Miscellaneous Amendments) (England) Regulations 2003 (SI 2003 No 26).

B. Seniority

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

3.2 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.

3.3 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.

C. Pensions

3.4 The Scheme

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.

The NHS PS is a defined benefit scheme under which beneficiaries' pensions are prescribed in scheme regulations rather than determined by the performance of the member's investment in a fund. Special conditions apply to the way pensionable pay is calculated for General Practitioners, which differ in important ways from those of other scheme members. Practitioner pensions on retirement are calculated as a percentage of total pensionable career earnings, rather than on the basis of a final year salary. Special rules

also apply where a doctor has worked both as a General Practitioner on his or her own account and for an employer such as a NHS Trust.

Calculation of Pensionable Pay

In line with GMS, pensionable pay under PMS will include net profits derived from the payments made to GPs in respect of NHS work in the following circumstances:

- Delivering services as a GMS or PMS provider, excluding work delegated to others;
- Delivering services under delegation directly from GMS or PMS providers, including locum work;
- Board, advisory or other work including delivering services carried out under employment with PCOs or other NHS bodies;
- Work carried out as NHS services under the collaborative arrangements with Local Authorities;
- Practice-based work carried out in educating or in organising the education of medical students, undergraduate, vocational and post graduate training funded through national Learning and Development Budgets or otherwise;
- Certification under the requirements of Schedule 9 of the NHS (GMS) Regulations 1992 as amended and the Scotland and Northern Ireland equivalents.

In future, contributions paid by General Practitioners as employees and the 'employers' contribution paid on their behalf, will be assessed on practice profits. In broad terms, pensionable pay will include all fees and regular remuneration, net of expenses and overtime, paid to practitioners in respect of the provision of primary medical services. This is in addition to any other services that are treated as NHS work, where the practitioner has entered into a GMS contract, a PMS contract, or a contract for services with an NHS employing authority for the provision of those services. But it excludes all income derived from work undertaken on behalf of a commercial organisation. It will also include profits, net of expenses, for the practitioner in providing clinical placements for students undertaking a recognised course of healthcare learning and development.

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.

3.5 Admission of non-GP Partners to the NHS Pension Scheme

Non-GP Providers in PMS are entitled to join the scheme. 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.

3.6 Dynamisation

On retirement, GPs' pensions are calculated as a percentage of their total pensionable career earnings. Each year's pensionable income is first increased by an uprating or "dynamising" factor. This is used to bring all years into the same currency or value. Historically the Dynamisation Factor has been based on forecast year on year changes in Intended Average Net Income (IANI). IANI is abolished under new GMS arrangements.

In future, the Dynamisation Factor will be based on actual growth in average GP pensionable earnings over the previous year. The Technical Steering Committee will assess and make recommendations on the adjustments.

3.7 New Pension Flexibilities

In line with GMS new flexibilities are introduced in the way that pensions are calculated for doctors who have worked in both general practice and other specialties.

Doctors working in both general practice and hospital care, or who move between them, accrue benefits under both assessment regimes and although the NHS Pension Scheme legislates specifically for these circumstances, the results may not always be optimal.

To support doctors who pursue portfolio careers, four new pension flexibilities are being introduced. These complement existing rights by broadening the range of methods used to calculate final benefits where there is a mixture of GP and non-GP accrual. All options will be tested at retirement and the most favourable will be applied.

The amending regulations came into force on 1st October 2003, through Statutory Instrument 2003 No. 2322, "National Health Service Pension Scheme (Amendment) Regulations 2003". The flexibilities covered in those regulations have retrospective effect from 1st April 2003. The new flexibilities are underlined below.

Doctors who work in hospital care or as a GP Registrar for less than 10 years before becoming a Principal Practitioner will receive the most favourable of the following:

- A separate pension for hospital work using the non-GP formula;
- An addition to the practitioner pension pro rata to hospital work;

- A GP pension for all NHS work.

Doctors who work in hospital care for more than 10 years before becoming a Principal Practitioner will receive the most favourable of the following:

- A separate pension for hospital work using the non-GP formula;
- a GP pension for all NHS work.

Doctors who work in general practice before moving to hospital care will receive a separate non-GP pension and the most favourable of the following:

- A GP pension plus pensions increases (linked to prices);
- A GP pension increase by dynamising factors linked to pay up to retirement.

Doctors who work in both general practice, and hospital care for more than one year, at the same time will receive the most favourable of the following:

- A separate pension for hospital work using the non-GP formula plus a separate GP pension;
- A GP pension for all NHS work.

Doctors currently working in the NHS will benefit automatically from the new flexibilities, and the impact will extend to their full scheme membership, not just that from the effective date of the regulations. All pension benefits will be automatically safeguarded when doctors move between GP and non-GP work.

D. Human Resources

3.8 Guidance

The HR principles that have been developed apply equally to all primary care providers. Primary care professionals need to be eligible to perform services. They need to be recruited and retained, their ongoing development needs to be supported during their working life and they are eligible for pensions when they retire.

More information about the HR agenda for all primary care contracts can be found in the HR and pensions chapter of the GMS contract guidance issued by the DH. This covers:

- Primary care performers list (this is also covered in detail in Annex (I) of this guidance);

- increasing workforce capacity and
- ongoing support and development.

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.

3.9 Increasing Workforce Capacity

The Department's human resources strategy can be summarised as more staff, working differently. The new contract will support an expansion of workforce capacity and changes in skill mix. This requires effective workforce planning as well as ways of supporting recruitment and retention of GPs and other primary care professionals.

3.10 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).

E. IM&T for PMS Providers

3.11 IM&T Needs

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.

Under the National Programme for IT (NPfIT) new Local Service Providers (LSPs) will oversee the delivery of high quality information services across all primary care organisations in the NHS in England.

Over time, systems and services will continue to be developed to ensure that the information requirements of the whole primary care workforce are supported and local quality schemes or OOH service providers are fully supported with integrated systems.

3.12 PMS and the NPfIT in the NHS

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. Issues that are currently under discussion include:

- PMS payments;
- Assessing the potential for national systems to support PMS quality and outcomes management;
- PMS contract management.

3.13 Revenue funding

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 practices from 1st April 2003, and is in addition to the £50m currently allocated to PCTs each year for this purpose.

3.14 Read Codes in PMS and GMS

Quality is covered extensively in chapter 4. As part of the GMS Payment Project a set of agreed Read Codes (all versions) for each of the 10 clinical domains in the quality framework which has been published and will be refined in line with changes to the contract. These cover:

- CHD
- Stroke and transient ischaemic attacks
- Hypertension
- Hypothyroidism
- Diabetes
- Mental Health
- Chronic obstructive pulmonary disease
- Asthma
- Epilepsy
- Cancer

3.15 Clinical coding

The associated codes and templates to support the 10 clinical domains for the GMS contract will be made available to practices by GP system suppliers. These may be helpful to PMS practices using the national scheme and in the development of local quality schemes with their PCT. The consistent use of these codes across both GMS and PMS schemes will help practices and PCTs in developing their financial awards and improve the use of consistent high quality clinical recording in primary care.

Where practices and PCTs agree to adopt identical indicators to GMS, practices may have to review their existing clinical recording methods and protocols and ensure that they are using the latest release of Read Codes.

3.16 Read Code Timescales

An interim release of Read Codes containing the new exception codes for the 10 clinical domains in the Quality and Outcome Framework was released on 1st October 2003. This work package also contains the revised “logical query specification” and associated business rules, which were released on 12 November. This “set” of coding documentation contains all the information required by suppliers to manage the coding aspects of the quality scheme.

The Quality and Outcome Framework requires an up to date set of Read Codes to be present in clinical systems for payment purposes where PMS practices are “mirroring” the GMS scheme. In these instances practices will need to ensure that they are working with the correct versions at all times. Further information on Read Codes is available from the NHS Information Authority Tel: 0121 3330333) or

<http://www.nhsia.nhs.uk/terms/pages/default.asp>

There are normally two releases of the codes each year and the codes and other documentation with the GMS Quality and Outcome Framework can be found at <http://www.doh.gov.uk/gmscontract/infotech.htm>

3.17 Data quality

PMS providers and PCTs will need to agree how they will implement and monitor consistent recording of clinical data including coding methods. All practices should assess and, if necessary, improve the consistency and completeness of data recording in practices and put in place procedures for carrying out regular audits of their data recording procedures. This will identify areas, which need attention, as well as supporting their clinical governance responsibilities and supporting payments. This may involve extracting and analysing the data recorded using query and reporting tools. Staff may need training or support in the use of these tools and in the analysis and interpretation of the results.

3.18 The Interim Aspiration Utility

The GMS Payments Project has recently released an Interim Aspiration Utility (IAU) to practices and PCTs to enable GMS practices to aspire to quality and outcomes payments for 2004/5. The IAU has been developed in Microsoft Excel. Where PMS practices intend to utilise the Quality and Outcome Framework in their own contracts for the delivery of high quality services, the Interim Aspiration Utility should be made available to support them.

By 16 December 2003 PCTs will distribute the IAU to GMS practices to enable them to record their first year aspiration in a structured way. PCTs should offer the IAU to all PMS practices. Alternatively, PMS practices can request a copy of the IAU from their PCT. PCTs will be required to agree the information with the practices by 16 January 2004.

The IAU will enable PMS practices to easily enter aspirations against each of the Quality Outcome Framework domains and indicator(s). Practices without computer systems will be able to record information on paper forms.

Discussions are taking place with system suppliers to ensure that practices are supported with simple practice based reports to inform the discussions between the practices and PCTs. This information will contain details of the number of patients recorded on clinical system with the conditions contained within the Quality and Outcomes Framework and will be valuable to help practices to monitor progress throughout the year. If the list does not contain as many patients with a particular condition as expected this may be because the correct Read Codes have not been used.

The PCT should pre-populate the form with the practice and PCT codes to act as a unique reference number for reference purposes. They will also enter some demographic data. The PCT will then issue the IAU to PMS practices with full guidance notes. If the practice requires further help at this point

because, for example, the practice does not have a copy of Excel or is unable to load the IAU, the PCT will need to visit the practice.

Practices should enter their aspiration for any of the areas in which they wish to participate covered by the Quality and Outcome Framework. In doing so they should use information from their clinical system.

On completion, the practice will return the IAU to the PCT who will need to discuss and agree the aspiration with the practice. Full guidance on the use of the utility will be provided when it is released along with a description of the end to end process.

The IAU is a one off exercise for the 2004/5 year. Following this, other aspiration and new arrangements will be put in place for PMS during 2004.

3.19 MIQUEST

MIQUEST remains a component of Requirement for Accreditation (RFA) 99 v1.2 and, as a means of extracting clinical information from heterogeneous GP clinical systems, is key to the success of PMS. The new national specifications to support the GMS Quality and Outcomes Framework Management System will be expressed generically rather than specifying any bespoke requirements e.g. MiQuest. However there is still an absolute requirement for the suppliers of accredited clinical systems to support MIQUEST in full, particularly for PMS practices that are not using the national QoF.

The GMS Payments Project has recently written to each supplier to remind them that they must comply with the following RFA requirement:

“The system *shall* comply with version 4.2.3 of MIQUEST”

Failure to comply with the statement may result in the withdrawal of accreditation status under RFA.

3.20 Preparing for Entry to the Quality Framework in PMS

New PMS practices can take action now to help them prepare for entry into the PMS scheme. These should be taken forward in conjunction with local training facilitators and PCTs and include:

- Carry out baseline survey of the practice clinical system and ensure that practices have RFA99 compliant clinical systems;
- Review system management and information governance in the light of the “Good Practice Guidance” recently published by the DH, BMA and Royal College of General Practitioners
<http://www.doh.gov.uk/pricare/computing/index.htm>;

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- Set up and maintain disease registers in accordance with good practice guidance
<http://www.nelh.nhs.uk/nsf/chd/sig/secondary/appendix1.htm>
 - Ensure that the correct clinical codes associated with the quality and outcomes framework are being used. Detailed further information on the codes as provided for the GMS contract is at
<http://www.doh.gov.uk/gmscontract/implementation.htm>
 - Review existing templates and protocols with system suppliers to ensure they meet the local quality scheme;
 - Ensure that the appropriate staff have easy access to clinical systems;
 - Undertake training needs assessment as part of your practice development programme.

F. Premises

3.21 New Arrangements

A modern fit-for-purpose estate is an essential ingredient to the effective delivery of primary medical services. New premises allocation arrangements are being developed under both the new GMS and PMS contracts. In addition, new funding scheme arrangements have been developed for appropriate use in both new GMS and PMS contexts. Details of how the new premises allocation and funding arrangements will operate are at www.doh.gov.uk/gmscontract

In summary, these provide for an allocation to be made to a lead PCT in each SHA area. This lead PCT will have responsibility for ensuring that funding is made available to all PCTs to meet the requirements of premises developments. These allocations will cover:

- Baseline spend;
- Contractual commitments to new developments at 30 September 2003;
- Additional growth for new priorities.

3.22 New Flexibilities

Additional premises payment mechanisms (also referred to as premises flexibilities) were developed and introduced on 18 September 2003. PCTs are able to use these arrangements to address estate problems that are common to both GMS and PMS practices. In this respect, PCTs will need to agree funding and support arrangements based on prioritisation of need regardless of the nature of the contract with practices. Once agreed at Board level and use made of the flexibilities, the new allocation and funding arrangements will be in place.

4 Chapter Four - Quality

Action Points to Note

- Quality delivery and quality frameworks should be broadly comparable between PMS and GMS;
- Contracts for quality must be agreed between the PCT and the PMS provider;
- Where local quality frameworks are developed a senior clinician (normally the PCT Medical or Director of Public Health) will be responsible for making a judgement that the framework is comparable to the national requirements and SHAs will be expected to ensure value for money and quality issues are being addressed;
- Quality arrangements must be in place by April 2004;
- PCTs should nominate a QOF lead who is responsible for planning annual visits to each provider to review achievement towards quality standards;
- A table of milestones and activities is provided at the end of this chapter.

4.1 IMPROVING THE QUALITY OF SERVICES

4.1.1 Introduction

PMS is intended to support the delivery of high quality services:

- (i) All PMS providers must comply with quality standards which already exist, some of which are statutory;
- (ii) New resources exist in PMS (and GMS) to underpin the delivery of quality through a Quality and Outcomes Framework (QOF) representing indicators, standards, incentives and assessment;
- (iii) Other contractual aspects, such as changes in OOH arrangements, are also intended to improve quality of care.

The following chapter lays out how (ii) will work.

4.2 Principles

Quality is equally important in PMS as in the new GMS contract. Patients have the right to similar opportunities and expectations from their care. In reality, patients should not be able to distinguish between providers of services whatever the contract that the provider is operating under.

PMS is not a one-size-fits-all model and is expected to be more locally sensitive than GMS.

Some quality payments are already included in PMS baselines. As we are not unpicking local contracts (as we have in GMS where some existing quality payments were mapped into quality), a deduction in points will be made in PMS equivalent to the resources in baselines. The points offset is 174 points in 2004/05 and 109 points in 2005/06. The examples in this document use the year one figure throughout.

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.

Equally, there should be similar rewards for similar effort between PMS and GMS.

4.3 Calculation of Points Offset for PMS

The PMS guidance published in December included a preliminary calculation of the PMS points offset. Using the financial data then available this was estimated at an average deduction of 196 points (equivalent to £14,700) per PMS practice. The methodology (which has been tested and agreed with PMS stakeholders including the NAPC, GPC and NHS Alliance) used to calculate the PMS offset is as follows:

- **Step 1:** Work out the proportion of existing GMS non cash limited spend that has been mapped to quality (covering Chronic Disease Management, Sustained Quality Allowance and half of monies paid for Cervical Cytology Screening)
- **Step 2:** Apply this proportion to the PMS baseline allocation
- **Step 3:** Convert the notional quality monies in PMS baselines (£51m) into a point offset for PMS practices.

Further financial data has now been collected from PCTs as part of the AWP exercise. Utilising the same methodology a final calculation has now been derived to establish the Quality Points offset for PMS practices. This suggests an average PMS practice will already have received within the PMS Baseline contract price £13,050 – equivalent to 174 points in 04/05. As the value of the quality points rises from £75 to £120 per point in 05/06, the PMS quality points offset will fall to 109 points in 2005/06.

4.3.1 Managing overlap between national QOF and funding for existing PMS service provision

Because of national commitments not to unpick existing PMS contracts, as long as practices continue to meet their contractual terms they are entitled to the full contract price, plus achievement payments for meeting agreed quality standards. Therefore, if PCTs agree to implement the full national QOF then practices will be entitled to receive achievement payments for hitting all the quality indicators - even if they have already been given additional money

through their existing PMS contracts to deliver the same benefits. However, PCTs can:

- Agree with practices a variation to the national QOF so practices are rewarded for achieving other additional quality indicators agreed with the PCT instead of those relating to that which they are already funded for within their existing contract; or
- Agree with practices (by way of a contract variation) that any additional funding within their existing contract can relate to payment for delivery of other agreed services, for delivering other changes, or that funding will stop. This can only be achieved through local agreement.
- Alternatively where no local agreements can be reached to either vary the national QOF or vary existing PMS contracts, a PCT may decide to terminate the existing PMS contract within the terms specified in that contract (normally 6 months notice).

4.4 Issues in Developing Local PMS Quality Schemes

PCTs and practices should ensure that the extra management resources in PCTs and practices required for implementation of local schemes is understood

- All schemes should reconcile to a points-based system to ensure comparable achievement from PMS and GMS practices;
- PCTs and PMS providers start from different levels of funding and achievement;
- The current IT solution will not support any national information about relative prevalence in local schemes - a complication in measuring workload and true achievement;
- Contracts for quality must be agreed with the PCT and subject to fair but thorough assessment of achievement, equivalent to that in GMS.

In the short term, the more quality schemes depart from the national QOF, the more difficult it will be to provide management information. There are flexibilities that are discussed later. These should be evaluated carefully. The effect on pay and information systems should be considered as part of that process.

4.5 Minimum Statutory Requirements

These refer to issues such as Health and Safety and vaccine storage. Many reside within NHS controls assurance standards. Others are part of existing core PMS contracts or are part of changing regulation within primary care, for example, the Performers List.

Requirements relating to quality 1	Clinical governance	<ul style="list-style-type: none"> • effective system of clinical governance in place • named clinical governance lead
2	General skill and care	To carry out obligations under the contract with “reasonable skill and care”
3	Complaints	To: <ul style="list-style-type: none"> • operate a complaints procedure in accordance with the NHS complaints procedure • provide the PCT with information on the number, subject matter and handling of complaints
4	Professional indemnity insurance	Hold adequate insurance against liability arising from negligent performance of clinical services
5	Qualification and skills of performers	Ensure: <ul style="list-style-type: none"> • performers are (i) suitably qualified (ii) competent (iii) have the necessary clinical experience and training (iv) where appropriate are registered on the Primary Care Performers List • performers have arrangements in place to maintain and update skills and knowledge • GP performers participate in appraisal • Compliance with NCAA assessment
6	Premises	Need to (i) suitable for the delivery of services (ii) sufficient to meet the reasonable needs of patients and (iii) comply with the requirements of the Disability Discrimination Act
7	Record keeping	Keep adequate patient records and ensure patient lists are kept up to date. Where records are computerised: <ul style="list-style-type: none"> • systems used must be RFA99 compliant • security measures must be enabled • provider must have regard to guidelines for GP electronic patient records • Have named Caldicott Guardian, who leads on the practices and procedures for handling the

		confidentiality of patient records.
8	Practice leaflet	Will: <ul style="list-style-type: none"> • compile a practice leaflet in line with regulations • review it at least every 12 months and ensure it is accurate • make available a copy to its patients and prospective patients
9	Infection control	Have effective arrangements in place for infection control and decontamination

This list is not exhaustive. PMS providers must also comply with all other relevant legislation, e.g. that covering employment, discrimination, data protection, child protection, medicines and Health and Safety matters.

