THE SCOTTISH OFFICE
Department of Health

NHS
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NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

24th July 1998

Dear Colleague

THE NATIONAL HEALTH SERVICE (PRIMARY CARE) ACT 1997
THE NATIONAL HEALTH SERVICE (GENERAL MEDICAL SERVICES) (SCOTLAND) (AMENDMENT NO 3) REGULATIONS 1997

Summary

1. Section 37 of the NHS (Primary Care) Act 1997 amends the NHS (Scotland) Act 1978 to give health boards' flexibility to improve the development and responsiveness of general medical services by giving local GPs financial incentives beyond those set out in the Statement of Fees and Allowances through the introduction of GMS Local Development Schemes. The NHS (GMS) (Scotland) (Amendment No 3) Regulations 1998 which will come into force on 27 July 1998 set out the conditions which apply to payments made under section 37 arrangements.

Guidance

2. The attached guidance and associated Direction and Designations are intended to help health boards plan and implement General Medical Services Local Development Schemes to provide services which help to address health inequalities and, particularly in areas of deprivation, to enhance the development of GMS to above that currently provided.

Action

3. Copies of the National Health Service (General Medical Services) (Scotland) (Amendment No 3) Regulations 1998 will be sent when they are available to health boards for distribution to all GPs in their areas.

Yours sincerely

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Director of Primary Care

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GMS LOCAL DEVELOPMENT SCHEMES

BACKGROUND AND CONTEXT

1. What are GMS Local Development Schemes?

1.1 Section 37 of the NHS (Primary Care) Act 1997 amends the NHS (Scotland) Act 1978 to give health boards flexibility to improve the development and responsiveness of general medical services, by giving local GPs financial incentives beyond those set out in the Statement of Fees and Allowances. Incentives can be paid for enhancing GMS to certain specified standards, or providing them in a particular way which is negotiated locally. Payments can also be made in respect of infrastructure (eg staff, premises, computers) to support enhanced GMS provision. Payments must not duplicate existing arrangements provided for in the Statement of Fees and Allowances.

1.2 Health boards will want to use GMS Local Development Schemes to provide services which help to address health inequalities, and, particularly in areas of deprivation, to enhance the development of GMS above that currently provided. Health boards should check that service development proposals are in line with local health improvement programmes and national health priorities, that they provide value for money, and that as far as possible, they are evidence-based. They should also consider how funding improvements in the development of general medical services might lead to more cost-effective use of the secondary sector; and should take account of local patterns of provision of secondary care when deciding what sort of GMS Local Development Schemes are needed.

2. What sort of initiatives will GMS Local Development Schemes cover?

Examples health boards might wish to consider are as follows:-

to fund a specific patient management programme by a practice for a condition which is neither covered by the existing national contract programmes nor traditionally undertaken locally in primary care, but which is a key priority set out in the local Health Improvement Programme;

to introduce local funding of workforce flexibilities eg: - funding to support the recruitment of GPs into advertised practice vacancies, to help small practices to work together, or to allow practices to share an assistant GP to free up time for training, practice management, etc;

to negotiate enhanced standards for provision of a certain facet of GMS service, and provide incentive payments to GPs who meet them;

for premises developments which would normally be eligible for an improvement grant under the Red Book, and where the developments are required in order to provide GMS to the standards or in the ways specified in the Local Development Scheme. GMS Local Development Scheme payments could be used to top up the

grant (up to 100% of the development cost) beyond the maximum allowable under the Red Book or locally determined GMS limits. Premises developments may have implications for future notional rent reimbursement and health boards should bear this in mind when providing funding support through GMS Local Development Schemes.

to fund "time out" for GPs to participate in specified team events within practice teams which lead to better services for patients;

to fund provision of GMS in nursing or residential homes where GPs work to a protocol over and above that normally provided.

3. **What is the legal framework for GMS Local Development Scheme?**

An explanatory note is at Annex A.

4. **How do GMS Local Development Schemes differ from secondary care contracts with GPs?**

4.1 Secondary care contracts are payments made by health boards to GPs out of general allocations for providing services which are <u>not</u> General Medical Services - eg:- performing vasectomies.

