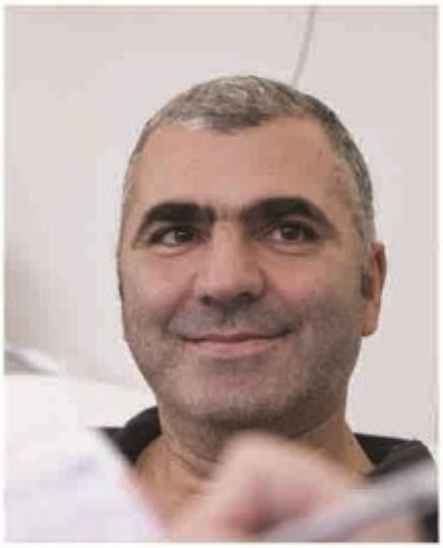
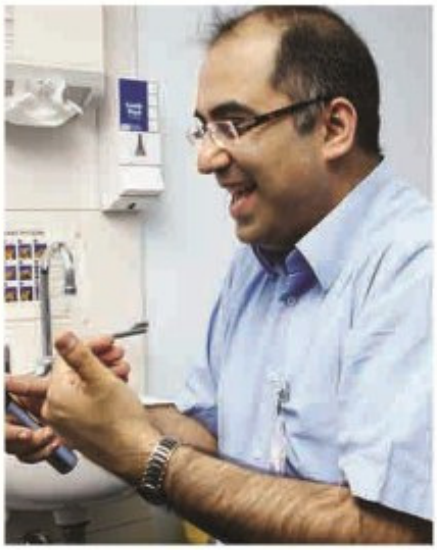
NHS England

Managing the end of time-limited contracts for primary medical services





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Managing the end of time-limited contracts for primary medical services

Standard operating policies and procedures for primary care

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Information Reader Box

Directorate	Purpose
Medical	Tools
Nursing	Guidance
Patients & Information	Resources
Finance	Consultations
Operations	
Commissioning Development	
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Contents

Purpose of policy

1 NHS England is responsible for direct commissioning of services beyond the remit of clinical commissioning groups, namely primary care, offender health, military health and specialised services.

2 This document forms part of a suite of policies and procedures to support commissioning of primary care. They have been produced by Primary Care Commissioning (PCC) for use by NHS England's area teams (ATs).

3 The policies and procedures underpin NHS England's commitment to a single operating model for primary care – a "do once" approach intended to ensure consistency and eliminate duplication of effort in the management of the four primary care contractor groups from 1 April 2013.

4 All policies and procedures have been designed to support the principle of proportionality. By applying these policies and procedures, area teams are responding to local issues within a national framework, and our way of working across NHS England is to be proportionate in our actions.

5 The development process for the document reflects the principles set out in *Securing excellence in commissioning primary care*[1], including the intention to build on the established good practice of predecessor organisations.

6 Primary care professional bodies, representatives of patients and the public and other stakeholders were involved in the production of these documents. NHS England is grateful to all those who gave up their time to read and comment on the drafts.

7 The authors and reviewers of these documents were asked to keep the following principles in mind:

- Wherever possible to enable improvement of primary care
- To balance consistency and local flexibility
- Alignment with policy and compliance with legislation
- Compliance with the Equality Act 2010
- A realistic balance between attention to detail and practical application
- A reasonable, proportionate and consistent approach across the four primary care contractor groups.

[1] *Securing excellence in commissioning primary care http://bit.ly/MJwrfA*

8 This suite of documents will be refined in light of feedback from users.

9 This document should be read in conjunction with the policy for *Managing Contract breaches, sanctions and termination for primary medical services contracts.*

Policy aims and objectives

10 This policy outlines the approach to be taken by NHS England when a time-limited medical services contract is coming to an end.

11 This policy should also be read together with the *Procurement guide for commissioners of NHS-funded services*

http://tinyurl.com/anfczbz

Background

12 There are times when a time limited contract/agreement is required/preferable and for each contracting route, there are a range of issues the AT would need to consider when that contract is due to reach its natural end.