Arrangements for dealing with breaches of the PMS contract are set out in the Annex (G) section 14.2 on contracting process.

4.6 A Framework for Quality and Outcomes

The national Quality and Outcomes Framework (QOF) provides substantial opportunities for PMS providers to deliver and demonstrate high quality care. The evidence-based standards described in the national QOF should benefit all NHS patients. PCTs should see, for example, fewer avoidable hospital admissions coming from providers where chronic diseases are better managed. This is just one of the ways that quality will benefit the whole system and PCTs should keep this in view when developing commissioning arrangements reflected in LDPs.

If PCTs and providers decide not to follow the detail of the national QOF, but instead to major on any of the variations suggested later in this section, or on developments of existing quality schemes then the requirements for quality delivery are that they:

- Be rigorous;
- Be evidence based;
- Are monitored fairly;
- Are assessed against criteria agreed between PCTs and providers and
- Paid at an appropriate and equitable rate.

A senior clinician (normally the PCT's Medical Director, Director of Public Health or other senior clinician nominated by the Chief Executive) will make as reasonable a judgement as possible, given the information supplied by the provider to the PCT, on how it has agreed quality targets with the PCT as to the workload and value of the different quality framework that has been

agreed. This should ensure fairness between national QOF and local QOF providers. The outputs must be seen to be at least broadly equivalent in delivering quality health care to the patients of the practice, accepting that PMS often care for non-standard groups of patients.

Monitoring will not be supported by national IT facilities and data collection unless national QOF indicators are used. The national IT facilities to support pay for PMS in 2004 will be available to all practices using the national QOF for data submission from August 04, additional functionality to support practices using part of the national framework at a later date. NPDT and the MA (NatPaCT) will be available to support PCTs and PMS providers and the use of MIQUEST queries.

4.7 Local Schemes: conditions

The conditions of a local scheme should be:

- If national QOF clinical indicators are used, then the indicator in each disease area relating to registers must be used, so that prevalence can be taken into account – in each clinical area, this is the basic, standard indicator;
- The local scheme, or part local / part national QOF scheme agreed between the PCT and PMS practice must have a value equivalent to scores set to a maximum of 1050 points to enable movement between different schemes and the national QOF. It is expected that each point shall be worth £75 in 2004/5 and in 2005/6 shall be worth £120 when the payment formulae, described later, are used;
- The part of the national QOF used should be proportionate between clinical areas and non-clinical domains (i.e. 550/500), otherwise pay calculations of the national QOF scheme cannot be derived fairly;
- 50 access bonus points (or the equivalent resources) should always be included;
- The outputs must be seen to be delivering equivalent quality health care to the patients of the practice, accepting that PMS (and especially Specialist PMS) often care for non-standard groups of patients;
- The difficulty in achieving the outputs must be fairly assessed by the DPH as being broadly equivalent to the achievement in the average national QOF-using practice. This broadly settles the issue of prevalence-related workload on the practice and how well the practice does, compared to the original aspiration, will affect final pay. This, whilst difficult, is achievable;
- PCTs may, in some circumstances, be able to apply locally devised prevalence factors. These should only apply in each separate disease area in the non-GMS parts of their schemes. They then may apply the prevalence formula, shown later, to calculate pay. However, supporting

data must be available locally along with a national comparable benchmark;

- In year monitoring and annual review should be equally rigorous, in the first years, as the national QOF (see later). It should be modelled on the methodology used for assessment of the national QOF;
- PMS providers only partly using the national QOF should still be connected to the QMAS so that their prevalence data can be used to give a more accurate picture nationally and to provide a useful source of data about the population to the PCT.

The same rules for dealing with patient confidentiality, potential fraud and PCT intervention will apply as for the national QOF originally developed for GMS, e.g. a 5% random check of practices.

4.8 National Framework

It is important to cover the national QOF in depth in this guidance. Detail in much of this chapter is similar to GMS guidance.

The national QOF measures achievement against a scorecard of 146 evidence-based indicators, allowing a maximum score of 1050 points, before any deduction for existing resources in PMS practices. Part 8 of the *New GMS Supplementary Documents* sets out the detail. It comprises the:

- Clinical domain: 76 indicators in 10 areas (CHD, stroke or TIA, cancer, hypothyroidism, diabetes, hypertension, mental health, asthma, COPD and epilepsy), worth up to 550 points;
 - Organisational domain: 56 indicators in 5 areas (records & information, patient communication, education & training, practice management and medicines management), worth up to 184 points;
 - Patient experience domain: 4 indicators within 2 areas (patient survey and consultation length), worth up to 100 points;
 - Additional services domain: 10 indicators within 4 areas (cervical screening, child health surveillance, maternity services, contraceptive services), worth up to 36 points.
- (i) The national QOF also rewards breadth of care through (i) holistic care payments (which measure overall clinical achievement and are worth up to 100 points) and
- (ii) quality practice payments (which measure overall achievement in the organisational, patient experience and additional services domains and are worth up to 30 points). The national QOF also rewards achievement against the access standards through 50 bonus points.

The national QOF has specific points scores set against each indicator. Points may not read across exactly in PMS because PMS practices have already received money in their baselines to improve quality.

In some exceptional circumstances, for example green field sites, it is possible that no additional money was put in the baseline for quality. Therefore, subject to local agreement it may not be appropriate to deduct the value of 174 points from the point's total achieved before paying the providers.

Providers should receive the full offset (174 points in year one) or no offset - there is little scope for local negotiation around the number of points to be offset. This is broadly fair, and recognises that it would be highly complex and time-consuming for practices and PCTs to calculate an individual offset for each PMS practice. In addition, QMAS functionality will not be able to support individual adjustments.

PCTs should note that the core philosophy underpinning the QOF is that incentives are the best method of driving up standards and recognising achievement. The QOF is not about performance management of providers but rewarding good practice. Participation in the QOF is voluntary for both GMS and PMS providers. However, there are substantial advantages for most PMS providers and their PCTs in delivering the national QOF as the heart of quality schemes within their own contracts.

4.9 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, it should be possible to develop some variations on the national QOF. Possible variations are offered below:

- **A core from national QOF plus local add-ons.** The core would be drawn from the national QOF. The options would be locally developed or use reputable sources that could develop an off-the-shelf option where PCTs do not have the resources to do this themselves;
- **Different interventions for related fields.** Such as replacing the patient questionnaires with a patient involvement group sponsored by the practice - provided the group was set up as part of a recognised authoritative approach. In clinical fields this should have an equal evidence base. In organisational fields, where possible, this should have an equal evidence base. This may then help develop subsequent iterations of the national QOF through feedback to the QOF Review Group. However, the application of this variation is limited;
- **Fewer indicators for the same disease areas.** If fewer indicators were used in any area, the practice would still have to demonstrate adequacy of other aspects of those services at annual review;

-
- **Local use of different indicators** using some of the indicators discussed but not used in the national QOF, such as depression;
 - **A different evidence base** than the RCT used for GMS - but nonetheless an acceptable and individually appropriate body of evidence – relevant in new areas. This option would fulfil an essential purpose of PMS as being locally sensitive and agreed and may have a narrow application. PMS practices will have more ownership and such an approach may help develop subsequent iterations of the national QOF;
 - **Use organisational quality frameworks (e.g. QTD)** in a fuller way than replacing part of the organisational of the national QOF. Rather than scoring the practices for payment within national QOF, the frameworks could be used developmentally. However, an appropriate points total must still be ascribed to this activity, within the 1050 of all quality schemes. PMS practices will have more ownership and again, this may help develop subsequent iterations of the national QOF;
 - **Different approaches.** Points for development of, for example, public health interventions, such as care for the homeless. This may fit especially well where the original focus of the PMS practice was to render some form of special care for special groups. However, QOF monies are only available to registered populations.

There may be some other options already being put into practice and working well. These should not be prejudiced by this guidance.

4.10 Operational Issues

The next section of the guidance explains in detail how the national QOF will work for PMS and how to manage other local schemes. It describes:

- The annual quality improvement cycle
- Activities and milestones for 2004/5
- Preparatory funding
- Aspiration calculation and payment
- Prevalence
- Annual quality visits
- Calculation of achievement points and payments
- Ensuring equity and probity

IM&T and data

- QOF review and adaptation;
- Support and development flows
- QOF review and adaptation
- Support and development.

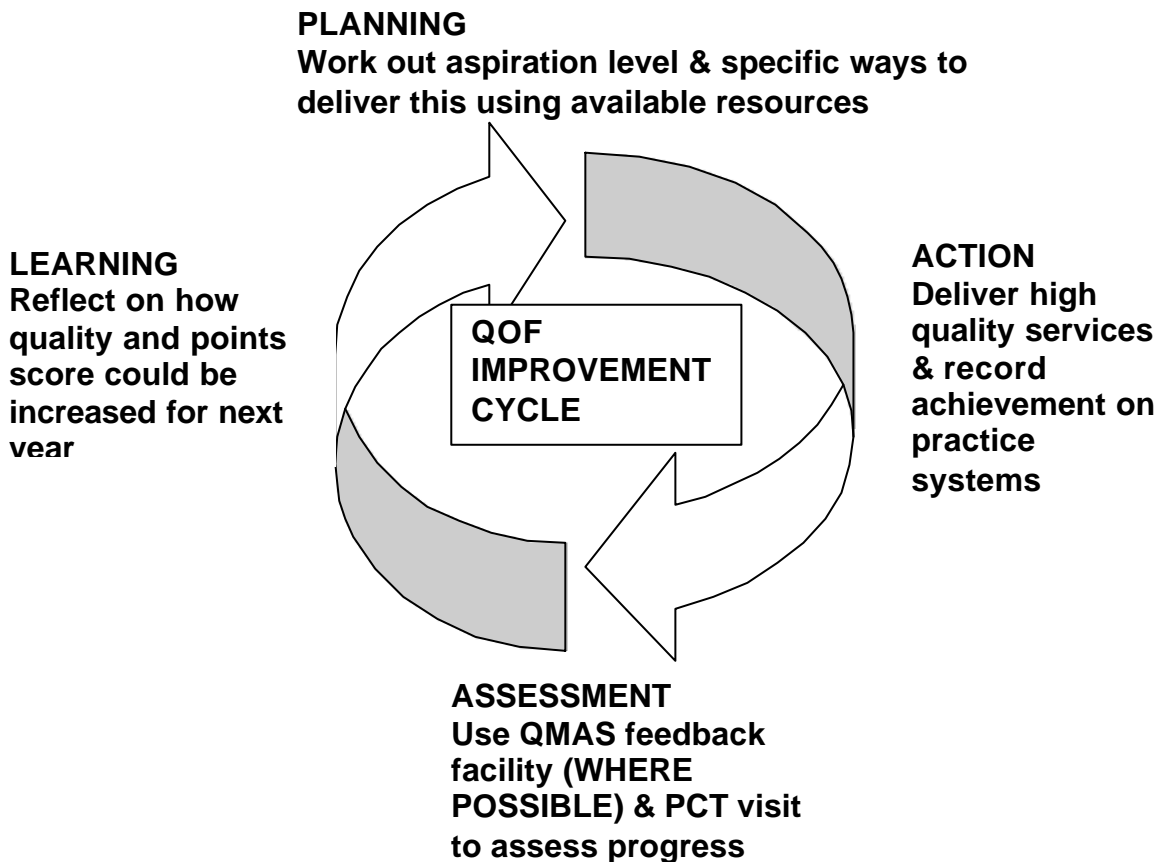
Each element is considered in turn.

4.11 A QOF annual improvement cycle

The QOF reflects a cycle of continuous quality improvement. This involves

- planning,
- involves (i) planning (ii) then action,
- then assessment and (iv) then learning, which in turn leads into the next cycle. This is illustrated in figure [1].

FIGURE [1] – THE QOF IMPROVEMENT CYCLE



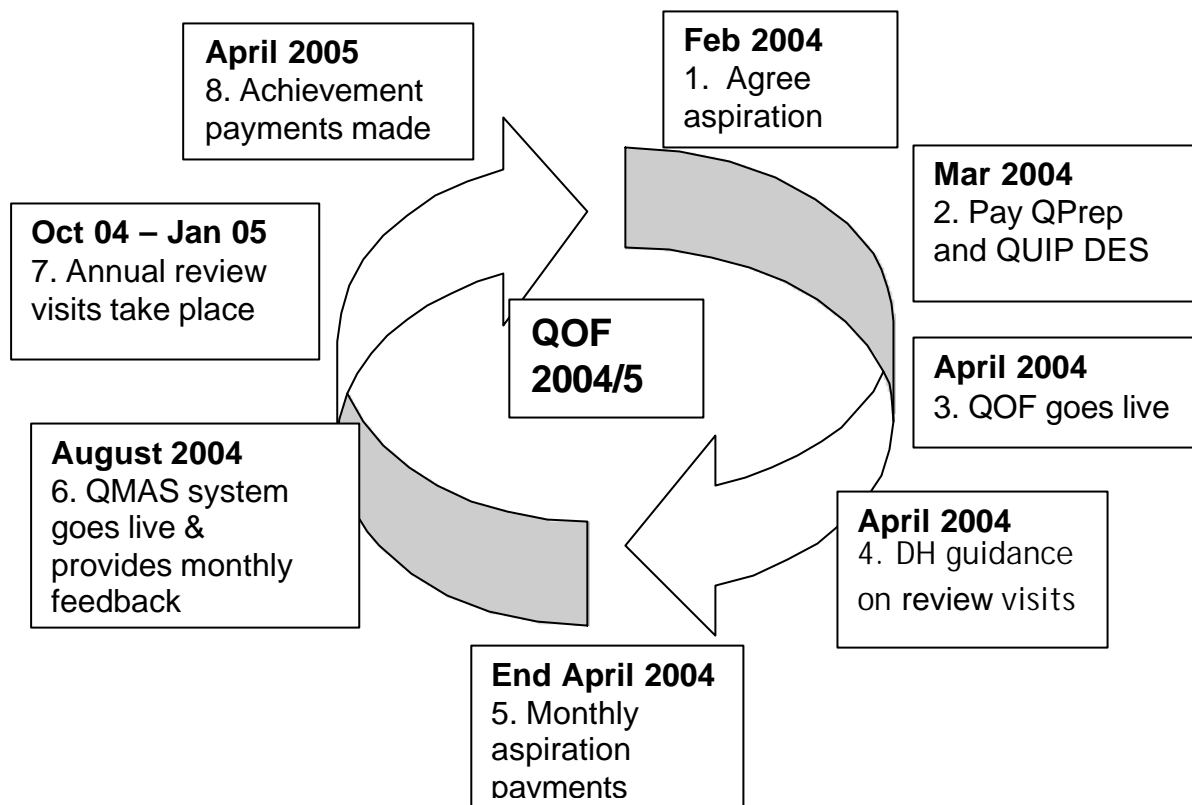
Key activities and timetable for 2004/5

Should PMS practices decide to use the national QOF, a sequence of key activities will make the national QOF fully operational in 2004/5. This is illustrated in figure [2]. The key activities, described in more detail later, are:

- agreeing aspiration levels by the end of February 2004. If PMS practices take part in the national QOF (i.e. using exactly the same format as the national QOF), then they must use the aspiration utility which helps practices to calculate where they might get to in the Framework;
- start of the QOF in April 2004;
- payment of QOF aspiration payment in monthly instalments from April 2004;
- publication of guidance on national QOF annual review visits by the end of April 2004;
- IT - Quality Management and Analysis Sub-System (QMAS) goes live in August 2004;
- QOF annual review visits, taking place from October 2004 to January 2005;
- achievement payments made by the end of April 2005 for most providers.

Payment of achievement monies is subject to annual review, just as in GMS. There will be publication of guidance on national QOF annual review visits by end of April 2004 and QOF annual review visits take place from October 2004 to January 2005. This timetable should also be broadly suitable for PMS, except that where the PMS practice departs substantially from the GMS counterpart. Here, because of lack of any wider standards, more in-depth review processes will be necessary, including pre-payment verification checks.

FIGURE [2] – QOF ACTIVITIES 2004/5



4.12 Preparatory Funding

PCTs will wish to consider the state of preparedness for PMS practices and the support they will require. As with GMS there are two possible payments - quality preparation (so that practices can prepare for the national QOF or equivalent scheme) and quality information preparation (the latter is designed to be spent on improving the quality of patient records).

4.13 Preparation Payments

PMS practices will receive additional quality preparation funding in 2003/04 for quality. A sum will also be available in 2004/05. Key aspects of this payment for 2004/5 are:

- (i) In 2004/5, where a contract is treated as taking effect on 1 April 2004 and an aspiration points total has been agreed, the lump sum payment is to fall on 30 April 2004. This will be based on the provider's list size at 1 April 2004 as held by DH statistical department. Where the contract takes effect after 1 April 2004 it will be adjusted to take account of the period to which it applies and will also fall due at the same time the providers first monthly payment is payable. This will be done using local payment mechanisms through the Exeter system;

- (ii) Payment in 2004/5 is conditional on the provider agreeing to participate in the national QOF or other quality scheme, usually shown through having an aspiration points total;
- (iii) Pro-rata payments would be made to new providers in year except where these arise from practice splits (such practices would have already received their payment);
- (iv) This will be the final payment – QPP will not be available in 2005/6.

4.14 Quality Information Preparation

The quality information preparation payment is to provide a contribution to providers' costs in summarising those medical records that have not already been summarised and continuing to summarise those that have. PCTs should offer separate schemes to all PMS providers for both 2003/4 and 2004/5 by the end of January 2004 and have agreed both with their providers by the end of February.

Key aspects of quality information preparation are:

- It is a plan agreed by PCT and provider, remembering that PMS providers may already have money for quality delivery in the baseline and may be better prepared than GMS practices;
- It must include a protocol for how the summarising is to be done and arrangements for ongoing maintenance. Non-medical personnel must:
 - (a) be fully trained;
 - (b) not take medical records away from the practice premises;
 - (c) have appropriate access to GP performers when they have queries,
 - (d) sign a confidentiality agreement and
 - (e) be appropriately supervised.
- The payment each year must be no less than £1000 and no more than £5000 for a provider with average list size. The precise figure depends on both list size and the amount of work that needs doing, bearing in mind the payment is not intended to cover the full cost. It is funded through existing unified budget allocations;
- When the payment is agreed in line with these conditions, PCTs must make payments for 2003/4 by the end of February 2004, and must make payments for 2004/5 by the end of April 2004. They can use the revised Exeter payment system to make the payments.

4.15 Aspiration Payments

Aspiration payments provide in-year financial support against likely QOF achievement. This section sets out how aspiration payments will work in 2004/5 and 2005/6.

4.16 Aspiration Payments in 2004/5

Before aspiration payments are made, PCTs and practices must agree 2004/5 aspiration levels. For practices using national QOF an Excel spreadsheet tool called the Interim Aspiration Utility (IAU) has been developed to help providers assess their likely level of quality achievement points. This was issued to PCTs by the National Programme for IT (NPfIT) in the first week of December 2003, with guidance notes. PCTs will in turn need to add practice identifiers and list sizes (taken from the Exeter payment system) and forward it to all their GMS providers by the end of December as well as those PMS practices taking part in the national QOF.

To ensure that their first monthly aspiration payment can be made from the end of April, providers should submit their completed IAU or local document by the 16th of January 2004 to the PCT. Providers that do not use the IAU must return an aspiration total for each of the domains they are working on, as well as any additions, in a format agreed in advance with their PCT. PCTs should ensure that practices receive whatever help they require to complete their returns. We are aware that some PCTs have developed their own spreadsheets for calculating aspiration payments.

