NHS

Primary Care Contracting

Primary Medical Services Contracts

- A guide for potential contractors

Contents

1. Introduction

One of the key objectives set out in the White Paper *Our health, our care, our say* is to secure better access to general practice.

In some places this will mean encouraging or allowing new providers, including social enterprises or commercial companies, to offer services to registered patients alongside traditional general practice.

This guide is aimed at these new providers, or potential primary medical services contractors.

The guide offers an introduction to primary medical services contracting and the surrounding regulatory framework. It also provides helpful insights into the issues that potential contractors will have to consider and describes the process by which potential contractors might secure a primary care contract.

While a useful resource in itself, the guide also provides signposts to where more detailed information can be found.

For more information:

- The White Paper *Our health, our care, our say* http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/OurHealthOurCareOurSay/fs/en
- The White Paper *Our health, our care, our say*- Chapter 3 Better access to general practice http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4127552&MULTIPAGE_ID=5666105&chk=SAopG8

Section 1 – Regulatory Framework

2. Primary Medical Services Contractors

Historically, primary medical care was the preserve of individual GPs, each working to nationally negotiated terms of service relating to their General Medical Services (GMS) NHS work.

The NHS (Primary Care) Act 1997 brought significant changes through the flexibility of local contracts and increased opportunities for the involvement of other health professionals in primary medical care contracting. These personal medical services (PMS) arrangements were taken up by significant numbers of existing practices (approximately 40%).

However, despite these changes, there continued to be persistent and particular problems in deprived areas, which have long been under-served by traditional primary medical care provision.

Major reform was considered necessary and the subsequent changes to legislation leading up to the new GMS contract in April 2004 have dramatically changed the contractual environment for primary medical care.

Where a PCT now decides to seek a new contractor for primary medical services, it may enter into a contract with anyone capable of securing the delivery of such services.

> A Primary Care Trust …. may (in addition to any other power conferred on it) -
> (a) provide primary medical services itself ….;
> (b) make such arrangements for their provision …. as it thinks fit, and may in particular make contractual arrangements **with any person**.
>
> [Section 16CC(2) of the National Health Service Act 1977 as inserted by the Health and Social Care (Community Health and Standards) Act 2003]

This means that contracts for primary medical services provision are no longer the preserve of traditional general practice but are now in the global marketplace, where any individual or organisation may apply to provide primary medical services.

As well as increasing contestability, the reforms also set out a range of contracting routes (or contract types) for primary medical services. The new regulatory framework continues to secure the interests of patients, professionals and the NHS by determining a minimum set of contractual requirements for each of these routes.

However, irrespective of the contracting route, to be successful, a potential contractor must be able to convince the commissioner that they can provide the range of skills and experience necessary to deliver the required range of services to patients, and meet the wider contractual obligations associated with the provision of primary medical services.

For more information:

- Department of Health - Primary Care Contracting
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/fs/en

3. Primary Medical Services

Primary medical services specified within a contract may include:

(i) Essential services;
(ii) Additional services*; and
(iii) Enhanced services.

(* while additional services are only defined for GMS purposes, the definitions are in common usage across all contracting routes)

3.1 Essential services

Essential services form the core level of service that patients would expect their GP to provide. These services are described in legislation to secure a uniform basis across all primary medical services contracting routes. These legal requirements are not subject to local negotiation (although there may be some matters of local interpretation), thus ensuring that all patients receive a consistent level of provision.

To summarise the legal requirements, **essential services** cover:

(i) the management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable;
(ii) the general management of patients who are terminally ill; and
(iii) the management of chronic disease in the manner determined by the contractor, in discussion with the patient.

The majority of primary medical services contracts will therefore require the provision of the full range of essential services to a registered list of patients. It is important to note that while that GPs are the only professionals qualified to deliver the full range of essential services to patients, the use of skill-mix will play an important part in effective service delivery.

The successful contractor must therefore satisfy the commissioner that all patients will have appropriate access to a GP and, where appropriate, relevant healthcare professionals. Thus, while the provider role i.e. a signatory to the contract, is open to all (GPs and non-GPs alike), GPs will still play a fundamental role in the delivery of primary medical services to patients

The contractor will normally be required to provide essential services at such times within core hours to meet the reasonable need of patients. In this context, ‘core hours’ means the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday except Good Friday, Christmas Day or bank holidays.

While the contract may also require the contractor to provide medical services outside of these core hours (out-of-hours), it is more usual for separate arrangements to be made by the PCT to ensure out-of-hours services are provided to all patients.

3.2 Additional services

There are a number of further services that general practice usually provides to patients. These additional services are also likely to feature in the service specification for potential primary medical services contractors.

Additional services include any or all of:

(i) cervical screening
(ii) contraceptive services
(iii) vaccinations and immunisations
(iv) childhood vaccinations and immunisations
(v) child health surveillance
(vi) maternity services - excluding intra partum care
(vii) the minor surgery procedures of curettage, cautery, cryocautery of warts and verrucae, and other skin lesions.

3.3 Enhanced services

To ensure that primary medical services contracts are flexible enough to encapsulate all services that the contractor can provide (and that the PCT is willing to commission), they may also include a range of enhanced services.

Enhanced services are:

(i) Essential, additional or out of hours services (or an element of such a service) delivered to a higher (enhanced) specified standard, for example, extended minor surgery; and/or
(ii) further services that are not essential or additional services.

PCTs are required to commission certain nationally-specified enhanced services, known as directed enhanced services (DES). In addition, the PCT may include a range of other enhanced services as it sees fit, but these are subject to local negotiation and agreement, hence they are referred to as local enhanced services (LES).

For example, enhanced services detailed within the service specification might include more specialised services undertaken by GPs or nurses with special interests and allied health professionals and other services at the primary/secondary care interface. They may also include services addressing specific local health needs or requirements, and innovative services that are being piloted and evaluated.

For more information:

- Royal College of General Practitioners - GP Services
  http://www.rcgp.org.uk/default.aspx?page=1370

- Department of Health - Enhanced Services
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PrimaryCareContractingArticle/fs/en?CONTENT_ID=4126088&chk=MNKvGl

4. Primary Medical Services Contracting Routes

The majority of primary care is delivered by existing (pre-April '04) contractors whose arrangements should now reflect the new legislative requirements.

