‘Implementing the new GMS contract in Scotland’

2. Flexible provision of services
2. FLEXIBLE PROVISION OF SERVICES

SUMMARY OF KEY POINTS

1. Health Boards will be under a new duty to secure the provision of primary medical services from 1st April 2004. They will have greater flexibility over how and from whom they secure the provision of primary medical services, using four routes: GMS, PMS (Section 17C), alternative providers (Health Board Medical Services) (eg the voluntary sector, commercial providers, NHS services, or other Health Boards), or direct Health Board provision. Guidance on the alternative provider and Health Board direct provider routes will be published by the end of February 2004. The new arrangements will support an expansion of primary care capacity, including delivery of a wider range of services. This will help reduce pressures on the acute sector, and improve convenience and choice for patients.

2. The GMS contract will preserve the status of existing practices as incumbent providers. It will enable primary care professionals to moderate their workload according to the income to which they aspire. Existing GMS providers have a right to a new GMS contract. This includes the obligation to provide essential services; the expectation and right to provide additional services; and the right to provide certain of the Directed Enhanced Services. Health Boards can also commission contractors to provide other enhanced services.

3. The legal definition of essential services reflects the agreement in Investing in General Practice. Contractors must also provide immediately necessary and emergency treatment and treatment to temporary residents. Obligations to provide annual health check for patients over the age of 75, patients not seen within three years and newly registered patients have been simplified. Contractors must provide home visiting where, in their opinion, this is medically necessary. The existing ban on charging patients for all but a limited range of services continues.

4. Contractors will be responsible for essential services during core hours (8am-6.30pm on weekdays, except for public holidays). Normal surgery hours must be to the extent necessary to meet reasonable needs.

5. List-based general practice remains at the heart of the new contract. Patients register with a contractor for essential services. They can choose which practitioner to see, subject to the practitioner’s
availability and the appropriateness and reasonableness of the request. Patient choice of contractor will be assisted by patient leaflets, which contractors should review before 1st April 2004, and a new Health Board Guide to Primary Care Medical Services, the contents of which will be subject to consultation prior to publication.

6. Key determinants of whether a patient can register with a contractor are (i) the contractor’s area, which should be agreed with the Health Board as part of the contract discussions during February 2004; and (ii) whether the contractor’s list is open or closed. Contractors will be required not to discriminate in refusing to register patients and to give reasons in writing for refusing to accept patients, or, subject to a limited exception, when removing patients from their list.

7. New formal procedures for closing lists and for assigning patients to contractors with closed lists will be introduced on 1st April 2004. To reduce the need for patient assignments to contractors with closed lists, Health Boards are encouraged to establish their own provision of services. From the date that contracts are signed, Health Boards will not be able to assign patients to contractors with closed lists without going through the new procedure. Health Boards will need to plan for this before April 2004 and they are advised to establish assessment panels (a sub-committee of another Health Board). The assessment panels will need to be ready to take referrals by April 2004.

8. The formal procedure for contractors to opt out from additional services starts on 1st April 2004. Health Boards can choose to agree opt-outs before then when agreeing contracts. When opt-outs are being considered, the simplest and least bureaucratic approach is for Health Boards and contractors to reach local agreement without using the formal procedure. Health Boards will want to review the expected provision of additional services in their area by 27 February 2004, and have developed arrangements for commissioning further additional services, if necessary, by 31 March 2004.

9. Where the Health Board agrees and has alternative provision in place, contractors can opt out of out-of-hours from 1st April 2004. Contractors will have a right to opt out of out-of-hours services from 1st January 2005, in all but exceptional geographical circumstances. In Scotland, all Health Boards will take on responsibility for out-of-hours service provision by this date. Delivery against this objective will be performance-managed. Health Boards should have ascertained contractors provisional intentions in relation to out-of-hours opt-outs by
27 February 2004 and developed plans for reprovision by 31 March 2004. It will be important for Health Boards to engage effectively with local communities in developing plans for out-of-hours services. Once contracts have been signed, contractors wishing to opt out of out of hours should submit notices to Health Boards by 1st April 2004.

10. The new out-of-hours responsibility is an opportunity for Health Boards to develop more integrated services. Patients will also benefit from national minimum quality standards applying across all out-of-hours providers from 1st January 2005.

11 Enhanced services will enable Health Boards to expand the range of services in primary care, improve convenience and choice for patients, and reduce pressures on hospitals. Health Boards must commission the five Directed Enhanced Services (DESs). They must offer contractors the quality information preparation DES and the childhood vaccination and immunisation DES where contractors are providing these additional services. Health Boards should offer these to contractors before contracts are provisionally agreed at the end of February 2004. It is for Health Boards, in consultation with the GP Sub Committee of the AMC, to decide how, from whom, and when they wish to commission other enhanced services to meet local needs.

12 Health Boards will be notified of local enhanced services expenditure floors in their February 2004 financial allocations, which they can exceed but not underspend on enhanced services. They are expected to draw up initial commissioning plans during February 2004. Health Boards must also seek to obtain agreement from the GP Subcommittee of the Area Medical Committee that the enhanced services they propose to commission count within the definition of enhanced services for financial monitoring purposes.
Introduction

2.1 This chapter describes Health Board duties and options in securing primary medical services, contractor obligations in relation to different GMS services, and patient registration arrangements. It takes in turn:

A. Primary medical services
B. Essential services
C. Patient registration
D. Additional services
E. Out-of-hours services
F. Enhanced services

A. Primary medical services

2.2 This section describes the new Health Board duty to secure primary medical services, the four delivery routes by which this can be discharged, and preferred provider status of GMS contractors.

(i) Duty to secure primary medical services

2.3 The Primary Medical Services (Scotland) Act 2004 places Health Boards under a new duty to provide or secure the provision of primary medical services. This will take effect from 1st April 2004. The Act says that a Health Board must provide or secure primary medical services to the extent that it considers it necessary to meet all reasonable requirements. This duty underpins the Patient Services Guarantee set out in chapter 6 of Investing in General Practice. Health Boards are advised that to fulfil the duty they must provide or secure sufficient (i) essential services, (ii) additional services (or equivalent; the term only relates to GMS), and (iii) out-of-hours services, to meet the needs of their whole population. This means that where contractors opt out of additional services or out-of-hours care, Health Boards must ensure effective alternative provision is in place at the time that opt-outs take effect.

(ii) Delivery routes

2.4 Chapters 2 and 7 of Investing in General Practice envisaged four delivery routes for primary medical services: GMS, Section 17C (PMS), Health Board direct provision, and alternative providers. These are shown in Table 1.

