September 2004

GPC

General Practitioners Committee

Personal medical services (PMS) agreements

Guidance for GPs

BMA

Personal medical services (PMS) agreements

PMS is a locally-agreed alternative to General Medical Service (GMS) for providers of general practice. Legislation has allowed for PMS since 1997 (with the entry into force of the Primary Care Act) but it is only in recent years that the number of practices choosing PMS has grown rapidly. Now almost half of general practices have PMS agreements.

In Scotland, PMS practices are now called Section 17 c practices (a reference to the relevant section of the Primary Medical Services Act). They constitute around 10% of all GP practices in Scotland. There are no PMS practices in Wales and Northern Ireland.

The defining feature of PMS agreements is their local nature. Unlike GMS contracts, they are negotiated between the PCO and the practice, and are not subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the BMA. Nevertheless, the new national GMS contract, which came into force on 1 April 2004, has had a strong impact on PMS policy and on the contents of PMS agreements. Moreover, the GPC is consulted, together with other organisations, on the development of PMS and provides valuable input to proposed legislative changes as well as on many other PMS-related matters.

This document is concerned mainly with how PMS has changed as a result of the new GMS contract. It is also intended as a general introduction to any practice considering entering into a PMS agreement.

1. Permanence

Until 1 April 2004, PMS agreements were "pilot" agreements. This meant that they were experimental and could not necessarily be considered permanent arrangements. However, the pilot phase of PMS is now over and, from 1 April, all existing PMS agreements have become permanent. The introduction of PMS agreements by way of centrally-coordinated, twice-yearly "waves" is over. As a contractual option, it is now on an equal footing with GMS and practices and PCOs can negotiate and sign PMS agreements at any time without needing to apply to the Secretary of State.

This fundamental change in the status of PMS agreements was set out in a letter from John Hutton to PMS GPs dated 15 October 2003. The letter stressed that making PMS permanent and transferring elements of the new GMS contract to PMS, should not lead to existing PMS agreements being "unpicked". Although the meaning of "unpicked" is ambiguous, the general intention is that the national changes to PMS policy should not disrupt local PMS agreements, or cause them to be re-written from scratch.

New PMS regulations came into force on 1 April 2004 and made permanence official. These are the *National Health Service (Personal Medical Services) Agreements 2004 Regulations* and they can be found on the HMSO website (www.hmso.gov.uk). Section 4 of this guidance covers some of the most important aspects of the new regulations, which introduce to PMS much of the regulatory regime of new GMS.

Most financial aspects of PMS remain ungoverned by statutory instruments. This is in marked contrast to new GMS, which is underpinned by a national, guaranteed system of payment laid down in the Statement of Financial Entitlements (SFE). So despite the broad equivalence of GMS and PMS in certain areas of law and policy, PMS remains a genuinely local agreement as far as practice level finance is concerned.

Practices should only enter a PMS agreement if they are confident with this fact and fully aware of its implications, which are laid out in more detail in this guidance note.

2. PMS and new GMS

Many elements of the new GMS contract – some involving new sources of funding - have been applied to PMS. These include;

- Quality and Outcomes Framework
- Ability to transfer responsibility for out of hours
- Enhanced services
- New premises flexibilities
- IT investment
- Seniority improvements
- Superannuation improvements

This section addresses how they relate to PMS. The new GMS contact documents are all available at http://www.bma.org.uk/ap.nsf/Content/__Hub+GPC+contract

2.1 Quality and outcomes framework (QOF)

The QOF is a system of paying practices for providing set levels of quality that are pre-specified and measured using detailed, evidence-based indicators. It uses a points system to translate achievement into payment after adjustments for average list size and, if applicable, prevalence of the disease area covered. It is an important new source of income for GMS and PMS practices.

To make sure that the quality of general practice is consistent across PMS and GMS, and to ensure equitable access to funds between PMS and GMS practices, the Department of Health agreed that PMS practices should be able to participate in the QOF. However, because the Statement of Financial Entitlements applies only to GMS, the participation of PMS practices in the QOF is not directly governed by regulation. As a result, PMS practices and PCOs can agree that the practice uses a varied version of the QOF, which could include different quality specifications and targets, although these must be evidence-based and at least as good than the QOF standard.

<u>The QOF points "offset"</u>

By introducing the QOF to PMS practices, the DoH intends to give them equal access to new funds for quality. However, this gives rise to a complication. For PMS practices to have received exactly the same quality payments as GMS practices would have benefited PMS practices to the detriment of GMS practices, as a proportion of GMS cash-limited expenditure (for chronic disease management, sustained quality allowance and half of cervical cytology payments) under the old GMS contract was mapped on to the new quality funds. However, the equivalent money remained in PMS baselines.

