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GPC

General Practitioners
Committee

Alternative Provider Medical Services (APMS)

Guidance for GPs

BMA 

Alternative Provider Medical Services (APMS) – Guidance for GPs

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Introduction

The government is currently initiating far-reaching reform of health services organisation and delivery. Its reforms are based on a philosophy of diversification of health care providers, patient choice and competition and include initiatives in primary care such as practice based commissioning, choose and book and Alternative Provider Medical Services (APMS).

APMS in particular has the potential to alter radically the face of primary care in the UK. The extent to which this will happen and the direction of any change following the introduction of APMS remain uncertain. While there are many legitimate concerns about APMS, this method of contracting, if fairly implemented, does offer GPs the potential to further shape primary healthcare provision.

This guidance provides a factual background on APMS and suggests ways in which GPs can best harness this new contracting route in the interests of their patients and primary care. It offers guidance on tendering for APMS contracts, working for APMS providers and contracting care through this route. Throughout the document it also highlights areas where inequities may arise and suggests ways GPs and their local medical committees (LMCs) can work to ensure a level playing field between different types of provider. As APMS is a rapidly developing area of health policy, this guidance will evolve over time and should be regarded as a living document.

What is APMS?

APMS is one of the four routes available for PCOs to make provision for primary medical services to patients. Its recent introduction has broadened the range of potential providers from whom PCOs can commission services.

PCOs may commission APMS to provide essential services, additional services, including where GMS/PMS practices opt-out, enhanced services and out-of-hours services. [Notably, more than half of the PCTs in England are currently using APMS contracts for out-of-hours services.] APMS may be used where specific needs arise, such as through practice vacancies, or in areas with rapidly expanding populations where extra capacity is needed. APMS opens up the provision of essential services to providers other than GMS and PMS practices, although it may in some areas initially be used for additional, enhanced and out-of-hours services.

PCTs' power to contract with a wide range of organisations to provide services is set out in Section 16CC(2)(b) of the NHS Act 1977. The Alternative Provider Medical Services Directions 2004 came into force in April 2004 and were slightly amended in November 2004 and January 2006. The National Health Service Act 1977 Alternative Provider Medical Services (No.2) Directions 2004, set out the minimum level of performance demanded by APMS contractors.

National variations

APMS is known as Health Board Primary Medical Services Contracts in Scotland. The Directions to Health Boards in Scotland came into force in November 2004. In Northern Ireland the APMS Directions came into operation in August 2005. The National Assembly for Wales issued APMS Directions in February 2006.

It seems likely that the Scottish Executive Health Department, the National Assembly for Wales Health Department and the Department of Health, Social Services and Public Safety in Northern Ireland will not be pursuing the implementation of this type of contract as vigorously as their counterpart in England.

The objectives of APMS

The English Department of Health expects PCTs to embrace APMS. In The NHS Improvement Plan (June 2004) it said:

'In the next four years, we will...focus on...an increased choice of providers from all sectors. New forms of service delivery will be supported by both the added commissioning freedoms available to PCTs and the introduction of new contractual arrangements such as Alternative Provider Medical Services (APMS), Personal Medical Services (PMS) and Primary Care Trust Medical Services (PCTMS). The flexibilities available to PCTs will enable the NHS to build on the traditional strengths of primary care, particularly in areas where there may be difficulties in recruiting GPs or where new forms of provision may be needed, for example for commuters. This will include PCTs directly providing care, and contracting with the independent sector where this is the best option.'

The government hopes that APMS will be used by PCOs to improve capacity in primary care, particularly in areas of under-provision. It is also being promoted as a means of improving access and introducing greater innovation in service delivery. PCOs are expected strategically to consider their commissioning options in response to population or practice changes, for example where there are changes to practice configurations or where new sites are under development.

APMS provision can also be seen as a means of introducing 'constructive discomfort' into the healthcare sector – a government attempt to ensure additional capacity and competition in order to drive up standards and efficiency in a primary care market. In this light, APMS can also be seen as part of the government's patient choice agenda. The White Paper *Our health, our care, our say: a new direction for community services* (published January 2006) says that improving access and building up capacity in poorly served areas will mean:

'encouraging or allowing new providers, including social enterprises or commercial companies, to offer services to registered patients alongside traditional general practice. Increased capacity – and contestability – will allow people to choose services that offer more convenient opening times, tailored specialist services or co-location with other relevant services.'

The White Paper also announced the government's intention to help PCTs to make the most of the new arrangements through nationally supported procurements:

'On their own, PCTs have not always had the size or clout to develop enough new provision in their locality to tackle inequalities...we will help **all** PCTs in under-served areas to draw upon national expertise to attract new providers of sufficient size to fill these gaps in provision...Change will be driven locally, with local authority input, and co-ordinated nationally in a series of procurement waves. This is an urgent priority if we are to make equal access for equal need a reality... We will ensure that both new and existing providers are allowed to provide services in underserved areas. Social enterprises, the voluntary sector and independent sector providers will all make valuable contributions in the longstanding challenge of addressing inequalities. The voluntary and community sectors often have strengths and experience in delivering services to those people who are not well served by traditional services.'

Who can enter APMS contracts?

PCOs can enter APMS contracts with any individual or organisation that meets the provider conditions set out in the Directions. These individuals and organisations include:

- independent sector – both UK-based commercial companies and overseas providers of healthcare, including Local Improvement Finance Trust (LIFT) schemes
- voluntary sector
- not-for-profit organisations/social enterprise bodies
- NHS Trusts (in England and Wales)
- other PCOs
- foundation Trusts (in England and Wales)
- General Medical Services (GMS) or Personal Medical Services (PMS) providers through a separate APMS contract
- groups of other health professionals such as community nurses

Where will APMS take primary care?

At this early stage it is impossible to predict how APMS will affect primary care or how much the government will come to rely on APMS providers in the future. There is as yet no target as to what proportion of primary care providers should be contracted through the APMS route and it is not known what type of providers will tender for APMS contracts. Several market-based models for primary care have been identified¹, all of which could emerge from APMS:

Possible market-based models for primary care, which could arise from APMS²

Commercial takeover - Comparatively large independent companies such as current or new independent sector providers, high street retailers, or pharmaceutical companies might buy up whole practices or establish new practices, employing all of the staff.

Mergers of existing practices - Successful established practices might want to take over other practices and either merge them or manage them using a common executive team.

Hospital based service - The NHS hospital sector may decide to provide primary care services, either in hospital outpatient departments or by setting up new primary care clinics linked to hospitals. This model is likely to be particularly attractive to foundation hospitals, which have the ability and incentives to expand their capacity.

Population specific service - General practice services targeted at specific populations (eg teenagers, elderly people, or commuters) could be established by any provider (moving away from comprehensive family practice).

Condition specific service - Discrete services targeted at conditions or procedures, such as hypertension clinics or investigative facilities, could be delivered by independent providers under contract to practices or primary care trusts.

Some of the possible models of primary care provision under APMS raise concerns that APMS will increase the fragmentation of general practice and threaten continuity of care.