GMS contracts
2.5 Under GMS contracts, Health Boards and contractors are bound by the GMS rules described in the Contract Regulations and will be using *The Standard GMS Contract* described in chapter 6. Primary medical services are described as general medical services only when they are delivered through a GMS contract. All GMS contracts must include essential services and will normally include additional services. GMS contracts can also cover enhanced services; alternatively, Health Boards and GMS contractors can hold separate contracts for enhanced services.
### TABLE 1 - FOUR DELIVERY ROUTES FOR PRIMARY MEDICAL SERVICES

<table>
<thead>
<tr>
<th>Contract</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Services (GMS)</td>
<td>Practices with at least one GP provider (single-handers, partnerships, or a certain type of limited company described in chapter 6)</td>
</tr>
<tr>
<td>Section 17C schemes (Personal Medical Services (PMS))</td>
<td>Practices (single-handers, partnerships, or a certain type of limited company described in chapter 6) &lt;br&gt; Nurses and other clinicians &lt;br&gt; Health Boards</td>
</tr>
<tr>
<td>Health Board Medical Services (HBMS)</td>
<td>Commercial providers &lt;br&gt; Voluntary sector &lt;br&gt; Not-for-profit organisations &lt;br&gt; NHS trusts and foundation trusts &lt;br&gt; Other Health Boards¹</td>
</tr>
<tr>
<td>Health Board Direct Provision</td>
<td>Health Boards</td>
</tr>
</tbody>
</table>

### Section 17C arrangements

2.6 Separate Section 17C guidance is being issued by SEHD in February 2004. The intention is to promote maximum flexibility in the development of Section 17C agreements (within the broader context of the implementation of the new GMS contract and other Primary medical services contractual forms), tailored to local circumstances and with bureaucracy kept to a minimum.

### Alternative providers (HBMS)

2.7 The Primary Medical Services (Scotland) Act 2004 allows a Health Board in relation to primary medical services to make “such arrangements for their provision (whether within or outside its area) as it thinks fit (and may in particular make contractual arrangements with any person)”. This power means that for the first time a Health Board can, from April 2004, contract for delivery of primary medical services with a range of alternative providers: commercial providers, not-for-profit organisations, the voluntary sector, NHS trusts, NHS foundation trusts or other Health Boards. The power may have

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¹ The primary legislation allows Health Boards to make arrangements outside GMS or Section 17C with any type of provider. This means that Health Boards can contract with practices under the HBMS arrangements, although we expect that this is unlikely to be their preferred route given the GMS and Section 17C options. If GMS contractors and Health Boards sign separate enhanced services contracts rather than including them as variations to GMS contracts, this is technically occurring under the legislation supporting the HBMS arrangements.
particular use for contracting for out-of-hours and enhanced services but Health Boards should note that primary legislation allows contracts with alternative providers to cover any or all aspects of primary medical services. These alternative providers could for example include voluntary sector providers of mental health, learning disability or drug misuse treatment services in primary care. Services delivered under contracts with alternative providers are described as Health Board Medical Services, or HBMS.

2.8

**Health Board direct provision**

2.9 From April 2004 Health Boards will be able to employ health care professionals to provide primary medical services themselves; at present, they only have the power to employ them to support GMS and PMS providers, or when they are the PMS provider. This could be for provision of any or all aspects of primary medical services. Such arrangements are described as Health Board Direct Provision. As envisaged in chapter 2 of *Investing in General Practice*, this option will further enable Health Boards to employ a range of full-time or part-time salaried staff and also support the creation of locum banks. It will also enable Health Boards to act as the employer of practice managers to work across small practices where this and the funding arrangements are agreed locally. Health Boards are encouraged to explore these options.

2.10 Where Health Boards provide the equivalent of GMS essential services, patients will register with the Health Boards. Health Boards can develop a minimum level of such services by April 2004 as a way of avoiding the need to assign patients to GMS contractors and Section 17C schemes with closed patient lists. As set out in paragraph 2.44 of *Investing in General Practice*, Health Board provision should not exceed an appropriate volume and should be on the basis that it can meet the same requirements as other feasible alternative providers. They are also expected to consult with the GP Subcommittee of the AMC.

**Common principles**

2.11 Common principles will apply across all four delivery routes to ensure minimum standards are met and to encourage high quality care. Some of the standards will apply only to the delivery of essential services to registered patients. The range of standards includes:
minimum legal requirements, such as having effective clinical governance systems in place; complying with the NHS complaints system, the new performer list arrangements, provider conditions and prescribing conditions; record keeping and providing information to the Health Board; having suitable premises; producing patient leaflets; and complying where appropriate with the GMS rules about charging registered patients for delivering other services. Sale of goodwill will also be subject to restrictions and the way in which these will apply will be set out in separate regulations which will be made before April 2004.

arrangements to achieve comparable quality to the GMS quality and outcomes framework, where appropriate given the range of services being provided. Where Health Boards and contractors propose different quality arrangements in relation to essential services these will need to be approved by the Health Board as being comparable to GMS standards. Health Board quality visits, and any further assessment of primary care quality, will need to cover all primary care providers.

funding. Chapter 5 describes how Health Boards will receive a combined allocation for primary medical services. They can choose to supplement this with resources from their unified budget should they so wish, just as they can similarly support GMS and Section 17C contractors.

consultation. The Health Board must involve and consult local communities about the planning of the provision of services, the development and consideration of proposals for changes in the way those services are provided, and decisions affecting the operation of those services. The Health Board must consult the Local Health Council and the GP sub committee of the AMC where appropriate.

2.12

Preferred provider status

Existing practices are protected by having preferred provider status for some services. Chapter 6 describes how existing GMS providers will have a right to a new GMS contract. Having a GMS contract confers the right and obligation to provide essential services; an expectation and a right to provide additional services; and a right to provide the , quality information preparation and childhood vaccination and immunisation DESs. GMS (and Section 17C
providers) do not have preferred provider status for other enhanced services, or out-of-hours and additional services that other contractors have opted out of providing. Having a Section 17C arrangement also confers the right to move to GMS, and GMS providers have a reciprocal ability to agree, at any stage, Section 17C arrangements with Health Boards.

**Greenfield sites**

2.14 Paragraph 7.20 of *Investing in General Practice* explained that when looking to commission for greenfield sites (that is, new surgeries that cover essential services as a result of significant increases in population), the Health Board “could advertise and seek applications through a two-stage process”. It also made clear that the Health Boards ability to provide such services itself would not be circumscribed by this process; if a Health Board was not free to establish its own provision, its ability to reduce patient assignments to GMS (and Section17C) providers with closed lists would be constrained.

2.15 In the first stage, Health Boards would draw up a specification of what they want by way of the range of and access to services and the quality of care. They could then invite bids from existing GMS (or Section 17C scheme) contractors. The Health Board would not be expected to go to stage two (inviting bids from alternative providers) unless there was no interest, or if those contractors did not in the Health Board view satisfy the criteria set out in the specification. In most circumstances it is likely to make best sense to contract with existing (GMS or Section 17C scheme) practices. This could be through a variation to their main contract, or a separate contract, which could be time-limited, should both parties agree. In some areas where there is a shortage of primary care professionals alternative providers may offer much needed additional local capacity.

**Brownfield sites**

2.16 The Health Board has a range of options when making decisions about securing primary medical services in “brownfield” sites (that is, pre-existing surgeries that were but are no longer delivering essential services, for example in the event of a single-handed GP retiring; or essential services in areas of historic under-provision). The options are to:

(i) seek to advertise a vacancy and enter into a GMS, Section 17C agreement, or HBMS contract, or

(ii) invite interest from existing primary medical services contractors, or
(iii) employ a GP using the Health Board Direct Provision route.

Before making a decision the Health Board is expected to consult with the GP Subcommittee of the AMC.