Therefore, to ensure that PMS practices in fact have equal access to **new** quality funds only, on a fair and equitable basis with their GMS colleagues, the DoH has recommended a standard deduction of points (which has become known as an "offset") from the achievement points of PMS practices. This has been calculated as 168 points for 2004/2005 (see section 2.7 for why this figure has fallen from the originally agreed 174 points), falling to 109 points for 2005/2006.

Only the agreed number of quality points should be deducted, irrespective of the baseline contract price, in respect of quality. PCOs may attempt to make further deductions because they believe that certain quality payments are included in the baseline contract price. These attempts must be resisted. The nationally determined offset calculation was agreed precisely because of the difficulties inherent in trying to separate PMS finance out into baseline, non-baseline and growth money.

In support of this principle, section 4.3.1 of the DoH guidance on PMS states;

> *"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."*
>
> (*Sustaining Innovation through new PMS arrangements*, section 4.3.1)

Variations to the national QOF

This process of varying the national QOF for PMS practices can become fraught with difficulties. **The GPC encourages all PMS practices to adhere as far as possible to the nationally agreed framework.** If agreeing variations to the national GMS QOF, practices must examine carefully all financial ramifications, preferably after consulting the local medical committee, and ensure that it is not signing up to a more demanding framework for the same rewards. They should also be aware that all the software, including that for monitoring the QOF, is specific to the nationally agreed framework

The DoH suggests the following possible categories of variation:

- Core based on the national QOF plus local add-ons
- Different interventions for related fields
- Fewer interventions for the same disease areas
- Local use of different indicators
- Different evidence base

For further information on the nationally agreed QOF, see GPC guidance *Focus on the Quality and Outcomes Framework* and *Focus on Quality Payments,* which are available at http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance

2.2 Out of Hours

The new GMS contract gives contractors the choice to transfer their responsibility for out-of-hours work. This provision has been extended to PMS. In GMS, the practice's global sum (the basic funding it receives to provide essential services) is reduced by 6% if a practice opts out of out-of-hours.

However, PMS practices do not receive global sums, but contract prices, or "baselines". The DoH has therefore recommended a set method of calculating the opt-out price. This involves calculating an average per-patient cost of opting out of OOH in GMS, equal to £3.31 per patient, then multiplying this by raw list size for the PMS practice.

The process for opting out is broadly the same as in GMS and is set out in Schedule 4 of the National Health Service (Personal Medical Services) Agreements Regulations 2004. It has not been reproduced in full here because of the complexity of the procedure.

2.3 Premises

PMS practices have equal access to the premises "flexibilities" negotiated as part of the new GMS contract and to any new funding to implement premises initiatives.

A separate GPC guidance note, *Focus on Premises Costs*, on this is available at
http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance

The relevant legislation covering premises costs are the National Health Service (General Medical Services – Premises Costs) Directions 2004. Although these are GMS Directions, the intention is for these to be used as best practice for PMS as well. There are no separate directions relating solely to PMS premises costs. The Directions are available at
http://www.dh.gov.uk/assetRoot/04/07/68/20/04076820.pdf

2.4 Enhanced Services

PMS practices have equal access to the funding streams available for enhanced services on the same basis as GMS practices. This is made clear by section 6.3 of *Sustaining Innovation Through New PMS Arrangements.*

> *"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".*

Comprehensive GPC guidance on enhanced services, *Focus on Enhanced Services* and *Focus on the Financial Monitoring of Enhanced Services*, can be found at
http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance

PMS practices are advised to consult these guidance notes for further information and guidance on enhanced services. They will also find it helpful to liaise with their LMC who, in many cases, will have negotiated the local provision of enhanced services.

If there is any clear disparity in treatment between GMS and PMS practices in the commissioning and pricing of enhanced services, the LMC should be consulted and the GPC office informed.

2.5 IM&T

New resources for IM&T must be made available to support both GMS and PMS practices.

For further information and guidance on IM&T see the GPC guidance notes, *Focus on Choice of Nationally Accredited System, Focus on Funding for IM&T* (three updates), *Focus on Exception Reporting*, which are all available at,
http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance

2.6 Seniority

PMS GPs will receive the same increases in seniority pay as GMS GPs will receive under the new contract.

