ANNEX C

PERSONAL MEDICAL SERVICES

THE NATIONAL HEALTH SERVICE
(PRIMARY CARE) ACT 1997

A COMPREHENSIVE GUIDE - VERSION 3 (UPDATED MAY 2001)

NHS SCOTLAND
HEALTH DEPARTMENT

ALSO AVAILABLE IN ELECTRONIC FORM (www.show.scot.nhs.uk/lhcc) – SEE PMS BUTTON
PURPOSE OF THIS DOCUMENT

This document has been prepared for:

- members of the "NHS Family" ie:
  - NHS Trusts, including Primary Care NHS Trusts who hold delegated responsibility for the development, implementation and local evaluation of the PMS pilot.
  - GPs.
  - NHS employees (employed either by NHS Trusts or by GP practices) who are interested in developing Personal Medical Services (PMS) pilots under the NHS (Primary Care) Act 1997.

This document is an update of the original Comprehensive Guide issued in early 1998.

This document consolidates and replaces the information contained in that document. It is framed in terms of Primary Care Trusts/Island Health Boards taking on responsibility for the development, implementation and local evaluation of PMS pilots. These functions have been delegated by mainland Health Boards to PCTs under the terms of the Delegation Direction made in October 1999 for pilot PMS schemes and a Delegation Direction for permanent PMS schemes made in April 2001.

This document sets out information and advice for approved pilot schemes, from the process of contract negotiation, to issues around the actual operation of pilots and for permanent PMS agreements.

Guidance on matters covering Personal Dental Services (PDS) pilots has been issued separately as "A guide to Personal Dental Service Pilots under the NHS (Primary Care) Act 1997".

Throughout this document any reference to Primary Care Act Pilots refers only to the provision of PMS and not PDS.
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### GLOSSARY OF TERMS

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<td>Personal Medical Services (PMS) Scheme</td>
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<td>PMS agreement</td>
<td>S.17C of the 1978 Act refers to the term 'agreement', so for the sake of consistency, we have adopted this term. 'Contract' and 'agreement' are synonymous in this context.</td>
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<td>PMS Personnel</td>
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<td>PMS provider</td>
<td>The collective term for those who are entering a PMS agreement with the PCT or IHB.</td>
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APPLYING TO BECOME A PMS PILOT

SECTION 1: BACKGROUND

Supporting recent developments in the NHS

1. Since implementation of the first wave of Personal Medical Service (PMS) pilots in Scotland, there have been significant developments in the NHS, particularly the introduction of Primary Care Trusts, the development of Local Health Care Co-operatives and the introduction of Clinical Governance arrangements. Therefore, it is important to ensure that any subsequent arrangements for PMS are consistent with the strategy of PCTs for the delivery of high quality, appropriate services to patients.

Primary Care Trusts/LHCCs

2. PMS offers a good opportunity to learn and develop practices that will be necessary to secure the objectives of the new NHS and the development of LHCCs. The types of organisational model available under PMS are extremely valuable as a vehicle for Primary Care Trusts and Island Health Boards (PCTs and IHBs) to:

- test out the move to a locally targeted contract, on a voluntary basis, thus allowing exploration of the benefits of such contracts, as a means to reward good clinical performance;
- test out shared management arrangements for the provision of multi-professional primary care particularly where, in practice, there may be reluctance to explore opportunities for changes to skill mix in primary care provision;
- tackle specific problems affecting the delivery of primary care services, eg creating greater equity of GMS usage; addressing recruitment and retention problems;
- tackle specific local health problems – ie tying in with the target areas eg on cancer, coronary heart disease or on other areas, such as: asthma, diabetes, health or school-age children, developing better services for vulnerable people, homeless patients;
- develop LHCC-wide or locality - based services and explore the opportunities for a more consistent approach to service delivery and economies of scale.

3. Island Health Boards and Primary Care Trusts working with providers - GPs, nurses and other members of the primary care team - will wish to consider what is the most suitable and appropriate way to achieve their objectives. Establishing a PMS scheme is one option, but consideration should also be given to developments and opportunities available through local development schemes or the salaried doctors scheme, for example.

4. PMS is first and foremost concerned with Primary Care and exploring new ideas for its delivery. Although there are many possible new organisational models and structures which could be tested within PMS, there seems little merit in pursuing ideas which are not based upon and which do not fulfil the basic principles of what makes up good primary care. Therefore, in establishing a PMS scheme, both those responsible for providing the service
and PCTs/IHBs (as the authorisers of services to be provided) should aim to ensure that its every aspect supports the basis of delivering good primary care.

5. The NHS (Primary Care) Act 1997 (the 1997 Act) was designed to allow those who wished to have flexibility to explore different models for the provision of Primary Care and to test the practical implications of these models and the benefits that they could bring.

6. Amendments were made by the Health Act 1999 to the 1997 Act. A "Personal Medical Services" agreement will now be made between the Primary Care Trust or Island Health Board and a Practice or other qualified NHS Staff.

7. Separate regulations have also been drawn up to allow permanent PMS schemes from April 2001.

**What are Personal Medical Services?**

8. The 1997 Act introduced the term "Personal Medical Services". These are the same types of services that are more widely known as "General Medical Services" (GMS) and provided by general medical practitioners under Part II of the NHS (Scotland) Act 1978. The use of the term "PMS" is simply to make it clear that the services are to be provided under the 1997 Act.

9. PMS is an opportunity for primary care teams and PCTs and IHBs to test different ideas for delivering existing GMS, focusing on local service problems and bringing about improvements. PMS is implemented through new contractual arrangements with the PCT for delivering PMS to the registered patients of practices involved in the scheme.

10. PMS schemes are intended to give PCTs and IHBs and providers different options for addressing primary care needs. All PMS schemes must seek to improve the access and quality of services provided within primary care, providing a vehicle for faster, more convenient, more widely accessible primary care services, delivered to high clinical standards. They can also be used to:

    - address recruitment and retention problems in respect of GPs
    - improve the equity of GMS resource usage
    - develop new arrangements/organisations for the delivery of services, giving different professionals greater scope and opportunities
    - reduce the bureaucracy involved in the management of primary care provision.

11. PMS schemes must include the services that patients are currently entitled to receive from their GPs under GMS. They will also need to ensure continuity of care for all their individual patients – as GPs do now – including the provision of out of hours cover. PMS schemes cannot pick and choose elements of service or remuneration to be retained outwith the new contractual arrangements, they must move all elements to the new contract.
12. The features which underpin these pilots are:

- participation will be voluntary
- new approaches will be tested through piloting review before decisions on permanent arrangements are made
- PCTs and IHBs may enter into a PMS agreement with a practice, or other qualified NHS staff, such as nurses or practice managers
- PCTs and IHBs may make a PMS agreement which covers services which it provides (in effect contracting with themselves)
- within PCT areas, participating practices should belong to an LHCC
- PMS pilots must be approved by Scottish Ministers. This requirement does not apply to permanent PMS schemes.
- accountability to local communities and to PCTs and IHBs will be delivered via the explicit contractual and consultation arrangements on which pilot schemes will be based
- the scope of a PMS scheme may include prescribing within a cash-limited budget
- where the existing Part II service arrangements include dispensing, pilot participants will have the option of including or excluding dispensing within the Part I cash-limited PMS agreement or continuing to provide this service under Part II
- some pilots will represent no more than the provision of existing service within a different contractual framework, ie under locally agreed arrangements. In these cases, existing resources will be transferred from national GMS non cash-limited budgets, including drugs, for allocation to Primary Care NHS Trusts via Health Boards. An appropriate share of local GMS cash-limited resources should also be made available to fund pilots
- other pilots will represent new or enhanced service provision. It will be for PCTs and IHBs to identify resources to be used from within current HCHS financial resources, or for an additional investment bid to be made to the Scottish Executive (see Section 3: allocation of resources)
- any additional resources provided to PCTs and IHBs, should be allocated equitably to GMS and PMS arrangements, as a general rule. Scottish Ministers are committed to the principles of achieving equitable distribution of resources, whilst ensuring that GPs who remain in the national contract (under Part II arrangements) will not be disadvantaged nor better off by any PMS-related resource transfers
the Act allows for new types of primary care organisations within the NHS Family to be developed which will be responsible for providing personal medical services through a specific contract with the PCT or IHB. These include:

- extending current partnership arrangements

- the establishment of limited companies owned by NHS Family members, ie NHS Trusts, or GPs or other NHS/PMS scheme employees. However, it should be stressed that it is expected that only a small minority of pilots will need to pursue this option and that its use is only intended for cases where a limited company is the only viable organisational model and it can be shown to be directly in the interests of pilot scheme patients.

- the establishment (through forming contractual arrangements) of new integrated primary and community care organisations

pilots will be evaluated and must be reviewed by Scottish Ministers before more permanent arrangements based on the pilots can be established. A review by Scottish Ministers is not required for permanent PMS schemes.

13. All PMS schemes will need to:

- have clear objectives

- have clear benefits to patients and professionals alike

- offer value-for-money for the NHS

- be approved by Scottish Ministers

14. PCTs and IHBs, can only enter into contracts with other members of the "NHS Family" to provide services under a PMS scheme. That is, one of the following:

- a suitably experienced medical practitioner - this means a doctor who does, or could, provide general medical services under the NHS (Scotland) Act 1978

- an NHS Trust

- an NHS employee or a PMS scheme employee - this means nurses, practice managers and others employed by an NHS Trust or within general practice could propose pilots but they have to include the provision of personal medical services by suitably qualified medical practitioners

- a qualifying body (which is a company limited by shares, all of which are legally and beneficially owned by NHS Trusts, suitably experienced medical practitioners or NHS/pilot scheme employees); partnerships or groups solely comprised of similar people could also put forward schemes
• partnerships or groups solely comprised of those listed above may also put forward schemes

15. PCTs and IHBs will wish to ensure that each PMS scheme offers value-for-money, is manageable and affordable within the anticipated resources available to the PCT or IHB.

16. All PMS schemes should begin from 1 April or 1 October.

DIFFERENT TYPES OF PILOT

Salaried GPs

17. GPs can be salaried either within practices or by PCTs, Island Health Boards or other health service bodies (but not by mainland Health Boards). Salaried GPs must be able to provide the full range of PMS services to the whole of a registered population.

18. The key benefits of this option are:

• to bring together separate organisations to work closer together to share resources and offer a wide range of services to patients

• to focus on service development in areas where primary care provision is deficient or to fill vacancies where recruitment is difficult

• to target particular patient groups not well served under existing arrangements, such as the homeless and drug misusers

• to free GPs from the need for capital investment and administrative responsibility to enable them to concentrate on meeting the needs of patients

19. If a practice wants to use PMS to employ a salaried GP it will mean entering into a practice-based PMS agreement for all PMS services provided by all the GPs involved. (See paras 23-28 below). The exception to this rule would be if GPs, in agreement with the Primary Care Trust, employed a salaried GP who would cover the registered list of another practice, eg in the case of a single-handed practice vacancy. This would be an instance in which they could enter into a local practice-based contract without affecting their own terms and conditions of service.

20. A Primary Care Trust or Island Health Board may want to use a PMS pilot to employ a salaried GP to:

• develop services in areas where the provision of primary care service is inadequate

• take over an existing practice to allow the GPs to concentrate solely on the clinical care provided to patients or to provide better support to single-handed practices

• fill a vacant practice where there is a continuing difficulty to recruit a GP under current arrangements
21. A PCT or IHB cannot use a PMS pilot to employ a salaried GP if:

- it would be in addition to existing general practice provision, eg to support existing GPs, unless the various GPs/practices involved have all agreed to enter a pilot, with a new single contract and a combined practice population for all their services
- it would be to provide a partial PMS service, eg out-of-hours provision only
- it would be for an unregistered population, ie the homeless population must be registered with the GP who provides their services. It cannot simply provide PMS at a "drop-in" centre, because (like GMS) PMS must always be for a defined and registered population

22. So, in most cases, to employ a salaried GP, the Trust must either employ a complete, existing GP/practice or appoint the salaried GP to an existing vacant list. Where an additional GP is to be provided over and above existing arrangements, the Trust will need to demonstrate that such a need exists and can be funded locally (or through a bid for additional investment to the Scottish Executive).

Practice-based contracts

23. There are 2 options for practice-based contracts - provision of Personal Medical Services only (PMS) or Personal Medical Services plus (PMS+).

PMS only

24. Personal Medical Services only are for the provision of those services to which a patient could normally expect to receive from any GP, eg GMS.

25. PMS only schemes may be seeking to:

- create flexibility in the delivery of services to better reflect the needs of the practice population
- deliver area-wide primary care services under the auspices of a single primary care organisation
- reduce bureaucracy and administrative costs for PCTs and IHBs and practices, allowing GPs to concentrate more time on delivering health care

What does PMS+ mean?

26. PMS schemes could embrace a wider range of services, for example by combining a practice's GMS with other non-GMS services. This would allow the primary care team to have a single contract for the direct provision of services over and above that normally provided within GMS.
27. The purpose of a PMS+ contract may be three-fold:

- to have GPs, community nurses and other professionals working together as a single integrated clinical team, delivering primary and community health services
- to provide defined secondary care services within the primary care setting
- to enhance accessibility of services for patients

28. A PMS+ scheme must also provide all existing GMS services. A PMS can only exclude services which are normally provided in addition to GMS, e.g. a drugs programme. It must then show which specific or additional services will be dealt with differently by the scheme, and explain how this will be done.

**Nurse-led pilots**

29. Nurses can hold the contract and take responsibility for the development, implementation and achievement of a PMS contract and in turn employ a salaried GP to provide the full range of PMS services to the registered population.

**GP/Nurse**

30. This option allows GPs and nurses to jointly hold the contract for the delivery of PMS and hold equal employment status.

**Effect on GMS vacancies**

31. Where the PCT/IHB receives a request to prepare a PMS proposal and the Scottish Medical Practice Committee (SMPC) had previously declared a GMS vacancy, which (a) remains unfilled and (b) relates to at least 50% of the patients expected to be on the GMS vacancy list, then the PCT/IHB shall freeze the GMS vacancy. The vacancy will remain frozen until Scottish Ministers make their determination as to whether the pilot scheme is approved or the proposal is withdrawn. If the PMS proposal goes ahead, then the PCT/IHB will need to seek formal revocation of the GMS vacancy from the SMPC.
SECTION 2: OBJECTIVES

What are the key objectives for PMS schemes?

32. The fundamental aim of PMS is to use the new flexibilities on offer to secure improved health outcomes.

33. The 1997 Act offers local flexibility to deliver services in a way which is better attuned to local needs and circumstances. Its objectives are to:

- promote high quality services for patients across the country;
- provide opportunities and incentives for primary care professionals to use their skills to the full;
- provide more flexible employment opportunities in primary care; and
- improve the NHS as a whole

Improving services for patients

34. Improving the quality, range and accessibility of services through:

- the development of services to meet the identified needs of patients
- tackling unmet needs with new or alternative services to specific populations:
  - disease-based services, eg asthma or diabetes
  - deprivation-based services, eg for the homeless, refugees or drug addiction
  - client-based services, eg for the disabled, elderly or ethnic minorities
- new models or arrangements for delivering care focused on the provision of appropriate and necessary care
- improvements to services targeted at providing improvements in the quality and access of treatment for all patients
- plans to reduce variations in the quality of services by raising standards in areas where patient groups are experiencing a lower quality of service
- provision to increase responsiveness of services to meet local needs and circumstances
Opportunities for Professionals

35. Improving the recruitment, retention, skills, development and flexibility of professionals through:

• provision of opportunities for greater co-operation between GPs, nurses and other clinical providers, as well as working with PCTs and IHBs to improve the planning and delivery of services across primary and secondary care and working with other care agencies to develop integrated local service provision

• offering ways to improve the interface with secondary care

• enhancement of team working and provision of closer professional integration in service delivery

• extension of opportunities for the provision of improved services by enhancing roles and through the development of clinicians within primary care

• the offer of greater opportunity for more flexible working between primary and community care professionals and wider caring organisations

Making improvements for the NHS in general

36. Improving the NHS as a whole through:

• the pursuit of equity in the allocation of and access to resources

• provision of value-for-money not only in financial terms but in improved quality of care

• creation of more flexibility in organisational and employment arrangements within general practice, which leads to more satisfying careers and improves recruitment and retention

• piloting strategic plans which take into account all the other local stakeholders in primary care, leading to greater co-operation in planning and developing local health service provision.

How are PMS pilots assessed?

37. In carrying out a review of the PMS pilots, Scottish Ministers will be judging the service and other benefits against the Scottish Parliament's stated objectives and the more general policy objectives of the National Health Service. The key questions to be asked are:

• have pilots improved fairness of provision by developing needs-related services, enhancing quality where standards are deficient, and improving access for disadvantaged patients?
• have pilots improved *efficiency* and provided value-for-money by making the best use of staff and non-staff resources through extended roles and development of primary care staff and by ensuring a given quantity and quality of service provision at minimum cost?

• have pilots improved *effectiveness* by providing appropriate and necessary care which is acceptable to patients, based on sound evidence, and able to produce intended outcomes?

• have pilots increased *responsiveness* by meeting identified patient needs in the context of local priorities and circumstances, and by taking better account of patient preferences?

• have pilots improved *integration* of local provision both within the NHS and with other local services by enhancing team working, increasing co-operation among clinical and inter-sector professionals, and contributing to strategic planning of local health services?

• have pilots introduced new *flexibility* in working relationships, organisational forms and employment arrangements which might improve professional morale, recruitment and retention in primary care?

• have pilots improved *accountability* to local communities and to Primary Care NHS Trusts?

38. Permanent PMS schemes will not need to be reviewed by Scottish Ministers.

**Competencies**

39. An important aim of PMS is to aid recruitment and to offer more rewarding careers to the whole range of primary care professionals by providing:

   • greater scope for influencing all aspects of primary care
   
   • shared objectives and joint ownership of initiatives
   
   • more opportunity for effective development and use of skills

40. However, this must be achieved within the context of strict adherence to the general and professional requirements and competency to carry out specific tasks. In practice, this means that careful planning is needed by PCTs, IHBs and PMS providers if they wish to seize the opportunity for developing the roles of professionals within their established competencies.
Contributing to National Objectives

41. The White Paper "Towards a Healthier Scotland" and Our National Health (ONH) published in December 2000 outlined aims and action on both national and local levels. The three action levels for better health:

- life circumstances
- lifestyles
- health topics.

42. Towards a Healthier Scotland and ONH recognise the need to tackle these issues by work at a national level across traditional boundaries and to deliver results through similarly co-operative initiatives at a local level. The action to improve people's health is to be focused in the following areas:

- a co-ordinated approach to better health with an overarching focus on tackling health inequalities. Improving life circumstances and attacking poverty with focus on NHS resources where the need is greater;
- a specific concerted drive to improve child health;
- a new sustained attack on the killing diseases – coronary heart disease and cancer;
- a cross-departmental approach to health in The Scottish Executive to help focus social and economic policy on positive health impact.

For maximum impact, headline targets have been identified in relation to coronary heart disease, cancer, smoking, alcohol, unwanted teenage pregnancy and dental health.

43. ONH states that "we will develop and invest in new contractual arrangements for GPs, building on pilots already underway, to allow Trusts to employ GPs directly to work in socially deprived areas and some rural areas". The introduction of the PMS permanency option is the first stage in the Health Department’s work to fulfil this commitment. This option will provide a useful additional tool for PCTs, IHBs, GPs and the wider primary care team in their development of improved primary care services.

Role of PMS in Contributing to Local and National Objectives

44. PMS schemes offer the flexibility and opportunity to innovate, which can make a real contribution to achieving these objectives, whether they engage in a purely local initiative or test a new way of contributing to the delivery of outcomes agreed with PCTs and IHBs for achieving national objectives.
45. PMS schemes throughout Scotland and England are addressing a range of health needs and possible areas for future PMS schemes to address could be:

- encouraging more effective treatment and care of patients in the community/at home;
- accident prevention – especially amongst children and older people;
- initiatives to tackle overweight/obesity issues;
- health services for school age children, such as out-of-hours accident and emergency provision;
- initiatives in the areas of cancer, diabetes, asthma and heart disease;
- the treatment of problem drug and alcohol users (supporting the work of the national drugs strategy);
- improving access to care for:
  - mentally ill patients
  - elderly patients in residential and nursing homes
  - homeless people
  - asylum seekers/refugees/non-English speakers
- improving equity in terms of the issues of:
  - the distribution of GPs
  - GP health promotion activity
  - public health immunisation arrangements

SUPPORTING THE DEVELOPMENT OF LOCAL HEALTH CARE CO-OPERATIVES

46. With the introduction of Local Health Care Co-operatives (LHCCs) from April 1999, Scottish Ministers have sought to put the primary care teams at the heart of the decision-making process in the NHS. PCTs will, therefore, need to consult their LHCCs on any PMS proposals and to work closely with the relevant LHCC and the pilot proposer, in developing the scheme.

Ensuring Proper Co-ordination an Support for PMS Schemes

47. PMS can offer important opportunities for LHCCs, the members of the primary care teams within them, and for Primary Care Trusts with whom they must work closely. As part
of the need to ensure that there is co-ordination and planned support for any PMS proposals being put forward, PCTs must ensure that proposals show how pilots would play a full part in LHCC activities and fit in with its organisational structure. PMS schemes must ensure that they fulfil all the obligations of the LHCC, including that of participant in Clinical Governance arrangements. They must also be consistent with the objectives of the Health Improvement Programme agreed for their area and this too must be demonstrated in any proposal.

Two Pilot Types of Particular Interest

48. Scottish Ministers are particularly interested in seeing proposals from groups of practices which form either localities or LHCCs. However, all proposals will be considered, provided they meet the criteria and are supported by all the relevant parties.

PROPOSALS

What should the PCT or IHB do?

49. Once a PCT or IHB and a primary care team agree that a PMS pilot proposal is worth considering, it should complete an Expression of Interest and submit this to the Health Department. An Expression of Interest proforma can be found at Appendix 5.

