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To: Chief Executives, PCTs and SHAs
Finance Directors, PCTs and SHAs

Cc: GP Practices

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Guidance on Non-GMS Contracting Arrangements for 2006/07

Dear Colleagues,

The attached guidance supports PCTs and SHAs in securing similar benefits to those achieved through the General Medical Services (GMS) contract for 2006/07, from local Personal Medical Services and Alternative Provider Medical Services contracts. It is essentially a companion document to recent guidance published by NHS Employers and the BMA, 'Revisions to the GMS contract 2006/07: Delivering Investment in General Practice.'

This guidance will be underpinned by a direction from Secretary of State that will require PCTs and SHAs to review local contracts and seek to constrain payments made under these in line with the 2006/07 GMS contract.

PCTs and SHAs should address any enquiries to the NHS Primary Care Contracting team in the first instance, see www.primarycarecontracting.nhs.uk

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Guidance on Non-GMS Contracting Arrangements for 2006/07

Introduction

1. The purpose of this guidance is to support PCTs and SHAs (where they are the commissioners of PMS) to secure similar benefits to those achieved through the General Medical Services (GMS) contract for 2006/07, from local Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts for the provision of primary medical care services. Through local negotiation, PCTs are asked to secure for 2006/07:
    - improvements in access for patients
    - the development of choice and booking
    - an expansion of the Quality and Outcome Framework (QOF) that brings in new clinical areas to drive up quality at no additional cost
    - the take up of new technology within the practice
    - the rollout of Practice Based Commissioning
    - the achievement of significant efficiencies

Context

2. Revisions to the GMS contract for 2006/07 arising from agreement reached between the British Medical Association (BMA) and NHS Employers has now been published (http://www.nhsemployers.org/primary/primary-632.cfm).

3. It is not the purpose of this document to repeat the detail contained within that publication. However, this companion document does provide guidance to Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) on:
    - how they could apply the principles of the GMS agreement to Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts from 1 April 2006;
    - matters of detail that specifically relate to non-GMS contractors.

4. Whilst the PMS and APMS contracting arrangements provide PCTs with flexibility and discretion in commissioning services, PCTs and SHAs need to be able to demonstrate that funding decisions between all primary medical care contractors are fair and equitable and represent value for money. In particular, that equivalent GMS and non-GMS contractors are treated in a similar way in respect of resourcing decisions.

Guidance

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

6. This document sets out guidance to assist PCTs and SHAs in :

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

7. In seeking to constrain payments made under PMS agreements and APMS contracts, PCTs and SHAs will wish to be mindful of the following elements of the GMS agreement:

   - no uplift to any existing element of the contract for inflation or cost pressures in 2006/07;
   - the efficiency savings sought for both 2006/07 and future years.

8. Where an existing contract with a PMS or APMS contractor provides for some form of uplift in payments made in 2006/07, PCTs and SHAs will want to attempt to negotiate additional efficiencies [with that contractor] with a view to producing the same net effect on payments made in 2006/07, to that for comparable GMS contracts.

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

Enhanced Services

10. There are four new Directed Enhanced Services in 2006/07:

    - New Access
    - Choice and Booking
    - Towards Practice Based Commissioning
    - IM&T Adoption

11. **It is the Department's intention to issue Directions that will require PCTs to offer these Enhanced Services to GMS, and all relevant PMS contractors**. [There will be no requirement to include those SPMS practices that do not hold a registered list of patients, although PCTs and SHAs may make offers where appropriate]. PCTs and SHAs will have flexibility over the format and quantum of payments made to non-GMS contractors. However, they will wish to have regard to the arrangements in place for GMS contractors, e.g. component payments, based on £ per registered patient and timings such that some payments may not be made until 2007/08.

12. At PCT discretion, these Enhanced Services can also be offered to APMS contractors (within the core contract).

Quality and Outcome Framework (QOF)

13. The national QOF has been improved for 2006/07. New clinical areas have been introduced and existing indicators strengthened that have effectively increased the value derived from the QOF by some 166 points in 2006/07 and at no additional cost.

