

**Investing in General Practice**

**The New General Medical Services  
Contract**

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# 1 Investing in general practice: summary of changes

- 1.1 If accepted by the profession, the new GMS contract will:
- (i) provide new mechanisms to allow practices greater flexibility to determine the range of services they wish to provide, including through opting out of additional services and out-of-hours care
  - (ii) reward practices for delivering clinical and organisational quality, through the evidence-based quality and outcomes framework which is in line with professional practice, and for improving the patient experience
  - (iii) facilitate the modernisation of practice infrastructure including premises and IT, support the development of best human resource management practice and help GPs achieve a better work/life balance, support the development of practice management, and recognise the different needs of GPs in different localities, including GPs in deprived communities and in rural and remote areas
  - (iv) provide for unprecedented and guaranteed levels of investment through a Gross Investment Guarantee, which replaces the current flawed pay mechanisms. The contract allocates resources on a more equitable basis and allows practice flexibility as to how these are deployed from the global sum
  - (v) as a result of these mechanisms, support the delivery of a wider range of higher quality services for patients and empower patients to make best use of primary care services
  - (vi) simplify the regulatory regime around how the contractual mechanisms will work
  - (vii) be implemented as soon as practicable in all GMS practices, and be revised following consultation and negotiation with the General Practitioners Committee (GPC) of the BMA.<sup>1</sup>

## More flexible provision of services (Chapter 2)

- 1.2 A key objective throughout the negotiations has been to address the issues of practice workload and to find ways which this could be managed without a detrimental effect on patient care. The new contract allows practices to control their workload by providing them with the ability to choose the services they will provide.
- 1.3 This will be achieved through a categorisation of services. All GMS practices will provide essential services. Practices will also provide a range of additional services and have the opportunity to increase their income further through opting in to the provision of a wider range of enhanced services. Where practices are experiencing difficulties such as recruitment problems they will be able to opt out of the provision of additional services, either temporarily or permanently.

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<sup>1</sup> The words 'negotiated', 'negotiation', 'consulted', 'consultation' and the expression 'discussion and negotiation' were used in the framework document and apply in this document to describe the process of consultation set out below together with the established negotiation process that is part of, and/or may follow, such consultation. Failure to reach agreement would not prevent the Secretary of State or Health Ministers from discharging their statutory obligations or exercising their statutory powers.

The Governments are committed to following good practice on consultation arrangements as set out in the Cabinet Office Code of Practice on Written Consultation which sets out the arrangements and timescale for consultation in normal circumstances. This provides that, where consultation on written documents takes place, the period of consultation should normally last at least 12 weeks, other than in exceptional circumstances.

- 1.4 At the same time, Primary Care Organisations<sup>2</sup> (PCOs) will be responsible for ensuring that patient access to services is not compromised. Where practices opt out of services, their global sum will be reduced and the PCO will be able to use this money to secure alternative provision from other practices or primary care providers including PCOs themselves.
- 1.5 Recognising the current issues with patient assignments, the NHS Confederation and GPC have developed a proposal which aims to prevent a further burden on practices which are already experiencing difficulties, whilst guaranteeing patients access to the services they require.
- 1.6 The new contract recognises the need for GPs to have a balance between their work and personal commitments. This will be achieved through the opt-out arrangements referred to above and removal of the default position for out-of-hours services. A key message from the 2001 GPC National Survey of GP Opinion was to ensure that GPs were able to retain the option to provide out-of-hours care where this was their desire. In other cases, however, it was recognised that GPs wished to opt out of providing this service. The new contract allows for both.
- 1.7 By 31 December 2004, all PCOs should have taken full responsibility for out-of-hours. The PCO will be able to exploit a number of models for delivering out-of-hours care using various providers and professions such as NHS Direct/24, GP co-ops, NHS walk-in centres, practice partnerships, paramedics, pharmacists, GPs and primary care nurses in A&E departments, commercial deputising services and social work services. Different models of care will be developed in different areas shaped around local needs and circumstances.

### **Rewarding quality and outcomes (Chapter 3)**

- 1.8 The contract provides a major focus on quality and outcomes. Practices will have the opportunity to receive additional funding to support aspiration to and achievement of a range of quality standards. The new quality framework will reward practices for delivering quality care with extra incentives to encourage even higher standards. The quality framework will have four main components focusing on:
  - (i) clinical standards, covering coronary heart disease (CHD), stroke or transient ischaemic attacks, hypertension, diabetes, chronic obstructive pulmonary disease (COPD), epilepsy, cancer, mental health, hypothyroidism and asthma
  - (ii) organisational standards covering records and information about patients, information for patients, education and training, practice management and medicines management
  - (iii) experience of patients covering the services provided, how they are provided and their involvement in service development plans
  - (iv) additional services.
- 1.9 The quality standards have been developed by an independent expert group on the basis of the latest evidence and are in line with current professional practice. At the beginning of the year, practices will aspire to achieve a number of quality standards and will receive a proportion of the quality payment, which includes the additional infrastructure associated with the delivery of these standards.
- 1.10 Once achieved, the practice will receive the remainder of the quality payment - the achievement payment. Separate preparation payments will also be made. In recognition of the increase in workload required to deliver good access at the same time as higher quality, practices will receive additional payments where they are achieving the relevant national access target.

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<sup>2</sup> In Northern Ireland, this will be the Health and Social Services Board.

- 1.11 A system of exception reporting will be put in place to ensure that practices providing a quality service will not lose out on quality payments through factors outside their control.
- 1.12 The quality framework will be measured within a high trust system developed to strike a balance between monitoring and demonstrating that standards have been achieved. This will be implemented in normal circumstances through an annual review, including a practice report and a visit by the PCO. Effective IM&T systems will be required to implement the quality and outcomes framework and these will be supported through new investment. Implementation will start in 2003/04.

## **Developing human resources and modernising infrastructure (Chapter 4)**

- 1.13 Practice infrastructure will be modernised to ensure that patients can have access to high quality services delivered in modern, fit-for-purpose premises. Premises and IM&T will receive a major boost through considerable additional investment.
- 1.14 A number of new premises flexibilities and revised payment arrangements will be introduced through the new contract to ensure that the quality of practice premises is adequate to provide a quality service to patients and funds are targeted at those areas where premises are most in need of improvement.
- 1.15 Practices will be incentivised to exploit the use of IM&T both in terms of clinical and management systems. PCOs will fund the costs of practice IM&T systems which have been accredited against UK-wide standards. Each practice will have guaranteed choice from a number of accredited systems with transition from practice to PCO ownership in line with new investment.
- 1.16 The new contract will recognise the different stages of a GP career and GPs will be able to adapt their career to suit their aspirations. Salaried and independent contractor status will be available with greater flexibility around moving between the two. The new contract will also reflect a three-module approach to the GP career based on skills, knowledge and experience.
- 1.17 The contract recognises the need for GPs and their staff to have a work/life balance and work is continuing to provide access to NHS childcare facilities as well as cover for those on maternity, paternity and adoptive leave.
- 1.18 Existing seniority payments will be increased and the scheme improved to help reward experience. The arrangements for appraisal will not change from those recently negotiated and the funding for this has been built into the global sum. The global sum also contains funding to provide for protected time for GPs to undertake a range of activities.
- 1.19 The function of practice management will be enhanced, recognising the contribution an effective practice management can have on reducing the administrative burden on clinical staff. Practice managers will be encouraged to develop new roles and responsibilities following a new competency framework.
- 1.20 We recognise that practices in rural and remote areas may not always be able to enjoy the same options as other practices. We therefore acknowledge that practices in these areas require additional support and this will be provided by PCOs.

## **Investing in primary care services (Chapter 5)**

- 1.21 The new GMS contract will provide an unprecedented level of investment into primary care to improve services to patients and to revitalise general practice. This investment will form a three year Gross Investment Guarantee which will be monitored by the Independent Technical Steering Committee.

- 1.22 The new Carr-Hill allocation formula will provide equity, recognise casemix and practice circumstances, and ensure money will flow according to patient need. The particular needs of patients will be taken into account when calculating the amount each practice receives in its global sum allocation to provide a range of essential and additional services. Practices will have the flexibility to use these resources in a way which suits local circumstances and meets patient need. Funding will be provided irrespective of whether or not doctors are in place. A UK tariff, adjusted according to practice circumstances under the Carr-Hill formula, will apply for opt-outs from additional services and out-of-hours care.
- 1.23 There will be a guaranteed floor of money from the unified budget of PCOs to ensure that enhanced services can be delivered where appropriate and this will help to make the shift of secondary care services to primary care a reality. PCOs will manage the funding for other elements of the contract such as certain HR initiatives, premises, and IT. Spend on many of these elements and the quality framework will be subject to fixed national rules to ensure equity.
- 1.24 Mechanisms for payments to dispensing doctors will continue but will be reviewed in the light of negotiations on a new pharmacy contract. Funding for dispensing, including some of the costs of dispensers, will be separate from the global sum.
- 1.25 As a result of the increased investment guaranteed under the new contract, practice income will rise and, together with the new changes to the pension scheme, the total percentage increase in pensions should, over time, exceed the percentage increase in net income. A number of changes will be made to the existing pension scheme including a new definition of pensionable pay, new pension flexibilities to facilitate portfolio careers for GPs who may wish to work at some stage as salaried GPs and independent contractors or in other NHS service and, in line with a practice-based contract, allowing non-practitioner providers into the NHS pension scheme.
- 1.26 Funding flows to PCOs will change to support these new arrangements, following the introduction of primary legislation.

## **Better services for patients (Chapter 6)**

- 1.27 A Patient Services Guarantee, underpinned by new duties on PCOs, will ensure patients continue to get access to the range of primary medical services. New arrangements for the registration of patients with practices will both recognise the need for practices to close their lists as a means of managing workload and ensure that all patients are able to register with providers to receive NHS primary medical services. These will help minimise the need for forced assignment of patients. PCOs will have new mechanisms to ensure that whenever a practice opts out of an additional service, patients will receive the care they need. Patients will also benefit from a wider range of enhanced primary care services. The measures to improve recruitment and retention will enable primary care capacity to expand.
- 1.28 Although patients will now register with the practice and not an individual GP, they will still retain the choice, where appropriate, to request to see an individual GP. Holistic care will be incentivised through holistic care payments under the quality framework. Rapid access to services will be rewarded through the quality framework and patients will be able to exercise new choices in relation to additional and enhanced services.
- 1.29 In addition, patients will be empowered to use primary care effectively. Whilst not strictly a contractual issue, improving public education, empowering patients and developing the role of skill-mix across primary care are crucial to the context and environment in which a new contract will work. PCOs will have the opportunity to develop a range of initiatives to improve access for patients and help them to manage their own conditions, learning from pilots already under way such as developing 'expert patient' schemes and working with community pharmacies in reducing general practice consultations for over the counter medicines.

- 1.30 These initiatives will enable services to be designed around patients' needs. Through the quality framework, practices will be rewarded for surveying patients' needs and taking account of these. Patients will also be consulted appropriately on decisions that affect the operation of services they receive.

## **Underpinning the contract (Chapter 7)**

- 1.31 The new contract will normally be an NHS contract between the local Primary Care Organisation (PCO) and the practice, not the individual GP. Together with supporting documentation it will set out:
- (i) what services practices will provide
  - (ii) the level of quality to which services will be provided
  - (iii) the infrastructure and support available
  - (iv) the financial resources to support this.
- 1.32 The practice-based approach will enable the practice to use the resources available to it, both people and money, to deliver services in such a way as to meet their needs and the needs of their patients. The existing system of statutory vacancies will be replaced by practice flexibility to introduce new partners or employ the staff they need to deliver services. Teamwork will be encouraged and other professionals including nurses and therapists will be able to have extended roles in delivering services and could be co-signatories to the local contract.
- 1.33 In England and Wales, the existing three separate GP lists - the Medical List, the Supplementary List, and the Services List - will be rationalised and replaced by a single Primary Care Performers List. The Scottish Executive and the Northern Ireland Health Department will announce their respective plans for future listing arrangements in due course. In recognition of the practice-based approach, the Primary Care Performers List will be extended over time to cover other primary care professionals delivering services to patients.
- 1.34 A national contract will reflect the agreements set out in this document and be used as the basis for contracting between the practice and PCO. The existing primary legislation will be replaced by new provisions, which will underpin the introduction of a new secondary legislative regime by April 2004, subject to Parliamentary agreement.

## **Making it happen (Chapter 8)**

- 1.35 If the profession votes in favour, the Doctors' and Dentists' Review Body will be asked in joint evidence between the GPC, the NHS Confederation and the four UK Health Departments to endorse the agreement, and primary legislation will be introduced.
- 1.36 The new contract will be implemented in a phased way, allowing those elements that are not subject to primary legislation to be implemented more quickly. Substantial implementation will occur in 2003/04.
- 1.37 Future changes to the contract will be consulted on according to existing good practice as outlined in the Cabinet Office guidelines. New work will be recognised and rewarded appropriately.

## 2 More flexible provision of services

- 2.1 Many problems result from the existing contract because the range of services is poorly defined and because of the obligation to ensure the provision of out-of-hours care. The existing contract:
- (i) does not allow practices to control their workload
  - (ii) does not provide sufficient additional resourcing or reward for additional workload
  - (iii) inhibits the development of new services and special interests that would benefit practices, the wider NHS and patients
  - (iv) makes general practice less attractive for many current and future doctors.
- 2.2 Practices also find it hard to obtain PCO funding to enable them to deliver a wider range of services, and PCOs do not have adequate powers to develop additional primary care capacity by providing services themselves or commissioning services from other providers.
- 2.3 This chapter sets out how these deficiencies will be addressed through:
- (i) the new system of categorising work into essential, additional and enhanced services, and new arrangements for out-of-hours care
  - (ii) fixed UK rules around opting out of additional services
  - (iii) removing out-of-hours responsibility and 24-hour availability from general practitioners
  - (iv) the ability for PCOs to provide and commission care to ensure that patients receive a wide range of high quality services.

### Service categorisation

- 2.4 Following primary legislation, PCOs will be placed under a new legal duty to ensure that patients receive access to the full range of primary medical services. This will underpin a new Patient Service Guarantee described further in chapter 6.
- 2.5 Under the new contract:
- (i) practices will be required to provide essential services
  - (ii) practices will have a preferential right to provide additional services, and will normally do so. They will also have an ability to opt out in accordance with fixed UK-wide rules
  - (iii) enhanced services will be commissioned by the PCO. There are three types:
    - (a) under national direction with national specifications and benchmark pricing which all PCOs must commission to cover their relevant population
    - (b) with national minimum specifications and benchmark pricing, but not directed
    - (c) developed locally.
- 2.6 There will be new arrangements for out of hours and services for non-registered patients. These, together with home visits, are considered in paragraphs 2.17 - 2.28.
- 2.7 All practices will receive funding through the global sum for essential services and those additional services they provide to their registered patients. This is described in chapter 5.

## Essential services

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

## Additional services

- 2.9 These cover:
- (i) cervical screening
  - (ii) contraceptive services
  - (iii) vaccinations and immunisations
  - (iv) child health surveillance
  - (v) maternity services - excluding intra partum care<sup>3</sup> (which will be an enhanced service)
  - (vi) the minor surgery procedures of curettage, cautery, cryocautery of warts and verrucae, and other skin lesions.
- 2.10 To maintain the professional ethos of general practice, practices will be funded through essential and additional services to continue to provide continuous holistic treatment and care for all registered patients, including opportunistic health promotion and management of patients' appropriate continuing care after acute referrals. Breadth of care will also be rewarded through holistic care payments within the quality framework and these are described in chapter 3.

## Childhood vaccinations and immunisations

- 2.11 Childhood vaccination and immunisation schemes are additional services, and the infrastructure costs of delivering these have been built into the global sum. At the same time, systems of financial incentives will remain to encourage high population coverage through a directed enhanced service. This specification will be based on the existing lower (70 per cent) and higher (90 per cent) target payments but will be subject to a review, in discussion with the GPC, to consider the scope for using target payments more effectively to achieve higher population coverage within the same overall cash envelope. Exception reporting including for informed dissent will not apply.

## Influenza immunisations

- 2.12 A further directed enhanced service will incorporate an influenza immunisation incentive scheme for both over 65s and under 65s at risk. Informed dissent will apply.

## Enhanced services

- 2.13 Enhanced services are:
- (i) essential or additional services delivered to a higher specified standard, for example, extended minor surgery

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<sup>3</sup> Maternity services exclude the examination of the newborn baby within the first 24 hours of life.

- (ii) services not provided through essential or additional services. These might include more specialised services undertaken by GPs or nurses with special interests and allied health professionals and other services at the primary-secondary care interface. They may also include services addressing specific local health needs or requirements, and innovative services that are being piloted and evaluated.
- 2.14 The Carr-Hill allocation formula, which determines global sum payments, recognises through the morbidity factor the varying workload involved for practices in delivering care to very different groups of patients. The PCO can choose to supplement this by funding enhanced services for particular groups of patients. For some services, eg support services to staff and the public in respect of the care and treatment of certain patients who are difficult to manage, all PCOs will be required to provide practices with the help they need to deliver care in a safe environment.
- 2.15 Key features of enhanced services commissioning are:
- (i) PCOs will be free and able to commission whatever enhanced services they consider appropriate to meet local health need above a guaranteed minimum level of investment. HSC 2002/012 set this at £315/£394/£460m for 2003-2006 in England. The figures have since been revised upwards to £315/£518/£586m, reflecting changes in service categorisation. Comparable funding will be made available in the other three countries. These figures are set out in chapter 5
  - (ii) this freedom will subsume existing Local Development Schemes, the Improving Primary Care incentive scheme, services currently delivered under HSG(96)31, GPs with Special Interests (GPwSIs) and schemes to improve patient access. Existing contracts for such services will be rationalised into a single arrangement for enhanced services under the contract between the PCO and practice from 2004/05 and will continue for at least the duration agreed previously between the PCO and the practice
  - (iii) specifications for those enhanced services that are nationally directed will be published shortly. PCOs will use these for commissioning those services. They cover support services to staff and the public in respect of the care and treatment of patients who are violent, improved access, childhood vaccinations and immunisations and flu immunisation and minor surgery and for 2003/04 and 2004/05, quality information preparation. Other enhanced services have national minimum specifications and benchmark pricing and includes services outwith current GMS arrangements that will contribute to the resourced shift of work from the secondary to the primary care sector. Where PCOs commission these services from general practice, they will use the specifications as the basis. They include intra-partum care, anti-coagulant monitoring, providing near-patient testing, intra-uterine contraceptive device fitting, more specialised drug and alcohol misuse services, more specialised sexual health services, more specialised depression services, more specialised services for patients with multiple sclerosis, enhanced care of the terminally ill, enhanced care of the homeless, enhanced services for people with learning disabilities, immediate care and first response care (as described in chapter 4), and minor injury services. Enhanced schemes may also be developed in response to local need for which the terms and conditions will be discussed locally between the PCO and the practice, and either party could ask the LMC (or its equivalent) to support it in this process
  - (iv) most contracts for enhanced services are likely to be placed with GMS or PMS providers, but some may be placed with alternative providers including NHS trusts (or their equivalents). The PCO will also be able to provide the services itself subject to rules around audit and fair competition described in paragraph 2.44.
- 2.16 Service categorisation will be subject to future review and adaptation following consultation and negotiation with the GPC in response to changing technologies, patient needs and service requirements. Changes in primary care workload will be taken into account through a process of continuous workload monitoring which will inform future consideration of gross investment. This is described further in chapter 5. There will be no

obligation on practices to provide any enhanced service (notwithstanding that they have previously provided it) unless they enter into a new contract for its provision.