50. The PCT/IHB should:

- ensure the Expression of Interest is clearly identified and includes:
  - the title of the project
  - its purpose, aims and objectives
  - the names, addresses and telephone numbers of the proposers
  - the outcome and the responses received from the local consultation on each proposal

- advise the Scottish Medical Practices Committee on proposals for PMS schemes in all instances where these proposals include changes (increases and decreases) in the medical workforce

- consider whether proposals meet the legal requirements and the Executive's priorities.

- consider the level of financial support needed to develop the business case and final proposal.

The Role of Scottish Ministers

51. When PCTs or IHBs submit proposals, Scottish Ministers must:

- approve a proposal, with or without modifications, or reject it
• decide which pilots will go ahead
• notify the PCT or IHB of their decision in writing.

52. Scottish Ministers must also consider what effect the proposals, including any modifications stipulated, are likely to have on the distribution of general practitioners.

53. Inevitably, there will be some very good ideas generated by the formal proposal process, which have plenty of local support but cannot be taken forward as PMS pilots. PCTs and IHBs will wish to think carefully about how they will take forward such proposals under existing arrangements.

54. Once a proposal is approved a full business case should be prepared and submitted to the Health Department. The decision to approve this final proposal will be provided in writing.

FUNDING PROPOSALS

Supporting the Preparation of Proposals

55. Funding to support the development of PMS proposals is made available to PCTs and IHBs who are strongly advised to discuss with potential PMS schemes the likely costs associated with preparing their proposals, as early as possible.

56. As part of the proposal process, proposers are asked to identify what preparatory costs will be required to enable their proposal to proceed by either 1 April or 1 October of the appropriate year. It is likely that not all pilots' preparatory costs can be met from the resources available centrally. PCTs and IHBs (in considering recommendations to be made on proposals) should indicate what support they are able to offer to proposers to assist them in the preparatory period.

Inclusions and Exclusions

57. Payment can be made for the following:

• relevant specialist professional advice, eg legal, accountancy and management consultancy advice.

• reimbursement as above but for the cost of any partner in the existing practice to cover the absence of the GP, ie to cover the situation where, instead of engaging a locum, the other partners agree to cover the extra workload engendered by the GP's absence between themselves. PCTs and IHBs should agree with each site in advance what is reasonable and necessary.

• reimbursement of employment costs of additional staff, specifically engaged in organisational development work to enable the scheme to go ahead, eg setting up new systems of work prior to commencement of the scheme.

• reimbursement of any appropriate training costs directly related to skills needed for the scheme to be operational from its first day, eg training on new
computer information management systems. The training should be approved by the PCT or IHB in advance.

- reimbursement of pre-implementation costs of minor alterations, eg internal partitioning, to allow staff engaged on preparatory work to be housed prior to the scheme starting up.

- payments may not be made in respect of any preparatory work for which a person may obtain reimbursement from the PCTs or IHBs under any other enactment, eg reimbursable under the SFA. In addition PCTs or IHBs must not reimburse the cost of provision of equipment or other capital items, by hire or purchase, eg photocopiers, extra phone lines.

Pilot Costs

58. In supporting the development of full proposals, Primary Care Trusts will want to ensure that proposals are fully costed. In addition, Primary Care Trusts themselves should clearly identify the planned sources of funding to be used to support the pilot contract and confirm that the pilot scheme would be affordable and offers VFM. The planned sources of funding for each pilot should be explained, as detailed under Section 3.

On-going Management Support for Pilots

59. It is a matter for contract agreement between the Primary Care Trusts and pilot sites to determine what management support is required to support individual pilot projects. All practice or project management costs should be allowed for within – either explicitly or otherwise – and form part of, the contract price agreed between the Primary Care Trust and provider.

60. When considering what management costs should be allowed for within the agreed contract price, Primary Care Trusts will want to ensure that they treat all pilots fairly, taking account of the additional responsibilities being taken on within a pilot and the resources that a site already has available.

Proposals for Permanent PMS schemes

61. Proposals to introduce permanent PMS schemes do not need to be submitted to Scottish Ministers. However, PCTs, IHBs and primary care teams are strongly recommended to follow the objectives and process outlined in this guidance to ensure that permanent schemes follow good practice guidelines.

Local Consultation

62. It is an established principle that the NHS should provide and develop health services and care which are responsive to the needs of its users. Since PMS schemes are new developments in the delivery of services and care, it is essential that the views of those who will be affected are sought and incorporated in the schemes' development.

63. PMS proposals should be consistent with the objectives of the Local Health Plan agreed for each NHS area and that this is demonstrated in the proposal.
64. PCTs and IHBs should consult with Community Health Councils, as well as with Area Medical Committees (AMCs) and local authorities.

65. PCTs and IHBs also have an express duty to ensure that the business case incorporates the views of local people who will be significantly affected by the pilot – whether they are: patients, carers, professional organisations, consumer and community groups, GPs, NHS Trusts or Health Boards. As pilots may vary significantly in size, scope and degree of innovation, this aspect of consultation has to be determined by the PCT or IHB, based on its analysis of the proposal and its local knowledge of interested parties.

66. A key principle of consultation is to attempt, wherever possible, to consult with as broad a constituency of individuals and/or groups as possible, to ensure that the perceptions, expectations and needs of all those potentially affected by an initiative are addressed. This can often be a challenging task, as there may be some people in the community (eg non-English speakers, ethnic minorities, people with hearing, speech or visual impairments, people with learning or communication difficulties, mental health service users, older people and children) who need special targeting or additional support, to ensure that they are able to participate equally.

67. However consultation can be expensive (both financial and in people's time) so it is also important that the scope of the consultation is kept in proportion to the scale of the proposed scheme and that those involved in the consultation are appropriate to the aims, objectives and focus of the consultation exercise.

68. A key issue for any consultation exercise should be to ensure that all potentially interested parties have the opportunity for their voices to be heard and their views taken into account. There is a danger that relying on any one method in isolation could exclude the views of important stakeholders, so it will often be appropriate to employ a combination of methods instead. In any case, the key principle is to use methods that are appropriate to:

- the aims, objectives and scope of the pilot scheme
- the individuals or groups who participate in the consultation.

69. There are a number of ways in which local views can be sought, including:

- **a public meeting**: a dedicated public meeting, which has been specially convened to focus on a particular issues such as a pilot proposal. It is essential that the meeting is well publicised to encourage attendance;

- **focus groups**: specially-convened groups of local people, who can assess public perception on the proposals being put forward;

- **local voluntary groups**: these can contribute in a number of ways, eg by providing information and views

- **health forums**: locality-based groups, drawn from a cross section of the local community, eg users, carers, voluntary groups, CHCs, local authorities. Given that public consultation should be an ongoing process of involvement with local people,
then health forums could offer a vehicle for maintaining just such a dialogue between Primary Care Trusts, GPs and local communities;

- **media**: local radio, local newspaper(s); community newsletters, leaflets;
- **a formal consultation document**.

This list is not exhaustive.

70. Public consultation should be an ongoing PMS process but the initial round of consultation and any resulting adjustments to the proposed PMS scheme needs to take place prior to the business case being submitted to the Health Department.

71. Those proposing PMS schemes may already have links with local organisations or groups and have discussed the proposal with them. If so, the business case should include the names of those organisations or groups, giving an indication of their level of support for the proposed new arrangement.

72. PCTs and IHBs must examine each new arrangement proposed and plan and record the consultation undertaken. This means achieving the right balance so that the scale of consultation is proportionate in extent, manner and detail to the scale and scope of the PMS scheme in question (see above). In each case, the consultation should include the effects that arise from the pilot, in terms of provision of services for the whole of their areas, taking into account:

- plans for direct employment for primary care staff, where applicable
- the impact both on patients and on providers of primary care
- the impact on secondary care, where appropriate.

**AREA MEDICAL COMMITTEES**

73. To achieve the goal of improving primary care, it is extremely important that there is co-operation and unity between GPs at a local level. AMCs, through their GP Sub-Committees have proved themselves to be very valuable in this respect and should be central to this process. Pilots are encouraged to discuss their proposals with the GP Sub-Committee.

74. When PCTs or IHBs prepare their recommendations to Scottish Ministers for pilot schemes they must include an analysis – derived from the public consultation – of the level of public support for the proposed new arrangement and a summary of responses to the consultation.

**FRAMEWORK OF CRITERIA FOR APPROVAL**

75. Given the potential diversity offered by the new contractual arrangements, Scottish Ministers will consider proposals within a broad framework of criteria for approval. It must be recognised however that not all criteria would be capable of being met equally in every case.
76. Generally though, in approving a PMS pilot, Scottish Ministers will want to be satisfied that the proposal meets a number of the objectives mentioned in paras 32-36 above.

77. In making judgements Scottish Ministers will have a range of information to take into account, when considering proposals. This will include:

- details of the proposal being put forward by proposers and information resulting from the consultation (which will have been carried out, in line with directions);

- the Primary Care Trust's and Health Board's recommendations on the planned arrangements, on: how they fit in within other local service developments (especially LHCCs and Local Health Plans); arrangements for appropriate evaluation; and the resources identified to implement proposals;

- national considerations; nationally identified priorities to improve the provision of care to patients; and how individual pilots or types of pilot will test out new contractual arrangements to address these needs.

78. In choosing to allow the establishment of pilot schemes under the Act, Scottish Ministers are required to carry out a review of those service arrangements within three years of them being established. This review will determine what benefits, if any, have been obtained for the National Health Service and whether such provision of services should continue.

79. A framework for local and national evaluation has been developed, to ensure a complementary but comprehensive programme is secured. This is set out in a separate document: "Personal Medical Services Pilots Under The NHS (Primary Care) Act 1997: A Guide To Evaluation" with further guidance contained in Section 11 of this document.

80. Scottish Ministers' evaluation of the 1st wave PMS pilots has been carried out, and a copy of the evaluation report can be found within SHOW.

INFORMATION TO BE INCLUDED IN THE FULL PROPOSAL

Information to be provided

81. Whilst putting together their full proposals for consideration by Scottish Ministers, those working up pilot schemes should consider including:

- clear identification of issues/problems which the pilot is intending to address, as well as the rationale for the proposed developments;

- the services provided and under what terms;

- a statement of the aims and objectives of the new arrangements and how they fit in with the objectives stated under paras 32-36 above.
as an absolute requirement:

- the provision for practitioners to withdraw from the scheme – Scottish Ministers cannot approve a pilot unless they are satisfied that satisfactory arrangements have been made for withdrawal;

- if the pilot changes the number of GPs in an area, Scottish Ministers will consult with the Scottish Medical Practices Committee.

82. How the proposals may benefit patients in terms of:

- meeting their needs, providing access to services, maintaining continuity of care, ensuring equity of access to current provision, and contributing to improvements in quality of care;

- the health outcomes/gains that will be produced;

- the impact on wider health and social care provision locally;

- how stability and continuity of patient care will be protected without limiting innovative arrangements.

83. How the proposal may benefit the Primary Health Care Team in terms of:

- recruitment and retention of primary care professionals;

- developing co-operation and care partnerships between GPs, nurses and other providers as well as: working with health authorities to improve the planning and delivery of services across primary and secondary care; and working with other care agencies to develop integrated local service provision;

- meeting good employment practices, eg equal opportunities, education, training and staff development requirements.

84. Other information:

- identification of the likely cost and timetable to establish new arrangements;

- identification of additional resources required (see allocation of resources section);

- the accountability arrangements, eg financial, clinical and to the public, including:

  - how possible conflicts of interest have been satisfactorily addressed;

  - transparency of complaints system to users;

  - transparency in management and decision-making arrangements;
that effective quality assurance mechanisms are in place, ie regular audit and clinical reviews;

- credible, but proportionate, proposals for necessary local evaluation;

- an agreement to participate in a central evaluation programme and to provide national data/information.

**Information which Primary Care Trusts/Health Boards may wish to include in recommendations to Scottish Ministers**

85. In making recommendations to Scottish Ministers, it would be helpful for Primary Care Trusts to consider:

- the likely impact on existing services and service arrangements, including consistency with – and contribution to – local medical and non-medical education and training plans;

- the proposing organisations' level of commitment and management skills, necessary to deliver and manage the project arrangements;

- how they would manage the cessation of any pilot, in terms of immediate local service provision and the impact on the wider location.

86. How the proposal will benefit patients in terms of:

- underpinning the development of good primary care and developing local services;

- addressing issues identified within the Local Health Improvement Programme;

- ensuring that patients and local people will continue to be involved in influencing service provision after the initial consultation process;

- demonstrating value for money – not only in financial terms but in realising improved quality of care.

**OTHER CONTRACTUAL MATTERS**

**Sub-contracting**

87. A procedure for varying contracts should be laid down in the PMS agreement between the PMS site and the PCT/IHB. Any change in the arrangements once the scheme has gone live is a contract variation. Any arrangements for subcontracting services to other organisations or individuals outside the pilot should be set out in the original proposals. Any changes to these arrangements, or any new subcontracting proposed prior to implementing the contract which represent a significant variation in the proposals, must come back to Scottish Ministers for approval.
Organisational Models

88. The proposal to become a PMS site should set out what sort of legal entity the provider(s) will be, ie partnership, company or some form of joint contractual venture between practices or with a PCT or IHB and whether it wishes to become an NHS body. This will need to be done for those intending to enter NHS contracts. Providers will also wish to consider whether it intends to enter agreements with PCTs or IHBs to own or lease premises, and its legal status as an employer.

NHS Contracts

89. The NHS (Primary Care) Act 1997 enables a PMS scheme to apply to become a health service body for the purpose of entering NHS contracts. There are advantages to NHS contract arrangements for both the providers of services and for PCTs/IHBs. Entering NHS contracts enables bureaucracy to be kept to a minimum without sacrificing security for contractors. It is therefore expected that most PMS sites will wish to be recognised as health service bodies.

90. Any dispute between health service bodies can be put to Scottish Ministers for resolution avoiding costly and time-consuming recourse to the courts. If a contractual dispute has been resolved in this way, the courts will be able to enforce Scottish Ministers Directions as to payment. Although this mechanism is unlikely to be used in practice, it is a useful fail-safe which will provide additional security for both sides. Both parties in an NHS or other contract are strongly advised to set out, in advance of signing the contract, their arrangements for settling such disputes at an internal arbitration stage.

91. If a PMS site becomes a health service body any contractual arrangement with another health service body (such as an NHS Trust) will be considered an NHS contract. If a PMS site opts not to become a health service body then any contract they enter will be legally binding.

Applying to Become a Health Service Body

92. In order to become a health service body an application should be submitted, in writing to Scottish Ministers and copied to the relevant PCT or IHB. The application should specify the scheme it relates to and include the name and address of each applicant. It should be sent to The Personal Medical Services Team, Health Department, St Andrew's House, Regent Road, Edinburgh EH1 3DG before the PMS contract is signed.

93. In granting an application, the Scottish Ministers will specify when the health service body status will come into effect. Any contract with another health service body entered into after that date will be an NHS contract.

94. If a PMS scheme comes to an end for any reason then the body will cease to have health service body status. If a scheme wishes to cease to have that status, all the members of the body should agree this in writing and inform Scottish Ministers and the PCT/IHB of their decision. The site will cease to have health service body status on the date specified by the members. This will have no effect on existing NHS contracts but contracts subsequently entered into will have a separate legal status.
Timing of Applications

95. Applications for health service body status can be made at any stage but it would be desirable if PMS sites applied at the earliest opportunity. This would enable contract negotiations between the PMS site and the PCT or IHB to go ahead as soon as possible and on the correct footing. Approval of applications for health service body status cannot be granted until the pilots themselves have been given approval.

Alternative to NHS Contracts

96. If providers prefer they can opt for ordinary legal contracts unless they are existing health service bodies such as NHS Trusts.

Evaluation

97. Evaluation is a requirement for PMS. If a scheme is not properly evaluated, then the time and resources spent on setting up and running it will have been wasted and the opportunity to extend its benefits to other parts of the NHS missed. It is clearly very important that providers make preparations as early as possible for their role in the evaluation process. Evaluation arrangements should be built into the PMS agreement and PCTs/IHBs are responsible for taking an active role in co-ordinating the evaluation activities of PMS sites, sharing information and encouraging learning throughout their area and across Scotland.

98. Additional information about this can be found at paragraph 309.

Employment Issues

99. Reference to the recruitment and employment policies of PMS providers should be explicit in the PMS agreement.

100. Detailed guidance about various employment and recruitment issues created by PMS pilots can be found at Appendix 3.

General Advice on Allowances for Management Costs

101. When considering the allowance for management costs within the agreed contract price, PCTs and IHBs will want to ensure they:

- treat all PMS sites fairly
- take account of any additional responsibilities taken on
- consider the level of management support already available within the proposed PMS scheme
Multi-Trust Pilots

102. Where a PMS scheme involves more than one PCT or IHB it will require the commitment of each one, although the management of the pilot should be delegated to one lead body. These arrangements will need to be discussed during the application process and, once the scheme is approved, will need to be confirmed and any necessary systems put into place to ensure continued support is available to the PMS site.
SECTION 3: FUNDING ARRANGEMENTS FOR PMS CONTRACTS

PRICING

103. PMS providers and PCTs or IHBs have considerable flexibility in determining the scope, form and value of the agreement negotiated between them. They should be innovative and creative in considering the health outcomes they are seeking to achieve, and in designing agreements they should aim to promote the achievement of those goals. As with all NHS agreements, PMS agreements should reflect partnership and the joint desire to improve health.

104. PCTs and IHBs have a general responsibility to ensure that the arrangements are affordable and offer value-for-money but there are no set rules on how these should be judged. Nevertheless, there are a number of common-sense principles which it is expected all PCTs and IHBs will wish to follow.

Determinating the Contract Price

105. In determining the contract price for a PMS agreement, PCTs and IHBs should:

- clearly identify and specify the services to be delivered under the agreement and its proposed duration

- identify a "baseline" value for PMS, probably representing the current year equivalent of the underlying level of GMS payments made to the PMS providers recently

- identify a "baseline" value for additional agreement components including, where appropriate, drugs and dispensing in a way which is compatible with the national budget-setting guidance

- regard the total of these "baseline" values as the starting point for considering the agreement value. However, negotiations should not be constrained by it as the total might be varied significantly for reasons including:

  - the opportunities for PMS schemes to achieve efficiency gains under these arrangements

  - plans to improve to expand services under the agreement compared with historical provision. These may be significant where a substantial change of focus on outcomes is envisaged

  - moves towards equity of resourcing across the PCTs or IHB's area.

- throughout this process have regard to:

  - the amounts of money transferred from the GMS budgets on account of their PMS schemes
- the arrangements for contract price adjustment/control of risk which are to be established for the PMS schemes.

106. The contract is agreed between PCT or IHB and either a GP, the practice, or, potentially, groups of practices. The contract value is negotiated locally. Additional PMS investment that is available is designed to support additional services and/or resources over and above those currently provided.

107. Except for the budget for preparatory costs, PMS contracts are currently funded from within existing resources. Transfers to HCHS for PMS can be made from the following budgets for Part II services:

A. GMS non cash-limited
B. GMS cash-limited
C. Drugs bill/prescribing
D. Dispensing (non cash-limited)

Currently, these provide the resources to fund the PMS sites but it is for the Primary Care NHS Trusts and PMS sites to negotiate the contract price.

108. The PMS investment allocation announced in February 2001, adds an additional funding stream to the above. This allocation will be available where additional services or resources are to be provided through the PMS contract. Once the additional investment allocation has been approved, the Scottish Executive will include this money in the Health Board's unified budget and it will thereby form part of its cash-limited provision. The procedure for applying for the additional investment allocation is described in para 124 below.

Identifying the Baseline Values

GMS non cash-limited

109. The baseline value will be the same as the indicative cash transfer from GMS non cash-limited, prescribing and dispensing and largely based on the PCTs or IHBs payments to the practices pre-PMS.

110. PCTs and IHBs should note that this baseline value is based solely on historic provision rather than any assessment of fair share of local resources. They should, therefore, consider whether the baseline value is appropriate for the needs of the population to be covered by the PMS scheme. Where it is not, they should bear this in mind when moving from baseline to agreement price.

GMS cash-limited

111. PCTs and IHBs should identify the level of GMS cash-limited payments which have been made to practices in the previous 2 years and consider whether these represent a reasonable value for the expected duration of the PMS scheme.
• **For GMS staff**

The baseline should be based on a fair share of available resources in accordance with local arrangements for all GPs.

• **For IT and premises developments**

A baseline based on recent payments may be of limited value in determining a contract price to apply in the forthcoming one to three years. Some PMS providers may not require any payments under these headings for the duration of the pilot, while others may have specific investment plans supported by the PCT or IHB, which are free to decide how much of their GMS cash-limited allocation will be used for their PMS schemes, but in reaching this decision they should have regard to the contribution which all Part II practices and PMS providers make to PMS/GMS service provision. The intention is that cash-limited allocations are available to PCTs and IHBs to use only to support GPs in the provision of GMS and PMS but not to support HCHS services either directly or through a PMS agreement. PCTs and IHBs may, therefore, estimate a baseline value for PMS schemes, based on the amounts of GMS cash-limited resource they would have expected to pay to the PMS practices over the relevant period (normally three years) if these practices had stayed in GMS. Clearly, this assessment will depend on the relative priority of the PMS practices' development needs in comparison to those of other practices.

Whatever detailed approach is adopted by each PCT or IHB, it will need to involve PMS providers in its consideration of GMS cash-limited resources.

**Prescribing**

112. Where the costs of prescribing are to be included within a PMS scheme, the baseline value should be calculated in accordance with the guidance on allocating drugs budgets to practices contained in the most recent allocation letter. PCTs and IHBs and PMS sites will also wish to consider how best to use the contracting mechanisms to develop cost-effective and high quality prescribing.

**Dispensing Costs**

113. If any PMS scheme includes the cost of dispensing, the baseline should be the same as the amount transferred from non cash-limited funds. The formula used for any savings or overspend should be in line with local PCT or IHB arrangements.