Primary medical services contracting routes

13 Where a primary medical services contractor holds a registered list of patients, and provides the full range of essential services, there are three possible contracting routes. These are:

- General Medical Services (GMS) contract;
- Personal Medical Services (PMS) agreement; or
- an Alternative Provider Medical Services (APMS) contract.

14 A single contractor may hold a variety of contract types with a variety of commissioners. For example, an existing GMS contractor might also hold an APMS contract with the same or another commissioner.

15 **General Medical Services (GMS)** arrangements are governed by the GMS regulations. These are based on national agreement between the Department of Health (or bodies acting on its behalf) and the British Medical Association and are underpinned by nationally agreed payment arrangements as set out in the statement of financial entitlements (SFE).

16 **Personal Medical Services (PMS)** arrangements are an alternative to GMS, in which the contract (the PMS agreement) is agreed locally

between the contractor and the commissioning organisation. The mandatory contract terms are set out in the PMS regulations but still allow local flexibility for negotiation and there are some distinct differences in the way in which GMS and PMS contract variations must be managed.

17 There is no requirement to follow the nationally agreed pay structure for GMS, i.e. the SFE does not apply to PMS agreements. Commissioners and PMS contractors are therefore free to negotiate entirely separate payment arrangements, although common elements are often found in both contract types e.g. quality and outcome framework (QOF), but this also needs to be taken into consideration for the purposes of variations across the differing routes.

18 The mandatory requirements that apply to **Alternative Provider Medical Services (APMS)** contracts are set out in directions. These directions place requirements on APMS contractors, which reflect those for PMS contractors but enable the remainder of the contract to be negotiated between the commissioner and the contractor.

19 Unlike GMS and PMS arrangements, which place significant restrictions on the organisational structure of the contractor, there are no such restrictions for APMS contractors.

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

Scope of the policy

21 Time-limited contracts can be in place regarding General Medical Services (GMS), Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and Specialist Personal Medical Services (SPMS) contracts/agreements.

22 GMS Regulations Part 5, Para 14 states that except in certain circumstances a contract must provide for it to subsist until it is terminated in accordance with the terms of the contract or the general law. So a general rule is that GMS is a contract in perpetuity (no end date).

23 The only circumstances in which this rule does not apply is when NHS England wishes to enter into a temporary GMS contract for a period not exceeding 12 months, for the provision of services to the former patients of

a contractor following the termination of that contractor's contract.

24 **PMS regulations** are silent regarding the duration of the agreement. Given that this is a local arrangement PMS regulations have allowed the flexibility for local commissioners to agree either a contract in perpetuity or for a time limited period. ATs should ensure they review the various models of PMS agreements, which fall under their responsibility to establish if there is a defined end-date to the agreement.

25 **APMS regulations** are also silent about the duration of the contract. Mostly, APMS contracts tend to be for a fixed-term period of three to five years, often with an option to extend for a maximum of a further two years. The main purpose for time limiting these contracts was to provide commissioners the scope for testing the market and ensuring value for money.

26 **SPMS regulations** do not mention the duration of the contract and are used in respect of specialist services that are accessible by the AT's population and not limited to the registered population of a single practice. The duration of the agreement will be based upon need and will have been determined by the commissioner, therefore ATs must ensure that they individually review each SPMS contract held and establish if there is a defined end date.

27 In each of the cases above there are generic principles that will apply and individual circumstances that will need to be considered. This policy will cover the steps to be taken in advance of the end of any contract/agreement and will support the ATs in planning procurements cycle and future service provision.

Timetable for managing contracts coming to an end

28 ATs need to be aware of the end dates of all contracts/agreements held, so that advance planning can be undertaken to ensure both capacity and timescales can be aligned with the key stages outlined below.

29 It is essential that ATs ensure continued communication with contractors throughout the stages to enable them to have a clear understanding of the processes, expectations and obligations. Outlined in annexes 2 and 3 are a guide to communications with contractors and a proposed checklist for documentation recording.

