

Securing the future of General Practice in London



Issue 4 – January 2010

PMS Contract Reviews

Introduction

We are all aware of the reporting on the financial challenges once again facing many of our PCTs in London and how this is replicated across the country. The extreme pressure PCTs are under in order to achieve financial balance and stay within their control totally is coupled with distinct drivers to get PCTs to monitor all their contracts and ensure they are achieving best value for money.

This briefing has been compiled in order to address and respond to a document issued by the Department of Health (DH) advisory body Primary Care Commissioning (PCC) called PMS reviews: a commissioning toolkit. Contact your PCT if you would like a copy of the PCC document. This briefing is for LMCs, GPs and practices, but the commissioning toolkit was produced for PCTs to assist them in undertaking PMS contract reviews. Please note that for the purposes of this briefing all direct quotes from the PCC toolkit are in quotation marks and labelled **(PCC Toolkit 2009)**.

From 2009-10, there will be an explicit focus on primary care arrangements as part of the 'World Class Commissioning' (WCC) assurance process. PCTs have been told that the risks of **not** reviewing PMS agreements are significant. Amongst other factors, 'PCTs risk failing to demonstrate themselves as 'World Class Commissioners', they risk paying practices excessively for the services that they are providing and perpetuating inequalities between local primary medical contractors.' **(PCC Toolkit 2009)**. Please refer to our [frequently asked questions](#) at the end of this briefing for more information.

Our internal local intelligence shows us that five PCTs have already completed a PMS contract review with another thirteen of the PCTs under the Londonwide LMCs umbrella either in progress or intending to do so very soon. Ultimately, we believe reviews will take place in all PCTs irrespective of whether we have current prior knowledge of them.

Our database shows us that across our LMC areas, PMS contracts constituent 41% of all contracts with 57% General Medical Services (GMS) and a mere, but growing 2% Alternative Provider Medical Services (APMS)/PCT Medical Services (PCTMS). Although this mirrors national statistics, there is a huge variation across London's PCTs. In short, the number of PMS practices likely to be affected by such reviews is large and practices should know how to prepare and approach this exercise.

LMC KEY MESSAGE:

Advise your LMC as soon as a PCT reveals its intentions to implement a review. Experience across the country has shown that this has paid big dividends in ensuring that the best deal is secured (even though it might not feel like it!). Equally, watch out for warnings and alerts from your LMC.

Background

Historically, we should remember that practices moved from GMS to PMS for three main reasons:

- 'leading edge' practices needed the flexibility and freedom of a contract to allow them to move ahead with new policy developments
- responses to the financial incentives that were produced to encourage the transfer both from a local and national perspective
- due to necessity because there was not the flexibility under the Red Book to survive the problems of failing to recruit partners and practice nurses

Additional payments were made to provide extra services. It could be well argued that part of those payments could be regarded as compensating for the inherent risk that the practices took as they relinquished the security of the national GMS contract.

LMC KEY MESSAGE:

Often these contracts did not have standards or monitoring requirements attached to them. This means that, for many PCTs reviewing whether practices have achieved and met their PMS objectives will be very difficult (this is especially relevant in evaluating growth monies). This part of the process will need careful handling by both LMCs and GPs, to create the right balance between 'no objectives' and 'too many objectives'.

The document [Reviewing PMS contractual arrangements – Guidance for PMS practices](#) (BMA, March 2007) still contains relevant information and advice.

The Beginning

The PCT has responsibility to provide high quality care for all patients, reduce variation and to address health inequalities (see [High Quality for All: Final Report of the Next Stage Review](#), DH, 30 June 2008). Undertaking PMS reviews provides an opportunity to deliver on this priority area. The toolkit acknowledges that due to a number of varying factors it cannot produce a 'one size fits all' which will suit all PCTs needs; what it does contain are options and ideas for local consideration and implementation.

LMC KEY MESSAGE:

This means that there can be no direct comparison or modelling on what has been done in one PCT with another; the local factors will determine any variations. PCTs may need reminding of this fact by LMCs and GPs. The mantra of sharing 'good practice' often knows no boundaries.