Where national QOF is used it is important that PCTs only use the IAU to calculate aspiration points totals and payments to ensure that all PCTs use the correct formula. The completed IAUs will also be loaded to QMAS in due course, to allow comparison of 2004/5 achievement to aspiration, and this system will also only accept practice aspirations using the IAU. PCTs that already have information on aspiration from providers should consider whether they have enough information to complete the IAU without re-sending it to them. However, if they do this, they should notify their providers that they will recalculate their aspiration using the IAU and give them the opportunity to do this themselves.

The PMS provider's proposed aspiration level must be realistic, and PCTs need to be satisfied on this before confirming aspiration levels. PCTs should bear in mind that, as a result of new contract QOF incentives, providers will be taking major steps during 2004/5 to improve the quality of their services. When submitting their completed IAU or alternative for a local QOF scheme, providers should include a brief covering explanation setting out why and how they think their aspiration level is achievable, for example through employing additional practice staff. This will normally be sufficient for the PCT to agree the aspiration level without the need for any further information from the provider. PCTs should agree aspiration points with providers by the end of February 2004. Figure [2] illustrates the process through a flowchart.

If a provider does not agree an aspiration with the PCT nor submit an aspiration claim it will not receive an aspiration payment. PCTs may wish to confirm that the provider does not wish to take part in the national QOF or a local scheme. In the case of any unresolved dispute about aspiration levels (after using the local process for resolution), the provider should be awarded the lowest level of aspiration agreed between the PCT and any of its constituent PMS providers.

Once the aspiration points are agreed, the PCT should pay the aspiration payment in monthly instalments, by the end of each month, starting from the end of April. For those using the national QOF, this will be done automatically, once the PCT has entered payment details on to the Exeter system. For those using the national QOF, the payment will be calculated automatically by the IAU by:

- dividing the number of aspiration points by three to calculate the third on which the payment is based;
- multiplying the third by £75 to get the raw payment;
- adjusting the payment by the provider's list size relative to the national average. In England the national average is 5891;
- for all PMS practices, the following formula takes all these points into account and also makes a proportional deduction for the 174 points already in the baseline in year one. It can be used where the aspiration utility has not been used because the provider is not taking part in national QOF.

4.17 Formula for Aspiration payments	
Practice list size	x (aspiration points agreed -174) x £75 = £
National average list size	3
	(£s paid, in 12 monthly parts)

Pro-rata payments would be made to new providers in year except where these arise from practice splits. Contracts that start at such a date that there is insufficient time to make a payment by the end of March 2005 would not receive an aspiration payment in advance of the achievement payment being made by the end of April 2005. If the contract comes to an end in year and the provider was receiving aspiration payments, then these are stopped on the date the contract ends. If the contract ends during a month, the practice receives a pro-rata payment in respect of the number of days the contract ran during that month. In the event of practice merger, the monthly aspiration payments of the two practices are added together.

Table1 provides a worked example:

TABLE 1 – WORKED EXAMPLE OF 2004/5 ASPIRATION PAYMENT

This example assumes a practice list size of 7000, an agreed aspiration points total of 650 and an average national list size of 5891, in PMS

$$\frac{(7000)}{(5891)} \times \frac{(650-174)}{3} \times £75 = \mathbf{£14,140.21}$$

in 12 monthly parts of **£1,178.35**

2005/6 aspiration payments

A different method for calculating aspiration payments will apply from 2005/6. The objective is threefold:

- to enable providers to receive a greater proportion of the QOF money in-year, to improve their cash-flow, but without putting at risk PCT cash management requirements;
- to make the payment calculation automatic to remove the possibility of local dispute, if the PCT and practice agree that they wish to do this;
- to make the process of planning for quality improvement, through agreeing aspiration levels, simpler and less liable to distortion as a result of financial considerations.

The new method of calculating aspiration payments will be as follows:

- the aspiration payment for 2005/6 will be based on 60% of the payment achieved by the provider in 2004/5. In effect this includes prevalence (where used) and list size weighting;
- the payment will be uplifted proportionate to the increase in the pounds per point, e.g. to £120/75;
- where the provider had not participated in the QOF in 2004/5, or only participated to a very limited degree, its aspiration will be worked out using the process for 2004/5 (i.e. it will agree an aspiration total with the PCT and be paid a third of this, with no weighting by prevalence).

This example assumes a list size of 7000 and an achievement of 401 points which resulted in payment of **£32,882**

(NB because prevalence influenced the point value to be, on average, greater than £75. The effects of prevalence are explained in 4.12)

$$£32,882 \times \frac{60}{100} \times \frac{120}{75} = £31,566.72 = \mathbf{£s\ paid,}$$

(in 12 monthly parts of **£2,630.56**)

4.18 Prevalence

If PMS practices take part in the national QOF (i.e. if they use the QMAS system to collect their data) quality payments will be adjusted by practice prevalence of disease as recorded by QOF data and relative to other practices. Mixed national / local QOF practices will be able to see their prevalence data on QMAS, but this will not be used in the national calculation of average prevalence and any prevalence adjustment for these practices must be agreed locally. The aim of the prevalence adjustment to national QOF clinical domain payments factors is to deliver a more equitable distribution of quality rewards in the light of the different workloads that practices will face in delivering the same number of quality points. It will target resources effectively at areas where both morbidity and provider achievement is greatest and thereby help tackle health inequalities.

In developing the prevalence adjustment methodology, initially for the national QOF, the following requirements were considered:

- the need to provide adequate income protection to those with lowest prevalence, such as university practices;
- the need to deliver appropriate rewards for those practices with the highest prevalence;
- the need to ensure that the QOF delivers the agreed overall levels of funding;
- the need to develop a sound method based on research evidence, where possible.

Applying the raw prevalence data, without an adjustment, would lead to a very significant redistribution of quality resources away from practices with the lowest prevalence to those with the highest. This would be unfair given that it would seriously destabilise those practices with the lowest relative prevalence. Intellectually it is not sound because even practices with low prevalence have significant fixed costs in identifying morbidity and establishing quality systems and the relationship between workload and prevalence is not a linear correlation. For these reasons the raw factor will be subject to an adjustment to reduce variation and protect the losers, whilst at the same time providing fair rewards to those who have the highest prevalence.

For the purposes of payment calculation, average relative disease prevalence will be calculated using prevalence data from GMS practices and those PMS practices doing the national QOF exclusively. No other PMS schemes will be included in the calculations of national prevalence, although they may have data relating to their own prevalence.

This raises some issues for PMS practices not taking part in the national QOF to attain higher quality care. As referred to earlier, a senior clinician will have

to make as reasonable a judgement as possible, given the information supplied by the practice to the PCT on how it has agreed quality targets with the PCT, as to the workload and value of the different quality framework that has been agreed. This should ensure fairness between national and local practices. It may also be possible to produce local prevalence figures through analysis of local statistics and apply the national pay formulae shown later.

4.19 Prevalence Factor Methodology

The calculation using national QOF involves three steps:

- the calculation of the provider's raw practice disease prevalence. A separate factor will be calculated for each disease area;
- making an adjustment to give an adjusted practice disease factor (APDF). This is necessary to avoid a radical and unjustified redistribution of quality resources from those with lowest prevalence to those with highest;
- using the APDF to adjust the pounds per point in each disease area.

The raw practice disease prevalence is calculated by dividing the number of patients on the relevant disease register by the number of patients on the registered list. This will be the most up to date list size held by the revised Exeter payments system.

The adjusted practice disease factor is calculated by:

- Calculating the national range of raw practice disease prevalence in England and applying a 5% cut-off at the bottom of the range. Practices below this will be treated as having the same prevalence as the cut off point. This recognises the fixed costs of providing care and provides a measure of financial protection for those with very low prevalence. There will not however be a cut-off at the top of the distribution, to recognise and reward those with the highest prevalence;
- Once the cut off has been applied, making a square root transformation to all the practice prevalence figures. This means that the prevalence distribution will be compressed to a narrower range. It will prevent financial destabilisation of those with the lowest prevalence and reflects the workload consequences of participation in the clinical domain in practices with the lowest prevalence;
- After the transformation, the practice figures are rebased around the new national mean to give the adjusted practice disease factor (ADPF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The rebasing ensures that the average practice receives the average number of £s per point after adjustment;

- The factor adjusts the practice's average pound per point for each disease, rather than the practice's points score. It does not adjust payments in the other domains.

4.20 Prevalence Data Collection

The ADPF is a measure of relative recorded disease prevalence. Disease register information will be extracted from clinical systems of all providers at the same time, through automated links and aggregated by the new Quality Management and Analysis Sub-System (QMAS) to calculate the national recorded prevalence for each disease area. Practices using the national QOF will know approximately what their prevalence will be from the reports available on QMAS throughout the year. Practices not using the full national QOF will still have data on the QMAS system and will be able to have reports on progress.

From 2005 14th February will be National Prevalence Day in both GMS and PMS practices. This is as late in the financial year as possible whilst enabling prompt payment of achievement rewards by the end of April. Providers that are not using the QMAS system will have to send each PCT details of its disease prevalence for each of the national QOF disease areas it is working towards for the prevalence data collection. They should send to the PCT:

- (i) the number of patients on the disease register for each disease area and
- (ii) the total number of registered patients, as measured on 14th February. This is information that practices should already have, as it is the first indicator in each clinical area.

Providers will be asked to submit this data by 21st February. Those that do not submit by 14th March, but are participating in the national QOF, will be treated as having the lowest national practice prevalence ([see 3.12.18 for more details](#)) when their achievement payment is calculated. They will not be included in the national calculation of practice prevalence factors. Practices that are not working towards the national QOF clinical domain, or are not working towards certain of the disease areas, will not be included in the prevalence collection as appropriate. PCTs should remind providers of the approaching data collection and confirm which disease areas the practice plans to achieve against.

4.21 Annual Review of the QOF

PCTs should visit their providers annually to review each provider's achievement against the QOF indicators. The frequency of visits may decrease in future years if the PCT is confident of the practice's performance against the QOF indicators. Equally, the frequency of visits may increase where there is serious concern about, for example, data accuracy or suspected fraud. There should be more frequent and in-depth visits where there is no in-year data on performance (either through QMAS or through a local system).

Experience from existing local quality incentive schemes shows that these visits will involve significant preparation and organisation for both PCTs and practices. It is therefore important that PCTs and practices plan this process thoroughly and well in advance. PCTs should:

- nominate a QOF lead who is responsible for planning of visits, and ensuring consistency of the visiting approach and reporting of visits;
- produce a schedule of planned provider visits by August of each year, for visits to take place between 1st October and 31st January. This timetable is necessary to allow sufficient time before achievement payments are made for remedial plans, if need be, to be drawn up, agreed, implemented and reviewed. A delay by the PCT in visiting the provider should not delay payment of achievement at the end of the year;
- bear in mind that their visits will require considerable workforce capacity involving trained assessors.

The exact process to be followed during the national QOF annual review visit is important and DH has therefore commissioned the School of Health and Related Research (SchARR) at the University of Sheffield to develop proposals. In the light of these the Department of Health and the NHS Confederation will develop guidance and discuss this with GPC and PMS Implementation Group. This will be published by April 2004. The methodology will apply to practices taking part in a different quality scheme, but the application may be slightly different.

The following principles will inform the annual review visit process:

- The visit process will build on best practice of existing review and inspection mechanisms;
- PCTs will have the flexibility to timetable review visits as they wish, within the October to January window. Scheduling of visits should take into account any other visits to the provider, e.g. by Patients' Forums, to minimise burdens on providers;
- Providers doing the national QOF will need to submit the written evidence (as also described in the *Supplementary Documents* to the GMS contract) a month in advance of the visit date. Providers must report the number of different exceptions used for each indicator. All information submitted must be accurate. There will be some form of verification of exception reporting during every QOF visit. Those providers doing other schemes will have agreed similar arrangements with the PCT and therefore also submit their evidence one month in advance of a visit;
- Each review visit must cover all of the domains the practice plans to submit an achievement claim for. Not all indicators will be assessed in equal detail on every visit. The process developed by SchARR will include

a mechanism to ensure balance between covering the breadth of the quality scheme and inspecting some indicators in detail Any indicators outside the national QOF will be looked at with particular care, and the DirPH may be asked to explain why they were approved as valid quality indicators;

- Practices that have been and remain accredited for Version 7 of the Royal College of General Practitioners' Quality Practice Award will not need to submit evidence for the quality review in relation to the organisational indicators in the national QOF. PCTs should ensure that the review of organisational indicators for accredited providers is very light touch, focusing on a few areas only (e.g. significant event review). Further organisational quality schemes will be accredited for use with the national QOF, and details of these will be sent to practices and PCTs. Each accredited scheme will have listed the national QOF organisational domain indicators it can be used against. All schemes will need to involve a visit to the provider for provider accreditation to take place;
- Assessors will have access to patient records in order to check practice achievement against the QOF. However, this will be subject to a code of practice, which is under development;
- Assessors will be selected on the basis of meeting certain competencies and will be appropriately trained. One of the assessors will normally be a lay person or patient representative (who is not a patient from that practice) and normally at least one will be a doctor. There may be occasional circumstances where it may not be appropriate for the clinician to be medically qualified, and in these circumstances an assessor could be another appropriately qualified healthcare professional, where both the PCT and practice agrees. Other assessors, as long as they have been appropriately trained and meet the necessary competencies, need not be PCT employees. The competencies, roles and responsibilities of the assessors will be defined alongside the national QOF annual visit process. National training will be offered for a certain number of assessors per PCT. It will then be up to PCTs or other bodies to commission further training as necessary, within national guidelines;
- Following the QOF annual review visit, the assessment team will provide the provider with their assessment of the practice's likely achievement against the QOF, and a written report of the visit. This report will be sent in draft to the provider;
- The practice's aspiration for the following year will also be discussed at the annual review visit.

The PCT should also visit the practice for an annual contract review, and this is discussed in more detail in other parts of this document. This can be combined with the QOF annual review if the provider so wishes.

4.22 Calculating Achievement Points and Payments

This section of the chapter sets out how achievement points are calculated in each of the domains. Providers will be entitled to receive payments in accordance with the rules summarised in this section. The method for calculating points varies by domain and each is considered in turn.

4.23 Clinical Points

In the national QOF, the provider either achieves all the points available for a disease register, if it can produce such a register, or none. If the provider does not have a register then it is not possible to calculate achievement points against any of the other clinical indicators in that disease area, or to calculate prevalence. The logic of this applies to local schemes where it is agreed between the PCT and provider that prevalence will be used.

The remaining clinical indicators in the national QOF have achievement thresholds. The number of points achieved is dependent on achievement between these thresholds. This is set out in the worked example in figure [3]:

FIGURE [3] – CALCULATING CLINICAL POINTS

80% of the practice's patients with hypertension have had their blood pressure recorded in the past 9 months (indicator BP 5). The minimum threshold for this indicator is 25%, the maximum is 90%. The total number of points available for this indicator is 20.

The calculation is:

$$\frac{(80 - 25)}{(90 - 25)} \times 20 = \frac{55}{65} \times 20 = 0.85 \times 20 = 17$$

Practice G has achieved 17 points for its performance against indicator BP 5.

Providers should ensure they use the correct Read codes in their patient records, as QMAS works by recognising and counting records with the relevant Read codes. Failure to use the correct Read codes may result in under-payment as patients will not be counted. Providers should also make sure they do not omit Read code information where patients have not been treated in line with the QOF indicators as this would constitute fraud. Providers using QMAS will be able to see if data is incorrect or missing by looking at the monthly reports on the QMAS system and should act to ensure this is corrected.

4.24 Organisational Points

As with the clinical disease register points, the organisational indicators are either achieved in full, in which case the provider receives all the points, or

not. A proportion of points will not be given for part achievement (e.g. for indicator Education 9, all the provider's staff must have had an appraisal. The provider cannot achieve half the points if only half the staff have had an appraisal).

4.25 Patient Experience Points

The same all or nothing rule applies to calculating points arising from the patient experience indicators. To achieve the patient survey indicators, the provider should:

- ensure that at least 25 questionnaires per 1000 patients are returned;
- use an accredited patient survey. Two patient surveys have already been accredited for use against the patient survey indicators of the national QOF. They are:
 - (a) Improving Patient Questionnaire (IPQ), developed by Exeter University and available at <http://latis.ex.ac.uk/cfep/ipq.htm>.
 - (b) General Practice Assessment Questionnaire (GPAQ), developed by the National Primary Care Research and Development Centre in Manchester and available at <http://www.gpaq.info>.

As in GMS, use of other surveys will not count towards quality achievement if scoring under the national QOF and using QMAS, although they may be allowed in local schemes. Earlier paragraphs noted different ways of moving to local contracts using, for example, a patient group with a clear mandate and outputs instead. Further validated patient surveys are expected to be formally accredited for use in the national QOF over the next few months. Details of these will be sent to all PCTs, and posted on the DH, GPC, NHS Confederation and NatPaCT websites.

4.26 Additional Services Points

The first cervical cytology indicator (CS1) has achievement thresholds and is measured in the same way as the clinical indicators. The remaining indicators are either achieved in full, or not, as with the organisational indicators. A requirement of payment is that the provider must offer the relevant services to 100% of the relevant target populations, defined as follows:

- (i) Cervical screening: women aged 25 to 64 years
- (ii) Child health surveillance: children aged under 5 years
- (iii) Maternity services: women aged under 55 years
- (iv) Contraceptive services: women aged under 55 years

The pounds per point for each of the indicators in these additional services will be adjusted by the relative size of the provider's target population, compared to the national average. This is to protect providers with large target populations and adequately reward them for their greater workload. The calculation is as follows:

$$\frac{(\text{provider's target population}) \div (\text{provider's registered population})}{(\text{national average target population}) \div (\text{national registered population})}$$

Where a provider opts out of an additional service during the year, its achievement against that indicator will be measured at the date of opt-out. However, the achievement will still be paid with the rest of the achievement payment in the first quarter of the following year.

4.27 Holistic Care Points

Holistic care payments reward breadth of quality achievement in the clinical domain. They are calculated by ranking the points scored in all the clinical areas on the basis of the proportion of points scored out of the total available. The third lowest proportion is the proportion of the 100 points to which the provider is entitled. This is illustrated in table 3 below:

TABLE 3 – WORKED EXAMPLE OF HOLISTIC CARE PAYMENTS FROM NATIONAL QOF

A practice achieves the following results in the clinical domain:			
	Points scored	Possible total	Proportion
CHD	85	121	70.25%
Stroke/TIA	15	31	48.39%
Hypertension	65	105	61.90%
Diabetes	50	99	50.51%
COPD	16	45	35.56%
Epilepsy	4	16	25%
Hypothyroidism	8	8	100%
Cancer	6	12	50%
Mental Health	0	41	0%
Asthma	50	72	69.44%

The third lowest ranking disease area is COPD, where the practice 35.56% of the possible points available. Therefore, the practice receives 35.56% of the 100 holistic care points, or 35.56 points.

4.28 Quality Practice Points

Quality practice payments reward breadth of quality achievement across the organisational patient experience and additional services domains. They are calculated by ranking the points scored in all five organisational areas, the two

patient experience areas, and the four additional service areas, on the basis of the proportion of points scored out of the total available. The third lowest proportion is the proportion of the 30 points to which the provider is entitled. This is illustrated in table 4:

TABLE 4 – WORKED EXAMPLE OF QUALITY PRACTICE PAYMENT

A practice achieves the following results in the organisational, patient experience and additional service's domains:			
	Points scored	Possible total	Proportion
Records	80	85	94.12%
Patient communication	8	8	100%
Education & training	13	29	44.83%
Practice management	15	20	75%
Medicines management	35	42	83.33%
Length of consultation	30	30	100%
Patient survey	40	70	57.14%
Cervical screening	16	22	72.73%
Child health surveillance	6	6	100%
Maternity services	6	6	100%
Contraceptive services	2	2	100%

4.29 Access Bonus Points

These are mandatory for all PMS providers. Providers that deliver access for patients to a GP within 48 hours and to a primary care professional within 24 hours, in line with the NHS Plan and PPF 2003-06 target, are recognised by the award of 50 bonus points (before any formulaic deduction). More information on how to achieve and sustain the 24/48-hour access target is available on a PCT toolkit at www.doh.gov.uk/waitingbookingchoice/pcaccess.