Sustaining Innovation Through New PMS Arrangements suggests two methods of calculating this (for 04/05 and 05/06). The first is to apply the uplifts that GMS GPs received for seniority to the baseline. In this case, the partners have to agree amongst themselves how then to distribute this increase to the more senior GPs. The second method is to calculate a notional entitlement for each partner separately (with reference to what their entitlement would be if they were still GMS) then apply the relevant uplift to that figure.

In 03/04 this generated some confusion, because the uplift in seniority for GMS GPs was rolled up in a global 3.225% uplift to fees and allowances. For ease of administration, therefore, many PCTs simply chose to apply the same 3.225% to PMS, intending it to include an equivalent uplift for seniority.

However, the DoH guidance mentioned above states that PCTs can do this only with the agreement of the practice. Practices should not be pressurised into one method.

2.7 Superannuation

The indexation transfer

There have been major changes to superannuation, both as part of the new GMS contract and as a result of the "indexation transfer" or "Treasury transfer", which is not related to the new contract. (This is the transfer from the Treasury to the NHS of responsibility for the element of pensions contributions arising from the cost of retail price indexation of NHS pensions). This means that employers contributions rise from 7% to 14%. In the case of general practices, this additional burden falls on practices not PCTs, in respect of practice staff.

GP superannuation

The changes to superannuation negotiated under the new GMS contract apply equally to GMS and PMS. There is detailed GPC guidance, *Focus On Superannuation Contributions*, and *Focus on the Dynamisation Factor* on the BMA website at
http://www.bma.org.uk/ap.nsf/Content/focuspension0704

PMS GPs are strongly advised to read this guidance, as the changes are complex. The main development is that GP pensions will in future be based on actual profits, rather than on Intended Average Net Remuneration.

The additional 7% employer superannuation resulting from the indexation transfer for PMS GPs should have been included within the baseline allocation.

Because of the considerable investment in general practice delivered through the new GMS contract and the changes in PMS described in this guidance, practice profits in GMS and PMS will rise. Because GP pensions are now based on actual practice profits, superannuation contributions (employer and employee contributions) will have to rise too.

The GPC has secured considerable new funding for these increased contributions (£88 million across 2004-2006) although it believes that this funding will be insufficient to cover the increased costs in full.

This PMS share of this money will be passed on to PMS practices in two ways. First, through an increase to the PMS baseline and also through a reduction in the quality points offset described in section 2.1 of this guidance. The result of this is that the offset was reduced from 174 points to 168 points for 2004-2005.

There is further detail in the GPC superannuation guidance.

Salaried PMS GP performers

Salaried GPs who became or in future become PMS GP performers for the first time in PMS, will accrue NHSPS membership on an assistant practitioner basis on or after 1 April 2004.

PMS practices who currently hold forms SD55 for salaried GPs accruing NHSPS membership on an officer (non-practitioner) basis, because they became GPs for the first time in pilot PMS, should liaise with their PCO and send a terminal form SD55 to the Pensions Agency showing the "last day of pensionable membership as an officer", as 31 March 2004. The PCO should then send a joiner form SS14 to the Pensions Agency, showing a "commencement date of membership" as an assistance practitioner, of 1 April 2004.

Staff superannuation

A sum has been made available nationally, and passed on to PCTs in their primary medical services allocations, to cover the increase in employers contributions from 7% to 14% for PMS practice staff.
It is up to local negotiation to determine how this funding is distributed to practices, although the GPC has been pressing the DoH to provide clear guidance to PCOs and practices.

Ideally, this money should have been added to PMS staff budgets as part of their 04/05 uplift, but it has become evident that many PCTs did not pass it on or were not aware they had received it.

Despite pressure from the GPC, the DoH has so far been reluctant to direct PCTs to do so. It is important for LMCs and PMS practices to be aware that a transfer of money was made to PCTs, whether they are aware of this or not.

3. PMS finance

Despite the fact that PMS agreements are now subject to a consolidated set of regulations, most financial matters are still determined by local negotiation. The PMS agreements regulations do not cover finance and so they do not offer the national protection provided by the new GMS contract, which has a binding Statement of Financial Entitlements (SFE). National Guidance is however contained in the National Association of Primary Care PMS Agreements Framework (Version 3.1) in Section 5 and in the AWP(04-05)PCT26 of 6 February 2004 allocation letter. Practices considering moving from GMS to PMS must be aware of this, and should only proceed to PMS if they are confident about the local nature of PMS finance.

3.1 Growth

During the pilot phase, many PMS practices received "growth" money from a central fund to pay for additional doctors or practice nurses. This central fund no longer exists and the costs of extra staff in PMS practices must be met from PCOs' unified budgets.

However, practices that have received "growth" money in the past are entitled to keep it in their baselines and use it flexibly, provided it benefits the patient population.