An additional cause of concern is that, operating under the 'commercial takeover' model, large independent companies may have a built in advantage or be given an advantage by commissioning PCTs. For example, there are concerns that private providers may bid for certain services as 'loss leaders', subsidising the business from other ventures in order to get a foothold in the area. [As detailed below, APMS is intended to sit alongside GMS, PMS and PCTMS and PCTs will have to pay for APMS from their existing allocations. GMS and PMS providers are entitled to hold APMS contracts and it is critical that established GP practices must face a level playing field in bidding for the work.]

The White Paper *Our health, our care, our say: a new direction for community services*, set out a plan for a nationally-led procurement programme for under-doctored areas in England. Termed Fairness in Primary Care, this plan opens the possibility of nationally-supported tendering for APMS contracts, focused initially on those areas with the most significant inequalities of access to primary care.

Fairness in Primary Care procurement principles – as set out by the White Paper *Our health, our care, our say: a new direction for community services*

“ 1. The Department of Health will begin immediately to identify the localities that are significantly under-provided, especially those in deprived areas.

2. Where PCTs are unable to provide robust plans for rapidly reducing inequalities of access to services, they will be invited to join the national procurement process.

3. There will be a competitive tendering process, which will provide a level playing field and ensure fairness. PCTs will purchase and contract manage the new services.

4. PCTs will draw up specifications for the new services they will procure.

These must include arrangements for convenient opening hours, open lists, a practice boundary, if any, very broadly defined, as well as quality incentives comparable to those in the GMS/PMS contract.

5. The Department of Health will manage the procurement process on behalf of PCTs, ensuring the principles of contestability and value for money are realised under a fair, transparent and consistent process.

6. All providers that pre-qualify to quality standards during the tendering process will be put on an accredited list of primary care suppliers, to ensure that in the future commissioners can procure GP services faster.”

Where APMS takes primary care will hinge not only on government policy but also on the way in which GPs respond to the challenges inherent in the government’s health services reform agenda. Londonwide LMCs is urging GPs in London to prepare themselves for the new competitive market environment by: considering methods of collaboration between practices, engaging in PBC and ensuring services are efficient, up-to-date and responsive.

Awarding APMS contracts – the process

Initial considerations for PCOs selecting contractors

The Department of Health document *Delivering Investment in General Practice: Implementing the new GMS contract* (2003) sets out certain guidelines for PCTs filling vacancies in general practice (2.15-2.16). For 'greenfield' sites (new surgeries that cover essential services as a result of significant increases in population) PCTs are expected to invite bids from existing GMS and PMS contractors and are not expected to progress to inviting bids from alternative providers unless there is no interest from GMS and PMS contractors, or if those contractors do not satisfy the criteria set out in the specification. For 'brownfield' sites (pre-existing surgeries that were but are no longer delivering essential services, for example in the event of a single-handed GP retiring, or essential services in areas of historic under-provision), PCTs have the option of inviting interest from existing primary medical services contractors, employing a GP using the PCTMS route, or advertising the vacancy and entering into a GMS, PMS or APMS contract. The PCT is expected to consult with the LMC before deciding which way to fill the vacancy.

The implications of *Delivering Investment in General Practice* for local GPs wishing to enter into APMS contracts are clear; those in brownfield sites are more likely to face competition from alternative providers. In reality, many of the APMS contracts available will be in these brownfield sites and consequently GMS and PMS contractors will not be offered the opportunity of first refusal for these services.

In many cases single-PCOs will commission services from providers under APMS arrangements. However, some APMS services may be commissioned across a number of PCOs. One advantage of this from the PCOs point of view is that private companies may not be interested in small contracts but might be willing to bid for services which have been packaged across areas.

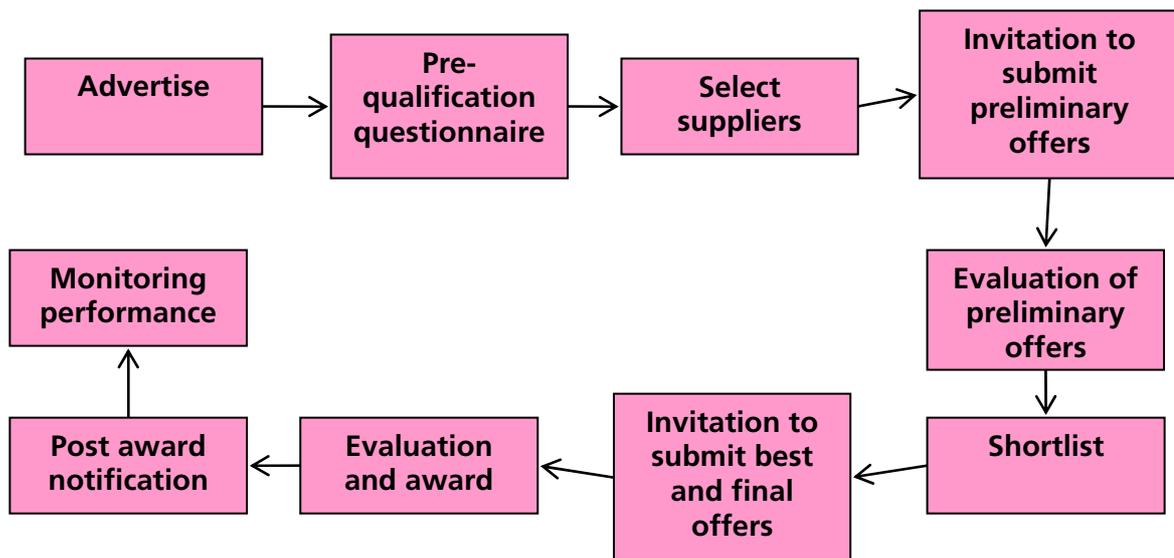
PCOs may choose to put certain services out to tender without specifying the contracting route. This means that the type of contract awarded for providing the service in question may be determined largely by the status of the other contracting party.

Outline of the process

PCOs can use different approaches when putting services out to tender. This section outlines the basic process and gives details of some of the key stages within this process.

A figure showing the procurement cycle as recommended by PASA's procurement guidance for APMS is shown below.

Recommended procurement cycle for APMS as recommended by the NHS Purchasing and Supply Agency (PASA)



Advertisement of APMS contracts

Medical services are subject to only limited controls under the EU Procurement Directive; namely that health and social services procurements with a total value, throughout the life of the contract, over a certain amount (£136,844 in 2006) must involve a technical specification and the publication of an award notice following the award of the contract. However, procurement for such contracts should comply with the principles of EU regulations (non discrimination, equal treatment, transparency, mutual recognition, proportionality).