For new arrangements, the contracting route will be determined by the commissioner (provided always that it is legally possible for the commissioner to enter into such a contract type – see below). The contracting routes are therefore options, not requirements.

Where a potential primary medical services contractor will be required to hold a registered list of patients, and consequently provide the full range of essential services, there are three possible contracting routes. These are:

- A general medical services (GMS) contract;
- A personal medical services (PMS) agreement; or
- An alternative providers medical services (APMS) contract.

A single contractor may hold a variety of contract types with a variety of commissioners. For example, an existing GMS contractor might also hold an APMS contract with a second PCT.

4.1 GMS

GMS arrangements are governed by the GMS Regulations. These are based on national agreements between the Department of Health (or bodies acting on behalf of the Department of Health) and the British Medical Association.

Negotiations in 2002/03 led to an overhaul of the GMS contract, which included practice-based rather than GP-based payments, stronger quality incentives, and more flexibility to increase the range of services provided.

More flexibility was also provided regarding the organisational types that could hold a GMS contract. However, GMS remains the most regulated of all the contracting routes in this regard.

GMS contractors must always provide the full range of essential services and maintain a registered list of patients. The requirements surrounding the contractual terms of GMS contracts are set out in GMS Regulations (as amended). There is a standard national GMS contract available from the Department of Health website.

The Statement of Financial Entitlements sets out the financial arrangements that apply to GMS contracts. The conditions set out in that document should also be considered as terms of the GMS contract.

4.2 PMS

Personal medical services arrangements are an alternative to GMS, in which the contract (the "agreement") is agreed locally between the contractor and the PCT.

PMS is designed to encourage local flexibility and innovation and a focus on local population needs. PMS offers greater service flexibilities than GMS, but where essential services are to be provided, they are secured in substantially the same way. The requirements for the contractual terms of PMS agreements are set out in PMS Regulations (as amended) and, in many ways, reflect the content of GMS Regulations.

Importantly, however, there is no requirement to follow the nationally agreed pay structure for GMS, i.e. the Statement of Financial Entitlements does not apply to PMS agreements. PMS contractors are therefore free to negotiate entirely separate payment arrangements, although common elements are often found in both contract types e.g. QOF.

PMS is more flexible than GMS in the range of individuals/organisations that may enter a PMS agreement.

4.3 APMS

APMS is a recent development and offers substantial opportunities for the restructuring of services to offer greater patient choice, improved access and greater responsiveness to the specific needs of the community. It is intended to help address need in areas of historic under-provision, enable re-provision of services where practices opt out, and improve access in areas with problems with GP recruitment and retention.

This new development is permitted following the legislative change that enabled PCTs to contract with "any person". The APMS route offers a minimum regulatory approach, leaving the commissioner and contractor to reach detailed agreement on most of the contract. However, where essential services are to be provided, they are secured in substantially the same way as GMS/PMS in order to ensure consistency of service across all contracting routes.

The mandatory requirements that apply to APMS contracts are set out in Directions to PCTs. These Directions draw, where appropriate, on the wording of the PMS Regulations. Like PMS, there is no requirement to follow the nationally-negotiated financial arrangements for GMS, although contractors should recognise that such arrangements offer a benchmark when considering the value of primary care contracts.

Unlike GMS and PMS arrangements, which place significant restrictions on the organisational structure of the contractor, there are no such restrictions for APMS contractors (but see section 5).

Table 1. Comparison of contracting routes for essential services

	GMS	PMS	APMS
Negotiation	National	Local	Local
Service specification	Must provide the full range of essential services as a minimum	May provide the full range of essential services, but not required (must provide essential services if there is a list of registered patients)	May provide the full range of essential services, but not required (must provide essential services if there is a list of registered patients)
Organisational structure of Contractor	Prescribed, at least one GP provider	Prescribed, but no requirement for GP provider	Completely flexible
Contract terms	Minimum requirements set out in GMS Regulations	Minimum requirements set out in PMS Regulations	Minimum requirements set out in Directions
Payment arrangements	Prescribed, as per Statement of Financial Entitlements (SFE)	Flexible, may be linked to the SFE if desired (SFE payments such as the QoF and Seniority are often replicated)	Flexible, may be linked to SFE if desired
Termination	Only as prescribed in GMS Regulations	Prescribed in PMS Regulations. PMS contractors providing essential services also have a conditional right to move to a GMS contract	As determined by local negotiation.

4.4 SPMS

All contractors who have a list of registered patients must provide essential services. However, unlike GMS Regulations, PMS Regulations do not require provision of essential services. Those PMS agreements that take advantage of this flexibility and do not include the full range of essential services are known as Specialist PMS (SPMS) arrangements.

While strictly not a route for delivery of the full range of primary medical services, Specialist PMS (SPMS) arrangements build on the ability in PMS to address local health and service needs, and recognise innovation. SPMS is designed in particular to give PCTs and providers flexibility to deliver services to people whose needs may not be fully met by other primary medical services options

By not including essential services, such SPMS agreements can be designed to address one or more specific services and as such they can facilitate a more flexible workforce that might not require specific GP involvement in the clinical delivery of the specified services.

It should also be noted that the same flexibility also applies to APMS and, unlike SPMS, such contracts would place no constraints on the structure of the organisation.

This means it is possible for the commissioner to offer an APMS or SPMS agreement that focuses on specialised services to meet patients' particular health needs. Such arrangements might cover an integrated service, including elements of both primary and secondary care, focused on a particular condition.

While such agreements might be for disease-specific services, they could also cover broader locality populations (as opposed to registered lists). Such arrangements might lend themselves to the provision of community or secondary-care type services.

The flexibility of such arrangements may be of particular interest to non-GP providers. There are a number of specialised services that could be provided by a wide range of other (non-GP) healthcare professionals e.g. nurses, pharmacists. This in turn may give rise to new provider organisations (with or without GP involvement) that can deliver such specialised services.