30 In each of the stages below there are a range of activities that may need to be undertaken, depending on the AT's preferred route, and ATs may wish to consult with the appropriate LMC throughout.

31 **Key stages**

Stage 1 – minimum 9 to 15 months before contract end (all essential)

- Needs assessment.
- Value for money.
- Impact assessment.
- Consultation proposal.

Stage 2 – 12 months before contract end

- Notice period – exit plan.
- Commence procurement.
- Begin negotiations for continuation with contractor.
- Begin mobilisation of any new provider.

Stage 3 – at contract end

- Contract end – possible dispersal of patient list.
- Variation to contract/extension.
- Commencement of new provider.

Stage 1 to 15 months before contract end

32 Below are listed the considerations that should be given when completing each action. This list is by no means exhaustive but does provide a platform for ATs to fully assess the existing and future service needs of its population. ATs should ensure that all appropriate stakeholders are given the opportunity to input into the needs assessment for their population, including but not limited to public health.

Needs assessment

- Is there still a demand for this service in this locality and a requirement for it to continue?
- Does the contract specification still address current local priorities?
- Has the contract delivered on the expected outcomes?
- Has it provided added value to the local population and service provision?
- Have you assessed the potential service needs for any forthcoming new developments?
- What is the capacity of other local providers?
- Have you given consideration to any specialist services needs in the

locality?

Value for money

- Have you considered all available outcome and delivery data held nationally and locally, regarding the current service?
- Have you compared the cost of the current service against other providers i.e. cost per head of population whilst taking into account any differences in the scope of the services provided?
- Is the current service still affordable within projected future budgets?
- Has the contract delivered on the expected financial outcomes?
- What other objectives might be set within the existing budget?

Impact assessment

- Have you considered the potential impact on service users/patients?
- Have you considered the potential impact on other service providers? i.e. GPs, pharmacy, local trust, out of hours, community services and so on?
- Have you considered the potential impact on the current provider? i.e. continued viability within the locality.
- Have you considered patient choice and equality?
- Have you considered the potential risks ie reputational (adverse publicity, commissioner/provider relationship), market testing, timescales and financial?

Consultation proposal

Each situation will need to be managed regarding each individual circumstance and the nature of the procurement process to be followed, if at all. However, where it has been deemed appropriate to complete a form of consultation before taking action, ATs should ask themselves:

- have you consulted with service users/patients?
- have you consulted with other local providers and other interested parties ie local medical committee (LMC), local members of parliament, review and scrutiny committee and so on?
- have you consulted with the local clinical commissioning groups?

33 If the answer is 'no' regarding any of the above, the AT should be able to identify the grounds under which they felt consultation was unnecessary and these should be included in the report defined below.

34 Completion of stage 1 will provide all the information required to enable the AT to make an informed commissioning decision on whether to re-

commission, procure or allow the service to end. At this stage, the AT must develop a **detailed report** (annex 4) about the investigations undertaken, consultation and outcomes. This report shall demonstrate that the AT has considered all possible options and the rationale behind the decision taken.

Stage 2 to 12 months before contract end

35 Below are the potential next stages following stage 1 based upon the AT decision regarding the proposed way forward. It is important to note that where a contract/agreement has duration or an end date specified, and the intention is to allow the contract to naturally expire, there is no requirement to issue a formal termination notice. However, it would be best practice to issue a formal letter of notice detailing the AT's intentions and the obligations on the contract holder throughout the remainder of the agreement period.

36 **Notice period – exit plan**

- Issue a letter of notice of intentions.
- Development of exit plan (annex 5) with contractor clearly defining commissioner/provider responsibilities. This should be developed whether the contract is to cease or transfer to a new provider.

Procurement

- In line with Official Journal of the European Union (OJEU).
- In line with the most current procurement guide for commissioners of NHS-funded services.
- Once preferred provider is established, operational management plan to be agreed (example template at annex 6).

37 **Begin negotiations for continuation of the contract with the existing contractor, if appropriate.**

ATs should be aware that extending a contract/agreement beyond a previously agreed end date is considered a material change to the terms of that arrangement unless there was already contracted an opportunity to extend beyond the natural end date.