Choosing not to advertise APMS contracts may open the PCO to accusations that the selection process was not truly open. EU treaty obligations of transparency and fairness in tendering processes are thought to indicate that tenders should be advertised at least as widely as there is likely to be an interest in providing the service. Even disregarding EU principles for tendering, competitive processes for the award of GMS contracts has established what the NHS Confederation refers to as 'considerable legal bias towards a competitive process of some sort'. PCOs have been advised by the NHS Confederation to tailor advertisements to the value of the contract available,³ but PASA recommends that APMS contracts should be advertised in at least one local and one national publication to reduce the risk of legal challenges and to ensure competition.

The slight ambiguity in the requirements of EU regulations and the mixed advice to PCOs on advertisement of APMS contracts indicates that advertising will vary. This variety may be compounded by the fact that individual PCO standing orders are also likely to apply to the tendering and procurement process. Some PCOs may, for example, choose to use the Official Journal of the European Union to advertise major contracts, while other PCOs may only advertise contracts locally.

Ensuring a level playing field – advertising

The method of advertising used may bias the process particularly if, for example, the PCO sends invitations to bid to selected organisations rather than advertising more publicly.

The Department of Health advises that approaching just one provider can not usually be justified because it is contrary to the principle of achieving value for money through open and fair competition. It therefore advises against 'single tender action' except where⁴:

- (a) the work concerns a new contract that is directly related to a recently completed contract, and the added value gained from the additional work being given to the same contractor outweighs any potential reduction in price that may be derived through competitive tendering
- (b) the expertise required is only available from one source

The government's plan for nationally-supported tendering for APMS contracts, as set out in the White Paper *Our health, our care, our say: a new direction for community services* includes the central development of a (nationally) 'accredited list of primary care suppliers to ensure that in the future commissioners can procure GP services faster'. The development of such a list could disadvantage existing local providers wishing to bid for APMS contracts by focusing PCTs' attention on larger providers who have bid for services or won contracts elsewhere in the UK. This is something for GPs to monitor as the government's project develops.

Creation of service specifications

The NHS Confederation advises PCOs to give potential providers clear guidance on what is required, but PCOs will not necessarily draw up a detailed specification. [Service specifications may also be known as statement of requirements or terms of reference.] In some cases the PCO will define and specify service requirements in detail. In other instances it may identify a lack of services but encourage bidders to propose the approaches required to fill the gap. The NHS Confederation has identified four possible models for an APMS procurement process based on the level of service specification⁵ (see box below).

Four possible models of APMS procurement identified by the NHS Confederation⁶

Model A: Competition against specification prepared by the PCO

Appropriate for: filling a practice vacating or contracting for a clearly defined service, possibly where there is an existing service which the PCO wishes to replicate

Process: PCO sets out service specification and puts this out to tender. PCO selects successful bidder based on the tenders to provide the specified service

Pros: Enables a straight-forward, single-stage exercise with minimal effort required from bidders

Cons: Limits service innovation

Model B: Competition against specification with variant bids encouraged

Appropriate for: a practice or service where the PCO has a reasonable idea of what it would like but has not closely defined the service model

Process: the PCO puts the service out to tender with less rigidly defined service specifications. It selects the successful bidder after evaluating bids and alternative approaches to the perceived problem

Pros: allows exploration of new service models

Cons: requires more initial research and more detailed bids from potential providers without any certainty of work or payment. Offers more scope than model A for uneven playing fields.

Model C: Competition to act as a partner in developing and providing a service

Appropriate for: circumstances in which the PCO is aware of a gap in services but is unclear how best to fill that gap

Process: the PCO invites bids to work in partnership in developing and providing a service. It must choose the bidder before detailed plans for the service have been developed. Once the successful provider is chosen, it will play a part in developing the service specifications.

Pros: this model allows for innovation but, by identifying the successful bidder at an earlier stage, potential providers may not need to invest as much time as in model B in developing service ideas before the contract is awarded

Cons: it may be more difficult for the PCO to choose the successful bidder, potentially resulting in a less transparent selection process.

Model D: Responding to a direct approach

Appropriate for: generally regarded as an inappropriate approach to procurement. The NHS Confederation does not recommend this model.

Process: the PCO is approached by a provider and awards a contract without open competition

Pros: a PCO may regard this as a quick way of awarding a contract, perhaps to an organisation with a particular history. The process may work in favour of established providers and possibly large organisations.

Cons: this model does not involve any advertisement or competition. The PCO may therefore fail to engage the best provider and the process may be open to challenge on the basis of non-compliance with EU procurement principles. There is obvious scope for uneven playing fields.

Ensuring a level playing field – service specifications

The different models of procurement process outlined above seem to entail different degrees of potential for non-transparent and unfair procurement. Awarding contracts on the basis of a direct approach from providers without advertising the service (model D above) poses a high risk of the contract being awarded on the basis of unfair advantage. The risk of the PCO awarding contracts to providers without advertising widely or applying stringent selection criteria is probably also greater when service specifications are still under consideration at the time the contract is put out to tender (see especially model C above).

Requirements for consultation

There are various requirements for PCOs to consult with patient representatives and (depending on the nature of the service development) overview and scrutiny committees when putting contracts out for tender. PCOs are also expected to consult LMCs, partly to ensure that new

services fit well with existing services provided by GPs in the area. LMCs should be aware of conflicts of interest arising during the bidding and tendering process. They can play a critical role in ensuring a level playing field for potential APMS contractors. The tips on 'Ensuring a level playing field' throughout this guidance should help with this and GPC can provide further advice on individual cases.

Ensuring a level playing field – local consultation

The NHS Confederation guidance cautions that vested interests may arise where providers of enhanced services participate in decisions about service development. LMCs may also wish to consider this possibility but should be alert to the risk of PCOs using this as a reason for limiting the involvement of local GPs in the procurement process.

Evaluation of bids

PCOs have been advised to state clearly the selection criteria for the tender in the procurement pack. For example, PCOs may set out a range of competencies and key considerations against which bids will be judged or may explicitly assess applications on the range of services planned for and the timescales for provision.

The Department of Health's APMS guidance states 'The PCT will want to ensure that it has transparent, non-discriminatory procedures in place for selecting a contractor, in order to encourage competition'.

PASA recommends that PCT evaluations of bids will typically consider the following factors:

- The ability to meet the service requirement laid out in the output based specification
- Governance procedures
- Meeting standards for Better Health or National Minimum Standards, whichever is appropriate
- How outcomes would be monitored
- What audit procedures would apply
- Internal performance assessments
- Internal employment procedures
- Assessment of risk of the proposals
- Staffing. The ability to have sufficient personnel to meet the physical volume of work
- Appropriate skill mix
- Access to additional/enhanced services if relevant
- Service commitment
- Innovation, including the extent to which providers may be able to offer new/different approaches and solutions
- Cost

In addition, the NHS Confederation advises that, when assessing bids, PCOs will also need to consider specific issues relating to individual contracts, such as provision of premises and equipment, employment issues including pension provision, implications of multiple organisations involved and warranties.

Example of the award of an APMS contract

In commissioning prison healthcare services for Her Majesty's Prison (HMP) in Cardiff, the Cardiff Local Health Board (LHB) developed a GMS core services specification which was approved by the multi-agency Prison Health Care Steering Group, before publication in the Health Services Journal. Potential providers were invited to express interest in tendering against the final services specification.