For more information:

- Department of Health – General Medical Services (GMS) http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/GMS/fs/en

- Department of Health – Personal Medical Services (PMS)
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PMS/fs/en

- Department of Health – Alternative Provider Medical Services (APMS)
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/APMS/fs/en

- Department of Health – Specialist Personal Medical Services (SPMS)
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PMS/PMSArticle/fs/en?CONTENT_ID=4125644&chk=1YPbQD

5. Eligibility for Primary Medical Services Contracts

The following section offers a summary of the legal requirements surrounding eligibility for primary medical services contracts but does not replicate the full legal text. This guide can only offer a broad introduction. Anyone entering into, or seeking, a primary medical services contract should refer directly to the legislation, or seek independent legal advice.

Potential contractors should also be aware that, in addition to the requirements on eligibility, there are further requirements across all contracting routes to ensure that the persons entering into the contract with the PCT are fit and proper e.g... they have not been adjudged bankrupt or have certain types of criminal record.

5.1 GMS Contractors

GMS contracts can be made with:

- A general medical practitioner;
- Two or more individuals practising in partnership;
  - At least one partner (who must not be a limited partner) must be a general medical practitioner; and
  - Other partners must be individuals from within the 'NHS family'.
- Company limited by shares:
  - At least one share must be legally and beneficially owned by a general medical practitioner;
  - All other shares must be legally and beneficially owned by a general medical practitioner or a person who could enter into a GMS contract as part of a partnership.

In this context, 'NHS family' means:

- Medical practitioners;
- Healthcare professionals;
- GMS providers or their employees;
- PMS providers or their employees; or
- Employees of PCTs, NHS trusts or Foundation Trusts.

It is important to note that 'healthcare professionals' is not restricted to employees of the NHS. It is a broad definition that includes persons registered with the professional bodies set out in legislation (provided that such professionals are engaged in the provision of services under the NHS Act). It can therefore include doctors, nurses, professions allied to medicine (PAMs), pharmacists, dentists, osteopaths, chiropractors and others.

5.2 PMS (and SPMS) Contractors

PMS agreements can be entered into with one or more of the following:

- A medical practitioner;

- A healthcare professional;
- An individual who is a GMS or PMS provider;
- An NHS employee, a GMS employee or a PMS employee;
- An NHS trust, NHS foundation trust, Primary Care Trust;
- A qualifying body (a company limited by shares, all of which are legally and beneficially owned by persons who may enter a PMS agreement as identified above).

Contractors should note that PCTs may not enter into PMS agreements with partnerships. The PMS agreement is made with the individuals themselves, who may then choose to deliver their contractual obligations by means of a partnership.

5.3 APMS Contractors

In principle, there are no restrictions on the types of organisations that may hold contracts under APMS arrangements. PCTs can enter APMS contracts with any individual or organisation that meets the provider conditions set out in Directions.

For more information:

- Health and Social Care Act 2003 – Persons eligible to enter into GMS contracts http://www.opsi.gov.uk/acts/acts2003/30043--n.htm#175

- Department of Health – Persons with whom PMS agreements may be made http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PMS/PMSArticle/fs/en?CONTENT_ID=4125644&chk=1YPbQD

- APMS Directions 2006 http://www.dh.gov.uk/assetRoot/04/13/73/82/04137382.pdf

Section 2 – Issues for Consideration

6. Organisational structure

The organisational structure of the contractor may be a key determinant for identifying the potential contracting routes, although other factors such as the flexibility of service provision should not be forgotten. However, potential contractors should be aware that the manner in which their business is structured will impact the type of contract that may be offered.

There are a wide range of organisational types for contractors to consider. There is no single 'right' answer. It is a matter of reviewing the intended business and exploring the most appropriate option for delivering the planned range of services - form follows function.

It should therefore be recognised that the regulations surrounding primary medical services contracts place restrictions on the organisational structures that are acceptable for some contracting routes, namely GMS and PMS.

This guide simply highlights the most common organisational structures that contractors may wish to examine further.

6.1 Individuals

Prior to the new contractual arrangements, the legal framework ensured that, with the exception of some PMS agreements, all arrangements for primary medical services provision were with individuals – GPs.

It is still possible to contract with the PCT as an individual, although it remains the case that, to secure a GMS contract, that individual must be a GP. However, to secure a PMS contract, the individual can come from the wider 'NHS family' (as defined above) and, under APMS, anybody could hold the contract, subject to compliance with the conditions set out in Directions.

6.2 Partnerships

The current environment of a multitude of general practice partnerships formed under the previous legal framework. It was often the case that individual GPs came together to form partnerships to derive benefits through economies of scale, shared premises etc.

Under GMS, it is now possible to contract directly with the PCT as a partnership. Recent developments in partnership law have increased the range of partnership options. Limited partnerships (where some partners limit their liability) are an allowable contractual form for GMS – provided always that there is at least one GP who is not a limited partner. This proviso means that limited liability partnerships (where all partners limit their liability) are not an allowable form for GMS contracts.

Under PMS, it remains the case that the agreement is with the individuals signing up to the agreement. Therefore, unlike GMS, the PCT cannot enter into a PMS agreement directly with a partnership (of any description).

However, it is a matter for the individuals concerned whether they formalise their arrangements for delivering the contractual requirements. This may lead to the creation of formal partnerships. Those wishing to work within a partnership but without a formal partnership deed should consider taking legal advice on the risks associated with working under a "partnership at will".

6.3 Limited companies

One of the issues associated with trading as an individual (a sole trader), or a partnership, is the disadvantage that the owner(s) remains personally liable for all debts should the business fail. To limit this liability, some form of incorporation (the creation of a company) is required.

A company is a separate legal entity. Put simply, it has a life of its own and is recognised by the courts as being able to take, or respond to, legal action in its own right; separate from either the owners of the company (shareholders/guarantors) or the people running the company (the directors). It is the company that enters into contracts, employs staff, owns assets and is liable for all debts.

A company is owned by its members, who are shareholders, if the company is 'limited by shares', or guarantors, if it is 'limited by guarantee'. In the former, the liability of the members is limited to the nominal value of the share, and in the latter, it is limited to the value of the guarantee, which is usually £1.