Principles

Some of the key principles contained in the toolkit can be readily supported:

1. That the toolkit (or any contract review) must not aim to assist PCTs in tackling poor professional performance – there are other appropriate channels for this.

2. Recognises that every PCT has a different starting point with contract reviews depending on the historical background to the development, frequency of variations and monitoring of the contracts held by independent contractors.
3. Review could also be used for APMS, PCTMS and Specialist Provider Medical Services (SPMS) agreements.
4. A strong need to treat PMS and GMS fairly and to ensure that all primary care contracts are equitable and robust.
5. It will be for each individual PCT to determine the purpose of its review depending on local circumstances. The PCT will need to have a clear vision for primary care service development and will need to understand how the review of PMS as a whole could contribute towards that.
6. PCT Boards will have a distinct interest in any contract reviews and will wish to understand whether PMS offers value for money and how the reviews could contribute towards the policy of fairer funding.

The Strategic Health Authority (SHA) view is therefore that PCTs should be undertaking a PMS review during 2009-10 as a means of demonstrating that they are world class commissioners of primary care, although the content, approach and outcome will be locally determined. PCTs will also be required to inform the SHA of the findings of the financial comparisons between GMS and PMS practices, as well as its action plan to taking any work forward.

LMC KEY MESSAGE:

LMCs, on behalf of all their local GPs should, wherever possible, approve the process before it begins and remind PCTs of the link between simplicity and success.

‘It is important to realise that simplicity may be the key driving factor here. Experience has shown that focusing on a small number of aims and objectives, or a small number of criteria may actually lead to more successful outcomes.’ (**PCC Toolkit 2009**).

Preparation

The toolkit suggests the following list of areas to explore ‘at the outset’ in order for PCTs to determine what they wish to achieve. We would encourage LMCs to ensure that PCTs do this preparation and establish and agree clear objectives at the very start of the process.

Toolkit Advice	LMC Advice
To map primary care provision and quality, and to identify any gaps, before the PCT can embark on making improvements to primary care services.	Ask the PCT to share their data with the LMC in order to understand the issues and extents within which each service provision is being reviewed.

Toolkit Advice	LMC Advice
To gain a better understanding of the differences between GMS and PMS in terms of £ per weighted patient, the range of services provided and quality/performance.	Be absolutely sure how the figures are made up – what’s included and what’s not. Does it make sense to compare on that basis? Explore why there may be unusual differences.
To take stock of the PMS agreements against the original aims and objectives and to understand if these need to be updated.	Share these objectives and contract examples and open mindedly consider whether they are equitable or robust enough. Consider what might be acceptable changes.
To understand whether PMS agreements give value for money and/or whether the PCT needs to develop a policy with regards to the fairer funding agenda.	This is purely an evaluation using the financial figures against contract services and quality outcomes. Make sure you have the right information on which to make the judgement.
To ensure the validity of all PMS legal agreements and variations.	Do not change or agree to any legal contract variations without securing advice through the LMC.
To clarify any outstanding issues such as superannuation and/or the definition of ‘essential services’.	Agreement on the definition of ‘essential services’ is paramount at the beginning of the process.
To set standards for PMS practices.	Ensure these are ‘reasonable’ and not too numerous or onerous. Negotiate – use time frame if phasing in is an option.
To review the agreements for compliance with the regulations and to identify any local clauses that need amendment.	Read with care and consult if unsure.
To use the reviews as a contribution towards an emerging quality improvement strategy for primary care – understand good practice and/or reducing unwarranted variation.	Know the areas requiring quality improvements at the start and have an understanding of what is achievable within the limitations of time and resources.