The final services specification was assessed and approved by legal and procurement advisors before consideration and short listing of the received expressions of interest. The bids were assessed on the following criteria

- Quality of documentation submitted
- Manpower assumptions
- Clinical Governance
- Service Standards
- Performance management
- Innovative service
- 24 hour cover
- Awareness of interface issues
- Experience/deliverability
- Service range contract finance

The organisations rejected at this stage were judged either to have failed to provide the requested information or were unable to demonstrate their ability to deliver a cost effective service.

The remaining candidates were asked to make a short presentation to the selection panel on "How would your organisation deliver an equivalent GMS service to HMP Cardiff?" Following evaluation of the candidates' performance using the same selection criteria as outlined for the short listing stage, two organisations were felt to be able to provide a quality service, although both had quoted higher prices than were available financially. The organisations were asked to resubmit their proposed financial package before the panel made its final recommendations. The LHB discussed its recommendations with the HMP Governor and an agreement was made that Serco Health should be awarded the contract following full financial background checks. Serco Health had an existing relationship (as an out of hours provider) with the LHB prior to winning the contract to provide medical services the HMP Cardiff.

Ensuring a level playing field – evaluating bids

In order to operate a transparent procurement process the PCO should have at least some idea of the desired service specifications (which should be unbiased) and should seek to develop output-based criteria against which to evaluate the bidders. The selection process should be fair and transparent throughout the choice of contractor should be defensible and capable of validation.⁷ The decision to select or reject any candidate must be based only on information that is a matter of fact.

The NHS Confederation recommends that PCOs bar potential bidders from involvement in evaluation of proposals or in decisions on contract award. PCOs have also been advised that they may wish to go further and say that any involved in the decision making process should not be able to step in as providers subsequently if no appointment is made.

The Department of Health recommends that PCTs maintain careful records of the evaluation process in order to be able to demonstrate impartiality. NHS PASA advises that the Offer process must be sufficiently robust and auditable to meet the PCT's own Standing Financial Instructions and Standing Orders. In addition, notes or minutes of all meetings must be produced and retained on file in order to demonstrate an appropriate audit trail. This process must be able to meet the mandatory disclosure requirements of the Freedom of Information Act and the Environmental Information Regulations.

Unsuccessful applicants should normally be sent a decline letter with an offer of a verbal debrief.

Monitoring performance

Once a contract has been established a contract manager will be expected to monitor aspects of the contract such as staffing levels and skills mix, outcome-based quality measures and billing. There will normally be penalties for missing targets and associated remedial actions.⁸

Ensuring a level playing field – appealing the process or outcome

There is no formal procedure for appealing unsuccessful contract applications, advertising or tendering processes.

GPs who are unhappy with any aspect of APMS tendering should start by contacting their LMC. PCOs should be honest and open and in most cases approaches to the PCO chair, strategic health authority chair and PCO audit committee will be appropriate. These avenues should usually be exhausted before pursuing other options. [It should be noted that the Freedom of Information Act may be useful in obtaining information about the process, though requests regarding bid or contract values are likely to be refused on the basis that they are commercially sensitive.] Under some circumstances it may be advisable for the LMC to involve bodies working at a higher level or even local MPs. There may also be an option of using judicial review. GPC would also like to be kept informed both of any problems which cannot be resolved locally and of examples of successful resolution of issues which could be used as examples of good practice.

Getting involved in APMS

GMS and PMS practices can contract with PCOs through the APMS route, subject to the normal provider conditions preventing PCOs from contracting with individuals, practices or companies subject to disqualification, suspension, bankruptcy, criminal conviction etc.⁹ GMS or PMS practices contracting with PCOs under APMS will hold a separate APMS contract alongside the existing GMS/PMS contract.

GPs may get involved with APMS in a variety of ways, for example they may:

- enter into an APMS contract as their sole primary medical service contract
- enter into an APMS alongside their existing GMS or PMS contracts
- work collaboratively with other practices to provide services under an APMS contract
- enter into an APMS contract as part of a not-for-profit social enterprise body
- enter into a business relationship, as a practice or as a group of practices, with a large health company to provide services under an APMS contract
- enter employment or work as a locum for an APMS provider

Rationale for involvement in APMS

Although the introduction of APMS raises legitimate concerns for many GPs, APMS contracts are open to GMS and PMS providers and can potentially offer GPs the opportunity to develop their businesses. While APMS contracts may not be attractive to all GPs, those that do choose to take them on have the chance to demonstrate the innovative qualities inherent in British general practice.

Working collaboratively under APMS

Although there is nothing to stop an ordinary partnership or individual holding an APMS contract, possibly alongside a GMS or PMS contract, GPs may choose to work collaboratively with other practices or with companies in order to bid for, or provide services under, APMS contracts. There are many collaborative mechanisms ranging from obtaining advice or finance from outside companies to joining other practices in business arrangements of varying degrees of formality or forming new companies with other practices or companies. Several large health companies are providing consultancy services to GPs aspiring to APMS contracts and there is no doubt that some GPs will find the addition of this corporate knowledge appealing. Other companies are willing to provide capital to GP practices where needed. A number of independent companies effectively take over existing practices but offer existing partners a share in the larger company, thus demonstrating a further type of collaborative arrangement. Forming collaborative arrangements with larger organisations may offer GPs the opportunity to expand their businesses while sharing the risks and administrative input with an organisation with greater corporate knowledge and experience. Even without involving established companies, many GPs will see APMS and practice based commissioning (PBC) as the rationale for forming wider alliances with other practices.

While practices working collaboratively with others may find traditional partnership arrangements plus collaboration adequate, more formal collaboration between practices for the purposes of PBC or APMS is likely to require new models of business arrangements, such as those outlined below.

Limited Liability Partnerships (LLPs)

LLPs are governed by the Limited Liability Partnership Act and not by the Partnership Act. In addition, large parts of the Companies Act 1985 and the Insolvency Act 1986 are adopted for use by LLPs. LLPs are usually adopted to reduce the liability risk resulting under normal partnership rules. Having an LLP means that liability incurred by one partner does not inevitably bind another partner elsewhere. Key features of LLPs include:

- LLPs have to be registered at Companies House and a Certificate of Registration must be issued
- An LLP is a body corporate, ie a separate legal entity distinct from its members. LLPs hold property, employ people and enter into contracts. LLPs are liable for the debts they incur up to the full extent of their assets
- the members of an LLP generally have limited personal liability for the LLP's debts and liabilities
- an LLP continues in existence despite any change in membership
- an LLP is required to maintain proper accounting records, prepare and deliver audited annual accounts to Companies House, and submit an annual return (there are some exemptions for smaller LLPs).

LLPs are not specifically mentioned in the GMS and PMS regulations. As PMS agreements are held by individuals not entities, there is nothing in the regulations that specifically prevents a PMS practice from operating as an LLP. The position with regard to GMS is different and as the GMS regulations currently stand, LLPs are not covered.