Although they are a common form for delivery of out-of-hours primary care services, potential contractors should note that companies limited by guarantee are not an acceptable form for either GMS or PMS arrangements. The only allowable corporate vehicle for GMS and PMS arrangements is a company limited by shares, and even then there are restrictions on share ownership as highlighted in the previous section.

6.3.1 Companies limited by shares

The ownership of shares confers certain rights and responsibilities in relation to the company and these have a monetary value. These rights and responsibilities include:

- A return from the company's profits (dividend);
- A right to transfer their interests to another person (sell shares); and
- A vote at general meetings where issues to do with the constitution, director appointment, business performance and liquidation of assets are discussed.

Although each share has equal value, shareholders themselves may own any number of the available shares. Thus the level of influence exerted on the company, and the overall financial return, is dependent on the number and proportion of the shares owned.

Potential contractors should recognise that the ability to sell shares in a company holding a GMS/PMS contract is restricted by the provider conditions and that, in all cases, changes in ownership have to be reported to the PCT.

6.3.2 Companies limited by guarantee

Companies limited by guarantee are usually set up where people want the advantages of limited liability but are not seeking a financial return. Although not required, there is often a constitutional requirement that profits are not to be paid out to members but must instead be put towards the company's purpose.

A key feature of these companies is that no share capital can be issued. Voting is therefore based on one member one vote. Members cannot transfer their rights and membership ceases on death.

This type of company has been widely used by GP out-of-hours co-operatives, member's clubs, charities and mutual financial companies.

6.3.3 Industrial and Provident Societies

Industrial and Provident Societies (IPSs) are also companies limited by guarantee. However, IPSs are regulated by the Financial Services Authority (rather than the Registrar of Companies), which ensures that these companies comply with the Industrial and Provident Societies Act 1965.

There are two types of IPS – a bona fide co-operative society and a society for the benefit of the community.

Co-operative societies are set up to conduct business through member participation for mutual benefit. They are democratic enterprises which, in general, are based on members having one vote regardless of the number of shares they hold.

A society for the benefit of the community must demonstrate that its activities will benefit people other than its own members. It has rules that specify how surpluses are to be applied and that require any assets remaining after the company is dissolved to be applied for similar purposes and not distributed amongst members.

6.3.4 Community Interest Companies (CICs)

This new type of vehicle is intended for organisations that want to ensure that their profits and assets are used for the good of the public.

CICs are limited companies (whether by shares or by guarantee) that are subject to further restrictions regarding the distribution of profits and assets to members. For example, if a CIC is wound up, its assets may only be transferred to another organisation that is subject to a similar asset lock.

Once incorporated, to become a CIC, the company must pass a 'community interest test' – the constitution must demonstrate that they are pursuing aims that are beneficial to the community rather than a small group of beneficiaries.

Then, in addition to the regulation surrounding all limited companies, CICs must deliver an annual report to the CIC Regulator outlining what the company has achieved within the communities it serves.

6.3.5 Limited Liability Partnerships

A Limited Liability Partnership (LLP) is an alternative corporate business vehicle that gives the benefits of limited liability but allows its members the flexibility of organising their internal structure as a traditional partnership. The LLP is a separate legal entity and, while the LLP itself will be liable for the full extent of its assets, the liability of the members will be limited.

The internal structure of the LLP is similar to that of a partnership. The members provide working capital and share any profits. An LLP is taxed as a partnership. Income derived by the members from the LLP will be closer to that of a partnership than to the dividends paid by companies.

However, LLP disclosure requirements are similar to those of a company. LLPs are required to provide financial information equivalent to that of companies, including the filing of annual accounts.

6.4 Social Enterprise

The term 'social enterprise' is not descriptive of any legal form or organisational structure; rather it describes the purpose and behaviour of a business venture.

Social enterprises – businesses with primarily social objectives whose surpluses are re-invested in the business or in the community - can be constituted in many ways, most commonly as a mutual, a co-operative, Community Interest Company or a Company Limited by Guarantee.

Many (but by no means all) social enterprises have adopted a model of social ownership where stakeholders, employees and the community are encouraged to take ownership of the company.

The key point is that the legal structure is chosen to best serve the social enterprise's core purpose and values. The choice is also bound up with who the enterprise considers to be its 'community' and how it wants this community – whether this means its staff, its customers, or a mixture of stakeholders – to influence or benefit from its activities.

For more information:

- Business Link – Legal structures
  http://www.businesslink.gov.uk/bdotg/action/layer?r.l3=1073865730&r.l2=1073859131&r.t=RESOURCES&r.i=1073789606&r.l1=1073858805&r.s=m&topicId=1073865730

7. NHS Pensions

When considering which organisational form is most appropriate, it is important to bear in mind that not all structures provide access to the NHS Pension Scheme for employees.

If the organisation is not, or cannot become, an NHS Pension Scheme Employing Authority, then this may have an impact on recruitment and retention of suitable staff.

However, access to the NHS Pension Scheme is intended to cover relatively small primary medical care contracting organisations, and many providers may prefer to design their own pay and pension packages to target their own recruitment need.

7.1 GMS/PMS contractors

If a potential contractor qualifies as a GMS or a PMS contractor (please refer to the definitions in section 5 – eligibility) then they may become an NHS Pension Scheme Employing Authority i.e. the contractor can offer NHS Pensions to their staff.

It is important to note that the pension arrangements for GMS/PMS contractors are slightly different from NHS organisations e.g. PCTs.

As members of the main NHS Pension Scheme, the GMS/PMS contractor's staff will be entitled to retirement benefits. However, they will not be entitled to the separate but related benefits in respect of injury, early payment or extra service on redundancy or Voluntary Early Retirement with the employer's consent (where the employer agrees to meet the cost so the pension is not reduced).

7.2 APMS contractors

If a contractor only qualifies for APMS contracts then they cannot be an NHS Pension Scheme Employing Authority i.e. the contractor cannot offer NHS Pensions to their staff (this includes staff who have transferred from the NHS).