4.2 Payments for GMS Local Development Schemes must fund General Medical Services provision <u>only</u>. They can be for enhancing service provision only or for providing services against a particular protocol, or for topping-up infrastructure (premises, staff, equipment) above the locally determined level, to support GMS Local Development Schemes. GMS Local Development Schemes must not be used to fund services which are funded from GMS cash-limited or non cash-limited funds and covered in the Red Book, and cannot be used to fund anything on Part I of the list of fundholder goods and services because these are secondary care services.

4.3 Health boards should take their own legal advice if there is doubt about whether or not a service falls within the definition of GMS.

4.4 Health boards may want to fund GMS Local Development Schemes in addition to secondary care contracts, where the two complement each other and help provide seamless patient care. Annex B shows examples of different sources of funding and how they can complement each other to provide an extensive package of care.

5. **How will GMS Local Development Schemes be funded?**

Funding for GMS Local Development Schemes must come from health boards' overall allocations ie, the Hospital and Community Health Services budget. GMS Local Development Schemes will not be funded from GMS cash-limited funds.

6. How will proposals for GMS Local Development Schemes be generated?

Proposals for GMS Local Development Schemes can be generated from a variety of sources including health boards and general practitioners. Health boards may wish to encourage proposals from GPs, who are well placed to assess local service development needs. Health boards are advised to discuss with Area Medical Committees, through their GP Sub-Committees, these arrangements and the timetable for making proposals and to publish the arrangements locally.

7. Who can take part?

7.1 There is no obligation on any individual GP or practice to participate in GMS Local Development Schemes. Equally, there is no entitlement as of right for GPs to receive Section 37 payments. Funding is at the discretion of the health board.

7.2 GMS Local Development Scheme payments can be targeted to particular areas, or particular practices, or particular individual GPs.

7.3 Health boards are advised to ensure that all GPs covered by a proposal have an opportunity to be involved in the same scheme if they so wish. (For example:- A health board wants to improve GMS services for teenagers on a local housing estate where there are high drug dependency and teenage conception rates. The health board invites all GPs in the locality who meet the determination criteria to run an outreach service with specified GMS components, and submit regular data returns to track progress. All GPs who volunteer can take part - incentive payments will be based on the number of teenagers seen within an agreed specific period).

7.4 In some cases, however, a proposal may be specific to a particular practice (eg provision of a special expertise service to neighbouring patients) in which case the area will be limited to that practice alone. Or a proposal might be targeted at particular individuals in that practice alone. Or a proposal might be targeted at particular individuals (eg a proposal to encourage service developments through collaborative working between 2 neighbouring single-handed practitioners).

7.5 GPs who are participating in Personal Medical Services pilots are not providing general medical services, and are therefore not entitled to receive payments under these arrangements. If a health board wishes to introduce a particular scheme across a locality which contains a PMS pilot practice it will need to consider whether and how the PMS contract should include provisions to achieve the same objectives being pursued through the use of Section 37 payments for GMS in the rest of the locality. Existing PMS contracts can be amended on application to the Secretary of State.

7.6 The way in which a health board uses its discretion in determining the scope of remuneration is not a matter for appeal by GPs. Health boards should ensure always that the correct procedures have been followed, and that the conditions set out in Regulations have been met.

8. **What are the conditions which apply to payments for GMS Local Development Schemes?**

Health Boards must check that proposals meet the conditions in the Secretary of State's Designation, which mirror those in Regulations:-

8.1 Remuneration must be paid in respect of **general medical service provision only**. Health boards should take their own legal advice if there is any doubt about whether or not a service falls within the definition of GMS.

8.2 Remuneration **must not duplicate** that paid from GMS cash-limited or non cash limited funds in respect of fees and allowances set out in the **Red Book**, (eg:- it would not be appropriate to fund a chronic disease management programme for asthma which duplicated in any way the scheme set out in paragraph 30 of the SFA, or for the salary of a practice nurse who was providing "SFA services" for 100% of his or her time). However, this flexibility can be used to "top-up" direct reimbursements for staff involved in GMS Local Development Scheme provision, and consequential premises improvement grants and computers up to 100%, using the discretionary level set by each health board as the "ceiling" above which GMS Local Development Scheme payments can become payable. For example, it will be possible for a health board to provide from GMS cash-limited allocation less than the maximum proportion (66%) of an improvement cost allowable under the Statement of Fees and Allowances, and meet either part or the whole of the remaining proportion (ie up to 100%) through GMS Local Development Scheme payments. (This gives health boards maximum "headroom" to use the flexibility for this purpose).