## Out-of-hours care

- 2.17 The existing default responsibility for all GPs to provide 24-hour care for their patients makes general practice unattractive for many prospective and current general practitioners and works against the achievement of an appropriate work/life balance.
- 2.18 To overcome these problems, if the contract is accepted by the profession the obligation on practices to ensure the provision of out-of-hours care for their patients will transfer to PCOs which will become responsible for commissioning and where necessary providing the out-of-hours service. The out-of-hours period will be defined as from 6.30pm to 8am on weekdays, and also the whole of weekends, Bank Holidays and public holidays.
- 2.19 Existing practices will retain the option to provide out-of-hours services on a practice-wide basis provided they meet mandatory accreditation standards taking account of quality and governance arrangements. After 31 December 2004, proposals from new practices to provide out-of-hours services will be considered by PCOs alongside proposals from other potential providers and will be subject to the same standards.
- 2.20 Practices will also be able to provide surgeries for routine consultations in the evening or at weekends where they choose to do so in response to patient need. Where practices decide to open in the evenings or at weekends, unless the PCO agrees to fund this as an enhanced service, it will be funded from the practice's global sum. Where the PCO requests a practice to open in the evenings or at weekends and where the practice agrees, this will be funded as an enhanced service.
- 2.21 PCOs will be able to consider a range of alternative provision for out-of-hours, for example NHS Direct/NHS24, NHS walk-in centres where available, GP co-operatives, partnerships between practices, paramedics, GPs and primary care nurses in A&E departments, community nursing teams and commercial deputising services. This will facilitate service integration and better use of triage and skill mix. Examples of local innovative schemes are published in supporting documentation. National teams of experts will help PCOs to develop new out-of-hours arrangements locally.
- 2.22 PCOs will be required to have a contingency plan in place which can be put into immediate operation should an out-of-hours provider fail. The default option will lie with PCOs, not practices as is currently the case. All out-of-hours providers, including practices, are required to meet the mandatory accreditation standards.
- 2.23 These arrangements may take time to put in place in certain areas. They will be implemented on a phased basis to allow PCOs, practices and new providers sufficient time to manage the change effectively without detriment to patient care:
- (i) until April 2004 out-of-hours will remain the responsibility of the individual GP. The existing ability to transfer responsibility to an accredited provider will remain and PCOs will be encouraged to facilitate this
  - (ii) between April 2004 and December 2004, out-of-hours will be a unique type of additional service. Individual practice opt-out will be considered and implemented in the context of a PCO-wide strategy
  - (iii) by 31 December 2004, all PCOs should have put in place effective alternative provision and, as a result, should have taken full responsibility for out-of-hours. Strategic Health Authorities (or their equivalents) will performance-manage this process. In certain exceptional circumstances, eg remote and isolated areas, there may be no alternative option to the practice provision.
- 2.24 The global sum payment described in chapter 5 includes payment for delivery of out-of-hours care. Where a practice opts out of such services, a fixed UK-wide tariff, adjusted by the practice weighted population under the new Carr-Hill formula, will apply and the global

sum payment will be reduced accordingly. The global sum of those practices that wish to continue providing out-of-hours care to their own patients after the default position changes will not alter. The existing Out-of-Hours Development Fund will continue to be allocated to PCOs to support the funding of alternative out-of-hours provision and will be increased.

- 2.25 The 2001 GPC National Survey of GP Opinion showed that whilst many GPs want to lose their 24-hour responsibility, others want to continue to provide out-of-hours care. In setting the tariff, a careful balance has been struck. Those practices delivering high quality care in hours will have access to additional earnings opportunities under the contract and in this way the opt out will be real and help recruitment and retention to the profession. As importantly, those practices which continue to provide out-of-hours will receive a fair reward. An average UK-wide rate in 2004/05 of £6,000 per GP with an average practice weighted population<sup>4</sup> (7 per cent of the global sum) achieves this balance. For practices which are unable to opt out of out-of-hours due to specific geographical circumstances, additional support will be available through the PCO as described in chapter 4.

## In-hours home visiting services

- 2.26 Under the new contract, patients will be made aware of the UK criteria for determining when home visits are necessary and these will be set out in the practice leaflet. These criteria state that a practice will provide at the home of a registered or a non-registered patient in its practice area such services as the practice is contracted to provide during hours which do not fall in the out-of-hours period when, in light of the patient's medical condition, the doctor considers that such services are needed and would most appropriately be delivered by means of a home visit.
- 2.27 Appropriate in-hours home visiting will normally be part of the practice's responsibility. However, the PCO can, in agreement with local practices, invest in an area-wide home visiting service through enhanced services to deliver better services to patients with less disruption to daytime surgeries. When this happens, practices will be able to delegate responsibility to the PCO in a manner similar to current out-of-hours deputising arrangements, normally following a locally agreed transfer of resources. PCOs can also provide patient transport services to improve access to primary care, where this is considered feasible and desirable.

## Non-registered patients

- 2.28 The obligation to provide immediate/necessary/emergency treatment and treatment to temporary residents will remain. The current Statement of Fees and Allowances (SFA) fees for emergency treatment, immediately necessary treatment and the care of temporary residents will be simplified into a single allocation included within the global sum. This will be calculated on the basis of the average number of claims in the practice over the previous five years. Where it is felt that the number of temporary residents being treated by the practice is insufficiently accounted for within the global sum (eg because of a new holiday park) this can either be resourced through a variation in the global sum for non-registered patients or as a local enhanced service.

## Non-NHS work

- 2.29 The proper role of the GP is the care of patients who are or believe themselves to be ill. Increasingly, GPs find clinical time diverted to responding to demands from outside organisations to provide medical reports. The existing Terms of Service deny practices any effective mechanism to regulate this additional, non-clinical workload or to secure

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<sup>4</sup> An average practice, with a list of around 5,500 patients, with around three whole time equivalent GP principals and average population needs and service delivery costs.

appropriate reward for their efforts. Given the Government's commitment not to introduce new NHS charges for patients, and the desire that it shares with the profession to avoid diverting scarce primary care staff and assets away from NHS patients, the existing arrangements in the Terms of Service (paragraph 38) will remain. However, under the new GMS contract the rules will be clarified so that it is clear that practices will be able to accept fees for:

- (i) examining (but not otherwise treating) a patient for the purpose of creating a report arising from a Road Traffic Accident or a criminal assault
- (ii) providing drugs and/or medical supplies, including travel kits, which a patient requires while he or she is abroad (this is in addition to existing provisions in respect of travel vaccines)
- (iii) attending and examining (but not otherwise treating) a patient at the request of a commercial, educational or not-for-profit organisation for the purpose of creating a medical report or certificate
- (iv) attending and examining (but not otherwise treating) for the purpose of creating a medical report required in connection with an actual or potential claim for compensation against any public or private body that the patient and his or her legal advisers believe may have been responsible for some harm that the patient has suffered (the issue of whether it is permissible in law for practices to be able to levy this charge in addition to any charge that the practice is entitled to make under the Access to Medical Records Act will be examined)
- (v) examining (but not otherwise treating) a patient for the purpose of creating a report that offers an opinion as to whether a patient is fit to travel by air.

The ability to accept charges from a dentist in respect of the provision at his or her request of an anaesthetic for a person for whom the dentist is providing general dental services will be ended.

## Opting out of additional services

2.30 Practices may not be able or wish to provide some additional services for the following reasons:

- (i) workload pressures or workforce shortages which mean the practice is in danger of not being able to provide, or can no longer provide, a satisfactory level of services to its patients and opting out would secure the quality of remaining services. This would be the basis for temporary opt-outs described below
- (ii) the practice has historically not provided the service under the existing GMS contract and does not wish to provide it in future
- (iii) there is a lack of available skills within the practice
- (iv) the practice feels unable to provide a service on conscientious grounds
- (v) there is an unacceptable pattern of temporary opt-outs (more than twice in three years) without a long-term solution having been identified. The PCO and practice should cooperate in finding a solution
- (vi) the practice is not fulfilling its obligations for that additional service under the new contract and there is a lack of practice commitment to solving the problem.

2.31 When a practice wants to opt out it will give notice to the PCO, with reasons. If a practice is providing any enhanced service(s), or any additional services to patients of another practice, the PCO may refuse to accept such notice.

2.32 The first step is dialogue between the practice and the PCO to identify how to solve the problems causing the practice to seek to opt out. If that is not possible, the practice would confirm to the PCO its intention to withdraw from the provision of a service. At this stage the practice will be required to notify the PCO as to whether this will be:

- (i) temporary withdrawal, ie less than a year

- (ii) permanent withdrawal.
- 2.33 Preparations for opting out can commence from April 2003 and the first withdrawals can occur from April 2004 subject to changes to legislation. Meanwhile, practices facing workload or workforce pressures may nonetheless discuss with their PCO how to solve the problems, including what support the PCO can provide. As part of the process of drawing up their contract during 2003/04, practices and PCOs will discuss any potential withdrawals or intention to provide additional or enhanced services not currently delivered. Where appropriate, consultation with affected patients should be carried out as quickly as possible and should not delay implementation of the opt-out.

## Temporary opt-out

- 2.34 The following UK-wide rules will apply for temporary opt-outs from additional services:
- (i) the PCO will seek to agree the opt-out as quickly as possible given the immediate nature of the problem, rather than follow the more time-consuming rules for permanent opt-out
  - (ii) duration will be a minimum period of six months and a maximum of 12 months from the start of the opt-out. More than 12 months will normally constitute a permanent opt-out, but the PCO can agree an extension taking account of exceptional circumstances
  - (iii) practices and PCOs will be required to agree how best to inform patients of the temporary transfer of the service, for example, through placing a poster in the practice waiting room or through the practice leaflet. In addition, information will need to be provided at the same time informing patients of the arrangements for alternative provision
  - (iv) the PCO will, where appropriate, agree with the original provider a programme of development, training or support in readiness for re-provision, where these were factors in the original decision to opt out
  - (v) the PCO will recoup a UK-wide fixed cost for the service (weighted according to the Carr-Hill formula) and the practice budget will be reduced by this amount
  - (vi) progress towards re-provision will be reviewed. If the PCO:
    - (a) agrees that the practice is able to re-provide the service, the service will revert back to the original provider at the agreed date
    - (b) does not consider the practice is able to provide the service within the agreed timescale, it can inform the practice of its intention to seek an alternative provider and follow the normal procedures for permanent opt-out. In some circumstances this may be due to factors outside the practice's control, in which case the PCO has discretion to extend the length of temporary withdrawal, whilst bearing in mind the position of the temporary alternative provider
  - (vii) should the original provider wish to opt out permanently it will inform the PCO as soon as possible and not later than three months before the agreed re-provision date. At this stage the PCO will be responsible for securing the alternative provision of services. If the temporary provider has delivered high quality care it will be in a good position to bid to provide the service on a permanent basis
  - (viii) where a practice gives notice to opt out of any additional service more than twice within three years, on the third occasion any opt-out request will be considered permanent.

## Permanent opt-out

- 2.35 The rules for permanent opt-out from additional services are:
- (i) the practice gives notice of its wish to opt out permanently. The PCO will seek to secure an alternative effective provider within a three or six month notification

period. Where necessary, the PCO will notify the practice at two months that the practice is required to continue provision for six months in total

- (ii) where alternative provision has not been secured after six months there will be a further and final three month transitional period. At this stage the PCO and practice will discuss and agree effective local mechanisms for providing the service until such a time as alternative provision is in place, but for not longer than three months
- (iii) the practice and PCO will be required to agree how best to inform affected patients of the permanent opt-out, for example through placing a poster in the practice waiting room or through the practice leaflet. In addition, information will need to be provided at the same time informing patients of the arrangements for alternative provision
- (iv) the PCO will become responsible for providing the service after nine months, unless it successfully appeals to the Strategic Health Authority (or its equivalent). Before it does so there is a clear expectation that it will have used all reasonable endeavours to secure an effective alternative provider
- (v) when a practice opts out of a service on a permanent basis, it cannot seek to re-provide it until the contract with the alternative provider ends. Open competition would then apply.

2.36 Opting out of an additional service will lead to an adjustment to the global sum. UK-wide tariffs have been calculated to ensure equity. To calculate these, the workload involved in delivering each service has been estimated, bearing in mind population coverage, consultations required to perform each service, length of consultation, and the primary care worker involved. Uplifted baseline spend for 2001/02 has been used. The tariff approach will be introduced from 2004/05 and will be uplifted for future years.

2.37 Figure 1 sets out the tariff for the average GP and the average practice. The amount will be adjusted by practice weighted population using the Carr-Hill formula.

Figure 1: UK tariffs for opting out of additional services

| <b>Additional services</b>                     | <b>Opt-out price for 2004/05 indicative<br/>£s per GP<sup>5</sup></b> | <b>Opt-out price for 2005/06 indicative<br/>£s per GP</b> | <b>Percentage of global sum</b> |
|--|---|---|---------------------------------|
| Cervical screening                             | 1,203   | 1,221   | 1.1                             |
| Child health surveillance                      | 758   | 769   | 0.7                             |
| Minor surgery                                  | 654   | 663   | 0.6                             |
| Maternity medical services                     | 2,296   | 2,330   | 2.1                             |
| Contraceptive services                         | 2,658   | 2,698   | 2.4                             |
| Childhood immunisations and pre-school booster | 1,059   | 1,075   | 1.0                             |
| Vaccinations and immunisations                 | 2,220   | 2,253   | 2.0                             |

<sup>5</sup> An average GP would have a list of around 1,800 patients with average population needs and service delivery costs.

## New ability for PCOs to provide or commission care

- 2.38 To deliver the Patient Services Guarantee described in chapter 6, PCOs will have a new ability to provide services themselves, or to commission them from alternative providers. Following primary legislation these will replace or amended where appropriate the existing section 56 of the National Health Service Act 1977 and the relevant part of section 33 of the National Health Service (Scotland) Act 1978 and Article 51 of the Health and Personal Social Services (NI) Order 1972.
- 2.39 When a practice wants to withdraw from an additional service, the PCO will be responsible for ensuring the effective alternative provision of services from:
- (i) another practice that is normally providing the full range of additional services to its own registered patients and has an open list, or
  - (ii) an alternative provider, or
  - (iii) it could provide the service itself.
- The extent of PCO provision will be further clarified in the implementation guidance.
- 2.40 The commissioning decision will normally be on the basis of quality and accessibility to the affected patients, which will be built into the terms of the contract and subsequently monitored. PCOs will consult, as appropriate, the affected patients, Patient Forums and LMCs (or their equivalents).
- 2.41 The PCO can also enter into further contracts for parallel additional services alongside those provided by practices. These would be funded by the PCO at no detriment to the practices. Normally, it would be considered good practice to discuss these issues with local practices and the LMC (or its equivalent). The extra care that patients receive would help the practice on whose list they are registered through reducing workload and delivering better quality.
- 2.42 Practices can also delegate services to other providers. Progress achieved against the quality framework would accrue to the practice except when the practice is inappropriately using secondary providers on a non-contractual basis to treat its patients. In that circumstance, quality and outcome payments will be questioned and could potentially be abated. Any proposed abatement will be subject to appeal.
- 2.43 The same income will not be pensionable more than once. Where practices delegate work, that part of the income due to the secondary provider will be pensionable in the hands of the secondary provider.

## PCOs as providers

- 2.44 A PCO will be able to provide services itself but where it does so this will be on the basis that it can meet the same requirements as other feasible alternative providers. Where it provides services it will do so subject to audit and routine standing orders/financial instructions and the constraints regarding the letting of contracts. This will ensure a level playing field and Strategic Health Authorities (or their equivalents) will have an important role in managing this and will ensure that the extent of PCO provision of services does not exceed an appropriate volume. Anti-competitive or fraudulent behaviour by PCOs and practices would be addressed by the relevant statutory authorities.
- 2.45 Within this context, PCOs will be able to:
- (i) provide additional or enhanced services if they are able to offer the same or better value for money, or the same or higher standards of care for patients than other interested parties

- (ii) offer support to practices to enable them to maintain their provision of additional services rather than have to withdraw as a first option.
- 2.46 PCOs will be able to provide or secure the provision of primary medical services in a range of ways including by:
- (i) maintaining a range of full-time or part-time salaried staff (clinical and non-clinical)
  - (ii) buying contracted sessions, as and when required, from existing practice-based staff on an ad hoc basis, in agreement with their employers
  - (iii) commissioning services from an alternative provider
  - (iv) making an agreement with doctors as a means of creating a bank of local support. This would enable the PCO to provide support to practices, as is currently the case in some areas.

## 3 Rewarding quality and outcomes

- 3.1 Practices already provide a quality service, although the existing GMS contract places far greater emphasis on high volume than quality of care. Less than 4 per cent of the total current spend on fees and allowances is explicitly derived from quality of care. This emphasis runs counter to GPs' professionalism, the interests of the NHS, and the interests of patients.
- 3.2 The new contract will address this through introducing a quality and outcomes framework based on the best available research evidence. High achievement against quality standards will bring very substantial rewards. Payments to prepare for entering the quality and outcomes framework will be guaranteed to all practices in 2003/04. Thereafter resources will rise significantly.
- 3.3 The framework represents the first time any large health system in any country will systematically reward practices on the basis of the quality of care delivered to patients. It is in line with professional opinion and reflects the ethos that higher quality care is most likely to be achieved through the use of incentives.
- 3.4 This chapter describes:
- (i) the contents of the framework
  - (ii) how payments will be made
  - (iii) how achievement will be calculated
  - (iv) monitoring arrangements
  - (v) review and updating arrangements.

### Contents of the framework

- 3.5 The framework contains **domains**. Each domain contains a range of **areas** described by key **indicators**. The indicators describe different aspects of performance. The four domains are:
- (i) **clinical domain**. This contains ten disease areas:
    - (a) coronary heart disease (CHD) including left ventricular dysfunction (LVD)
    - (b) stroke and transient ischaemic attacks (TIA)
    - (c) hypertension
    - (d) hypothyroidism
    - (e) diabetes
    - (f) mental health
    - (g) chronic obstructive pulmonary disease (COPD)
    - (h) asthma
    - (i) epilepsy
    - (j) cancer.
  - (ii) **organisational domain**. This contains five areas:
    - (a) records and information
    - (b) communicating with patients
    - (c) education and training
    - (d) medicines management
    - (e) clinical and practice management.

- (iii) **additional services domain.** This contains four areas:
    - (a) cervical screening
    - (b) child health surveillance
    - (c) maternity services
    - (d) contraceptive services.
  - (iv) **patient experience domain.** This has two areas:
    - (a) patient survey
    - (b) consultation length.
- 3.6 Although the whole practice population will benefit from the range of clinical and organisational standards, older people will benefit particularly from the focus on active management of those patients suffering from stroke, CHD, diabetes and hypothyroidism. Additionally, the new contract will incentivise greater quality of care for children generally through child health surveillance and particularly through the focus on asthma in the quality framework.
- 3.7 The **indicators** for each domain are attached at Annex A. These were developed by an expert group, based on the following principles:
- (i) indicators should be based on the best available evidence
  - (ii) the number of indicators for each clinical condition should be kept to the minimum compatible with an accurate assessment of patient care
  - (iii) data should never be collected purely for audit purposes. Only data that are useful in patient care should be collected. The basis of the consultation should not be distorted by an over-emphasis on data collection, and an appropriate balance should be struck between excess data collection and inadequate sampling
  - (iv) data should be obtainable from existing practice clinical systems.
- 3.8 The clinical indicators are split into three different types:
- (i) **structure.** For example, is a disease register in place?
  - (ii) **process.** For example, is the indicator being measured and an appropriate intervention being made, across what percentage of the relevant population?
  - (iii) **outcome.** For example, how well is the condition being controlled, across what percentage of the population?

