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Alternative providers of medical services

a contracting guide for primary care trusts

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Executive summary

With the broader range of service providers now available to PCTs, negotiations and contracts need to be appropriate to the parties involved and the service to be provided.

EU principles require that the system for procuring the service of a provider be fair and transparent. In practice, although advertising for tenders is not a requirement, this is likely to be the favoured route to approach potential providers; in many cases, not advertising may risk the challenge that the selection process was not truly open.

PCTs need to give potential providers clear guidance on what is required. This does not necessarily mean drawing up a detailed specification. Where a PCT has defined its requirements, these should be specified but where, for example, a PCT has identified a gap or lack but is unclear about how best to fill it, it might encourage bidders to propose new approaches. Selection criteria and the parameters of the tender document should be clearly stated in the procurement pack.

PCTs should bear in mind the requirements for consultation with various bodies in differing circumstances, such as patient representatives, overview and scrutiny committees and local medical committees. They also need to be aware of potential conflicts of interest, both among bidders for the contract and in issues arising from the contract.

A contract template drafted by Bevan Brittan with the assistance of colleagues from the Department of Health and the NHS Procurement and Supplies Agency (PASA), in conjunction with the NHS Confederation, provides a useful basis. However, PCTs will need to consider specific issues relating to individual contracts, such as:

- the service to be provided, and the length of time for which it is contracted
- performance, quality control and governance
- payment schedules and pricing structures
- provision of premises and equipment, whether by the NHS, the service provider or a third party
- employment issues, including pension provision
- provision of information
- implications of multiple organisations involved
- warranties.

Introduction

Alternative provider medical services (APMS) contracts are a tool for the delivery of primary care services which enable primary care trusts (PCTs) to contract with a wide range of organisations to provide services.

APMS can be used alongside the other options of general medical services (GMS), personal medical services (PMS), special personal medical services (SPMS) and primary care trust medical services (PCTMS) or instead of those options, or to complement them. Collectively the contracting routes give PCTs considerable flexibility to shape service provision. Although this document is particularly focused on the requirements of an APMS contract, it should be remembered that in many cases PCTs will not need or want to specify the type of contract at the start of the process. Depending upon the type of service being sought, the same services could be provided under either PMS and GMS, and the choice of contract may be largely determined by the status of the other contracting party rather than any other factor.

As an aid to successful negotiation and contracting, the Department of Health, NHS Procurement and Supplies Agency (PASA) and the NHS Confederation have drawn up a contract template, available from the NHS Confederation website, www.nhsconfed.org

This report is intended to be read in conjunction with the contract template, and provides a short guide to the issues that need to be considered, both in the approach to seeking possible providers and in drawing up a fair and appropriate contract. It has been produced by Bevan Brittan with the assistance and valued contribution of officials from NHS PASA and the Department of Health. NHS PASA will soon be issuing a more detailed procurement pack and contract commentary; users can check availability on the NHS PASA website (www.pasa.nhs.uk).

The legal framework

The technical power that enables PCTs to contract with a wide range of organisations to provide services is set out in Section 16CC (2)(b) of the NHS Act 1977. Using the power is subject to directions from the Secretary of State, currently the Alternative Provider Medical Services (no 2) Directions 2004. These incorporate by reference a number of provisions from the National Health Service (Personal Medical Services Contracts) Regulations 2004 and provide the legal framework within which the power can be used.

What type of development is involved?

APMS contracts are particularly likely to be relevant to:

- essential services that may involve replacement of a vacant GP practice or practices
- providing additional or enhanced services, which may well include locally enhanced services
- out-of-hours services (for which there is a separate model contract)
- any combination of the above.

A PCT may not necessarily have a clear idea of what the service will look like at the start of the process. It may be more a matter of having identified a particular problem or service need and then looking for ideas or solutions. This type of approach may be constructive in encouraging more innovative solutions.

There is no hard definition of primary medical services, and there is a degree of overlap between the powers as legally defined (see page 3) and the longstanding power PCTs have had under Section 23 of the 1977 Act to purchase services from the independent and voluntary sector. When services are more clearly identified as a replacement to existing hospital services this longstanding power may prove an alternative and perhaps less cumbersome contracting form, although many of the considerations set out in this report will none the less apply.

Procurement principles

General

Medical services are subject to limited controls under the EU Procurement Directive and the only formal requirement under the services directive and regulations would be to publish a contract award notice following the award of the contract. Even this would not apply if the value of the contract does not exceed the relevant limit, currently (2005/06) £129,462. However, this does not mean that there are no procurement constraints.