The most important word here is 'qualifies'. The key point is whether the organisational structure is such that it could legally enter into a GMS or PMS arrangement, not whether the organisation actually holds such contracts.

In other words, an organisation that only holds an APMS contract may still offer the NHS Pension Scheme to its staff, provided that it meets the eligibility criteria for either a GMS or PMS arrangement, even though such a contract may not be on offer.

If this is the case, then the APMS contractor will be offering the NHS Pension Scheme to its employees on the same terms as GMS/PMS contractors ie. with retirement benefits as per the main scheme but without the entitlement to benefits indicated in the previous section.

For more information:

- NHS Pensions (part of the Business Services Authority) http://www.nhspa.gov.uk/site/index.cfm

8. Workforce

The potential contractor will be required to secure (and provide evidence of) a suitable workforce. It is a requirement that (with very limited exceptions) all medical practitioners performing services under the contract should be included in a medical performers list of a PCT. Equally, all health care professionals must be appropriately registered with their relevant professional body.

Further, the contractor must ensure that there are appropriate arrangements in place for maintaining and updating the skills and knowledge of all health care professionals involved in the performance of (or assisting in the performance of) services under the contract.

More broadly, the contractor should be able to demonstrate that all employees will have reasonable opportunities to undertake appropriate training with a view to maintaining that employee's competence.

It may be that the contractor is free to develop the workforce in the manner they see fit to successfully deliver the specified services. However, there will some circumstances where services that were previously provided by the PCT (or other NHS organisations) are now being contracted out.

In such circumstances it is likely that the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) will apply. These regulations are intended to safeguard employees' rights when the business in which they work changes hands between employers.

8.1 The Transfer of Undertakings (Protection of Employment) - TUPE

The PCT and the contractor should maintain an open and transparent dialogue throughout the TUPE process. It is important to ensure that information and consultation procedures with both the commissioner and union representatives, where necessary, are clearly understood by all parties.

This guide can only offer a brief summary of the legislation and it is recommended that, where TUPE applies, potential contractors secure independent legal advice.

The Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) (TUPE 2006) is now the main piece of legislation governing the transfer of an undertaking, or part of one, to another. The regulations are designed to protect the rights of employees in a transfer situation enabling them to maintain the same terms and conditions, with continuity of employment, as they formerly enjoyed. TUPE 2006 entirely replaces the Transfer of Undertakings (Protection of Employment) Regulations 1981 (SI 1981/1794).

A TUPE Code of Practice that only applies in the public sector is available from the Department of Communities and Local Government (the department that replaces the Office of the Deputy Prime Minister – ODPM). The Code requires that those employees who join the organisation after a transfer has taken place should be offered fair and reasonable terms and conditions of employment, which are overall no less favourable than those of the transferred employees.

8.1.1 When TUPE applies

By way of broad guidance, TUPE has been found to apply to:

- contracting out of services
- mergers
- changing contractors
- sale of a business by sale of assets
- where all or part of a sole trader's business or partnership is sold or otherwise transferred.
- a change of licensee or franchisee
- the gift of a business through the execution of a will

Any trade or business is included, as are non-commercial concerns such as charities and the public sector.

8.1.2 Service Provision Changes

TUPE 2006 makes it clear that it applies to service provision changes as well as business transfers, most of which already fall into the previous provisions of TUPE 1981.TUPE 2006 will therefore apply to contracting out, contracting in and re-tendering situations.

Questions to consider as to whether there has been a relevant transfer are:

- Has there been a transfer of an economic entity that retains its identity (a business transfer)? or
- Is there a service provision change?

A service provision change arises when a commissioner appoints a provider to do work on its behalf when either reassigning such a contract, or bringing the work 'in-house' (a service provision change).

It will not be a service provision change if the contract is wholly or mainly for the supply of goods for the commissioner's use or the activities are carried out in connection with a single specific event or a task of short-term duration.

Some transfers will be both a business transfer and a service provision change.

8.1.3 Recent changes to TUPE and employers compliance

The essence of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) (TUPE 2006) reflects the previous legislation. However, contractors should be aware of some of the following important changes:

- Contractors (new employer/transferee) should ensure that the commissioner (old employer/transferor) informs them of all the employment liabilities that are to be transferred
- Contractors will need to gain clarification of the circumstances in which employers can lawfully make transfer-related dismissals (as there are a number of circumstances in which an employee's dismissal are held to be automatically unfair)
- Contractors will need to consider whether any transfer-related changes to the terms and conditions of employment fall within the definitions of 'economic, technical or organisational' (ETO) reasons
- Contractors can expect that both the commissioner and themselves will be jointly liable for any failure on information and consultation with the transferring employees

8.1.4 Changes to Practice

The changes introduced by TUPE 2006 to any transfer that takes place on or after 6 April 2006 means that there are some changes to practice. Therefore contractors should consider the following factors:

- Contractors should conduct a thorough review of standards, proposed transfers and transfer documentations, taking into account the potential new liabilities and new obligations in providing employee liability information
- Contractors should make certain that all the necessary employee information can be processed, so HR departments need to be able to prepare, supply and retrieve this information as and when needed
- Contractors should be aware that the transfer agreement may include extensive provisions about the ongoing notification of employee information, as this will facilitate the process of any future transfers or service provision changes
- Contractors should keep an open dialogue and review transfer agreements throughout the process to guarantee that both parties are fulfilling the duty of providing employee liability information and meeting information and consultation requirements.

8.1.5 Pensions

HM Treasury have issued specific guidance on treatment of pension issues in compulsory transfers of public sector staff to private sector partners delivering public services.

The main points are:

- when transferred staff have to become early leavers of a public sector pension scheme, it is essential to provide them not only with a 'broadly comparable' private sector scheme for their future service, but also with the cover of a 'bulk transfer agreement' to allow them, if they wish, to maintain a link between their future earnings growth and their past service pension benefits;
- the costs of the bulk transfer agreement may be a significant element in the overall costs of the project;
- the procurement of the bulk transfer agreement should be handled as an integral part of the competition for the overall procurement, with the terms of the agreement being advertised at the earliest stage and being finalised before staff transfer;

8.2 The Employment Equality (Age) Regulations

On October 1 2006, new laws will come into force to protect workers from age discrimination. The Employment Equality (Age) Regulations will make it illegal for employers to discriminate against employees, trainees or job seekers because of their age and ensure that all workers, regardless of age, have the same rights in terms of training and promotion.