## Evidence base

- 3.9 The evidence base underpinning the indicators is set out in the supporting documentation. The clinical indicators draw on best research evidence.
- 3.10 Many of the organisational indicators are derived from existing evidence-based schemes such as the Royal College of General Practitioners Quality Team Development and Practice Accreditation Scheme. Practices already delivering the requisite quality standards in line with these and other accredited schemes will have already made considerable progress within the quality framework and will be rewarded accordingly.
- 3.11 The inclusion of patient experience in the quality framework of the new contract represents an opportunity for practices to obtain systematic feedback from their patients about the services they provide and how they are provided, and to include these in their service development plans as well as engaging patients in service redesign. Many practices are already doing this and there are a number of patient questionnaires in existence. Initially, two questionnaires have, following adaptation, been accredited for use in the new GMS contract:

- (i) Improving Patient Questionnaire (IPQ) developed by Exeter University
- (ii) General Practice Assessment Questionnaire (GPAQ) developed by the National Primary Care Research and Development Centre in Manchester.

Further information about these questionnaires will be included in supporting documentation.

- 3.12 Statutory and mandatory requirements that will replace existing terms of service will be set out in the national practice-based contract being developed in line with primary and secondary legislation, and are attached at Annex B.

## Making payments

- 3.13 Three types of payments will be made:
- (i) preparation payments (in the first three years only)
  - (ii) aspiration payments that include additional infrastructure costs but excluding premises and IT
  - (iii) achievement payments.

## Preparation payments

- 3.14 Implementing the quality framework will take time for practices. In recognition of this, substantial quality preparation payments will be made in 2003/04, 2004/05 and 2005/06. These payments are not conditional on achievement but they will enable practices to collect initial data to establish their current position in the framework. This will assist them in determining their aspiration for achievement in the following year.
- 3.15 These will be made on a practice weighted population basis using the Carr-Hill formula (see chapter 5). From 2003/04 they amount to an average of £9,000 per practice in each of the three years. They will be paid at the beginning of the financial year (or as early thereafter as practicable in 2003/04, in the event of a yes vote).
- 3.16 Points will be the currency used to distribute the aspiration and achievement payments within the framework and have been allocated, weighted according to workload, costs and importance, to each of the indicators.

## Aspiration payments

- 3.17 From 2004/05, practices will agree their aspiration with PCOs (see paragraph 3.38(iv)) and aspiration payments will be paid monthly alongside the global sum. These payments will be a third of the predicted total points. Even if the practice thinks it is only scoring a relatively low number of points in 2003/04, it will be free to aim as high as it wishes provided it can demonstrate to the PCO that it has a reasonable chance of achievement.
- 3.18 For example, if an average practice, which thinks it is scoring about 300 points in total across the framework in 2003/04, is aspiring to 750 points in 2004/05, it would receive an 'aspiration' payment for 250 points during 2004/05. This payment will help meet additional infrastructure costs associated with delivering higher quality. To recognise the relative workload involved in delivering high quality care to different numbers of patients, the total practice entitlement to aspiration and achievement payments will be adjusted by practice weighted population using the Carr-Hill formula.

## Achievement payments

- 3.19 Achievement for 2004/05 will then be measured at the beginning of the following year (starting from 2005/06), and an achievement payment will be made. If the practice cited above achieved 750 points in 2004/05, it would receive an achievement payment for the remaining 500 points. However, as there will be no cap on quality, if the practice

performed better than expected and achieved 900 points it would receive 650 points as its achievement payment, irrespective of the number of points it aspired to. Equally, if the practice did not perform as well as expected and only achieved 400 points, it would only receive a further 150 points as its achievement payment. In this way repayments will be avoided unless the practice achieves less than a third of its aspiration points. In that situation the overpayment will be deducted from the aspiration payment for the following year.

- 3.20 At the beginning of 2005/06, the practice will also set out what it is aspiring to in that year, and similarly receive payment for a third of the points for that aspiration during the year, alongside the achievement payment for 2004/05.
- 3.21 Computer software will be provided in 2003/04 to all practices to enable them to calculate, at any point in time, what they are achieving.

## Calculating achievement

- 3.22 A practice's entitlement to quality payments will be determined through a [quality scorecard](#), which assigns up to 1,000 points for achievement and 50 points for maintaining improved access. In designing the quality scorecard arrangements, the following principles were borne in mind:
  - (i) simplicity
  - (ii) transparency
  - (iii) voluntarism
  - (iv) continuous improvement
  - (v) rewarding breadth of service provision as well as depth
  - (vi) minimising perverse incentives.
- 3.23 An appropriate balance has been struck between these principles. Given the pioneering nature of the quality framework and its pricing, the scorecard arrangement will be kept under review. Beyond 2005/06 it may be adjusted in the light of lessons arising from its practical application in consultation and negotiation with the GPC.

## Distribution of points

- 3.24 Figure 2 sets out the distribution of points within each area of the framework in 2004/05 and 2005/06. In 2004/05, based on current average list size, each point will be worth £75 per practice with an average weighted population. In 2005/06, this figure will rise to £120.<sup>6</sup> In order to calculate their entitlement, practices will need to multiply the number of points aspired to by these values. This sum will then need to be multiplied by the ratio between their weighted practice populations and the average weighted population. Initial estimated weighted practice populations will shortly be made available to practices.
- 3.25 Each practice will have complete freedom to choose which areas of the quality framework to focus on. To reward breadth of achievement across different areas, practices will also be eligible for [holistic care](#) and [quality practice payments](#).

Figure 2 - 2004/05 quality scorecard

|                            |               |
|----------------------------|---------------|
|                            | <b>Totals</b> |
| <b>Clinical indicators</b> |               |

<sup>6</sup> In line with the Gross Investment Guarantee, if there is an overall underspend on quality the pounds per point could increase.

|  |            |
|--|------------|
| CHD including LVD etc                    | 121        |
| Stroke or transient ischaemic attack     | 31         |
| Cancer                                   | 12         |
| Hypothyroidism                           | 8          |
| Diabetes                                 | 99         |
| Hypertension                             | 105        |
| Mental health                            | 41         |
| Asthma                                   | 72         |
| COPD                                     | 45         |
| Epilepsy                                 | 16         |
| <b>Clinical maximum</b>                  | <b>550</b> |
| <b>Organisational indicators</b>         |            |
| Records and information                  | 85         |
| Patient communication                    | 8          |
| Education and training                   | 29         |
| Practice management                      | 20         |
| Medicines management                     | 42         |
| <b>Organisational indicators maximum</b> | <b>184</b> |
| <b>Additional services</b>               |            |
| Cervical screening                       | 22         |
| Child health surveillance                | 6          |
| Maternity services                       | 6          |
| Contraceptive services                   | 2          |
| <b>Additional services maximum</b>       | <b>36</b>  |
| <b>Patient experience</b>                |            |
| Patient survey                           | 70         |
| Consultation length                      | 30         |
| <b>Patient experience maximum</b>        | <b>100</b> |
| <b>Holistic care payments*</b>           | <b>100</b> |

|   |       |
|---|-------|
| Quality practice payments   | 30    |
| Total for clinical, organisational, additional, patient experience, holistic care and quality service | 1,000 |
| Access bonus  | 50    |
| Total   | 1,050 |

\* The registration of patients in different disease areas is also designed to allow identification of those patients with greatest risk. This will be particularly important in the case of older patients who may be at greater risk as a consequence of multiple pathology and will allow the practice to focus additional support for these patients.

## How points are scored

3.26 Points are awarded for depth of quality in particular areas and breadth of achievement across the framework.

### Measuring depth of quality

- 3.27 To score points for the process and outcome indicators in a particular clinical area, a practice must have first achieved the structure indicator.
- 3.28 Reflecting the key principle of voluntarism whereby clinicians may choose where to focus their energies, achievement against each indicator gives a points score which differs according to the associated workload. Achievement for each process and outcome indicator in the clinical areas is assessed by a percentage. A proportion of the points score for each indicator will be awarded in a direct linear relationship for achievement between the minimum, set at 25 per cent for the clinical indicators, and the maximum set for each indicator based on the evidence for the maximum practically achievable level to deliver clinical effectiveness. For example, if 15 points were available for an indicator with a maximum level of achievement of 85 per cent and the practice had achieved 65 per cent, they would receive 40/60ths of 15 points ie 10 points.
- 3.29 Achievement for each indicator in the organisational domain, additional services domain (with the exception of the indicator for cervical screening coverage) and patient experience domain is based on a yes/no determination. The full number of points per indicator will be awarded for achieving each one. The total points scored for all the above domains are then added together.
- 3.30 Practices will be able to exclude certain categories of patients from the calculation of performance, for example:
- (i) patients who have been recorded as refusing to attend review who have been invited on at least three occasions
  - (ii) patients newly diagnosed within the practice or who have been newly registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months, for example lowering of cholesterol or blood pressure
  - (iii) patients for whom it is not clinically appropriate, for example those who have an allergy, and other contraindications or adverse reaction, and the terminally ill
  - (iv) where a patient has given informed dissent to treatment and this has been recorded in the records
  - (v) where a patient has not tolerated relevant medication
  - (vi) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal

- (vii) where a patient has a supervening condition that makes treatment of their condition inappropriate, for example, cholesterol reduction where the patient has liver disease.
- 3.31 The PCO will normally expect the practice disease register to be broadly comparable to the overall level of morbidity within the PCO. Further guidance on this will be made available. However, there may be cases where the variation is greater because of practice population characteristics. In wholly exceptional cases, where the differences cannot reasonably be explained, the PCO, in consultation with the Local Medical Committee (or its equivalent) and after discussion with the practice, will be able to rescore the clinical achievement payments on the basis of an adjusted disease register reflecting average PCO morbidity. The practice will have a right of appeal against such a decision.

## Measuring breadth of quality

- 3.32 In order to support the intrinsic nature of general practice a separate [holistic care payment](#) will recognise breadth of achievement across the range of different clinical areas. A [quality practice payment](#) will recognise breadth of achievement across the organisational, additional services and patient experience domains.
- 3.33 The scale of the holistic care payment is calculated by considering the proportion of points achieved in each of the 10 clinical areas. The proportion of points achieved for the third lowest clinical area determines the proportion scored of the total holistic care points available.
- 3.34 For example, if a practice achieves half of the total number of points available in five clinical areas, a third in two, a quarter in another and nothing in the remaining two, the practice will be eligible for one quarter of the total holistic care payment.
- 3.35 The same approach applies for quality practice payments, which span all the areas within the organisational, additional services and patient experience domains. The proportion of points achieved in the third lowest area determines the proportion scored of the total points available for the quality practice payment.
- 3.36 Many practices are already achieving the access targets set in England, Scotland and Wales. In recognition of the increase in workload required to deliver good access at the same time as higher quality, practices will be rewarded by a 50 points bonus score if they are achieving the relevant target.

## Recording and reviewing arrangements

- 3.37 In order to measure achievement, practices will have to enter and retrieve high quality information from their practice clinical systems. To qualify for payment, quality framework data will be recordable, repeatable, reliable, consistent and auditable. IM&T systems are required in order to deliver such requirements. Education and training of practice staff will be supported through funded national programmes. UK-wide reporting queries will be developed and the GPC will be fully involved in defining these to meet the requirements of the quality framework and software will be provided to all practices to enable them to calculate how their points will translate into rewards.
- 3.38 The practice quality review will be founded on the development of a relationship between the practice and the PCO based on the principles of high trust, evidence base, appropriate progression and development within the practice context, minimising bureaucracy, and ensuring compliance with the statutory responsibilities of the PCO. The PCO's role will be given appropriate underpinning in legislation. Within this the following arrangements will apply:
- (i) achievement against the quality framework will be reviewed by the practice providing annual information on its performance, together with a PCO visit to the practice, which will initially take place annually. Over time, visits may become less frequent subject to the mandatory requirements for financial audit. This

review will be strongly evidence-based against the agreed national standards set out in the quality and outcomes framework. The practice will submit a single standard return form, which is being developed by the NHSC and GPC and which cannot be extended locally. It will be used for practices to self-evaluate their performance and to provide evidence to substantiate their achievement of the quality standards. Each PCO visit will include a comprehensive review and discussion with clinicians and the practice manager. The visit will avoid disruption to patients or other members of the practice. The LMC (or its equivalent) may be involved in this process at the discretion of either party. The practice costs of preparation for the visit are built into the aspiration element of payments

- (ii) the frequency of visits may increase and additional supporting evidence may be required where there is concern around, for example, inaccurate practice information or suspected fraud
- (iii) participation in and approval through an accredited organisational quality programme can count towards points on the organisational domain. Existing schemes will be accredited for use in this way, and as a result validated achievement against relevant indicators will be subject to lighter touch monitoring as part of the annual review
- (iv) where the practice achieves the standards aspired to, the PCO will confirm the level of achievement funding to be given. The practice will also discuss with the PCO the points to which it is aspiring in the following year. Where the practice fails to achieve the standards aspired to, there will be a discussion as to the action to be taken in the following year
- (v) the review will be followed up in writing by the PCO for sign-off by the practice
- (vi) PCO-wide achievement against the quality framework will be independently inspected, in England and Wales by the Commission for Healthcare Audit and Inspection and by equivalent organisations in Scotland and Northern Ireland.

3.39 Guidance will advise PCOs how best to manage the quality framework and will be subject to the usual process of consultation and negotiation with the GPC. This will ensure consistency of approach across PCOs, including any necessary training for reviewers. IM&T systems will support the process of contract review and quality review. Practices will be able to appeal against a PCO decision through the appeals mechanisms set out in chapter 7.

## Review and update

3.40 The quality framework will be reviewed and updated as necessary in the light of changes to the evidence base, advances in healthcare, changes in legislation or regulation and the need for further clarity, or so as to include new areas. These decisions will be based on a review of the quality framework and direct monitoring of the quality standards through PCOs and indirect monitoring through academic research and tracking studies. The benefits of change will be balanced against the benefits of stability.

3.41 An independent UK-wide expert group will oversee the process. The group will consider the latest evidence available and make recommendations to the four Health Departments or their agents and the GPC. It will be the responsibility of the negotiating parties to negotiate any changes to the quality framework, including pricing changes.

## 4 Developing human resources and modernising infrastructure

- 4.1 Delivering high quality care across a wide range of services requires high quality support and infrastructure. The new GMS contract will facilitate this through:
- (i) helping implement good human resource management practice to improve the working lives of GPs and practice staff, and encourage recruitment and retention
  - (ii) supporting practices in rural and remote areas
  - (iii) investment in information management and technology
  - (iv) better mechanisms to modernise premises.

### Human resource management and improving working lives

- 4.2 The new GMS contract will:
- (i) facilitate the introduction of a new career structure
  - (ii) support the introduction of protected time for skills development
  - (iii) enable the widespread employment of salaried GPs in GMS where this best suits practice and practitioner preferences
  - (iv) deliver family-friendly improvements
  - (v) encourage recruitment and retention through national schemes such as golden hello schemes, sabbatical schemes, flexible career schemes and returners schemes
  - (vi) support the development of practice staff including nurses and managers.

### Career structure

- 4.3 GPs have suffered from the lack of a recognised career pathway. Enabling GPs to pursue a fulfilling career will boost the recruitment of new entrants into general practice and the retention of both new entrants and established GPs. The role and status of a GP as a generalist will be developed and valued. The new contract will also enable GPs to develop a portfolio approach to career development and provide options that are equally available to all GPs. The contract will underpin a modular approach to planning GP careers:
- (i) **skills development.** This phase of a GP career typically, but not exclusively, recognises the needs of newly qualified or returning GPs to broaden their clinical experience and possibly work in different settings so as to tackle the wide range of clinical problems they will face in their careers as GPs. This phase may be facilitated, but not prescribed, as a phase of salaried work, taking in a variety of practices
  - (ii) **special interest development.** Currently special interest work is done as an add-on, but it could be made more integral to the GP contractual options (dependant on numbers and capacity to meet basic requirements within the practice). The types of interests here would include both clinical and non-clinical commitments (eg more specialised minor surgery, more specialised chronic disease management, management roles in PCOs, education, academic general practice, research, occupational health etc). GPwSI services will be developed in a variety of clinical areas
  - (iii) **clinical leadership.** This phase will recognise a reduced clinical commitment while undertaking roles such as those in education, mentorship, clinical leadership in PCOs and Strategic Health Authorities (or their equivalents), clinical governance, appraisal, membership of national bodies, Boards and LMCs (or their equivalents).

- 4.4 Although GPs may tend to opt for different phases at different points in their career (eg clinical leadership phase later than skills development phase), the career phases will not be linear. Some new GPs will wish to carry out special interest or leadership work immediately after qualifying. Some older GPs may wish to refresh their skills development (especially if this was tied in to returning following a career break or as a result of a need identified through the appraisal process). Further work will be undertaken on the details of this approach.
- 4.5 The examples above are not comprehensive, but give a flavour of the wide variety of roles that GPs may undertake in the NHS. They will be supported by flexible approaches in all four countries to temporary retirement and pre-retirement work such as career breaks, sabbaticals, returners schemes, flexible career schemes and a reduced clinical commitment in return for PCO or professional work.
- 4.6 The current career opportunities for GPs are extensive and can provide for a satisfying and fulfilling working life. However, they are not uniformly available throughout the UK and the funding for them, in terms of rewards and practice cover arrangements, is variable and rarely protected. To maximise opportunities for GPs to develop their careers, funding has been built into the global sum to enable practices to replace a general practitioner absent from work for whatever reason. This can be achieved in part by using other healthcare professionals.
- 4.7 The contract will also bring new career opportunities for practice staff, including nurses, by extending their roles and responsibilities and by facilitating skill mix.

### Protected development time arrangements

- 4.8 Under the new contract learning and personal development will be supported through protected time. An element for protected development time has been built into the global sum. All GPs and their practice staff will have opportunities for protected development time but a single model is not appropriate. Learning and development should be focused on the individual's needs although some core subjects, for example child protection or cardiopulmonary resuscitation training, will be universally applicable. Activities covered by protected time could include, for example continuing professional development, appraisal preparation, revalidation, clinical governance, audit, and practice management and development.
- 4.9 Practices will develop their own methodologies for supporting professional development. PCOs will also have an important role to play in supporting protected time through, for example sponsoring protected development time events, and in considering what support is needed for isolated GPs, including those in rural and remote areas, particularly where a GP's personal education plan can only be satisfied by travelling to a distant course. The costs of such PCO-sponsored or PCO-approved training, including travel and subsistence for GPs, will be met by the PCO.

### Appraisal

- 4.10 The new protected time arrangements will support appraisal. The contract will carry forward the recent agreements on appraisals between the GPC and the Health Departments and will ensure proper funding of appraisal in every PCO. Work is continuing to develop appraisal arrangements for all general practitioners.
- 4.11 To ensure adequate supply and continuing development of appraisers, the number of appraisers per PCO will be reviewed and appraisers will take part in a review process. PCOs should make arrangements to share appraisers where appropriate and where local arrangements permit. All GPs could act as appraisers if they are sufficiently experienced and have been properly trained and rewarded. UK-wide agreements are required for the training, support, pay and cover arrangements for GP appraisers.
- 4.12 Where, following assessment by the National Clinical Assessment Authority in England and Wales (or corresponding support mechanisms in Scotland and Northern Ireland), the GMC or agreed local procedures, it is determined that a doctor requires remediation,

some or all of the costs of GP remediation including education and training requirements will be provided by the Workforce Development Confederations (or their equivalents). The exact proportion of these costs will depend on the particular circumstances and will be discussed with the LMC (or its equivalent).

- 4.13 The fixed retirement age of 70 will be abolished as all GPs will be subject to appraisal and revalidation.

### Salaried GPs

- 4.14 An increasing number of GPs have expressed a preference for salaried contracts. The global sum will give practices new flexibility to appoint salaried staff, and PCO direct provision will offer a new PCO salaried option. PCO and practice salaried GPs will work under national terms and conditions set out in model national contracts which PCOs and practices will use as the basis for their employment of GPs. These are published in the supporting documentation. As stated in the framework document, the NHS Confederation, the GPC and the four Health Departments will shortly be putting forward joint evidence to the DDRB to support the determination of a salary range for salaried GPs. In assessing the appropriate point in the range, the principle of local job evaluation will apply and personal experience will be taken into account. Both PCO and practice employers will have the flexibility to offer enhanced terms and conditions and pay rates in order to aid recruitment, but it will not be possible to offer diminished terms, conditions or rates.