38 If there is no extension period already included in the contract, ATs will need to consider carefully whether such a material change should instead be subject to a full procurement process to ensure best value and mitigate the risk of challenge from previous and/or potential alternative service providers. If the AT decision is that no procurement process is necessary

then it must ensure it is aware of the necessary steps which must be taken to satisfy EU procurement rules and the NHS principles of equality and transparency.

39 Once the decision to extend has been reached and all correct processes have been followed the AT will need to consider:

- the length of extension;
- any alterations to the existing contract; and
- any agreement of new (key performance indicators (KPIs).

40 Completion of stage 2 will provide the AT with the firm foundations and detailed preparations ready to manage the end of the contract.

Stage 3 – at contract end

41 Below are the possible outcomes culminating from stages 1 and 2.

Contract end

- Service ceases.
- Dispersal of list if applicable (See policy for *Managing contract breaches, sanctions and terminations for primary medical services*).
- Communication to be sent out to all those parties involved e.g. management of patient communication working with provider, management of the press, notification of contract end to relevant stakeholders.

Variation to contract – extension

- Contract variation issued and signed off by both parties (See policy for *Managing contract variations for primary medical service contracts*).

Commencement of new provider

- Issue of new contract (See policy for *Managing a PMS contractor's right to a GMS contract* for the basic principles on issuing a new contract) this should include setting up the new contract on the central Exeter system, providing the new contractor with their practice code.
- Operational management plan implemented.
- Relevant communications undertaken, internally and externally.

42 On completion of stage 3, the AT will have reached an agreed, structured outcome about the management of contract end.

Annex 1: abbreviations and acronyms

A&E	accident and emergency
APHO	Association of Public Health Observatories (now known as the Network of Public Health Observatories)
APMS	Alternative Provider Medical Services
AT	area team (of NHS England)
AUR	appliance use reviews
BDA	British Dental Association
BMA	British Medical Association
CCG	clinical commissioning group
CD	controlled drug
CDAO	controlled drug accountable officer
CGST	NHS Clinical Governance Support Team
CIC	community interest company
CMO	chief medical officer
COT	course of treatment
CPAF	community pharmacy assurance framework
CQC	Care Quality Commission
CQRS	Calculating Quality Reporting Service (replacement for QMAS)
DAC	dispensing appliance contractor
Days	calendar days unless working days is specifically stated
DBS	Disclosure and Barring Service
DDA	Disability Discrimination Act
DES	directed enhanced service
DH	Department of Health
EEA	European Economic Area
ePACT	electronic prescribing analysis and costs
ESPLPS	essential small pharmacy local pharmaceutical services
EU	European Union
FHS	family health services
FHS AU	family health services appeals unit
FHSS	family health shared services
FPC	family practitioner committee
FTA	failed to attend
FTT	first-tier tribunal
GDP	general dental practitioner
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services

GP	general practitioner
GPES	GP Extraction Service
GPhC	General Pharmaceutical Council
GSMP	global sum monthly payment
HR	human resources
HSE	Health and Safety Executive
HWB	health and wellbeing board
IC	NHS Information Centre
IELTS	International English Language Testing System
KPIs	key performance indicators
LA	local authority
LDC	local dental committee
LETB	local education and training board
LIN	local intelligence network
LLP	limited liability partnership
LMC	local medical committee
LOC	local optical committee
LPC	local pharmaceutical committee
LPN	local professional network
LPS	local pharmaceutical services
LRC	local representative committee
MDO	medical defence organisation
MHRA	Medicines and Healthcare Products Regulatory Agency
MIS	management information system
MPIG	minimum practice income guarantee
MUR	medicines use review and prescription intervention services
NACV	negotiated annual contract value
NCAS	National Clinical Assessment Service
NDRI	National Duplicate Registration Initiative
NHAIS	National Health Authority Information System (also known as Exeter)
NHS Act	National Health Service Act 2006
NHS BSA	NHS Business Services Authority
NHS CB	NHS Commissioning Board (NHS England)
NHS CfH	NHS Connecting for Health
NHS DS	NHS Dental Services
NHS LA	NHS Litigation Authority
NMS	new medicine service
NPE	net pensionable earnings
NPSA	National Patient Safety Agency
OJEU	Official Journal of the European Union