LLP example

A group of GPs in the south west of England has formed a limited liability partnership called 'GPCare' with the aim of becoming a provider organisation capable of competing with even the major private sector companies. Interested practices paid a patient capitation based 'start-up' investment to employ staff and prepare business cases. In March 2006 86 practices were partners within GPCare. Full information can be found at www.gpcare.org.uk/index.htm

Limited liability companies

It is possible for practices to be set up as companies limited by shares. This is a similar concept to the qualifying body provided for in Section 28D of the 1977 NHS Act. The ownership rules for GMS companies are that:

- (i) all shares in such a company must be legally and beneficially owned by a person who could lawfully enter into a GMS contract as an individual or as part of a partnership
- (ii) at least one share must be legally and beneficially owned by a medical practitioner whose name is included in the GP Register (or is suitably experienced)
- (iii) any other shares owned by a medical practitioner must be so owned by a medical practitioner whose name is included in the GP Register or who is employed by a PCT, a Local Health Board, an NHS trust (including an NHS Trust in Scotland), an NHS foundation trust, a Health Board, or a Health and Social Services Trust

Companies limited by guarantee

Companies limited by guarantee have been a key vehicle for GP-run corporate ventures to date. This type of entity is normally registered for non profit making functions and may be more appropriate for consortia than limited companies. The key features of a company limited by guarantee are:

- the company has members, rather than shareholders, who have liability limited to the extent of their guarantee and then only on winding up
- although it can still make a profit, this is normally used for non profit making causes and cannot be distributed to the company's members. Most companies of this kind are not for profit.

Community Interest Companies

Community Interest Companies have been created recently as a new type of company for those wishing to establish social enterprises. Organisations wishing to be a Community Interest Company can choose one of three company forms: private company limited by shares, limited by guarantee or public limited company. To ensure that Community Interest Companies use their assets and profits for the community interest, they are restricted from distributing profits and assets to their members. To register as a Community Interest Company, companies must satisfy a community interest test. Community Interest Companies limited by shares have the option of paying a capped dividend on shares to investors. More information on these bodies can be found at www.dti.gov.uk/cics

More detailed information on ways of working collaboratively can be found in the GPC's forthcoming practice based commissioning guidance. This has been drawn up with consortia for PBC in mind but it is also relevant for GPs thinking about establishing companies for the provision of services under APMS contracts.

How to bid for APMS contracts

The way in which potential providers bid for APMS contracts will obviously depend on the procurement process adopted by the the PCO. The way the bids are structured will also depend largely on the service specifications set out by the commissioning body.

Expressions of interest and pre-qualification questionnaires

Once the contract has been advertised (see above for details on this) and before submitting a formal bid, potential providers may be asked to submit an expression of interest. Pre-qualification questionnaires may also be used to short list potential providers before detailed offers are requested. Prequalification questionnaires are used for potential providers to provide information upon which their suitability to be sent an invitation to submit a preliminary offer can be judged.

PCTs are allowed to exclude service providers that do not meet certain economic, financial and technical requirements and are permitted to set whatever selection standards they consider appropriate, providing they are proportionate to the contract. PCOs may therefore request bankers' statements, financial accounts, statements of turnover, statements of previous relevant experience and statements of average annual manpower. The PCO should give a clear and unequivocal commitment to preserve their confidentiality and use them only for the purpose requested. This is especially important should the PCT's provider arm be involved in a competing bid.

Ensuring a level playing field – pre-qualification criteria

The information requested by the PCO as part of the pre-qualification questionnaire must reflect the declared shortlist criteria and be relevant to the service. It is usual for PCOs to evaluate the prequalification questionnaire information on the basis of a pass/fail system.

During the procurement process potential contractors should have the opportunity to ask questions of the PCO and will usually have an opportunity to attend briefings.

Ensuring a level playing field – relations with the PCO during the procurement process

The Department of Health recommends that briefing meetings are held during procurement processes and that individual enquiries which are answered for one tenderer should be copied to all to ensure a level playing field. The decision not to attend briefing meetings should not be held against prospective bidders and notes of all questions and answers at any briefing meeting should be copied to all tenderers.

Submitting a bid

In some cases, the PCO will provide potential bidders with a business case pro forma for tendering for the APMS contract. This provides bidders with a framework on which to build their bid, even if use of the pro forma is not compulsory. PCOs may, for example, direct bidders to explain their strategies for meeting PCO requirements regarding access, quality, service provision, training, patient liaison and service management and monitoring. PCO tendering packs may also set out considerations that potential providers are required to take into account in their bids (in the past these have included use of information technology and waste disposal). This too will help bidders to write a comprehensive response.

In the absence of a pro forma, bids are likely to need to cover the following:

1. Name of the provider making the bid
2. Service aim – a statement summarising the main purpose of the service which could also refer to the principal health gains to be achieved
3. Service objectives – a statement describing how the main objectives of the proposed services will be achieved referring to the practice's relevant expertise in the area.
4. Anticipated commencement dates for service provision
5. Management arrangements – including the name of the service manager, the member of the practice team who will be responsible for establishing and maintaining the service, other proposed staffing, job descriptions and responsibilities.
6. Relationships with other providers/agencies – arrangements for ensuring co-operation should be explained, for example 'we intend to establish both formal and informal links with the local hospital physiotherapy service, and the currently limited community based service, to avoid duplication of these'. Bidders may also wish/be asked to outline plans for taking forward practice based commissioning as part of the service.
7. Timetable for developing the service, which could include both a short term timetable and longer term timetable encompassing service evaluation and necessary modification
8. Resources and level of support required from the PCO
9. How the service and service delivery will be evaluated by the practice, possibly including for example an assessment of value for money, impact on waiting lists etc.
10. Additional supporting information e.g. the medical aspects of the service to be offered, the population and its needs, the particular strengths and interests of the practice and individual members.

Potential bidders shortlisted by the PCO on the basis of their tender will generally be required to attend a further selection process including, for example, an interview and delivery of a presentation.

Pricing the contract

When tendering for APMS contracts GPs need to cost all the components of any service they are proposing to provide. These costs, which include the expense of acquiring and maintaining new skills, the time and resources incurred by the GP and/or practice manager in organising a service, and the staff, premises and equipment actually used to provide it, must all be met if a service is to be financially secure and successful. For example, practices should be careful not to sign a contract requiring extended opening if they do not have the staff to deliver this. PCOs may ask bidders to compare the costs of their model of provision with the available contract value.

Providers should research local service provision before deciding on whether to tender for specific APMS contracts. It is important to remember that there may be opportunity costs when practices provide a new service if other current commitments are dropped to accommodate the new work. Any such loss of practice income should be assessed when bidding for the new service.

It may be helpful to summarise the resources required for the bid and to then provide a detailed analysis of costs. Detailed breakdown of specific costs such as that for specialist equipment could be included in an annex. Potential providers will need to estimate the level and range of staff required to deliver the services outlined in the service specification and should think about how these staff will be secured. In some cases potential providers will need to consider the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) arrangements. These regulations preserve employees' terms and conditions when a business, or part of one, is transferred to a new employer and are discussed in further detail below under 'continuity of employment'.