From 2005-06, improving access under the QOF will be assessed annually based on performance across the year using practice data already collected by PCTs for the monthly Access Survey (PCAS). Measurement will be assessed against up to a total of 24 data points -12 for access to GPs and 12 for access to a primary care professional. The assessment will include some tolerance to take account of unavoidable short-term dips in performance, for example sickness absence, or an outbreak of flu.

Providers scoring 21 to 24 data points will be awarded 50 quality points, provided that there were no more than two failures on either GP or primary

care professional access. Providers scoring less than 21 points will receive no award.

A transitional arrangement is required for 2004-5 because the 24/48-hour access target is for achievement by December 2004. For that year only assessment will be based only on the four months from December 2004 to March 2005. Measurement will be on the basis of up to 8 data points: access to a GP within 48 hours each month and access to a primary care professional within 24 hours each month. Practices scoring 6-8 data points, with no more than one failure on access to a GP or primary care professional will be awarded 50 quality points.

4.30 Calculating Achievement Payments

For PMS practices using the national QOF, the achievement payment may be calculated automatically by the QMAS IT system, in the following way:

- Points achievement is assessed on National Quality Achievement Day – 31st March by the QMAS system. QMAS will automatically use the data on it at 31 March to create an achievement report for each practice and send it directly to the PCT. Practices will be able to see the report, and must confirm by 7 April that it is correct, using a form on QMAS. Delays in confirming that the data is right, or in submitting data by paper-based practices will lead to delays in PCTs making payments;
- For the clinical domain, the £75 pounds per point in 2004/5 (£120 in 2005/6) is multiplied by the Adjusted Disease Prevalence Factor (ADPF) for each disease area and this is in turn multiplied by the points achieved in each disease area;
- For the other domains (except the additional services domain), the £75 pounds per point in 2004/5 (£120 in 2005/6) is multiplied by the points scored, including the holistic care and quality practice payments and access bonus. Points scored in the additional services domain are multiplied by £75 (£120 in 2005/6) but are not adjusted by any other factor;
- These payments are added together and adjusted by the provider's list size relative to the national average of 5907 - our best estimate for PMS providers.

Before payment is finalised, an adjustment is made for the reduction of 174 points already credited to PMS providers. Prevalence need not be taken into account; the deduction of 174 points in the baseline is not related to prevalence but to other domains. List size is however taken into account. The formula for the deduction is given here (although applied as the last step in the process).

Formula for PMS Achievement payment deduction, 04-05

$$\frac{\text{Practice list size}}{\text{National average list size}} \times 174 \times \text{£}75 = \text{Deduction from QOF value}$$

(calculated as per GMS)

- The aspiration payment is deducted from the total QOF payment to produce the achievement payment. Should this be a negative amount, the full amount will be deducted from the following year's aspiration payment in monthly instalments. The PCT normally confirms the payment (section H of this chapter sets out exceptional circumstances) and ensures it is paid as a lump sum by the end of April. PCTs must verify all achievement claims before authorising them for payment. The assumption will be that the claim is correct and can be authorised for payment, unless there is evidence to the contrary, e.g. from the annual review;

To ensure consistency of calculation, providers who do not use the QMAS system (i.e. those without adequate computerisation) will need to supply records of achievement against the 146 national QOF indicators to PCTs, who will then ensure calculation of the achievement payment and make payments accordingly. Verification of such records, and manual input by the PCT of the data into QMAS, will take considerable time and effort. As a consequence achievement payments for such providers will be delayed. For these reasons PCTs and practices are strongly advised to use the QMAS system and PCTs should offer support to paper-based practices to become computerised.

Providers are entitled to receive an aspiration payment in respect of each day for which they have submitted data to QMAS if they are taking part in national QOF and no other quality scheme. They need not have agreed an aspiration payment to be eligible for an achievement payment. Providers whose providers start or end during the year receive a payment in respect of the days for which the contract runs.

Achievement payments, year one**4.31 PMS Providers Taking Part in the National QOF**

Calculation of pay for all practices taking part in the national QOF, for the **non-clinical domains** will be according to the following formula

$$\frac{\text{Practice list size}}{\text{National average list size}} \times \text{points achieved} \\ \times \quad \pounds 75 \quad \times \quad = \text{£s paid}$$

For the additional services domain indicators, the £75 per point will be adjusted by the calculation in paragraph 4.20 on page 53 to reflect target population size.

Calculation for clinical areas is as in the GMS

$$\frac{\text{Practice prevalence, square rooted}}{\text{National prevalence}} \times \frac{\text{Practice list size}}{\text{National average list size}} \\ \times \text{points achieved} \times \quad \pounds 75$$

This formula is applied in each of the ten clinical domains, as in GMS

4.32 Practices Taking Part in other Agreed Quality Schemes, Not Involving the National QOF

For practices not taking part in the national QOF, where the pay formula does not take account of local prevalence but does take account of the total points which should be deducted.

$$\frac{\text{Practice list size}}{\text{National average list size}} \times \text{points achieved} \\ \times \quad \pounds 75 \quad \times \quad = \text{£s paid, before deduction formula}$$

4.33 Practices Taking Part in Agreed Quality Schemes, Partly Involving the National QOF

For a practice partly taking part in the national QOF both the national QOF formula and the local QOF formula have to be applied, proportionately to the percentage (agreed in advance) that the practices are taking part in the national QOF. Otherwise the points total could go (astronomically) higher than 1050. The formulae, i.e. prevalence and none prevalence formulae, applied proportionately to the number of points in the scheme then give a

calculable total potential payment to the local PMS quality monies, if the schemes are derived fairly.

So, the sequence of calculations is;

Calculate the achievement payment in the non-prevalence areas. Add the achievement payment in the prevalence areas. Apply the deduction formula to calculate the final payment.

If a contract starts or ends in-year and the practice is participating in the QOF, then its achievement against the QOF indicators is measured for the period that the contract is running. The practice's achievement total is calculated as normal. This total is then adjusted pro-rata payment according to the length of time the contract ran during the year. This is to avoid paying for quality twice in the event of practice splits. The amount of aspiration payment the practice has already received is deducted from this total, and the resulting figure is the final achievement payment due to the practice. In 2004/5 the payment will not be adjusted by prevalence if the contract ends before 14th February 2005. In subsequent years it will be adjusted by the previous year's prevalence figures. The DH will produce a spreadsheet, containing all the formulae, which PCTs can use to do these calculations automatically. Table 5 provides a worked example:

TABLE 5 – QOF PAYMENTS FOR CONTRACTS ENDING IN YEAR

The practice final achievement payment (after 174 points deduction) is £42,575.00. This is adjusted according to the number of days the contract has run during the year.

$$\text{£}42,575.00 \times \frac{201}{365} = \text{£}42,575.00 \times 0.55 = \text{£}23,445.41$$

The practice has already received £10,281.25 in aspiration payments. These are deducted from the achievement total to give the final aspiration payment.

$$\text{£}23,445.41 - \text{£}10,281.25 = \text{£}13,164.16$$

Practice D's final achievement payment is £13,164.16.

Providers using local schemes where prevalence is taken into account should use the formula 3, substituting the value of "local" for the value of "national" in the prevalence calculation.

If the provider has quality money in its baseline there should be a proportionate deduction. But if the provider has no quality money in its baseline eg. a greenfield practice there should be no deduction.

4.34 Year Two et seq.; deduction equation for PMS

In year two, the pounds per point increases from £75 to £120. Unless the baseline increased at the same rate then if the point's deduction is not recalculated, the pound's deduction will be disproportionately greater than the money in the baseline. The calculation to achieve fairness in year two is:

$$\frac{\pounds 75}{\pounds 120} \times 174 = 109 \text{ pts}$$

4.35 Year Two et seq. achievement payments

For year two, whenever applying the pay formulae, wherever 174 appears it should be replaced with 109.

The general principles of the equation to be used in each year to calculate the points deduction are:

$$\frac{(\text{next yr point value in } \pounds \text{ s})}{\text{current year points value in } \pounds \text{ s}} \times \text{current year deduction} = \text{following year deduction of points}$$

In some future year, the formula may reach or go beyond parity and is then abandoned.

4.36 Ensuring Equity and Probity

All providers have a legitimate expectation that the QOF will be applied in a fair manner within and across PCTs. This will be ensured through:

- application of the rules set out in this chapter, and mechanisms to ensure that they are not being misapplied, including through any dispute resolution procedures, or deliberately flouted;
- QMAS providing consistency of calculations for those practices using the national QOF. For practices not using QMAS, a fair method of monitoring, assessment and measurement must be agreed between the practice and the PCT (involving a senior clinician such as the DirPH) at the outset;
- consistency of approach for PCT visits and training of assessors.

PCTs should note that the QOF is built on the principle of high trust. The systems described thus far in this chapter have been designed to minimise bureaucracy and intrusion on the vast majority of providers who will submit accurate QOF data. In order for the high trust system to operate, it is

necessary to have robust mechanisms in place to deal with the extremely small minority of providers who may seek to submit incorrect claims and obtain falsely inflated levels of rewards. PCTs have a duty both to financial auditors in respect of the proper use of public funds, and to ensure fairness for the honest majority.

The PCT is required to confirm all achievement payments before they are made. For most providers this will be automatic. In the following exceptional cases, the achievement payment may not automatically be paid by April:

- where monthly reports and/or annual visits throw up issues around data accuracy (or where monthly reports are not available), and these have not been remedied in sufficient time to the satisfaction of the PCT. This could for example include:
 - (i) include (a) inexplicably low or high numbers of patients on disease registers given the PCT average prevalence, e.g. as a result of not coding or miscoding patient records, or
 - unusually high levels of exception reporting. Specialist PMS practices (and possibly other PMS practices) that have very abnormal populations will necessarily be outliers in things like prevalence and coding. The PCT should be aware of this at the outset, when the quality scheme was agreed with the practice. These should normally be assessed during the practice visit. In the event of data accuracy being questioned during a visit, the provider and PCT will draw up a remedial plan, which the provider will normally implement this within a month of the visit, and the PCT will seek to confirm it has been implemented within a further two weeks. Given the last visits would take place by end of January, this would then enable achievement payments to be made by end of April. In the event of remedial action not having taken place to the satisfaction of the PCT, the PCT could re-score the achievement points. Providers would be able to challenge such decisions under contract resolution procedures;
- where there is an inappropriately high level of referrals to secondary care providers. The QOF is intended to reward providers for the work that they are doing, rather than for work that is carried out on their patients in secondary care. If a PCT has evidence which shows that a provider has been systematically and inappropriately referring patients to secondary care in order to maximise quality achievement points, the PCT could re-score the achievement points calculation;
- where there is a substantial unexplained variation between aspiration and achievement. The assessment of likely achievement arising from the PCT visit should normally significantly reduce the likelihood of this occurrence. If such variations do occur, the PCT would be under a financial obligation to make further inquiries to satisfy itself of the validity of the claim before making payment;
- in the event of suspected fraud or other illegality;

- where local indicators have been set based on incorrect or dubious data.

If the PCT has concerns in relation to the issues above, it should discuss this in the first instance with the provider. The PCT can ask the provider for more information to support their achievement claim. The PCT may also wish to check the provider's records in more detail, or ask to see certain documents.

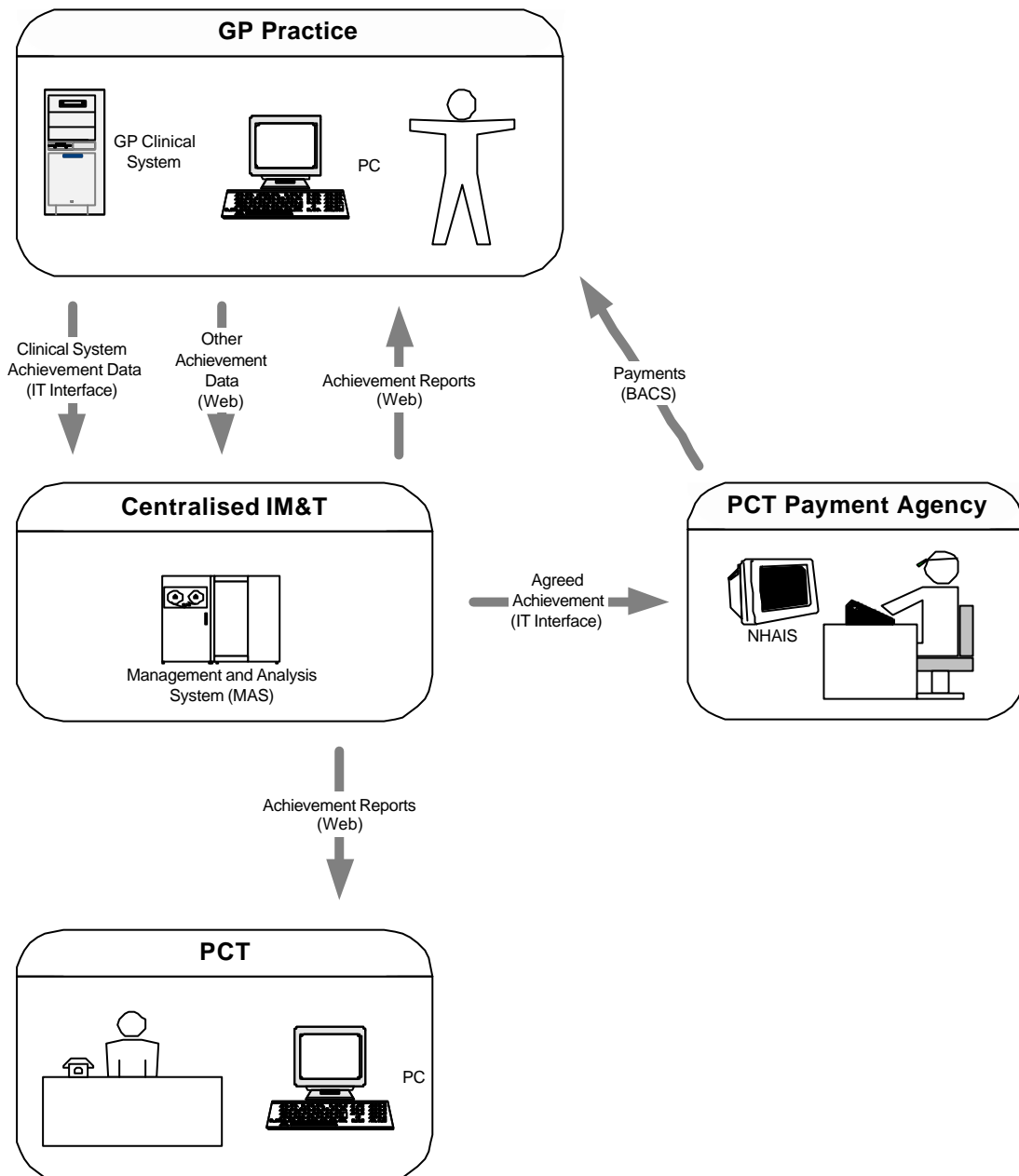
Where the PCT has good reason to suspect fraud, it should involve the NHS Counter Fraud and Security Management Services (CFSMS) at the earliest opportunity. Any fraud or attempt to defraud around QOF payments will be treated as seriously as other forms of NHS fraud, and could lead to criminal prosecution. It could also lead to visits without notice or the provider's consent.

A random 5% sample of practices will also be checked thoroughly as part of counter-fraud measures. Wherever possible, this will draw on the pre-existing written material provided for the annual review, to minimise bureaucracy. Where checks require a visit, this would normally occur as part of the following year's annual visit, to minimise disruption to providers and their patients.

IM&T and data flows

IM&T support for the national QOF will be provided through three mechanisms:

- the Interim Aspiration Utility, (an aspiration spreadsheet discussed in the section on aspiration payments, for assessing quality aspiration levels in 2004/5;
- all providers having clinical systems that are RFA99 (version 1.1 or higher) compliant.. PCTs should provide funding to upgrade the clinical systems of those relatively few providers that are not compliant. This is a necessary precondition for PMS providers doing national QOF or mixed QOF;
- the introduction of the Quality Management and Analysis Sub-System (QMAS). This system will ensure consistency in how quality achievement and prevalence is calculated, and be linked to the NHS Information Authority payment systems. Data from clinical systems will be extracted through automated links to QMAS, while non-clinical information (the yes/no organisational, patient experience and additional service's indicators) will be added to QMAS by the practice using a web-based interface. Clinical systems will be subject to a process of certification by the National Programme for IT (NpfiT) to ensure that they are compliant with QMAS. It is expected that this process will be complete, and QMAS introduced, by August 2004. This will be accompanied by guidance and training provided by NpfiT. Figure below illustrates how QMAS will work;



- With the help of the PCT local QOF practices should develop their own system that allows monthly reports on points and prevalence, where used, to the PCT, ad hoc reports for the practices and where the electronic data record cannot be manipulated after 31 March each year by the practice but can be changed by the PCT in certain circumstances.

4.37 Data flows

QMAS will enable providers to:

- assess their current quality achievement points, estimated relative prevalence and current achievement payment whenever they wish;

(ii) compare their current position with the average achievement in the PCT, the SHA and nationally. Such comparisons would not involve disclosure of information that identifies other providers. This facility will be available later than the main system going live;

(iii) check that the data they are providing is correct and full.

(i) and (iii) can be achieved through a local system that practices and their PCTs can design together, but (ii) is only possible with a national system. To be part of this national system, PMS practices must use the national QOF - although they can gain some benefit by using some national QOF indicators.

At the end of every month (and whenever a provider wishes) QMAS will automatically compile a report for each practice. This will show the practice's prevalence at that time, as well as the points it has earned so far and its progress relative to its aspiration. It will also provide a nation wide picture of likely quality achievement spend. The end of February and March prevalence figures will not be used for achievement calculation purposes given that National Prevalence Day is 14th February.

PCTs will also have links to QMAS. When planning cash flow, PCTs should note that QOF achievement could rise disproportionately during the last few months of 2005/6 as practices strive to maximise their QOF achievement payments. QMAS will provide for each PCT information on:

- current individual practice points achievement, prevalence, and payments. This information is essential for financial planning and risk management purposes. PCTs should ensure that identifiable information about the provider is carefully handled and not routinely shared outside the PCT;
- overall PCT achievement against the national QOF, set against other PCTs in the SHA and nationally. This would not include information that identifies individual providers. This functionality is likely to go live later than the basic payments system.

QMAS will also provide:

- monthly information to SHAs on likely PCT points achievement prevalence and spend. This is also necessary for financial management purposes. Such reports would not include information that identifies individual providers;
- information to inform national policy development e.g. the reviews of the national QOF, or research. Where this includes data on individual providers it would be anonymised;
- information to statutory authorities including NHS Counter Fraud and Security Services, auditors and CHAI. Access to identifiable provider level information would normally be at the request of the PCT and with the

permission of the provider. In exceptional circumstances e.g. serious fraud the PCT may need to access data without the provider's permission. For practices not using QMAS, equivalent access would need to be provided.

PCTs should not use this information for performance management purposes as the QOF is voluntary. PCTs and practices could, however, use the information as a way of offering support to the provider.

PCT wide achievement against the QOF will be independently inspected by CHAI. CHAI is intending to publish information showing relative achievement at PCT and SHA level on an annual basis from 2005. The Department will also be reviewing how PCT star ratings might best capture achievement against the QOF, again from 2005.