The affects of these new regulations will need to be considered by contractors especially when relating this legislation to pensions. The Department of Trade and Industry have produced guidance on The Impact of Age Regulations on Pension Schemes and this is an important source of information for contractors.

For more information:

- Department of Trade and Industry (DTI) – Guide to TUPE 2006 http://www.dti.gov.uk/files/file20761.pdf
- Cabinet Office's Statement of Practice 'Staff Transfers in the Public Sector' http://www.civilservice.gov.uk/publications/pdf/stafftransfers.pdf
- Fair Deal For Staff Pensions: Procurement Of Bulk Transfer Agreements And Related Issues *Guidance Note by HM Treasury, June 2004.* http://www.civilservice.gov.uk/publications/doc/btapublicfinal.doc
- DTI - The impact of Age Regulations on pension schemes http://www.dti.gov.uk/files/file28230.pdf

9. Premises

The contractor must ensure that the premises used for the provision of services are suitable for the delivery of those services and sufficient to meet the reasonable needs of the contractor's patients.

It may be that suitable premises already exist and arrangements have been made for the successful contractor to occupy those premises. Alternatively, there may be an expectation that suitable premises will be secured by the contractor as part of the new contractual arrangements.

Contractors should be aware that details of the arrangements to be used to calculate and make payments for premises under GMS contracts are included in the Premises Costs Directions. Given the central allocation of funding for premises arrangements, it is to be expected that these will also form the basis of premises arrangements under the other contracting routes.

Contractors considering use or development of the NHS estate will need to review the local Strategic Service Development Plan (SSDP). While the emphasis is on primary care, a comprehensive SSDP should reflect local and joint aspirations between health, social services and other stakeholders to develop integrated services and where appropriate joint premises within a modern primary care estate.

As part of the SSDP, there are also many Local Improvement Finance Trust (LIFT) programmes in many health communities providing primary care facilities as part of public/private partnership arrangements. Utilisation of these facilities may be necessary to maximise use of the primary care estate. Contractors will need to be aware of LIFT responsibilities and existing lease arrangements.

Following the publication of the White Paper – *our health, our care, our say* – there has been a new programme of investment announced by the Department of Health for community hospital facilities. This should encourage further development of these local facilities by existing and future commissioners and providers.

The White Paper also emphasises the shifting of services into community settings where appropriate. There is a desire to develop far more integrated health and social care services and these will be supported by the development of suitable primary care facilities. This is advantageous in respect of co-location of staff and services, more integrated patient/service user pathways and clinical networks.

Key factors to consider if developing or expanding a local primary care facility include:

- An end result of a more modern, sustainable, flexible, and high quality facility which ensures it is 'fit for purpose'
- Incorporating improved and up-to-date technology links with functionality in relation to Connecting for Health IM&T system specifications
- Accessibility and improved opening times to suit users
- Consumerism and the way the facility will be used, particularly function and aesthetic quality to improve the patient experience
- Ensuring the facility provides a multi-disciplinary working environment
- Appropriate levels of privacy and dignity for users are ensured
- Safety and security are optimised for staff and users
- A workplace which is good for staff moral and well-being
- Convenient location for staff and users which is close to public transport links with reduced journey times for users as a result
- Maximising patient input into the design of the facility, perhaps as 'design champions'
- Compliance with Infection Control (COSHH), Health and Safety, and Disability Discrimination Act (DDA) regulations
- For a new facility, consideration of the standards set in or by
  - AEDET – Achieving Excellence in Design Evaluation Toolkit
  - CABE – Commission for Architecture and the Built Environment
  - NEAT – NHS Environment Assessment Tool

For more information:

- Department of Health - Guidance and documents about the aspects of the new primary care contracting arrangements relating to premises, including *National Health Service (General Medical Services - Premises Costs) (England) Directions 2004*
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PrimaryCareContractingArticle/fs/en?CONTENT_ID=4078444&chk=j9yTaA

- NHS Estates - Primary and Social Care Premises
  http://www.primarycare.nhsestates.gov.uk/secure/content.asp

- Department of Health - Estates and Facilities Management
  www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EstatesAndFacilitiesManagement/fs/en

- Department of Health - NHS LIFT
  www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/fs/en

Section 3 – Securing a Primary Medical Services Contract

10. Primary Medical Services Procurement

Procurement of medical services is subject to limited legislative control. However, the principles laid down in legislation require that the system for procuring the service of a contractor be fair and transparent. Indeed, with reference to primary medical services contracts and APMS in particular, the DH website 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."

In practice, although advertising for tenders is not a formal requirement, this is likely to be the favoured route to approach potential new contractors for primary medical services arrangements. However, PCTs are likely to consider service opportunities on a case by case basis to ensure their procurement response is both pragmatic and proportionate and that could see arrangements other than full open competitive tenders being utilised to select a contractor.

10.1 The procurement process

It is therefore likely that potential contractors will have to go through a fixed procurement process with a set timetable. In these circumstances, it is essential for potential contractors to give all the information required and to meet the relevant deadlines at each stage of the process. Failure to do so will mean elimination from the process.

The procurement process will probably involve a formal Expression of Interest - a pre-qualification stage used to identify realistic candidates for the contract. Potential contractors will be asked for information about the financial position of their business and details of their experience (with references).

Once through the pre-qualification stage, potential contractors may then receive an Invitation to Tender or contract notice inviting them to bid for the contract. These bid documents set out the key criteria that must be met.

Contracts are awarded on the basis of value for money (best value) - which means getting the right balance between the price and quality – rather than simply on lowest price.

PCTs are expected to provide feedback to unsuccessful contractors if requested. Also, information about the contract is subject to the Freedom of Information Act, such that all contractors have a right to ask for detailed information about the procurement/selection process - but there may be a charge.