There are general principles under EU treaty obligations of transparency and fairness in tendering processes and there have been recent indications from the European Commission that even for 'part B' services such as this or for contracts that fall below the threshold, it would be expected that the opportunity would be advertised at least as widely as there is likely to be an interest in providing the service. There is consequently a degree of risk in not going through some form of advertisement and selection process, although this needs to be tailored to the size and type of the contract. Contracting PCTs may wish to seek specialist advice on individual circumstances.

PCT standing orders are also potentially relevant. The current model form is not explicit as to whether it is intended to apply to the procurement of clinical services. But they do provide that, where the PCT elects to invite tenders for the supply of healthcare, standing orders shall apply as far as they are applicable to the tendering procedure. There are limited exceptions to the requirement for tendering.

PCTs should also bear in mind that past practice in relation to GP vacancies may have created a legitimate expectation that there would be a tendering process for such decisions, and that in any event the guidance on implementation of the new GMS contract explicitly contemplates either a single-stage or two-stage competitive process for vacancies. There is therefore considerable legal bias towards a competitive process of some sort.

Private sector concerns

The procurement process needs to address some of the private sector concerns that have been expressed in discussions about the development of APMS. These include:

- repetitious pre-qualification procedures on quality
- time-consuming discussions that progress nowhere
- an over-bureaucratic process.

More seriously there is a concern about either being engaged in lengthy discussions with the PCTs about developing a scheme or in drawing up proposals for a service, only to be told that the PCT is going to put the work out to competitive tender. This either results in a sham exercise in which the party involved is the only realistic bidder, or running the risk of losing a lot of intellectual capital when it is put into the public domain and shared with others.

Coupled with this there is also the underlying concern that public procurement is a relatively costly and bureaucratic procedure. Accordingly, care should be taken to ensure that the process is not disproportionate to the value of the contract concerned.

Types of process

Model A: Competition against specification prepared by the PCT

This is likely to be appropriate for filling a practice vacancy or contracting for a clearly defined service, possibly where there is an existing service which the PCT wishes to replicate. It will enable a single-stage exercise.

Model B: Competition against specification with variant bids encouraged
This could be used for a practice or areas of an existing service, or services where the PCT has a reasonable idea of what it would like but has not closely defined the service model. This type of approach would enable the PCT to test the market for alternative approaches to the perceived problem and possible new ways of working.

Model C: Competition to act as a partner in developing and providing a service
This type of approach directly addresses the concern that private sector bodies have over engaging in detailed discussions with PCTs without any certainty of work and/or payment. It enables the PCT to meet the concern about propriety over the tendering process by ensuring that there is competition, albeit at the earlier stage of identifying a partner who could work with the PCT to develop the service specification and then provide that service.

This model has disadvantages in being much more difficult to evaluate and this will necessarily involve a number of intangible elements. In order to produce a robust system, the PCT should at least scope the area identified as the problem, and seek to develop some output-based criteria against which to evaluate the bidders. It is also important to ensure that the selection process is fair and transparent. The nature of the process may lend itself to the selection of a preferred bidder with whom to develop the specification and other aspects of the contract. The choice of contractor will need to be defensible and to be capable of validation.

This model may be appropriate for circumstances in which the PCT is aware of a gap in services but it is unclear how best that gap can be filled. The approach could be adapted to seek a framework arrangement for succession planning across a particular area.

Model D: Responding to a direct approach
This model would not involve any form of advertisement or competition. The anxiety here is that as there is no competition the PCT will need to be satisfied that it is getting value for money and that it has properly considered alternatives. There is a risk of challenge on the basis on non-compliance with EU principles. Even if standing orders do not require competition, consideration might be given as to whether the circumstances do fit within one of the exceptions to standing orders. One example might be where the provider has some unique skill or ability which the PCT wishes to tap into. In the light of these concerns, this model is not recommended, and PCTs considering it should take advice as to the risks and ways of dealing with them.

Types of competition

Although not required, there is nothing to prevent the PCT seeking to use the official journal of the European Union to advertise, although it is anticipated that this would only be likely to be appropriate for major contracts. More local advertising may be appropriate in other cases, and this would certainly address the European Commission concerns about advertising.

Alternatively, the invitation to bid could be sent to selected organisations, although this runs the risk of not reaching all those who might be interested. In the context of increasing interest from abroad in providing services in the UK, advertising provides the opportunity to find out whether there are others apart from the usual suspects who would wish to make a proposal.