This is confirmed in John Hutton's letter to all PMS practices of 15 October 2003 which said

> *"The Government's commitment to "no unpicking" means that you will be able to retain the baseline funding you receive now, together with any growth monies you have been awarded during the piloting process, as part of your PMS contract price after 1 April 2004. This includes those considering*
> *signing PMS contracts shortly. The growth money that has already been agreed will be for you to use flexibly as part of your local agreement. It will no longer be restricted to its current use for GPs and nurse practitioners".*

The full text of this letter is available on the internet at
http://www.dh.gov.uk/assetRoot/04/07/94/39/04079439.pdf

3.2 Payments for specific purposes

There are English directions (The Personal Medical Services Agreements (Payments for Specific Purposes) Directions 2004) covering payments for the following:

- Golden Hello Scheme
- Flexible Career Scheme
- Returners' Scheme
- Doctors' Retainer Scheme
- Prolonged Study Leave

These directions are available on the Department of Health's website www.dh.gov.uk.

3.3 Annual uplifts

Although there is no national agreement on annual uplifts to PMS baselines, the GPC would expect these to be in line with future increases in the GMS global sum and this is echoed by the DoH guidance

> *"Uplift to PMS baselines will be proportionately equivalent to the uplift in baseline funding given to the same services delivered through GMS contractual arrangements".*
>
> [Sustaining Innovation Through New PMS Arrangements states, paragraph 6.5]

It is highly unlikely that the DDRB will recommend future uplifts for PMS practices, as it is no longer doing so for GMS practices.

There have been incidences of PCOs applying uplifts only to certain elements of the PMS budgets (for example, only to growth monies or discretionary elements). The GPC considers this totally unacceptable and believes uplifts awarded should apply to the entire baseline budget.

4. The PMS regulatory framework

Like GMS contracts, PMS agreements are now subject to a set of consolidated regulations – *The National Health Service (Personal Medical Services Agreements) Regulations 2003*, with which all agreements must comply.

Agreements signed after 1 April 2004 must be drawn up to comply with these regulations. Existing agreements must, under transitional arrangements, have been brought into line with the regulations by 30 September 2004, either by introducing the necessary variations, or by signing completely new contracts. There are a number of models contracts available.

If the necessary variations have not been made by then or no new agreement signed by 30 September 2004, the PCT may (under the *General Medical Services and Personal Medical Services Transitional and Consequential Provisions Order 2004*) vary the agreement without the consent of the contractor but only to the extent that is required to make the existing agreement compliant with the new PMS Agreements Regulations.

The PMS agreements regulations carry across a great deal of the content of the *National Health Service (General Medical Services) Contracts Regulations 2004*. They deal with such matters as the OOH opt-out procedure, list closure procedure, restrictions on private practice, removal of patients from lists, prescribing and complaints procedures.

It would be pointless to provide here a summary of the regulations in their entirety. Any disputes arising from them can only be resolved with reference to the actual regulations. However, there are a few areas which are worth mentioning in this guidance.

4.1 List of patients

The regulations require that it is the contractor who has the list and patients now register with a contractor rather than individual GPs, i.e. it is a practice list as in the case of GMS.

4.2 PMS Provider Status

The following are eligible to become PMS providers, i.e. enter into a PMS contract:

- medical practitioners who meet the conditions set out in the new PMS regulations;
- health care professionals (including General Dental Practitioners) who meet the conditions set out in the new PMS regulations;
- NHS employees;
- employees of PMS or PDS providers
- individuals providing services under a GMS, GDS, PMS or PDS contract
- PCTs or Local Health Boards (LHB);
- NHS Trusts (including NHS Foundation Trusts).

4.3 Right to refuse to register new patients

This is a controversial area in both GMS and PMS. The GPC has produced a guidance note, *Focus on Patient Registration*, which gives its legal interpretation of the regulations. This is available at http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance

Readers of this guidance should note that the relevant paragraph of the PMS Agreements Regulations is Regulation 16 of Part 2 of Schedule 5, as opposed to Regulation 17 of Part 2 of Schedule 6 of the GMS Regulations.

4.4 Dispute resolution

Part 7 of Schedule 5 of the Regulations sets out the procedure for dispute and appeals. Note that the function of the Secretary of State with regard to disputes over proposed or actual PMS agreements has been delegated to the Family Health Services Appeals Authority (FHSAA) under the *Directions as to the function of the Family Health Service Appeal Authority (PMS Agreement Dispute) 2004*.