### Improving working lives

- 4.15 In support of recruitment and retention, GPs and their staff will have the same access to NHS childcare in each of the four countries as other NHS employees. This access will also be available to all GPs and GP registrars. PCOs will consider the specific needs of GPs and their staff when developing local provision, including childcare options that are appropriate to GPs and their staff who are working parents, such as time and place of provision, opening and closing times and access in times of practice crisis and domestic emergencies.
- 4.16 Maternity, paternity, adoptive and special leave will follow national legislative requirements. NHS conditions, where they are more generous, will be available to GPs and practice staff who wish to take advantage of them. Funding will be held at PCO level. Sick leave arrangements will be reviewed in the light of the introduction of the global sum.

### Seniority payments

- 4.17 The existing seniority payment scheme will be improved to reward experience. The new scheme will deliver a 30 per cent increase in total resources over current spend by 2005/06. The scheme will be based on years of NHS reckonable service. As with the current scheme, the new scheme will recognise the working commitment of general practitioners with superannuable income being used as a measure of that working commitment. Under these arrangements, GPs who are receiving at least two-thirds of average superannuable income will be entitled to full seniority payments. GPs receiving between one-third and two-thirds of average superannuable income will be entitled to 60 per cent of full seniority payments. GPs in receipt of less than one-third of average superannuable income will not be eligible for the payment. The existing payment steps will be subject to some smoothing. The revised arrangements will be published in supporting documentation. GPs salaried by the PCO or by the practice will not receive separate seniority payments but these will be reflected in their overall salary scales.

### Recruitment schemes

- 4.18 Recruitment schemes, such as golden hellos, will be developed in all four countries to meet their particular needs and be introduced, where appropriate, by no later than April 2004.

## Supporting practice staff

- 4.19 Organisational standards in the quality framework will reward practices for ensuring employment standards comply with good human resources practice in line with *Agenda for Change* principles that are expected to apply to non-medical staff and to prevent exploitation.
- 4.20 Nurses will be given the freedom and support to work with GPs in new ways and to take on more advanced and specialised roles:<sup>7</sup>
- (i) all practice-employed nurses should be supported to participate in clinical supervision and appraisal and to have access to professional advice and continuing professional development and to IM&T
  - (ii) these new roles taking on, where appropriate, more advanced and specialist roles in first contact care, chronic disease management and preventive services will need to be supported by the necessary skills and knowledge provided by training and education and an understanding by the nurse and GP of the Nursing and Midwifery Council Code of Conduct
  - (iii) in line with a practice-based approach we envisage that the new GP performer list arrangements described in chapter 7 will, over time, be extended to other professions as appropriate
  - (iv) the global sum payment arrangement will enable practices to develop greater skill mix with more registered nurses, pharmacists (subject to rules governing conflict of interest) and allied health professionals providing opportunities for a range of professionals to work at all levels as part of the practice team. The skills and expertise of nurses in general practice working at a more specialised level will be developed. Nurses and others should be fully involved in practice decision-making that impacts on their work
  - (v) the quality framework will apply to the practice team rather than separate professionals.

## Supporting practice managers

- 4.21 The new contract will encourage an expanded role for practice management in primary care, supported by the development of practice management competencies. Following consultation with a number of representative organisations a competency framework for practice management has been developed and is attached at Annex C. This competency framework covers strategic issues, the development and delivery of services to patients and practice infrastructure. It is not envisaged that every practice manager will have all these competencies but that the framework should be used as a resource for helping individuals' competencies and ensuring that the practice has access to the skills it needs.
- 4.22 Under the new contract, practices will receive funding for practice management through the global sum. In some cases it will not be cost-effective for every practice to have its own full-time practice manager. In such cases a practice may pool resources with other practices and share a practice manager or request access to practice management expertise through the PCO. The latter approach will be supported through new primary legislation.

## Supporting practices in rural and remote areas

- 4.23 GPs in rural and remote areas of the UK form a small but essential part of the NHS. The new contract will recognise their specific needs and help ensure they receive proper support:
- (i) through the Carr-Hill allocation formula, which includes a specific adjustment for rurality. This takes account of population sparsity and dispersion, and means that

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<sup>7</sup> In England, the development of practice nursing is supported through the document "*PCTs Liberating the Talents: helping PCTs and nurses to deliver the NHS Plan*".

rural and remote GPs will benefit in their global sum and the practice weighted population adjustment to quality payments

- (ii) through the powers described in chapter 2 for PCOs to employ staff to provide GMS and support practices. The new flexibility for PCO and practice-based salaried options may also be particularly useful in rural and remote areas
- (iii) through funding arrangements that will ensure support for practices in recognition of the extra burdens of being a remote and rural GP, for example extra travel costs to attend PCO-sponsored or PCO-approved training and the continued need to provide out-of-hours care which will be supported by the Out-of-Hours Development Fund. There will be a range of independent contractor and employed options, which will improve upon and replace the current inducement scheme, which will cease on 31 March 2004
- (iv) for immediate care and first responder services. Rural and remote GPs are often more involved in the provision of emergency care outside the setting of their surgery or a local community hospital. This work requires extra training (eg BASICS), equipment, resource, commitment and reward. Under the new contract, these services will be commissioned and funded as an enhanced service. PCOs will normally wish to commission such services where land ambulance response times are relatively long or the practice is remote from the nearest appropriate hospital. Practices providing these services will need to ensure relevant practitioners have the necessary skills, for example through attending a BASICS course at least once every five years
- (v) for GPs working for community hospitals and minor injury clinics. Staffing of community hospitals and minor injury services is an integral part of many GP practices, particularly in rural or remote areas. Under the new contract these services will be commissioned and funded from the unified budget or its equivalent in Northern Ireland. A specification for the minor injuries enhanced service provided within a practice will be published shortly in supporting documentation.
- (vi) through twinning arrangements. Under the new contract, PCOs will support arrangements to minimise the impact of geographical isolation on all professions in rural and remote areas. The Remote And Rural Areas Resource Initiative (RARARI) in Scotland will examine how twinning arrangements could best support GPs in remote and isolated areas. Lessons learned from this will be implemented throughout the UK. Where twinning is feasible, and supported by the LMC (or its equivalent), the PCO will do its utmost to support implementation.

## Supporting practices in deprived areas

- 4.24 The new contract will recognise the additional workload involved in providing care in deprived inner city areas through the morbidity factor in the Carr-Hill formula. Underdoctored areas will also gain from the allocation of money on the basis of patient need rather than the number of doctors. Practices will be able to seek to provide a range of enhanced services for the specific needs of their population.

## Modernising information management and technology in general practice

- 4.25 Future information systems in primary care will be based on integration at a community level and on the concept of GPs receiving an information technology service rather than simply being provided with hardware and software. The national IM&T programmes will be responsible for developing these arrangements and ensuring that all key stakeholders, especially clinicians, are fully involved in determining appropriate standards and methods of provision. The objective will be to provide clinicians and others with access to information wherever and whenever it is needed to support patient care. This will be subject to nationally agreed security and confidentiality conditions which take into account the requirement that information must be available for other medical practitioners looking after patients, subject normally to the patient's informed consent.

- 4.26 New arrangements will be established to provide these integrated services and applications. Inevitably this will involve a period of transition from the current situation during which systems will be upgraded or replaced and new systems will be developed and implemented. Suppliers will need to upgrade their products to meet new national standards in line with agreed national arrangements.
- 4.27 GPs and other healthcare professionals will have access to all the information they need to support delivery of patient care regardless of their location on a real-time basis. The support arrangements for data hosted by GPs will need to reflect this requirement.
- 4.28 The stated strategic direction for information systems to support primary care, including branch surgeries, is that systems must enable:
- (i) clinicians to access appropriate information about individual patients held on other systems for the clinical care and treatment of the patient
  - (ii) users to interrogate and maintain individual patients' electronic health records with appropriate confidentiality safeguards
  - (iii) inter-communication between clinical and administrative systems
  - (iv) remote access to research papers, reviews, guidelines and protocols via the Internet and NHSnet
  - (v) health professionals to access the knowledge base of healthcare at the point of contact with patients
  - (vi) dispensing practices to have synchronous links
  - (vii) the development of a framework for electronic prescribing.

### Ownership and liability issues

- 4.29 To facilitate the use of IM&T within primary care, PCOs, rather than practices, will be responsible for funding the purchase, maintenance, future upgrades and running costs of integrated IT systems as well as telecommunications links to branch surgeries and other NHS infrastructure and services.
- 4.30 This will mean that as new money is spent on providing new systems and upgrading existing systems, PCO ownership of the asset and the responsibility of the PCO to provide the full supporting service, including maintenance, future upgrades, paying for running costs of the new integrated systems and training, will be established at the same time. Under the new contract, IM&T services will be delivered to the practice based on a Service Level Agreement setting out in detail the responsibilities of the system suppliers. Costs of maintaining existing systems up to the point of migration to PCO ownership will be met in full by the PCO.
- 4.31 The GPC will provide an effective stakeholder and specification group for new systems, allowing GPs to be confident that these are fit for purpose and offering GPs the vital guarantees on security and confidentiality referred to in paragraph 4.25.
- 4.32 Future nationally specified IM&T initiatives will be delivered to practices with 100 per cent funding for initial and continuing costs.
- 4.33 PCO ownership of practice IM&T systems (hardware and software) will deliver the following benefits to practices:
- (i) **funding for IM&T systems.** Provision of funding, maintenance, support and future upgrades of practice IM&T systems will be clearly specified
  - (ii) **service level agreements.** These will be based on a national template, allow local enhancements and additions to support future developments, and ensure that practices will receive higher quality IM&T services whilst preserving choice
  - (iii) **supplier management mechanisms.** These will be put in place to manage supplier failure to deliver systems in line with the SLA

- (iv) **nationally accredited systems.** There will be PCO and practice involvement in defining national agreements, standards and systems requirements for national IT programmes which will support integrated healthcare. This will be achieved by the delivery of managed services that support whole communities, not just individual organisations
- (v) **data confidentiality and security.** The PCO will be responsible for ensuring data confidentiality and security are in accordance with agreed protocols
- (vi) **liability.** Liability issues will be fully managed by the PCO in line with local agreements with practices and via UK national service level agreements with suppliers removing the responsibility from the GP.

### Choice of nationally accredited systems

- 4.34 Systems will be accredited against national standards. Each practice will have guaranteed choice from a number of accredited systems that deliver the required functionality. Such choices will be consistent with local development plans (or their equivalents) and in line with local business cases and service level agreements. From 1 April 2003 every practice in the UK will have the choice of RFA-accredited systems. Practices will not subsequently be expected to exercise this right more frequently than every three years.
- 4.35 As patient care is increasingly delivered across multiple organisations, professions and sectors, the ability to implement nationally specified systems to support these arrangements is regarded as essential.
- 4.36 The GPC, NHS Confederation and Health Departments across the four countries appreciate and value the information held in current practice systems. Future strategies will ensure this information is protected.

### Development, implementation and support for primary care IM&T systems

- 4.37 UK standards that accommodate the specific requirements of the four countries will cover the development, implementation and support of IT systems in primary care. These will include standards and protocols relating to the access and management of electronic patient records, including the transition from existing arrangements.
- 4.38 Taking into account the different models of purchasing systems across the four countries, a national template SLA will be developed to support the development of future primary care IT systems providing practices with assurances on training, maintenance and support. The national template will allow local enhancements and additions in line with national programmes.
- 4.39 Practices will receive hardware and software upgrades from their supplier in a rolling programme as specified in their SLA. Mechanisms will be put in place to manage supplier failure to deliver systems in line with the SLA, which may also be subject to periodic reviews of implemented systems against the approved practice business case.
- 4.40 Professional bodies, including the GPC, will be fully involved in the definition of national agreements, standards and systems requirements and service level agreements that underpin them.

### Minimum functionality specification

- 4.41 Work is continuing to develop a minimum functionality specification for practice systems that defines the information requirements to deliver integrated care and meets the requirements of the new GMS contract.

## Education and training in use of IM&T

- 4.42 The initial and continuing education, training and support in the use of IM&T will be managed and properly funded by the PCO as part of a continuing practice development programme. Further information will be provided as part of the overall guidance on implementation of the contract.
- 4.43 In order to fulfil their new contractual obligations, practices will have to enter and retrieve high quality information from their practice clinical systems. Mechanisms will be put in place to ensure practice staff are fully supported with continuing training and education to ensure they are able to:
- (i) use and manage their particular clinical and administrative information systems including data entry and retrieval
  - (ii) understand clinical nomenclatures and classifications
  - (iii) ensure data quality
  - (iv) implement change management and strategies to enable the move from paper to electronic records
  - (v) manage the risks associated with an IT-dependent working environment including disaster recovery and ensuring operational continuity
  - (vi) develop and implement workforce strategies to cope with the summarisation tasks associated with all clinical data flows into the practice.
- 4.44 Practices will ensure that practice IT systems which have been funded in whole or in part under previous NHS funding arrangements will continue to be available to support the new GMS contract on the basis of the new funding arrangements outlined in this chapter.

## Innovation in IM&T

- 4.45 Funding for innovation in the use of IM&T to support and enhance the delivery of patient care in general practice will come from a variety of funding streams including national sources.
- 4.46 It will be important for PCOs to ensure that any funding used to develop IM&T over and above the minimum requirements is in line with each country's IM&T strategy and an evaluation programme is developed.

## GP-to-GP patient record transfer

- 4.47 The new GMS contract requires greater use of the clinical system to record patient information. Key to the successful delivery of efficient and accurate data recording will be ease of transfer of data between practices. The 'GP-to-GP record transfer' project will enable clinical information to be transferred from one clinical system to another without the need for re-keying and therefore will save time and resources.

## Implementation

- 4.48 Arrangements for implementation of the above process will be developed for Scotland, Wales, Northern Ireland and England in line with developing policy. As part of continuing discussions on the implementation of the new contract, the NHS Confederation will consult and negotiate with the GPC about how to address the transitional arrangements and timescales to meet the requirements of the new GMS contract.

## Premises

- 4.49 The contract will support the development of premises through new UK-wide flexibilities accompanied by new UK-wide standards. Funding flows will also change and these are described in chapter 5.
- 4.50 The provision of modern practice premises requires that GPs incur significant cost liabilities that require specific funding scheme arrangements to support their availability. The private sector is increasingly playing the role of provider of capital to build the premises and acting as landlord to its GP tenants through binding legal agreements. Explicit funding scheme arrangements will be available to provide robust, UK-wide arrangements to support GPs on a similarly favourable basis as those for third party developers, in terms of revenue stream, overall return on projects and risk. This will provide stability for GPs as well as giving assurances to funders and landlords that premises costs will attract consistency of support under the new GMS contract.

## Flexibilities

- 4.51 Areas with poor returns on capital have historically attracted low levels of investment in primary care infrastructure. To overcome barriers to investment, a first tranche of premises flexibilities has already been introduced. A second tranche was set out in the April 2002 framework. This was designed to overcome hurdles to capital investment in primary care and to enable GPs to move from old to modern premises. These changes have been introduced to maintain GP choice in investment routes and to provide parity in access to funding. It will be implemented from April 2003 and contains the following flexibilities:
- (i) the payment of a grant to meet mortgage deficit costs, to enable GPs to sell their existing premises and move to appropriate alternative premises
  - (ii) the payment of a grant to meet mortgage redemption costs
  - (iii) allowing PCOs to take an option on land
  - (iv) allowing PCOs to continue cost rent payments to GPs who buy premises from a single-handed/two partner practice
  - (v) allowing PCOs to review cost rent payments when GPs re-mortgage to lower interest rates
  - (vi) reimbursement of legal and other professional fees for GPs in new premises developed by public-private partnership
  - (vii) revised arrangements to pay notional rent in addition to cost rent when premises are modernised or extended
  - (viii) abatement of notional rent to pay full notional rent on GP capital invested in premises and abated notional rent for NHS capital equivalent to additional costs for heating, lighting, maintenance etc
  - (ix) payment of notional rent to leaseholder GPs who improve their premises
  - (x) extension of the timescale to repay improvement grants and PMS equivalents to 10 years for owner-occupiers and for renting GPs to re-negotiate the terms of their lease to 15 years
  - (xi) allowing PCOs to directly reimburse insurance and utility costs, maintenance and service charges etc
  - (xii) introducing periodic (potentially quarterly) reviews of building cost location factors
  - (xiii) introducing index-linked leases (eg RPI-based) to support capital invested in primary care premises better
  - (xiv) a revised premises schedule and a revised commentary
  - (xv) issuing a letter on safeguards and security for GPs signing leases with third party developers with the intention that PCOs will be able to have a lease assigned to them temporarily if the departing GP is unable to assign it.

## Quality standards

- 4.52 The new contract introduces a new set of quality standards. Subject to appropriate funding agreed between the PCO and the practice, premises will not be accepted unless the accommodation provided is deemed by the PCO, following a visit, as satisfying the minimum standards. The visiting team will include representatives of the PCO and the LMC (or its equivalent). The standards which should apply to both main and branch/split-site surgeries to include the following:
- (i) practices should take reasonable steps to comply with the Disability Discrimination Act 1995. This includes providing for all users of the building ease of access to premises and movement within them, adequate sound and visual systems for the hearing and visually impaired, and the removal of barriers to the employment of disabled people. Adequate facilities should also be provided for the elderly and young children, including nappy-changing and feeding facilities
  - (ii) a properly equipped treatment room, where provided, and a properly equipped consulting room for use by the practitioners with adequate arrangements to ensure the privacy of consultations and the right of patients to personal privacy when dressing or undressing, either in a separate examination room or in a screened-off area around an examination couch within the treatment room or the consulting room. An additional treatment room may be required where enhanced minor injury services are provided
  - (iii) practitioners, staff and patients having convenient access, including wheelchair access where reasonably possible, to adequate lavatory and hand washing facilities which meet current infection control standards. There should be washbasins connected to running hot and cold water in consulting rooms and treatment areas or, if this is not possible, then in an immediately adjacent room
  - (iv) adequate internal waiting areas with enough seating to meet all normal requirements and provision, either in the reception area or elsewhere, for patients to communicate confidentially with reception staff including by telephone
  - (v) the premises, fittings and furniture to be kept clean and in good repair, with adequate standards of lighting, heating and ventilation
  - (vi) adequate arrangements for the storage and disposal of clinical waste
  - (vii) adequate fire precautions, including provision for safe exit from the premises, designed in accordance with the Building Regulations agreed with the local fire authority
  - (viii) adequate security for drugs, records, prescription pads and pads of doctors' statements
  - (ix) where the premises are used for minor surgery or the treatment of minor injuries, a room suitably equipped for the procedures to be carried out.

## Branch/split-site surgeries

- 4.53 Unavoidable costs of branch surgeries cannot be adequately picked up through the allocation formula which is unlikely to reflect the increased infrastructure costs of split-site/branch surgeries. Branch surgeries and outlying facilities can vary in size and quality and existing or proposed new facilities can improve patient access to services where convenient access to main surgery facilities is difficult.
- 4.54 For a branch surgery to qualify as a second main/split-site it should meet the following criteria:
- (i) be open for at least 20 hours a week for provision of medical services automatically entitling it to proper IT support
  - (ii) meet the minimum standards set out in paragraph 4.52 above
  - (iii) deliver essential and additional services.