Qualification also arises here. If the PCT is proposing to impose any other pre-qualification criteria it may need to adopt a two-stage process. There are requirements under the directions which limit who can hold an APMS contract but these restrictions are relatively low-level. If a pre-qualification process is being used, PCTs will need to be clear about the criteria used and how organisations may satisfy them.

Overall selection criteria and weighting should also be published in the procurement pack and be explicit. The usual obligations to ensure fairness in the process and evaluation will apply.

Consultation

PCTs should be mindful of their consultation obligations, in terms of legal requirements in this area but also to enable patient voices to be heard in developing services and to encourage support for innovation. There are three principal levels of consultation involved.

- **Section 11 Health and Social Care Act 2001.** PCTs should be familiar with the public and patient involvement agenda under Section 11, which requires PCTs to have in place arrangements to ensure that patients or their representatives are involved in and consulted on: planning of provision of services; development and consideration for proposed changes; decisions affecting those services.

- **Overview and scrutiny.** If the proposed changes amount to a substantial development or variation in the existing service, there is an obligation to consult with the overview and scrutiny committee of the social services authority responsible for the patient population. In practice many APMS arrangements are likely to be less substantial, but the PCTs are reminded of this obligation and in case of doubt they may wish to raise the matter informally with either council offices or the committee chair to clarify whether the overview and scrutiny committee would regard the proposal as a substantial variation. It is apparent from experience across the country that different committees are taking a range of views as to when they wish to become involved in a formal consultation.

- **Local medical committees.** There is an expectation in the guidance relating to filling vacancies that the LMC will be consulted, and this is recommended. It would be good practice in any event, particularly because of the need to ensure that new services dovetail effectively with existing services provided by local GPs within the PCT area.

Conflicts of interest

By their constitution PCTs are prone to real or apparent conflicts of interest arising in their management of primary care matters. Conflicting interests are particularly likely if:

- there is a proposal for the services to be provided directly by the PCT
- GPs in the PCT area are potential bidders for services
- GPs could potentially lose their enhanced services to the proposed scheme.

Examples could be in relation to a vacancy. GPs involved in the temporary provision of services or potential bidders should not be involved in the evaluation proposals or in decisions on contract award. Indeed the PCT might wish to go further and say that any who are involved should not be able to step in subsequently if no appointment is made. This may be important to avoid suggestions either that individuals have benefited from inside information or a suspicion that the decision not to appoint was coloured by self-interest.

Development of enhanced services

Where enhanced services are currently provided it is suggested that current providers should not participate in the decision about service development and there would be significant risks involved in them being parties to the evaluation of proposals. In these circumstances it may be appropriate for PCTs to make reciprocal arrangements with neighbouring PCTs to provide general medical services expertise for evaluation.

Inappropriate benefits

There are also conflict issues which can arise in the contract. The contract template, available from the NHS Confederation website, includes provisions regarding the potential conflicts of interest, but there are particular issues that the PCT may wish to address where the provider has links to other organisations with commercial interests in the health service. One example would be a subsidiary of a major drugs company. The PCT needs to ensure that there are robust provisions in place to ensure that the position as an APMS contractor cannot be manipulated either for the contractor's own benefit or for the benefit of other organisations. This will require monitoring and the PCT may need to identify specific restrictions on prescribing or referral practice or provide for clawbacks in the contract price to ensure decisions taken do not adversely affect the NHS. This will be particularly relevant if the APMS contractor is involved in practice-based commissioning.

However, in this context the PCT also needs to consider the extent to which the APMS contractor may legitimately also hold other contracts, for example for pharmacy or dentistry, with a view to providing an integrated service. The key here is ensuring that there is adequate protection for patient choice, while at the same time seeking to provide effective services for the local community.

Contractual issues

References to schedules and clauses in this section relate to the contract template which is available on the NHS Confederation website.

The contract template is not intended to be prescriptive, although it does incorporate the mandatory terms for an APMS contract required by the 2004 Directions. These requirements include a number of provisions that may not be relevant to all contracts, depending on the nature of the service, but they must be included. There are also some suggested provisions that may not be relevant in particular circumstances.

However, the contract template is merely a common framework, and there are a number of issues that it does not address, and these will need to be considered on an individual basis before finalising any contract.

Specification – Schedule 1

The contract will need to specify the service to be provided. At present there are some suggested points in the draft schedule 1, but PCTs will need to consider their particular requirements.