PCOs may be willing or expecting to offer a period of guaranteed funding to new providers while services are established. Such payments may help to counteract the risks involved in taking on new services but are also open to accusations of unfairness, particularly where GMS and PMS practices in the same area are not entitled to similar guarantees. GPs wishing to engage in APMS will wish to establish how the APMS contract will be funded throughout its duration.

Summary of resources required

	Planned current year	Equivalent full year costs	Second year costs
Revenue			
Capital			

Detailed analysis (possible headings)

	Current year	Full year costs
REVENUE Staff pay* including national insurance contributions, 'on cost' (sick pay, holiday pay and other employers' liabilities) Non pay items including: <ul style="list-style-type: none"> • Training • Staff unions • Practice management charge • Other practice overheads • Protocol development Other revenue includes <ul style="list-style-type: none"> • Premises rental • Premises heating • Lighting • Cleaning • Maintenance • Stationery • Office consumables • Rates 		

TOTAL REVENUE		
CAPITAL Including as applicable:		
<ul style="list-style-type: none"> • Room refurbishment⁺ • Minor building works⁺ • Specialist medical equipment • Other medical equipment • Computer and software maintenance • Office equipment 		
	+ VAT where appropriate	
TOTAL CAPITAL		

* Staff costs are at 2006/07 price based. Costs in future years will increase in line with NHS pay awards and non-pay inflation

+ These will be one off 'start up costs' and can be itemised as such. Some services will not require any capital investment. The extent to which start up costs are included will depend on the extent to which the facilities to be used are dedicated to the new service.

APMS contracts

There are no statutory requirements for the price of APMS contracts, the price of each being negotiated locally by the PCO and provider (local and national components in pricing arrangements for the national procurement outlined in the White Paper are as yet unclear, but it must be presumed there will be an element of national arrangement involved).

A contract template has been drafted by the legal firm Bevan Brittan with the assistance of the Department of Health and the NHS Procurement and Supplies Agency (PASA) in conjunction with the NHS Confederation. This can be found on the NHS Confederation's website: www.nhsconfed.org/docs/apms_contract_template.pdf. This incorporates the mandatory terms for an APMS contract required by the 2004 Directions, some of which are not relevant to all contracts. The Department of Health's APMS guidance advises that although PCOs need to ensure that APMS contracts reflect the directions, there is substantial freedom for PCOs to develop APMS contracts. The Bevan Brittan contract is, in fact, not mandatory. Anyone taking on an APMS contract would be well advised to take legal advice, particularly as in some cases APMS contracts will entail significant risk for the provider. Even where the model contract is used, it should be noted that, as the NHS Confederation has pointed out, a number of issues are not addressed by the contract and will need to be considered on an individual basis, as follows:

Specification

The contract will need to specify the service to be provided at a level of detail which may vary between contracts. The specification may focus on outputs or both output and process. The specification will be linked to quality provisions and, in the case of essential services provision, to the patient list. APMS contractors operating with registered lists should check the provisions for list closure and PCO assignment of patients. The specification may borrow provisions from the GMS contract in relation to patient lists or additional services. Where the service is not attached to a patient list the specification should be clear about the patient groups for whom it is to be provided.

Payment

The contract must detail the payment method and will set out whether payment is to be fixed price, volume or performance related. The PCO may also build in provisions dealing with access to financial information. For long-term contracts the contract should make provisions for price variation.

Premises

The contract should ensure that premises are fit and appropriate for purpose and, if the PCO is providing the premises, either the contract or a separate lease or licence will have to set out user rights.

Staff and pensions

If the service is replacing an existing service the contract may need to outline issues arising under TUPE. See below for more information on pensions under APMS.

Training and workforce planning

PCOs may wish to include provisions dealing with access to training by contractor staff and provisions to require trainee placement where appropriate.

Equipment

If the PCO will be making equipment or other facilities available the contract will need to include provisions for risk, repairs and renewals.

Exit strategy

There are provisions for termination of the contract in the model contract template but individual contracts may include additional specific provisions for termination or re-tendering.

Communications, review and the provision of information

There are provisions in the contract template dealing with communication, review and the provision of information but individual contracts will reflect what is relevant to each situation. The contract will outline what information is required and to what use it will be put, the information the PCO needs to be able to supply to others, the information the PCO requires the contractor to provide to third parties and arrangements for contract monitoring.

Warranties

If there are specific issues on which the parties are relying on information it may be desirable to include warranties for the information provided.

Governance structure

The contract template does not set up any specific governance structure and consideration may need to be given in appropriate cases for a review board.

In addition to some of those contract considerations outlined above by the NHS Confederation, the Department of Health's APMS guidance states that PCTs should consider the following when drawing up contracts:

- **List arrangements.** The PCT must establish and maintain a registered list of patients to be held on behalf of the contractor, and have systems in place for registration and removal of patients from the list, in the case of essential services.
- **Performance monitoring and reporting arrangements.** When stipulating quality standards to be adhered to, it is up to the PCT to negotiate a method for monitoring adherence to these standards.
- **Termination and sanctions in respect of contracts.** APMS contracts must stipulate the circumstances in which sanctions, up to and including termination of the contract, may be imposed, and the procedure by which they may be terminated.
- **Subcontracting arrangements.** The PCT has discretion to negotiate arrangements under which subcontracting will be allowed, if at all, with the contractor. Directions stipulate certain circumstances in which subcontracting will not be allowed.
- **Complaints procedure.** The PCT has discretion to negotiate a complaints procedure with the contractor, until regulations are made to establish a common complaints procedure which will cover all primary care contracting routes.
- **Dispute resolution procedure for organisations without NHS body status.** The PCT has freedom to negotiate an appropriate dispute resolution process to be stipulated in the contract. It is recommended that the PCT considers including non-binding independent arbitration or adjudication procedures.

Working for an APMS provider

Many GPs are likely to choose to bid for APMS contracts in order to provide services under the new arrangements. APMS will also undoubtedly have considerable implications for sessional GPs who may be employed, by other GPs or by commercial or voluntary sector organisations, to perform services commissioned through APMS contracts.

APMS and use of the salaried model contract

Only GMS practices and PCOs are obliged to employ salaried GPs under nGMS model terms and conditions of employment using the salaried GP model contract. These minimum terms and conditions do not apply to doctors employed by contractors providing services under APMS or PMS arrangements, although many PMS practices do use this employment model. Some APMS providers may choose not to use the salaried model contract in order to contain staff costs. Whether or not this is a sustainable option will depend largely on whether salaried GPs are prepared to accept work under poorer conditions than those offered by the contract. LMCs may also be able to negotiate use of the salaried model contract as a requirement for APMS providers bidding for contracts. GPs considering employment by an APMS provider not using the salaried model contract should be particularly aware of the following risks:

- a decrease in entitlement of annual leave from six weeks to the statutory minimum of four weeks
- disputes over pro rata entitlement to bank holidays for part-time salaried employees
- demise of protected time for CPD
- loss of current terms for maternity leave, and a resulting return to statutory maternity pay or maternity allowance
- loss of current terms for sick leave, and the resulting return to statutory sick pay
- loss of automatic LMC membership (though the salaried GP will still be entitled to join the LMC)
- increased work hours
- possible loss of any financial support given for professional fees.