- 4.55 Branch surgeries that do not meet the above criteria will not automatically be considered eligible for the funding as a second main/split-site surgery. In addition, where it is deemed that proper services cannot be supplied on such sub-standard premises action should be taken as set out in paragraph 4.58. Where the shortcomings cannot be remedied or the cost of doing so is disproportionate to improvements in service delivery, and following public consultation, the premises can be closed.
- 4.56 A branch surgery can be closed subject to agreement between the PCO and providing practice. In the event that there is no agreement the practice can give notice that it wishes to close a branch surgery. There will be a given period in which the PCO can issue a counter-notice, to allow for any required consultation, requiring the surgery to remain open until the issue is resolved. Normal appeal procedures will apply. If the branch surgery is unable to close, because a counter-notice was successful, or where both the practice and the PCO agree that the surgery should remain open, then the PCO is required to continue supporting it with the necessary funding.
- 4.57 Branch surgery standards need not be fully met where a practice provides outlying consultation facilities using premises usually used for other purposes.
- 4.58 Following a visit, PCOs will determine whether premises accepted for the delivery of services are continuing to meet the relevant standards. If there are shortcomings:
- (i) the LMCs (or GP subcommittee of the Area Medical Committee) will be consulted
  - (ii) where the shortcomings can be rectified, the practice will agree with the PCO within a month how the shortcomings can be rectified within a reasonable period of time, ensuring that patient safety is not at risk
  - (iii) if the shortcomings have not been put right within six months (or such longer period as may be agreed between the practice and the PCO) premises payments will cease or be abated, until the shortcomings have been put right
  - (iv) a practice may appeal against the PCO decisions in line with the arrangements described in chapter 7.
- 4.59 Specific arrangements for implementation of the premises flexibilities and standards will be developed for Scotland, Wales and Northern Ireland. In Wales, separate allocation arrangements will apply to premises funding. From April 2004, subject to primary legislation, there will be a Welsh GMS Premises Fund that will be held by the National Assembly for Wales. Local Health Boards will be guaranteed baseline funding to support existing projects and projects that have already been agreed. Baselines will be updated annually for property cost inflation. Decisions on growth money will be taken by the Assembly, taking account of the needs of Local Health Boards as set out in their Estate Strategies and on specialist advice provided by Welsh Health Estates.

## 5 Investing in primary care services

- 5.1 This chapter sets out how the new contract will:
- (i) bring unprecedented guaranteed UK-wide investment to primary care over a three year period, raising total spend by 33 per cent from £6.1bn to £8.0bn
  - (ii) recognise the differential workload associated with the needs of different patients, and the costs arising from different practice circumstances, through the new Carr-Hill resource allocation formula
  - (iii) provide a guaranteed level of resources, and allow practices flexibility in how they spend the resources received, through global sum payments on the basis of the Carr-Hill formula from 2004/05. Transitional protection of income will also be provided
  - (iv) support the growth of enhanced services without destabilising existing payments for Local Development Schemes, GPwSIs, delivering improved access, and local incentive schemes, through a funding floor in England of £315m in 2003/04, £518m in 2004/05, and £586m in 2005/06. Comparable funding arrangements will apply in the other countries
  - (v) provide for a range of other payments for specific purposes
  - (vi) change the ways in which funds flow between the Health Departments, PCOs and practices, to support these new arrangements
  - (vii) improve GP pension arrangements.

### Additional investment

- 5.2 If the GMS contract is accepted by the profession, UK expenditure on primary care will rise from around £6.1bn in 2002/03 to £8.0bn in 2005/06, an unprecedented increase of 33 per cent. About two-thirds of the increased investment will be spent on rewards for higher quality.
- 5.3 This expenditure covers all GPs including those in PMS. The English and Scottish Health Departments are considering the basis on which increases in PMS income will be calculated in future. There are no PMS practices in Wales or Northern Ireland.

### Gross Investment Guarantee

- 5.4 Under the old contract, the Doctors' and Dentists' Review Body (DDRB) made recommendations about changes to the GMS feescale needed to deliver an Intended Average Net Income (IANI) for GPs, based on the expected level of expenses incurred by GPs.
- 5.5 Overestimation of GP expenses and other factors have also led to overpayment of GPs according to the old contract methodology. According to the DDRB's 2001 report the debt amounted to £7,214 per GP. The latest Technical Steering Committee (TSC) work shows this figure is now £6,688 per GP. This figure would have been progressively clawed back under the old contract. The transition from the old contract to the new will see the debt written off. On the basis of the balancing mechanism which the DDRB has operated since 1983, the amount of debt written off would represent 2.4 per cent of net income in 2003/04, 1.5 per cent in 2004/05, and 1.2 per cent in 2005/06.
- 5.6 The new contract will move away from this complex structure of IANI, expenses and the balancing mechanism and its associated problems. Under the new contract the concept of the intended average net remuneration for GP principals will disappear. Instead, increases in resources from 2003/04 will be based on an intended overall level of investment in primary care for doctors. The main ways of increasing investment beyond

2005/06 will be through uplifts to the global sum, increases in quality payments and enhanced services but there could also be increases in other funding streams.

- 5.7 The new contract will provide a **Gross Investment Guarantee** that the resources promised in this document will be delivered. To ensure delivery of this the pricing of the contract could be adjusted. The level of investment in will be monitored by the TSC, which will in future include the NHS Confederation and Northern Ireland representation. The information from the TSC will be used to inform negotiations between the Health Departments and the GPC on the future pricing of the contract.
- 5.8 The TSC will also oversee a new UK-wide annual survey of GP workload beginning in 2003/04. The TSC will monitor factors including workload, skill mix, resource use, GP net incomes and expenses and will inform future levels of resourcing for primary care, future DDRB awards for general practice and the development of the Carr-Hill formula.

## Investment in enhanced services

- 5.9 The TSC monitoring will include investment in enhanced services which will also be performance-managed by Strategic Health Authorities (or their equivalents) to ensure effective and appropriate deployment. Given that the purpose of the guaranteed expenditure floor is to develop new services, any spend on enhanced services where these are currently being funded from GMS monies (excluding LDS) will not count towards the Gross Investment Guarantee. The floor includes significant new investment to be spent on developing new services at the primary and secondary care interface, and on managing demand in primary and secondary care by resourcing the shift of services from secondary to primary care. It will reward innovation.
- 5.10 PCOs will be required to consult their constituent local practices, LMCs (or their equivalents) and Patient Forums (or their equivalents) about the level of investment they propose to make on enhanced services, and how it will be used in line with the PCO's strategic objectives. Were the PCO not to develop adequate plans for developing enhanced services in primary care the Strategic Health Authority (or its equivalent) will intervene to ensure that the guaranteed floor is not breached and is spent for the purposes intended.

## GMS allocation formula

- 5.11 Under the existing contract, practices receive per doctor payments such as the basic practice allowance, capitation fees and item of service payments. The current arrangements have meant that:
- (i) casemix is not adequately reflected
  - (ii) differing practice circumstances are not adequately taken into account
  - (iii) resources follow the distribution of doctors rather than patients and their needs
  - (iv) resources are lost if the number of doctors in a practice reduces
  - (v) practices do not have security of income
  - (vi) changes in skill mix are not encouraged
  - (vii) practices have insufficient financial incentives to provide high quality care.
- 5.12 The introduction of a global sum payment, combined with new rewards for quality, will address these flaws. A new GMS resource allocation formula, developed by Professor Roy Carr-Hill of York University, will provide the basis for allocating funds for global sum resources and for quality payments.

- 5.13 The Carr-Hill formula, a report of which is published separately in supporting documentation takes account of six key determinants of practice workload and circumstances:
- (i) patient gender and age for frequency and length of surgery and home visit contacts
  - (ii) patient gender and age for nursing and residential home consultations. The research which lies behind the formula shows these to be an average of 1.43 times higher than (i) by age and gender band
  - (iii) morbidity and mortality
  - (iv) newly registered patients, who generate around 40 per cent more workload in the first year than the average
  - (v) unavoidable costs of rurality, to take account of population density and dispersion
  - (vi) unavoidable higher costs of living through a Market Forces Factor applied to all practice staff. In particular, this will compensate for those additional costs involved in delivering services in areas such as the south east of England.
- 5.14 The formula is to be applied using a common methodology across all four countries to calculate the global sum and the quality payments in line with the scorecard arrangements described in chapter 3. The calculation of the relevant global sums will not impact on the distribution of resources across the four countries. These resources will continue to be allocated on the basis of the Barnett formula.
- 5.15 Separate adjustments for Scotland will reflect the specific circumstances of practices in Scotland. The continuing need for these adjustments will form part of the review of the formula. There will be an off-formula adjustment recognising the particular circumstances of practices in London. An adjustment may also be required in Northern Ireland in the light of statutory equality impact assessments under section 75 of the Northern Ireland Act 1988. As more comprehensive data become available it is intended to review the need for such adjustments. The weightings associated with each factor, including the adjustments in Scotland, are shown in the supporting documentation. Applying the indices together to a practice's population creates a practice weighting. In Scotland, references to the Carr-Hill formula and weighted populations will be based on the adjustments made to take into account these specific circumstances.
- 5.16 To calculate practice entitlement under the global sum, the list size adjusted for list inflation will be multiplied by the practice weighting. At present, most of the current fees and allowances on each GP list are scaled back by six per cent to take account of list inflation - the practice registered population is around six per cent higher than the Office for National Statistics (ONS) population estimates. This unfairly penalises those areas of the country where list inflation is lower. A more equitable method will apply in future as practice list size information becomes more accurate. Each PCO population will be scaled back to its own census population estimate. PCOs will then scale back the practice lists, taking into account the PCO average list inflation, rather than the national average.
- 5.17 A further additional need is the treatment of temporary residents and the provision of immediately necessary and emergency treatment. This additional need is reflected in the global sum (see chapter 2).
- 5.18 Further unavoidable costs may arise in certain geographical areas, where the physical location of the practice or distance from other healthcare providers means that the practice provides a wider range of services. These will be addressed through additional support for the most isolated and remote practices. This support will be provided by the PCO according to local practice needs.
- 5.19 Although we believe the formula to be robust, given the available data, it will inevitably not be a perfect model of the future workload and of the costs that practices may face. When dealing with practice size populations it is very unlikely that any formula could wholly accurately predict demand, due to random fluctuations.

- 5.20 The formula will be revised in the light of more timely and accurate data being available. Beyond 2005/06, we anticipate that the additional needs adjustment will take account of new practice-level information on disease prevalence following collection of data in the quality framework. Practices will therefore wish to ensure accurate reporting of prevalence in their disease registers given that this could affect future entitlement under the global sum and quality payments.

## Global sum payments

- 5.21 The global sum includes provision for the delivery of essential and additional services, staff costs, locum reimbursement including for appraisal, career development, and protected time. Provision for uplifting non-medical staff costs as a result of the principles of *Agenda for Change* has been, and will continue to be, included in the arrangements for revising the global sum.
- 5.22 Resources will be allocated to PCOs which, in turn, will be obliged to allocate resources to practices in accordance with UK-wide arrangements guaranteed in law. An average UK practice, with an average practice weighted population,<sup>8</sup> will receive £300,000 in 2004/05, an average per patient of £53 and £305,000 in 2005/06, an average per patient of £54. It is important to recognise that there is a balance between the money allocated through the global sum and the likely potential for achieving higher rewards within the quality and outcomes framework. When assessing the impact of the new contract, practices should take into account not only the resources they are likely to receive through the global sum, but also the substantial potential income from the delivery of quality and the provision of enhanced services.
- 5.23 The global sum will be allocated to practices on the basis of the Carr-Hill formula from 2004/05 as part of the introduction of the practice-based contract. The formula will be implemented in full from 2004/05 to ensure the principle of equity applies at the earliest possible opportunity.

## Transitional protection

- 5.24 The formula inevitably has a significant redistributive effect at PCO and practice level, given the shift from largely doctor-based allocations to patient needs-based allocations. However, it is vital that the process does not destabilise existing practices. Those areas which have been under-resourced under the existing funding arrangements will for the first time receive a fair entitlement to GMS monies.
- 5.25 To allow PCOs and practices to manage the impact of this, transitional protection will apply from 2004 on an individual practice basis. Practices will be asked to submit details of their 2002/03 income on fees and allowances during 2003/04, in the form of a standard template, and validation checks will be carried out by PCOs. This will enable the calculation of the initial baseline against which transitional protection will be assessed.
- 5.26 This initial baseline will be adjusted to take account of quality preparation and aspiration payments to determine the final amount. In order not to disincentivise the achievement of higher quality, the transitional support will assume a modest baseline level of aspiration payment throughout the three year period. This will be set at 100 points for 2004/05, 150 points for 2005/06 and 200 points for 2006/07. As a consequence, those practices achieving higher quality payments will continue to be rewarded, as quality achievement payments will be excluded from the transitional protection calculation. The amount of transitional support will be adjusted for the cost of opting out from additional services and out-of-hours.
- 5.27 Transitional protection will be provided until March 2007 when it is anticipated that adjustments arising from the review of the formula, including the impact on any further transition, might be implemented.

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<sup>8</sup> An average practice, with a list of around 5,500 patients, with around three whole time equivalent GP principals and average population needs and service delivery costs.

- 5.28 PCOs will be given an initial allocation of resources on the basis of the data they submit early in 2003/04. Sums of £297m and £197m have been put aside for 2004/05 and 2005/06 respectively. Practices will be reassured that this is higher than the total level of support that we believe is necessary, on the basis of current data, given that it does not take account of quality aspiration payments. The principles of the Gross Investment Guarantee will apply. If, for example, there is a need for additional transitional protection beyond the amount set aside, any underspends on quality or the unified budget could be used to increase the spend on transitional protection. The GPC will be fully involved in working up these precise arrangements.
- 5.29 Under the modelling of the total resource envelope it has been anticipated that full transitional protection will be available in 2004/05, and a modest reduction in 2005/06 and 2006/07.
- 5.30 Replacing some of the existing fees and allowances with global sum payments from 2003 could create losers next year; require a separate transitional protection scheme; reduce the overall across-the-board pay award to GPs; and increase the risk of late payments given the need to make rapid changes to the GP payments systems. To avoid these problems, in 2003/04 fees and allowances will be uplifted and practices will also gain from substantial investment in modernisation including additional income arising from quality preparation payments, the new retention payment, improvements to the seniority scale, the write-off of existing GP debt and increased investment in enhanced services.
- 5.31 The global sum will be calculated quarterly to reflect changing practice circumstances and paid monthly. PCOs will supply the relevant practice level data every three months to centralised systems which will make the calculations in each country.

## Other PCO-administered resources

- 5.32 PCOs will also receive funding for the new retention payments and improved seniority payments, golden hellos, maternity, paternity and adoptive leave and sick leave. Practice entitlement to these payments is non-discretionary for the PCO. These resources will be administered by the PCO and drawn down by practices as a supplement to their global sum.
- 5.33 The designated area allowance, specific rural and remote payments and inducement payments will be replaced. The initial development of practices in greenfield sites will be supported through new money provided through the unified budget. When the new practice is financially viable it will be funded through the global sum.

## Funding flows

- 5.34 To support the arrangements set out in this section, and give confidence to GPs that the pricing of the contract is fixed and not subject to PCO discretion, the entitlements will be guaranteed, including, where appropriate, in regulations or legal determinations. While it is expected that funding flows in Northern Ireland will, in time, involve the use of unified budgets, the present systems and structures are unable to accommodate this. In the interim, for the purposes of the GMS contract, the principles set out above will equally apply in Northern Ireland albeit via different funding structures.
- 5.35 A total sum in respect of GMS services will be allocated to each PCO as part of an enlarged unified budget allocation. This allocation method will replace the existing arrangement whereby PCOs draw down money from the Health Departments according to the fees and allowances paid, and will be provided for in primary legislation. Spend on the component parts will then be monitored by the reconstituted TSC. PCOs will be responsible for administering the GMS budget locally.

## Quality

- 5.36 PCOs will receive full funding from the Health Departments allocated on the basis of the Carr-Hill formula, such that they can afford to pay all practices for achieving high quality. They will be responsible for distributing this element of their budget and will be required by law to pay practices the fixed reward per point described in chapter 3. In this way, the existing 'GMS pool' arrangements, whereby high overall payments to GPs can lead to a reduction in GMS fees and allowances, will end.

## Premises

- 5.37 Separate allocation arrangements will apply to premises. Under current arrangements, GPs receive premises payments through a variety of routes. Notional and actual rents and ongoing rents for vacated premises are funded from the centrally managed and locally paid non-cash limited GMS budget. Cost rents, improvement grants and grants to surrender leases are funded by PCOs from their cash-limited unified budgets. At present, all premises payments to GPs are paid out as revenue with the large majority paid recurrently.
- 5.38 Under the new GMS contract, all premises funding will form part of a single fund in each country from 2004/05, subject to primary legislation. This fund will operate alongside the global sum and the quality framework. The arrangements for distribution of these resources into the NHS will be reviewed.
- 5.39 In England, a lead PCT within each Strategic Health Authority (or its equivalent) will hold the resources for premises on behalf of all PCTs within the Strategic Health Authority (or its equivalent). Decisions on the distribution of these funds to individual PCTs will be subject to joint arrangements with the Strategic Health Authority (or its equivalent) holding the ring.
- 5.40 Existing spend, and additional funds needed to support new projects that have already been agreed between practices and PCTs, will be guaranteed to PCTs as a baseline. This will ensure that allocations match existing spend of individual PCTs, their future investment needs, and their capacity to deliver. This baseline will be updated annually for property cost inflation. These baselines are being prepared with the Valuation Office Agency.
- 5.41 Decisions on allocating growth monies to PCTs, over and above existing commitments for growth, will be taken jointly by the PCTs with the Strategic Health Authority (or its equivalent) holding the ring and supporting how the lead PCT determines allocations to PCTs based on local priorities and PCT needs and capacity as set out in their Strategic Service Development Plans. This arrangement will be similar to the responsibilities Strategic Health Authorities (or their equivalents) have for strategic capital investment in hospitals.
- 5.42 Once agreement has been reached for a programme to go ahead, the funding will be allocated recurrently to the PCT to meet the revenue consequences of new capital investment in GP premises. Any capital charge liability that arises from direct PCT involvement in the development will need to be recognised. This will provide GPs and the private sector with assurances on funding being available to support premises developments agreed by PCTs and Strategic Health Authorities (or their equivalents).
- 5.43 The lead PCT arrangement in each Strategic Health Authority (or its equivalent) will be developed for prioritising new investment in 2003/04, and to meet the revenue consequences for it from 2004/05 onwards.
- 5.44 The existing SFA provisions for premises costs will be replaced. Under the new funding arrangements, PCOs will have greater flexibility in funding premises to allow, for example, investment in premises to facilitate delivery of an extended range of enhanced primary medical services. Under the new contract, there will be a system of rules which set

minimum standards for new or refurbished buildings and guidance which offers support to PCOs on costs by setting benchmark costs rather than limits.

- 5.45 A first tranche of premises flexibilities was introduced in January 2000 and those that involve payments to GPs are met from a mix of funding sources. The second tranche set out in the framework agreement will be introduced from April 2003. Following introduction, costs for use of all flexibilities that involve a payment to GPs will initially be met from the existing GMS non-cash limited funding stream.
- 5.46 Separate arrangements will apply in Scotland, Wales and Northern Ireland because of their different NHS structures and funding arrangements.

## Dispensing and stock order

- 5.47 Issues relating to dispensing, stock order and CSSD will be addressed by a separate expert group including GPC representation to consider future potential changes. The negotiating parties will be scoping the feasibility of introducing a stock order system in England and Wales similar to that which exists in Scotland and Northern Ireland. The group will report by September 2003. The money to fund doctor dispensing will form a separate source of funding outwith the global sum. The current payments system will continue but with higher payment rates to reflect the transfer of reimbursed dispenser costs from the global sum and the intention to separate dispensing payment arrangements from those for GMS.

## Pensions

- 5.48 GPs' pensions are calculated under a career earnings method rather than a final salary scheme. Each year of pensionable income is increased by an uprating or dynamising factor on a cumulative basis. The uprating factor is currently based on year on year changes in the Intended Average Net Income (IANI). An accrual rate is then applied on retirement age to the individual GP's total uprated career earnings to provide an annual pension entitlement. In addition, a tax-free lump sum of three times the annual pension is payable. Once a pension is being paid, it is uprated annually by retail price inflation.
- 5.49 Many GPs believe that their current pension arrangements are unsatisfactory. In particular, they are concerned that:
- (i) pensions are unfair relative to the pensions that consultants receive given their respective NHS earnings
  - (ii) their pensions do not take account of all NHS earnings, unlike the pensions of their PMS counterparts, and some locum work is not superannuable
  - (iii) practice manager partners are excluded from the scheme, as are staff who work for not-for-profit GP out-of-hours co-operatives which provide services to the NHS
  - (iv) the uprating factor is not based on changes year on year in all NHS earnings
  - (v) differences between how officer and practitioner pensions are calculated can militate against the development of portfolio careers.