- How much detail is required in the specification and to what level should it be developed?
- Is the specification aimed at a description of the output required or should the method also be specified?

The specification will also need to link to quality issues and the provisions of clause 6. Clause 6 may well need to be expanded to deal with any specific quality requirements which the PCT wishes to incorporate.

- Is it intended that there should be a link to the quality and outcome framework? (Specific provision is made in schedule 1 part 3 for local quality thresholds to be imposed if this is desired.)

Where the contract includes essential services and the contractor will be *holding a registered list* of patients, part 2 of schedule 1 will need to be expanded to cover the management of the list.

- Incorporating the standard terms from the GMS contract dealing with lists is one option. This would ensure similar treatment of differing contractors. However, the PCT and the contractor may agree different terms as long as provision is made for PCT assignments to the list.
- There should be clarity as to how the list will work.
- Should there be proposals for list closure? It may be appropriate to limit the contractors' rights to close the list.

For additional services it may be appropriate to borrow the provisions from the GMS contract dealing with the description of these services.

Where enhanced services are being provided, the specification may also need to address and amplify the provisions on co-operation with other clinicians, or indeed other services such as social services or education, in relation to care for patient groups.

The specification should also be clear about the patient groups for whom the services are being provided, particularly if the provision is of a service not attached to a list.

- Is it entirely open access, access by referral or based on pre-qualification?
- Any administrative provisions relating to referrals or pre-qualification will need to be incorporated.

Payment – Schedule 2

At present the contract template contains some outline terms regarding payment, but the PCT will need to negotiate in more detail around the payment mechanism.

- Is payment to be a fixed price or is it to be performance-related, volume-related or tied to any other measure?
- The PCT may wish to build in appropriate incentives for high-quality performance, and the payment mechanism may also be used to address some of the risk-sharing, particularly in terms of volume of take-up. Care should be taken to avoid too complex a payment mechanism that would be an administrative burden.
- Depending on the pricing structure used, the PCT may wish to have specific provisions dealing with access to financial information, or indeed a fully 'open-book' accounting system, which would enable the PCT or its auditors to have access to the full cost information from the contractor. This is more likely to be relevant in the context of longer-term arrangements, when such information can assist in maintaining value for money, although it may need supporting price variation provisions to limit excess profits. This may also be relevant to supporting conflict of interest management.
- There may need to be provisions for price variation. In a long-term contract consideration must be given to how the price is to be varied in the future. It is likely that failure to agree will result in termination.

Premises

Where are the services to be provided?

- If the contractor is providing its own premises which it either owns or leases privately, the contract requirements will merely focus on ensuring these are fit and appropriate for the purpose.
- If the PCT is providing the premises, either wholly or in part, the arrangements will necessarily involve either additional provisions in the agreement or a separate lease or licence dealing with user rights. In either case, the PCT will need to have regard to the provisions of Estatecode in connection with any property interest being granted.

Lease or licence?

In general, a lease will arise where there is exclusive occupation of defined premises by the user, and it will be important to have this properly documented, to address issues arising under the security of tenure legislation for businesses.

If use is more akin to sessional use of a room or building, then a licence is more appropriate. This should be adequately documented either through a separate licence annexed to the contract or through explicit licence terms incorporated into the contract.

- Issues will also arise regarding the cost of services provided on PCT premises. The contract may need to address any services or support being provided by the PCT to the contractor. In relation to these issues and the provision of property itself, care may need to be given to avoiding state aid restrictions on public sector bodies providing free or discounted goods and services to commercial organisations.
- Where the premises are in the hands of a third party but linked to the NHS or other partner organisations, a tripartite agreement over the use of the premises and the interface arrangements may be necessary. This could arise, for example, in circumstances where an APMS contract is being used to provide additional services in connection with services provided by an acute NHS trust, or in relation to the provision of prison health services by a third party. Each party needs to be clear about its respective rights and obligations in relation to access to the premises and the overall operation of the service.

Staff

If the service is replacing an existing service, whether provided by a predecessor GP or an acute trust for example, issues may arise under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE).

Specialist advice may need to be sought if there is a

risk that this will be the case, but in principle, 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.

Pensions

There would be an expectation that equivalent pensions would be provided. It is proposed to allow some limited acceptance into the NHS pension scheme, relating to organisations that could provide services under a PMS or GMS contract, but at present APMS contractors cannot join the NHS pension scheme. Consideration may therefore have to be given to obtaining Government Actuary's Department (GAD) certificates of an equivalent pension scheme if there are staff transferring from the public sector to a new contractor.