**HCHS Services within PMS+ Contracts**

114. In principle the baseline should be based on estimates of:

- the average expected level, quality and types of activity for these services, given the size and need level of the practice's list
• the average costs for this activity which are incurred by providers of these services to the PCTs or IHBs population.

115. The services contracted for may have an historic level which is untypical for the PCT or IHB area, or the services may have previously been contracted from a provider whose costs were untypical. In such cases, the baseline should still be based on PCT or IHB average activity and costs. The PCT or IHB will wish however to have regard for these differences when it comes to determining the actual contract price, applying a pragmatic pace-of-change approach.

116. Management Costs

Moving from Baseline Value to Contract Price

117. The PCT or IHB should regard its assessment of the baseline value as the starting point for negotiating an agreement price. It is likely that the PMS scheme will also have estimated this baseline. As for all other service deliberations, open discussion of these respective estimates is strongly recommended to both parties, with the shared aim being a fair price for the agreed services.

118. The PCT or IHB may wish to consider variations to each component of the baseline, or to the overall total. In either case, it should have regard for the provider's freedom to move resources between the different items. However, the PCT or IHB will probably wish to specify and record the components of the contract price pertaining to such items as prescribing and premises to allow subsequent agreement monitoring and control.

119. The PCTs and IHBs should be guided by the baseline as a starting point, but is not constrained to follow it closely. In particular, PCTs and IHBs are free to deploy resources from their general cash-limit in order to secure improvements to primary care through PMS schemes. However they need to have regard to equity in the provision of all services and they may seek to negotiate reductions in resourcing, which may particularly be appropriate where a pilot with historically high resource levels will be afforded new opportunities for increasing efficiency.

120. PCTs and IHBs should pursue a number of key objectives in negotiating the agreement price:

• To be sensitive to the agreed objectives and needs of the PMS scheme

In particular, PCTs and IHBs may, where practicable, wish to add resources to enable the PMS scheme to make identified improvements in primary care services, to reward quality improvements, or to support the proposed new ways of working. PCTs and IHBs should also recognise that the scheme's internal management costs will need to be found from within the agreement price.
• **To seek increases in value-for-money**

PMS providers have new opportunities for changing the way in which services are delivered. In some cases there will be clear opportunities for increases in cost effectiveness and PCTs and IHBs should seek to ensure these are reflected in the contract price.

• **To move towards greater equity in primary care**

In general, PCTs and IHBs:

- should seek to use such flexibilities as they have, in order to increase funding for those PMS schemes starting from a low base of GMS provision locally

  **but**

- should not increase total funding for those whose primary care resourcing and outcomes are already at or above the average.

• **To ensure affordability**

• **To have regard for long term cost consequences**

PCTs and IHBs should remember that a PMS pilot may run for only a year or might be continued in similar form beyond the three year pilot phase. In all cases, PCTs and IHBs need to ensure that the financial commitments involved are sustainable and affordable within anticipated resources.

121. On equity, the PCT and IHB may need to have regard to three different measures of fairness:

- a fair share of total **resources** available to the PCT or IHB for the population served by the PMS scheme

- a fair share of GP **workforce**. In particular, if an additional GP is proposed, the PCT or IHB will need to demonstrate that need

- a fair share of **outcome** of primary healthcare, as judged or measured by the PCT or IHB, which may wish to divert resources into an area where the service is perceived to be poor, even if this area scores adequately on both GP numbers and financial inputs.
122. It is not expected that PMS agreements will necessarily have their prices fixed exactly in advance. Instead, the agreement should set out the scope, and the limits, for variation of the overall price to meet changes in circumstances. Variations may be necessary for the following reasons:

- **To build in incentives for the PMS providers**
  
  Some parts of the contract payment may be dependent on the achievement of specific goals agreed in advance.

- **To allow for reviews for the second and third years of the pilot**
  
  The parties to a PMS contract might wish to specify a range within which the contract value for these years could be expected, but it is unlikely that they will wish to set a single figure.

- **To allow for agreed risk control arrangements**
  
  If demand on the PMS scheme should rise or fall, eg through changes in list size, then the contract value may need to be adjusted.

- **To adjust for excessive contract price variations by the PMS scheme**
  
  It is expected that, within limits, these risks should be borne by the PMS scheme. However, PCTs, IHBs and PMS providers may wish to agree the treatment of any variations beyond these limits, eg that the excess would be shared in some pre-set way.

123. PCTs and IHBs will wish to pay close attention to procedures for managing variations in both agreement value and service levels.

124. Once a full business case is submitted, it should state:

- Notification of proposed start date for PMS arrangements.
- The requested amount to be transferred from GMS non-cash limited to the Board's unified budget.
- The amount of additional resource required and the purpose for which this will be used, namely, whether this is required to fund:
  
  - an additional GP;
  - an additional member of the nursing team;
  - an additional member of the primary care team (specify);
  - a new service (specify);
  - enhancement to current service (specify)

125. If the business case is approved, the PCT should confirm the start date for PMS arrangements (1 April or 1 October). The resource transfers shall be made to coincide with the start date.
126. The Health Department will monitor PMS expenditure on a regular basis. PMS spending will be monitored via the monthly and quarterly monitoring forms shown below (as well as the detailed information on additional investment which Trusts will provide within their full business cases):

**Monthly Monitoring Form (FHS Expenditure Form 16)**

Contract Payments - this section should detail all payments related to the "contract sum" for a PMS pilot or PMS site. (Items A-D, listed in para 107 above).

**Quarterly Monitoring Form (DDRB Form)**

Contract Payments - as above.

Preparatory Support Costs - this section should detail the monies used for the working up of PMS pilot bids (under the NHS (Pilot Schemes: Financial Assistance for Preparatory Work) Amendment Regulations 1997).

Additional Investment - this section should detail the monies used for additional PMS development (eg an additional GP, member of primary care team, a new service, enhancement to current service).

**Additional Background for Finance Directors of Primary Care Trusts and Island Health Boards**

127. GPs retaining the existing national contractual arrangements (GMS) should be left neither better nor worse off as a result of PMS-related resource transfers. To fulfil this commitment, the joint Health Departments and General Practitioners Committee's (GPC) Technical Steering Committee (TSC), which supports the Doctors and Dentists Review Body's (DDRB) annual review of GPs’ remuneration, re-bases the GMS remuneration pool excluding PMS GPs leaving the remuneration system. This then forms the baseline from which to calculate the following year's remuneration pool, including average gross and intended net incomes, for those GPs who remain GMS.

128. TSC uses data collected from Health Boards in April and May on the previous financial year’s GMS payments to or on behalf of pre-PMS practices. The Health Department (Finance Directorate) will collect this data from Health Boards alongside the quarterly GMS Monitoring Return for quarter 4. Funding transfers at national level will need to be made well before then. The arrangements for each budget are set out below:

**GMS payments**

129. GPs who transfer to PMS status must be excluded from the GMS payments system with effect from the transfer date (although they will, of course, be entitled to payments in respect of their former GMS activities until immediately before the transfer).
130. There may be exceptional circumstances in which practical problems preclude a pilot going "live" on the target date. It is essential in such circumstances that the arrangements made avoid prejudicing the commitment given to GPs remaining within the national contract, that they will be left neither better nor worse off as a result of resource transfers related to PMS.

131. In these exceptional cases, the details of the PMS contract will not have been completely finalised or the GPs will be, for various reasons, unable to take on all envisaged PMS commitments from the target. The PCT or IHB in these cases will need to agree with the GPs to enter into a PMS contract, but with interim arrangements for the basis of the payment.

132. Payments would be made from PCT or IHB cash-limited funds, rather than from FHS non cash-limited accounts. They may be based on what the national GMS contract would have provided or on what the planned PMS contract is expected to deliver, with provision for adjustments to be made (if necessary) after the full PMS contract details are finalised and the commitments taken on. Whatever the payment basis, the payment and contractual arrangements should be PMS and not GMS.

GMS Non-Cash Limited

133. PCTs and IHBs will be asked to provide with each application, details of the GMS non cash-limited payments made to or on behalf of relevant pre-PMS practices in the previous year. At the same time, PCTs and IHBs also have the opportunity to highlight any significant changes that have affected, or will affect, the level of payments to a pre-PMS practice in the past 3 years. This data is required for all applications to ensure that full details are available.

134. Data is requested in cash (as reported on the PCT's and IHB's Monthly Monitoring Returns Form 1b) rather than accruals (income/expenditure) terms. This is because PMS-related allocation to PCTs and IHBs will be in cash and will be made as allocation adjustments. Any subsequent adjustments, eg if a PMS site ends prematurely, would similarly be made in cash terms.

135. PCTs and IHBs data on payments to pre-PMS practices will also be used to provide indicative allocations to Health Boards for the following year and the allocations will be adjusted on the basis of the information collected by the TSC in April and May.

GMS Cash Limited

136. Although the GMS cash-limited budget is ring-fenced, PCTs and IHBs may use an appropriate proportion of their GMS cash-limited allocations to fund pilot contracts. This places PMS costs within the GMS cash-limited ring-fence - in part because many cash-limited reimbursements (mostly IT and improvement grants) are non-recurrent and existing spend is not a reliable indicator of a "fair share" of future resources.

137. These arrangements mean that no transfers or adjustments at national or PCT or IHB level will be needed for GMS cash-limited budgets and it is for PCTs and IHBs to determine relative priorities between PMS and GMS, ie PCTs and IHBs are able to use these funds to support the delivery and development of appropriate services via PMS or under the Part II
reimbursement arrangements set out in the Statement of Fees and Allowances. PCTs and IHBs will, however, need to ensure that the PMS GPs and those GPs covered by Part II arrangements are treated equitably.

**Drugs Bill/Prescribing**

138. The Health Department will continue to make prescribing allocations to PCTs through Health Boards. In turn, PCTs and IHBs will make allocations to practices. Essentially, the introduction of PMS will not materially affect the allocations process. Each PMS site, whether a single practice, a group of practices or a number of GPs entering salaried employment, will be allocated a prescribing budget, agreed within the contract price, for the patients on their list.

139. Prescribing spend will continue to be monitored via the Pharmacy Practice Division (PPD). All GPs, including those employed by NHS Trusts, will prescribe medicines for their patients on Form GP10 and community pharmacies will submit the forms to the PPD when the medicines have been dispensed. PMS prescribing sites will be subject to the usual monthly reporting arrangements from the PPD.

**Dispensing**

140. Funding transfers from non cash-limited provision will be needed only if any PMS sites involve existing dispensing practice(s) who propose to dispense as a Part I service as part of the contract. Transfers will be calculated using a similar methodology to that for GMS non cash-limited but allowing for expected growth/reduction in activity.

**HCHS**

141. It will be for each PCT or IHB to decide whether to use any of its existing HCHS funding, and how much, to fund the provision of PMS, enhanced PMS or additional services to meet local priorities.

**Pilot GPs' Share of Past Cumulative Overpayment or Underpayments Under Part II Arrangements.**

142. The national Part II pay system for GPs has a balancing mechanism for correcting previous years' overpayments or underpayments to the profession of GMS expenses and intended net income. That correction is built into the GMS feescale rates recommended by the Doctors' and Dentists' Review Body (DDRB) each year. PMS GPs will, of course, not receive GMS fees and allowances, once they leave the national GMS contract but will still be owed a due share of the overpayment or underpayments incurred while they were within the national contract. The allocations to PCTs and IHBs for PMS sites, based on transfers from GMS non cash-limited and dispensing budgets (described above), will automatically reflect the correction for overpayments or underpayments attributable to PMS GPs, while they were within the national contract and which would have been corrected through their feescale earnings, had they remained within Part II arrangements. No action by PCTs, IHBs or PMS GPs is necessary.
Mixing Funding for Health and Social Work

143. The Primary Care Act does not provide for the funding of health services and those services provided by Social Work Departments to be mixed in a PMS Contract.

TRANSFERS FROM THE EXISTING PART II GP REMUNERATION SYSTEM

144. GPs who decide to enter the PMS scheme will leave the current remuneration system on becoming a PMS site. All practices transferring from existing GMS arrangements will have to start from 1 April or 1 October. To ensure that their departure does not affect the income of remaining GPs, PMS sites will be required to provide for the TSC, in the strictest confidence, details of professional earnings and expenses for the preceding 3 financial year before becoming PMS, when this information becomes available. It will be similar to the questionnaire which the TSC has prepared for collecting earnings and expenses data from the tax self-assessment returns of a sample of all GPs. Accountants' charges for providing this data will be reimbursable from PCTs and IHBs. Further details on this will be issued with the questionnaire. Data will be anonymised and used solely for the purposes of the existing GP remuneration system. It will not be used in the approval process and in no circumstances will information from individual GPs or practices be made available to PCTs and IHBs.

INCENTIVES AND RISKS

- **Incentives** should be used innovatively - not simply transferring over the existing GMS incentives but using them as a basis from which to frame mutually advantageous agreement conditions

- **Risks** should be compensated by appropriate incentives and should be shared amongst all parties. An inappropriate burden of risk could simply lead to a collapse in the PMS scheme which would harm all parties and patients.

145. There are a number of potential areas where PCTs and IHBs and PMS schemes will wish to consider how they should work together to manage the potential risk. These include:

- where errors occur in calculating appropriate fair share cash limit adjustment transfer, both non cash-limited and cash-limited GMS

- variations to contract value as a result of GP remuneration negotiations

- significant in-year change to the demand for services, eg resulting from list size increases or decreases

- in-year changes in the scope of services to be delivered within the PMS scheme

- under/over performance, either in activity or in quality terms, against agreement targets

- cost pressures resulting from changes in clinical practice, new drug treatments or treatment protocols etc
146. PCTs and IHBs will want to consider the range of possible options for working with PMS sites to ensure appropriate risk management mechanisms are in place to manage such eventualities. Examples include:

- developing PCT or IHB or local pool/contingency funds - such contingency arrangements may also be condition specific, eg access to prescribing contingency
- making long-term financial arrangements - spreading risk over time
- developing appropriate demand management mechanisms, eg clinical referral or protocols
- ensuring incentives as well as penalties are in contracts
- ensuring an assessment of risk for each pilot is carried out during the preparatory stage, eg District Valuer's assessment of current market rent of premises and likely impact of premises improvements or developments on Part II funding should the PMS scheme end. Such an assessment should also consider the potential for redundancies for staff employed on short-term contracts

All risk management strategies should be explicitly stated in the agreement.

Identifying Risks

147. It should be recognised that these PMS schemes carry some financial risks for all parties. Whilst there are always financial risks associated with change, such risks can be exacerbated when, as here, the financial context is one where the initiative is to be funded in large measures from a programme which is fixed, and where in-year cash flow is demand led.

148. The Health Department is unable to transfer funds from non cash-limited to cash-limited budgets in-year. In addition, once funds have been allotted to PCTs or IHBs they are not readily recoverable. PMS sites can only proceed where the PMS providers and the PCTs or IHBs have been able to agree a satisfactory agreement. There is therefore a risk that not all approved PMS sites will go live. If PMS allocations were made before contracts had been agreed there is a risk of over-funding PMS schemes at the expense of GMS. There is also a possibility that schemes will wish to revert to Part II arrangements in-year resulting in costs reverting to GMS provision.

149. Depending on the terms of the contract, PCTs and IHBs may face the risk in-year of additional payments to PMS schemes to reflect changes in patient registrations. Under established GMS arrangements, the extra payments would follow automatically from the non cash-limited budget with any resultant overall pressure, e.g. because of delays in de-registering the transferred patient from the doctor's former practice, being managed by the
Health Department. Under the PMS scheme, if consequential payments are specified in the contracts, PCTs will need to make contingency plans to meet those costs.

(3) PMS Providers

150. PMS providers will also face risks. These should be explicitly considered between PCTs and IHBs and the providers when making agreements, eg there is a possibility that they may, albeit unintentionally, receive excess or reduced income from the contract due to problems in collecting data and agreeing accurate baselines.

151. Other potential risks include the following:

- significant in-year changes to list size or service pressures could cause PMS sites to overspend against contracts where they are not flexible enough to cover such changes
- inflationary pressures may be greater than those agreed through the agreement, though some of these risks exist at present, eg drug or practice staff inflation
- some elements of expenditure, eg capital and staff, may be committed by a PMS site on the basis of the continuation of a PMS agreement but who subsequently reverts back to Part II where funding may not be appropriate or available
- where practices or GPs join together to enter into PMS arrangements there is a chance that these partnership arrangements may not endure. There is also a risk that the assets and liabilities of the PMS scheme may not be adequately covered or distributed. All parties on entering into a PMS scheme should therefore reach an agreement which states what actions will be taken in the event of a dispute.

Use of profits achieved through efficiency savings by PMS sites

152. PCTs and IHBs should agree with PMS providers in the agreement how efficiency savings should be used. In common with current practice, PCTs and IHBs will want to ensure that efficiency savings achieved by a provider are used in such a way as to maximise the resources available to patients generally, whilst retaining incentives to providers to fully achieve potential efficiencies.

153. Currently, NHS Trusts are able to retain and roll-over efficiency savings achieved from one year to another. These can be retained to invest in agreed planned service developments, utilised to increase activity where patient demands requires, or reduce prices generally in future years. Primary Care Trusts will wish to ensure similar incentives remain for all PMS providers. However, discussions should take place in-year with contractors when efficiency savings are identified, so that agreement can be reached at an early stage as to how such resources can best be utilised.

154. Where PMS sites achieve savings on prescribing activity, PCTs and IHBs will want the agreement to provide for these funds to be used to achieve benefits for patients. PCTs and IHBs may, however, identify other areas for priority investment. Local agreement will
provide for the deployment of these resources for such purposes during the period of the agreement. In general, agreements on priorities for investing efficiency savings should be made as part of the contracting process rather than making ad hoc decisions when, and if, they are achieved.
SECTION 4: MONITORING AND EVALUATION

Guiding Contractual Principles

155. The contract should be designed to support the health service objectives of the PMS scheme which will need to be set out clearly. The contract should be used not just to record volumes but to embody the agreement between the PCT or IHB and the PMS site. The contract presents an opportunity to promote quality and to embed a framework which rewards appropriate and effective care. It is this spirit of co-operation that should guide the negotiation process to ensure that it is achieved swiftly and fairly and to the satisfaction of all parties.

156. General principles in this regard are:

- wherever possible, services to be delivered should be identified in terms of measurable health outcomes covering quality, quantity and effectiveness
- explore the provision of contractual incentives connected to the delivery of these outcomes - wherever there are sufficient flexibilities around absolute contractual requirements to allow for this
- reach agreement in advance on how outcomes will be measured and fed into variations in payment through contract
- reach agreement in advance on how the contract will be monitored around both measurable indicators and for other quality indicators. This might include work on patient satisfaction. How often contract monitoring activity would take place in respect of the various elements in the contract, by whom and how this will be done in line with the need to keep bureaucracy at a minimum. It will also be necessary to consider and agree:
  - what information flows are necessary
  - the necessity for, and the structure of, regular review meetings
  - the resolution of disagreements, where parties are interpreting duties and/or rights differently
- the evaluation which is to be carried out:
  - Monitoring of the agreement relates to checking that the agreement itself is working - that targets are met, clinics held, transactions are within agreed parameters, employment arrangements are satisfactory etc
  - Evaluation looks at how well objectives are being met, the views of patients and local representative groups of services provided and the local resources used to do so
• explore the provision of sufficient flexibility within PMS agreements to allow for review and reward, within predetermined parameters, of service developments which lead to an overall value-for-money outcome

• reach agreement on penalties for non-delivery of specified outcomes

• ensure contract arrangements cover all parties involved in the scheme, with a clear statement of where responsibilities lie

157. One of the guiding principles behind the pilots is to allow the flexibility to enable local agreements to address local problems and needs. PCTs and IHBs should aim to focus their contractual relationship with pilot sites on rewarding PMS specifically tailored to address local health problems. For example, in the case of a PMS scheme designed to provide PMS to a predominantly elderly population, there will be more flexibility to agree and reward achievement of a range of outcome or quality measures, as opposed to the current GMS requirement for over-75 checks only.

158. It is essential that PMS providers and PCTs and IHBs should work together in the contract to set out the ways in which patients will be informed and involved in the objectives, progress and implications of the PMS scheme - **on an ongoing basis**.

159. When agreeing contracts for delivery of PMS or taking on responsibility for provision of any elements of HCHS, Primary Care NHS Trusts should ensure that they have made sufficient provision for maintenance of national or local data requirements for the management of the contract in health service and financial terms - **even where these are no longer part of payment for achieving target rates**. It will be important for pilots to be clear about the types of information that they will be required to collect and report with regard to:

- contract monitoring systems and Minimum Data Set - between the pilots and contracting organisations and also between the pilots and health boards

- other evaluation issues

Information requirements about the national minimum data set needed for PMS pilots can be found at paragraph 276 et seq.

160. PCTs and IHBs need to carefully consider the possible future financial liabilities that may result either as a consequence of termination of the pilot at the participants’ request or at the direction of the Scottish Ministers.

161. In entering into contracts for the provision of PMS, the resources provided must not be used to cross-subsidise other service provision.
SECTION 5: PATIENT REGISTRATION

162. Under PMS, patients will retain the right to choose the medical practitioner from whom they are to receive primary medical services (subject as under GMS to consent and capacity). There will, as in current GMS arrangements, be the provision for another person to apply on behalf of the patient.

163. There will be a single list held of all the patients in a PMS scheme. This will be needed for payment purposes and because the PMS scheme holds the overarching responsibility for the provision of PMS to those named patients. Within that framework patients will be able to register on individual lists of doctors performing PMS and designated by the PMS scheme as internal list holders. This will safeguard the rights of patients to choose a particular doctor who will have specific clinical responsibility for them and will also provide continuity where GMS practices either enter or leave PMS.

164. It will be possible under PMS to decide to offer to patients the choice of not remaining on, or going onto, an individual doctor's list but to become simply a pooled practice patient. In this case the clinical responsibility for the patient will not be delegated to a particular doctor within the practice but to the pilot's medical practitioners as a whole. The PCT and IHB will need to be informed of any patient moving from an individual to a pooled list, or indeed from a pooled to an individual list.