OMP	ophthalmic medical practitioner
ONS	Office of National Statistics
OOH	out of hours
PAF	postcode address file
PALS	patient advice and liaison service
PAM	professions allied to medicine
PCC	Primary Care Commissioning
PCT	primary care trust
PDS	personal dental services
PDS NBO	Personal Demographic Service National Back Office
PGD	patient group direction
PHE	Public Health England
PLDP	performers' list decision panel
PMC	primary medical contract
PMS	Personal Medical Services
PNA	pharmaceutical needs assessment
POL	payments online
PPD	prescription pricing division (part of NHS BSA)
PSG	performance screening group
PSNC	Pharmaceutical Services Negotiating Committee
QOF	quality and outcomes framework
RCGP	Royal College of General Practitioners
RO	responsible officer
SEO	social enterprise organisation
SFE	statement of financial entitlements
SI	statutory instrument
SMART	specific, measurable, achievable, realistic, timely
SOA	super output area
SOP	standard operating procedure
SPMS	Specialist Personal Medical Services
SUI	serious untoward incident
UDA	unit of dental activity
UOA	unit of orthodontic activity

Annex 2: Guide to communication with contractors

- All direct communications, whether face to face or over the telephone, should be recorded in writing and held on the file.
- All written communications with contractors should not arrive 'out of the blue' as the contractor should be aware of the situation from a prior meeting or telephone call.
- All negotiations regarding contract extension or contract end should be undertaken face to face.
- These meetings should cover as a minimum, reasons for extension/contract end, future plans for the service/exit plan, terms of extension/management of the list, communication strategy with staff and patients.
- All meetings should be minuted by an agreed party and shared with the contractor for acceptance as an accurate record of the discussions.
- Following all meetings the minutes should be accompanied by any action plan agreed regarding the next steps with responsible parties identified.
- Staged follow-up meetings should be held at appropriate intervals, to ensure all actions agreed upon are being implemented and are on track to have been appropriately executed before contract end or extension.

Annex 3: Checklist for documentation recording when contract ends

- Statement of rationale – clear and objective reasons providing justification for the decision to cease the service at contract end.
- Minutes from all meetings held throughout the process.
- Assessments – copies of needs assessment, value for money, impact assessment and consultation proposal. This information could be documented by way of the completion of stage 1, detailed report.
- Formal notice of contract end – a copy of the letter sent to contractor stating that the AT will not be renewing the contract when it expires.
- Exit plan – a copy of the exit plan agreed with the contractor to ensure that all elements of the services are managed smoothly and effectively.
- All written communications between the contractor and the AT about contract end including any file notes of telephone conversations that are pertinent to the decision making process.

Annex 4: Template for detailed report to be completed at the end of stage 1

Consolidation report to inform commissioning decision
Introduction and background to existing service • Length of current provision. • Type of contract held. • Proposed end date of contract. • Current population/demographics. • Current services provided outside of core. • Current performance against contracted requirements. • Current contract value. • Current premises arrangements, and so on.
Needs assessment Summary of needs assessment findings to be inserted • Is there still a demand for this service in this locality and a requirement for it to continue? • Does the contract specification still address current local priorities? • Has the contract delivered on the expected outcomes? • Has it provided added value to the local population and service provision? • Have you assessed the potential service needs for any forthcoming new developments? • What is the capacity of other local providers?
Value for money Summary of value for money findings to be inserted • Have you considered all available outcome and delivery data held nationally and locally, regarding the current service? • Have you compared the cost of the current service against other providers of like services i.e. cost per head of population? • Is the current service still affordable within projected future budgets? • Has the contract delivered on the expected financial outcomes?
Impact assessment