B. Essential Services

2.17 This section explains:

(i) the definition of essential services

(ii) core and normal hours

(iii) arrangements for temporary patients

(iv) other statutory services

(v) charging for services.

Each is taken in turn.

(i) Definition of essential services

2.18 Chapter 2 of *Investing in General Practice* defined essential services. It was agreed during UK negotiations that this definition is best translated into regulation 15 of the Contract Regulations as follows:

“(3) The services described in this paragraph are services required for the management of its registered patients and temporary residents who are—

(a) ill, or believe themselves to be ill, with conditions from which recovery is generally expected;

(b) terminally ill; or

(c) suffering from chronic disease,

delivered in the manner determined by the practice in discussion with the patient.

(4) For the purposes of paragraph (3) –

“disease” means a disease included in the list of three-character categories contained in the tenth revision of the International Statistical Classification of Diseases and Related Health Problems(\(^2\)); and

“management” includes—

(a) offers of consultation to and, where appropriate, physical examination for the purpose of identifying the need, if any, for treatment or further investigation; and

(b) the making available of such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient’s treatment and care.

(5) The other services described in this paragraph are the provision of appropriate ongoing treatment and care to all registered patients and temporary residents taking account of their specific needs including-

(a) the provision of advice in connection with the patient’s health, including relevant health promotion advice; and

(b) the referral of the patient for other services under the Act. “

2.19 Health Boards and contractors are invited to note the following points:

(i) chronic disease is as defined in the International Statistical Classification of Diseases and Related Health Problems. This includes, for example, patients with disabilities, patients suffering from long term conditions including for example hypertension or infertility but who are otherwise healthy, and patients suffering from mild to moderate psychopathic disorders. The contractor must provide services to the extent that the condition can be dealt with appropriately in a primary care setting.

(ii) paragraph (5) of Regulation 15 reflects paragraph 2.10 of Investing in General Practice, which refers to “continuous holistic treatment and care”. To reflect this paragraph (5) provides an obligation for all contractors to provide “appropriate ongoing treatment and care for all registered patients and temporary residents taking account of their specific needs”. Paragraph (5) includes an obligation on the contractor to provide advice in connection with the patient’s health, including relevant health promotion advice.

Additional services are not essential services and so if a contractor has opted out of providing these, it clearly does not have to provide them under essential services.

(iii) the specifications for enhanced services in Supplementary Documents make clear that “no part of the specification by commission, omission or implication defines or redefines essential or additional services”. Health Boards should note that, with certain exceptions, GMS contractors are funded through the global sum and MPIG to provide the equivalent services for which they were previously funded under
existing GMS. Exceptions are set out in the mapping diagram in Supplementary Documents:

(a) influenza immunisation is now commissioned as a DES, and the childhood vaccinations and immunisation target payments are also a DES

(b) part of the funding for cervical cytology is in the Quality and Outcomes Framework

(c) the funding for intra partum care is also in enhanced services

(d) part of the funding for minor surgery is in enhanced services.

In addition, following the new definition of the contraceptive additional service, intrauterine contraceptive devices and contraceptive implants are not funded through the global sum and MPIG, but through enhanced services.

(ii) Core and normal hours

2.20 The Contract Regulations define:

(i) core hours. These are Monday to Friday, 8am to 6.30pm, except Christmas Day, New Year’s Day and other public or local holidays agreed with the Health Board. It is the responsibility of the contractor to ensure (and, if need be, fund cover for) the provision of essential services during these core hours. Health Boards can provide and fund alternative cover at their discretion

(ii) normal surgery hours. These are the days and hours when services under the contract are normally available. The Contract Regulations state that these must be “to the extent necessary to meet reasonable need”. Normal hours may be different for different services. Normal hours do not have to be within core hours; a contractor might propose for example that existing surgery hours are changed and daytime sessions substituted for early morning, evening or weekend surgeries. Alternatively, the contractor may propose to provide such surgeries in addition to their existing surgery hours, in which case these could be funded through enhanced services. Health Boards and contractors may
wish to discuss normal hours as contracts are finalised by 27 February 2004, and as part of the annual review process described in chapter 6.

To reflect the move to a practice-based contract, the old GMS obligation on any individual full-time GP to be available for face-to-face consultations for 26 hours a week will end from 1st April 2004.

(iii) **Temporary patients**

2.21 The obligation on contractors to provide treatment to patients who are not registered with them remains in the new contract. Fees for providing Emergency Treatment, Immediately Necessary Treatment and the care of Temporary Residents have been simplified into a single off-formula adjustment in the global sum, described in annex C of the Scottish Statement of Financial Entitlements. This is calculated on the basis of the average number of claims in the practice over the previous five years. If Health Boards and contractors agree that the incidence of non-registered patients at the practice is insufficiently accounted for within the global sum, funding could be supplemented through an enhanced services contract.

2.22 There are three different types of circumstances when a contractor must accept temporary patients for treatment:

(i) ordinarily, services will be provided where: (a) a contractor’s list is open, and (b) services are requested by a person who is temporarily away from his or her normal place of residence and, (c) that person is not being provided with essential services (or their equivalent) under any other arrangement in the locality where he or she is residing, or who is moving from place to place, and is not for the time being resident in any place. For this purpose the person is temporarily resident if when they arrive they intend to stay for more than 24 hours but for not more than three months

(ii) in core hours a contractor must also provide for the necessary treatment for a period of up to 14 days of a person whose application to be accepted as a temporary patient has been refused

(iii) finally a contractor must provide in core hours immediately necessary treatment for a person to whom the contractor has been requested to provide treatment owing to an accident or emergency at any place in its practice area.

(iv) **Other statutory services**
2.23 Other statutory requirements from old GMS that have been funded through the global sum and MPIG, and which should be set out in the contractor’s patient leaflet, are:

(i) home-visiting. Under the new contract, the contractor must attend a patient outside practice premises if the patient’s medical condition is such that, in the reasonable opinion of the contractor, it is necessary to do so. This does not stop the Health Board from investing in a home-visiting service if it so wishes, as set out in paragraph 2.26 of *Investing in General Practice*

(ii) newly registered patients. The contractor is obliged to invite all newly registered patients for a consultation within six months. The extra workload involved is reflected in the list-turnover adjustment within the global sum

(iii) the three-year rule. This obligation has been simplified. The contractor must, if a patient is 16 or over, provide a consultation if the patient requests it and has not had a consultation or attended a clinic provided by the contractor within three years

(iv) patients of 75 years or over. The contractor is obliged to provide a consultation to patients aged 75 or over who request it if the patient has not had a consultation within the last twelve months. The workload associated with these checks is reflected in the age/sex cost curve in the global sum formula. The new GMS arrangements represent a change from the existing GMS rules, where the GP has to write offering the consultation. This reflects the objective of promoting self-responsibility for health, and will reduce bureaucracy for contractors. The ongoing need for these consultations to be retained will be reviewed in the light of possible future inclusion of new indicators within the quality and outcomes framework, such as the management of falls.

(iv) **Charging for services**

2.24 Primary medical services for NHS patients remain free at the point of delivery. The existing prohibition on charging NHS patients, except for a very limited range of circumstances, remains under the new GMS contract. The GMS contract regulations outline and clarify those circumstances. Currently, travel vaccines are provided free for infectious diseases where there is a risk that, on
return, the traveller could pass the disease to members of the home population, namely, vaccination against typhoid, poliomyelitis and Hepatitis A.