165. The sum total of the individual doctors' registration lists and, if the pilot operates the option, the pooled patient list will make up the whole practice list. PCTs and IHBs will maintain a record of both the whole practice (including pooled patients) and individual doctor's lists. In practice for ease of administration this can be a single list subdivided into the above component parts.

166. Where a pilot practice reverts back to GMS those patients on a personal list will remain with their named doctor. Patients on a pooled list will need to be informed that the current registration arrangements no longer apply and they will have to join the personal list of a doctor. How this process will be handled may be prescribed in the PMS agreement or, alternatively, it will need to be agreed between the PMS scheme and the PCT or IHB at the time. Any process must enshrine the patient's right to exercise choice in obtaining their doctor.

167. Similarly if a pilot decides to end the pooled patient option patients who wish to remain in the pilot will need to be given choice over which pilot doctor's list they join. PCTs and IHBs will need to be informed over such changes.

168. PCTs and IHBs will retain the power to assign a patient when requested to do so by the patient. It will be important in doing so that the PCT or IHB keeps the balance of assignments fair between GMS and PMS. This is an extension of their current role in ensuring that patients are assigned equitably between the GMS principals in their area. To do this they will need to take into account that PMS sites may be set up in a slightly different way to GMS practices. They will need to consider what is the fair and reasonable proportion of patients that the pilot as a whole should be assigned. The PMS practice itself will be responsible for then arranging for assigned patients to be allocated to one of the individual medical practitioners. Once allocated the patient may, if the option is available in the pilot, decide to go onto the pooled list.
169. Where a pilot crosses PCT boundaries, the PCTs involved will need to keep each other informed of any assignments they make.

170. PMS sites will be able to ask PCTs/IHBs to remove patients from their lists. The procedures will be similar to those under GMS including special provisions for dealing with violent incidents.

171. PCTs and IHBs will still be required to remove certain patients from the list of doctors/practices as required by existing GMS regulations, ie:

- service personnel on enlistment into HM forces
- any patient leaving the UK with the intention of being away for at least three months or any patient whose absence from the UK has exceeded three months
- a patient serving a prison sentence of more than two years or sentences totalling in aggregate more than that period
- any patient who dies
- any patient who no longer resides at the address given to the practice/health board.

172. PCTs and IHBs will not be constrained to any centrally set maxima as to the number of patients on a doctor's or a practice's list. They are required to balance the nature of the scheme and the need to ensure quality patient services in arriving at individual contractual limits. The calculation of these limits may be informed by the existing GMS limits.

173. PMS schemes will need to consider what would happen to patient lists should it come to an end or a doctor wishes to leave the scheme. Agreements should be made between the GPs in a similar way to the agreements currently made under GMS. If a practice list is in operation, doctors will want to consider what will happen to these patients should the pilot end. Any arrangements made should take into account the patients' right to choose. Pilots may be required to notify patients should their doctor move from PMS back to GMS.

**Temporary Residents/Immediately Necessary and Emergency Treatment**

174. Patients' rights to treatment in these circumstances will remain. This will avoid disproportionate demands being placed on GMS providers and will avoid areas where temporary cover is non-existent.

175. A PMS site will provide to anyone not on any of its doctors' list of patients, including overseas visitors, emergency and immediately necessary treatment in line with the present GMS provision. This includes maternity medical services/obstetric emergencies. Immediately necessary treatment is interpreted as treatment that in the clinical and professional judgement of a pilot doctor cannot reasonably wait until the patient returns home.
176. A PMS site will provide treatment to patients, including overseas visitors and travelling people where applicable, staying in the locality of the PMS scheme for not more than three months, in line with the temporary resident provisions. The PMS scheme’s right not to accept a patient as a temporary resident will replicate that for GMS medical practitioners, as will the right of the PCT or IHB to assign a patient as a temporary resident to either a GMS or PMS doctor.

177. A PMS site will provide immediately necessary treatment where the patient has been:

- refused acceptance for inclusion on the list
- refused treatment as a temporary resident
- removed from the list under procedures dealing with acts of actual or threatened violence

for a period not exceeding 14 days from the date of the PMS doctor's decision or until the patient has been accepted by or assigned elsewhere - whichever occurs first.

**Medical Records**

178. Pilot schemes will still be required to comply with legislation appertaining to medical records in the same way as GMS providers, eg the Access to Health Records Act 1990 and Data Protection Act.

179. PMS providers must keep and maintain medical records in accordance with the current GMS provisions for registered patients and for those for whom they provide treatment as temporary residents, or under the immediately necessary or emergency treatment provisions. Records created under temporary resident, immediately necessary or emergency treatment procedures should be forwarded via the PCT or IHB to the patient’s registered doctor.

180. Records will be on the same forms as those currently used for GMS provision and will be provided for that purpose by the PCT or IHB.

181. Records will have to be forwarded to the PCT or IHB on request or in the event of a patient's death.

182. Pilot schemes will have to transfer their records to GMS providers, via the PCT or IHB as appropriate, where a patient changes doctor. Equally GMS providers will have to transfer records to PMS schemes.

183. Under GMS procedures, no charges are made in respect of these activities and this principal should be carried forward into the new procedures.

**Computer Reimbursement**

184. PCTs and IHBs are free to decide how they will support the computer requirements of PMS schemes. In deciding whether funding should be available, PCTs and IHBs should take into account the present GP computer reimbursement scheme.
Medical Certificates

185. Patients of PMS schemes will, in prescribed circumstances, continue to receive free certificates and doctors will still be obliged to provide information for social security purposes.

186. Free medical certificates will be issued to patients or their personal representatives in circumstances which are equivalent to those described in paragraph 13(7) of Schedule 1 and Schedule 9 to the NHS (GMS) (Scotland) Regulations 1995. (For example to support a claim for social security benefits on account of incapacity for work).

187. Doctors will provide in response to a request from a medical officer, relevant clinical information about patients of the doctor or practice to whom a medical certificate has been issued or refused in line with the provisions of paragraph 34 of Schedule 1 to the NHS (GMS) (Scotland) Regulations 1995.

188. Doctors will answer any enquiries by a medical officer about a prescription form or medical certificate issued by a doctor under his terms of service or pilot scheme contract or about any statement which the doctor has made in a report under his terms of service or pilot scheme contract.

RESPONSIBILITY OF CARE AND FOR QUALITY OF CARE

189. Each PMS site is responsible for ensuring the provision of personal medical services to the pilot patients throughout each day those patients are covered by the contract, ie 24 hr duty of care:

190. Personal medical services are equivalent in scope (though not necessarily identical in detail) to those provided as general medical services. PMS schemes do not necessarily require the provision of child health surveillance, contraceptive services, minor surgery services nor, except in an emergency, maternity medical services:

191. All necessary and appropriate personal medical services to the patient in a PMS scheme includes the following:

- giving advice, where appropriate, to a patient in connection with the patient's general health, and in particular about the significance of diet, exercise, the use of tobacco, the consumption of alcohol and the misuse of drugs or solvents:

- offering to patients consultations and, where appropriate, physical examinations for the purpose of identifying or reducing the risk of disease or injury:

- offering, as appropriate to individual patients' needs, all immunisations which are currently available as part of GMS where these are not required in respect of foreign travel and offering, for the purposes of arranged foreign travel, appropriate immunisations against typhoid, paratyphoid, cholera, poliomyelitis and infectious hepatitis:
- arranging for the referral of patients, as appropriate, for the provision of any other services under the 1978 Act:

- giving advice, as appropriate, to enable patients to avail themselves of services provided by a local social work department:

- upon request, providing a cervical smear test to all eligible pilot patients who are women aged between 21 and 60 at intervals of no more than 5½ years or at a shorter interval where indicated by the previous smear test result or other treatment.

192. PMS scheme doctors performing within the scheme comply with the obligation that where treatment is not personally provided by the scheme doctor, reasonable steps are taken to ensure continuity of the patient's treatment:

(i) whether:

- by another doctor

- by some other healthcare professional to whom treatment is delegated and who the doctor is satisfied is competent to carry it out

- by an organisation with whom the PMS practice has entered into an agreement to provide such services (the PMS practice being satisfied as to the quality of that service and competence of the doctors provided)

(ii) but shall not arrange for the provision of certain services by another doctor/organisation unless in the case of:

- maternity medical services, the doctor has been approved by the PCT or IHB to perform that service, except in the case of an obstetric emergency

- child health surveillance or minor surgery, the doctor has been approved by the Health Board to perform that service.

Transfer of Responsibility for the Duty of Care Under Paragraph 19 of Schedule 1 to the NHS (GMS) (Scotland) Regulations 1995

193. The provision of paragraph 19 of Schedule 1 to the NHS (GMS) (Scotland) Regulations 1995 enable individual GP principals to transfer to another GP on a medical list their personal responsibility under these terms of service for their patients during part of the 24 hour duty of care period. It is intended that the transfer from GMS to PMS of a doctor who is party to such an arrangement, whether he has relinquished or accepted responsibility, will bring an arrangement of this kind to an end. It is not intended these sorts of arrangements will be carried forward into PMS. PMS schemes will, of course, be free to subcontract the provision of out of hours services to, for example a commercial deputising service, or participate in a GP co-operative.
194. GPs and/or PCTs and IHBs currently involved in these arrangements will need to consider and agree alternatives in the light of the following:

- **GP relieved of responsibility moves into PMS**
  The doctor will take full responsibility for his patients into the pilot.

- **GP taking responsibility moves into PMS**
  The GP does not take responsibility into the PMS scheme. The transferring GP will need to seek a fresh arrangement with a different and willing GMS doctor.

- **GP who has transferred responsibility moves into PMS**
  Full responsibility for patients is taken by the doctor into the PMS scheme.

- **GP who has accepted responsibility moves into PMS**
  The GP does not take responsibility into the PMS scheme. The PCT or IHB is under an obligation to find a replacement from within GMS for as long as the doctor benefiting from that relief remains on the medical list.

**When and Where a Patient should be seen**

195. When deciding when and where a patient should be seen, both inside and outside normal hours, a GMS GP is bound by paragraph 13 of Schedule 1 to the NHS (GMS) (Scotland) Regulations 1995. To ensure equity of treatment for both GMS and PMS patients PCTs and IHBs should ensure PMS schemes and doctors performing PMS in them comply with the following criteria:

- **In normal hours**
  - at the normal place **or**
  - at the place where the patient is at that time residing or, if that is inappropriate, at some other place in the PMS area if, in the doctor's reasonable opinion, the patient's condition makes it inappropriate for him to attend at the normal place.

- **Outside normal hours**
  - a PMS doctor shall consider, in the light of a PMS patient's medical condition, whether a consultation is needed, and if so, when
  - if in the doctor's reasonable opinion a consultation is needed before the next time at which the patient could be seen during normal hours, the doctor shall render the personal medical services:
- at the normal place or
- at the out of hours place or
- at the place where the patient is at that time residing or, if that is inappropriate, at some other place in the PMS area if, in the doctor's reasonable opinion, the patient's condition makes it inappropriate for him to attend either at the normal place or at the out of hours place.

Services and Treatment for which a charge may be made

196. Doctors providing GMS may choose to provide any or all of those non-GMS services described in paragraph 36 of Schedule 1 to the NHS (GMS) (Scotland) Regulations 1995, as amended, and if so provided are entitled to charge the patient for that service.

197. All PMS schemes will be able to do the same. Therefore, PCTs and IHBs should set out in contracts that PMS scheme doctors will not, on behalf of the PMS scheme, charge a fee to or accept a fee from any patient for whose treatment they are responsible, except in the following circumstances:

- in those cases specified in sub-paragraphs (a) to (e), (g), (i) to (m) and (o) of paragraph 36 of Schedule 1 to the GMS Regulations
- where the doctor provides necessary treatment to a person who claims to be on his list or that of the PMS practice but fails to produce his medical card on request and the doctor has reasonable doubts about that person's claim. The doctor is entitled to demand and accept a reasonable fee on behalf of the PMS practice for any treatment given, subject to any provisions in the PMS scheme agreement relating to the repayment of the fee to the patient
- for treatment consisting of an immunisation against a disease other than typhoid, paratyphoid, cholera, poliomyelitis and infectious hepatitis which was requested in connection with travel abroad

Child Health Surveillance, Contraceptive, Maternity Medical or Minor Surgery Services

198. The details of any child health surveillance, contraceptive, maternity medical or minor surgery service to be provided by a PMS scheme are a contractual matter to be agreed with the PCT or IHB. There is no requirement for PMS agreements to include provision for these services. However, should a PMS proposal omit provision of one or more of these services, the PCT or IHB may wish to consider how best to satisfy patients' reasonable expectations that there will be a measure of continuity in available services. Some alternative arrangement would be necessary.

199. The PMS agreement will specify the content and scope of the service to be offered and the arrangements between patient and doctor to provide for access to and delivery of the service.
200. It may be necessary for PCTs and IHBs to consider terms relating to consent and payment providing for:

- a PMS scheme to offer a service to a patient not on its list
- another practice to offer a service to a patient on the PMS scheme's list.

201. In particular, the PCT or IHB will need to ensure that patients continue to be able to receive contraceptive and maternity medical services from a practice other than their own. This freedom of choice for patients should be safeguarded whether they are on the list of the PMS scheme and seek contraceptive services at another practice or on another practice list and seek contraceptive services at the PMS scheme.

202. The PCT or IHB must satisfy itself that any doctor proposing to provide child health surveillance, maternity medical or minor surgery services has appropriate medical training and experience. It is recommended that such considerations apply also in the case of non-medically trained designated individuals (such as health visitors, midwives or practice nurses) who might assist with provision of the service. Competencies should be reviewed if, during the period of the agreement, there is a change to the individuals providing the services.

203. Where a PMS scheme is to provide contraceptive services, it is recommended that the PCT or IHB seeks an undertaking that designated individuals intending to perform the service will have regard to, and be guided by, modern authoritative medical opinion. Where nurses, midwives or health visitors undertake these services they must be trained in Family Planning.

Guidance on Minor Surgery

204. Professional guidance entitled "Minor Surgery in General Practice" is available and commended to PCTs and IHBs and any PMS scheme which proposes to offer a minor surgery service. The guidance was issued by the Royal College of General Practitioners in association with the General Medical Services Committee of the British Medical Association (revised 1996).

Health Promotion and Chronic Disease Management

205. PMS scheme providers are required to offer opportunistic health advice and health checks to patients where appropriate.

206. PMS schemes are encouraged to use flexibilities to seek innovative approaches to the delivery of health promotion and health checks, which remain important elements of the primary care service. It is not compulsory therefore that agreements require pilots to offer or provide health checks in the form required under general medical services rules, ie on registration, at three yearly intervals or annually to patients aged 75 and over. PCTs and IHBs are advised to take account of modern authoritative medical opinion, national and local health strategies and priorities along with patient needs when considering such arrangements with PMS scheme providers.

207. In particular, PCTs and IHBs should consider the value of doctors initiating and participating in asthma and diabetes programmes as an integral part of good quality clinical practice. Most practitioners are committed to existing schemes, as are their patients.
Immunisation

208. The success of the childhood immunisation programme is demonstrated by the incidence of childhood diseases being at their lowest level ever. In pursuit of their public health function, PCTs and IHBs will wish to ensure that PMS scheme providers continue to provide all appropriate immunisation for individual patients, in line with up-to-date medical opinion. The achievement of the childhood immunisation programme should not be prejudiced.

209. It is intended, therefore, that PMS scheme agreements should contain target payment arrangements that parallel the highly effective GMS arrangements. To this end, PCTs and IHBs are required to establish and administer a target payment scheme in respect of each pilot scheme. PCTs and IHBs are asked to ensure that PMS scheme arrangements are the same as those in respect of GMS providers.

210. PMS scheme doctors are required to provide all appropriate immunisation (except those in connection with travel abroad) at no cost to their patients. In respect of travel abroad, they should provide immunisations against certain defined diseases, also at no cost to their patients, except those which are not available on the NHS, ie yellow fever. This duplicates present arrangements under GMS. It will be for the PCT or IHB and the PMS scheme provider to agree detailed arrangements for the delivery and payment mechanisms of the service to be offered and the arrangements between patient and doctor to provide for access to and delivery of the service.

Cervical Cytology

211. PMS scheme doctors are required, upon request, to provide a cervical smear test to all pilot patients who are women aged between 21 and 60 at intervals of no more than 5½ years, or shorter if indicated.

212. There is no requirement to participate in arrangements equivalent to the GMS target payment scheme. PCTs and IHBs and PMS scheme providers are encouraged to explore new approaches to the delivery of a cervical cytology screening programme within the limited flexibility consistent with the PCTs and IHBs public health function. There will be some women for whom a test is not necessary, ie women without a cervix, and the PCTs or IHBs could consider reflecting this in its contract with the PMS scheme provider.

213. PCTs and IHBs are advised to continue to collect data about cervical smear tests to support the calculation of target payments should PMS scheme doctors decide that they wish to resume participation in the GMS scheme.

214. New approaches must also maintain a clear focus on the critical issues of ensuring the good quality of screening tests. Audit and training are therefore essential elements to be covered.
COMPLAINTS AND BREACH OF CONTRACT PROCEDURES

Complaints

215. PMS providers should have in place a complaints procedure which as far as possible mirrors the arrangements currently in place for GMS.

216. Each PMS site must:

- establish a complaints procedure to deal with any complaints made by or on behalf of its patients and former patients. This procedure will apply to complaints made in relation to any matter reasonably connected with the provision of PMS

- specify a person to be responsible for receiving and investigating all complaints, which must be recorded in writing, acknowledged within three days and properly investigated. The PMS scheme must inform its patients about the complaints procedure which it operates and the name (or title) of the person responsible for dealing with complaints

- co-operate with any investigation of a complaint by the PCT or IHB.

217. The PCT or IHB has a key role in investigating complaints about PMS providers. It will be required to appoint a complaints manager and a conciliation service analogous to the current arrangements for handling complaints against Family Health Service practitioners.

218. The PCT or IHB will be required to appoint a convenor to consider whether an Independent Review Panel should be appointed to investigate a complaint further, where the complainant is dissatisfied with the outcome of the investigation by the PMS scheme or the conciliation process. Convenors will be required to consult where the matter relates to clinical judgement. The decision of the convenor will be notified to the complainant, the PMS scheme and the PCT or IHB. Where the decision of the convenor is to take no further action, the complainant will retain the right to complain to the Health Service Commissioner under the Health Service Commissioners Act 1993. There will be a right for the matter to be reconsidered if the complainant is referred to the Health Service Commissioner and he recommends that the decision to take no further action is reconsidered.

Contract Disputes and Breaches

219. Disciplinary procedures which PCTs or IHBs can currently use against GMS contractors apply only where there has been an alleged breach of the GPs' terms of service. Because of the legal framework under which PMS will be established these procedures will not be appropriate.
220. Regulation 2, Schedule 4 of the PMS Regulations 2001 (must introduce the permanent option) provides a framework for a dispute resolution procedure to cover allegations that there has been a breach of the agreement, including those more serious allegations which, under Part II services, would be dealt with through the disciplinary procedures or by the NHS Tribunal. We recommend this is followed for both pilot and permanent schemes.

**Arbitration**

221. In most cases it is anticipated that minor breaches of contract will be resolved as part of the normal agreement monitoring process. PCTs and IHBs and PMS providers should work together to agree principles for settling minor disputes, ie where there is disagreement or uncertainty as to the interpretation of a detail in the agreement. The principles and procedures that are to be used should be settled in advance, form a part of the agreement and be the first recourse wherever possible.

222. The Health Department expects effort to be put into genuine attempts to resolve any differences ahead of arbitration, in the interest of making best use of resources for the population concerned, rather than in pursuit of narrow sectional interests. Reaching local solutions rather than seeking arbitration will be an important measure of success in developing the partnership approach set out in this guidance.

223. However, where disputes cannot be resolved successfully, there will need to be a more formal process. Both parties to the contract will have access to these procedures.

224. As outlined in the dispute resolution framework, either party to the agreement (whether an NHS or legal contract) will be required to refer any dispute as to whether there has been a breach of agreement to an arbitrator appointed by Scottish Ministers for investigation. The arbitrator will be required to notify both parties of the referral, give them the opportunity to make in writing any representations which they may wish to make about the matter and to give each party the opportunity to comment on what the other side has said. The arbitrator will also have the option of inviting the parties to appear before him and of consulting other persons whose expertise the arbitrator thinks would be helpful.

225. The arbitrator will be required to inform both parties of his decision, and the reasons for it, in writing.

**Acts and Omissions**

226. In the case of GPs providing GMS under the current Part II system that GP is responsible for the acts and omissions of a deputy unless the deputy is also on the list of a PCT or IHB (paragraph 18 of Schedule 1 to the NHS (GMS) (Scotland) Regulations 1995, as amended).
The following table shows what procedures or combination of procedures may be initiated in the even of an act or omission:

<table>
<thead>
<tr>
<th>Act or Omission on the part of ...</th>
<th>PMS scheme subject to breach of contract procedures under the terms of PMS practice/health board agreement</th>
<th>Individual subject to breach of GP’s terms of service procedures under the terms of Regulations (overlapping obligations)</th>
<th>Individual Subject to PMS scheme's internal disciplinary procedures under the terms of individual's contract with the pilot practice</th>
<th>Organisation supplying deputy subject to breach of contract procedures under the terms of the contract between the PMS practice and organisation</th>
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<tbody>
<tr>
<td>Individual employed or engaged by pilot practice:</td>
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<tr>
<td>* GMS principal</td>
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<td>* GMS non-principal</td>
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<td>* PMS doctor</td>
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<tr>
<td>Individual employed by or engaged by organisation(^1) in contract with pilot practice:</td>
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<td>* GMS(^2) principal</td>
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<td>* PMS(^2) doctor</td>
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**Doctors Including GMS GP Principals Acting as Deputies on Behalf of PMS Pilots**

227. NHS (General Medical Services) (Scotland) Regulations 1995 Schedule 1. GMS GP principals engaged by and acting as a deputy on behalf of a PMS performer will be responsible for their act or omissions under the GPs' terms of service where the PMS agreement and GMS obligations overlap. Any act or omission on the part of a deputy in carrying out services covered by the contract between the PCT and IHB and PMS practice which is both a break of that contract and would have been a breach of the terms of service were the doctor providing GMS, will be treated as though it were a breach of the terms of service.