These concerns will be addressed under the new GMS contract.

- 5.50 As a result of the increased investment guaranteed under the new contract, average practice income will rise. It is not possible to state how much that rise is likely to be, given that the future ratio of profit to expenses is unknown and the concept of IANI will disappear. The pensions changes that will be made will mean that, over time, the total percentage increase in pensions should exceed the percentage increase in net income, because of the change in the definition of pensionable earnings. The additional spend on pensions is in addition to the Gross Investment Guarantee.

## Definition of pensionable pay

- 5.51 If the profession accepts the new contract, the definition of pensionable pay will be broadened. Under the new GMS contract, it will include net profits derived from the payments made to GPs in the respect of NHS work in the following circumstances:
- (i) delivering services as a GMS or PMS provider, excluding work delegated to others
  - (ii) delivering services under delegation directly from GMS or PMS providers, including locum work
  - (iii) board, advisory or other work including delivering services carried out under employment with PCOs or other NHS bodies
  - (iv) work carried out as NHS services under the collaborative arrangements with Local Authorities
  - (v) practice-based work carried out in educating or in organising the education of medical students, undergraduate, vocational and postgraduate training funded through national levies or otherwise
  - (vi) certification under the requirements of Schedule 9 of the NHS (General Medical Services) Regulation 1992 as amended and the Scotland and Northern Ireland equivalents.

This definition will be kept under review. This will ensure that it can be expanded to cater for unforeseen future developments.

- 5.52 The change will provide new incentives for GPs to engage in delivering a wider range of NHS services. It will also enable certain GP co-operatives to become NHS bodies for the purposes of pensions regulations. NHS work undertaken by GPs for commercial organisations will not be pensionable, in line with wider Government policy.
- 5.53 In response to concerns raised by the GPC, regulations will also shortly be laid to enable GP locum earnings to become pensionable retrospectively back to 2002/03.

## Calculating superannuable profits

- 5.54 GPs will make monthly payments on account to the Pensions Agency for their employer and employee superannuation contributions. When the practice accounts have been finalised, the practice accountants will produce a certificate of NHS profits in specified form to be forwarded to the Pensions Agency with any balance in payment.
- 5.55 From 1 April 2004, we expect that all practice employers' and employees' contributions will be allocated to practices when responsibility for the full costs of employers' contributions, including pensions indexation costs, is devolved to NHS employers.

## Uprating (dynamisation) factor

- 5.56 It is essential that practitioners have certainty about the factor that will be applied at the point in time when they are contemplating retirement, and yet the abolition of IANI necessarily means that the actual year-on-year change in earnings cannot be known in advance. Equally, practitioners reasonably expect that increases in earnings that accrue under the new contract will be fully reflected in the uprating factor as soon as is feasible.
- 5.57 The uprating factor is currently based on the year on year percentage increase in IANI. IANI will disappear as a concept and a new method will be needed. We intend that the uprating factor, moving forward, should be based on the year on year percentage change in all pensionable earnings from NHS work (the aggregate of net NHS pensionable income, divided by the number of practitioners), adjusted by the TSC annually to allow for the shift towards less than full-time working. The TSC will also rebase the uprating factor on 1 April 2004 to ensure that the transfer of out-of-hours work does not depress the uprating factor.

- 5.58 Aggregated net pensionable NHS GP income will be derived from the employers' contributions. The uprating factor will never be less than one.

## Pensions flexibilities

- 5.59 In line with good human resource management practice, three new pension flexibilities will also be introduced to facilitate portfolio careers for GPs who may wish to work at some stage as salaried GPs and independent contractors or in other NHS service:
- (i) **service before becoming a principal practitioner.** Under the current arrangements, this service is treated in whichever of the following ways achieves the better outcome:
    - (a) as a separate officer (ie employed doctor) pension, or
    - (b) by conversion of the service into a GP pension through increasing the GP pension proportionately

Under the new contract, a further option will be available which is to treat the income from this service as GP income and uprate it in the normal way. It is anticipated that in certain circumstances this additional option is likely to be of benefit to part-time GPs
  - (ii) **salaried service concurrent with GP service.** This is currently treated as officer service and pensioned separately (if more than one year). Under the new contract, a second option will be introduced which is to treat this income as GP income and uprate it in the normal way
  - (iii) **when a self-employed GP becomes salaried.** The practitioner pension will continue to be uprated, and not just index-linked to the retail prices index, as now
  - (iv) **purchase of added years.** Under the current arrangements, where the purchase of added years takes place before the doctor becomes a self-employed GP, it is possible that this purchase will cause total pre-GP service to exceed 10 years. In that case, the option to convert this service to GP service (explained in (i) above) does not apply and the pension has to be taken as a separate officer pension. Under the new contract, a second option will be introduced which is to convert the final officer salary during the added years purchase into a pay credit and then to uprate this immediately along with GP pay.
- 5.60 The improved flexibility set out in clauses (i) to (iv) above will apply to the pensions of GPs who retire from 1 April 2003.
- 5.61 In PMS, active non-practitioner providers are eligible to join the NHS pension scheme. To ensure flexibility and equity of treatment with PMS, the same flexibility will apply under the new GMS contract.

## 6 Better services for patients

- 6.1 The new GMS contract offers many benefits for family doctors and other members of the primary health care team. But its ultimate purpose is to improve patient care. This chapter sets out how key changes within the new contract will help deliver this through new responsibilities and rights including:
- (i) the allocation of resources to practices according to patients' needs
  - (ii) choice of practice supported by better information
  - (iii) choice of practitioner
  - (iv) a Patient Services Guarantee, and access to a wider range of services
  - (v) higher quality services
  - (vi) the collection of patients' experience through practice surveys and involvement in service development
  - (vii) a programme of initiatives involving patients to manage demand for services.

### Allocation of resources to meet patients' needs

- 6.2 Under the new contract, resources for the basic practice infrastructure will be allocated to practices on the basis of the weighted needs of their patient population. The allocation formula is described in chapter 5. This new arrangement replaces the old contractual model where resources were made available on the basis of the number of doctors in a particular area. This meant that if an area was under-doctored, or lost doctors through retirement or career changes, the remaining doctors were left with greatly reduced resource available to them in order to meet the continuing needs of their patients.
- 6.3 Under the old contract little or no account was taken of the differing needs of patients in allocating resources to different practices. This will now change. With the exception of premises and IM&T, resources for the infrastructure costs of staffing and basic operating costs will be allocated to practices on the weighted needs of the population they serve. This will be independent of the number of doctors in the practice. If a doctor, nurse or staff member leaves the practice, the resources will remain. This will allow the practice to reorganise the service or increase their remuneration in order to recognise the increased workload experienced as a consequence.
- 6.4 Typically, as the new formula is introduced, patients will benefit from the increased resources available, particularly in areas with older populations, with high mortality and morbidity levels, with higher staff costs, or serving rural and remote areas.
- 6.5 The global sum funding arrangements will also mean that practices have greater flexibility to organise their services in whatever way best enables them to deliver high quality services for their patients.

### Practice assignment and choice of practice

- 6.6 Patients will continue to be free to register with any local practice that is open and practices will continue to have discretion over new patient registrations. However, it is expected that in exercising this discretion, practices will have reasonable and fair grounds for doing so.
- 6.7 Even if all the local practices have closed lists, patients will still be able to register and obtain services through arrangements made by PCOs.
- 6.8 Patient choice will be supported by better local information. Patients will receive this through:

- (i) information provided by the PCO about different practices, for example, the PCT prospectus in England
- (ii) the practice leaflet which will set out information on opening times and the services offered by the practice.

The requirement to produce such information will be supported by legislation.

- 6.9 Practices that have not gone through the procedures set out in paragraphs 6.12 to 6.18 below will be required to accept assigned patients. This is important given that the new processes are intended to facilitate the dialogue between practices and the PCO at 'stage one' about how the practice could be assisted to handle its workload and what support the PCO can provide. These procedures should focus the attention of both the practice and the PCO on the workload pressures and will ensure that the need for forced patient assignments is progressively reduced to zero.
- 6.10 The new arrangements will:
- (i) introduce a formal transparent process to establish list closure
  - (ii) include a right to have a proposed closure reviewed by an assessment panel and a specific right of appeal against an adverse assessment to the Strategic Health Authority (or its equivalent)
  - (iii) require PCOs to take all reasonable measures to minimise the need for forced assignment of patients.
- 6.11 Where a practice is closed to assignments following the procedure set out below it is then closed to all patients with the exception of the immediate family of existing patients.
- 6.12 Where a practice has concerns about workload it can seek to apply to close its list following the process set out below. It is expected, that in the large majority of cases, there will be no need to progress further than stage one.

#### Stage one

- 6.13 Discussions will take place between the practice and the PCO focusing on what additional support the practice could receive to keep its list open, the options for alternative provision including the feasibility of the PCO or other practices registering patients for the provision of GMS and the appointment by the practice of a salaried doctor or a nurse practitioner or other support staff. These discussions will normally take place within seven days of a notification by a practice that it may wish to close its list. The practice will be obliged to cooperate with the PCO in undertaking this review and, where appropriate, putting in place agreed changes.

#### Stage two

- 6.14 Following the procedures in stage one, which should be completed within 28 days, if the practice and PCO agree that list closure is inevitable, the practice will formally confirm that it wishes to close its list by submission of a closure notice. When such a notice has been served, it cannot be withdrawn within a period of three months unless the PCO agrees. This is to discourage ill-considered or inappropriate requests for list closure.
- 6.15 Within 14 days of receiving the notice, the PCO must either:
- (i) approve the closure notice, in which case the practice list closes either for a period of 12 months, or until the number of patients recorded on the practice list has reduced by a percentage of the practice list size agreed by the PCO and the practice, or until the list size has fallen to the lower limit of an agreed specified range, which will apply for a twelve-month period, or by agreement otherwise between the practice and the PCO or
  - (ii) reject the closure notice, in which case the notice will be remitted immediately for determination by an assessment panel under the dispute resolution procedures set out in chapter 7.

- 6.16 Where the range mechanism is used the list closure will be suspended when the lower figure of the range is reached. The practice list will then reopen for applicant or assigned patients, until the higher figure in the range is reached when the lists would close again until the lower figure is reached.

### Stage three

- 6.17 Where necessary, each PCO will establish an assessment panel, both to consider practice closure notices which have been rejected by the PCO and to determine how requests for new patient registrations should be dealt with where there is mass closure. The assessment panel will comprise: a PCO Chief Executive, a patient representative, an LMC representative (or its equivalent) and a Director from the Strategic Health Authority (or its equivalent).
- 6.18 The procedure will be investigative and not adversarial. The panel will consider the individual circumstances affecting the applicant practice.
- 6.19 If a situation arises where most or all of the practices in a particular area are likely to have closed their lists to forced assignments, the assessment panel will determine how requests for new patient registrations should be dealt with. In such cases the Strategic Health Authority (or its equivalent) can insist that a separate review will be held to determine what arrangements should be put in place by the PCO to prevent the need for forced assignments.
- 6.20 Each rejected closure notice will be considered on its merits to prevent different standards being applied to the first or last practice to apply for list closure in a particular area. Both the PCO and the applicant practice will be required to demonstrate that they have satisfied the respective steps required of them in stage one. To help inform its decisions, the practice should be visited by at least one of the panel members.
- 6.21 The determination must be made within 28 days of the reference made in accordance with paragraph 6.15(ii). The panel can either:
- (i) agree that the list may close within seven days
  - (ii) disagree, in which case the list will remain open. However, it will then be incumbent on the PCO to have further discussions with the practice concerning what assistance can be given to the practice to allow it to discharge its responsibilities to its patients in a safe and effective manner. The practice will not normally be able to reapply for list closure within three months from the date of the determination of the Panel unless there is a significant change in circumstances.
- 6.22 Practices with closed lists will have a fast-track right of appeal to the Strategic Health Authority (or its equivalent) against an adverse decision made by the assessment panel in respect of forced allocations. The Strategic Health Authority (or its equivalent) will consider whether the PCO has taken all practicable steps to secure accessible alternative provision.
- 6.23 The fast-track appeal process will be initiated within seven days from the date of determination of the assessment panel and will be completed within 21 days after the notice of appeal.
- 6.24 Where all processes have been followed and there is no option other than to force an assignment, the PCO will discuss with the practice what additional support is required until such time as the practice list is open.
- 6.25 A copy of each panel decision will be sent to the relevant Strategic Health Authority (or its equivalent). The PCO and Strategic Health Authority (or its equivalent) will include details of decisions made by the panel, or on appeal the Strategic Health Authority (or its equivalent), in their annual reports. In addition, the PCO's management of list closure issues will be taken into account when decisions are made in respect of the PCO's star ratings or equivalent rankings and levels of forced assignments will be published.

- 6.26 During the period of the process set out above, it is important that patients continue to have access to primary medical services and they will continue to have access to services under the immediate/necessary/emergency rules.
- 6.27 Practices that seek formally to close their lists do so in order to manage excessive workload. For this reason, whilst formal list closure will not prevent a practice from applying to provide opted-out additional services to the patients of other practices or to provide enhanced services, it is likely to prejudice its application.
- 6.28 These new arrangements will help make assignment of patients to closed lists a thing of the past. PCOs will no longer have an unfettered right to force patients onto a closed list irrespective of the practice's workload. The continuing need for the reserve power to assign patients will be reviewed in 2005/06.

## Removal of patients

- 6.29 The relationship between a practice and a patient can sometimes suffer an irreconcilable breakdown. In these circumstances the right of the practice to remove a patient from the practice list remains. Patients too will be able to apply for registration with a different practice if that is their preference. Removal from a list will follow a transparent process that normally would include a warning to the patient before removal. When a patient is removed, practices will be required to give specific reasons to the patient as to why the removal has occurred, though it is accepted that, in certain specific circumstances, a statement to the effect that the relationship between the patient and the practice has irrevocably broken down will suffice.
- 6.30 The right of a practice to remove a violent patient will be extended to safeguard all those who might have reasonable fears for their safety. These will now include members of the practice's staff, other patients and any other bystanders present where the act of violence is committed or the behaviour took place. Violence includes actual or threatened physical violence or verbal abuse leading to a fear for a person's safety. It is the responsibility of the PCO to ensure that there is a service available for patients who are difficult to manage, and this will be commissioned separately as an enhanced service as set out in chapter 2.

## Choice of practitioner

- 6.31 Patients will now register with practices rather than individual GPs. However, patients will retain the flexibility that they currently enjoy to request to be seen by the practitioner of their choice. This is particularly important for patients who value seeing a practitioner of their choice for the purposes of continuing care, care of particular conditions, gender or ethnicity. Primary legislation will provide for choice of practitioner to be set out as a legal right within regulations governing the contract between the PCO and the practice.
- 6.32 Where a patient wishes to exercise this right:
- (i) the patient may have to wait longer to see their preferred practitioner and, where this was accepted, it would not count against achievement by the practice of any rewards for improved access
  - (ii) the practitioner would still be allowed the rights of reasonable refusal (eg in respect of a violent patient)
  - (iii) the patient may be asked to accept an alternative if for example the service required was now being delivered by another professional member of the practice (eg if a service had been designated by the practice as a nurse or therapist led service rather than a doctor led service).
- 6.33 These rights will not undermine a practice's flexibility to organise its services in order to best meet patient needs.

- 6.34 This means that a practice cannot force a patient to see a doctor that the patient does not wish to see. The practice will still have an obligation to offer immediately necessary treatment to non-registered patients.

## The Patient Services Guarantee

- 6.35 The new GMS contract is a UK-wide contract. The aim is to ensure that patients receive a consistent range of high quality services throughout the UK. The contract does, however, recognise that certain services are provided in different areas in response to local need.
- 6.36 The new contract will ensure that patients have access to a wide range of services delivered in primary care settings. In addition, the quality and outcome rewards in the new contract will incentivise good chronic disease management and holistic personal care within general practices. Patients who need continuity of care will be able to receive it.
- 6.37 The mechanisms set out in chapter 2 enable more flexible configuration of services across PCOs. These are designed to recognise that many practices are facing considerable challenges in managing increasing workload. Combined with the introduction of better human resource management policies described in chapter 4, including measures to improve the recruitment and retention of GPs, they will help ensure that primary care capacity is expanded. This will enable better services to be delivered to patients.
- 6.38 It is expected that most practices will deliver the full range of additional services. However, where practices have no other option, they may opt out of the provision of one or more defined additional services. In these circumstances, the PCO is responsible for ensuring that the [Patient Services Guarantee](#) is delivered. This guarantee states that 'patients will continue to be offered at least the range of services that they currently enjoy under the existing contract.' In some cases, however, this service may be made available to the patient from somewhere other than their own local practice. Whilst local circumstances may differ, it is expected that the PCO will use the opportunity of seeking to ensure an alternative service is provided to increase the range of choice available to the patient and minimise any travel times. The guarantee will be backed up in primary legislation by a new legal duty on PCOs.
- 6.39 Practices and PCOs will be required to agree how best to inform patients of service changes in accordance with the provisions of section 11 of the Health and Social Care Act 2011. Similar provisions exist in Scotland and Northern Ireland.
- 6.40 The arrangements set out in chapter 2 also offer new opportunities for extending patient choice:
- (i) where possible and practicable, patients who require it will be given choice, in particular, for single or short duration healthcare episodes and problems. This will be achieved through enabling patients to use alternatives such as NHS walk-in centres, NHS Direct, NHS24 or community pharmacists as complementary alternatives to attending the surgery
  - (ii) where a practice has opted out of provision of an additional service and there are a number of alternative providers identified by the PCO, patients will have the choice as to which provider they wish to attend for that service
  - (iii) PCOs will be given new powers to commission parallel additional services, which would not affect the income of existing GMS practices, but would offer patients an extra choice and may help to ease the workload of some practices
  - (iv) where a PCO has entered into contracts for the provision of an enhanced service, patients will have the choice as to which provider of the service they choose to attend.

## Higher quality services

- 6.41 Chapter 3 outlines the substantial additional investment that will support the implementation of a wide-ranging quality framework based on latest research evidence. This will help ensure excellent management of a wide range of chronic diseases. It will have a very significant impact in improving clinical outcomes for patients. It will also help avoid unnecessary referrals to hospitals. The organisational standards will also provide assurance to patients that practices are well run. The investment in premises and the quality standards attached to the new premises flexibilities described in chapter 4 will help ensure that patients receive care in a high quality physical environment.
- 6.42 It is considered good practice to book consultations at 10 minute intervals. The quality framework will provide a direct financial incentive for practices to achieve this.
- 6.43 GPs will be rewarded directly for their success in achieving improved access through an enhanced service, and maintaining it through bonus access maintenance points (see chapter 3).

## Assessing and rewarding patient experience

- 6.44 The quality framework will also provide a strong financial incentive for practices to consider the patient's experience by asking patients to complete an accredited questionnaire, to consider and discuss the results of the analysis, and to implement appropriate improvements. This development will allow the patients of the practice to comment on numerous aspects of their care including the physical environment, the convenience and accessibility of the services offered, the practice/patient relationship, the helpfulness of support staff and the appropriateness and timeliness of the whole episode of care.
- 6.45 The two accredited questionnaires have been tested and approved through a process of peer review. They have been shown to have real benefits not just in creating an opportunity to assess patients' views, but also in alerting the practice to both strengths and weaknesses.