Family Health Services Appeals Authority
30 Victoria Avenue
Harrogate
HG1 5PR

Appeal enquiries: 01423 535411
e-mail: mail@fhsaa.nhs.uk
website: www.fhsaa.org.uk

4.5 NHS body status

Unlike in GMS, PMS practices must opt **not** to have health service body status. They must do so by written notice before the agreement is made. If the agreement has already been signed, the contractor can request a variation to the contract to remove the health service body status provision. The choice should be entirely a matter for the contractors and PCTs should not exert pressure on them either way.

For information on what health service body status entails, see GPC guidance, *Focus on NHS Body Status*, which is available at
http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance

5. Movement to GMS

Before 1 April 2004, individual doctors had a right of return to PMS. Under the PMS Agreements Regulations, this right now applies to contractors, rather than individual doctors. Return to GMS is therefore now a practice decision (see part 6, Regulation 19).

The contractor must notify the PCO that it wants to enter into a GMS contract three months before the date on which it wants the GMS contract to take effect. The notice to the PCO must specify the date on which the contractor wants to terminate the PMS agreement, the names of the persons with whom the contractor wishes the PCO to enter into a GMS contract and to confirm that those persons meet the relevant conditions (as set out in Regulations 4 and 5 of the GMS Contracts Regulations).

There is no agreed formal mechanism for determining the financial position of PMS practices who wish to enter into a GMS contract. Whilst these practices have no statutory right to a Minimum Practice Income Guarantee (the income protection guarantee that GMS practices had on transfer from the old to new GMS contract), John Hutton's October 2003 letter to PMS GPs stated

> *"A PMS pilot practice could make a strong and robust case for having an MPIG from 1 April in discussion with the PCT. The practice would be expected to provide the data which could be assessed by the PCT using:*
>
> *- the local data on payments for Global Sum Equivalent items that they may have available for the pilot; this might include some or all of growth monies relating to contract variations forming part of the practice's Global Sum Equivalent*
>
> *- a national average calculation (if the supporting data are not robust enough to do the calculation) based on PMS earnings and GSE".*

There is no automatic entitlement to retain growth monies on movement to PMS. However, the Hutton letter stressed that this should be allowed "*where a practice provides evidence that some growth should form part of the GSE*". If the growth money is retained, the PCO may use it for the benefit of patients across GMS and PMS practices.

There is some further guidance on this in section 6.12 of *Sustaining Innovation Through New PMS Arrangements.* However, at the time of writing no more detailed guidance had been produced.

6. Practice-led commissioning in PMS

At the time of writing, the Department of Health has plans to introduce "practice-led commissioning" through PMS agreements. This proposals are defined in very vague terms, but the intention is to allow practices, or consortia of practices, to "take responsibility for", while not actually holding, a budget to use for procuring the delivery of specified services to their patients, essentially making them commissioning agents of the PCO. It may be possible to then reinvest any savings made in patient services in general.

This guidance will be updated when the proposals become clearer.

7. Appraisal funding

£13 million has been made available nationally to fund appraisal for PMS. £7.15 million is intended for PCO-administered resources and £5.85 million for contractor payments. This is based on a 55:45 proportional split of available funds, and the same method is being used in GMS.

PCOs will therefore retain 55% of the funding in order to make contributions to the costs of appraisers, as well as the appraisee costs of doctors directly employed by PCT and locum GPs. The remaining 45% of should be distributed to PMS contractors

8. Political representation of PMS GPs

Local representation

Although PMS GPs do not have to pay the statutory levy to local medical committees, they can be asked to make a voluntary contribution to the running of the LMC. Most LMCs have developed considerable expertise in PMS-related matters and are able to offer their PMS GPs a comparable level of local representation to GMS GPs.

National representation

PMS GPs are represented nationally through the GPC negotiating team and the GPC PMS subcommittee, which is made up of regionally-elected PMS GPs. Any queries on PMS matters can be referred for consideration by this subcommittee by sending them to John Maingay at the GPC office, preferably by e-mail to jmaingay@bma.org.uk. Responses to queries sent by mail may take considerably longer.

9. Further reading

Sustaining Innovation Through New PMS Arrangements (March 2004)
Delivering Investment In General Practice: implementing the new GMS contract (December 2003)
(both available at www.dh.gov.uk)

National Association of Primary Care PMS Agreements Framework (available at www.napc.co.uk)
Version 3.1 29/03/04

PMS GPs and The Future – Letter from John Hutton to PMS GPs (October 2003) (available at http://www.dh.gov.uk/assetRoot/04/07/94/39/04079439.pdf**)**

Allocation Letter AWP(04-05)PCT 26 of 6 February 2004