8.3 Health boards are advised to discuss with Area Medical Committees, through their GP Sub-Committees, the priorities which will guide consideration of Local Development Scheme proposals, and to share available information about funding implications to enable AMCs to tender helpful advice.

8.4 Health boards must publish the following information about Local Development Schemes as soon as possible after the end of each financial year:-

8.4.1 the aggregate amount of payments made or due to doctors in respect of Local Development Schemes taken together for that financial year;

8.4.2 the number of doctors to whom payments were made;

8.4.3 a description of the aspects of GMS covered by Local Development Schemes during the financial year.

In addition, when planning GMS Local Development Schemes health boards are advised:-

8.5 to check proposals are in line with local and national health priorities;

8.6 to check that as far as possible, proposals are evidence-based;

8.7 not to offer payments where the provision of a GMS Local Development Scheme might create disincentives (eg:- GPs should not stop providing Chronic Disease Management Programmes (CDMPs)) for asthma or diabetes in order to run one for the care of the chronically mentally ill). Health boards may want to specify in their Determination that payment is conditional on the practice or GP continuing to deliver services to an existing or improved standard.

9. What should the Health Board Determination cover?

Health boards should draw up a written statement which sets out the arrangements for each GMS Local Development Scheme. The statement will look like a local addition to the Red Book, and be similar to a normal health board contract. It should cover:-

- the detail of the service or development to be provided (including the conditions which apply) and the benefit for patients;
- the locality, or practices, or individuals to which the arrangements apply;
- the timescale: health boards and GPs may want to agree the duration of arrangements in the light of the nature of individual schemes. For example, a care management programme for patients with chronic mental illness may be a long term development requiring funding over several years before benefits can be fully assessed.
- Reimbursement of the cost of employing staff is likely, in some circumstances, to require a longer term investment. Where GMS Local Development Schemes are being used in conjunction with GMS cash-limited funds to reimburse staff costs, health boards should ensure that the funding and review periods (usually 3 years for GMS cash-limited arrangements) are the same for both schemes. Health boards are advised to take account of any difficulties sudden variations in funding arrangements might have on individual practices and set an appropriate time limit and evaluate, rather than enter into open-ended commitments;
- success criteria;
- monitoring and/or audit arrangements;
- the amount to be paid by the health board to the GPs who are participating;
- the payment arrangements;
- arbitration arrangements.

A sample determination is at Annex C.

Health boards should try to keep the determination process clear and concise, open and non-bureaucratic.

10. What will the payment arrangements be?

10.1 In the light of local priorities health boards can agree an appropriate payment rate for each scheme, which will be set out in the Determination. There is no pre-set national "going rate" for particular service development, but health boards will need to be fair and consistent in terms of the rate paid for a particular service within their boundaries. Neighbouring health boards and GPs may wish to agree a common rate where a service development plan involves practices on both sides of a health board boundary.

10.2 Payments to GPs for provision of GMS Local Development Schemes should be made from health board general allocation, and not from cash-limited GMS resources. Health boards should decide when and how payments will be made. This should be set out in the Determination.

10.3 Payments to GPs should be made separately from payments in respect of fees and allowances set out in the Red Book. GPs should show income from GMS Local Development Schemes separately in their accounts. Data will be collected nationally for Departments of Health/BMA Technical Steering Committee purposes.

10.4 Pension arrangements for GPs who receive GMS Local Development Scheme payments will mirror those in respect of payments made under the Statement of Fees and Allowances. Detailed guidance on this point is in Annex D.

11. What will the accountability arrangements be?

Health boards should:

- include GMS Local Development Scheme plans in the HIP
- record section 37 payments separately in their accounts
- report on GMS Local Development Schemes in their Annual Report.

12. What will the role of Primary Care Trusts be?

The legislation governing GMS Local Development Schemes relates to Health Boards. Consideration is being given to whether responsibility for these schemes should transfer to Primary Care Trusts from 1 April 1999.

13. Enquiries

Health boards who have questions about this guidance should seek advice from Elinor Mitchell, Room 54A, St Andrew's House, Tel No: 0131 244 2415, or Susan Malcolm, Room 29C/1, St Andrew's House Tel No: 0131 244 2680.