The BMA can advise members on employment contracts. Members requiring advice can contact askBMA on 0870 60 60 828.

The GPC does not wish to see APMS employed GPs disadvantaged in relation to their GMS and PCO-employed colleagues and recommends that APMS providers use, as a minimum, the terms set out in the salaried model contract. Failure to do so could result in poor recruitment and retention with migration of salaried GPs to GMS or PCO practices.

Continuity of employment

Continuity of NHS employment has important implications for maternity and sickness benefits and for seniority pay. NHS Employment is defined as the total of the periods of employment by an NHS Trust, PCO, Strategic or Special Health Authority, or any of the predecessors in title of those bodies or the equivalent bodies in Wales, Scotland and Northern Ireland, together with the total of the periods during which the practitioner provided or performed primary medical services. GPs employed by APMS providers will usually be providing primary medical services, although some APMS contractors providing out-of-hours services may be involved in more extensive care.

If the APMS service is replacing an existing service it may be affected by TUPE (regulations which preserve employees' terms and conditions when a business, or part of one, is transferred to a new employer). Generally speaking, staff employed in an existing undertaking will transfer to a

new undertaking, carrying on the same business on existing terms of employment except for pensions. Individuals have the right to object to being transferred to a new provider. Normally this would result in them being deemed to have resigned but there is a possibility that the previous employer can agree to retain them and supply their services to the new provider. The NHS Confederation's model APMS contract contains clauses relating to TUPE.

Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE)

TUPE provides protection for employees following the transfer of the business in which they are employed. It acts to ensure that following a transfer the new employer is bound to take over the role and duties of the old employer. This means that the new employer inherits the contractual terms, rights, powers, duties and liabilities owed by the previous employer to the employee. This will include liability for any wages owed or where there is an unresolved claim regarding, for example discrimination, the new employer will be responsible.

Any employee who was employed immediately before the transfer of the business or who was dismissed in advance but in connection with the transfer will be protected (unless the employer can show that the dismissal was due to an economic, technical or organisational reason unrelated to the transfer).

Employees who do not want to transfer to a new employer should note that because continuity of employment is not broken under TUPE, there is no entitlement to a redundancy payment. However, as of 6 April 2006 there is an obligation for employees to be informed and consulted prior to transfer of employer. The provisions of TUPE are complicated. The statutory instrument can be found here: www.opsi.gov.uk/si/si2006/uksi_20060246_en.pdf but BMA members are advised to contact the BMA for more detailed advice where this is needed.

APMS and other key considerations

APMS and pensions

If an APMS provider is an NHS trust or a foundation trust, staff will have the same pension rights as other NHS trust or foundation trust employees. In addition, the NHS Pensions Scheme Regulations were amended in April 2005 to allow Scheme membership for certain APMS contractors. APMS contractors that offer NHS primary medical services and that would be eligible to enter into a GMS contract or PMS agreement with a PCO can apply to the NHS Pensions Agency for NHS Pension Scheme Employing Authority status. Where granted, its staff (including GPs) will be able to participate in the NHS Pension Scheme. Staff working for these APMS providers will therefore be able to continue to contribute to, or to join, the NHS pension scheme.

APMS providers who are only eligible for APMS contracts are supposed to be required to provide 'similar' pension arrangements, but this is probably not enforceable. There is considerable leeway in the use of this term and these private arrangements may be less favourable than the NHS pension scheme. The NHS Confederation had suggested that consideration may need to be given to obtaining Government Actuary's Department (GAD) certificates on an equivalent pension scheme if there are staff transferring from the public sector to a new contractor (because of TUPE).

The eligibility criteria for holding GMS and PMS contracts is set out in GMS and PMS regulations 4 and 5. As these are effectively also the qualifying conditions for receiving NHS Pension Scheme Employing Authority Status, profit-making companies limited by shares which include a GP will be able to provide NHS pensions, as long as none of the shareholders falls under the categories in regulation 5. Companies limited by guarantee are another matter as these are not mentioned in the regulations as qualifying for GMS or PMS contracts. Consequently, some companies with APMS contracts will qualify for the NHS pension scheme while other similar companies with a slightly different mix of share-holders will be ineligible for Employing Authority status. It is possible that by establishing a subsidiary company, with a share held by a qualifying GP or health professional, even those companies which are themselves ineligible for the NHS pension scheme, may be able to operate as an APMS provider with access to the scheme. Hence, large parent-company corporations, by distancing themselves from their public-ownership may be able to provide, indirectly, APMS services with an NHS pension scheme. This can be achieved, for example, through a financial collaboration with a smaller, privately-owned company which qualifies for GMS and PMS contracts.

Ensuring a level playing field – pensions

The White Paper *Our health, our care, our say: a new direction for community services* identified pensions issues as a barrier for the 'third sector' competing for services on a level playing field and committed to look at tackling these issues. In fact, there would seem to be a variety of potential consequences of the various pension scheme arrangements for APMS contractors. Ineligibility for the NHS pension scheme may, as the White Paper suggests, dissuade some health professionals from working for certain APMS contractors. However, the fact that some APMS contractors cannot or can choose not to offer NHS pension scheme benefits also means that they may be able to bid to provide services at a lower price than those contractors who provide access to NHS pension benefits. This may prevent services from being tendered on a strictly level playing field but the best possible solution is unclear. In any case, it seems that, for now, the issue of whether NHS staff transferring to alternative providers can retain their pension rights is still under discussion.

When a salaried GP is employed by an APMS provider which has not been approved for NHS employing authority status, any previous NHS pension contributions will be preserved until retirement or until it is transferred out to another provider, providing they have accrued more than 2 years of NHS service. Advice should be sought regarding the transfer values of contributions either from the NHS Pension Scheme to pension schemes offered by APMS providers or from pension schemes offered by APMS providers back into the NHS Pension Scheme. It should be noted that a GP working for an APMS contractor which is ineligible for the scheme, in addition to working for an eligible contractor, will not lose their rights to an NHS pension for that work undertaken for the eligible provider. GPs will not be able to contribute to the NHS scheme unless they are working for an eligible contractor. GPs should also be aware that APMS providers which are eligible for the NHS pension scheme are not obliged to provide NHS pensions to their employees.

Any member concerned about their pension rights should contact the BMA's pensions department for advice.