One other option has been considered in relation to this type of situation. Developed in the context of PFI schemes, it is commonly known as the retention of employment model. Although the parties cannot contract out of TUPE, 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 the previous employer can agree to retain them and supply their services to the new provider. There are problems with this model, particularly where the old provider is not party to the new contract and if these issues arise the PCT will need to take specialist advice to deal with them.

Otherwise, employment will normally be the responsibility of the contractor, although as a part of the termination arrangements, there are provisions in the contract to deal with re-tendering and handover and the provision of information in that context.

Training and workforce planning

PCTs may want to include provisions dealing with access to training by contractor staff and wide provisions to require trainee placement where appropriate.

As part of the information and reporting, PCTs may want workforce planning information. This raises issues about whether, as with independent sector treatment centre (ISTC) contracts, there should be restrictions on contractors recruiting from the local pool of staff. However, these restrictions are not placed on GMS/PMS contractors and equally may suggest that it would be unfair to do so on a long-term basis for APMS contractors.

Equipment

The PCT may be asked to make equipment or other facilities available. At present the contract template does not address this, and suitable provisions, including risk, repairs and renewals, would need to be incorporated.

Exit strategy – Clauses 4 and 61

The PCT will need to consider whether the length of the contract has any implications.

- Is it intended to be indefinite or fixed term?
- What happens on termination or re-tendering?

There are winding-down provisions in the contract template but PCTs may wish to consider, in the context of the particular service, whether specific provisions need to be inserted.

Communications, review and the provision of information – Clauses 31, 33, 36 and 37

There are provisions in the contract template dealing with these points, but PCTs should consider what is relevant to their individual situation.

- What information is required, and to what use will it be put?
- What information does the PCT need to be able to supply to others?
- What information does the PCT require the contractor to provide to third parties?
- The contract provides for an annual review, but

the provisions of schedule 5 need to be worked out in detail to ensure proper contract monitoring high performance.

- Is information needed to cross-refer to any performance-related elements of the payment mechanism or other matters of concern to the PCT?

Practice-based commissioning

Where an APMS contractor is holding a list it is apparently the case that they will be able to participate in practice-based commissioning.

- To what extent should any agreements about practice-based commissioning be reflected in the APMS contract, or should these be dealt with separately through other arrangements that the PCT has with practices in the area?

Parties

Much of the above has focused on single-PCT commissioning but, as with out-of-hours provision, it may be appropriate to commission some services across a number of PCTs. In such cases consideration needs to be given to:

- who the parties are
- whether all the PCTs sign the same contract
- whether there is a lead PCT and, if so, what the arrangements are between the lead PCT and the others to cater for the delegation of authority and the collaboration between organisations. A simple form of consortium agreement may be helpful to deal with this
- the effect of one PCT dropping out: does it change the price, terminate the contract or merely vary the area for which the service is provided?

Warranties

The contract template suggests alternatives. The default gives only a limited warranty in relation to a capacity to enter into the contract. The alternative is a fuller warranty of all information provided prior to the signature of the contract. This has been deliberately watered down to a provision that merely states the party has used reasonable endeavours to ensure that the information is accurate. If there are specific issues on which the parties are relying it may be necessary to amend these to explicitly warrant the relevant information.

This warranty differs from the Department of Health model for out-of-hours contracts as it is considered unlikely that the PCTs could properly warrant all the data that they may be asked to provide in pre-contract negotiations.

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.

- A review board or committee will be particularly relevant where the proposal is intended to relate to services linking across the health and social care services or involves significant other participants, such as prison health.
- In establishing such a board or committee, care will need to be given to establishing its terms of reference, powers and the route by which its authority is given.
- Such a board could be set up either through the contract or separately.
- Alternatively, there may be an existing partnership or board that could be given an oversight role; this would need to be reflected in the contract.

Further information

For further information, potential APMS suppliers may wish to register on the NHS Supplier Information Database, nww.pasa.nhs.uk, also accessible to PCTs and SHAs on registration.

Alternative providers of medical services

Alternative providers of medical services contracts are a tool for the delivery of primary care services which enable primary care trusts to contract with a wide range of organisations to provide services.

With the broader range of service providers now available to primary care trusts, negotiations and contracts need to be appropriate to the parties involved and the service to be provided.

This document provides a short guide to the issues that need to be considered, both in the approach to seeking possible providers and in drawing up a fair and appropriate contract.

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