Toolkit Advice	LMC Advice
To use the reviews as a means to improving access and responsiveness (in line with the NHS Operating Framework 2009-10 requirements).	Be practicable. Try and get the right balance with PCTs over access and quality. Access alone is no good if consultation times are cut so short that quality is removed.
To disinvest from PMS baseline contract values and to reinvest appropriately, in line with PCT priorities.	Aim for funding to stay in general practice and for services to be provided across the PCT area, using collaboration where needed.
To collate information which could be presented to patients to support the choice agenda.	Ensure this is user friendly information which has explanations and does not allow for misinterpretations.
To collate information which could be used in due course as part of quality accounts.	Make sure this is 'reasonable' and will not go to public print where the public can make incorrect interpretations.
To inform the PCT in terms of practices' support needs and to assist the PCT in its provider development/market stimulation role.	Knowing the practices support needs is one thing, knowing how they are going to be met is another. Be explicit in agreeing what support practices will get.

Key Critical Success Factors

'It is essential that the PCT discusses its plans with the LMC. To be successful PCTs will need to be judged as fair and transparent by the local GP community with clearly defined principles that are universally applied.' (**PCC Toolkit 2009**).

LMC KEY MESSAGE:

LMCs and GPs alike have three 'C's to remember in order to ensure that PCTs provide:

- **CONSULTATION**
- **CLARITY**
- **CONSISTENCY**

Setting Objectives

Setting new objectives as a variation to the current contract will undoubtedly centre around attaching new or increasing current 'Key Performance Indicators' (KPIs) to specific services.

KPIs dominate the recent document [Primary Care & Community Services: Improving GP services](#) published by the DH.

Equally if you feel you only want to brush up on the headlines you can access our [summary briefing](#).

Practices and LMCs should resist attempts by PCTs to introduce extra services and reductions in funding unless these can be fairly and transparently justified. Re-distribution of funds through Local Enhanced Services (LEs) accessible by all would be one way of retaining funds in general practice and achieving an equitable service across a given geographical area.

LMC KEY MESSAGE:

The thing to do with KPIs in PMS is to keep them restricted to things which follow from the PMS agreements regulations and get the target set at a level which most practices are already achieving, or are in reasonable reach of most practices.

Finance and Contract Values

Recognition should be given to the fact that GMS contracts currently carry a value of approximately £68 per patient whereas an average basic rate for PMS is approximately £80 per patient. Any differences will be due to the fact that each PMS contract is a locally agreed contract with locally agreed terms and conditions and therefore should reflect an appropriate contract value. This is imperative to remember when comparisons are being made as this is a very difficult thing to do for price setting unless the services, quality standards, the workload of individual practices and deliverables are exactly the same.

Unless there is an explicit statement set out in the contract to state otherwise (and it is highly unlikely), PCTs cannot claw back funding retrospectively.

LMC KEY MESSAGE:

LMCs will have to ensure that contract reviews and comparisons give the variations between different contracts due consideration and not apply funding or quality standards which are not appropriate.

The first principle when looking at the funding and finance of PMS contracts is to adjust the figures so that the baselines are comparable. The next step is to compare activity and then look at the extra services that justify any additional resources. Access to the provision of extra services should be available to all practices.

Under PMS, 126 QOF points were deducted from any final achievement payments to represent services already provided within the PMS contract price. If an equitable price is set by PCTs across GMS and PMS contracts then the QOF points should be reinstated for PMS contractors.

LMC KEY MESSAGE:

LMCs will need to oversee all contract reviews and ensure that any released funding is directed back into general practice, preferably through achievable LEs which will need to be offered to all.

'The objective should not only be about delivering equity, but to question and understand the reasons behind any variations between PMS practices and across PMS and GMS.' (**PCC Toolkit 2009**).

Conclusion

Most London PCTs and PMS practices use the Lockharts model PMS Agreement commissioned by Londonwide LMCs. This is currently in its 14th edition. We strongly encourage its retention as the core of any review, with any local variations forming part of the schedules that are attached to it.

We believe that it is in the best interests of PMS practices in any one PCT area to negotiate collectively, by signing a local mandate giving their LMC some strength of power with which to negotiate. LMCs should, when negotiating with their PCT, acknowledge and use the expertise of Londonwide LMCs (advised by Lockharts where appropriate), but still recognise that practice specific changes would need to be agreed on an individual basis.

Frequently Asked Questions

Do PCTs have to do it?