2.25 The prohibitions, with certain stated exceptions, not only apply to those services a contractor has contracted to provide under GMS but also to any other service it could contract to provide under the NHS. For example a GMS contractor opting out of vaccinations and immunisations may not charge any registered patients for that immunisation if they were eligible to receive the immunisation on the NHS.

C. Patient registration

2.26 Patients register with a contractor for essential services; list-based general practice remains at the heart of the new GMS arrangements. The new arrangements are also designed to increase patient choice and reduce the number of patient assignments to contractors with closed lists. This section explains how the new patient registration arrangements will work and considers:

(i) patient choice of practitioner
(ii) information about patient choice of contractor
(iii) open and closed lists
(iv) the new list closure procedure
(v) assignment of patients to contractor lists
(vi) removal of patients from lists.

2.27 As under old GMS, the Health Board is under a duty to keep and maintain a list of patients. It will be aided in this task by information provided by contractors to the registration systems. From 1\textsuperscript{st} April 2004, lists will show individual patients as being registered with contractors rather than individual GPs. This change will happen automatically. Contractors will be under an obligation in the Statement of Financial Entitlements (SFE) to ensure that their lists of patients are accurate to the best of their knowledge, and that they provide timely notifications of patient registrations and removals. It is important they do this and ensure their lists are clean, not only to ensure accurate calculation of their global sum, but also because their global sum will - given the way in which all allocation formulas work – affect the weighted
populations of other contractors. Contractors with ghost patients on their list will potentially be adversely affecting the income of other contractors.

(i) Choice of practitioner

2.28 Although patients will, from 1st April 2004, register with a contractor rather than an individual GP, patients can still ask to be seen or treated by a particular practitioner. This could for example be the same GP for continuing care, or for a particular condition, or another GP who specialises in that area. When patients register with the contractor, contractors should ask patients if they want to name a preferred practitioner; for example, a female GP. The general assumption would be that the GP with whom patients are currently registered will be the preferred GP but when patients attend they may wish to record an alternative preference which should then be recorded in the patient’s medical record.

2.29 Choice of practitioner cannot be absolute; it also depends on availability, appropriateness and reasonableness. Where a patient asks to see a particular practitioner, the contractor must endeavour to meet these wishes and take into account the following

(i) the availability of the health professional. The patient may have to wait longer to see their preferred practitioner
(ii) patients should bear in mind their general obligation not to unfairly discriminate for example by refusing to see a doctor of a particular ethnic minority
(iii) the practitioner would still be allowed the rights of reasonable refusal, such as in relation to violent patients (if the contractor does not have facilities to deal with such patients), or threats to, or fear for the personal safety of, any practice staff
(iv) the patient may be asked to accept an alternative if, for example, the service required was being delivered by another type of primary care professional. An example is if the contractor’s protocol specifies that a service is nurse-led or therapist-led rather than doctor-led.

(ii) Information about choice of contractor

2.30 Patients can decide which contractor they want to apply to register with and will be helped in this by the proposed new Health Board Guide to Primary Care Medical Services. This will replace the Directory of Family Doctors. Regulations will set out what must be covered in the guide.
2.31 Patient choice is also supported by the requirement that all contractors produce a practice leaflet. The Contract Regulations set out what must be covered by the leaflet. The practice leaflet must be reviewed by the contractor at least annually. The contractor must also make any amendments needed to maintain its accuracy, and all contractors are advised to review and amend their patient leaflets in the light of the new arrangements by 1st April 2004. Key requirements include:

(i) names of clinical staff and partners

(ii) details of how to register, ability to specify a preferred practitioner, and a description of the practice area

(iii) the services available and Health Board contact details (to obtain information about additional services that are not provided by the contractor), including home visits, checks for over-75s etc as described in paragraph 2.23

(iv) the appointment system, where one exists, and normal surgery hours

(v) whether the practice premises have suitable access for disabled patients

(vi) the method of obtaining repeat prescriptions

(vii) how to make complaints

(viii) action that may be taken where a patient is violent or abusive, and a reminder of the rights and responsibilities of the patient, including keeping appointments and respect for race, gender, disability.

2.32 There are two key determinants of whether a patient can register with a contractor. First, the contractor’s practice area, in other words its catchment area. The Contract Regulations specify that this must be agreed with the Health Board as part of the contract agreement, just as it currently is. This should be discussed before the contract is provisionally agreed by 27 of February 2004. The second key determinant is whether or not the contractor’s list is open or closed.

(iii) Open or closed list status
2.34 Under new GMS, contractors are required to declare if their list is open or closed. This will help patients know which contractor they could register with and ensure transparency. The new rules commence on 1st April 2004 and are set out in the Contract Regulations. The Health Board and contractor will need to discuss whether the list is open or closed before they provisionally agree contracts by 27 February 2004. Contractors are therefore advised to reach a view during February 2004 about whether they want their list to be open or closed. Where contractors and Health Boards cannot agree, contractors may wish to note that they can submit an application to close their list when their contract comes into force.

**Open lists**

2.35 If the contractor’s list is open:

(i) the contractor must accept any application to join their list, unless it has fair and reasonable grounds for not doing so. In deciding whether or not to accept a patient, the contractor may not discriminate on grounds of disability or medical condition, age, appearance, race, gender, social class, religion or sexual orientation

(ii) the contractor’s grounds for refusing include:

(a) just cause, for example a patient with a history of violence or the relatives of violent patients, or threats, or fear of personal safety of any of the practice staff. This would not apply if the contractor has been commissioned to deliver the violent patients DES

(b) the patient having previously been removed from the practice list, for example because of an irreconcilable breakdown in the relationship

(c) the patient being from outside the contractor’s area

(iii) the contractor must give reasons for refusals. This has been agreed as part of the UK negotiations and is set out in the Contract Regulations. The contractor must do so in writing and keep a record in relation to each patient, except for applications to become temporary residents. The Health Board may also request such information from the contractor
(iv) the Health Board can assign patients to the contractor with an open list without going through the new patient assignment process. However, in this circumstance the contractor would still have access to the dispute resolution procedure described in chapter 6.

Closed lists

2.36 Health Boards and contractors should note that if a contractor’s list is closed:

(i) contractors must not accept new patients, except immediate family members of existing patients

(ii) obligations in respect of immediately necessary and emergency treatment would continue

(iii) Health Boards can only assign patients to contractors with closed lists in line with the new procedures described in paragraphs 2.37-2.38

(iv) given closed lists are designed to help the contractor manage workload, and the provision of more services would increase workload, the Health Boards may reasonably decide not to offer such contractors:

(a) opted-out additional services for the patients of other practices, or

(b) enhanced services for which the contractor does not have a preferential right, or

(c) further essential services, for example those arising from greenfield or brownfield sites

(v) contractors may wish to note that an increased proportion of funding under new GMS is capitation-based, compared to old GMS. Operating a closed list may therefore have a greater adverse effect on income.