14. PCTs and SHAs with PMS agreements or APMS contracts, where that agreement/contract requires the contractor to use the national QOF framework, will want to introduce these improvements. The new national QOF is effective from 1 April 2006.

15. In other cases, PCTs and SHAs can, with the agreement of the non-GMS contractor, either adopt the new QOF measures or develop alternative local QOFs. The process for developing local QOFs is set out in *Sustaining Innovation through new PMS arrangements*. Any QOF specification that varies from the national one is classed as a local QOF.

16. The arrangements for the PMS deduction have not changed.

Dispensing Doctors

17. The changes agreed to the arrangements for remuneration and VAT allowances for GMS contractors must also be applied to PMS, APMS and PCTMS doctors with consent to dispense under the Pharmaceutical Services Regulations (paragraph 8 of Schedule 2 to the Pharmaceutical Regulations (SI 2005/641).

18. Any PMS contractor with consent to dispense under Schedule 5 of the National Health Service (Personal Medical Services) Regulations 2004 (PMS Regulations) will receive remuneration and reimbursement for dispensing in accordance with the PMS agreement agreed with their PCT or SHA.

19. If in practice, these arrangements are the same as for GMS contractors and payments calculated through the Prescription Pricing Division of the NHS Business Services Authority (PPD) (formerly the Prescription Pricing Authority) system, then the PPD will calculate the payments for items dispensed and personally administered from 1 April 2006 onwards in accordance with the new system.

20. PCTs and SHAs may need to review their agreement with their PMS providers to ensure that they are in line with the new arrangements from 1 April 2006. Chapter 4 of the GMS guidance explains in detail the new arrangements for dispensing doctors.

21. It is likely that all dispensing practices will register with HM Revenue and Customs for VAT from 1 April 2006. This may have implications for any reimbursement provided by PCTs to contractors for premises and IT if the reimbursement is gross of VAT. If contractors are registered for VAT they may be able to claim reimbursement of some of the VAT costs of capital expenditure from HMRC. PCTs therefore need to be aware of the VAT status of practices,

and the sums practices can reclaim from HMRC, to avoid double payments of VAT.

22. It may be that the PCT or SHA has agreed a different system for remuneration and reimbursement with the PMS contractor and/or set up arrangements for payment outside the PPD system. In these circumstances, the PCT will wish to review these arrangements in light of the changes made to the GMS arrangements and decide whether any changes need to be agreed with the contractor.

Maternity, Paternity and Adoptive Leave

23. PCTs and SHAs who provide locum support to their contractors in the form of reimbursements during periods of maternity, paternity and adoptive leave will wish to note and consider the implications locally of the GMS agreement, which increases the discretionary ceiling during such leave to £1500 per week.

Performance Management

24. A key role for PCTs is to ensure that the totality of funding they provide to contractors (both GMS and non-GMS) is appropriate and subjected to robust contractual and performance management mechanisms. Such mechanisms are a necessary characteristic of good financial management and better ensure that patients receive a high quality of care.

25. In particular, PCTs and SHAs are reminded of their responsibilities to ensure that the text of all primary care contracts satisfactorily delivers both the relevant legislative requirements and any specific requirements PCTs may have in relation to the management of the contract. These need to include any financial arrangements discussed in this document. This may require taking independent legal advice, particularly where a standard template has been used in delivering local contracting arrangements.

26. SHAs are expected to take positive action during 2006/07 to ensure that such mechanisms are in place within PCTs and are being properly applied.

Clinical Letters

27. PMS providers are expected to ensure that they have arrangements in place to ensure that patients receive copies of their clinical letters.

Enquiries

28. PMS and APMS providers should address any enquiries to their local commissioner. PCTs and SHAs should address enquiries to NHS Primary Care Contracting in the first instance, see www.primarycarecontracting.nhs.uk