Summary of impact assessment findings to be inserted • Have you considered the potential impact on service users/patients? • Have you considered the potential impact on other service providers? ie GPs, pharmacy, local trust, out of hours, community services and so on. • Have you considered the potential impact on the current provider? ie continued viability within the locality. • Have you considered patient choice and equality? • Have you considered the potential risks ie reputational (adverse publicity, commissioner/provider relationship), market testing, timescales and financial
Options appraisal • List dispersal. • Extension of current arrangements. • Reconfiguration of service. • Procurement of new provider.
Consultation Summary of consultation process followed and outcomes to be inserted • Have you consulted with service users/patients? • Have you consulted with other local providers and other interested parties ie local medical committee (LMC), local members of parliament, overview and scrutiny Committee and so on? • Have you consulted with the local clinical commissioning groups?
Conclusion Recommended outcome regarding commissioning decision to be inserted for consideration and final decision by AT.

Annex 5: Example exit plan template

The exit plan is a list of processes to manage the exit of any contractor from performing a service. This should be developed in accordance with the terms of the contract as a minimum. The exit plan comes into effect as the notice to cease the service is issued by the AT and a joint exit group should be established comprising staff of both parties to manage the contract coming to an end. Note, there is no obligation on behalf of the contractor to comply with the establishment of a joint exit group; however a joint approach would be in the best interest of their registered population/service users. The role of the joint exit group will be to manage all activities to ensure a smooth culmination of the contract or transition to a new provider, where appropriate.

Example exit plan

Areas for consideration	Details of tasks to be undertaken	Timescales	Responsible lead
Clinical	Up-to-date clinical summaries for all patients; referrals and transfer of care; prescriptions; test results; patient related communications		
Workforce	Consideration of staffing issues – if contract ceasing, the responsibility regarding the staff would normally sit with the contractor. If the service is to transfer to a new provider, consideration regarding TUPE will apply		
Documentation and records	All relevant documentation and records will		

	be transferred to the Family Health Shared Services (FHSS) or the new provider, whichever is applicable		
IM&T	All relevant electronic documentation and records held by the contractor are to be transferred in a recognised industry-standard computer format to the FHSS or the new provider whichever is applicable Licences should be transferred where possible		
Premises	Consideration of the practice premises and whether the premises will cease to be used or lease arrangements negotiated with the new provider		
Equipment	Consideration of any IT hardware or other equipment held by the contractor that requires return to the AT Full stock list		

	should be compiled defining which items will be remaining		
Facilities	Consideration of any existing facilities contracts and whether these will cease or transfer to a new provider		
Patient and Public involvement	Consideration of the needs to consult and inform throughout.		
Other	As required		

Annex 6: Example operational management plan template

It would be good practice for any new contract to contain an operational management plan, which should be produced by the new provider and contain detailed information regarding the implementation of the service. This plan should describe their key tasks, milestones, timeframes and responsible leads including the stages leading up to contract commencement.
Implementation of the operational plan should commence before the contract start date, to ensure that the new contractor will be in a position to begin service delivery on the contract start date. The timeframes for completion of each element must be agreed with the AT to provide assurance of the contractor's readiness at the appropriate stages of the project.

Example operational management plan

Areas for consideration	**Details of tasks to be undertaken including milestones – examples**	**Timescales**	**Responsible lead**
Clinical	Clinical team identified and in place Due diligence checks completed		
Workforce	Workforce identified and in place – TUPE'd staff		
Training and induction	Have all team members received adequate training and formal induction?		
IM&T	Have all relevant electronic/hard copy files been transferred from the previous provider? Is the IT		

	infrastructure in place and ready for use? Have necessary licences been acquired? Have staff been trained on use of IT system? Go-live date of any new system		
Premises	Are the premises secured and lease arrangements in place if applicable? If new build – what is the completion date? (Time should be allowed for 'snagging' before opening)		
Equipment	Identification of all equipment required Licences and maintenance contracts secured		
Facilities	Are all relevant facilities management contracts in place?		
Other	As required		

Version control tracker

Version Number	Date	Author Title	Status	Comment/Reason for Issue/Approving Body
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