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\(^1\) the organisation employing or engaging the individual may be a co-operative, deputising service or locum agency etc

\(^2\) the individual may additionally be subject to breach of contract procedures under the terms of his contract with the organisation
228. Any act or omission during the course of providing services which fall outside of this overlap is to be dealt with under either the internal PMS arrangements for dealing with complaints, or as part of the normal agreement monitoring process, and may initiate a PMS scheme's internal disciplinary procedures, or in instances of a more serious nature, breach of PMS/PCT or IHB agreement.

229. The PMS agreements should:

1. ensure appropriate procedures are in place for dealing with acts and omissions on the part of any deputy, whether a:

   a. GP principal (where the obligations do not overlap);

   b. GP non-principal; or

   c. PMS doctor (engaged from another PMS practice).

   This would, for example, involve setting up internal PMS disciplinary procedures that can deal with the kind of act or omission which is not so serious as to constitute a breach of contract but needs a formal internal remedy; and

2. to provide in contracts with individual doctors employed or engaged to perform PMS on behalf of the PMS practice that they will:

   a. co-operate with:

      i. the PMS scheme’s complaints procedures; and, if appropriate

      ii. breach of contract procedures; and

   b. be subject to the PMS scheme’s internal disciplinary procedures.

230. Many deputies are supplied through organisations, eg a commercial deputising service or locum agency. Procedures for dealing with acts and omissions committed by a deputy in circumstances whether by a:

   • GMS non-principal

   • PMS doctor working in another PMS practice, or

   • GMS principal (where obligations do not overlap)

whilst performing PMS services on behalf of a PMS practice are matters to be settled in terms of the contract or between the PMS scheme and organisations supplying the deputy.

231. Where a GMS GP principal is deputising through an organisation and an act or omission occurs whilst performing PMS which corresponds to the doctor’s GMS obligations, it is intended that it will be treated as breach of the terms of service (see paragraph 1(a) above).
Doctors Engaged in Performing PMS Acting as Deputies on Behalf of GMS Doctors

232. Regulations provide that, whilst working on behalf of the pilot practice (ie during contracted hours) as a deputy to a GMS GP, any doctor, whether:

- a PMS scheme provider, or
- employed by the PMS practice to perform PMS (whether or not the doctor holds an individual patient list)

will be responsible for his own acts and omissions within the remit of the GMS doctor's terms of service.

233. The Regulations provide that any act or omission by such a doctor acting as a deputy to a GMS GP outside of the doctor's contracted hours, ie as part of a private arrangement, is the responsibility of the GMS GP.

234. PCTs and IHBs should include in agreements with PMS practices a term requiring the practice to provide in their agreements with individuals performing PMS doctors that they will:

- co-operate with breach of contract procedures if, during the course of contracted hours, they act as a deputy to a GMS doctor and while doing so, commit an act or omission which, if they were a GMS doctor, would constitute a breach of the terms of service, and
- be subject to the PMS scheme's internal disciplinary arrangements for dealing with complaints of a less serious nature.

Indemnity

235. It is anticipated that all PMS schemes will have adequate professional indemnity cover. PCTs will wish to consider including such a clause in every PMS agreement. For salaried PMS schemes, this will be the responsibility of the PCT, and the Trust will need to negotiate the provision; for PMS practice-based contracts, the doctors themselves will require to have in place appropriate arrangements ie MDDUS - but should specifically negotiate their cover, based on the PMS agreement.

236. Potential PMS+ providers should be aware that their existing indemnity cover may not be sufficient. They will wish to review their cover with their medical defence organisation.
COMPETENCIES

Competence of PMS scheme practitioners

237. All medical practitioners who are to perform personal medical services under an agreement between a PMS practice and PCT:

- must be fully registered medical practitioners;
- must be suitably experienced, ie vocationally trained (the requirements will be the same as those which apply to GMS doctors);
- must not be disqualified or the subject of a declaration of unfitness to be engaged in any capacity in the provision of general medical services and suspended by direction of the NHS Tribunal;
- must declare any convictions or professional proceedings against them, and where any GP is convicted of murder or receives a jail sentence of six months or more, the PCT or IHB is required to remove that doctor from its medical or supporting medical list. Such doctors will cease to participate in the PMS arrangements;
- must ensure, through the PMS agreement, that doctors comply with all competence requirements before they perform PMS on behalf of that scheme.

238. Although a doctor must have undertaken the "prescribed experience" for GP trainees under Section 21 and 22 of the 1978 Act and the Vocational Training Regulations Subsection 2, Section 11 of the Primary Care Act provides that this does not prevent the performance of PMS by trainees in the course of acquiring the prescribed experience and Pre-registration House Officers (PRHOs).

Competence of employees and delegates

239. All PMS practices, before employing or engaging any person other than a doctor to assist in the provision of PMS services, must take reasonable care to satisfy themselves that the person in question is both suitably qualified and competent to discharge the duties for which the doctor is to be employed or engaged. In particular, they should have regard to that person's academic and vocational qualifications and their training and experience in employment.

Competence of subcontractors and delegates

240. In addition to satisfying itself about the competence and experience of sub-contractors and delegates, agreements must include a term to the effect that:

- no PMS practice may enter into a contract (with either a person or organisation) to assist in the provision of PMS on behalf of the scheme, unless reasonable steps have been taken to satisfy itself that the service to be provided will be adequate and appropriate, having regard to the interests of the scheme's patients, and
• the PMS practice will check from time to time (or when there are grounds for doing so) that the service continues to be so.

Provision of some Elements of Secondary Care within PMS

241. Where PMS practices are to provide HCHS services in their PMS+ schemes, PCTs and IHBs will wish to ensure that they have in place appropriate arrangements for authorising the provision of secondary care services in general practice to ensure the safe and effective provision of those services.

Vocational Training

242. What follows applies to practice-based PMS schemes only. Consideration is being given to vocational training under other contractual arrangements. Regulations governing the arrangements for vocational training for general practice in GMS means that the Joint Committee on Postgraduate Training for General Practice (JCPTGP) will be responsible for approving training and for approving trainers and all training posts relating to vocational training for general practice.

Trainers

243. The JCPTGP advise that the changes to practice organisation involved in moving from GMS to a PMS practice-based scheme means that trainers in such practices should in all cases have their approval as a trainer reviewed. The intention is that the quality of training provided in practice-based PMS sites will at least equal that currently available in GMS practices. It will be important to ensure that the range, quality and depth of experience available to GP Registrars is maintained, especially in cases where a practice becomes or ceases to be a pilot site part-way through the GP Registrar's employment. During transitional arrangements we will ensure that trainees are not adversely affected.

244. Trainers in practices which are under consideration for practice-based PMS schemes should, in the first instance, approach the Director of Postgraduate General Practice Education (DPGPE) for advice. Trainers currently employing GP Registrars should establish whether that GP Registrar's employment will continue after the point the practice moves across as a pilot site. If so, the trainer, in consultation with the DPGPE, should review the continued employment of the GP Registrar in that practice. If both the trainer and DPGPE agree that the training environment will remain stable and the full training curriculum can be adequately covered, the trainer should apply to the JCPTGP for re-approval as a trainer.

245. It may not be necessary to seek immediate re-approval as a trainer from the JCPTGP if it is unlikely that the practice would be employing a GP Registrar in the first year of PMS status. However, trainers in PMS sites who are considering employing a GP Registrar should in all cases obtain confirmation of their re-approval as trainers from the JCPTGP before employing a GP Registrar.

246. Our intention is to provide a right of appeal for trainers in PMS practice-based sites aggrieved by a decision of the JCPTGP to reject an application for approval or re-approval as a trainer, or to withdraw approval.
Trainee's pay and conditions will remain the same as that currently provided for within GMS, both during the duration of a PMS practice-based pilot and during any process of transition.

**Continuing Professional Development**

248. When negotiating contracts, PCTs and IHBs will wish to take into account the continuing medical educational needs of PMS practitioners. PCTs and IHBs are advised to discuss the educational arrangements for PMS practitioners with the DPGPE.

**Primary Health Care Teams**

249. PMS schemes need to ensure that clinical placements and supervision to pre- and post-registrations healthcare students (eg health visitors, district nurses, practice nurses) continue to be available and that, where their schemes involve community nursing services, they pick up their share of this obligation. It is also essential that all trained staff have their need for continued professional development and clinical supervision addressed within the contract. PCTs and IHBs will need to consider addressing these issues within the agreement.

250. Appraisal systems should be put in place, in line with the GMS arrangements for PMS practitioners. This should include plans, currently under discussion, for supporting under-performing doctors.

**ORGANISATIONAL MODELS**

**Limited Companies/Partnerships**

251. The 1997 Act allows companies limited by shares to be formed for entering into PMS pilot schemes. These limited companies must be established solely and exclusively to provide the personal medical services agreed in the PMS agreement. The Act states that a company limited by shares may only enter into an agreement with PCTs or IHBs to carry out a PMS scheme if all the shares are legally and beneficially owned by one or more of the following:

- a suitably qualified medical practitioner
- an NHS Trust
- an NHS employee or a PMS scheme employee
- an individual who is providing personal medical services under that or another PMS scheme

252. Such a company is a 'qualifying body' under the terms of the Act.

253. This option provides a means for those entering into a PMS scheme to have a collective legal identity for the purposes of contracting with PCTs or IHBs. PMS schemes which are considering establishing a limited company will need to make provisions for how the shares in the company may be transferred. PCTs and IHBs will be directed to include in the PMS agreement a term providing for that agreement to end if any member, or member's...
personal representative, sells a share to anyone other than members of the "NHS Family". To avoid the PMS agreement ending prematurely for this reason, a PMS scheme will want to have appropriate arrangements in place to cover any eventuality requiring a transfer of shares, eg the death of a shareholder, a shareholder retiring etc. A potential vehicle for such arrangements is the company's articles. The Scottish Ministers must be notified of any changes in the company's shareholding.

254. Companies limited by shares must be registered with the Registrar of Companies, and must comply with the Companies Act 1985. There are a number of legal, financial and accounting implications of having limited company status. Potential PMS providers considering establishing a limited company will want to take professional advice at the earliest possible opportunity to assess the implications for themselves collectively and as individuals.

Partnerships

255. PMS schemes which propose to use the partnership model will want to review their existing partnership agreement in light of their PMS proposals. They may also wish to have legal and financial advice on this issue.

Nurse-Led Pilots

256. Practice-based contracts will provide an opportunity for nurses, professions allied to medicine, and managers in general practice to hold contracts for the delivery of PMS and for them to become equal partners in practice. It will also provide an opportunity to evaluate the effect of general practitioners directly employing community nurses. The Act offers the opportunity for nurses to be responsible for the development, implementation and achievement of the PMS contract and in turn to employ a salaried GP.

Premises Issues

Basic Principles

257. PCTs and IHBs should agree in contracts with PMS providers the nature and extent of premises from which to provide PMS.

Normally agreed contract prices would include the revenue costs of providing premises.

PCTs and IHBs may agree (initially or during the pilot) to meet through the contract all or part of the capital cost of improvements to premises.

PCTs and IHBs may agree plans for substantial refurbishment or building of new premises and reflecting revenue consequences in the contract price.
General

Providers responsible for suitable accommodation for services

258. The PMS providers delivering services will be responsible for arranging suitable accommodation of a standard agreed under the contract. Where appropriate, commissioners and PMS providers will wish to consider the existing nature of those premises and any changes to them during the term of the PMS scheme and reflect this in the agreement.

Factors for the PCT or IHB to consider

259. The Statement of Fees and Allowances (SFA or "Red Book") arrangements do not apply to, and SFA allowances are not available to, PMS providers during the contract. The cost of premises required for the delivery of PMS are likely to be one of the costs covered by the agreement price. In agreeing an agreement and associated costs, PCTs and IHBs may wish to compare the premises overheads to the existing levels of payment for premises made to proposed PMS schemes. This may provide a starting point from which to assess value-for-money against the nature and level of services to be provided under the PMS schemes arrangements.

260. The agreement may take into account all premises running expenses incurred by GPs for the services provided under the PMS arrangements including rental or borrowing costs, heating, lighting, insurance, ongoing maintenance etc.

261. Under the PMS agreement, PCTs or IHBs may agree to a reassessment of current market rents by the District Valuer for GPs in rented property or in receipt of notional rent prior to the start of a PMS contract. This will provide up-to-date assessments which PCTs and IHBs and PMS providers may wish to take into account when agreeing overall contract prices.

Contract options for improvements costs

262. Under the contract, PCTs or IHBs may agree to meet all or part of the capital costs of general improvements to premises to meet the requirements of the agreed services. Alternatively, PCTs or IHBs may agree to reflect in the contract price the cost of borrowing by GPs or increased rental costs they incur to meet the cost of improvements or substantial refurbishment of premises. Capital required by PCTs or IHBs will continue to be covered by their capital regimes with any increased capital charges reflected in the agreement price.

GP Premises Schedule

263. The GP premises Schedule (SFA paragraph 51 Schedule 1a and 1b) provides overall size and building cost maxima for premises built under the scheme. The publication "General Medical Practice Premises in Scotland – A Commentary" provides advice on good principles of design and construction. It also gives typical sizes for the different function areas required for modern general practice. The Schedule and the Commentary are not restricted only to premises built under the cost rent scheme nor only those for the provision of general medical services. The standards provided in both documents can be used by PCTs and IHBs when making value for money assessments on proposals for new PMS premises or existing PMS premises which undergo substantial modification, whether owner-occupied or rented.
Conditions on length of availability of improved premises

264. In agreeing premises improvements or developments, PCTs and IHBs GPs will wish to reach agreement on a period of time that the premises should be available for the delivery of NHS services, commensurate with the level of funding provided under the agreement. They should consider whether, in the case of PMS agreement ending or not being renewed, there is a reasonable expectation of other NHS uses which will justify the investment, and that the additional premises' costs can be met, within SFA rules, from GMS or alternative NHS contract income. PMS providers investing in larger premises without suitable assurances from the PCT or IHB will do so at their own risk. When considering the need to rent new or additional premises, PMS providers will wish to take into account the likely period of time for which the premises will be required and reflect this in the lease or licence occupancy agreement that they enter into with the landlord.

Accommodation provided as a service

265. In cases where owners or leaseholders of the premises from which a pilot scheme operates provide the use of the accommodation to the PMS provider as a service, costs will be part of the overall agreement price negotiated between the providers and PCTs or IHBs. Whatever the basis for these negotiations, both parties should consider what happens if a PMS contract comes to an end and the GP providers wish to return to GMS. It will be prudent to ensure that an easy return to other funding arrangements at the end of the PMS scheme can be managed. It is recommended that there is a sufficient transparency in the PMS premises arrangements to facilitate this.

Options where joint providers use one member's premises

266. Where two or more providers come together to be involved in a PMS scheme, they and the IHB or PCT will wish to consider the most appropriate contractual arrangements relating to the use of premises. If premises from which piloted services will be provided are owned or leased by one member of the pilot group, payment in respect of those premises may be dealt with in contractual arrangements between the PCT or IHB and that member.

Legal advice needed by PMS groups and PMS companies

267. PMS groups are recommended to seek legal advice about the arrangements for the ownership and use of premises, including issues such as:

- who would be liable if any of the members defaulted on payments or left the PMS scheme, and
- what is to happen to the premises at the end of a PMS pilot.

Before a PMS company buys premises owned by GPs, the GP and the PMS company should get legal advice on sale of goodwill.

Capital expenditure on PMS premises

Reflecting necessary capital expenditure on premises in the contract
268. The remainder of this section provides advice on situations where there is a need for a PMS provider to undertake capital expenditure on premises and how those costs might be reflected in the contract price.

Costs and expected benefits of planned work

269. In all cases, the PMS scheme will need to discuss with the PCT or IHB, the nature of the work to be carried out, the improved delivery of services that will accrue and associated costs both in terms of the work planned and any revenue consequences in the contract price. PMS schemes that undertake capital spending without first obtaining PCT or IHB approval will do so at their own risk.

Three categories of capital spending

270. Three categories of capital spending are expected to arise:

- building work on NHS Trust-owned property
- minor structural or other improvements to existing GP owned or rented premises
- a programme of building work to substantially modify or replace existing GP owned or rented premises.

NHS Trust-owned property

Continuing current arrangements

271. NHS Trusts that wish to carry out improvements to property that form part of their estate used for the provision of service under the contract will be covered by their capital regimes. This is likely to attract a higher rate of capital charges which should be discussed with the PCT and, where agreed, reflected in the contract price.

Minor structural or other improvements to existing GP premises

Two options for meeting costs

272. Examples of this type of work include building an extension, reconfiguring existing rooms, improvements to access and building security etc. Two options exist to meet associated costs and early discussions between the PMS scheme and the PCT or IHB will assist in determining which to adopt under the contract.

Under the first, the PMS scheme may choose to raise all of the capital itself and seek agreement from the PCT or IHB to review the contract price to take account of associated borrowing costs.

Under the second, the PCT and IHB and the PMS scheme may agree to each contributing a proportion of the capital required with the additional borrowing costs incurred by the PMS
scheme reflected in the contract price. For either option, the PMS scheme can seek the agreement of the PCT or IHB to have any additional heating, lighting, insurance etc costs reflected in the contract price.

Substantial modification of replacement of GP premises

Agreeing premises improvement

273. As part of the PMS agreement negotiations, both parties will wish to consider and discuss the provision and development of premises to support the services provided. In agreeing premises improvements or developments, PCTs, IHBs and GPs may wish to consider whether, in the case of a PMS agreement ending or not being renewed, there is a reasonable expectation of other NHS uses which will justify the investment, and that the additional premises costs can be met from GMS or alternative contract income. PMS providers investing in larger premises without suitable assurances from the PCT or IHB will do so at their own risk.

Where PCTs or IHBs agree that there is a need to replace or substantially modify premises during the period of the PMS scheme, agreement should be reflected in the PMS agreement. The manner in which the associated costs should be treated within the contract is determined by whether the PMS premises are owner-occupied or rented premises.

Owner-occupied premises

274. Owner-occupied GPs secure the capital required to buy or build premises from which to provide services. GP PMS owner-occupiers are no different in this respect. Any plans to replace existing premises either through substantial modification of existing property or new build should be discussed with the PCT or IHB. Where agreed, the agreement price may be reviewed to reflect the borrowing cost incurred by the PMS scheme. The standards set out in the publication, "General Medical Practice Premises-in Scotland– A Commentary" also provides useful advice to PCTs or IHBs, GPs and their building advisers on models of practice premises suitable for the delivery of PMS services.

Rented premises

275. There is an increasing activity by private sector developers in providing purpose built premises to be leased to GPs, with the developer assuming responsibility for capital funding of the completed developments. The GPnet web site http://www.show.scot.nhs.uk/gpweb also provides guidance to GPs, PCTs, IHBs and the private sector on how this type of partnership might best be approached. PMS schemes considering a move to premises provided in this way should discuss their plans with the PCT or IHB. Where agreed, the contract price may be revised to take account of any additional costs incurred by the PMS scheme.
IT/INFORMATION REQUIREMENTS: defining information needs

276. At an early stage PMS schemes should consider and discuss with their PCT or IHB:

- what information they will use to monitor and demonstrate that they are meeting their objectives and satisfying contractual responsibilities, and
- how they intend to collect and report it

277. Such information may include:

- levels and types of activity, or progress towards health gain targets, for specified patient groups, eg residents of a locality, within an age band, with an existing disease
- data relating to adherence to treatment protocols for patients with chronic diseases
- outcomes or indicators of outcome for patients with specified illness
- screening for and taking action on at-risk groups

278. There may also be a need for information on prevalence of morbidities and activity levels to inform needs assessment and service planning. 'Before' (baseline) and 'after' figures may be needed to assess change over time.

279. The means by which these needs will be met will be an important element of the Information Management & Technology (IM&T) development plan (or equivalent) that should be drawn up by each PMS scheme prior to the start of operations.

GP PRACTICE SYSTEMS

280. Practices working together in a group do not need to have the same type of clinical computer system, but they should work towards consistent recording methods. Where pilot sites' information systems do not use Read Codes, they may wish to consider converting to Read Codes, especially where there is a mixture of coding systems in use within a group of practices.

Extracting Data from GP Systems

281. As far as possible this information should be obtained directly from operational systems, especially from practice clinical computer systems which are used as the primary record of patient health status, contracts and treatments. Provided data recording is reasonably complete and accurate, the types of information outlined at the start of this section can be produced by selecting and aggregating data using query or data extraction tools provided with each GP system and then feeding this data into an analysis facility.
COMMUNITY NURSING SYSTEMS

282. Many PMS schemes will wish to achieve greater co-ordination of care by the Primary Care Team (PCT) to achieve better outcomes for patients and greater efficiency. This suggests the need for a strategy of moving towards shared/common clinical systems support for all PCT members. Such systems should provide shared access to information on patients, their condition, disability, domestic circumstances, care plans, the care provided by each team member, changes in the patient's condition and expected outcome. However, in the short-term it may be necessary to make more effective use of existing systems and/or to put in place affordable medium term solutions consistent with longer term aims.

Electronic Communications

283. PMS schemes are encouraged to retain existing GP/PCT/IHB Registration Links in order to maintain the accuracy of patient registers including the NHS Central Register.

284. The NHS Network (NHSnet) is the secure strategic network for the NHS. It is the preferred means of exchanging electronic data between NHS organisations and of gaining access to health related applications and services, both voice and data. Guidance on NHSnet connection is available from PCTs, IHBs and local telecommunications groups.