10.2 Freedom of Information Act

All contracts with public bodies are subject to the Freedom of Information Act and information must be disclosed to anyone who asks for it, unless it is exempt (for example, as a trade secret).

Therefore, when potential contractors provide information to the PCT, they should clearly indicate which information is commercially confidential. If the information is particularly sensitive, the contractor might want to ask for a non-disclosure agreement to be part of any negotiations.

10.3 Summary of the selection process

Figure 1 sets out the type of process that potential contractors can expect followed by a brief description of the various stages.

10.3.1 Expression of Interest

This is an initial response to any advert with notification to the Commissioner of interest in submitting a formal business case proposal for the service. It does not commit the contractor to anything at this stage.

10.3.2 Information pack/Memorandum of Information/Tender Prospectus

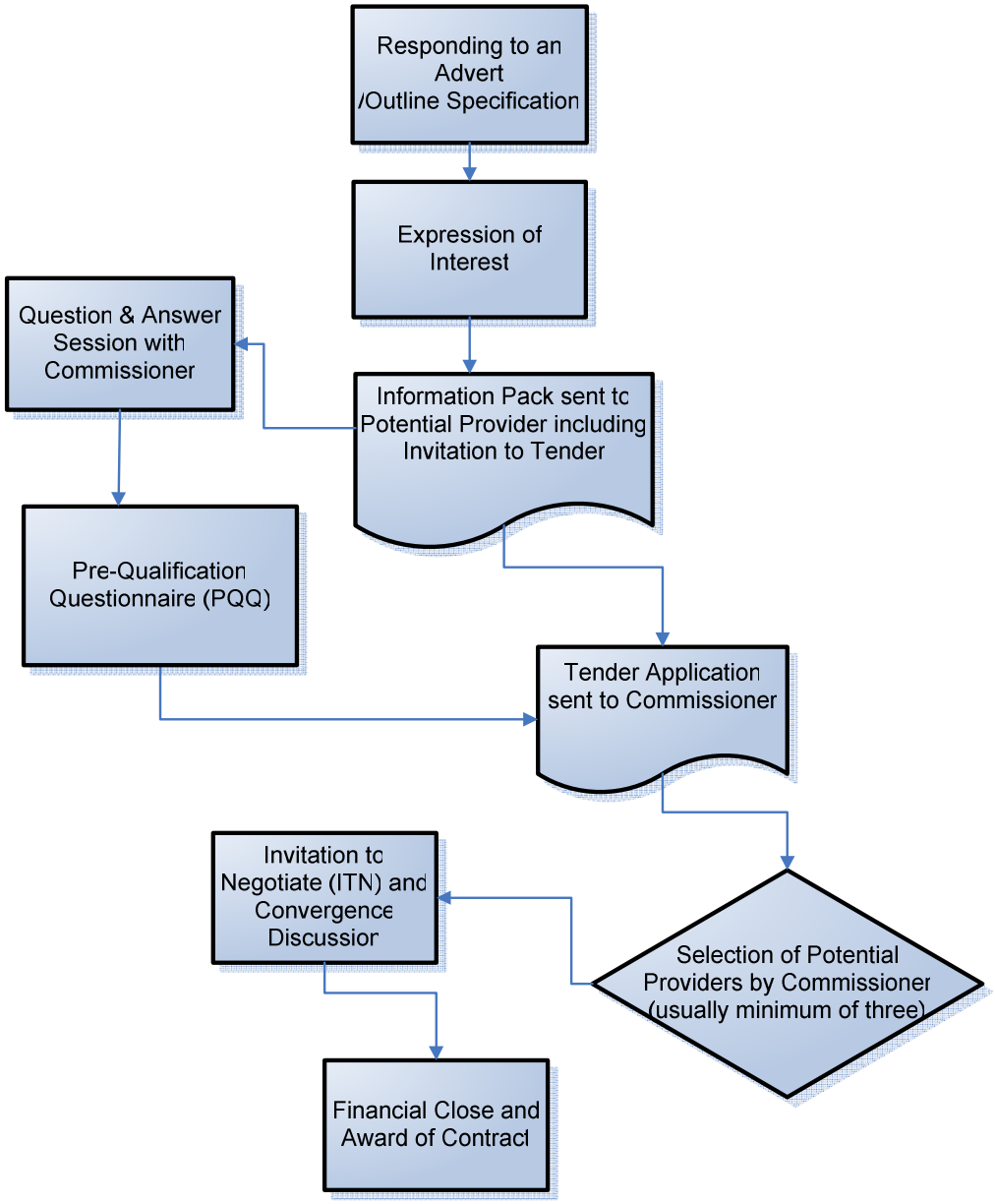
A pack will usually be sent out to all potential contractors expressing an interest in the service. The pack is likely to include:

- Key information about the local health community, other services and locations, local population demographics and health inequalities,
- Any future and agreed service development plans, partnership links, or any other strategic policies.
- Service specification and expectations around service quality standards
- Available resources i.e. funding, staffing, premises or other PCT support.
- Other aspects of the pack may cover
  - Instructions to Tenderer, with details of second stage evaluation criteria
  - Standard Conditions of Contract
  - Pricing schedule
  - Correctly labelled Tender Envelope
  - Tendering timetable.

10.3.3 Q&A

Some commissioners may include a Q&A session to assist understanding among potential contractors. Potential contractors will be required to attend. This can act as a useful natural filter mechanism as many details in advert or information pack can be clarified and potential contractors can decide if they wish to continue further into the process. However, this stage is not normally used as a method of formal selection by Commissioners.

Fig.1 – Provider Selection Process



N.B. The process for selection will be fundamentally the same for each service being tendered. However, providers will need to establish which of the following steps will apply in each individual tender submission process as these may differ slightly depending on the service and the Commissioner.

10.3.4 Pre- Qualification Questionnaire (PQQ)

The PQQ is part of the formal selection process and sets out initial criteria for selection. It is a mechanism to demonstrate a contractor's credibility, suitability and capability to provide the service.

Commissioners should clarify if scores on PQQ will be used to contribute to overall formal selection. Contractors should note that a more detailed accounting assessment of a potential contractor may take place at this stage.