Access to data, including, where appropriate, patient identifiable data (by PCT assessors and staff from other organisations) will be subject to a code of practice which will be published in 2004

4.38 Review of the National QOF

The national QOF should not remain static and will need to be updated, particularly in the light of new evidence and changing best practice including new and revised NSFs and NICE recommendations. There will be a formal review process through which changes to the national QOF will be recommended by a UK-wide independent expert group. This process will be in place before the end of 2004, with the precise arrangements confirmed next summer. However, no changes to the national QOF will be made before April 2006 (i.e. they will first take effect in 2006/7), other than in the case of a change in the evidence base or the law that made a particular current indicator inappropriate. PMS practices that choose not to use the national QOF should contribute to the review by providing feedback on the implementation and usefulness of the alternative indicators that they have used.

It is expected that the review group will consider all aspects of the national QOF with the twin aims of improving care to patients, whilst recognising changes to practice workload. The group will consider:

- whether new indicators should be added, existing indicators revised, dropped or combined;
- what the workload implications might be of such changes and how the points for indicators might be adapted to reflect this.

4.39 Support and Development

Support will be available through the following mechanisms:

- The nine contract implementation conferences in January and February for PCTs, being organised by the MA (NatPaCT) in conjunction with the DH, together with four one day Quality and Outcomes Framework seminars arranged by the National Primary Care Development Team (NPDT);
- A conference held in partnership by the National Clinical Governance Support Team, the Institute of Healthcare Management and the Royal College of General Practitioners and the MA (NatPaCT) for practice managers. This will be held in London on 4 March 2004. Further details are available from www.natpact.nhs.uk/primarycarecontracting;
- a national helpline, run by the National Primary Care Development Team in conjunction with the MA (NatPaCT). The helpline can be contacted on 0845 9000008.
- the National Primary and Care Trust Development Programme. The website can be found at <http://www.natpact.nhs.uk>.
- Expert seminars, which PCTs are encouraged to arrange for all their providers to explain how the QOF will work and suggest ways in which practices can maximise achievement against the QOF. These can be supported by local Modernisation Agency facilitators. PCTs should contact their SHA modernisation lead for help in arranging such roadshows;
- If a provider is not achieving as high a score as it had aspired to, it may welcome an opportunity to see how other providers in its PCT area (or outside) are managing to achieve for example 1000 points, so that it can learn from the experience, maximise income and improve services to patients. PCTs should consider what support they might offer to facilitate this if there is local demand, for example through funding protected time for the benchmark partners to share learning.

4.40 Milestones and Activities

Table 6 provides a summary of 20 QOF activities and milestones in 2004/6.

TABLE 6 – QOF ACTIVITIES AND MILESTONES FOR 2004/5

	MILESTONE	ACTIVITY
1	By end Dec 2003	PCTs forward interim aspiration utility to all providers
2	By 1 st Jan 2004	PCTs invite all practices to participate in the quality information preparation (QuIP) DES for 2003/4 and agree a plan for implementation.
3	By end Feb 2004	PCTs agree aspiration levels for all participating providers
4	By end March 2004	PCTs and providers sign contracts.
5	April 2004	QOF goes live
6	End of month from April 2004	PCTs make monthly quality aspiration payments to participating providers
7	By end of April 2004	Following discussions between the NHS Confederation and the GPC, DH publishes guidance on QOF annual review visits
9	30 th April 2004	PCTs pay QuIP DES for 2004/5 as part of monthly payments, if the scheme has been agreed on or before 1 st April.
10	30 th April 2004	PCTs pay QPP for 2004/5 where a contract is treated as taking effect on 1 st April 2004, and aspiration levels have been agreed.
11	By end July 2004	PCTs produce a schedule of QOF annual review visits for between 1 st October 2004 and 31 st January 2005 and inform providers
12	By end August 2004	Quality Management & Analysis Sub-System (QMAS) goes live.
13	Monthly from end of Sept 2004	Data from providers who are (using QMAS) clinical systems automatically uploaded to QMAS every month, and more often if providers wish. Providers use the web interface to add yes/no data for the organisational, patient experience and additional services indicators to QMAS. QMAS will provide monthly information to PCTs for financial planning, and information for providers on current achievement levels and payments, adjusted for the latest available relative practice prevalence.
14	Between 1 st Oct 2004 and 31 st Jan 2005	PCTs complete all QOF annual review visits. PCTs write up the visits and ensure consistency across their areas. In cases of (i) data accuracy and (ii) missing data, the PCT and practice agree a remedial plan. Normally within a month of the

		visit, providers confirm that remedial actions have taken place. Normally within two weeks of such confirmation, the PCTs confirms they are content with the action. Cases of (iii) inappropriate practice behaviour and (iv) fraud will be dealt with through established PCT poor performance procedures or referral to NHS counter-fraud services.
15	14 th Feb 2005	QOF national prevalence day, at which point relative recorded practice prevalence is measured. This will take place automatically for practices using QMAS.
16	21 st Feb 2005	Providers not using QMAS but using prevalence submit data for the prevalence calculation to their PCT
17	14 th March 2005	Providers using national QOF that have not submitted data are treated by QMAS as being at the bottom of the prevalence range for that clinical area
18	31 st March 2005	QOF national achievement day. QMAS calculates payment levels for 2004/5 for those doing national QOF, using the latest list size and with clinical payments adjusted for prevalence as at 14 th February. For all other schemes, PCTs must have derived payments locally using formulae in this guidance.
19	By end April 2005	PCTs make 2004/5 achievement payments as a lump sum on the basis of QMAS calculations. If any quality remedial plans are not achieved, PCTs may delay payments.
20	From end April 2005	PCTs make monthly aspiration payments for 2005/6. These will be based on an automatic calculation of 60% of previous year's achievement points, with pounds per point updated to £120, and adjusted by the previous year's prevalence. (NB the start of payments may be delayed if confirmation of final achievement is delayed.)
21	July 2005 onwards	Scheduling of QOF annual review visits, visits and payment activities are repeated as per 2004/5.

5 Chapter Five – New Innovation

Action Points to note

- New arrangements for Specialist PMS contracts can be agreed to commence from the 1st April 2004;
- Specialist PMS contracts can commence at any time as agreed by the PCT and the provider;
- Where Specialist PMS arrangements propose clinical service changes, the PCT Professional Executive Committee will be responsible for advising the PCT Board.

5.1 New Developments in PMS

A key benefit of PMS has been the opportunity for practitioners to address local health and service issues, to step out of the norm and to innovate. The Government remains keen to sustain this innovation and to expand on the opportunities for modernisation.

To achieve this aim, two new initiatives will be developed with the local PMS contractual framework that will allow primary care practitioners to continue to seek new ways for meeting the needs of the patients they care for. These are:

- Specialist PMS arrangements and
- Practice-led Commissioning

5.2 Specialist PMS

Existing PMS and new GMS will remain the cornerstone of family medical care for the majority of the population. However, there are significant groups of people that are sometimes not well served by these models. These people may find that traditional services do not meet their needs or are inaccessible. They may choose not to present themselves for care and be less likely to access preventative care. They often make greater use of emergency and unscheduled services.

Others have complex needs that go beyond the ability of practices to address using standard PMS and GMS. In order to serve the whole population, PCTs must be able to access bespoke models of delivery that can be tailored to the needs of specialist groups. This would help ensure comprehensive coverage and increase choice.

Specialist PMS is a tool that can help to address such unmet needs. It is about PCTs using flexible arrangements to commission patient-centred health care to be delivered in an environment that is both convenient and appropriate

to the individual. This might involve secondary care clinicians delivering health care that is otherwise delivered in a hospital setting in a primary care environment.

To date, PMS schemes have been required to be responsible for delivery of a full range of 'GMS equivalent' services with at least one GP involved. Neither of these stipulations will apply in Specialist PMS.

The extent of Specialist PMS will be for local determination but we would envisage at least the following three aspects would be well served by this approach;

- Care for vulnerable groups;
- Extending the range of services delivered in primary care;
- Delivering OOH services.

5.3 Registration of Patients

Specialist PMS will not normally be about General Practice provision, but could encompass a range of clinicians in any appropriate grouping to deliver care to patients in a primary care setting. It includes both a "traditional" practice approach and a clinical group approach, where a group of clinicians operate in a single team to deliver care to a specified population.

Through these arrangements the Specialist PMS provider and the PCT can agree a contract where patients would register with the Specialist PMS provider. In such a situation the provider would not be personally required to deliver the totality of essential services to that registered patient group. However the specialist PMS provider would be required to ensure that it's registered patients received as a minimum essential services.

Alternatively, the Specialist PMS provider may agree a contract with the PCT that does not require them to register patients. They would be purely responsible for the delivery of the specialist care agreed with the PCT. The contract would need to contain details of arrangements for referral to that service and from whom.

Patients could also be registered separately from the Specialist PMS provider e.g. with the PCT. Here the PCT would have the responsibility to secure essential services for patients registered with them.

5.4 Examples of Specialist PMS:

Clinical Group Specialist PMS

Population groups that are currently not well served by GMS and PMS but need both specialist and essential services may well benefit from a Specialist PMS approach. They could be client groups (often the most vulnerable) such

as older people living in care homes, people with learning disabilities, the homeless and Looked After Children.

In these situations, a practice or a group of clinicians working together may design a Specialist PMS provider approach to deliver specific services to the particular client group. If they can reach agreement with the PCT they would operate under a contract that specifies the services to be delivered and to whom. Practitioners with a Special Interest could make up such teams with nurses or Allied Health Professionals with special interests.

The client group could register with the Specialist PMS provider for the services they need, but the Specialist PMS provider would not be required to provide the totality of primary medical care directly. The Specialist PMS provider could choose to contract for the provision of primary medical services from an appropriate medical clinician which could be a GP, geriatrician or other appropriate medical professional.

Secondary Care Team Specialist PMS

In this example, the Specialist PMS Provider would consist of secondary care clinicians (including NHS consultants) to provide specialist care in a primary care setting. Such specialist care would not normally require acute medical intervention requiring access to acute beds but it might involve access to day care beds. Typically, examples would include the management of chronic conditions where it is more appropriate to deliver care in a primary care setting.

It is unlikely that patients would register with this Specialist PMS Provider. The provider would treat patients registered with a GMS contractor, PMS provider or the PCT and it would be for the PCT to agree a contract to ensure access to essential primary medical care services for the appropriate patients.

Non-standard Professional Care

Including the 'prescribing professional' of the future may be another area to consider developing a Specialist PMS proposal. Other practitioners could be employed to deliver some aspects of primary care, particularly where GPs or nurses are difficult to find. Such an arrangement would open up the possibility of new professional groups being added to the professional pool available to the NHS.

Another possible variation of this would include 'alternative' primary care providers such as Chiropodists, Chiropractors and those practising complementary and alternative medicine.

Delivery of Out-of-Hours Services

Specialist PMS could also be used as a way of securing OOH services. For example, rather than making an APMS contract or providing PCTMS services

itself, a PCT might decide to use specialist PMS to contract for OOH services for patients of practices that have opted-out.

The Specialist PMS provider in this example would be contracted to the PCT to deliver OOH care for a defined population. This could be the whole or part of the PCT's area or perhaps several PCT areas (in which case, the PCTs might want to set up either lead or joint commissioning arrangements.)

As with all OOH services, the contract with the provider would need to ensure that its services were properly integrated with other OOH provision (e.g. A&E, social care). In addition, any specialist PMS contract for OOH services must require the provider to comply with the National Quality Standards for OOH Services.

5.5 Commissioning Specialist PMS

The requirement for a specialist PMS contract may stem from the PCT seeking new arrangements as part of their local service developments or it could be a proposal put to the PCT by a potential provider. In the latter case, the proposal would need to be assessed by the PCT against identified health needs and the views of the public before any contract could be agreed.

In matters where clinical service changes were being proposed it would be the role of the PEC to advise the PCT Board on the effectiveness of the approach being proposed.

Specialist PMS providers could be:

- Existing or new Nurse-led PMS providers;
- Other existing or new PMS providers;
- Groups of clinical practitioners (secondary and/or primary care);
- Existing or new GPs providing only specialist care to patients other than those registered with them.
- NHS Trusts or Foundation Trusts

In some cases the Specialist PMS provider may be a single "practice," in others it may be a number of practices grouping together within a single agreement. The NHS limited company scenario could apply to both these approaches (see Annex (A) for more details on a qualifying body as a limited company).

Where new services are to be delivered, the PCT would take the same approach as it would when commissioning secondary care from NHS Trusts, i.e. ensuring that the provider was able to deliver within a robust accountability agreement.

The contract itself would be a PMS contract and therefore will need to be negotiated, monitored and any variance agreed in the same manner as PMS permanent contracts. It will also be for the two parties to decide upon the length of the contract and any review or break clause to be included.

5.6 Resources

As the commissioner of primary care services, the PCT will be responsible for providing funding to Specialist PMS providers. The PCT will need to make decisions based upon the needs of their local population. Funding might come from use of the PCTs overall primary care budget, the enhanced services floor or from the PCT unified budget depending on the services requiring provision by the Specialist PMS provider.

As part of the contracting process, the potential Specialist PMS provider would need to put forward a costed business case on how they will deliver the service. The final amount agreed will be the outcome of the negotiation process.

Where the Specialist PMS provider is contracted to meet the needs of patients registered with them, the contract price would need to include sufficient resource to secure the essential primary care services their registered population would need. The Specialist PMS provider would then contract with a GP or other appropriate medical or clinical practitioner to deliver those other primary medical services required by the patient.

5.7 Links to GMS and PMS

Specialist PMS is only likely to be relevant to meet specific service or client group needs and is unlikely to be relevant to the normal primary medical care of the population. However, through a combination of these approaches a PCT should be able to commission a flexible primary care service for the local population.

Where patients are registered with them Specialist PMS providers will be responsible for securing the delivery of primary medical services, probably from a GMS contractor or PMS provider.

A specialist PMS contract will be very different to a PMS Plus contract. Under PMS Plus the “practice” will be already delivering as a minimum, essential primary medical services plus additional primary or secondary care services

6 Chapter Six – Finance

Action Points for PCTs to Note

- PCTs should use their 2004-05 primary care allocations (to be notified in the New Year) to fund PMS and GMS services they require to meet the needs of their population;
- PCTs have a responsibility to work within their overall cash-limited resource allocation;
- Out-of-Hours services funding comprises four elements;
- PCT allocations will include three elements in respect of GP premises costs.

Action Points for SHAs to Note

- SHAs will need to ensure that the arrangements for the allocation of premises;
- Funds are being handled fairly;
- SHAs should establish lead PCT arrangements now so that decisions can start to be made on outstanding premises developments as early as possible in January 2004.

Action Points for PMS Practices to Note

- PMS practices will be able to move to GMS arrangements in discussion with the PCT;
- Where PMS practices do wish to move to GMS from April 2004, detailed information will have to be provided by the practice to the PCT based on data in the year immediately prior to entering into PMS.

6.1 OVERVIEW OF PMS ALLOCATIONS

Funding for existing PMS schemes will form part of the primary care allocation that will be allocated to PCTs for 2004-05 early in the New Year. PCTs should use these primary care resources to fund the GMS and PMS services they require to meet the primary care needs of their population.

The broad principles of how PMS works will remain the same – the schemes will continue to be based on locally agreed contracts. However, as with the GMS funding, there will be some major changes in the way funding for PMS will be allocated to PCTs.

6.2 General Note on Funding

PCTs will have flexibility in determining how they use their primary care allocations between GMS and PMS. They will have some restrictions, such as:

- The need to fund all primary care contractual commitments they have entered into deliver the floor on enhanced services;
- To meet key service targets.

Beyond these constraints, PCTs will be free to make best use of the funding available to them for primary care. But they will always need to be able to demonstrate that funding decisions between GMS, PMS and any other primary care contractual arrangements they enter into are fair, equitable and transparent.

Alongside this increased flexibility, PCTs will continue to have a responsibility to live within their overall cash-limited resource allocation.

The resources made available to PCTs for primary care services will cover funding for new PMS schemes, any new investment in existing PMS schemes and to meet the appropriate and reasonable costs of practices that move between GMS and PMS contractual arrangements. There will no longer be any in-year claw back of unspent PMS allocations and there will no longer be opportunities to 'bid' for PMS growth during the year.

Guidance on completing and reporting expenditure via FIMS and reporting accounts will be issued in January 2004.

6.3 Allocations in 2004/05

There will be a single main allocation to PCTs for PMS and GMS. The PMS element will be based on the allocation for 2003-04, for all waves up to and including Wave 5b. This will be adjusted for 2004-05 to take account of the full year effect (where applicable) and it will be uplifted to 2004-05 prices.

This initial PMS allocation should be supplemented with other funds. Some of the funding streams will be allocations covering both PMS and GMS. This includes enhanced services, OOH funding, additional funding for premises and IT. These resources should be used equitably to fund primary care services across GMS and PMS practices. There will also be funding to allow PMS schemes to benefit from the delivery of high quality services to patients and to facilitate quality improvement, in the same way as the Quality and Outcomes Framework operates in the GMS contract, as described in Chapter Four above. Each of these funding streams is covered further in this chapter. Indicative contractor budget spreadsheets are also currently being prepared for PMS schemes and will be available along with further technical guidance in January 2004.

6.4 PMS Baseline funding

The baseline PCT funding for PMS schemes in 2004-05 will be based on the funding allocated in 2003-04. On the 5th June 2003, John Hutton the Minister of State for Health, wrote to PMS GPs and stated that:

“... PMS practices’ existing financial arrangements will continue to be agreed locally between the PMS practice and the PCT and will not be unpicked through new national requirements.”

To ensure that PCTs are adequately funded to deliver on this commitment, the Department of Health has conducted rigorous exercises to:

- Produce an up-to-date list identifying GMS and PMS practices to ensure PCTs receive the appropriate amount of funding for each of the funding streams. Details of this exercise can be found in Allocation Working Paper (2004-05)PCT05 and
- Determine the 2003-04 baseline allocation for the live PMS schemes. Details of this exercise are set out in Allocation Working Paper (2004-05) PCT12.

The PMS baseline allocations for 2003-04 includes the full-year effect of in-year funding (where applicable) and the 2003/04 uplift of 3.225%. It takes account of the following 2003/04 allocation streams:

- Main allocations for Waves 1 to 5b;
- In-year lump-sum allocation to support changes to in-year activity (exceptional changes and actual costs);
- Additional funding for rent increases;
- Contract variations and
- “One-off” allocation adjustments that support baseline activity year-on-year.

It excludes 2003-04 PCTs’ allocations for PMS schemes’ quality preparation funding, 2003-04 allocations for flu, pneumococcal and HIB immunisation. Where applicable, these items will be dealt with separately under the new funding streams, linked to the implementation of the new GMS contract. It also excludes any additional PMS services that have been contracted for by PCTs from their Unified Budget.

An uplift will be applied to the 2003-04 baseline to bring it in line with 2004-05 prices. In the letter on 5th June 2003, John Hutton the Minister of State for Health wrote to all PMS GPs and made the commitment that they would

receive fair and comparable shares of all the new primary care investment the Government is making.

6.5 Uplifting PMS allocations in future years

Uplift to PCT PMS baselines will be proportionately equivalent to the uplift in baseline funding given to the same services delivered through GMS contractual arrangements. It will include expected increased costs for items previously funded through the PMS discretionary budget, which for GMS formed part of the GMS non-discretionary budget. Under the new GMS contract these items include premises, enhanced services and the global sum. Details of the uplift will be provided at the time of allocations.

6.6 Personal Administration and Dispensing

Personal administration and dispensing will continue to be funded from a transfer from the non-discretionary PhS budget.