Governance arrangements for APMS

The APMS directions essentially mirror the GMS/PMS regulations but these regulations are cross referenced in the short APMS directions. This raises the possibility that APMS providers will use the directions without adequate understanding of, or adherence to, those regulations which are not listed in the APMS directions

There are fewer rules and regulations governing APMS than GMS, PMS or PCTMS. However, while these arrangements are governed by service level agreements between the commissioner and provider, APMS is usually governed by legally enforceable provisions. Since the contract need not be an NHS contract, different mechanisms will be/are in place for resolving disputes and breaches of contract and these mechanisms, which will reduce the risk of litigation, should be specified for contracts at law.

APMS providers, training and education

There has been considerable debate about the possibility of training NHS junior doctors in independent sector treatment centres (ISTCs) but this is partly because ISTCs often have a limited scope of work and mix of patients and sometimes lower complexity of cases. Where APMS providers are contracted to provide essential services to specific populations, these considerations will not be relevant and, in theory, they should be able to provide training to GP registrars, subject to the posts being quality assured; the APMS directions require contracts to include the clauses from the PMS regulations on GP registrars and training.

GPs providing primary medical services under APMS contracts must be on the performers list and must therefore undertake appraisal. It is critical that practitioners operating under APMS are subject to the same performance processes, checks and balances as other practitioners because APMS is providing NHS services to NHS patients.

APMS providers and Freedom of Information Act requirements

Despite providing NHS services to NHS patients, APMS providers are not currently covered by the Freedom of Information Act in their own right because they are not necessarily public authorities, or specified as being treated as such by the Act. Guidance from the NHS Confederation does suggest that contracts should include a clause requiring the contractor to respond to Freedom of Information requests as if covered by the Act. However, the GPC does not believe that current arrangements are adequate to ensure a level playing field for different providers and is pursuing this issue. In the mean time, PCOs can be approached for information

on their APMS contractors, though they may often argue that the information requested is commercially sensitive and therefore exempt from disclosure. There are set procedures for appealing refusals of requests for information under the Freedom of Information Act. The PCO's internal appeal mechanisms should first be exhausted. Where internal appeal does not produce a result, cases can be appealed to the Information Commissioner. Extensive information on the requirements of the Act and appeal mechanisms can be found on the Information Commissioner's website: www.ico.gov.uk/

APMS providers and the law on sale of goodwill regulations

Under the NHS Act 1977, it is unlawful to sell the goodwill or any part of the goodwill of the practice. The Primary Medical Services (Sale of Goodwill and Restrictions on Sub-contracting) Regulations 2004, which have been in force since 1 April 2004, relax this ban in relation to enhanced, out-of-hours and additional services, but not in relation to essential services. If premises previously used for the purposes of essential medical practice are sold for a sum substantially in excess of the consideration which might reasonably have been expected if the premises had not previously been used as a medical practice, it may be deemed that there has been a sale of goodwill. Sale of goodwill is a very complex matter, further advice on which can be found in separate guidance from the BMA's General Practitioners Committee (GPC), but specialist legal and accountancy advice is recommended.

Commissioning services from an APMS provider

How can practices form an APMS arm for PBC

Practices which are collaborating for the purposes of practice based commissioning (PBC) may in some cases wish to form a distinct organisation, operating under an APMS contract, to enable the provision of some of those services which will be identified by PBC. Further information on the organisational and legal basis of these new bodies can be found above under 'how to work collaboratively under APMS'.

Practices who have either already formed provider organisations for the purposes of PBC, or are in the process of doing so, may wish to consider how their services can be best promoted locally. Although there are still considerable concerns over the Choose and Book (C&B) initiative, it would still be worth provider organisation looking at registering their details on the C&B directory of services, which does the following:

- holds information that describes the services that organisations offer
- enables referring clinicians to search for appropriate services to refer patients
- provides a window through which providers can promote their services
- holds the commissioning rules between a PCT and provider
- provides patients with a list of suitable providers for their treatment

More information can be found online at the following website address:

www.chooseandbook.nhs.uk/staff/dos/

GMC good practice guidelines state that doctors with financial or commercial interests in organisations providing health care must not let this affect the way in which they prescribe for, treat or refer patients. Doctors are expected to tell their patients and the health care purchaser about any financial or commercial interest in the organisations to which they are being referred.

Ensuring a level playing field - commissioning

PCOs have been told that they must be aware of any potential conflicts of interest including, for example, where the APMS provider is also involved in practice-based commissioning or where the provider is linked with a drugs company or secondary care facility. It should also be noted that there may be a potential conflict of interest if the PCT is part of a LIFT consortium bidding for an APMS contract with the same PCT.

Sources of further information

The BMA's general practitioners committee will continue to monitor policy developments surrounding APMS and will update this guidance as necessary. It will also take a proactive lead wherever the need for firm policy or central intervention arises.

Local Medical Committees (LMCs) are also able to provide GPs with advice and support on APMS issues and should play a key role in consultations with PCOs on the development of local services.

The NHS Confederation has produced a contracting guide for PCTs, *Alternative providers of medical services: a contracting guide for primary care trusts*. This can be found on its website: www.nhsconfed.org/publications/reports/apms_contract_guidance.asp

A contract template has been drafted by the legal firm Bevan Brittan with the assistance of the Department of Health and the NHS Procurement and Supplies Agency (PASA) in conjunction with the NHS Confederation. This can be found on the NHS Confederation's website: www.nhsconfed.org/docs/apms_contract_template.pdf

The NHS Purchasing and Supply Agency has a detailed procurement guide for APMS. This is designed for PCTs but may also be helpful for potential providers seeking to understand the procurement process for APMS. Thus guidance is available from PASA but is not publicly available. In addition to setting out in detail the procurement process for APMS, this PASA guidance contains appendices of sample: advertisements, pre-qualification questionnaire, abbreviated output based specification and contract acceptance and rejection letters. PASA's website address is www.pasa.doh.gov.uk/

The Department of Health also produces guidance on procurement in the form of its *Desk guide to procurement* which can be found at: www.dh.gov.uk/assetRoot/04/12/00/75/04120075.pdf

¹ Marshall M & Wilson T (2005) "The NHS revolution: health care in the market place. Competition in general practice". *BMJ*. **331**: 1196-9.

² Marshall M & Wilson T (2005) "The NHS revolution: health care in the market place. Competition in general practice". *BMJ*. **331**: 1196-9.

³ The NHS Confederation (2005) *Alternative providers of medical services: a contracting guide for primary care trusts*. London: NHS Confederation.

⁴ Department of Health *Desk guide to procurement*

⁵ The NHS Confederation (2005) *Alternative providers of medical services: a contracting guide for primary care trusts*. London: NHS Confederation.

⁶ The NHS Confederation (2005) *Alternative providers of medical services: a contracting guide for primary care trusts*. London: NHS Confederation.

⁷ The NHS Confederation (2005) *Alternative providers of medical services: a contracting guide for primary care trusts*. London: NHS Confederation.

⁸ NHS Purchasing and Supply Agency (2005) *Procurement guide – APMS*. NHSPASA: London.

⁹ Paragraph 3. The National Health Service Act 1977 Alternative Provider Medical Services (No.2) Directions 2004.