## Working in partnership

- 6.46 The new GMS contract recognises that if the primary care sector is to be expanded and practices are to be allowed to manage their workload and earnings to suit their aspirations, a clear strategy to use clinicians' time effectively whilst improving availability of services for patients is essential. This strategy will identify those situations in which patients could be enabled to manage their own conditions, use services effectively, or where the services could be offered by other health professionals, especially where these services could be accessed more easily and more cost-effectively than through traditional general practice. There are many examples of progress being made, but in some instances this work is on a small scale and implementation of proven initiatives patchy.
- 6.47 Under the new GMS contract there will be national arrangements to coordinate and facilitate the development of schemes to maximise the effective use of health services and provide evidence based alternatives to general practice. In Scotland, Wales and Northern Ireland existing arrangements will take forward this agenda. In England, there will be an integrated multi-disciplinary group under the aegis of the Modernisation Agency working with relevant external bodies. It will also have significant public and patient involvement as a part of its membership and hold a programme budget of £10m over three years to sponsor, evaluate and encourage spread of good practice. It will also champion these issues in discussions across Government.
- 6.48 Its work programme will cover a number of important areas for development, including:
- (i) development of minor illness management and self-care education programmes by professionals such as nurses, therapists, pharmacists and paramedics

- (ii) development and support for *Expert Patient* initiatives to make better use of primary care and general practice, building on the evaluation and roll out of the current national scheme, but extending its principles to more local practice-driven schemes
- (iii) supporting non-GP based chronic disease management schemes aimed at helping to manage ongoing, and develop, new secondary prevention initiatives
- (iv) promoting effective use of health services, better patient communication, and better self care through initiatives such as those developed by, for example, the Doctor Patient Partnership and other national health charities
- (v) furthering attempts to reduce certification work within general practice. National initiatives such as those established through the Cabinet Office will be implemented. Major local pilots in large companies and the NHS will be sought to evaluate the effectiveness of in-house occupational health services as an alternative to using general practice for certification. Should the pilots be successful the aim would be to allow the system to be refined so certification responsibility can be moved to occupational physicians and occupational health nurses, making significant progress towards national coverage by April 2006
- (vi) promoting the education of young people via the National Curriculum about management of health, maintaining their health status and how to use health services responsibly through initiatives such as the proposed *Making Sense of Health*<sup>9</sup>
- (vii) evaluating how patients use services and understanding how best to communicate with them about effective use of, and changes in, services. This work will build on that started by the Department of Health, the Doctor Patient Partnership and the University of Southampton and will be used to inform all the demand management programmes.

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<sup>9</sup> *Making Sense of Health* is an initiative from the Doctor Patient Partnership. Its aims include encouraging a culture shift in public involvement in their own health care management, improving people's ability to use the NHS appropriately and increasing the number of those in future generations who choose careers in the NHS. The initiative will provide imaginative and impartial health education and training to teachers, parents and pupils via the National Curriculum.

## 7 Underpinning the contract

- 7.1 The agreements set out in this document will be underpinned through new contractual mechanisms. This chapter explains the way in which this will be achieved, including:
- (i) the nature and contents of the contract
  - (ii) who can provide services
  - (iii) vacancies and practice splits
  - (iv) contract review arrangements
  - (v) how the list arrangements for professionals will be rationalised
  - (vi) mechanisms for dispute resolution, and appeals
  - (vii) the role of LMCs (or their equivalent) and Area Medical Committee GP subcommittees
  - (viii) changes needed to primary legislation.

### Nature and contents of the contract

- 7.2 The current GMS contract takes the form of statutory arrangements made by the Health Departments of the four countries between PCOs and individual GPs. A fundamental change in the new GMS contract is that in future practices will enter into contracts with their local PCO. This requires the existing statutory arrangements to be replaced. The legal basis of GMS will change for all GMS practices. Subject to the approval of new legislation, existing GMS practices will transfer to the new contract on 1 April 2004. This will not, however, prevent earlier implementation of many of the proposals in this document. Chapter 8 sets out what will be introduced in 2003 and what will wait until 2004 because of the need for primary and associated secondary legislation.
- 7.3 The contract and supporting documentation will set out, either directly or by reference to an external source (eg the Carr-Hill formula), the agreement between the practice and the PCO and will determine:
- (i) which services will be provided, in the light of the new arrangements around service commissioning described in chapter 2
  - (ii) the level of quality of essential and additional services that the practice aspires to deliver, as described in chapter 3
  - (iii) the support arrangements to be provided including human resource management, IM&T, premises and support for rural and remote GPs, as set out in chapter 4
  - (iv) the total financial resources that the practice will receive, as set out in chapter 5.
- 7.4 It is expected that the contract will normally take the form of an NHS contract (in Northern Ireland, a Health and Social Services contract) rather than a private law contract, following granting of Health Service Body status. Where there is an NHS contract, this means practice disputes on contractual matters that are not resolved locally will be resolved through the FHSAA(SHA) (or its equivalent) rather than the courts. It is anticipated that most GMS providers will opt for these contracts but no-one will be forced down this route and, if the practice requires, the new GMS contracts can be ordinary contracts at law. Appeals and dispute resolution procedures are considered further in this chapter.
- 7.5 A UK contract will be published later this year. It cannot be published in full detail at this stage because it depends on the precise provisions of primary legislation to be enacted before April 2004, subject to Parliamentary agreement. The contract will be negotiated between the BMA's GPC and the NHS Confederation and will set out the contractual obligations under the new GMS contract. Subject to Parliamentary approval, regulations made under new primary powers will underpin these obligations and the main provisions

will be in place before 1 April 2004. The UK contract will permit local variations for the provision of local enhanced services.

- 7.6 The practice-based contract is fundamental to the new arrangements. It will permit the allocation of the global sum monies, and will mean that should a GP within a practice retire it will be for the practice to decide how best to continue to meet its service obligations, rather than the PCO advertising and appointing GPs to vacancies as at present. It will also allow practices to have other primary care professionals including nurses and practice managers sign up as parties to the contract. Whilst partnership law would allow one partner to sign on behalf of the whole practice it is envisaged that all partners will have to sign the contract.

## Providers of services

- 7.7 A number of basic principles underpin the new definition of a GMS practice (the GMS 'provider'):
- (i) a GMS contract is with the provider, made up of one or more individuals who act in their personal capacity
  - (ii) a provider must always include at least one general medical practitioner holding a Joint Committee on Postgraduate Training (JCPTGP) certificate (or who is suitably experienced within the meaning of section 31 of the National Health Service Act 1977 (or its equivalent))
  - (iii) a provider must be constituted from individuals from within the NHS though not necessarily from a clinical discipline, for example a practice manager
  - (iv) a provider unit will, subject to (ii) above, be made up of one or more of the following groups:
    - (a) a general practitioner (defined as a registered medical practitioner on the GP Register, subject to the introduction of proposed legislation, or suitably experienced in the interim) together with one or more persons listed in (b), (c), and/or (d)
    - (b) a healthcare professional defined as a person who is a member of a profession regulated by one of the regulatory bodies referred to in section 25(3) of the NHS Reforms and Health Care Professions Act 2002, who provides services to the NHS
    - (c) an individual employed by an NHS Trust, Foundation Trust or PCT or equivalent body in Scotland, Wales and Northern Ireland; a GMS or GDS contractor or equivalent body in Scotland, Wales and Northern Ireland; a PMS or PDS provider or equivalent body in Scotland, Wales and Northern Ireland
    - (d) a qualifying body as set out in the NHS (Primary Care Act) 1997.
- 7.8 Practices will be permitted to include in their partnership, if they wish, other healthcare professionals such as nurses, pharmacists (where there is no conflict of interest and there is no interest held on behalf of a commercial body), allied health professional and non-clinical NHS staff such as practice managers. The fundamental issue is that there must be a GP in the constitution of the partnership and as one of the contract signatories.
- 7.9 Although there will not be a list of suitable providers along the lines of the existing medical and supplementary lists, which are focused primarily on suitability to practise, there will be a mechanism to prevent totally unsuitable individuals from contracting to provide GMS. Purely by way of illustration these might include those with a serious criminal history, for example those guilty of serious arrestable offences; of questionable financial standing, for example undischarged bankrupts; or with a record of serious disciplinary action by their professional body or serious internal NHS disciplinary action, for example a national disqualification by the FHSAA, or persons who have been convicted of an offence in the Schedule to the Children's and Young Person's Act 1933. The actual conditions that

might de-bar a provider will be subject to full consultation with the profession as part of the implementation process.

- 7.10 Whilst it is highly desirable that every practice should have an effective partnership agreement, the absence of such an agreement cannot prevent the PCO awarding a practice a contract as in the absence of an agreement the provisions of the Partnership Act 1890 will apply. It is anticipated that the GPC will produce a model partnership agreement.

## Alternative providers

- 7.11 As described in chapter 2, subject to primary legislation, PCOs will be able to commission or directly provide primary medical services. This ability will sit in law alongside the GMS and PMS statutory arrangements. It will facilitate practices opting out of additional services and will help prevent the assignment of patients to practices that are not accepting new registrations, as described in chapter 6. This will also ensure that the PCO has maximum flexibility to commission enhanced services from other providers. The ability to commission primary medical services from alternative providers includes private sector organisations. PCOs currently have this ability in relation to hospital and community health services.
- 7.12 Use of alternative providers for essential primary care is also possible, for example, employing GPs in walk-in centres in England. Some practices may choose to enter into specific funded agreements with, for example, walk-in centres on a voluntary basis to help them achieve improved access and clinical standards or to deliver services such as vaccinations and immunisations. In these cases, unless the practice has 'opted-out' of the provision of a certain additional service they will continue to be funded for this service from the global sum.

## Vacancies and practice splits

- 7.13 Subject to there being at least one GP in every practice, the new contract will take the form of a 'rolling' contract which will allow partners to retire and allow new partners to join the practice on the basis of continuing obligations on each of the PCO and the provider practice. It may be necessary for the contract to be linked to the practice partnership agreement in order to achieve this. In most cases this will overcome the need for a substantial variation when a provider leaves a practice or when a new provider joins a practice, subject to there being at least one GP in each partnership. It represents an opportunity to delineate more clearly the practice as an autonomous provider of services, with greater flexibility to determine for itself the workforce necessary to suit the needs of its population and the desired work patterns of its workforce. When making changes to the working practices of nurses and other healthcare professionals, the practice will be expected to involve them in the decision-making and to seek advice from the relevant professional lead in the PCO.
- 7.14 Where there is a retirement or a new partner, the GMS provider may decide to continue to provide the services within the terms of the contract by, for example, recruiting a replacement GP or a nurse practitioner, or by increasing the hours of the practice nurse and engaging another health professional. The flexibility is owned by the practice and the global sum will not vary unless the services are varied eg if the practice opts out of a service.
- 7.15 In the event of a more substantial practice split, for example into two groups of three practitioners each, the existing contract would come to an end and the two groups would each seek a new contract with the PCO. Whilst most contract changes will come about through the 'rolling' mechanism described in paragraph 7.13 there will inevitably be occasions where there is a partnership 'split' resulting from a disagreement between the partners or from the expulsion of one or more partners.
- 7.16 Whilst an expulsion in accordance with the terms of an effective partnership deed will bring about the compulsory retirement of a partner when the 'rolling' principles will

continue to apply, there may be a practice split which either comes about from the dissolution of a partnership at will or where various members of the partnership wish to reform into two or more separate groups. In both such cases the contract will terminate at the time of dissolution.

- 7.17 Where a substantial partnership splits into two or more groups it will probably be by agreement and sufficient notice can be given to PCOs so as to permit the timely establishment of new contracts with the continuing groups. At the same time, there should be sufficient opportunity for the practice patients to be fully informed of the new arrangements. Where, however, there is a partnership split in a two or three partner practice it can often happen without any notice and considerable problems can arise in ensuring continuity of care for patients. It is expected that in the event of partnership splits the PCO will wish to establish a temporary contract arrangement with each of the practitioners who were formerly in partnership, whilst reaching a clear understanding about patient needs and their wishes to register with one or other of the disputant doctors.
- 7.18 As part of the understanding, the PCO will normally agree to grant a new formal contract after a specified period of time to each of the doctors. Guidance will be issued on how to manage this process and the procedures will include consultation with the LMC (or its equivalent). To ensure continuity of patient care at the time of dissolution the new temporary contract will provide that, save in case of agreement with the PCO, the temporary services will normally continue to be provided from the practice premises that were in use at the time of the dissolution.
- 7.19 When a single-handed GP resigns, the PCO would still have an obligation to ensure the provision of primary medical services to that former GP's patients. The PCO could discharge that duty by entering into a contract with existing or new providers, or deliver primary medical services itself. Whilst the concept of a statutory vacancy will disappear, the LMC (or its equivalent) will be consulted about all proposals in relation to the retirement of a single-handed practitioner and greenfield sites and any existing affected patients will be kept informed.

### Greenfield sites

- 7.20 Significant increases in local population may warrant a need for additional providers of essential and additional services in an area and the PCO has an obligation to ensure provision of primary medical services to its population. The PCO could advertise locally and/or nationally the need for a practice in the area and seek applications, through a two stage process: first, competition between GMS and PMS practices which would have preferred provider status, and then open competition. The PCO would normally contract for such services through a variation to a contract with an existing GMS or PMS provider which has a preferential right to provide such services if it so wishes. However, in stage two, the open competition stage, the PCO could commission it from another potential provider. The LMC (or its equivalent) will be consulted. To support the new arrangements around opt-outs and patient assignments, the PCO's ability to provide primary medical services itself including through PCO-led greenfield site provision, subject to the rules set out in chapter 2, would not be circumscribed by this process.

### Sale of goodwill

- 7.21 The existing arrangements prohibiting the sale of goodwill of a medical practice – including so-called deemed sales in the form of unfair partnership agreement - will continue.

### Contract review

- 7.22 The contract will be subject to a formal review process based on the principle of high trust. Although this process is distinct from the quality review process set out in chapter 3, the contract review could be carried out at the same visit so as to minimise disruption to the

practice if the practice wishes. Funding for the contract review process has been built into the global sum.

- 7.23 The review will be based around an annual return from the practice submitted on a standard electronic pro-forma, including declaration by the practitioners/partners in the practice that they have met their statutory and other mandatory responsibilities under their contract.
- 7.24 There will also be an annual review, typically involving a visit. This will include a review of the practice workload based on self-appraisal by the practice. Where a practice considers its workload is so excessive it may be considering opting out or closing its list, this review allows a discussion of the practice capacity. Alternatively, it also provides the opportunity for the practice to discuss with the PCO opportunities for expanding its services.
- 7.25 Increasingly as the new contract moves into further years, this discussion will be strongly evidence-based allowing the PCO to comment, offering its view of the previous year, drawing on comparable experience of workload in other practices, techniques for reducing workload, and a discussion about what levels of support the practice might expect or desire. At this point there will be a formal agreement if the practice wishes to withdraw from any form of service provision in line with the usual opt-out process. There will always be an opportunity for in-year discussions about contract variations etc when required, and practices will retain their option to close their list outwith this review.
- 7.26 The review will be followed up in writing by the PCO and the practice will be given an opportunity to comment on a draft. Either party to the contract can choose to have a representative of the LMC (or its equivalent) to support it in both the contract review and/or the quality review.
- 7.27 PCOs must not neglect the informal process of developing and maintaining where appropriate a sustained empathetic relationship with the practice based on the principle of high trust and understanding the practice's needs, pressures and aspirations, which may change in year.

## Remedial notices

- 7.28 Where the PCO believes, with reasonable cause and justification, that in any particular case:
- (i) the provider has failed to perform the service, including failure to meet minimum standards in accordance with the provisions in the contract; or
  - (ii) is otherwise in breach of the contract.
- 7.29 The PCO and provider will consult or use all reasonable endeavours to agree how the breach or failure should be resolved. Either party may invite the LMC (or its equivalent) to be involved in the discussion. Following this discussion, the PCO will issue a notice informing the practice in writing of the action to be taken, where possible, to resolve the breach or failure within a timeframe to be determined by the PCO. Unless the PCO believes patient safety is at serious risk or there is serious financial impropriety, the timescale will not be less than 28 days.
- 7.30 Where a notice has been served and the practice does not comply within the agreed timescale, or where the breach is so serious it is not possible to resolve, there are a number of options open to the PCO. It may:
- (i) seek alternative provision at the cost of the original provision at the expense of the original provider until the relevant service can be re-provided by the practice within the original terms of the contract; and/or
  - (ii) terminate the contract in respect of that part of the service subject to the remedial notice; and/or

- (iii) withhold and/or deduct monies which would otherwise be due and payable under the contract to the practice in respect of the element of the service not performed in accordance with the contract; and/or
  - (iv) charge the practice the costs of additional administration in connection with any default on their part; and/or
  - (v) terminate the contract.
- 7.31 Should any of the above be required, the PCO will consult with the LMC (or its equivalent) whenever any of these steps are to be taken but the PCO reserves the right to take reasonable urgent action where patient care or safety may be at risk or where there is a serious risk to public funds.
- 7.32 Unsatisfactory performance by an individual GP will be dealt with either through the monitoring, appraisal and revalidation arrangements to which all GPs will be subject or, through the disqualification procedures presently set out in section 49 et seq of the 1977 Act in England and Wales, sections 29 to 32E of the 1978 Act in Scotland, and Schedule 11 to the Health and Personal Social Services (NI) Order 1972.

## **Rationalising performer lists**

- 7.33 At present there is provision for three separate list arrangements for GPs: the Medical List for GP principals, the Supplementary List for non-principals and locums, and the forthcoming Services List for PMS providers. Inclusion on one of these lists is a precondition of GPs performing primary medical care to patients. In England and Wales, subject to legislation, these three lists will be merged into a single primary care performers list. The Scottish Executive and the Northern Ireland Health Department will announce their respective plans for future listing arrangements in due course. Consideration will be given to the desirability of extending the new list over time to other primary care practitioners under GMS or PMS arrangements to reflect the practice-based approach.

## **Right of return**

- 7.34 Following legislation, PMS practices will have the ability to move to GMS on a practice basis, and vice versa.

## **Indemnity cover**

- 7.35 The cost of indemnity cover has been factored into the global sum and the compulsory introduction of indemnity cover will be brought in through successor arrangements to section 9 of the Health Act 1999, to reflect the practice basis of the new contract.

## **Dispute resolution and appeals**

- 7.36 The Devolved Administrations are fully committed to the principles which underpin the mechanisms set out below, but these mechanisms will have to be tailored to be compatible with the administrative and organisational structures that pertain in each country.
- 7.37 As with the existing arrangements that govern the relationship between the PCO and providers of GMS there will continue to be occasions where it becomes necessary to resolve disagreements between the respective parties. Following the introduction of the new GMS contract we envisage these being categorised as either a 'dispute resolution' or as an 'appeal'. These two categories have different characteristics and need to be clearly distinguished.

- 7.38 A dispute resolution procedure is needed to resolve issues that arise within the contract, for example a dispute as to whether a contract provision has been properly performed by either the PCO or the providers, or a dispute involving financial entitlement under the contract.
- 7.39 An appeal mechanism is needed to deal with matters that arise outside the contract. These will largely relate to matters that deal with the relationship between the PCO and an individual GP. However, the appeal mechanism would also be appropriate where there are disagreements between the PCO and the GMS provider that do not involve matters that relate to contractual terms, obligations or rights.