(iv) The list closure procedure

2.37 Chapter 6 of Investing in General Practice describes the new list closure procedure. Table 2 provides a summary for ease of reference, updated to reflect the draft Contract Regulations. For a definitive statement of law Health Boards and contractors must read the Contract Regulations.

TABLE 2 - LIST CLOSURE PROCEDURE
<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
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</table>
| **1** | **INFORMAL DISCUSSION**  
1. The contractor must write to the Health Board if it wishes to close its list  
2. Normally within 7 days - or as soon as is practicable - the Health Board should discuss with the contractor what can be done to keep the list open, eg by providing locum support (for which, to avoid unfairness to other contractors, the Health Board may wish to charge), or commissioning enhanced services from other providers  
3. Discussions should be completed within 28 days of the notification  
4. If following these discussions both sides agree that the list should remain open, the Health Board confirms this in writing |
| **2** | **FORMAL CLOSURE NOTICE**  
1. The contractor has to submit this if agreement is not reached, or if both sides agree the list should close. The Notice sets out the terms of the closure  
2. The contractor will not be able to withdraw a formal closure notice for three months starting from the date of receipt by the Health Board, unless the Health Board agrees otherwise. This rule is designed to discourage ill-considered, rash or otherwise inappropriate requests for list closure  
3. The Notice should include:  
   (i) The proposed closure period; the default is 12 months  
   (ii) The number of registered patients at the time  
   (iii) The proposed percentage reduction in, or absolute number of, patients before the list closure would be suspended and the list would temporarily reopen. This can only happen once in a year except where agreed between the contractor and the Health Board  
   (iv) The proposed percentage increase in, or absolute number of, patients before such a suspension is lifted. Again, this would only happen once a year unless agreed between the contractor and the Health Board  
   (v) Withdrawal from or amendment to the provision of any additional or enhanced services |
| **3** | **HEALTH BOARD DECISION**  
1. The Health Board should confirm receipt immediately in writing  
2. Further discussions may take place to resolve any differences of opinion or disputes about its content  
3. Health Board decision must take place within 14 days from the date of the receipt of the formal closure notice  
4. If the Health Board approves the closure notice:  
   (i) The contractor’s list will close in accordance with the notice  
   (ii) Closure starts from the date that confirmation has been received by the contractor, unless otherwise agreed  
   (iii) The Health Board must confirm its decision in writing  
   (iv) As the closure period draws to an end, the Health Board is advised to write to the contractor giving notice that the list will reopen on a certain date |
| **4** | **ASSESSMENT PANEL DETERMINATION**  
1. If the Health Board rejects the notice, this would lead to determination by an assessment panel. This is a new subcommittee of a different Health Board, comprising a Health Board Chief Executive (or appropriate deputy as defined by the Contract regulations) from another Health Board (to provide |
independence), a patient representative, and a representative of the GP Subcommittee of the AMC.

2. The Health Board provides information to the panel which must include written observations received from the contractor.

3. The panel will be required to consider each rejected closure notice on its merits. This must be carried out in such a way that consistent standards are applied; practices should not be prejudiced according to whether they applied first or last for list closure in any particular area.

4. At least one of the panel members must have visited the contractor, who must comply with such requests, before the panel makes its decision.

5. The decision must take place within 28 days of the Health Board rejecting the closure notice and the Health Board and contractor must be informed in writing.

6. If the panel approves the notice, it must state a start date for closure within seven days. It will also state the arrangements for reopening the list.

7. If the panel rejects the closure notice, the list will remain open. The Health Board should discuss further with the contractor whether any steps should be taken to enable it to continue to practise safely and effectively.

8. The contractor cannot seek to reapply for a closure notice within three months of the panel’s determination.

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# FORMAL DISPUTE

1. Either the Health Board or the contractor can refer a dispute to the Scottish Ministers under the contract dispute resolution procedure described in chapter 6, but only following prior consideration of the assessment panel.

2. Throughout the process, lists remain open until otherwise determined.

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2.38 Whilst Health Boards and contractors are under an obligation to use their reasonable endeavours to avoid invoking the formal procedure, Health Boards should work together to establish assessment panels by April 2004 in readiness for potential disputes over list closures or patient assignments.

**(v) Patient assignments**

2.39 Where a large number of contractors’ lists are closed, it may not initially be possible for a patient to register with a practice. By establishing its own provision, the Health Board can prevent this from happening. However, this may not always prove possible, for example if, following recruitment exercises, there is insufficient supply of local GPs, or in a large rural Health Board where the Health Board provision is too far from the patient’s home and there is no practical alternative provider to a contractor with the closed list.

Given that the Health Board is under a duty to ensure the provision of sufficient primary medical services to meet the reasonable needs of its population, it may in such instances need to assign patients to contractors with closed lists. In assigning patients to a practice the Health Board must take the following into consideration:
(i) the patient’s wishes and circumstances including the distance between the patient’s home and the contractor’s premises

(ii) the contractor’s list status

(iii) whether during the previous six months the patient has been removed from the list of any contractor in the Health Board’s area, and whether the patient has been removed from a contractor’s list because of violence.

Assignment procedure in relation to contractors with closed lists

2.40 The procedure for assigning patients to contractors with closed lists is in some respects the same as that for list closure. It is summarised in Table 3 (again, for a definitive statement of law, Health Boards and contractors should read the Contract Regulations).

<table>
<thead>
<tr>
<th>TABLE 3 - ASSIGNING PATIENTS TO CONTRACTORS WITH CLOSED LISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>1</td>
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<tr>
<td></td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>
1. The Health Board or contractor can ask the Scottish Ministers to review the determination of the assessment panel. This will be determined using the NHS dispute resolution procedure which involves the appointment of a panel of three members with sufficient local knowledge to act as an adjudicator. The adjudicator is the formal arbiter when making binding decisions about patient assignments.

2. Referrals to Scottish Ministers must be initiated within seven days of the date of the determination.

3. More than one contractor may jointly ask the Scottish Ministers to review the determination of the assessment panel. Where that does happen, the adjudicator shall consider the referral in respect of all the contractors as a whole.

4. The adjudicator shall write within seven days to the parties to the dispute notifying them of its appointment and in doing so give them the opportunity (within a given period of up to two weeks) to provide written representations. The adjudicator would copy these to the other parties inviting them to respond in writing, also within two weeks.

5. In considering the dispute, the adjudicator may give the opportunity for oral representations to be made on behalf of the parties. It may also consult with experts (subject to any conflicts of interest) who may be able to help.

6. The adjudicator should make a determination within 21 days and send copies to the parties. This could be extended by mutual agreement of the parties and the adjudicator.

2.41 Health Boards should note that when these procedures take effect they will no longer be able to assign patients to contractors with closed lists without going through this formal procedure. This will require a change of behaviour for those Health Boards that currently assign a large number of patients. Health Boards:

(i) are expected to take steps to reduce patient assignments to contractors with closed lists, for example by establishing Direct Provision.

(ii) may also need to consider whether they will need to put proposals to assessment panels from 1st April 2004 to ensure that they can fulfil their duty to ensure that patients can access primary medical services, and may need to prepare such proposals by then.

(iii) should ensure that assessment panels are established to deal with forced assignments and list closures.