Yes, as already stated, all the current documentation points PCTs in the direction of all the benefits from doing it and the risks of not doing it. They have to be able to demonstrate above all else value for money and a robust monitoring system.

What will happen to any funding withdrawn from any contracts?

Page 4 of the toolkit is the first reference to released funds stating that 'PMS may release funds that can be reinvested through new enhanced services benefiting the wider GP community'.

Can PCTs alter contracts without agreement?

Existing contractual provision is based on an agreement jointly entered into, and changes to those arrangements may only be achieved through proper consultation and negotiation with practices.

Any additional efficiencies or targets over and above those currently within the contract agreements can only be achieved with the agreement of the practices concerned.

What is meant by a variation to a PMS contract?

Where both parties agree to changes the variations can be included in as an appendix in the schedules at the back of the main body of the contract. From a Londonwide LMCs perspective we would strongly advise that the main body of the contract (Lockharts) is retained without change and any variations subsequently agreed to the services, quality or price are contained in a schedule.

Can existing contracts be terminated if agreements cannot be reached?

Each locally negotiated PMS contract may have its own termination clause so it is difficult to be generic. Check your contract. It is likely that either party may terminate the agreement by serving notice in writing but the termination period should be reasonable if not explicitly stated. On this basis a minimum of three months would be considered 'reasonable' and six months 'preferable'. Reasons for the termination should be given but there are no regulations covering what might be considered 'acceptable'.

Can a PCT terminate a contract by serving a breach notice?

A contract cannot be terminated using a breach notice **if no breach has occurred**. A contract can however be changed or terminated with adequate notice and with appropriate reasons.

What if I want to revert back to a GMS contract?

Any GP is entitled to revert back to GMS. John Hutton's letter of 5 June 2003 states:

'I can confirm that, as the contract document states, PMS practices will be able to move to GMS, and vice versa.....financial arrangements for such transfers will be fair for PMS GPs in relation to GMS GPs.'

Unfortunately, the work that he then refers to which would be required in order to establish a mechanism for delivering this has never successfully been done and it is unlikely that PMS GPs would be allowed to access the MPIG and would also lose any growth monies.

This would be the challenge if reverting back either as an individual practice or on mass within a PCT area.

You may also wish to refer to the GPC guidance from February 2007 entitled '[Primary Medical Contracts – who can hold what?](#)'. This is still valid and explains all the contract options available to general practitioners.

What if I am a GMS contract holder and the PCT offers me a PMS contract?

Some PCTs are indeed doing this, especially where there is a high percentage of existing PMS and relatively low GMS; the objective being to get as many GPs onto the same one contract as possible. This can also work where a 'same' price is established per patient for either GMS or PMS contracts. It would not matter so much if the GMS practice converted, the money would be the same, there may be a gain financially and in the extra flexibility of having a locally negotiated contract but there would be a forfeit of security in giving up a nationally negotiated contract. Each case should be weighed up on its own merits to see, on balance, whether the conversion would be worth it.

How can Londonwide LMCs help?

They, along with your Local Medical Committee can assist in a number of ways:

- provide support to practices in difficulty with their contract
- offer assistance with negotiating with the PCT
- offer to act collectively on behalf of all practices if appropriate (to create negotiating power)
- provide an impartial and realistic view on when to accept a wise agreement with the PCT
- advise on alternative contractual options

If you need support, please contact the LMC Director of Primary Care Strategy for your area:

- **Greg Cairns**, Bexley, City and Hackney, Greenwich, Newham, Tower Hamlets, Redbridge and Waltham Forest, gcairns@lmc.org.uk
- **Julie Freeman**, Lambeth, Lewisham, Southwark, Sutton and Merton and Wandsworth, jfreeman@lmc.org.uk
- **Andy Michaels**, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster, amichaels@lmc.org.uk
- **Gill Rogers**, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster, grogers@lmc.org.uk
- **Mazzie Sharp**, Barnet, Brent, Camden, Enfield, Haringey and Islington, msharp@lmc.org.uk