THE LEGAL FRAMEWORK FOR GMS LOCAL DEVELOPMENT SCHEMES

Section 37 of the NHS (Primary Care) Act 1997 amends the NHS (Scotland) Act 1978 to allow health boards that have become "Determining Authorities" to make payments from health board general allocations to GPs providing general medical services.

The Designation at Appendix 1 gives health boards power to determine[1] any remuneration for general medical services (GMS), any remuneration which they do so determine and which is of a type designated[2] by the Secretary of State in the Designation at Appendix 2 for the purposes of this provision will fall to be paid out of cash-limited money.

This provision secures that where health boards determine locally to pay extra remuneration (on top of that payable under national arrangements) for the provision of GMS in particular ways, that remuneration will be paid from the health board's cash-limited budget.

The new sub-section (1AA) to section 85 of the NHS (Scotland) Act 1978 explains that "main expenditure" is attributable to 2 things one of which is remuneration paid to persons providing GMS under Part II of the 1997 Act. This is expenditure which is determined by the health board concerned and is of a particular type designated by the Secretary of State. It is intended that this will be used by health boards to pay for any remuneration which they may become entitled to determine as payable for GMS over and above standard payments from their cash-limited pool of money. Health boards are specified as determining authorities any payments they might determine, to provide an incentive for general medical practitioners to provide GMS in specific ways to suit local circumstances, will be payable from their cash-limited allocation.

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[1] Health Board Determination and GMS Regulations

This is a statement by the health board setting out which services or initiatives will be funded, the conditions which apply to them, and what payments will be made. It is a bit like a local addition to the Statement of Fees and Allowances.

The NHS(GMS) (Scotland) Regulations (Amendment No 3) 1998 sets out the conditions which apply to payments made under Section 37 arrangements.

[2] Secretary of State's Designation

A Designation has been made by the Secretary of State. It describes the conditions which apply to these arrangements, which will mirror those set out in Regulations. The Designation is the legal equivalent of a Direction by the Secretary of State, and health boards should check carefully, with lawyers if necessary, that local use of this flexibility complies with the Designation.

DESIGNATION OF HEALTH BOARDS AS DETERMINING AUTHORITIES

The Secretary of State in pursuance of powers set out in sections 28A and 28 B of the National Health Service (Scotland) Act 1978 as read with section 7 of the Health and Social Security Act 1984 hereby designates each Health Board in Scotland as the determining authority for the remuneration of doctors whose names are included in its medical list for the purposes of any GMS Local Development Scheme it may establish under regulation 35B of and Schedule 8A to the National Health Service (General Medical Services) (Scotland) Regulations 1995 (SI 1995/416).

These provisions were inserted by the National Health Service (General Medical Services) (Scotland) Amendment (No 3) Regulations 1998 (SI 1998/1600), which come into force on 27 July 1998, and each Health Board must exercise its power of determination in line with those provisions.

DIRECTION TO HEALTH BOARDS

The Secretary of State by virtue of his power of direction under section 2 of the National Health Service (Scotland) Act 1978 hereby directs each Health Board in Scotland to include in each determination made by the Health Board under the above designation the arrangements for claiming the remuneration in question, and to publish the determination (and any amendment or revocation) in a suitable way for bringing it to the attention of the doctors whose names are included in its medical list.

Signed ..... (Agnes Robson) on behalf of the Secretary of State

Date ..... 15 July 1998

EXPLANATORY NOTE

This Designation gives Health Boards the power to make determinations in respect of GMS Local Development Schemes and the separate designation set out at Appendix 2 designates the remuneration to be paid in respect of such schemes as coming out of the Health Boards main expenditure.

The Designation and Direction above and the Designation at Appendix 2 shall come into force on 27 July 1998.

DESIGNATION OF REMUNERATION AS FALLING WITHIN SECTION 85(1AA)(b) OF THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT 1978

Remuneration paid to doctors under a GMS Local Development Scheme pursuant to regulation 35B of the Schedule 8A to the National Health Service (General Medical Services) (Scotland) Regulations 1995 is hereby designated in relation to the allocation covering Hospital and Community Health Services (HCHS) to each Health Board for the purpose of section 85(1AA)(b) of the National Health Service (Scotland) Act 1978.