CONFIDENTIALITY

285. Privacy, confidentiality and data protection considerations must be borne in mind when making clinical systems more widely accessible within a primary care team or within a larger organisational unit and in designing data exchange procedures. Those responsible for designing systems and procedures should be aware of the guidance in the following publications:

- Introduction to Data Protection in the NHS (NHS Executive Information Management Group, 1994)
- Information Security Within General Practice (NHS Executive Information Management Group, 1995), and
- The protection and Use of Patient Information, (DH, 1996)
- Data Protection Act.

Sources of Help and Advice

286. Local GP computing facilitators are valuable sources of guidance and recommended procedures on the use of GP systems.

PCT, IHB and Central Information Requirements

287. The management information and financial reporting requirements of PCTs and IHBs will be a matter for individual discussion and should be specified within the agreement between the scheme and its PCT/IHB. The systems and procedures that will be needed
should be considered when this aspect of the agreement is being drawn up. As noted above, it would obviously be desirable if the data required could be obtained from existing clinical and financial systems. More information about the proposed national minimum data set required for PMS schemes can be found at paragraph 276 et seq.

Points to Note

288. PCTs and IHBs will need to ensure that where PMS providers do not participate in the relevant target payment scheme, they have data collection arrangements which are either capable of creating or re-creating the necessary records to enable pilot scheme practitioners to step back into GMS and, in turn, the target payment scheme, if they were to elect to do so.

PRESCRIBING AND DISPENSING

• PMS GPs should prescribe on the usual GP10 prescription form and patients obtain their medicines from the community pharmacist

• the restrictions on GP prescribing, namely the selected list and those in the Drug Tariff, should apply to Part I GPs as they do to those working under Part II. NB: The “Selected List” provisions are contained in Schedules 10 and 11 to the GMS (Scotland) Regulations. The Scottish Drug Tariff Lists for appliances and oxygen services are set out in Parts 3 and 10 respectively

Replicating the Control of Entry/Exit for Dispensing by Doctors

289. A PMS GP will be allowed to dispense medicines but only in circumstances equating to the Part II regime, i.e., to patients living in designated rural areas more than 3 miles from a community pharmacy. The provisions in the Pharmaceutical Services Regulations will be replicated in Directions to ensure that control of entry under Part I is the same.

Dispensing Doctor Lists

290. Regulations provide for the preparation by PCTs and IHBs of one or more lists of medical practitioners who undertake to provide drugs, medicines or listed appliances. This will give the NHS Tribunal a locus with dispensing doctors. There will be 2 lists, one for dispensing doctors working exclusively under Part I and a second for the PMS doctors who continue to dispense under Part II.

Nurse Prescribing

291. The current nurse prescribing scheme gives prescribing powers to those with a district nursing or health visiting qualification who have undertaken additional nurse prescribing training. Such nurses can prescribe from the Nurse Prescribers’ Formulary.

292. The nurse prescribing scheme has been introduced into all PCT/IHB areas.
SECTION 6: VARIATIONS WITHIN THE PMS AGREEMENT

Pilot Schemes
Managing Agreement Variations

293. There are 2 kinds of agreement variations:

- **Prior to implementation** - those that occur between Scottish Ministers approving a proposal (with modifications in some circumstances) and implementation

- **Post implementation** - those that occur once the agreement is signed and implementation of the scheme is underway

Prior and Post Implementation

294. It is important to note that changes to original proposals, both prior and post implementation, must be agreed by both parties to the agreement.

295. The exemptions to the general rule that all variations to approved proposals require the Scottish Ministers' authorisation are:

- changes to overall costs of the scheme which are agreed by both parties to the contract and which fall within 20% parameters may be determined by bilateral agreement

- changes to staff named in original proposals who are not performers of clinical services or are not qualified persons who entered into the agreement with the PCT or IHB

- changes to the times of delivery of services specified in the proposal which do lead to an overall reduction in time services are available to the public

296. For ease of administration we would request that PCTs or IHBs inform Scottish Ministers of major changes as they arise in the development of contracts. Examples of major changes are:

- any change to providers and performers as designated in a proposal, including any change to sub-contracting

- any changes to the proposed legal relationship within the pilot

- costs in excess of 20%

- population change of more than 10%

- significant change to services to be provided or the circumstances in which they are provided, ie hours/days/times
any significant changes to the geographical boundaries of the PMS scheme

297. Once the negotiations are concluded, PCTs and IHBs should then send the finalised agreement to Scottish Ministers. It would be helpful if PCTs and IHBs highlighted both the major changes which have already been seen and authorised and any minor variations. Once the agreement has been agreed and the scheme implemented. Variations can be requested by either party (ie any of the PMS providers or the PCT or IHB) and Scottish Ministers may, if they decide that the variation is necessary, direct that the scheme is changed accordingly. They can also do this at their own behest, ie such action is not dependent on either of the parties making the request.

Permanent Schemes

298. There is no need to submit such variations to permanent schemes to Scottish Ministers for approval.

299. PCTs and IHBs should agree arrangements for managing variations in contract value. In reaching agreements, all parties should have regard to the need to make the most effective use of resources in order to improve the delivery of services to patients. PCTs and IHBs will also wish to ensure that they have mechanisms in place to monitor the delivery of contracted services to ensure that value for money has been achieved in respect of the expenditure.

Reversion to Part II

300. During the application process, applicants and PCTs and IHBs should take account of the long-term funding implications of PMS pilot schemes and the ability of PMS pilot GPs to return to Part II arrangements. The next stage is to ensure that these issues are reflected in the contract.

Termination of PMS agreements

301. When drawing up PMS, parties may wish to consider the following general principles:

- a three month period of notice for a voluntary withdrawal from the agreement by PMS providers is required. Agreement should be made on the obligations to provide continuity of service through hand-over and transitional arrangements

- agreement is needed on the period of notice if the agreement is terminated on a non-voluntary basis and how this should be handled. Scottish Ministers must be satisfied, at the approval stage of the proposed PMS scheme, that such arrangements are sufficiently robust

- provision should be made for what happens to medical practitioners, other professionals - both parties to the contract and employed staff - on termination of the contract. This should pick up on the preferential rights of return to medical lists for PMS pilot practitioners and how continuity of service and employment and pension rights will be addressed
• provision should be made for what happens to any sub-contracts held between providers and others in respect of the main agreement.
SECTION 7: MONITORING/AUDIT/ACCOUNTABILITY: Audit

302. PMS agreements between PCTs/IHBs and PMS schemes must establish a framework on which probity and accountability issues are present and can be applied appropriately.

303. The contract enables the PCT/IHB to demonstrate that it has maintained appropriate internal controls over funds. Expected key controls which will be relevant to PMS pilots and which should be subject to ongoing appraisal will include:

- adequate procedures to monitor quality and performance of the levels of service
- the existence of a satisfactory system to ensure that "contracted" services have been received, invoiced, paid and accounted for correctly
- that appropriate management review takes place of all PMS pilot schemes regarding financial performance and exposure to risk

304. The PMS scheme should provide external auditors\(^1\) access at all reasonable times to any documents containing information relevant to the accounts of the body as the auditor considers necessary. The term document includes information stored or transmitted electronically. In addition any officer or member of the PMS scheme shall provide such explanation and information as the auditor thinks necessary.

Assurance and Internal Controls

305. The systems applied with regard to PMS agreements should be subject to appropriate review. As a subset of a PCT/IHB's purchasing function, the PMS scheme may be subject to review by the relevant internal auditor in order to establish:

- adherence to the terms of statutory regulations and consistency with this guidance
- adequacy of contractual agreements and mechanisms employed at a PCT/IHB level to evaluate adherence to the agreements
- adequacy of systems employed at PMS scheme level to:
  - support the reliability of information provided to the PCT/IHB
  - demonstrate appropriate application of the funding in accordance with the PMS agreement

\(^1\) The primary external auditors are appointed by the Accounts Commission for Scotland and their rights of access are defined under the Local Government (Scotland) Act 1973. In addition the 1983 National Audit Act confers rights of access to their auditors to enable them to carry out the audit of the NHS summarised accounts.
Accounts Arrangements

306. For the purpose of recording PMS agreements in PCTs/IHBs accounts, all PMS schemes (including NHS Trust-led schemes) should include in their supplementary financial return (SFR9) at line 440, any PMS schemes' income and associated expenditure, but PCTs/IHBs will not have to prepare separate accounts for PMS contracts. The contract should allow PCT/IHB auditors to examine the appropriate PMS accounting records.

307. The 1998/99 Primary Care NHS Trust accounts will include a new sub-heading in note 2.1: Purchase of Healthcare from PCAPs. Primary Care NHS Trusts should analyse this expenditure between the additional lines for PMS and PDS.

Accountable Officer

308. Accountable officer responsibility for expenditure on and agreements with PMS schemes rests with the Chief Executive of the PCT/IHB. The accountable officer is responsible for the reasonableness of the contract and for ensuring that the PCT/IHB obtains from the PMS provider the services specified in the contract. The accountable officer is **not** responsible for the actions of the PMS provider in supplying those services.
A PILOT IN ACTION

SECTION 1: EVALUATION

EVALUATION FRAMEWORK

309. Evaluation is a key component of the PMS initiative. An evaluation framework has been established by the Department, see "A Guide to the approval and evaluation of Personal Medical Services Pilots under the 1997 Act, Section 11.

310. A review by Scottish Ministers of permanent PMS schemes will not be required. However it would be good practice to follow this guidance on local consultation for permanent schemes.

311. The broad aims of the valuation framework are to:

- support the requirement under the 1997 Act for a review by Scottish Ministers of each PMS pilot within 3 years of commencement
- facilitate learning and development locally
- inform policy formulation centrally
- enhance the R&D base in primary care

LOCAL EVALUATION

312. The guide to local evaluation issued by the Health Department provides guidance on undertaking local evaluation for PMS pilot schemes. No central funding is available as direct support for local evaluation. PMS schemes and PCTs/IHBs can draw upon other local sources of expertise and support, such as medical audit advisory groups, AMCs, LHCs and other representative groups, and primary care R&D networks. PCTs/IHBs will be responsible for ensuring that agreed evaluation arrangements are in place and for facilitating this process.

313. The design of local evaluation should flow from the concept of the PMS project in terms of its purposes and scale. Planning and implementing local evaluation is a helpful discipline for clarifying why the PMS scheme has been established, to what ends it is working and what would count as sound evidence for the achievement of its objectives. The essential building blocks for local evaluation are, therefore, clear objectives and a robust system for generating relevant information for monitoring performance against objectives.

314. An important consideration in establishing local evaluation is to ensure that assessment of PMS schemes is properly tailored to the local context and takes account of the particular circumstances in which it is operating. Local evaluation should ascertain whether each scheme is successfully fitted for its local purpose.

315. PCTs/IHBs will want to work with PMS schemes to ensure that learning produced by local evaluation is made available to all those who have an interest in this information including local people.
316. The findings of a GB-wide central evaluation of 1st year PMS pilots will be disseminated once they are received, towards the end of 2001.

**SCOTTISH MINISTERS’ REVIEW**

317. The 1997 Act specifies that:

- at least one review of the operation of each PMS pilot scheme must be conducted by Scottish Ministers;

- the review must occur within a period of 3 years from initial commencement of the pilot scheme;

- the PCT/IHB and pilot will be given an opportunity to provide comments relevant to the review, but otherwise the review procedures will be determined by Scottish Ministers.

318. Under the Primary Care Act, Scottish Ministers are required to review each pilot within 3 years of its establishment. The review will be based upon the wider lessons and principles generated by national evaluation but also upon the detailed local evaluation work on each individual pilot scheme. Scottish Ministers will have the ability to give approval for making individual pilots into permanent arrangements, ie the pilots which are shown to be successful, in that local environment, for those people and in those circumstances, so long as those local people (Primary Care NHS Trust and providers) wish to retain those arrangements. Only local evaluation can provide the level of detail to enable that judgement to be made and that is why it needs to be done well.

319. The review of each pilot will determine what benefits and costs for the NHS have been produced and whether such provision of services should continue and be generalised more widely. Local evaluation will provide the main and complementary source material for the conduct of the review. The review will be specific to each pilot and will, therefore, look carefully at the findings from the local evaluation. The findings from the central evaluation will provide the additional dimension of a national perspective to inform reviews, offering a wider context within which the performance of individual pilots can be located and enabling the transfer of identified good practice where appropriate.

320. Six of the seven first wave pilots in Scotland have now been reviewed by Scottish Ministers. The review was conducted in 2 stages:

- a desk top review of local evaluation reports, financial performance, assessment of the extent to which the pilot has met its original objectives; a report on whether the relevant PCT would support the pilot being established on a permanent basis.

- a visit to each pilot where Health Department officials will carry out a series of interviews with key stakeholders including a representative of the PCT, LHCC, pilot team and a patient representative.

Copies of the Review Report are available from [www.show.scot.nhs.uk/lhcc](http://www.show.scot.nhs.uk/lhcc) – see PMS button.
Extension of pilots

321. It is possible that in some cases, Scottish Ministers review of a pilot will not produce definitive "yes" or "no" evidence on which Scottish Minister can base their decision. In those limited number of cases, it may be that Scottish Ministers will agree to a limited addition to the pilot period until it is clearer what should be done. However, it is expected that this would only to apply to a small number of pilots and within a clear and defined extension period.

Powers to deal with unsatisfactory pilots

322. Where a pilot scheme is unsatisfactory, Scottish Ministers have the powers to:

(a) direct a PCT/IHB to vary the scheme in a way which remedies any of its shortcomings

or

(b) where (a) is not appropriate or has not worked, to direct a PCT/IHB to bring the scheme to an end

323. Scottish Ministers can require the pilot to be ended in line with any particular Directions specific to that termination. They might, for instance, direct that the period and manner of winding up the pilot are set out to ensure that any problems of continuity of care specific to that pilot are addressed.

324. This does not remove the need for PCTs/IHBs and pilot scheme providers to make within their contracts appropriate arrangements for the ending of a pilot scheme to ensure the effect on patient care is minimised and any outstanding liabilities are picked up. In making Directions on termination, Scottish Ministers would wish to take into account the existing contractual provisions.

SECTION 2: EMPLOYMENT/PENSION ISSUES

Guidance for Employers and Employees

325. PMS schemes will give an opportunity for primary care services to be provided in a variety of innovative ways. However, the transfer of staff into such schemes poses a number of important questions which need to be addressed. The information included in this section should assist both employers and employees to ensure that staffing issues are handled sensitively, fairly and legally. Appendix 8 provides further information on employment issues including questions and answers which you may find helpful. Each PMS scheme will be established in a different set of circumstances so, in some cases, questions may arise which are not covered here. Therefore it is recommended that, if they have not already done so, those entering into a PMS scheme seek legal and financial advice as soon as possible.
The Transfer of Staff into PMS Schemes

326. The majority of PMS schemes will be set up in circumstances which will involve staff who are currently providing the existing services through either a NHS Trust or a GP practice. The Transfer of Undertakings (Protection of Employment) Regulations (TUPE) may apply to some transfers of service, but secondment of staff to pilots or permanent PMS schemes may also be appropriate and is the preferred method of transfer for Trust staff.

327. PMS providers may wish to take on the employment of staff to provide certain services, eg community nursing, although PCTs/IHBs will need to ensure that the arrangements fall within PMS providers' powers. In the first instance PMS providers should approach those staff who are currently providing services to transfer to the scheme. They should discuss with the staff and their current employers the options available and agree the most suitable arrangement for all the parties. If these staff are unwilling to transfer it may be possible for the PCT/IHB to arrange a re-deployment of staff, so that their employees with similar experience who do wish to enter the pilot, may be found. Only if this route were also to fail would we recommend open recruitment. In approving such schemes, Scottish Ministers will take into account the way in which the staff have been, or are to be, recruited, and the impact of this on other local service providers. An important consideration will be whether any recruitment or secondment from outside the original PCT/IHB will cause any risk of redundancies there.

328. Therefore, the preferred method of transfer for PCT/IHB staff is through the secondment route. This will protect the staff's terms and conditions of employment, whilst providing the security that PMS employees will want. In addition, it provides protection to PMS providers who would otherwise be responsible for any redundancy costs in respect of these staff should the scheme end prematurely. PCTs/IHBs may benefit from any additional training and experience these staff gain during the scheme and patients will benefit from the continuity of service such an arrangement can provide. PCTs/IHBs will want to ensure by taking their own legal advice that the employment relationships they propose are within their powers.

329. For practice staff whose current employing practice becomes a pilot to develop a practice-based PMS contract, the transition should be fairly seamless. For GP practice staff transferring into a NHS Trust-led scheme, TUPE (which protects the terms and conditions of their employment) is likely to apply. But where the practice is taken into a PMS scheme run by a NHS Trust there will be employment issues to resolve if staff do not wish to make this transfer. Where there are practice staff who do not wish to transfer across under TUPE then they should discuss this with the project leader for the scheme.

Secondment

330. An NHS Trust may second staff to a PMS scheme, provided that the Trust does not incur any costs in relation to the secondment, without acting outside its statutory powers. Managing the secondment arrangements and any financial implications should be settled by prior agreement between the PMS scheme and the Trust concerned and Trusts will need to ensure that the secondment arrangements are within their powers.

331. If Trust staff transfer to a PMS scheme on secondment, the secondment agreement should provide for their existing terms and conditions of employment to be protected. This
will provide PMS employees with the security they need to enter the scheme. The Trust will need to make forward plans for the possible return of its staff if the PMS scheme or the period of secondment should end.

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

332. There may be circumstances where an undertaking, eg a Practice and its staff, is transferred into a PMS scheme. In this case there would be a TUPE transfer, ie the TUPE Regulations become applicable. A summary of these regulations are shown at Appendix 7.

333. Employers will want to consider, as soon as possible, whether TUPE is likely to apply and take legal advice. TUPE's application to individual cases must always be a question of fact in each case.

334. TUPE will apply if a body is transferring part of its business to another. The part being transferred must retain its essential identity and must continue to provide the same kind of services it provided. In such circumstances, the PMS scheme takes on the liability for the employment relationships of the previous employer. Before any transfer takes place there are statutory rights of consultation for affected employees. The employee retains his/her terms and conditions of employment unless and until the PMS scheme wishes to make any alterations permitted by law. This should be done in consultation and with the agreement of the employee, and applies to employees on all types of contract, eg part-time, fixed term, permanent etc. If there is to be a change generally to the terms and conditions of employment, representatives of the workforce should, as a matter of employment law, be consulted.

335. If a PMS scheme, pilot or permanent, ends and the undertaking transfers back to that or another PCT/IHB, then TUPE would almost certainly apply again. This means the new employer would step into the shoes of the PMS scheme insofar as its employment obligations are concerned in relation to all those staff in the transferring part of the business at the time of the transfer. Any changes to terms and conditions agreed during the time of the PMS scheme would continue to be enjoyed by the staff unless, and until, the new employer wished to make any alterations permitted by the law. Again this should be done in consultation and with the agreement of the employee and, if there is to be a change generally in the terms and conditions of employment, representatives of the workforce should, as a matter of employment law, be consulted.

**Employment of GPs**

336. One option available within a practice-based PMS agreement, is the direct employment of GPs. Remuneration and terms and conditions will be a matter to be discussed between the PMS scheme and the prospective salaried GP and a contract of employment drawn up to reflect this.

337. The GP grade is not one of the recognised grades as defined within the Hospital Medical and Dental Staff Terms and Conditions Handbook (Scotland), so PMS salaried GPs will need to negotiate the terms and conditions of their employment locally.
Protecting the Rights of Employees

338. The rights of PMS employees will be protected in a number of ways. In the first instance this is a matter for an individual's contract of employment, backed up by employment law which sets out a number of statutory rights. In addition, PMS schemes should be aware that considerable importance is to be attached to the contract monitoring by PCTs/IHBs, one element of which will be on the PMS provider's role as an employer. If a PMS pilot was unsatisfactory in any significant respect, including employment issues, Scottish Ministers have the power to direct a PCT or IHB to bring the pilot scheme to an end.

Consultation, Grievance and Disciplinary Procedures

339. PMS schemes are expected to put in place their own local consultation machinery, grievance and disciplinary procedures. This will be particularly important in the context of medical practitioners, because PMS schemes will want to ensure that, where they take up the responsibility for any acts or omissions of their medical staff, they have their own internal arrangements to ensure that the matter can be dealt with appropriately. Given the expertise of the local PCT/IHB management and Staff Associations in this area, PMS schemes would be well advised to consult and seek their advice when making these arrangements.

340. In the event that there may be a professional disagreement, PMS schemes should consider the use of a professional adviser from the local PCT/IHB in the first instance.

PMS Pilots Which End Prematurely

341. Where staff are transferred on secondment by the PCT/IHB and a pilot ends prematurely, then the staff will return to the Trust under the terms of the secondment. If there has been a TUPE transfer of staff into a pilot, staff have no right of return to the original employer. The patient population will, however, continue to require services regardless of who is responsible for the provision. This means that the existing function will be transferred elsewhere, in all likelihood back to the original or another PCT/IHB. The existing staff could therefore, if they agree, be transferred to the new employer. It is likely that TUPE will apply again in the case of such a transfer.

Employment Good Practice

342. Good employment practice requires that employers have policies in place which cover the following areas. PMS providers are recommended to consider such policies.

- The Management of Health and Safety at Work Act 1974 and the Health and Safety at Work Regulations 1992 place duties on employers systematically to assess all workplace risks, and to take all reasonably practicable action to minimise those risks.

- Employees need to know the identity of the person to whom they can apply if they are dissatisfied with any disciplinary action relating to them. Good model disciplinary procedures give a clear indication of the arrangements to be followed when an employee is dissatisfied with any action taken against him/her and at any
subsequent formal hearing. Advice on good practice and on how to handle grievances and disciplinary problems is available from the Advisory, Conciliation and Arbitration Service (ACAS).

- Employers have statutory responsibilities for providing equal opportunities in recruitment and selection procedures. Discrimination on the grounds of race, sex and disability are prohibited under the Sex Discrimination Acts 1975 and 1986, the Race Relations Act 1976 and the Disability Discrimination Act 1995. In operating all policies, employers and their employees should develop and practice positively the concept of equal opportunities for all.