6.7 Funding Flu and Pneumococcal Immunisation

The flu and pneumococcal immunisation funding for PMS providers was subject to a separate allocation in 2003-04, and is not part of the PMS baseline. Funding for flu and pneumococcal immunisation for 2004-05 for PMS schemes will form part of the primary care allocation.

6.8 Out-of-Hours Services

Out-of-hours funds

When determining how to secure integrated out-of-hours (OOH) services, PCTs will need to consider all the resources available to them both in the unified budget (e.g. resources used for emergency care networks) and elsewhere.

Additionally, they will have access to three specific sources of funding:

- (i) Allocations to PCTs from the Out of Hours Development Fund (OOHDF) are to be doubled from £45.6m to £91.2m pa;
- (ii) There is to be a further non-recurrent addition to the OOHDF of £28m over two years to support areas facing the greatest challenges in developing OOH services;
- (iii) These resources will be supplemented by the tariff for practices who opt-out of OOH services (see 6.13).

OOHDF allocations for 2004/2005 were announced on 1 November 2003 (see <http://www.out-of-hours.info/>). The 2004/05 method allocates the first £45.6m on the basis of current OOHDF and the additional £45.6m on a weighted capitation basis. From 2005/06 the intention is that the whole of the allocation will be on a weighted capitation basis. The OOHDF will remain ring-fenced for use on OOH primary medical services, however they are provided, but need no longer be used exclusively to reimburse costs incurred by practices.

The Department of Health is discussing with SHAs the best way to allocate the further £28m (£14m in 2004/2005 and 2005/2006). Details will be made available to PCTs in January. These funds will also ring-fenced for use on OOH primary medical services.

6.9 Premises

PCTs allocations will include three elements in respect of GP premises costs:

- A baseline of existing premises spend;
- An additional element to meet the cost of new agreed premises developments (i.e. those ready for occupation, under construction and others contractually agreed between the practice and the provider) contractually agreed before 30 September 2003;
- A further element weighted to take account of premises inflation to meet costs of, for example, use of flexibilities and new premises developments which are agreed after 30 September.

The first two elements will be allocated directly to individual PCTs. The third element will be allocated using a modified weighted capitation formula, which includes a premises market forces factor, to lead-PCTs for onward cascade to support premises new initiatives agreed with the Strategic Health Authority. For PMS practices, baseline funding is already in PCT allocations that will be topped-up as described above for the other two elements.

The lead PCT will have two main functions:

- To act as the conduit for new premises funding to pass to other PCTs and hold funds yet to be reallocated;
- To advise PCTs as a group on primary care estate procurement, management and disposal.

SHAs will need to ensure these arrangements are being handled fairly and should establish lead PCT arrangements now so that decisions can start being made on outstanding new premises developments as early as possible in January 2004.

6.10 Information Technology

A significant part of the existing IM&T funding for PMS practices is included as part of the “GMSCL” part of the Unified Budget. This covers the costs associated with part-reimbursement of the purchase, leasing, upgrades, and maintenance of computer systems in practices.

Guidance on identifying this expenditure and moving it to a primary care allocation, was set out in AWP PCT (04-05-06). Additional funding of £20m has also been allocated in 2003/04 to allow PCTs to meet their new obligations to fund 100% of the costs associated with minor upgrades and maintenance costs. This level of funding will be guaranteed in the allocation for 2004/05. The Department has also agreed that PCTs may be able to access additional funds for minor upgrades and maintenance where they can demonstrate central support has been insufficient in supplementing historical spending levels.

6.11 PMS Quality and Outcomes Framework (QOF) Allocations

Chapter 4 explained how PMS contractors can receive four types of quality payment: quality preparation (QPREP), quality information preparation (QuIP), quality aspiration and quality achievement.

Allocations to fund the different quality payments will be made on the following basis:

- QuIP is a directed enhanced service and needs to be funded from the unified allocation;
- QPREP for 2004/05 will be allocated on the same basis as 2003/04 i.e. according to unweighted contractor population as determined by patient list size. This information is being collected from the Exeter payment system;
- Quality aspiration resources will be allocated to PCTs for PMS contractors on this basis in April 2004. From 2005/06, when the aspiration payments become based on the previous year’s achievement points, resources will be allocated on the new basis once the achievement points have been confirmed by PCTs;
- the balance of quality funding to meet quality achievement for PMS will be held by the NHS Bank and the resource allocated in year. This will allow funding to be held above the local level and allocated to the right places on a demand led basis. This helps to manage financial risk as effectively as possible across the whole NHS.

6.12 PMS to GMS Movement – National Benchmark when considering applications for MPIG

PMS practices will be able to move to GMS arrangements. MS(H) has made it clear that in some cases, practices can apply for income protection:

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

- *The local data on payments for Global Sum Equivalent items that they may have for the pilot. This might include sum or all of the growth monies relating to contract variations forming part of the practices global sum equivalent;*
- *A national average calculation (if the supporting data is not robust enough to do the calculation) based on PMS earnings and GSEs.*

This national average calculation should be used to provide a benchmark that PCTs and practices can use as a basis for discussion of what their actual MPIG should be. Any figure calculated by this method is not a practice entitlement to the MPIG and it is likely that the final figure agreed between PCTs and practices will need to be adjusted to reflect local circumstances.

The benchmark is based on the average Global Sum Equivalent per patient for GMS practices, as collected through AWP (04-05) PCT07. Given that current global sum equivalent income per patient is not linear with respect to list size, prices for different list size bands have been provided.

Table 1 below provides the benchmark price per patient by banded list size. So for example, the price per patient for a practice with a list of 6500 is £59.15 and the benchmark GSE for this practice is £384,475.

Table 1: Benchmark Global Sum Equivalent Prices [provisional figures]

List Size	£ per patient
0-2000	66.68
2001-4000	59.03
4001-6000	59.35
6001-8000	59.15
8001-10000	57.84
10001-12000	58.47
12001+	56.56

Where PMS practices do wish to move to GMS from April 2004, detailed information will have to be provided by the practice to the PCT based on data in the year immediately prior to entering into PMS. Then the PCT can apply an appropriate uplift. The GMS uplifts are shown in the table below:

	Annual %	Cumulative	Uplift Index
96/97	n/a	26.68%	1.267
97/98	3.04%	22.94%	1.229
98/99	2.75%	19.65%	1.197
99/00	9.61%	9.16%	1.092
00/01	0.91%	8.17%	1.082
01/02	2.34%	5.70%	1.057
02/03	5.70%	n/a	n/a

6.13 OOH Opt Out Price for PMS

Where PMS providers exercise their right to opt-out of OOH services their contract price will be reduced by a fixed amount. For 2004/2005 this will be based on a tariff broadly equivalent to that for GMS contractors (6% of the global sum), which will be around £6,000 per average GP.

To calculate the annual tariff for a PMS provider, the provider's registered list should be divided by the average GP list (1838) then multiplied by the opt-out tariff. So if the practice list was 5,400, the average list size [1838] and the tariff £6,000 the formula would be:

$$5400/1838 * £6,000 = £17,628$$

The opt-out tariff and the average list size by which it is to be adjusted can only be confirmed once the GMS Statement of Fees and Entitlements (SFE) has been finalised. The final figures for 2004/2005 will be made available by the end of February 2004. They will then be revised with effect from 1 April 2005 (and annually thereafter) to maintain parity with the GMS tariff.

PCTs should calculate the tariff on the date on which the opt-out takes effect. The tariff deduction is a one-off change to the baseline annual contract price. If the opt-out takes effect during the year, the amount actually deducted from payments for that year should be reduced pro rata to the number of days in the year for which the provider was responsible for OOH services.

Where the deduction takes effect after the contract price for the year has been agreed, it should be spread proportionately across the payments scheduled to be made to the provider over the remainder of the year, unless the parties agree otherwise.

7 Chapter Seven – Support for PMS

Action Points to note

The Modernisation Agency (MA) and National Primary Care Development Team (NPDT) are developing a range of national and local level support arrangements for PCTs and practices including:

- Nine regional events to be held during January and February;
- On line “See and hear” presentations on a number of topics relating to primary care contracting are available via the NatPaCT website;
- A support programme for practice managers;
- Four learning events on the Quality and Outcomes Framework (QOF) for PCTs and practices are planned;
- Specific support arrangements will be available for nurses and nursing;
- Resources in each Strategic Health Authority area to put local support on the ground;
- The former PMS facilitators have broadened their role to offer support in a wider range of primary care contracting issues.

7.1 Support for PMS contractual arrangements

The MA and the NPDT have been commissioned by the DH to provide a package of support for SHAs, PCTs and General Practices to support the implementation and development of primary care contracts i.e. PMS and nGMS. The programme of support has been developed as a result of meetings with practices, PCTs and SHAs which identifies the need for additional support to deliver the operational functions and benefits arising from the new contracts.

Details of this support have been published in a prospectus entitled Support for practices, PCTs and SHAs as they enter new GMS and PMS Contracts. This is available at the NatPaCt Website www.natpact.nhs.uk/primarycarecontracting/

7.2 The prospectus summarises the support available:

- Nationally
- Locally
- On key issues
- Contacts

National Support Available:

7.3 Website

A great deal of information is at present being put on the NatPaCT and NPDT sites and will be continually updated. This will include:

- Frequently asked questions
- News on support for implementation
- Updates of the prospectus
- Events information and booking
- Links to PCT competencies and other resources
- Subscribing to weekly email update
- Details of the quality events
- Information on QuISP (Quality Improvement Skills for Practices)
- Improvement science for primary care

7.4 Learning Exchange Events

Nine regional events are being run in January and February 2004 (dates & venues detailed below) to enable directors, PEC members, managers and support staff to:

- Understand the context of new primary care contractual arrangements
- Question DH specialists
- Share learning across PCTs and practices
- Think through solutions

Details of these events are contained in the prospectus and the NatPaCT website. For an invitation and booking form for these events contact your SHA GMS/PMS/Primary Care lead.

Date	Venue
7-8 January 2004	Robinson College Cambridge
12-13 January 2004	Ramada Hotel & Resort, Sutton Coldfield
14–15 January 2004	Park Hall Hotel & Conference Centre, Chorley
19-20 January 2004	Holiday Inn, Kings Cross, London
26-27 January 2004	Hilton, Leeds City Centre
28-29 January 2004	Holiday Inn, Seaton Burn, Newcastle upon Tyne
2–3 February 2004	Hanover International Hotel, Hinckley
4–5 February 2004	The Imperial Hotel, Torquay
9–10 February 2004	Le Meridien, Gatwick

7.5 National Helpline and Help Inbox

The PMS helpline can be contacted for all queries on PMS and GMS. The number of the helpline is 0845 9000008. This is currently being updated and the new number and email address will be announced through the Chief Executive Bulletin <http://www.doh.gov.uk/cebuletin/index.htm> and [New@NatPaCT](http://www.natpact.nhs.uk/ma/ma@natpact.nhs.uk) <http://www.natpact.nhs.uk/ma/ma@natpact.nhs.uk>

7.6 On Line Presentations

“See and Hear” presentations on a number of topics relating to primary care contracting are available. Questions can be answered during the broadcast and past recordings can be viewed of past presentations from any PC with Internet access and a sound card.

The prospectus outlines the topics to be covered, how to register and dates of the sessions.

7.7 Revised PCT competencies

The Primary Care Competency Framework is being updated to reflect the current changes to primary care contracting. This framework is a self-assessment and support tool for PCTs. The updated framework will be on the MA (NatPaCT) website in January. www.natpact.nhs.uk

Support Nationally on some of the Key Issues

7.8 Contracting and Commissioning

NatPaCT is developing work on commissioning and contracting acute services which is relevant to primary care contracting. These are outlined in the prospectus.

The NPDT nGMS/PMS Collaborative will help create awareness of the different models of primary care provision and place primary care contracting in the wider context of commissioning for all services (see below under 'Good Practice').

7.9 Practice Management

A support programme is being developed for practice managers and will include:

- A Guide for Practices
- Local Mentor Teams
- National discussion forum

Further details will be available on the websites.

7.10 Quality

Four learning events on the Quality and Outcomes Framework (QOF) for PCTs and practices will support the implementation of the QOF and development of quality frameworks in PMS to improve the quality of primary care services. Further information on these will be available at www.npdt.org and www.natpact.nhs.uk/primary care contracting.

The NPDT nGMS/PMS Collaborative will help PCTs and practice teams to maximise the benefits achievable under PMS and nGMS (see below under 'Good Practice').

Quality Improvement Skills for Primary Care (QuISP) is a programme that has been developed and successfully evaluated by NPDT and RCGP, now to be rolled out to all PCTs through the local NPDT Centres. It will deliver training and practical tools in improvement techniques to primary care professionals and PCTs. Further information is available at www.npdt.org

There will be continued rollout of the National Primary Care Collaborative (NPCC) by NPDT to all PCTs and practices. Measurable improvement in chronic disease management will help with the utilisation of the QOF and its equivalent in PMS. See www.npdt.org

7.11 Premises

The MA (NatPaCT) and NHS Estates ran a series of briefing events to share the new arrangements for handling future capital investment in premises. Information and frequently asked questions from these events will be on the NatPaCT website www.natpact.nhs.uk and more information on the new arrangements is available on <http://primarycare.nhsestates.gov.uk>

7.12 Nursing

The MA will be supporting nurses and nursing in a number of ways to ensure successful implementation of developments in primary care contracting, including:

- Running two conferences for practice nurses to raise awareness about primary care contracting and its potential implications for nurses and nursing;
- An action learning set for nurses already working as partners is also to be formed. This group will provide practical guidance and support for other nurses wishing to become partners;
- Nine nursing-related workshops are also planned across the country in May, June and July.

More information about these will be available on the NatPaCT website www.natpact.nhs.uk in due course.

Support Locally on some of the Key Issues

7.13 Primary Care Contracting Advisors

The former PMS facilitators have broadened their role to offer support in a wider range of primary care contracting issues. The Advisors are working to identify the support needed within local provision and will agree with these stakeholders how best to provide that support. They will be working together to identify and share examples of good practice from around the country. In addition, they each have specialist knowledge areas and collectively provide a knowledge resource holistically across primary care contracting for PCTs, Practices and SHAs to access. For details on how to contact your local Advisor please refer to the prospectus, www.natpact.nhs.uk/primarycarecontracting.

7.14 More integrated support in each SHA area.

Additional resources have been provided to each SHA area to support PCTs with all the current key challenges in primary care. These resources will fund the equivalent of 2 posts in each SHA area.

7.15 NatPaCT Associate Directors/NPDT Centre Lead Managers

NatPaCT Associate Directors have been working with all PCTs in their area to assess their organisational development needs and develop shared, sustainable support in partnership with SHA and other MA teams. They will continue to arrange and support local primary care contracting events alongside NPDT Centre lead managers.

7.16 Practitioners with a Special Clinical Interest (PwSI) Facilitators

These provide tailored support to PCTs and SHAs in redesigning services around Practitioners with Special Interests, as part of the integrated programme of work with the MA's New Ways of Working Team

7.17 OOH Regional Co-ordinators

The OOH Review Implementation Team has appointed 14 regional co-ordinators to work closely with PCTs and OOH providers, offering advice and support to help take forward local implementation of the OOH Review, including the accreditation of OOH providers. The prospectus contains the contact details of all the above by area.

7.18 Good Practice in Primary Care Contracting

The national and local support outlined above will contribute to the spread of good practice in primary care contracting so that organisations have the opportunity to learn from each other about what works well. Specific initiatives to spread good practice include:

The nGMS/PMS Collaborative is being established by NPDT to support the development of the capability and capacity within organisations and individual clinicians, in order to apply improvement methods to a range of clinical or organisational challenges they may face when contracting for primary care.

The collaborative method works by spreading existing knowledge to multiple sites that have a common aim. It shortens the time and resource input required by any one individual seeking information or advice on specific topics. It can put people in touch with those who have already solved some of the problems, give them the tools for improvement and then pro-actively help with the implementation of change in their own organisations.

The nGMS/PMS Collaborative will work by creating exemplar sites, show case examples of good practice of primary care contracting and draw on the expertise of others to share what is possible. It is intended that exemplar sites will be created in every SHA area and then, using examples from this first cohort, local collaboratives will spread the learning to other PCTs supported by the 11 local NPDT Centres. More information will be available shortly at www.npdt.org

Web-based sharing of best practice and top tips The NatPaCT website (www.natpact.nhs.uk.primarycarecontracting) will provide an additional resource for the sharing of good practice. PCTs and practices will be able to input examples of good practice and top tips based upon real experiences of implementation. Updated information and areas of support will appear on the NatPaCT website as they are developed.

8 Annex (A) PMS providers

This section sets out who can be a PMS provider and conditions that need to be met before entering into a PMS contract. These conditions are intended to prevent unsuitable individuals from contracting to provide PMS. They have been drawn from those conditions that apply to GMS providers, PCT board members and the new primary care performers' list.

8.1 Who can be 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 which will be set out in the new PMS regulations;
- (ii) health care professionals (including General Dental Practitioners) who meet the conditions which will be set out in the new PMS regulations;
- (iii) NHS employees;
- (iv) employees of PMS or PDS providers (or equivalent in Scotland or Northern Ireland);
- (v) individuals providing services under a GMS, GDS, PMS or PDS contract (or their equivalent in Scotland or Northern Ireland);
- (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 PCT or LHB;
- (iii) a person providing services under a GMS or GDS contract (or equivalent in Scotland or Northern Ireland);
- (iv) a provider or performer of PMS or PDS (or equivalent in Scotland or Northern Ireland).

PCTs may also enter into a PMS contract with a qualifying body, which is a company limited by shares, **all** of which are legally and beneficially owned by one or more persons falling within one of the groups.

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. Consequently these conditions in no way operate as a substitute, in whole or in part, to those set out in the primary care performer list regulations which apply in full to all GPs performing clinical services under the PMS contract.

9 Annex (B) Medical Practitioners

Where a PMS provider includes a medical practitioner, that practitioner must either

- (i) have his name included in the General Practitioner Register set up under the *General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* (the 2003 order);
- (ii) be employed by a PCT, LHB, NHS Trust, NHS Foundation Trust, a Health Board (in Scotland), or a Health and Social Services Trust (in Northern Ireland).

It is possible that the PMS contract regulations and this guidance may come into operation before the coming into force of the 2003 order. In this case the condition in para (i) may be treated as being met if the medical practitioner is suitably experienced within the meaning of section 31(2) of the 1977 NHS Act, section 21 of the 1978 NHS (Scotland) Act, or Article 8(2) of the Health and Personal Social Services (Northern Ireland) Order 1978.

10 Annex (C) Partnerships

A PMS Provider may be made up of one or more individuals (from any of those listed at para (i) to (iv)) practising together in partnership. A change in the partnership may require a variation in the PMS contract, but subject to the PCTs agreement and the continued compliance with the provider conditions will not result in the termination of the contract. However, if in the reasonable opinion of the PCT, the change in membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the PCT to perform its obligations, the PCT may serve notice terminating the contract.

It is therefore important that the PMS provider informs the PCT immediately:

- (i) when a partner leaves or informs his or her partners that he or she intends to leave the partnership and the date upon which he or she left or will leave the partnership;
- (ii) when a new partner joins the partnership;
- (iii) when any dissolution of the partnership is ordered by a court or tribunal or an arbitrator;
- (iv) when the partnership is dissolved;
- (v) on the happening of any event which would make it unlawful for the business of the partnership to continue or for members of the partnership to carry on in practice;
- (vi) any circumstances that give rise to a PCTs right to terminate a contract. See Annex (G).

Where a contract is with two or more persons practising in partnership the contract will provide for it to be continued with the partnership, as it is from time to time constituted. Any routine change in the partnership will not therefore affect the contract. The contract will also therefore require the PMS provider to ensure that any person who becomes a member of the practice is bound by the contract, whether by partnership deed or otherwise.