The PQQ usually includes questions on:

- Administrative information
- Business probity
- Economic and financial standing
- Health and safety
- Quality Assurance
- Technical capability
- Equal Opportunities
- Environment
- References

Commissioners may require the following documents from the potential contractor:

- Certificate of Incorporation
- Group structure chart
- Audited accounts for the last 3 years
- Employer's Liability Insurance certificate
- Public Liability (3rd Party) Insurance certificate
- Health and Safety
- Quality Assurance Policy
- Documents to support your technical capability
- Equal opportunities policies.

10.3.5 Business Case/Formal Tender submission

The potential contractor will need to submit a formal and comprehensive tender document to the commissioner. Evaluation of this submission will usually be based on a set of formal selection criteria or competencies, which are weighted for priority and considered by a selection panel. These could build on PQQ elements where applicable or may be new criteria.

Following initial evaluation, potential contractors may then be invited to an interview to discuss the formal submission and to answer any competency-based questions. This interview will usually require the contractor to give a presentation to a panel.

Commissioners should make any scoring process clear to all potential contractors. The contractor may be asked to re-submit information following this stage if clarification is needed before any final decision is made. Further, an accounting assessment may take place as well as follow up of any references provided within the submission.

Following this, a preferred Bidder/Contractor will be selected and informed. Usually unsuccessful bidders will be informed and commissioners may follow these up if further negotiation with the preferred bidder/contractor proves unsuccessful.

To assist the submission of a formal tender, see additional points below.

10.3.6 Invitation to Negotiate/Convergence Discussion

- Preferred bidder/contractor will be invited to discuss finer detail of service provision with Commissioner
- Service Specification and contracting method will be agreed
- Length of contract and service start date will be agreed

10.3.7 Financial Close/Contract Award

During the contract award stage, the commissioner may need to inform any Board structure of process and decisions made.

The commissioner and contractor will:

- Clarify the formal contract documentation which binds and protects both parties
- Discuss the final elements of the service specification which build on the original tender submission
- Provide formal contract signatures.

Depending on the value of the contract award, it may be necessary to place a Contract Award Notice in the OJEU.

10.4 Key Areas for Contractors

The following areas underpin many commissioning decisions and should be considered when potential contractors address the stages in a tender process:

- ***Communication***
  Relationship management is important so key individuals will need to be named as contacts or as holding service responsibility.
  Contractors should seek clarification from commissioners where appropriate at any stage in the process. Be honest about any difficulties which may be envisaged. Suggesting ways in which these may be overcome would be advantageous.

- ***Follow instructions***
  Comply with the bid process by following instructions, pricing the service accordingly, carefully following the evaluation criteria, and responding by the correct submission date.

- ***Have a robust business case.***
  Submitting a fully-developed plan/proposal is critical. It should demonstrate that the contractor can meet all the requirements in a cost-effective manner.

- ***Stand out from the crowd***
  Describe key innovations. Emphasise any unique selling points and a track record in relation to any previous service or market competitors.

- ***Financial clarity***
  Actual costs and value for money need to be clearly spelt out with a complete forecast for the service. Commissioners wish to see realistic prices for service provision with an indication of whether the submission is at a fixed price or not. Contractors may wish to consider benchmarked prices for aspects of their service.

- ***Highlight efficiency gains***
  Cost improvement mechanisms will enhance any proposal and the contractor should demonstrate ways of either being more efficient than current service costs or more efficient that other providers in the market.

- ***Delivering high quality services***
  All submissions will be judged on key quality criteria and the potential contractor will need to provide evidence and assurances of service quality levels.
  Robust clinical governance protocols and procedures will need to be in place. Internal performance management will need to be highlighted and reassurances given to the commissioner including controls assurance, management of risk, and quality assurance processes.

- ***Patient and Public Involvement (PPI)***
  PCTs will require contractors to undertake rigorous patient, public and stakeholder engagement, provide evidence of this and show how they have responded to the issues raised by local people. For substantial developments or variations to services or the provision of new services the PCT will be required consult the local authority overview and scrutiny committee.

- ***Solid infrastructure***
  Demonstration of strong business management will be fundamental. All staffing and HR aspects will need to be covered in depth including managing any transfer of existing staff, capacity, recruitment, staff structure, clinical leadership, and continuing professional development.
  Premises and IT considerations will be important if taking over an existing NHS space or developing a new one (see earlier section). This may involve leasing or further capital investment detail and commitment to upgrade premises to fulfil NHS Connecting for Health requirements.

For more information:

- APMS Toolkit http://www.pasa.nhs.uk/pct/APMS_pg-final_version_22_August_2005.doc
- APMS contracting guide http://www.nhsconfed.org/docs/apms_guidance.pdf
- PASA website http://www.pasa.doh.gov.uk/purchasing/PPNTHRESHOLD.doc
- Official Journal of the European Union (formerly the OJEC) www.ojeu.com

Section 4 – Resources

List of useful addresses for more information, advice and support

- NHS Primary Care Contracting www.pcc.nhs.uk
- Department of Health www.dh.gov.uk
- Department of Trade and Industry www.dti.gov.uk
- NHS Purchasing and Supply Agency www.pasa.doh.gov.uk
- Primary Care/NHS Estates www.nhsestates.gov.uk
- NHS Employers www.nhsemployers.org
- NHS Pensions (part of the Business Services Authority) http://www.nhspa.gov.uk/site/index.cfm
- Chartered Institute of Personnel and Development (CIPD) www.cipd.co.uk
- ACAS www.acas.org.uk
- Department of Communities and Local Government (formerly the Office of the Deputy Prime Minister - ODPM) http://www.communities.gov.uk/
- Department of Work and Pensions (DWP) www.dwp.gov.uk
- Employment Tribunal Services (ETS) www.employmenttribunals.gov.uk
- Civil Service www.civilservice.gov.uk

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Disclaimer:
Every attempt has been made to ensure that the information contained within this document is correct at time of publishing (17 Nov 2006) but this may have changed subsequently. The information is designed as guidance only and legal advice should be sought before developing any contractual arrangements.