- It is important that employers consider the particular needs of employees' domestic responsibilities. Employers should consider flexible working arrangements such as retainer schemes, part-time working, job sharing, and flexi-time. Special leave arrangements may also be appropriate.

- A statement should be provided of what is considered to be inappropriate behaviour at work and it should be made clear that the policy applies to all grades and all levels of employees. Harassing a colleague is inappropriate behaviour and should be treated as a disciplinary offence.

- It is good practice to provide clear guidelines on the length of maternity leave which would normally be available, whether it should be paid or unpaid and on the procedures for applying for such leave. The right to statutory maternity leave is set out in DSS leaflets N1257, Employer's Guide to Statutory Maternity Pay and N117A, Maternity Benefits. For those staff who are covered by Whitley Rules, Section 6 of the General Whitley Council Handbook gives details of maternity leave and pay entitlement.

- Equality of access to training has an important role in promoting and developing the potential of all staff. It is recommended that training and staff development opportunities are made known and available to all employees.

- To ensure a clear understanding in the event that redundancies need to be considered, employers will need to be aware of the statutory rights and existing contractual entitlements of their staff. ACAS can provide advice and assistance as required.

- It is recommended that employers have policies in place which allow staff to raise concerns relating to provision of health care or matters of probity without fear of victimisation.

- PMS providers will need to ensure that all staff – including those on secondment – are covered by their employers' liability insurance. It is important to note that PCTs/IHBs cannot be liable for staff who are not carrying out PCT/IHB functions/activities.
Professional Conflicts in Primary Care

343. Professional staff must only work within the framework of the relevant codes of conduct and the scope of professional practice. However, there may be occasions at local level where there are professional disagreements about the appropriateness of duties an individual has been asked to undertake. These should be dealt with in the first instance between the individual and the employer/GP. If the issue cannot be resolved locally, then a relevant professional advisor from the PCT/IHB should be asked to investigate the problem. At the outset both parties should agree to abide by the outcome of the investigation and honour whatever recommendations are made.

344. The individual may wish to have his/her trade union/professional association present during the investigation to provide support and guidance.

Pensions

The people who are entitled to become or remain members of the scheme

345. The NHS Pension Scheme Regulations were amended in 1998 to allow NHS staff involved in PMS Pilots either as Providers, Performers or Pilot Scheme employees to remain or become members of the Pension Scheme. The regulations took effect from 01.04.98. These regulations will be updated to include permanent PMS schemes.

346. PCTs/IHBs are employing authorities within the meaning of the pensions regulations and will continue to be so as pilot providers. Anyone, medically or non-medically qualified, employed by a PCT/IHB and not already a member of the scheme will be entitled to join automatically. Staff employed by a GP who become employed by a PCT or IHB will retain their membership.

347. Nurses employed in Pilot Schemes where the NHS Trust is the Provider will have full access to benefits. Only nurses employed in a Pilot Scheme led by any other Provider will remain, or join, the Pension Scheme on the same basis as GP practice staff. We will confirm the position for permanent PMS schemes, in due course.

348. GPs entering pilots as independent contractors will continue to accrue practitioner benefits. Income from the contract, whether PMS or PMS+, will be pensionable. Health authorities will continue to pay the employer's contributions of these GPs.

349. The NHS Pension Scheme Regulations were amended in 1998 to allow all existing GPs to continue to accrue benefits as practitioners for the duration of Pilot Scheme.

350. Regulations have been amended to allow a new PMS independent contractor to enter the NHS Pension Scheme on a practitioner basis. Where a newly qualified GP enters a pilot on a salaried basis, pensions will be calculated on an officer basis. GPs may have up to ten years of officer benefits dynamised when they become independent contractors under current regulations.

351. The regulations for permanent PMS providers are currently being considered. One option is to calculate pensions on an officer basis for this Group.
352. At a SE-level, the effects of these arrangements on the NHS Pension Scheme during the pilot period are being monitored.

FUNDING ARRANGEMENTS

353. Under the pilot PMS scheme, PCTs will continue to pay the employers' part of GPs' personal contributions to the NHS Pension Scheme, except in the case of salaried GPs and GPs employed by a limited company. In order for the pension contributions to be paid, the level of superannuable earnings for each pilot practitioner will need to be agreed between the PCT and the pilot providers. This will be based on the GPs' current pensionable earnings for GMS, wherever possible. For PMS+ pilots, any earnings from the "+" element should be included. Only the basic salary is pensionable, any bonuses (from profits), overtime etc are not.

SECTION 2: REVERSION TO PART II: Right of Return

354. When medical practitioners cease to perform personal medical services under a PMS pilot scheme, they may wish to apply to be included in a PCTs/IHB medical list. Under the 1997 Act, Scottish Ministers have a duty to determine whether each pilot's practitioners are to be given preferential treatment. This decision must be taken prior to approval of the scheme. Scottish Ministers must make the same determination where a scheme is varied to include a new pilot scheme practitioner part of the way through the pilot period. In either case Scottish Ministers must notify the PCT/IHB and the practitioner(s) concerned of their determination.

355. In practice, Scottish Ministers have, to date determined that every PMS pilot GP is to be given preferential treatment, this means that on application the doctor will be included on the list. This will apply so long as no other reasons emerge, between the time of Scottish Minister's determination and the application being made, for not allowing the medical practitioner back on the PCTs/IHBs medical list.

General Principles Under which Scottish Ministers will Exercise Their Powers of Determination

356. Scottish Ministers will apply a number of general principles in using their powers to determine these matters of preferential treatment, including that:

- medical practitioners leaving a medical list to join a PMS pilot should have the preferential right to be re-admitted to the list of the Trust in which the pilot has been operating - but not to any other medical list, subject to any more detailed criteria set out below;

- when a pilot scheme practitioner who had previously been on a medical list in the pilot area and who is not himself returning to that list is replaced, the replacement practitioner should also have a preferential right to be admitted onto that medical list, again subject to any more detailed criteria set out below. This replacement might take place either at the outset of the pilot or once it was operational but the principle would apply in both cases. It would be part of the determination process for Scottish Ministers to decide whether in each case replacement had occurred;
• medical practitioners in pilots who do not fall into either of the above categories will not have a preferential right to be admitted to a medical list;

357. There will be no preferential right to be admitted on to a PCT/IHB's medical list, for permanent PMS providers. However, if a permanent PMS provider ceases to perform PMS and wishes to apply to be included on the PCT/IHB’s medical list, the following criteria should be considered positively by the PCT/IHB.

• Is or was the potential participating medical practitioner previously on the medical list of the PCT/IHB in which the PMS scheme is taking place?

• Is or was the potential participating medical practitioner previously on the medical list in another area?

• If the potential participating medical practitioner was not previously on a medical list, is he/she to take over in part, or in whole, the patient list of either a GMS or PMS doctor?

• Is there any serious unresolved disciplinary matter or outstanding complaint against the medical practitioner at the time of the determination - this would include GMC and both criminal and civil legal proceedings?

• Is the medical practitioner due to leave the medical list on grounds of age or any other reason within 6 months of the determination. What, if any, attendant special circumstances apply, eg planned career break?

Representations Against Preferential Treatment

358. Under the Act, a PCT/IHB or any other person can challenge an application for inclusion on a PCT/IHB medical list made by a medical practitioner who is eligible for this preferential treatment. Representation can be made to the NHS Tribunal that inclusion of the applicant's name on their medical list would be prejudicial to the efficiency of general medical services provided in their area. This will allow any serious problems which emerged concerning the performance of personal medical services to be taken into account at the stage of considering entry onto the general medical services list. Should the applicant withdraw his or her application the Tribunal may proceed to inquire into the representation and exercise its powers in relation to disqualification.

359. The NHS (Service Committee and Tribunal (Scotland) Amendment Regulations 1998 (SI 1998/674) set out the manner in which such representations should be made. These broadly follow current regulations in respect of how representations to the Tribunal must be made and the timescales to apply.

360. These Regulations also cover the publication of information on applications for preferential rights of return and the right to make such representations. Publication arrangements mirror previous publication arrangements concerning representations to the Tribunal, ie to PCTs and Local Health Councils.
361. If serious concerns come to light about the performance of a medical practitioner under a pilot scheme after the doctor's name is entered in a medical list, the situation will be covered by Section 29 of the 1978 NHS Act. Representations against a doctor's name remaining on a GMS list may be made on the basis of concerns about his or her performance whilst the doctor was providing personal medical services under a pilot scheme. The Tribunal may, under Section 29, direct that the doctor's name be removed from a PCT's medical list and may also direct that the doctor's name should not be included in any other board's list.

**Winding up Procedures: Notice Period**

362. Scottish Ministers place the duty on PCTs to ensure that, within their agreements with PMS scheme providers, there will be an agreed notice period. PMS providers have the right under the 1997 Act to withdraw from PMS schemes.

363. The period of notice, not less than 3 months, is designed to ensure that patient care can be protected by means of transitional arrangements which underpin continuity of care. The period of notice also provides the opportunity for PMS providers to make appropriate provision for winding up any subsidiary liabilities they may have. For example, they may wish to ensure that any agreements they have with sub-contractors have a notice period in line with their main contract.

**Seniority payments and PGEA on return to Part II general practice**

364. Any period working in general practice in a PMS pilot will be counted toward seniority, if a PMS 'main performer' or 'a doctor' who is primarily responsible for the performance of PMS' returns as a principal to GMS.

365. Similarly, any attendance at PGEA accredited events, whilst a doctor is working in PMS, will count towards PGEA on return to GMS.

**Return to Arrangements Under the Statement of Fees and Allowances**

366. Where a pilot ends, GPs returning to GMS arrangements will resume reimbursement of premises costs under the Statement of Fees and Allowances (SFA). Practices in rented premises at the time of return and those whose premises costs under the pilot were paid analogous to the notional rent scheme will again be reimbursed as appropriate under SFA paragraph 51.1 to 51.49.

367. Where premises costs under a PMS contract were not analogous to the notional rent scheme, GPs returning to GMS will be eligible to receive payments under the SFA cost rent scheme. PCTs will therefore need to take account of this renewed call on their GMS cash-limited resources.
APPENDIX 1

PRIMARY CARE NHS TRUST/ISLAND HEALTH BOARD SUMMARY OF RESPONSIBILITIES

ACCEPTING AND PREPARING PROPOSALS FOR APPROVAL

Primary Care NHS Trusts/Island Health Boards:

- may only put forward proposals for PMS schemes from members of the "NHS Family" (each PCT/IHB affected by a proposal must put it forward, although this clearly can be a joint exercise)

- should examine whether the proposed idea needs a PMS scheme or could be done under existing arrangements

- will work with PMS proposers to prepare proposal documents, eg:
  - looking together at the objectives for the proposed PMS scheme
  - sharing information in order to complete a detailed proposal
  - looking together at the impact of a proposal on other local services

- must ensure that PMS schemes:
  - meet local needs
  - are supported by all parties
  - satisfy the legal requirements and Government policy objectives for PMS schemes
  - fit in with the overall policy direction for Primary Care Services

- must examine each new arrangement proposed and carry out appropriate, but proportionate local consultation. This must include LHCCs, LHCs, AMCs and LAs

- recommendations to Scottish Ministers must include:
  - a justification of new contractual arrangements
  - a clear assessment of the impact on existing services and service arrangements
  - explanation of how the proposal underpins the development of good primary care and delivers benefits both to patients and in developing local services
- demonstration that the proposal has addressed issues identified within the local Health Plan

- confirmation that the proposed pilot is affordable, offers value for money (financially and in improved quality of care) and is manageable within the resources available to the PCT/IHB

- an indication of what support if any the PCT/IHB can offer to assist applicants in the preparatory period

- agreement to ensure that patients and local people will continue to be involved in influencing service provision after the initial consultation process

- demonstration of the commitment and necessary management skills at an adequate level for the project

- a consideration of the capacity of the applying organisation's skills to manage within the PMS arrangements

- an analysis derived from the public consultation of the level of public support for the proposed new arrangement and a summary of responses to the consultation

- will inform applicants of the Scottish Ministers approval (including any modifications stipulated) or refusal of the PMS scheme

- should discuss with providers the support which will be needed, in preparing PMS agreements (eg lawyers and accountants) and the likely costs involved

MANAGING A PILOT

Primary Care NHS Trusts/Island Health Boards:

- will wish to:
  - maintain compliance by the PMS practice with the requirements to produce central data and information
  - retain existing Registration links
  - agree the range of information to monitor and demonstrate whether or not pilots are meting objectives and satisfying contractual responsibilities and collection and reporting arrangements
  
- should seek to achieve equitable distribution of resources, ensuring PMS schemes receive funds comparable to the responsibilities and services that are to be provided
will, under the PMS scheme, continue to pay the employers' part of GPs' personal contributions to the NHS pension scheme (except in the case of salaried GPs and GPs employed by a limited company). In order for the pension contributions to be paid, the level of superannuable earnings for each PMS practitioner will need to be agreed between the PCT/IHB and the PMS providers.

are required to implement approved PMS schemes in the form agreed by Scottish Ministers. Any changes to the proposal agreed by Scottish Ministers in the formulation or implementation of the agreement must be returned to the Scottish Ministers as outlined under para 294-299.

who have a PMS pilot which covers more than one PCT/IHB should agree with the pilot site which will be the lead body.

PMS Agreement Considerations

Primary Care Trusts/Island Health Boards:

should be satisfied that any potential conflict of interest in the PMS provider's delivery of services is discussed and satisfactorily resolved in the agreement.

should be satisfied that the employment arrangements within the PMS scheme provide satisfactory guarantees of clinical freedom for staff in order to serve the best interests of patients.

in agreeing new contractual arrangements with the PMS sites, must ensure that it will safeguard delivery of all PMS to all the registered patients of practices involved in the scheme.

will ensure that the PMS agreement specifies all services to be provided and by whom.

in agreeing new PMS agreements should seek ways to support closer working amongst members of the primary health care team.

Contract Price Considerations

Primary Care Trusts/Island Health Boards:

in considering the allowance for management costs within the PMS agreement price, will want to ensure they:

- treat all PMS schemes fairly
- take account of any additional responsibilities taken on
- consider the level of the resources that the PMS scheme already has available.
should, in considering an agreement price for a PMS scheme:

- clearly identify and specify the services to be delivered under the contract and its proposed duration

- identify a "baseline" value for PMS, probably representing the current year equivalent of the underlying level of GMS payments made to the PMS providers recently

- identify a "baseline" value for additional contract components including, where appropriate, drugs and dispensing in a way which is compatible with national budget-setting guidance

- have regard to the total of these "baseline" values as a starting point for considering the contract value.

Reasons for variations to the "baseline" include:

- the opportunities for PMS schemes to achieve efficiency gains under the pilot arrangements

- plans to improve or expand services under the PMS agreement, compared with historical provision. These may be significant where a substantial change of focus on to outcomes is envisaged

- moves towards equity of resourcing across the PCTs/IHBs area

should, throughout this process, have regard to:

- the amounts of money transferred from the GMS budget on account of their PMS schemes

- the arrangements for contract price adjustment/control of risk which are to be established for the PMS schemes

Audit and Accountability Considerations

Primary Care Trusts/Island Health Boards:

- (and applicants) should take account of the long-term funding implications of PMS schemes and the ability of GPs to return to Part II arrangements

- should demonstrate that appropriate internal controls over funds are being maintained. Expected key controls include:

  - adequate procedures to monitor quality and performance of the levels of service
the existence of a satisfactory system to ensure that "contracted" services have been received, invoiced, paid and accounted for correctly

that appropriate management review takes place of all PMS schemes regarding financial performance and exposure to risk

will have to include in their own accounts any PMS schemes' income and associated expenditure

Data Collection Considerations

PCTs/IHBs are required to provide data:

• to support general funding processes
• to support GPs remuneration process
• to support primary care policy monitoring, evaluation and development
• to monitor activity and performance which may well span HCHS and PMS areas
• to allow review by Scottish Ministers for PMS pilot schemes

The following principles should apply to information gathering in relation to PMS schemes:

• Community Health Index Numbers should continue to be used to identify patients;
• Information which practices are currently required to provide to the SMPC must continue to be provided; and
• information currently provided to SIRS must continue to be provided.

Local Evaluation

Primary Care Trusts/Island Health Boards:

• have an important role in keeping patients informed about and involved in the PMS scheme. In particular, reporting back to any individuals, groups or organisations with whom they consulted directly during the application process (including LHCCs, LHCs, AMCs and Local Authorities)
• will be responsible for ensuring that evaluation arrangements are in place at the local level and for facilitating this process:
  - agreeing plans with PMS schemes for appropriate project evaluation
  - overseeing delivery on these plans
• will ensure that good R&D support is available
• will need to ensure that the approved appropriate project evaluation is put in place
• are responsible for taking an active role in co-ordinating the evaluation activities of pilots, sharing information and encouraging learning - not only from their own area but also across the country
APPENDIX 2

A STATEMENT OF REQUIREMENTS

The 1997 Act enables GPs, other NHS professionals, NHS Trusts and Health Boards to test different ways of contracting for general medical services so as to address local service problems and bring about improvements. The new flexibilities mean that GPs, other "NHS family members", NHS Trusts and Island Health Boards can enter into a single local contract for the delivery of local services to meet the needs of the local population.

Within the context of these new flexibilities there remains the need to provide protection for or to safeguard the rights of patients, GPs and other clinicians involved in a PMS provider pilot scheme. It is necessary, therefore, to include certain terms and clauses in the PMS agreement between PMS providers and PCTs/IHBs to afford this protection. Regulations and/or Directions to PMS pilot schemes provide a number of further requirements.

REQUIREMENTS

For patients

The agreement must show that the pilot will:

- deliver services under PMS which are equivalent in scope but not necessarily identical in detail to those provided under GMS
- make provision for 24 hour care and ensure there is continuity of care
- provide treatment for temporary residents and in circumstances where a patient requires emergency and immediately necessary treatment
- have in place arrangements for where and when a patient should be seen under PMS which mirror those currently provided under GMS
- offer opportunistic health advice and health checks
- participate in a childhood immunisation target payment scheme parallel to GMS arrangements
- provide, at no cost to the patient, all appropriate immunisations and, in respect of travel abroad, immunisations against certain prescribed diseases
- provide on request cervical smear test to all eligible women at intervals of no more than 5½ years or less if previous smear test result or other treatment indicates
- continue to provide patients with free medical certificates and to provide information for social security purposes - subject to the rules which govern this in GMS and which will also apply in PMS
The PMS agreement must indicate:

- details of those services and treatments for which a pilot will not charge
- that a practice leaflet will be produced which will set out specific information about services, which will be made available not only to the PCT and each patient on the pilot's list but to any other person who might need one, and that it will be reviewed and amended on an annual basis

**For professionals**

The PMS agreement must show that the pilot will:

- maintain professional indemnity cover and ensure it meets both the pilot responsibilities and those of individual clinicians within pilots
- ensure that a trainee's pay and conditions mirror those currently provided for within GMS

The PMS agreement should also:

- show that all the GPs who are to perform PMS under a contract between the pilot and the PCT/SB are fully registered medical practitioners, are suitably experienced and are not disqualified or subject to any adverse NHS Tribunal directions
- show that the PCT/IHB will approve those GPs who will perform Child Health Surveillance, Maternity Medical or Minor Surgery and Cytology Services
- ensure that all persons other than doctors intended to be employed or engaged to assist in PMS are appropriately qualified and are competent
- ensure that all persons or organisations intended to be contracted to assist in PMS satisfy tests of adequacy and appropriateness having regard to the interests of the PMS provider's patients
- show that there is a complaints procedure in place which mirrors, as far as possible, those arrangements for GMS (including options for requesting Independent Review and access to the Health Service Commissioner)
- show that the principles have been established and there is an agreement for settling minor disputes. Also to show that the procedures for dealing with contract disputes and breaches (including access to a Scottish Ministers appointed arbitrator for more serious disputes and breaches) have been agreed by both parties
• ensure that appropriate procedures are in place for dealing with acts and omissions on the part of any deputy performing PMS on behalf of the PMS practice

• underpin the procedures for patient registration, removal and assignment

• ensure that medical records will be kept, maintained and forwarded to health boards in accordance with current GMS provision for registered patients and for those treated under temporary residence and emergency and immediately necessary provisions
APPENDIX 3

EMPLOYMENT/PENSIONS ISSUES

TRANSFER OF UNDERTAKINGS (PROTECTION OF EMPLOYMENT) (TUPE) REGULATIONS 1981

What is TUPE?

The TUPE regulations implement the European Community Acquired Rights Directive 1997 into Scots law.

TUPE is an employment protection measure. The Regulations preserve employees’ terms and conditions of service and employment rights when body is transferring part of its business to another. In a case such as a practice and its staff transferring into PMS, TUPE would apply.

When an undertaking is transferred TUPE requires that:

• The transfer the employer must inform and consult any staff and staff representatives with a view to reaching agreement to the proposals, prior to the transfer.

• The new employer takes over the contracts of all employees who were employed in the undertaking immediately before the transfer. Subsequent changes to the employment contract can be negotiated after the transfer where the co-employee agrees to the change or where changes are made by varying the contract.

• An employer takes over all rights and obligations arising from the contracts of employment except criminal liabilities and occupational pension rights.

• The new employer takes over any collective agreements made on behalf of the employees which were in force immediately before the transfer.

• Neither the new employer nor the previous one may fairly dismiss an employee because of the transfer or a reason connected with it unless the dismissal is necessary for an economic, technical or organisational reason entailing changes to the workforce.

• The new employer may not unilaterally worsen the terms and conditions of employment of any transferred employee.

PROTOCOL GOVERNING THE RELATIONSHIPS BETWEEN A PILOT EMPLOYER AND PILOT EMPLOYEES

It is in the interests of all PMS sites to follow good employment practice. PMS sites and PCTs/IHBs should consider whether this protocol, or a local variation of it, should be included in the PMS agreement.
Any alterations/amendments to an employee's contract of employment should be made after consultation between the employee and the PMS provider.