## Dispute resolution

- 7.40 The relevant dispute resolution procedure is dependent on the nature of the contract held by the GMS provider. The contract might be an NHS contract or an ordinary contract for services. Contractual disputes are considered under three headings:
- (i) disputes where the contract is an NHS contract
  - (ii) disputes where the contract is an ordinary contract at law
  - (iii) pre-contract disputes.
- 7.41 These procedures will apply to all disputes that relate to matters relating to contractual terms including:
- (i) payments, including the global sum and quality payments, due under the contract
  - (ii) contract variations
  - (iii) opt-outs and list closures
  - (iv) contract termination
  - (v) disputes as to contract compliance.
- 7.42 As is the case with PMS, practices will have the right to elect whether or not to become an NHS body.
- 7.43 If a dispute arises between the parties to this agreement they shall try to resolve the dispute locally in the first instance. If necessary, this should include a conciliation meeting between the provider and the chief executive of the PCO and, where it appears appropriate, could include an appropriately qualified/skilled adviser. At the time of conciliation either one or both of the parties may request the presence and assistance of the LMC (or its equivalent).
- 7.44 Conciliation cannot be a mandatory precursor to formal dispute resolution. However, there is an expectation that both the PCO and the GMS provider will be encouraged to follow this route as it provides a speedier and more efficient method of resolving disputes. Where the dispute is not resolved through local conciliation then the appropriate procedure will apply.

## NHS contract

- 7.45 A practice will have the option of becoming a Health Service Body. The PCO would decide the application. If Health Service Body status were granted, the GMS contract would then have the status of an NHS contract (in Northern Ireland a Health and Social Services contract). Such contracts are primarily governed by section 4 of the NHS and Community Care Act 1990 or equivalent and the NHS Contracts (Dispute Resolution) Regulations 1996 (SI 623/1996). It is expected that most practices would choose to enter into NHS contracts.
- 7.46 Such disputes are resolved by the Secretary of State (or equivalent) or by a person appointed by the Secretary of State (section 4(5) of the 1990 Act) or the Health Department in Northern Ireland. The FHSA(SHA) (or its equivalent) would normally be

appointed to resolve all such disputes. Where, however, it is important to factor local knowledge into the process of adjudication the Strategic Health Authority (or its equivalent) may be appointed. These cases involve list closure, patient assignment and adherence to opt-out procedures.

- 7.47 Where the Strategic Health Authority (or its equivalent) is to be appointed as adjudicator the Authority must, to preserve its independence, have played no part in the local dispute resolution process.

### Ordinary contracts

- 7.48 Where a practice opts for an ordinary contract at law they will have the option of asking the courts to resolve any resultant contractual disputes.
- 7.49 However, it is the intention to provide an optional internal dispute resolution procedure. Whilst the use of such adjudication will be optional, its availability will be mandatory. The process will be modelled on the existing PMS procedure, which draws heavily on the NHS contract dispute resolution procedures. Ordinary GMS contracts, which are contracts at law, will be required to include a clause that provides for dispute resolution involving binding adjudication by the Secretary of State or the Health Department in Northern Ireland. The practice therefore will have a choice of routes when there is a difference that cannot be resolved locally; either the courts or binding adjudication.
- 7.50 Where the dispute is referred for adjudication, the dispute would ordinarily be referred to the FHSAA(SHA) (or its equivalent). In certain circumstances, however, the Strategic Health Authority (or its equivalent) would be asked to adjudicate.

### Pre-contract disputes

- 7.51 In the early stages where initial contracts are being negotiated the potential GMS provider is unlikely to be a Health Service Body. It is therefore the intention that primary legislation will provide by subsequent regulation for the potential GMS providers to have access to adjudication in relation to a dispute that relates to the terms of a proposed GMS contract in a manner that is equivalent to the system outlined above. The outcome of the adjudication will be binding where a contract is subsequently signed but it cannot be used to force a potential GMS provider to enter into a contract.

### Appeals

- 7.52 There will potentially be only a limited number of areas where a dispute might arise in an area not dealt with under the contract or pre-contract resolution procedures. These would include the right to perform GMS (ie matters to do with the primary care performers list).
- 7.53 Appeals will be dealt with at three different levels. In the event of an appeal against a decision made at level one, the appeal would be referred to level two.

#### Level one

- 7.54 The first level will involve local resolution of those non-contractual issues. This would be a process modelled along the lines of the existing paragraph 80 of the Statement of Fees and Allowances (SFA) requirements. This process will allow a practice to make representations to the PCO relating to the decision that is being disputed. As with the existing SFA procedures the local adjudication procedures will not be set out in regulations. However, subject to local agreement, it is envisaged that the aggrieved practice will have access to a PCO local review panel. The PCO local review panel could comprise the chairman of the PCO, an LMC (or its equivalent) or GP subcommittee appointed member, and a lay person but could vary eg according to the nature of the dispute.

#### Level two

- 7.55 Appeals at level two would relate to matters which remain in dispute when the level one procedure has been exhausted. Such appeals will normally be dealt with by the FHSAA(SHA) (or its equivalent).

### Level three

- 7.56 At the highest level appeals will lie with the FHSAA(SHA) (or its equivalent). Such appeals will deal with issues such as a practitioner's right to have his or her name entered on a primary care performers list and comparable rights related to a practitioner's right to perform GMS.

## Local Medical Committees (LMCs) and their equivalents

- 7.57 The role of LMCs (and their equivalents) and GP subcommittees of Area Medical Committees under the new contract arrangements will be analogous to their existing role in each of the four countries. Under the new contract, the LMC (or its equivalent) will be involved in decisions to assign patients to practices with closed lists through the new panel arrangements. At the request of either party it could be involved in contract review or quality assessment visits, and local dispute resolution. It will also be informed of local variations to practice contracts, practice splits and the establishment of new practices including greenfield sites, breaches or failures of the practice contract, proposed commissioning arrangements for enhanced services, and re-provision of additional services when a practice has opted out.
- 7.58 The existing arrangements in section 44 (recognition of local representative committees) and section 45 (functions of local representative committees) of the National Health Service Act 1977 (or equivalent) will be continued in a form which will provide for the continued recognition of local representative committees and the collection from practices and the allotment to local representative committees of sums necessary for defraying the committee's administrative expenses.

## Primary legislation

- 7.59 To enable implementation of the new contract, we envisage that primary legislation provisions will be brought forward following the outcome of the ballot of GPs. We anticipate this will include:
- (i) repealing and completely replacing the existing GMS legislation in part II of the NHS Acts 1977 and 1978
  - (ii) placing a duty on PCOs as regards the provision of primary medical services, to underwrite the Patient Services Guarantee whilst ensuring sufficient flexibility for services to develop in line with changes in medical technology and provision
  - (iii) allowing PCOs directly to provide primary medical services, or commission care from alternative providers, to support the opt-out arrangements and help obviate the need for assignment of patients to closed lists
  - (iv) allowing PCOs to provide support to GMS practices
  - (v) providing a legal definition of a GMS provider, and allowing them, should they wish, to be Health Service Bodies able to enter into NHS contracts with PCOs
  - (vi) setting out regulation-making powers to specify what must be included in a GMS contract, including provisions that will underpin the working definitions of essential and additional services
  - (vii) providing for existing funding arrangements to be replaced by provisions comparable to those which underpin the allocation of unified budget resources, to implement the new funding arrangements including allocation of global sum monies to practices
  - (viii) rationalising the existing professional list arrangements for England and Wales.



## 8 Making it happen

- 8.1 The NHS Confederation, the GPC and the four Health Departments have a shared desire to realise the benefits of the new GMS contract for GPs, patients and the wider NHS at the earliest opportunity. Given that the new contract is radically different from the existing arrangements, the implementation task is considerable, but the work will nonetheless be completed as quickly as possible.
- 8.2 This chapter describes the three main processes:
- (i) action at national level to reform legal, administrative and financial arrangements
  - (ii) action at local level including support and performance management of PCOs
  - (iii) ongoing monitoring, review and negotiation.

It also sets out a timetable of what will happen when.

### Legal administrative and finance processes

- 8.3 Chapter 7 sets out how the statutory framework needs to be replaced with new provisions that are fit for purpose. Primary legislation will be introduced at the earliest opportunity. In England and Wales this will happen in the current session of Parliament. If the profession votes in favour of a new contract, the Government will introduce the necessary clauses into the forthcoming Health and Social Care Bill subject to Parliamentary agreement. In Scotland it is expected to follow the forthcoming election, subject to the agreement of the new administration. Primary legislation will also be introduced in Northern Ireland at the earliest opportunity and the mechanism will depend on the constitutional position.
- 8.4 The clauses will reflect the agreements reached in this document. The Department of Health in England, the GPC and the NHS Confederation have been discussing, and will continue to discuss, how best to achieve this. Discussions will also be held with the other three Health Departments.
- 8.5 The clauses will describe the parameters for a new framework of secondary legislation, such as regulations and directions, that sets out what is included in the contract and how it will operate. Subject to Parliamentary approval it is intended that the key elements of the secondary legislation will be in place by April 2004. The secondary legislation will entirely replace the existing GMS regulations and will be simpler wherever possible.
- 8.6 In addition to the work on primary and secondary legislative reform, the NHS Confederation working with the GPC and the Health Departments will produce:
- (i) a national contract which PCOs and practices will use for their agreements. The contract will include revised terms, which will be set out in secondary legislation, and these will include the statutory requirements set out in Annex B.
  - (ii) a new Statement of Financial Entitlements will set out the statutory financial entitlements of practices including the global sum and quality payments. This will also be included in the contract. The exact amounts will be calculated quarterly, and set out in a letter from the PCO to the practice
  - (iii) guidance for PCOs about the operation of the contract (including specifications for enhanced services) and a model contract for PCO and GMS practice employed GPs.
- 8.7 The GPC will be fully involved in the development of these documents through a continuing process of consultation and negotiation led by the NHS Confederation on behalf of the Health Departments. The GPC will also develop a model partnership agreement and guidance for GPs.

- 8.8 Primary legislation will provide for a new method of allocating GMS monies to PCOs as described in chapter 5. PCOs will take full responsibility for the first time for managing a single allocation of GMS monies alongside the unified budget allocation. To support the implementation of the Gross Investment Guarantee, expected PCO spend on enhanced services will be identified separately and this will be performance-managed by Strategic Health Authorities (or their equivalents) as described in chapter 5.
- 8.9 The allocation will be made by the Health Departments to PCOs covering all the funding streams outlined in this document, with the exception of premises as described in chapter 5 where the risk will be managed above PCO level. The finalised allocation will include monies for transitional protection following the submission of returns from practices of their relevant 2002/03 spend. From their allocation PCOs will allocate monies to practices in accordance with the new statutory rules. Centralised systems will be developed to support the PCO in this process but it will also require a major change in the PCO finance function which will need to be reviewed in conjunction with existing shared services arrangements.

## Local level

- 8.10 Successful implementation of the new contract critically depends on the capacity, capability and competence of PCOs and Strategic Health Authorities (or their equivalents). Practices will also need to undertake preparation.

## PCOs

- 8.11 PCOs have a most important set of functions in relation to implementation. These range from broad strategic to detailed operational roles. They will wish to optimise the benefits of the new contract to deliver strategic change in relation to:
- (i) the general modernisation of primary care
  - (ii) expansion of the primary care sector and the resourced shift of secondary to primary care work
  - (iii) the recruitment and retention of the primary care workforce
  - (iv) the management of demand for primary care services.
- 8.12 The key PCO operational function is to develop and maintain effective locally held practice-based contracts. In moving away from GMS arrangements managed by the Secretary of State, to a locally held practice-based contract, PCOs become the commissioners of primary care services. The contracts and supporting letters will be developed by the PCO in line with the national contract and will reflect:
- (i) the range of essential, additional and enhanced services to be provided by the practice. This will follow discussions between the PCO and practice about:
    - (a) workload pressures
    - (b) the application of the opt-out rules described in chapter 2
    - (c) the commissioning of effective alternative additional services that practices opt out of
    - (d) the commissioning of enhanced services in line with the guaranteed investment floor
  - (ii) the overall level of quality that the practice expects to achieve
  - (iii) the financial and other resources available to support delivery. This will reflect decisions to deploy resources for strategic investment in premises and IM&T appropriately, which will involve working collaboratively with their fellow PCOs, Strategic Health Authorities (or their equivalents) and appropriate national bodies.

- 8.13 The contracts and letters will be discussed and agreed with practices. PCOs will also have responsibility for the ongoing monitoring of the contract, and for ensuring agreements to vary the contract are properly documented.
- 8.14 PCOs will also need to:
- (i) develop an appropriate level of in-house provision of primary medical services as described in chapter 2; and
  - (ii) develop a strategy for commissioning or providing out-of-hours care so that the default responsibility of GPs is removed at the earliest opportunity, and by no later than December 2004 save in exceptional circumstances and subject to agreement by the Strategic Health Authority (or its equivalent).
- 8.15 Many PCOs already have experience in these areas. Effective mechanisms will also be put in place to support the development of PCO competencies. In the main, these will be provided in England by the Modernisation Agency. The National Primary and Care Trust Development Team (NatPaCT), the National PMS Development team (NPMSDT), the National Primary Care Development Team (NPDT) and the Out-of-Hours Development Team will work together with other colleagues from the Agency and with other stakeholders to develop, coordinate and establish a programme of effective support for PCTs and primary care to help with the implementation of the new GMS contract. Comparable arrangements will be established in the other three countries.
- 8.16 The programme will draw on the skills and knowledge of the individual teams to support PCOs, general practices and the interface between them, and deliver a programme that builds on lessons learned so far about the most effective way to introduce change and improvement. Each team will bring to the programme expertise in how best to develop PCOs and the people who work within them, how best to commission and contract for primary care services and how best to promote continuous quality improvement in service delivery within primary care. The programme will be targeted to match support to priorities as they arise, as the new contract is introduced.
- 8.17 PCOs will wish to consider the considerable capacity they will require to discharge their new GMS functions, bearing in mind their existing expenditure on supporting primary care and their ability to supplement this from within their unified budget resources.

### Strategic Health Authorities (or their equivalents)

- 8.18 Strategic Health Authorities (or their equivalents) have two distinct roles within the new contract. These are:
- (i) ensuring the effective performance of PCOs in respect of their requirements to implement the new contract, including providing developmental support and routine performance management. In particular, Strategic Health Authorities (or their equivalents) will need to ensure that PCOs are working with practices to deliver the key strategic objectives outlined in paragraph 8.11; that the guaranteed investment floor on enhanced services is delivered in each PCO; and that PCOs rapidly develop effective strategies for commissioning out-of-hours care
  - (ii) discharging a limited range of technical functions as directly required of them under the new contract. These include appeals on opt-outs and forced assignments of patients, ensuring appropriate PCO arrangements are in place for the deployment of IM&T and premises funds, and a general role in performance management.
- 8.19 Strategic Health Authorities (or their equivalents) will require support to understand and discharge these new roles. A programme of support is being developed under the aegis of the NHS Confederation to help them with this. It is envisaged that lead Strategic Health Authorities (or their equivalents) will coordinate with lead PCOs in each Strategic Health Authority (or its equivalent) area to create an ongoing platform for local implementation, dissemination of best practice and specification of learning needs.

- 8.20 Strategic Health Authorities (or their equivalents) will also coordinate their performance management roles with that of external inspectorates such as the Commission for Healthcare Audit and Inspection (CHAI), which will be charged with assessing PCO performance, and in some countries, developing star ratings systems. This will minimise bureaucracy and burdens on PCOs.
- 8.21 Other stakeholder bodies including the Royal College of General Practitioners, NHS Alliance, National Association of Primary Care, the National Association of GP Co-operatives, the Royal College of Nursing, and the Commission for Patient and Public Involvement, will also be involved through an implementation reference group designed to support the process of implementation.

## Ongoing monitoring, review and negotiation

- 8.22 The GPC, NHS Confederation and the four Health Departments are committed to ensuring that the implementation of the contract is consistent with the original intentions of this document and that effective mechanisms are put in place to ensure effective subsequent adaptation in the light of changing circumstances.
- 8.23 New arrangements are needed for the monitoring of workload, expenditure, resource allocation and the quality framework. Under the current contract the Technical Steering Committee considers the data required to enable the current pay system for GPs to function effectively. Given the very different nature of the new contract, this group will no longer need to undertake its work in the same way, but will be required to provide new support systems in order to ensure that the practice-based system operates effectively. In future, the new GMS Technical Committee, reconstituted to include NHS Confederation and Northern Ireland membership, will ensure the provision of accurate data on workload and expenditure to inform consideration of future uplifts in gross expenditure. The monitoring of workload may be achieved by developing a system of spotter practices, that are tracked throughout the year by recording their workload.
- 8.24 A UK-wide expert group will review the effectiveness of the new primary care resource allocation formula and make recommendations on any future changes.
- 8.25 A UK-wide expert group will be established to monitor, review and update the standards set within the quality framework. Its role will include:
- (i) ensuring that the standards continue to be consistent with the best available evidence and data
  - (ii) making recommendations on the operation of the framework and possible corrective action in the event of standards being misinterpreted, corrupted or difficult to manage
  - (iii) making recommendations on the introduction of new standards.
- 8.26 The membership and terms of reference for this group will be considered by the negotiating parties. The group will not be a decision-making body, but will make recommendations to the GPC and to Ministers, which will form the mandate for the NHS Confederation, as the negotiating body on their behalf. These recommendations will be considered as a part of the continuing negotiation process.
- 8.27 The NHS Confederation will continue to lead the ongoing process of negotiation of the contract. Whilst this role will diminish in volume, once the contract has been agreed and the further national work identified in paragraph 8.6 completed, there will be a requirement for both sides to continue to oversee its implementation in practice and to negotiate any appropriate variations or adjustments to the contract that are required.

## Timetable

- 8.28 Subject to acceptance of the contract by the profession, substantial implementation will occur in 2003/04:
- (i) primary and secondary legislation will be put in place, subject to Parliamentary agreement
  - (ii) model contracts and guidance will be prepared and published
  - (iii) national programmes for local support will be established
  - (iv) PCOs will review the capacity and competence they require to implement the contract and Strategic Health Authorities (or their equivalents) will performance-manage this process
  - (v) PCOs will prepare locally held contracts and letters in accordance with fixed UK requirements and will discuss and agree these with practices, which will also want to review their partnership arrangements in the light of new GPC guidance
  - (vi) PCOs will develop strategies for out-of-hours commissioning and encourage transfer of responsibility to accredited providers
  - (vii) PCOs will discuss workload issues with practices and practices will indicate which additional services they may wish to opt out of or the additional or enhanced services they may wish to provide
  - (viii) PCOs will commission enhanced services and Strategic Health Authorities (or their equivalents) will performance-manage this spend
  - (ix) PCOs will submit returns in a national template on transitional protection
  - (x) the Health Departments will allocate resources to PCOs
  - (xi) centralised systems will be developed to support PCOs in allocating resources to practices
  - (xii) revised payments for seniority payments will be introduced
  - (xiii) the definition of pensionable earnings will be changed and locum pay will be pensionable retrospectively from 1 April 2002
  - (xiv) practices will prepare for the quality framework and be allocated preparation payments based on the Carr-Hill formula
  - (xv) practices supported by PCOs will take advantage of the practice management competency framework
  - (xvi) the baseline assessment of premises spend will be carried out and future spend agreed
  - (xvii) IM&T modernisation will begin, with transitional arrangements agreed nationally and discussed locally
  - (xviii) the new monitoring arrangements will be established
  - (xix) the DDRB will be asked to set salary ranges for PCO and practice employed GPs.
- 8.29 In 2004/05:
- (i) all GMS practices will transfer to the new practice-based contract in April 2004
  - (ii) the global sum, recalculated quarterly, and quality aspiration payments will be paid monthly. Transitional protection will also be paid
  - (iii) it will be possible for opt-outs from additional services to occur from April 2004. Opt-outs from out-of-hours will occur, usually on a PCO-wide basis, from April 2004. The expectation is that all PCOs will have taken on responsibility for commissioning out-of-hours by December 2004 and Strategic Health Authorities (or their equivalents) will performance-manage this process

- (iv) from April 2004 PCOs will be given the ability to develop direct provision of primary medical care, and to commission additional and enhanced services from alternative providers
- (v) the new rules concerning patient assignments will be introduced
- (vi) the new performer list for England and Wales and appeals procedures will be established.

8.30 The forthcoming guidance on implementation will provide further detail. Tailored arrangements will reflect the specific circumstances of Scotland, Wales and Northern Ireland.