2.42 (vi) Removal of patients from contractor lists

2.43 When patients register or stop being registered with the contractor, the contractor must supply the necessary information as soon as practicable to the Health Board and CSA through the registration system. Where either the Health Board or contractors remove patients from lists they must notify the patients and inform them of their right to receive primary medical services.
from another contractor. Patients may be removed from contractors’ lists for a variety of reasons. A simple summary is provided in Table 4 (again, the Contract Regulations provide the definitive statement of law).

**TABLE 4 - REASONS FOR REMOVING PATIENTS**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Point of removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patient chooses to register elsewhere</td>
<td>14 days after Health Board is notified by the contractor or patient or date when Health Board receives notification that patient is registered with another provider, whichever is the sooner</td>
</tr>
<tr>
<td>2 Teacher or pupil was receiving primary medical services through a school but has left</td>
<td>When Health Board receives list from the school which does not include the patient</td>
</tr>
<tr>
<td>3 Patient moves outside the practice area</td>
<td>Date Health Board is notified by the contractor or patient or 30 days after writing to patient</td>
</tr>
<tr>
<td>4 Patient’s address is no longer known</td>
<td>Health Board notifies the contractor that the patient’s name will be removed from the list after 6 months</td>
</tr>
<tr>
<td>5 Patient joins the armed forces</td>
<td>Enlistment date, or date Health Board is notified by the contractor or patient, whichever is sooner</td>
</tr>
<tr>
<td>6 Patient leaves the country for more than three months</td>
<td>Date patient leaves UK, or date Health Board receives notification from the contractor or patient of intention to leave or that patient has left, whichever is sooner</td>
</tr>
<tr>
<td>7 Patient death</td>
<td>Date the Health Board is notified by the contractor of the patient’s death. Contractors must notify the Health Board by the end of the first working day following the death where death occurs on the practice’s premises - otherwise as soon as is practicable</td>
</tr>
<tr>
<td>8 Contractor requests that an individual patient is removed</td>
<td>Immediate for violent patients When the patient is accepted by/assigned to another practice, or eight days after the date of the request by the contractor to the Health Board for removal, whichever is sooner If at the date of removal, a patient is receiving treatment at intervals of seven days or less, the practice will be required to inform the Health Board of this and removal will take place on the eighth day after the Health Board has received notification from the practice that the person no longer needs such treatment, or on the date that the person is accepted/assigned to another practice. Doctors are also under an obligation under <em>GMC Good Medical Practice</em> guidance to</td>
</tr>
</tbody>
</table>
Removals proposed by contractors

2.44 Where contractors remove patients from their lists they must always inform the Health Board in writing. For individual cases contractors must have reasonable grounds for wishing a patient to be removed. Those reasons cannot be due to the person’s disability or medical condition, appearance, age, race, gender, social class, religion, or sexual orientation. Legitimate grounds for removal may include for example:

(i) violence, or threatening behaviour. This could involve, for example in relation to home visits, the patient, a relative, a household member or pets such as unchained dogs

(ii) crime and deception, for example fraudulently obtaining drugs for non-medical reasons, stealing from the premises or causing criminal damage

(iii) where the relationship between the contractor/practitioner and patient has been broken to the extent that it is necessary to end the professional relationship with the patient. Contractors should note they should not remove patients simply because they are exacting or highly dependent, exhibit high levels of anxiety or demand about perceived serious symptoms, or because they have made a complaint against a practitioner or the contractor.

Warnings and giving reasons for removal

2.45 Contractors should warn the patients before steps are taken for their removal. They may do so by any means they feel appropriate in the circumstances. It may not always be practically possible for a warning to be given to the patient, for example where a warning could result in physical or mental harm to the patient, or put at risk the safety of other people. Warnings should be recorded in writing. This record should note the date that the warning was given. Where a removal does take place and no warning was given, the contractor should also record why. A warning is not required where a patient is removed from a list because that patient moves out of the practice area.

2.46 Contractors will be required to explain in writing to patients their specific reasons for taking action for removing them from their list. In certain cases it may be sufficient to say that there has been a breakdown of the doctor-patient
relationship. The Contract Regulations also require the contractor to keep a written record of the reasons and the circumstances for removing a patient, and these records should be shown to the Health Board if it so requests.

**Administrative removals**

2.47 Administrative removals are where groups or large numbers of patients are removed:

(i) for severe workload reasons, for example the departure of a GP who cannot be replaced in a two-handed practice. The removals are normally achieved by varying the contractor’s area. In these cases, contractors would be required to discuss and agree this with the Health Board

(ii) because a contractor stops holding a primary medical services contract.

2.48 The Health Board must write to all affected patients with as much notice as is reasonably or practically possible, setting out the options available to them. It must ensure they can receive primary medical services, if need be by allocating them to lists of other providers, bearing in mind their best interests. Where the other providers are GMS contractors with closed lists, the Health Board must comply with the assignment procedure.

**D. Additional services**

2.49 Under new GMS there are seven additional services. This section summarises the contractual requirements in Schedule 1 of the GMS Contract (Scotland) Regulations, which are set out in Table 5, and the opt-out rules.

**TABLE 5 - ADDITIONAL SERVICES**

<table>
<thead>
<tr>
<th>Additional service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Cervical screening</td>
<td>1. Providing information &amp; advice to women</td>
</tr>
<tr>
<td></td>
<td>2. Performing cervical screening tests, arranging for women to be informed of the results, ensuring appropriate follow-up</td>
</tr>
<tr>
<td></td>
<td>3. Keeping an accurate record of tests and follow-up</td>
</tr>
<tr>
<td></td>
<td>4. Carrying out screening in accordance with the guidance relating to the NHS Scotland Cervical Screening Programme</td>
</tr>
<tr>
<td>2 Contraceptive services</td>
<td>1. Providing advice about the full range of contraceptive methods</td>
</tr>
<tr>
<td></td>
<td>2. Where appropriate, examining patients seeking</td>
</tr>
</tbody>
</table>
### 3 Vaccinations and immunisations

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Providing all necessary vaccinations and immunisations (except flu and childhood vaccinations and immunisations and certain travel vaccines) set out in the 2003/04 Red Book</td>
</tr>
<tr>
<td>2.</td>
<td>Providing necessary information and advice to patients, and where appropriate to parents, about such vaccinations and immunisations</td>
</tr>
<tr>
<td>3.</td>
<td>Recording in the patient’s records consent to, or refusal of, an offer; the batch numbers, expiry date and title of any vaccine given; the date of administration; where two vaccines are administered in close succession, the injection site of each vaccine; any contraindications to immunisation; any adverse reactions to a dose of vaccine</td>
</tr>
<tr>
<td>4.</td>
<td>All staff involved in administering vaccines must be trained in the recognition and initial treatment of anaphylaxis.</td>
</tr>
<tr>
<td>5.</td>
<td>Ensuring all vaccines are stored in accordance with the manufacturer’s instructions.</td>
</tr>
<tr>
<td>6.</td>
<td>Ensuring all refrigerators in which vaccines are stored have a minimum/maximum thermometer and that readings are taken on all working days. (This requirement, and point 5 above, apply for all vaccinations provided by the contractor including flu and childhood vaccinations and immunisations)</td>
</tr>
</tbody>
</table>