Staff working in PMS sites should at all times observe their duty of care, the public interest, and professional codes governing the conduct of PMS staff. Nothing will be done by action or omission to undermine this commitment to patients’ interests. Due consideration should be given to allocate time for training and professional updating of staff.

At all times, the PMS employer and the attached staff should ensure that no acts or omissions adversely affect professional accountability, especially where matters of practice and judgement are concerned. Commercial considerations originating in any service contract between the PCT/IHB and the PMS site should not override that professional accountability.

Staff working in PMS schemes should, as professionals, respect the professional opinions and contributions of each other. No behaviour regarded by any party as being of a bullying or harassing nature should be permitted. Any such action should be dealt with speedily and decisively through agreed procedures. This applies whether bullying and harassment relate to professional practice, sexual and racial harassment or any other form of harassment.

Disagreements on whether professional accountability is being placed at risk will rest initially with the appointed individual within the PMS site.

The PMS scheme must recognise the legitimate concerns of recognised professional associations and should have in place some form of consultation procedure.

The PMS site should not seek the removal or suspension of attached staff on any grounds other than those provided for within the scheme's disciplinary and capability procedures or those laid down in the terms and conditions of secondees.

It is against the law to discriminate or harass sexually, racially or on the grounds of physical or mental disability. Therefore, PMS schemes should follow good employment and equal opportunity practice.

All matters of concern about staff or by staff arising from the matters raised in the protocol should be dealt with through locally agreed procedures.
QUESTIONS AND ANSWERS ON EMPLOYMENT ISSUES

These questions and answers cover employment issues and are intended to help inform employees, GPs and PCTs/IHBs who might be considering taking part in the pilots under the NHS (Primary Care) Act 1997. They are not exhaustive and are not intended to cover every eventuality. It is recommended therefore, that if they have not already done so, those entering into a pilot scheme seek legal advice as soon as possible.

Q & A FOR EMPLOYEES AND EMPLOYERS

How will staff join a pilot? (Employee Perspective)

Staff may be transferred from their current employment in a Trust or practice under TUPE if there is a transfer of an undertaking (see above) or they may be transferred under secondment if they are currently working in a Trust. In some circumstances they may be directly recruited to the pilot if they are not currently employed in the NHS.

How can staff transfer to a PMS Scheme? (Employers Perspective)

Where a prospective PMS site is proposing to directly employ staff currently performing services either for a Trust or a practice, you will need to discuss the plans with the pilot and your staff. You should consider with them the options of secondment or transfer of employment under TUPE to see which is applicable and which best suits all parties to the arrangement.

What is TUPE?

The Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) are an employment protection measure. The Regulations preserve employees' terms and conditions of service, employment rights and continuity of service when a business or undertaking is transferred to a new employer.

What is an undertaking?

An undertaking is a discrete area of work or unit of work which when considering a transfer to another organisation, can be identified as still continuing to provide a broadly similar service for the new organisation as it originally provided.

What is secondment?

Secondment is a measure under which an employee may work or provide services to another employer whilst still being employed by his/her original employer. This way the employee's terms and conditions normally remain unchanged.
Will TUPE or secondment apply to me?  (Employee Perspective)

If you are currently working in a Trust and the functions you perform are transferring to a pilot, then you will want to consider whether to joint the pilot as a permanent arrangement or whether to opt for secondment. In either case you should consider this carefully and discuss it with your Trust employers, your prospective pilot employers and, where appropriate, your trade union/professional association.

If you are currently working in a practice and the practice transfers into a pilot, then secondment will not be an option as the undertaking is not being transferred to a new employer.

TUPE or Secondment?  (Employer Perspective)

For PCTs/IHBs, their employees might transfer either under TUPE or secondment. The advantages of secondment for employees would be that not only will it protect their current terms and conditions of employment, which would also be protected under a TUPE transfer, but it will also provide job security against a PMS scheme ending prematurely. In such circumstances they would return to the PCT/IHB, as the duty to provide services to the patients they treat is likely to remain.

From the PCT/IHB perspective, should the PMS scheme end prematurely or not become permanent at the end of its pilot period, then the staff will simply revert to Trust employment and be able to continue the provision of the services as before. Under secondment this will involve the minimum of bureaucracy, as the staff in question will not have formally left their employment. It is thought that PCT/IHB can second staff to a pilot and still be within its statutory powers, provided that the Trust does not incur any costs in relation to the secondment. Trusts will need to ensure, however, that the secondment arrangements they enter into are within their powers.

For practices, secondment will not be an option for its employees if the practice itself is to become part of the new pilot, because employers are not transferring to another employer.

What are the advantages of opting for secondment from an employee's perspective?

The secondment route will not only protect current terms and conditions of employment, which would also be protected under a TUPE transfer, but will also provide job security against a pilot ending. In such circumstances, they would return to the Trust and in all likelihood this would be mirrored by the services to patients also returning to the Trust.

What protection is there if an employee is transferred under TUPE?

If TUPE applies, the pilot takes on the liability for your current employment relationship. Employees will retain your terms and conditions of employment unless, and until, the pilot wishes to make any alterations permitted by the law.
Will employees be told if a pilot is being considered?

Those hoping to set up pilots should approach staff at the earliest stage. They should discuss the employment options with the staff and their current employers to ensure that the most suitable arrangements are reached for all parties.

What happens if individuals do not want to move voluntarily?

If employees currently work in a trust but do not want to transfer across into a prospective pilot then the PCT/IHB will try to make other arrangements. It will canvass other employees performing the same kind of services to see if they want to take up the opportunity of working in the pilot. Only if this route fails would we recommend open recruitment. If the Trust finds that no staff are willing to transfer across to the pilot then the pilot proposal will need to be reconsidered.

If employees currently work in a practice and do not wish to transfer across under TUPE they should discuss this with the project leader for the PMS proposal.

How will an employee's rights be protected?

Individual employment contracts and statutory employment law afford protection to employees in the first instance. The consent of the primary care team to process with a pilot proposal is a case requirement for PCTs/IHBs wishing to submit an application to Scottish Ministers.

Those staff transferring from NHS Trusts on secondment will continue to have Trust terms and conditions. For those staff transferring from GP Practices, they may have their existing rights protected under TUPE.

Who will deal with employee grievances?

Grievances on matters relating to areas of professional responsibility will continue to be supported by the trade unions/professional associations. PMS schemes should consider the use of a professional adviser from the local PCT/IHB in the first instance.

For staff on secondment, their original PCT/IHB employer and the PMS scheme should agree how any grievances which occur in the scheme should be handled to ensure that secondees have access to the same standards and mechanisms as they would do in the PCT/IHB. Secondees should ensure they understand and are content with these arrangements.

For other employed staff it is expected that each PMS scheme will have a local grievance procedure agreed, where appropriate, with staff associations. Disciplinary and grievance procedures need to be agreed locally before the scheme begins and in all cases staff should ensure they understand the processes to which they will be subject.
**Will the pilot employer have to recognise staff membership of trade unions?**

Staff who transfer on secondment from NHS Trusts will continue to benefit from the terms and conditions in their contracts of employment. Other staff will have whatever rights are guaranteed under TUPE. In all other cases formal recognition agreements in PMS schemes will be a matter to be settled between schemes and their staff, but in the spirit of co-operation around PMS it is hoped that arrangements proportionate to the size and scope of the PMS scheme will be agreed locally.

**What if an employee picks up new skills while working on a pilot - will they be entitled to a higher rate of pay if they return from the pilot?**

There is no obligation for the PCT/IHB to pay increased wages or provide a better job to staff returning from secondment to a pilot. However, staff with transferable new skills may be more attractive to prospective employers and find that they have greater opportunity for improvement.

**What will happen to pension rights, sickness leave, annual leave, maternity leave etc?**

For staff who join a PMS scheme on secondment, their existing terms and conditions will continue unless they, together with the scheme and PCT/IHB, have agreed on alternative arrangements.

For those who transfer under TUPE, the new employer must honour the terms on which the staff were transferred until such time as any alternative terms are negotiated with staff.

**Can the Trust/Practice guarantee that jobs will still be available if the pilot ends and staff wish to return to my original employer?**

For staff transferred on secondment, the PCT/IHB should have planned for the return and it will be responsible for re-integrating staff back within the Trust at the end of the secondment. Details of the secondment should be agreed between the PMS scheme and the Trust/Practice and the employee.

For staff who are transferred under TUPE, there is no legal obligation on your previous employer to take you back, unless they take back the functions which were in the pilot.

**Should employees be given details of their contractual terms?**

The Employment Rights Act 1996 entitles an employee to a written statement of the major terms of his/her employment. Prior to joining a PMS scheme all staff should know what the existing terms of their employment are. All employees of a pilot should be given a statement of their contractual terms. An example of what such a statement should contain is set out at the end of this appendix, under Employment Rights Act 1996: Part One: Employment Particulars.
What sort of contract can PMS schemes offer a directly employed individual?

A PMS pilot scheme is likely to offer a fixed term contract which would not exceed three years, with the option to extend if the pilot was a success. A permanent PMS scheme could be fixed-term or indefinite. The Employment Rights Act 1996 requires that a contract of employment covers a range of particulars. Further information about these particulars can be found at the end of this appendix. Good employment practice requires that employers have policies in place which cover the areas listed in this guidance.

How will the performance against good employment practice be monitored?

All PMS sites are expected to adhere to good employment practices. A model protocol showing good employment practices can be found earlier in this appendix.

If a pilot ends and does not become a permanent arrangement, will staff be entitled to redundancy payments and on whom does the responsibility for meeting these payments fall?

Secondees would simply return to their previous employer under the terms of the secondment agreement. Those staff transferred under TUPE would be entitled to such redundancy terms as stated in their original contract of employment unless altered during the course of the pilot.

Will any changes in a member of staff’s terms and conditions agreed during the pilot have to be respected by the PCT/IHB when the staff return, either from secondment or, if TUPE applies, on services reverting to the PCT/IHB?

Staff seconded by the PCT/IHB will simply return on their original terms and conditions, as modified by any changes effected to terms and conditions for that grade/professional group by the PCT/IHB during the secondment period.

For other staff, normal TUPE conditions will apply and any changes to contractual entitlements which have been made during their time at the pilot will be honoured. The law provides a remedy for the employee if they are not, and equally, the law enables an employer to change terms if it acts reasonably.
THE FOLLOWING QUESTIONS ARE MORE SPECIFICALLY AIMED AT SALARIED GPs

What length of contract can be offered by the PMS employer?

A PMS pilot is likely to offer a fixed term contract for the duration of a pilot, with an option to extend if the pilot is successful, but this will be subject to your negotiation with them. If it is a permanent PMS contract, the contract will probably be a permanent one.

What will happen to GPs NHS pension rights?

GPs entering pilots as employees will retain the practitioner benefits they currently accrue as independent contractors. Where a newly qualified GP enters a pilot on a salaried basis, pensions will be calculated on an officer basis. GPs may have up to ten years of officer benefits dynamised when they become independent contractors under current regulations. More information about pensions can be found at paragraph 325 et seq. GPs entering permanent PMS arrangements will be paid at the officer level.

Will GPs be employed under the terms and conditions of employment outlined in the Hospital Medical and Dental Staff - Terms and Conditions Handbook (Scotland)?

The General Practitioner grade is not one of the recognised grades, as defined within the Hospital Medical and Dental Staff - Terms and Conditions Handbook (Scotland). The terms and conditions of a GP employed by a Trust do not form part of national terms and conditions therefore, and will need to be negotiated locally.

What remuneration and terms and conditions will a Trust be required to offer?

The remuneration and terms and conditions of employment will be for individual GPs and pilot employers to negotiate locally. The outline contract provides information of the terms and conditions which need to be negotiated locally and which will affect remuneration levels.

What services might I be expected to provide?

The range of services provided by salaried GPs will at least be equivalent to those provided under GMS. The details of what you will do will depend on your particular PMS scheme. The GP and the employer will need to agree the GPs exact role during your contract negotiations.

Who will provide "out of hours" cover?

PMS providers are responsible for ensuring there is adequate "out of hours" provision. The GP's individual responsibility in this respect should be agreed in your contract.

Will being a salaried GP affect professional development?

PMS sites will be expected to provide opportunities for continuing professional development for all its medical practitioners.
**Will being a salaried GP affect their clinical freedom?**

PMS providers will be expected to ensure that any salaried GP can maintain their clinical freedom to treat patients in their best interests. Salaried GPs will want to ensure that this issue is addressed to their satisfaction within the terms of their contract.

**What will the relationship to patients be? Will salaried GPs have a defined list of patients?**

Salaried GPs may have a defined list of patients but this will vary between PMS schemes. This is an important issue that should be settled early on.

**Do salaried GPs have a preferential right on transferring to a medical list?**

In almost all situations, GPs who leave a medical list to enter a pilot scheme will have a preferential right on transferring to a medical list. GPs entering a permanent PMS scheme will not have a preferential right to return to a Board's medical list. Further information about reversion to Part II can be found at paragraph 354 et seq.
EMPLEYMENT RIGHTS ACT 1996: PART 1 - EMPLOYMENT PARTICULARS

Statement of initial employment particulars

Where an employee begins employment with an employer, the employer shall give to the employee a written statement of particulars of employment.

The statement may be given in instalments and shall be given not later than two months after the beginning of the employment.

The statement shall contain particulars of:-

- the names of the employer and employee
- the date when the employment began
- the date on which the employee's period of continuous employment began (taking into account any employment with a previous employer which counts towards that period)

The statement shall also contain particulars, as at a specified date not more than seven days before the statement is given of:-

- the scale or rate of remuneration or the method of calculating remuneration
- the intervals at which remuneration is paid (that is, weekly, monthly or other specified intervals)
- any terms and conditions relating to hours of work (including any terms and conditions relating to normal working hours)
- any terms and conditions relating to any of the following:
  - entitlement to holidays, including public holidays, and holiday pay (the particulars given being sufficient to enable the employee's entitlement, including any entitlement to accrued holiday pay on the termination of employment, to be precisely calculated)
  - incapacity for work due to sickness or injury, including any provision for sick pay
- pensions and pension schemes (except where the employee's pension rights depend on the terms of a pension scheme established under any provision contained in or having effect under any Act or where any such provision requires the body or authority to give to a new employee information concerning the employee's pension rights or the determination of questions affecting those rights)

- the length of notice which the employee is obliged to give and entitled to receive to terminate his contract of employment

- the title of the job which the employee is employed to do or a brief description of the work for which he is employed

- where the employment is not intended to be permanent, the period for which it is expected to continue or if it is for a fixed term, the date when it is to end

- either the place of work or, where the employee is required or permitted to work at various places, an indication of that and of the address of the employer

- any collective agreements which directly affect the terms and conditions of the employment including, where the employer is not a party, the persons by whom they were made

- where the employee is required to work outside the UK for a period of more than one month:-
  - the period for which he is to work outside the UK
  - the currency in which remuneration is to be paid, while he is working outside the UK
  - any additional remuneration payable to him, and any benefits to be provided to or in respect of him by reason of his being required to work outside the UK
  - any terms and conditions relating to his return to the UK
APPENDIX 4

TECHNICAL STEERING COMMITTEE RETURN
INLAND REVENUE ENQUIRY: QUESTIONNAIRE - EXAMPLE

Please complete the bold outlined boxes below with figures consistent with the 1996-97 tax return as provided to Inland Revenue. If you have supplied two sets of accounting data to Inland Revenue one for each of 1995-96 and 1996-97, you may find it convenient to enter these figures in the two columns to the left and add them together to give the entries in the final columns.

<table>
<thead>
<tr>
<th>Item</th>
<th>Tax Return Box Numbers</th>
<th>12 month period ending 1/196 to 5/4/96</th>
<th>12 month period ending 1/197 to 5/4/97</th>
<th>24 months period ending 1/1/97 to 5/4/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>From partnership tax return (if selected individual is a partner)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales/business income</td>
<td>3.11 or 3.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>plus</td>
<td>Other income</td>
<td>3.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less</td>
<td>Deductions from profit</td>
<td>3.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net - please calculate</td>
<td></td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Expenses against gross profit</td>
<td>3.33 or 3.35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>plus</td>
<td>Other expenses</td>
<td>3.12 or 3.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less</td>
<td>Disallowable expenses</td>
<td>3.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net allowable - please calculate</td>
<td></td>
<td></td>
<td></td>
<td>27</td>
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<tr>
<td>Net Profit for tax purposes</td>
<td>3.70</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Average Profit</td>
<td>3.71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balancing charges</td>
<td>3.73</td>
<td></td>
<td></td>
<td>44</td>
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<tr>
<td>Capital Allowances</td>
<td>3.74</td>
<td></td>
<td></td>
<td>43</td>
</tr>
<tr>
<td>Net profit (loss)</td>
<td>3.80 or 3.81</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>From selected individual's tax return</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If individual is a partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest on qualifying loans</td>
<td>15.3</td>
<td></td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>Share of partnership net profit</td>
<td>4.7</td>
<td></td>
<td></td>
<td>43</td>
</tr>
<tr>
<td>If individual has a sole trade</td>
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<td></td>
</tr>
<tr>
<td>Sales/business income</td>
<td>3.11 or 3.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>plus</td>
<td>Other income</td>
<td>3.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less</td>
<td>Deductions from profit</td>
<td>3.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net - please calculate</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Expenses against gross profit</td>
<td>3.33 or 3.35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>plus</td>
<td>Other expenses</td>
<td>3.12 or 3.51</td>
<td></td>
<td></td>
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<tr>
<td>less</td>
<td>Disallowable expenses</td>
<td>3.55</td>
<td></td>
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<td>Net allowable - please calculate</td>
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<td>Item</td>
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<td>12 month period ending 1/197 to 5/4/97</td>
<td>24 months period ending 1/1/97 to 5/4/97</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------</td>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Net Profit for tax purposes</td>
<td>3.70</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>Average Profit</td>
<td>3.71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balancing charges</td>
<td>3.73</td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Capital Allowances</td>
<td>3.74</td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Net profit (loss)</td>
<td>3.80 or 3.81</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. From individual's tax returns for all 'Salaried' partners in partnership(^1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share of partnership net profit</td>
<td>4.7</td>
<td></td>
<td></td>
<td>50</td>
</tr>
</tbody>
</table>

\(^1\) Please identify all partners receiving a fixed or pre-determined cash amount from the profits, including cases where this exceeded the percentage share. Please enter the total of boxes 4.7 for all such partners.
TSC RETURNS (Continued)

Section A:
If the doctor is a partner, entries in this section should relate to the total partnership income and total allowable expenses borne jointly or individually by the doctor in respect of the business. All other professional earnings and associated expenses of the partner which are not connected with the business (ie outside the partnership) should be reported in Section B. If the doctor has several professional incomes outside the partnership, please aggregate the entries for reporting in Section B.

Section B:
If the doctor has taken a qualifying loan in connection with the business (ie partnership), the amount of interest paid should be reported against item 'interest on qualifying loans' (box 15.3). Entries against item 'share of partnership net profit' should be restricted to the doctor's share of partnership net profit (box 4.7).

If the doctor is a sole trader, entries in this section should relate to the total professional earnings including any income(s) generated outside the business (ie practice) and total allowable expenses.

Section C:
If the partnership to which this doctor belongs also has 'salaried or fixed share' partners, entries in this section should relate to the total share of net profit of all such partners.
EXPRESSION OF INTEREST TO PILOT PERSONAL MEDICAL SERVICES UNDER THE NHS (PRIMARY CARE) ACT 1997

<table>
<thead>
<tr>
<th>Project Name:</th>
<th></th>
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<tbody>
<tr>
<td>Name of Contact:</td>
<td>DR/MR/MRS/MS</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>e-mail address:</td>
<td></td>
</tr>
<tr>
<td>Primary Care Trust(s):</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>LHCC:</td>
<td></td>
</tr>
<tr>
<td>HEALTH BOARD(S):</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
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</tbody>
</table>

**PROJECT DETAILS:**

<table>
<thead>
<tr>
<th>Title</th>
<th>Forename(s)</th>
<th>Surname</th>
<th>Role in the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
**BRIEFLY OUTLINE:**

<table>
<thead>
<tr>
<th>Project Details (contd)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The range of services to be included in the pilot, for example GMS/Personal Medical Services alone or with a wider range of services, which will be provided.</td>
<td></td>
</tr>
<tr>
<td>The contractual change sought, for example salaried employment through a Trust, a practice based contract, etc.</td>
<td></td>
</tr>
<tr>
<td>How your proposal will address the service problem identified earlier, including details of any benefits to health care outcomes, team working, co-ordination of services, employment, etc that your pilot seeks to provide.</td>
<td></td>
</tr>
</tbody>
</table>
How you see the proposal contributing to the local Health Plan.

Has there been any initial discussion of the proposal? If there has, what are the views emerging?
LHCC

Please indicate whether you would support the further development of this proposal; please include any other relevant information.

Primary Care Trust(s):

Please detail how this proposal fits with your view of local issues and primary care development. Add any further comments, including whether the proposal is likely to have any significant resource consequences.
APPENDIX 6

NHS CIRCULARS AND PMS PILOT AND PERMANENT REGULATIONS

The National Health Service (Personal Medical Services) (Scotland) Regulations 2001

The NHS (Scotland) Act 1978 – Directions to Health Boards concerning the Delegation of Functions to Primary Care NHS Trusts

* * * *

National Health Service (Primary Care) Act 1997: "Directions to Health Authorities and Health Boards Concerning the Preparation of Proposals for Pilot Schemes (Personal Medical Services)";

National Health Service (Primary Care) Act 1997: "Directions to Health Boards Concerning the Implementation of Pilot Schemes (Personal Medical Services)";

National Health Service (Primary Care) Act 1997: "Directions to Health Boards Concerning Patients Lists (Personal Medical Services)";

National Health Service (Primary Care) Act 1997: "Directions to Health Authorities and Health Boards Concerning Variation of Proposals for Pilot Schemes (Personal Medical Services)";


Statutory Instrument 1997, No.2289 National Health Service, Scotland: "The National Health Service (Proposals for Pilot Schemes) and (Miscellaneous Amendments) Regulations 1997".