11 Annex (D) Qualifying bodies

A qualifying body is a company limited by shares. All shares must be legally and beneficially owned by a person who could lawfully enter into a PMS contract as an individual or as part of a partnership. Again, as with contracts with partnerships, any routine change in the ownership of the shares will not affect the contract, as long as the relevant conditions continue to be met.

11.1 A PMS provider that is a qualifying body should inform the PCT immediately if:

- (i) any share in the contractor is transmitted or transferred (whether legally or beneficially) to another person;
- (ii) it passes a resolution or a court of competent jurisdiction makes an order that the contractor be wound up;
- (iii) a receiver, administrator or administrative receiver is appointed for the contractor;
- (iv) circumstances arise that might entitle a creditor or court to appoint a receiver, administrator or administrative receiver for the contractor;
- (v) circumstances arise that would enable the court to make a winding up order in respect of the contractor;
- (vi) the contractor is unable to pay its debts within the meaning of section 123 of the insolvency act 1986;
- (vii) any circumstances that give rise to a PCT's right to terminate a contract as set out in paragraph 105(2)&(3) of Schedule 6 . See Annex (G).

11.2 Conditions relating to all PMS contracts

A PMS contract cannot be entered into if any individual, partnership, company limited by shares, person owning shares in that company or any director or secretary of that company is subject to any of the following conditions:

- (i) he or it has been the subject of a national disqualification;
- (ii) he, she or it is disqualified or suspended (other than by an interim suspension order or direction pending investigation) from practising by any licensing body anywhere in the world;
- (iii) (within the period of five years prior to signing of the contract) he or she has been dismissed (otherwise than by reason of

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- redundancy) from any employment by a health service body unless he or she has been subsequently employed by that, or any other, health service body (as a member of the same profession), or the dismissal was the subject of a finding of unfair dismissal;
- (iv) within the period of five years prior to the signing of the contract, he, she or it has been removed from or refused admission to a primary care list by reason of efficiency, fraud, unsuitability (within the meaning of section 49F(2), (3) and (4) of the 1977 Act, unless his or her name has subsequently been included in such a list;
 - (v) he or she has been convicted of murder;
 - (vi) he or he has been convicted of a criminal offence in the United Kingdom and has been sentenced to a term of imprisonment of over six months;*
 - (vii) he or she has been convicted elsewhere of an offence which would if committed in England and Wales constitute a criminal offence and been sentenced to a term of imprisonment of over six months;*
 - (viii) he or she has been convicted of an offence referred to in schedule 1 to the Children & Young Persons Act 1933.* See Annex (E);
 - (ix) he, she or it has been adjudged bankrupt or had sequestration of his or her estate awarded unless he has been discharged or the bankruptcy order has been annulled
 - (x) he, she or it has made a composition or arrangement with or granted a trust deed for his, her or its creditors unless he, she or it has been discharged in respect of it;
 - (xi) he, she or it has an administrator, administrative receiver or receiver appointed in respect of it;
 - (xii) he or she has been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners or high court on the grounds of misconduct or mismanagement in the administration of the charity for which he or she was responsible or to which he or she was privy or which he or she by his conduct contributed to or facilitated;
 - (xiii) he or she has been removed under section 7 of the Law reform (miscellaneous provisions) (Scotland) Act 1990 from being concerned in the management or control of any body
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- (xiv) he or she is subject to a disqualification order under the company directors disqualification Act 1986, the companies (Northern Ireland) order 1986 or to an order made under section 429(2)(b) of the Insolvency Act 1986.

Additional points to note are:

- (i) in relation to the conditions in(vi)-(viii) above, marked with an asterisk, the offences in question must have been committed after the commencement date of the contract regulations. This is expected to be the end of February 2004;
- (ii) the condition specified in paragraph (vii) need not apply if the PCT is satisfied that the conviction does not make the person unsuitable to be a contractor or to hold shares in (or be a director or secretary of) a company which has a PMS contract;
- (iii) similarly the condition in paragraph (ii) shall not apply if the licensing body is not a UK licensing body and the disqualification or suspension does not make the person unsuitable to be a contractor or to hold shares in (or be a director or secretary of) a company which has a PMS contract;
- (iv) Before entering into a contract the PCT should ensure that any potential PMS provider confirms in writing that it satisfies all of the conditions mentioned above. PCTs should consider carefully whether they require any additional information to support this statement. Where the individual is a GP, PCTs will already have received much of this information in response to enquiries made under the primary care performers' list regulations;
- (v) Where a PCT is of the view that the conditions for entering into a contract are not met it should notify in writing the person or persons intending to enter into the contract of its views. The PCT should at the same time inform any other person who is subject to the PCTs decision;
- (vi) Any person refused a contract on these grounds may appeal to the FHSAA concerning the PCT decision that the provider conditions have not been met by writing to the FHSAA within 28 days beginning on the day that the PCT served notice. These appeals are to the independent FHSAA but notices of appeal should be sent to:-

FHSAA
30 Victoria Avenue,
Harrogate HG1 5PR.
The chairman of the FHSAA is Mr Paul Kelly

- (vii) PMS contractors must give notice to the PCT in writing that any new partner joining a partnership after the PMS contract has been signed meets these conditions. Here again it is for the PCT to decide the extent to which it seeks to verify this statement;
- (viii) The PCT may serve notice terminating the contract immediately if any of these conditions is broken. This is set out further in Annex (G).

12 Annex (E) Children & Young Persons Act 1933

12.1 Offences referred to in schedule 1 of Children & Young Persons Act 1933

Murder of a child or young person
 Manslaughter of a child or young person
 Infanticide
 Cruelty to persons under the age of sixteen
 Allowing a child under the age of sixteen to reside in or visit a brothel
 Allowing a child under the age of sixteen to be used for begging
 Exposing a child under the age of 12 to risk of burning
 Causing or procuring a child under the age of sixteen to take part in a performance endangering life or limb
 Abandoning, or exposing to danger or permanent injury, a child under 2 years
 Common assault or battery
 Any offence against a child or young person under sections 2 – 7, 10 – 16, 19, 20, 22 – 26 and 28 of the Sexual Offences Act namely;
 Procurement of women by threats or false pretences
 Administration of drugs to obtain or facilitate intercourse
 Intercourse with girl under 13
 Intercourse with girl aged between 13 & 16
 Incest
 Buggery
 Indecency
 Indecent assault
 Assault with intent to commit buggery
 Abduction of an unmarried girl
 Prostitution
 Procuring a girl under 21 for intercourse
 Detention of a woman in a brothel
 Permitting a girl under 13 to use premises for intercourse
 Permitting a girl aged between 13 & 16 to use premises for intercourse
 Causing or encouraging prostitution of, intercourse with, or assault on girl under 16
 Any other offence involving bodily injury to a child or young person

This is not intended to be an authoritative or accurate copy of the relevant legislation and is provided for guidance only. If PCTs believe that an offence under the Children & Young Persons Act may have been committed they should seek details of the offence and/or conviction and seek further advice from their own legal advisers.

13 Annex (F) Contract variations

- Once a PMS contract has been agreed and signed it will be open to either party to seek to vary or amend the terms of the contract. Any such variation or amendment must be agreed by both parties and should be set out in writing and signed by or on behalf of the PCT and contractor;
- However, the PCT may vary the contract without the contractor's consent where it is reasonably satisfied that it is necessary to do so to comply with the NHS Act 1977 or any regulations or directions made under that Act. In these circumstances the PCT must notify the contractor in writing of the proposed variation and the date the variation is to take effect, which should where possible be at least 14 days after the date of the notification;
- If the contractor is unhappy with a variation made it has a right of appeal to the FHSAA (SHA) through the dispute resolution procedures. However given that PCTs should only be following Secretary of State directions in these matters it is likely that such appeals will fail. A matter referred for dispute under this provision shall not prevent the PCT implementing the variation from the stated date pending the decision of the adjudicator.

13.1 Variation due to change in the membership of 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 (or equivalent in Scotland or Northern Ireland);
 - (v) individuals providing services under a GMS, GDS, PMS or PDS contract (or their equivalent in Scotland or Northern Ireland);
 - (vi) PCTs or LHBs;
 - (vii) NHS Trusts (including NHS Foundation Trusts).
- The PMS contract must specify the name and address of each party to the contract. Where the PMS Provider is made up of one or more individuals (from any of those listed at (i) to (iv)) practising together in partnership the contract will also specify the names of all the partners, whether or not it is a limited partnership and, if so, their status as a general or limited partner;
- A routine change in a partnership or membership of a PMS provider will not normally have any effect on the PMS contract. However it may be necessary to vary the PMS contract to take into account such changes;

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- Where a PMS contractor is an individual medical practitioner and he or she proposes to practice in partnership with one or more persons, he or she must give at least 28 days notice in writing to the PCT. The notice should include the name of the person or persons with whom he or she proposes to practice in partnership, the date on which the change of status is due to take effect and should be signed by him or her and any person with whom he or she is proposing to practice in partnership.
 - (i) The notice should also confirm that the person or persons with whom the contractor wishes to practice in partnership meet the conditions that have to be met by all PMS providers
 - (ii) The contractor must ensure that any person who will practice in partnership with him or her will be bound by the contract whether by virtue of a partnership agreement or otherwise;
 - (iii) Where a contractor consists of two or more individuals practising in partnership and the partners wish to terminate or dissolve that partnership (for example if one of the partners is to retire) the contract may continue with one of the remaining partners as long as he or she continues to meet the required conditions. In this situation the contractor should notify the PCT in writing at least 28 days in advance of the date on which the change of status is to take effect. Any such notice will need to specify the date on which the change in status is to take effect and the name of the partner with whom the contract is to continue. The notice should be signed by all the partners;
 - (iv) In the event of the death of a partner the contractor must give notice in writing to the PCT as soon as reasonably practicable;
 - (v) The PCT should acknowledge receipt of notifications received under this paragraph in writing as soon as practical. If the PCT is satisfied as to the accuracy of the information given in the notice it shall write to the contractor confirming that the contract will continue with the partnership, wherever possible from the date requested by the contractor. The PCT may refuse to allow the contract to continue where it considers that the change in the membership of the partnership is likely to have a serious adverse impact on the ability of the contractor to perform its obligations under the contract;
 - (vi) The PCT may vary the contract following such notification(s) in this paragraph but only to the extent that it is satisfied a is necessary as a result in the change in status of the contractor. If it is proposed to vary a contract the PCT must give notice to the contractor of the wording of the proposed variation and the date upon which that variation is to take effect.
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14 Annex (G) Contract termination, breach and sanctions

This section explains the rules concerning contract (i) termination, (ii) remedial and breach notices and (iii) sanctions.

14.1 Termination

- The PCT and contractor may agree in writing to terminate the contract at any time. Any such agreement will need to include the date and any other terms on which the contract is to be terminated;
- A contractor may at any time give notice to the PCT terminating the contract. In these circumstances the contract will terminate in line with the terms of the contract. Where this date does not coincide with the end of a calendar month, the contract will cease on the last day of the month in which the termination date given in the notice falls;
- Where the PCT fails to make payments due to the contractor under the contract the contractor may terminate the contract. To do so the contractor must first issue a “late payment notice” to the PCT announcing its intention to terminate the contract if the Trust fails to make any payments due to the contractor promptly and in accordance with the contract. The late payment notice will include details of the payments that are overdue;
- The PCT should be allowed time to make the necessary arrangements or to refer the disputed payments for dispute resolution. However, if it still fails to make good the payments [after the dispute adjudication process has been completed] the contractor may give a further notice to the PCT terminating the contract with effect from a date at least 28 days after the late payment notice has been served;
- The contractor may also terminate, with or without notice, the contract under general law if the PCT commits a repudiatory breach of the contract, that is a breach that is fundamental to the operation of the contract;
- A PCT may serve notice terminating the contract immediately if the contractor or any person who forms part of the contractor no longer satisfies the conditions set out in PMS Regulations;
- In operating this provision the PCT should note that:
 - (i) where a contractor (or partner or shareholder) is dismissed from any employment by a health service body, the PCT should not terminate the contract for at least three months following the dismissal or, if the person concerned begins court proceedings or proceedings before a competent Tribunal, until those proceedings are completed to the extent that a decision is reached by the first tier of the respective process;

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- (ii) a PCT should not issue a notice terminating a contract if it is satisfied that a conviction for a criminal offence outside the United Kingdom does not make the person unsuitable to be a contractor, partner, or shareholder, director, or company secretary in a company holding a PMS contract;
 - (iii) a PCT should not issue a notice terminating a contract if it is satisfied that a disqualification or suspension imposed by a licensing body outside the United Kingdom does not make the person unsuitable to be a contractor, partner, or shareholder, director, or company secretary in a company holding a GMS contract;
- Although in most circumstances a PMS contract may not be terminated simply because there is a change in the structure of the partnership (for example the acquisition or loss of partners) the PCT does have the ability to terminate a contract following such changes in two specific circumstances:
 - (i) if the contractor consists of two or more persons practising in partnership and during the existence of the contract one or more partners have left, the PCT will wish to consider the impact this may have on the ability of the contractor to meet its obligations under the contract. If the PCT considers, in its reasonable opinion, that the change in the partnership is such that it is likely to have a serious impact on the ability of the contractor, or the PCT, to perform its obligations under the contract it may serve notice terminating the contract forthwith or from such other date as it might indicate. Any such notice should specify why the PCT has chosen this course of action and should where practical include consultation with the LMC (or a notification to the LMC where this is not practical);
 - (ii) a change in the structure of the partnership might be sudden and/or acrimonious. In these circumstances (which include a two partner practice splitting and not indicating which partner should continue with the contract) the PCT may be unable to determine which of the remaining partners should retain the PMS contract. It would be unreasonable for the PCT to be involved in any practice dispute, or to take sides. In these circumstances the PCT may serve notice terminating the contract forthwith or from such other date as it might indicate. Any such notice should specify why the PCT has chosen this course of action and should where practical include consultation with the LMC (or a notification to the LMC where this is not practical);
 - Where a PCT takes such action it will need to take steps to secure the provision of patient services. It is normally expected that in these circumstances the PCT will wish to enter into short term contracts with any
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of the parties to the former PMS contract who wish to continue to provide PMS services and who meet the GMS provider conditions. The PCT could make alternative arrangements if for example the temporary contracts required the provision of new practice premises, or if the granting of temporary contracts would otherwise be to the detriment of NHS efficiency;

- It is similarly envisaged that at the end of temporary contracts the temporary contractor(s) will normally be offered a permanent contract or, where they agree, be allowed continue to provide services under a wider PMS contract with other persons, for example by merging with another PMS provider;
- PCTs should consult with:
 - (i) the patient representatives apprised of all decisions made under the termination arrangements, to ensure that individual patients are aware of the choices available to them.
- Notwithstanding the above paragraphs a PCT may serve notice in writing terminating a contract immediately, or from such other date as may be specified if:
 - (i) the PCT considers that the contractor has breached the contract and as a result of that breach the safety of the contractors patients is at serious risk;
 - (ii) if the contractor's financial situation is such that the PCT considers that the PCT is at risk of material financial loss.

14.2 Remedial and breach notices

- If a contractor breaches any of the other terms of the contract and the breach is capable of remedy the PCT may give notice to the contractor requiring it to remedy the breach. A breach capable of remedy might be a failure to provide a practice leaflet or to make arrangements for a home visiting service. This "remedial notice" will specify the details of the breach, the steps to be taken to remedy the breach, and the period during which those steps must be taken. Unless it is necessary to protect the safety of patients, or the PCT from material financial loss, such notice period should be at least 28 days from the date of the notice;
- If following this period the contractor has not remedied the breach or taken steps to do so the PCT may terminate the contract with effect from such date, as it considers appropriate. In these circumstances the PCT should give further notice to the contractor specifying the date on which the contract is to be terminated;
- Where a contractor has breached the terms of the contract and the breach is not capable of remedy, for example a one off act such as a failure to

visit a particular patient, the PCT may serve notice on the contractor requiring the contractor not to repeat the breach;

- If following a “breach” or “remedial” notice the contractor repeats the breach, or otherwise breaches the contract resulting in another breach or remedial notice, the PCT may give notice terminating the contract from such date as may be specified;
- Before issuing such a notice the PCT should give careful consideration to the cumulative effect of any breaches. For example, a run of minor breaches over a short period or occasional breaches over a longer period ought not, in themselves, to lead to a termination. However a persistent stream of minor breaches could justify termination if it was clear to the PCT that the contractor was unwilling or unable to take steps to stem the flow. It is expected that each decision will be taken in the light of the contractor's individual circumstances. Circumstances that might be considered include the likelihood of temporary support from the PCT being helpful, practice workload and the views of patients. The LMC should be consulted before reaching decision under these provisions. A notice terminating the contract should only be issued if the PCT is satisfied that the cumulative effect is such that it would be prejudicial to the efficiency of patient services to allow the contract to continue;
- If the contractor is in breach of any obligation under the contract and a breach or remedial notice has been issued, the PCT may consider withholding or deducting monies which would otherwise be payable under the contract, but only those monies payable in respect of the contractual obligation that has been breached;
- Where the contractor is a qualifying body, if the PCT becomes aware that the contractor is carrying on any business which may be detrimental to its performance of its obligations under the PMS contract, the PCT may give notice terminating the contract. Before doing so the PCT should give notice to the contractor requiring it to cease carrying on that business before the end of a specified period, which should not be less than 28 days after the date of the notice. If the contractor has not satisfied the PCT that it has ceased carrying on that business by the specified date then the PCT should issue a further written notice terminating the contract, either immediately or from such date as may be specified;
- All notices to terminate a GMS contract should give at least 28 days notice before the termination takes effect unless it is necessary to specify a shorter period to protect the safety of patients or to protect the PCT from material financial loss. A shorter period includes immediate termination;
- The contractor may challenge any notice given by the PCT under these provisions through the dispute resolution procedures. If the contractor does raise a dispute within the specified period given in the notice, the contract termination will not take effect until either there has been an initial determination of the dispute by the relevant adjudication authority or

competent court or the contractor ceases to pursue the dispute whichever is the sooner;

- A PCT may terminate the contract before the conclusion of the NHS dispute procedures if it is satisfied that it is necessary to do so to protect the safety of patients or itself from material financial loss. However, in doing so the PCT should exercise due care and diligence. If, on terminating a contract the PCT decision is still subject to challenge and if the resolution of the subsequent dispute were to find in favour of the contractor the PCT could be liable for substantial damages. It would have wrongly deprived the contractor of its livelihood under a contract that was not limited as to its duration. The scope for damages is very substantial. PCTs would normally wish to seek legal advice before terminating a PMS contract to limit any risks that it might be exposed to.

14.3 Contract sanctions

- Where a PCT is entitled to serve notice terminating a contract it may instead impose one of the other available contract sanctions. These are:
 - (i) termination of specified obligations under the contract;
 - (ii) suspension of specified obligations for a period of up to six months or
 - (iii) withholding or deducting monies otherwise payable under the contract.
- If the PCT decides to impose one of the contract sanctions it should notify the contractor of the sanction, the date on which that sanction is to take effect and the effect of the sanction. As with other notices the sanction should not be imposed until at least 28 days after the date of the notification, unless it is necessary to do so to protect the safety of patients, or the PCT from material financial loss;
- Where a PCT imposes a contract sanction it may, if appropriate, charge the contractor the reasonable costs of additional administration incurred by the PCT in order to, or as a result of, imposing the sanction;
- The contractor may challenge a decision by the PCT to impose any of the contract sanctions through dispute resolution. If the challenge is made via dispute resolution within the period before the sanction is to take effect, the sanction should not be imposed until the initial adjudication by the relevant adjudicator or competent court or until the contractor ceases to pursue the dispute whichever is the sooner;
- If the contractor does not take matters to dispute resolution within the specified period the PCT may impose the sanction. This does not however stop the contractor from appealing at a later date should it wish but it must

do so before the expiry of three years from the date of the notice;

- The PCT may impose the contract sanction before the dispute resolution procedure is completed if it is satisfied that it is necessary to do so to protect the safety of patients, or itself from material financial loss, pending the outcome of the dispute.