### 4 Childhood vaccinations and immunisations

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Providing all necessary childhood vaccinations and immunisations in accordance with the 2003/04 Red Book</td>
</tr>
<tr>
<td>2.</td>
<td>Requirements for the vaccinations and immunisations additional service also apply</td>
</tr>
</tbody>
</table>
| 5 | **Child health surveillance** | 1. Monitoring the health, well-being and physical, mental and social development of children under 5 to detect any deviations from normal development  
2. Examining the child at a frequency that has been agreed with the Health Board in accordance with the publication *Health for all Children*  
3. Keeping an accurate record of the development of the child while under 5 |
|---|---|---|
| 6 | **Maternity medical services** | 1. Providing through the ante-natal period all necessary maternity medical services to pregnant women  
2. Providing throughout the post-natal period all necessary maternity medical services to patients and their babies other than neonatal checks  
3. Providing all necessary maternity medical services to women whose pregnancy has terminated as a result of miscarriage or abortion. Where the contractor has a conscientious objection to the termination of pregnancy, it must promptly refer the patient to another provider of primary medical services which does not have such conscientious objections |
| 7 | **Minor surgery** | 1. Curettage, cauterity and cryocautery of warts, verrucae, and other skin lesions  
2. Must ensure patient consent is recorded |

**Commissioning additional services**

2.50 Health Boards and contractors should note the following points about the provision of additional services:

(i) Health Boards must ensure that sufficient additional services are in place from 1st April 2004. They may therefore wish to review expected provision with this in mind by 27 February 2004 and draw up plans for filling gaps in services as a result of historic or future opt-outs to take effect from 1st April 2004

(ii) contractors do not have to provide an additional service if they are not currently providing the equivalent service under old GMS

(iii) if contractors are providing the equivalent of that service, they are required to continue to do so under their new GMS contract. However, Health Boards may agree with the contractor, before the formal opt-out rules apply, for the contractor to opt out of some or all additional services. Contractors may therefore wish to consider now, if they have not done so already, whether they may wish to opt out of any additional services
(iv) Health Boards and contractors should ideally reach provisional agreement on additional services by 27 February 2004. In agreeing opt-outs by 27 February 2004, before the contract is signed by 31 March 2004, the Health Board must also ensure that alternative provision is in place.

Additional services pricing

2.52 Contractors are funded through the global sum for the provision of additional services and the tariff for opting out is set out in Table 6. The percentage reduction is only from the global sum, not the global sum and MPIG combined.

<table>
<thead>
<tr>
<th>Additional service</th>
<th>% deduction from the global sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical screening</td>
<td>1.1</td>
</tr>
<tr>
<td>Child health surveillance</td>
<td>0.7</td>
</tr>
<tr>
<td>Minor surgery</td>
<td>0.6</td>
</tr>
<tr>
<td>Maternity medical services</td>
<td>2.1</td>
</tr>
<tr>
<td>Contraceptive services</td>
<td>2.4</td>
</tr>
<tr>
<td>Childhood immunisations and pre-school booster</td>
<td>1.0</td>
</tr>
<tr>
<td>Vaccinations and immunisations</td>
<td>2.0</td>
</tr>
</tbody>
</table>

2.52 There is no fixed price for Health Boards to use when they re-commission additional services that contractors have opted out of; however, the opt-out tariff offers a useful benchmark. The exception is where a contractor is re-commissioned by the Health Boards for providing additional services it had previously opted out of, in which case the opt-out tariff price (that is, the percentage of the global sum at the time) must automatically apply. This is only the case when the re-provisioned contract is solely for the contractors’ registered patients rather than a wider contract to provide, for example, cervical cytology across multiple contractor areas. Where Health Boards are re-commissioning additional services they may wish to do so for a fixed time period rather than for an unlimited duration.

Opting-out of additional services
2.53 Chapter 2 of *Investing in General Practice* explained that opt-outs can either be temporary or permanent. Health Boards and contractors should note that the formal procedure exists so as to provide contractual certainty in the event of local disagreement. Its use embodies a failure to maintain good local relationships that are essential in any contracting arrangement. It is always cheaper and less bureaucratic for both parties, as well as being better for ongoing relationships, if the Health Boards and contractor can simply reach agreement, and where opt-outs are agreed, come to a mutually acceptable start-date.

2.54 The formal procedures for temporary and permanent opt-outs are similar; key differences are that:

(i) temporary opt-outs are designed to enable contractors to cope with temporary workload pressures. As a result they need to be processed and effected quickly; and they normally last for between six and twelve months

(ii) permanent opt-outs require more planning by the Health Board, and so the Health Board may specify a start date of 3 months from receipt of the permanent opt-out notice; and it may extend this by up to two further periods each of three months.

2.55 Table 7 summarises the temporary opt-out process.

TABLE 7 - TEMPORARY OPT-OUT PROCEDURE FOR ADDITIONAL SERVICES

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INFORMAL DISCUSSION</td>
</tr>
<tr>
<td></td>
<td>1. Contractor talks to Health Board - or submits preliminary notice - about wanting to opt out of a specific service on a temporary basis</td>
</tr>
<tr>
<td></td>
<td>2. Within 7 days the Health Board discusses possible solutions to avoid need for opting out</td>
</tr>
<tr>
<td></td>
<td>3. Normally within 10 days discussions are complete and the contractor either decides to submit a formal opt-out notice, or agrees to continue to provide the service</td>
</tr>
<tr>
<td></td>
<td>4. Temporary opt-out is for a period of less than a year</td>
</tr>
<tr>
<td>2</td>
<td>TEMPORARY OPT-OUT NOTICE</td>
</tr>
<tr>
<td></td>
<td>1. The contractor submits a formal opt-out notice</td>
</tr>
<tr>
<td></td>
<td>2. The notice must set out the service concerned; reasons for wanting to opt out; preferred start date - not less than 14 days from the notice date, and preferred duration, normally 6-12 months. A separate notice must be submitted for each service</td>
</tr>
<tr>
<td></td>
<td>3. Health Board will want to start planning for reprovision, unless it has good grounds for rejecting the notice</td>
</tr>
</tbody>
</table>
PCT DECISION
1. Health Board must make a decision within 7 days
2. It can accept the notice, in which case the Health Board specifies the start and end date. Normally these will be those set out in the notice or otherwise agreed
3. Or it can decline, for example if the contractor is providing additional services to patients other than its own or any enhanced services, or it does not agree that the contractor's workload is a temporary problem
4. If the opt-out notice is the third notice from the contractor - for either temporary or permanent opt-out, in relation to any service - within 3 years, the Health Board can treat the notice as a request for permanent opt-out

MAKING TEMPORARY OPT-OUTS PERMANENT
1. Both sides should review progress towards the contractor reproviding the service
2. Contractor can seek to make a temporary opt-out permanent. To do so it must notify Health Boards 3 months before the end date of a temporary opt-out. The Health Board can only refuse by seeking the approval of the assessment panel
3. Alternatively the Health Board may notify the contractor that a permanent opt-out is to follow before the temporary opt-out end-date, where it considers the contractor will not be able to provide the service satisfactorily at the end of the temporary opt-out. The contractor can refer such decisions to the Scottish Ministers. The outcome of this will be determined using the NHS dispute resolution procedures. In this case the end date of the temporary opt-out will be extended whilst dispute resolution is followed

Permanent opt-out procedure

2.56 Permanent opt-out is subject to the procedure summarised set out in Table 8. The detailed procedure is complicated and it is particularly important that reference is made to the full text of the Contract Regulations.