ARRANGEMENT	LEVEL OF CARE	POWER	DESCRIPTION OF SERVICE	"CONTRACTOR"	NOTES	EXAMPLE: ADULT MENTAL HEALTH	EXAMPLE: COMBINED CHILD HEALTH SERVICE
Non cash-limited GMS	1°	1978 Act as amended - General Part II Expenditure	GMS	GP Principal		PGEA for continuing professional development re mental health	Child health surveillance
Cash-limited	1°	1978 Act as amended - 'Other' Part II Expenditure	GMS	GP Principal		Premises improvement grant to provide space for GMS counselling provision	Administrative support for child health clinic
GPFH Scheme	2°	1990 Act and GPFH Regs 1978 Act as amended - Main Expenditure	HCHS	NHS Trust or other health care provider		Clinical psychology session	Community children's nurse
'Add-on contracts'	2°	1978 Act as amended - Main Expenditure	Secondary care in primary care setting	GP Principal	Needs HB approval	N/A	Audiology tests
PCA Pilot	1°	1997 Act, 1978 Act S[97(3)] - Main Expenditure	PMS	PMS Pilot	HB contract SoS direction 1.4.98	Full personal medical service to treat mental illness, as one element of overall PMS	Full child health personal medical service including disease prevention, health promotion and self-limiting acute illness, as one element of overall PMS
Local Development Scheme	1°	1978 Act as amended - Main Expenditure	GMS not already being provided under national SFA	GP Principal	SoS designated description, HB determines	GP or Practice Nurse with a special interest in management of chronic mental illness	GP with special interest in the promotion of children's health - could include premises improvement

Notes: 1978 Act = National Health Service (Scotland) Act 1978
1990 Act = National Health Service and Community Care Act 1990
1997 Act = National Health Service (Primary Care) Act 1997

SAMPLE DETERMINATION

The following is intended as a guide only. Each health board will wish to draw up its own format for a contract.

Date of Agreement

Between

Introduction: a brief statement of aims and objectives

Outline: specifying what services are to be covered, the population to be covered, the district of residence, any exclusions and the type of contract.

Contract Duration: covering the length of the contract, when notice of further intentions is to be given and arrangements for negotiations of contract price.

Volume of Services: indicative volumes and arrangements for managing workload.

Fee Levels:

Payment: including when payments are made and how and when invoices will be raised.

Development: standards and agreement.

Monitoring: arrangements, timing, form and type of monitoring.

Complaints: policy for complaints and arrangements for action.

Arbitration:

Breach of Contract: specifying what will happen in the event of a breach, arrangements for negotiating action in case of a breach and sanctions.

Other Terms:

Contact Points:

SUPERANNUATION ARRANGEMENTS

1. Pension arrangements for payments made under section 37 of the Primary Care Act will mirror those in respect of payments made under the Statement of Fees and Allowances.

2. In practice, health boards and practitioners will need to agree locally what, if any, element of Section 37 payment will be pensionable. In doing so health boards and practitioners may wish to consider which group GP payments should be in for the purposes of calculating superannuation. Group one payments consist entirely of reimbursement of expenses for superannuation purposes; group 2 payments consist entirely of net income for superannuation purposes; and group 3 payments consist partly of reimbursement of expenses and partly of net remuneration for superannuation purposes.

3. Each year the percentage deduction for superannuation purposes of payments in group 3 is agreed between the profession and the Department. The current guidance on this is contained in PCA(M)1998(20) which includes a list of payments within each group.

4. The examples used in paragraph 2 of this guidance are expanded below to show how pension arrangements might apply in each case:

- A health board might agree to fund a specific patient management programme by a practice for a condition which is neither covered by the existing national contract programmes nor traditionally undertaken locally in primary care, but which is a key priority set out in the local Health Improvement Programme. This payment is likely to be partly expenses, partly earnings and could be calculated on the same basis as other group 3 payments.

- A health board might negotiate agreed arrangements for the support of doctors returning to the profession from career breaks, where this is linked to enhanced GMS provision. The employing doctor would receive no pension on this allowance. An employed assistant or salaried doctor is entitled to join the NHS pension scheme and pay the usual rate of contribution on his/her salary.

- A health board might negotiate enhanced standards for provision of a certain facet of GMS service, and provide incentive payments to GPs who meet them. It is likely that this payment will be made up of expenses and earnings similar to those in Group 3.

- A health board might fund provision of GMS in nursing or residential homes where GPs work to a protocol over and above that normally provided. There is likely to be an expenses and an earnings element to this payment and the pensionable element may be calculated using group 3 as a guide.

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