15 Annex (H) Contract Dispute Resolution Procedures

15.1 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 for consideration and determination by the FHSAA (SHA).

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.

This pre-contract dispute mechanism will take effect from the date that the contract regulations are expected to take effect. PCTs and contractors should note that there may not be sufficient time for such formal disputes to be resolved if contracts are to be signed on 31st March. It should also be noted that the outcome of any dispute resolved through the NHS dispute resolution procedures may be backdated. PCTs and potential PMS providers may therefore consider it better to sign the contract in March and pursue any difference through the NHS dispute procedures.

15.2 Dispute resolution

The PMS contract 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, opt-outs and individual patient assignment. As a rule of thumb virtually all disputes will be capable of being referred for adjudication. Dispute resolution does not however apply to complaints made under the NHS complaints system as set out in the GMS contract regulations.

It is anticipated that most contractual disputes can be resolved as part of the normal contractual relationships. PCTs and PMS contractors should make every reasonable effort to communicate and co-operate with each other in an attempt to resolve any disputes before considering referring the dispute for determination in accordance with the dispute resolution procedure, or (where appropriate) for consideration by the courts. 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.

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. In addition both PCT and PMS provider may, if it so wishes, invite the Local

Medical Committee to participate in any discussions. If no solution can be found locally it will be open to either part to the dispute to refer a matter to dispute resolution.

Unless the matter is to go to a competent court the Secretary of State will appoint the FHSAA (SHA) to determine most disputes. Such disputes should therefore be addressed directly to either the FHSAA (SHA) or, where appropriate, the local Strategic Health Authority. The FHSAA (SHA) address is:

FHSAA (SHA)
30 Victoria Avenue,
Harrogate HG1 5PR.

The Chief Executive of the FHSAA (SHA) is Mr Paul Burns

The one exception is disputes concerning contract termination where the termination relates to a member of the contracting body (or the body itself) no longer meeting the conditions. Appeals against the PCT decision that the relevant conditions have been broken go to the independent FHSAA. They should be sent to the FHSAA at

30 Victoria Avenue
Harrogate
HG1 5PR

The chairman of the FHSAA is Mr Paul Kelly.

15.3 NHS Disputes

Where a dispute arises out of or in connection with a NHS contract either party may refer the matter to the FHSAA (SHA) or, where appropriate the SHA, for consideration and determination.

The main features of the process are:

- (i) any party wishing to refer a dispute should write to the relevant body setting out the details of the parties to the dispute and the nature and circumstances to the dispute. A copy of the contract should also be sent. Unless the contract states otherwise, any request for a dispute to be considered must be sent within 3 years of the date on which the dispute arose or should reasonably have come to the attention of the party wishing to refer the dispute;
- (ii) the body appointed to consider the dispute (the adjudicator) will give notice within 7 days of receipt of any request, and will invite both parties to make any written representations they may wish to make about the matter, within a specified period

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- (iii) copies of any written documents provided by one party will be copied to the other. The adjudicator will invite the parties to make written observations on those representations within a specified period;
 - (iv) the adjudicator may invite representatives to appear before him to make oral representations either together or, with the agreement of the parties, separately, and may provide the parties in advance a list of the issues that it wishes to explore with them;
 - (v) the adjudicator may consult any other person he considers appropriate to assist him in his consideration. Where he does so, he will inform both parties to the dispute and may give them opportunity to make observations on the result of any such consultation.

In considering the matter the adjudicator will consider:

- (i) any written representations if they are made within the specified period, and any observations made on those representations if they are made within the specified period;
- (ii) any oral representations;
- (iii) the result of any other consultation he has made and any observations made on that result;
- (iv) the specified period mentioned in (iii) may be set by the adjudicator but will not be less than 2 weeks nor more than 4 weeks after issuing the invitation. However, he may, where he considers it appropriate to do so, extend this period;
- (v) the adjudicator, subject to any constraint in the regulations, or agreements by the parties, shall have wide discretion in determining the procedure of the dispute resolution to ensure just, expeditious, economical and final determination of the dispute;
- (vi) the adjudicator will record its determination and the reasons for it, in writing and send this to both parties.

15.4 Non-NHS contracts

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.

16 Annex (I) PMS Technical Guidance

16.1 Medical Performers Lists

16.1.1 Aims

To transfer seamlessly all doctors who perform GMS or PMS respectively, from the medical, supplementary medical or services lists, to the new primary medical performers list on the date the new GMS contract comes in to effect.

To maintain the existing arrangements for admitting or conditionally admitting doctors to lists who wish to perform primary medical services for patients, and for suspending, removing or contingently removing them, using the NHS (Performers Lists) Regulations 2004.

16.1.2 Background

Before the introduction of the integrated primary medical performer lists, individual doctors who perform GMS and PMS were regulated by means of separate provisions in the GMS Regulations, GMS Supplementary List Regulations and the PMS (Services List) Regulations. This form of NHS regulation is generally known as the “list management” arrangements.

Detailed information on the regulation of individual GPs by PCTs, using the list management arrangements can be found at www.doh.gov.uk/pclists.

Listing is mandatory for individual, qualified doctors who personally perform NHS primary medical services for patients, or who intend to perform such services. Providers of the services, whether or not they are doctors, are not entitled to be listed unless they personally perform, or intend to perform, the services.

Transitional and consequential provisions will:

- Ensure that the migration of doctors from existing lists to the new medical performer lists proceeds smoothly;
- Make transitional provision for the treatment of any doctors in relation to whom issues are being dealt with under the existing list regulations, using the medical performer list regulations;
- Ensure that relevant decisions that were taken under the provisions of the existing regulations continue to have effect (or equivalent effect) once the performer list regulations come into force.

16.2 Migration of doctors to medical performer lists – General:

In most cases (those doctors on the supplementary medical list, those on the services list and many of those on the medical list) migration will be straightforward. If their names are included on one of these lists on 31st March

2004 they will transfer automatically to the primary medical performer list on 1st April 2004.

This will also apply to doctors who are suspended on 31st March 2004, since their names remain on the appropriate list. These doctors will have their names transferred automatically to the performer list on 1st April 2004.

16.3 Exemptions from listing: the following clinicians are exempted from a requirement to be listed:

16.3.1 Clinicians employed by NHS Trusts

This exemption applies only to clinicians employed by NHS Trusts who are engaged by providers (e.g. on a sessional basis) to perform secondary care in a primary care setting.

16.3.2 Certain Pre-Registration House Officers and Senior House Officers in Training

This very limited exemption applies where a doctor is provisionally registered under sections 15 or 21 of the Medical Act. Such doctors may perform GMS or PMS when their names are not included in the performer list, but only when acting in the course of their employment in a residential capacity in an approved medical practice within the meaning of the Medical Act.

Sections 15 and 21 of the Medical Act provide that a person who is provisionally registered is deemed to be fully registered so far as is needed to be engaged in employment in an approved medical practice. Section 11(4) of that Act defines approval in relation to the provision of experience, or of a pattern of experience, by a university or equivalent institution, in GMS or PMS. These provisionally registered doctors will either be Pre-Registration House Officers (PRHOs) or Senior House Officers (SHOs). They are likely to be involved in Scheme exercises of the type envisaged in "Modernising Medical Careers" in order to get a taste of what life is like as a GP. Equivalent programmes operate or will operate in specialities such as obstetrics and gynaecology, mental health, microbiology and anaesthetics. The arrangements for PRHOS and SHOs will mean that they spend varying amounts of time in GP practices, from one day a week for a period, up to a continuous spell of three or four months.

16.3.3 Limited easement for GP Registrars

All GP Registrars must apply to join a list before the start of their vocational training in general practice. However it is not always possible to complete the admission procedure before the date on which they are due to begin their training. If the start of their training is delayed it can have a serious impact on their training programmes, and may mean they are unable to complete the minimum 12 months training in general practice that the Vocational Training Regulations require. As a result it may have a serious effect on both their training and future careers.

To overcome such difficulties [Paragraph 42(2)(c) of Schedule 6 to the NHS (GMS Contracts) Regulations 2005] permits training practices to employ GP Registrars without confirming that their names appears in the performer list until the end of the first two months of the training period. PCTs are asked, nevertheless, to give priority to the processing of performer list applications from GP Registrars.

16.4 Transitional provisions for the treatment of any doctor being dealt with under the existing regulations

Transfer to performer lists raises questions about how list management questions being dealt with on 31st March 2004 will be dealt with. These matters include outstanding applications to join PCT lists, unresolved deferrals of decisions on applications, continuing suspensions, and consideration of removals and contingent removals.

Any matter that was being dealt with under the medical, supplementary medical and services list provisions on or before 31st March 2004 will be dealt with under the medical performer list provisions from 1st April 2004. Any action that had being taken under the old lists is deemed to have been taken under the performer list regulations.

Special arrangements again need to be made for those doctors who change PCT on 1st April 2004. Advice on the detail of these arrangements will be provided in www.doh.gov.uk/pclists early in 2004.

16.5 Appeals and applications to the Family Health Services Appeal Authority (FHSAA)

There are no special provisions for the treatment of decisions taken by PCTs or the FHSAA on or before 31st March 2004 in relation to:

Refusing a doctor admission to a list, or removing a doctor from a list, where such a decision was not challenged, or such a decision was challenged but the appeal processes had been exhausted by 31st March 2004.

Decisions of this type applied at the time they were made and will continue to apply in the PCT in respect of which they were made. Unless the doctor has been nationally disqualified, there is nothing to prevent him/her making a fresh application to that PCT or to any other PCT to join a list. Any further decision is therefore taken by a PCT to which any further application is made, and any subsequent appeal will be against that PCT's determination

Where there is a change of PCT, any appeal, application or question outstanding will be the subject of transitional provisions. Advice on application of the provisions will be provided on www.doh.gov.uk/pclists in early 2004.

16.6 New requirements on applicants for admission to lists: Enhanced Criminal Record Checks

Applicants to PCT medical performer lists must provide an enhanced criminal record certificate as part of their applications. PCTs will only get a copy of the enhanced criminal record certificate (the original will go to the doctor) where they countersign the doctor's application to the Criminal Records Bureau, and only if the information is required to assess the suitability of an individual for a post. There is a fee payable to the CRB. This is currently £29. The cost should be borne by the PCT and not by the practitioner.

A PCT has to register with the CRB in order to be entitled to countersign an application, and therefore receive a copy of the enhanced certificate. In return the PCT is required to adhere to a strict "Code of Practice." The Code of Practice is available from the CRB or via its web-site at www.crb.gov.uk. PCTs should register now if they have not already done so. There is a registration fee, currently £300, which also covers registration of the lead counter-signatory for applications. For each additional counter-signatory to be included within the registered body a further fee, currently £5, has to be paid.

The CRB is not a source of data about overseas offences and convictions, although they may hold very limited data about some countries. If so, the data will be limited to whatever data from overseas is held on the Police National Computer. The CRB may however be able to advise PCTs on how they might themselves go about trying to check details of convictions outside the UK.

For the time being, PCTs should not attempt to conduct bulk exercises to obtain certificates from doctors who are already listed, and who have not already provided certificates. Further advice will be provided about this. PCTs should only ask listed performers to provide a certificate if they have reasonable cause, in individual instances where information comes to their attention that throws into doubt the openness of the declaration a performer had previously provided.

16.7 Performance of new PMS, aims, objectives, targets, monitoring, evaluation and audit in new PMS

PCTs should have in place agreements to review and evaluate PMS schemes. Where the PCT is also the PMS provider, they should have a similar arrangement in place with the SHA. The SHA will in turn be accountable to the Secretary of State. SHAs are also ultimately responsible for ensuring sound clinical performance, patient safety, and the smooth running of public health networks within their areas and facilitating local learning and development. Further sources of support are detailed in chapter eight of this guidance.

As with piloting, the monitoring of contracts is down to local discretion, however it is advisable that Annual Performance Agreements are put in place covering:

- The PMS schemes role in achieving Primary Care Targets set by the SHA as part of their agreement with the DH to deliver the NHS plan;
- Targets and objectives included within the PMS scheme's individual contract;
- An evaluation of the schemes role within the PCT / SHA wide organisation boundary particularly if the scheme was implemented to address a specific local problem.

16.8 Under-performance in PMS

Until Services Lists are fully introduced², the contract is the route by which action has to be taken where serious concerns arise about a PMS doctor's performance, including patient safety. Then we suggest the following approaches can be adopted:

- Doctor is a salaried performer and named in a PMS agreement;
- Direction 6 of the PMS Implementation Directions requires a PMS doctor who is primarily responsible for performing the full range of PMS³ or any particular aspect of PMS to be named in the PMS agreement. Other doctors may be similarly named;
- The PMS "commissioner" (SHA or PCT) can seek from the Secretary of State a variation to the PMS agreement (Section 8 of the Primary Care Act) to exclude the doctor from the agreement and thus prevent him performing PMS under that particular agreement;
- The Department of Health PMS policy branch will act on behalf of Secretary of State where the PCT is the provider, but it is the SHA to act on his behalf where the PCT is the "commissioner."

The terms of the variation may be temporary (equivalent of suspension) or permanent (equivalent of removal). *A notice period is not required in the same way that either party to the PMS agreement is required to give notice of withdrawal from a PMS scheme under article 27 of the PMS Implementation Directions. This is because in some cases it may be matter of some urgency.*

There is no formal content to such a determination – a letter from Secretary of State (SHA) directing or authorising the variation to the contract under section 8 of the Primary Care Act is enough.

16.9 Doctor is not named in the contract

If the doctor is not named in the contract, the Secretary of State or SHA can be requested to direct that the PMS agreement is varied so as to include a

² See section on Services lists for timing

³ a "primarily Responsible" doctor is required to hold a list of patients (article 6(1)(a)) of the Implementation Directions

term that specifically excludes that doctor from performing PMS in any capacity under that agreement. Such variations also do not require notice.

None of the above, of course, prevents the provider who employs the doctor from dealing with any breaches of the salaried doctor's terms of employment through internal disciplinary procedures. Under these arrangements the provider may elect to suspend the doctor pending a fuller investigation and/or a subsequent formal hearing of the issues and, of course, may result in the provider terminating the doctor's employment.

16.10 Doctor is a provider/performer

If the need is to prevent a doctor who is both a provider (i.e. contract holder) and performer from performing PMS the variation route as above can be used. The provider continues in his role as a PMS provider and would need to engage some form of locum cover for the performance of PMS to maintain his obligations under the terms of his PMS agreement.

If the PCT also wished to exclude the doctor temporarily from providing PMS, it would need to vary the contract in such a way as to require the doctor to delegate his/her provider responsibilities to, e.g. Dr A N Other. In a multi-partner practice, the delegation would likely be to another partner.

16.11 Doctor has single-handed practice

Using the variation route so as to suspend a sole provider from providing service would be tantamount to suspending the scheme, which would mean that the provision of all medical services under the scheme would similarly be suspended and no one would have the power to provide locum doctors. Since a scheme is a "contract" between the PMS "commissioner" and the provider varying the contract to substitute a different party to that contract effectively terminates the scheme. This raises questions on what if the allegations proved to have no substance.

As a temporary measure the approach advocated is for the PCT to identify a doctor to whom the "suspended" doctor would delegate provision and performance of the services. In this way the "suspended" doctor formally remains the provider and "contract-holder" and can take up the reins of his PMS role in the event the allegations are held to be unfounded. This approach would be the PMS equivalent of the PCT making arrangements under regulation 25 of the GMS Regulations.

Where allegations against a single-hander are so serious that his/her removal (rather than suspension) is justified the PCT could terminate the contract. A period of notice would have to be given in line with article 27 of the PMS Implementation Directions.

However, where the PCT are seriously concerned about the safety of patients, they could ask the Secretary of State (under the arrangements

outlined above) to terminate the PMS scheme with immediate effect (section 8(4) of the Primary Care Act). No notice is needed.

If as a result of the termination of the scheme the doctor exercises his preferential right to return to GMS, the PCT should consider whether it should make representations to the FHSAA against the doctor's inclusion in the medical list (Schedule 1 to the Primary Care Act 1997 and the FHSAA (Primary Care Act) Regulations 2001 (SI 2002/3743).

16.12 Services Lists

The Services List Regulations will require all PMS doctors to be included in PCT lists (and therefore be subject to interim suspension and to sanctions such as removal. Removal means that they must stop performing PMS in that PCT's area)

The Services List Regulations will come into force in *November* and PCTs will have until *February* to build their lists

However this does not mean that action will be impossible under the regulations before February. Doctors have until 3rd of December to apply to join the PCT lists. If a PCT has information that might lead to a doctor's removal if that doctor were already on its list, the regulations will require the PCT to decide the application immediately. That means that if the information is prejudicial to the doctor, his/her application can be rejected as soon as it is made: effectively bringing to an end his/her PMS work straightaway. Such a doctor could of course then attempt to exercise his/her preferential right to return to GMS. However that right is circumscribed by the fact that PCTs are entitled to make representations to the FHSAA against the doctor exercising the right. If the FHSAA agrees with the representations, it directs that the doctor may not return to GMS - effectively this means there is no means by which he/she can continue to work in primary care as a doctor. So it is possible to say that "sanctions" under the Services List Regulations will be available to PCTs from December 2003. (Note that suspension is not a sanction, and it would not apply to these cases since the action the PCT would take is to refuse to admit such a doctor to its list in the first place).

In April 2004 there will be a new list (the primary medical performer list). But this is simply an amalgamation of the existing lists, on which doctors can be named (the Medical List for GMS Principals, the GMS Supplementary List for GMS assistants and deputies. Doctors on existing lists will be passported automatically to this new list. But transitional and consequential provisions in regulations will ensure that suspensions and/or sanctions that were taken under any one of the old lists will continue to be enforced under the new lists.

Practice splits and mergers

This section is covered in Annex (G) variation and termination.

17 Annex (J) Acronyms Guide

PMS	-	Personal Medical Services
GMS	-	General Medical Services
SHA	-	Strategic Health Authority
PCT	-	Primary Care Trust
GP	-	General Practitioner
LDP	-	Local Development Plan
LMC	-	Local Medical Council
LRC	-	Local Representative Committee
TSC	-	Technical Steering Committee
GIG	-	Gross Investment Guarantee
MA	-	Modernisation Agency
FHSAA	-	Family Health Services Appeal Authority
PALS	-	Patients Advice and Liaison Service
ICAS	-	Independent Complaints Advocacy Service
LSP	-	Local Service Provider
NASP	-	National Application Service Provider
IAU	-	Interim Aspiration Utility
OOH	-	Out -of-Hours
PEC	-	Professional Executive Committee
OSCAR	-	Online System for Comparative Analysis Recording
NHSPS	-	NHS Pension Scheme
NHSPA	-	NHS Pension Agency
CRB	-	Criminal Records Bureau
NatPaCt	-	National Primary & Care Trust Development Programme

NPDT	-	National Primary Care Development Team
QuISP	-	Quality Improvement Skills for Practices
NPCC	-	National Primary Care Collaborative
LHB	-	Local Health Board
GDS	-	General Dental Services
PDS	-	Personal Dental Services
NCAA	-	National Clinical Assessment Authority
Npfit	-	National Programme for Information Technology
QTD	-	Quality Team Development
TIA	-	Transient Ischaemic Attack
COPD	-	Chronic Obstructive Pulmonary Disease
RCT	-	Randomised Control Trial
QTD	-	Quality Team Development
QPrep	-	Quality Preparation Payment
QuIP DES	-	Quality Information Preparation Payment Design Enhanced Service