TABLE 8 - PERMANENT OPT-OUT PROCEDURE FOR ADDITIONAL SERVICES

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
</tr>
</thead>
</table>
| 1     | INFORMAL DISCUSSION  
1. Contractor talks to Health Board - or submits preliminary notice - about wanting to opt out of a specific service on a permanent basis  
2. Within 7 days the Health Board discusses possible solutions to avoid need for opt-out  
3. Normally within 10 days discussions are complete and the contractor either submits a formal notice or agrees to continue providing the service |
| 2     | PERMANENT OPT-OUT NOTICE  
1. The contractor submits a formal opt-out notice  
2. The notice must set out the service concerned and reasons for wanting to opt out. A separate notice must be submitted for each service  
3. On receipt the Health Board is advised to start planning for reprovision - unless the Health Board is planning to reject the notice because the
HEALTH BOARD DECISION
1. Health Board must make a decision as soon as possible and in any event within 28 days
2. It can approve the opt-out. In which case the opt-out is that requested by the contractor in its opt-out notice (which will either be the date three or six months after receipt of the notice, or an otherwise agreed date). Once approved, the contractor cannot withdraw the notice without the Health Board’s agreement.
3. The Health Board and contractor should discuss how best to inform patients of the changes. If requested by the Health Board, the contractor must inform its registered patients of an opt-out and the arrangements made for them to receive the additional service by placing a notice in the surgery, and/or including details in a revised patient leaflet.
4. Or the Health Board can reject the notice, for example if the contractor is providing enhanced services or additional services to patients registered with other contractors. In this situation it need not seek the approval of the assessment panel, but the contractor can refer a dispute to the Scottish Ministers. The outcome of this will be determined using the NHS dispute resolution procedures.

HEALTH BOARD EXTENSION NOTICES
1. The Health Board can extend the start date before which permanent opt-out occurs, by up to two further periods each of three months where the start date is three months after service of the notice or one period of three months where the start date is six months after service of the opt-out notice. This is to allow further time for re-commissioning. The Health Board needs to give notice of these to the contractor at least one month before the expected start date of the opt-out.
2. At the end of the period, if despite using reasonable endeavours the Health Board cannot find an alternative provider, the Health Board can, if it considers there are exceptional circumstances, seek approval of the assessment panel to reject the opt-out, or for a further extension.

ASSESSMENT PANEL DETERMINATION
1. The assessment panel must consider such applications by the Health Board to reject or delay opt-out as soon as it can.
2. The assessment panel may decide that there are exceptional circumstances preventing the opt out, e.g. in very rural areas where it has not been possible, despite the Health Board’s reasonable endeavours, for it to re-commission from another provider without detriment to NHS patients.
3. The assessment panel may recommend a different start date for an opt-out, in which case it will start from that date.
4. The assessment panel may refuse the Health Board’s application and so the opt-out start date will be 9 months after the date of the opt-out notice, or 28 days after the contractor is notified of the assessment panel’s decision, whichever is the later. The Health Board must act in accordance with the assessment panel’s decision.
5. Where an assessment panel approves a decision to refuse a permanent opt-out, or itself recommends that a permanent opt-out be refused, that contractor is not normally entitled to submit another opt-out notice (for either a permanent or temporary opt-out) for a period of 12 months following the assessment panel decision.
2.57 Health Boards are advised to start planning for the establishment of assessment panels so that arrangements are in place to discharge their functions under both procedures by April 2004.

E. Out-of-hours services

2.58 This section explains the arrangements for out-of-hours services in the new contract. It considers:

(i) out-of-hours services in GMS contracts

(ii) opt-out arrangements

(iii) sub-contracting, transfer and accreditation

(iv) commissioning alternative out-of-hours services.

Each is described in turn.

(i) Out-of-hours services in GMS contracts

2.59 The out-of-hours period is:

a) the period beginning at 6.30pm on any day from Monday to Thursday and ending at 8am on the following day

b) the period between 6.30pm on Friday and 8am the following Monday and

c) Christmas Day, New Year’s Day and other public or local holidays as agreed by the Health Board

Key features of the new arrangements for out-of-hours services in GMS contracts are:

(i) contractors that wish to retain their existing responsibilities will have the right to do so, provided they can meet national quality standards from 1st January 2005

(ii) where the Health Board agrees, contractors will be able to opt out of their current out-of-hours responsibilities between 1st April and 31st December 2004. From 1st January 2005, contractors will have a right to opt out in all but exceptional circumstances.

2.60 All GMS contracts that come into effect before 1st January 2005 must include out-of-hours services unless the Health Board has agreed to the opt-out, or the contractor is exempt. After 1st January 2005, new GMS contracts will only include out-of-hours services where both parties agree. Where out-of-hours
services are required to be included in a contract, the contractor must provide throughout the out-of-hours period both essential services and any additional services that are part of the core hours contract. However, this does not mean the contractor must provide the same level of service that it provides during core hours. The contractor must meet the urgent needs of patients that cannot safely be deferred. In deciding what service to provide, the contractor is allowed to consider whether the patient could reasonably be expected to wait until core hours to obtain the service.

2.61 Contractors that do not opt out can continue providing those services indefinitely, subject to termination rules set out in chapter 6. From 1 January 2005, all out-of-hours services included in GMS contracts must meet the National Quality Standards for Out-of-Hours Services. These quality standards are currently being developed by NHSQIS and will be available in draft form for consultation on 20 March 2004.

2.62 Some GPs have preserved rights under old GMS paragraph 18(2) to be exempt from out-of-hours services. Where all the GPs in a contractor are exempt in this way, then (unless or until the relevant Health Board agrees otherwise) the duty to provide out-of-hours services to that contractor’s patients will fall instead to any contractor that includes a GP who was responsible for providing out-of-hours services to those patients on 31 March 2004 under the old GMS terms.

(ii) Opt-outs

2.63 The opt-out process for out of hours is set out in the Contract Regulations and is largely the same as for permanent opt-out from additional services. The opt-out tariff is 6% of the global sum. Key points in relation to out-of-hours opt-outs are:

(i) Health Boards are encouraged to find out contractors’ intentions as early as possible, and confirm these by 27 February 2004

(ii) where Health Boards have firm plans for implementing alternative out-of-hours provision, the easiest approach is for the Health Board and contractor to agree an opt-out date when they are discussing the content of contracts in February 2004. This avoids the need to go through the formal procedure

(iii) Health Boards and contractors can give opt-out notices after signing their contracts. Unlike additional service opt-outs, there is no preliminary notice process
(iv) opt-out from out-of-hours services is permanent; there is no temporary opt-out

(v) opt-out is all or nothing. The contractor cannot for example, opt out only at weekends, or only in respect of certain groups of patients; though once the opt-out has happened, it could be commissioned by the Health Board to provide such services

(vi) unlike additional services, the contractor does not have to give reasons for opting out. It has to specify the date it wants the opt-out to come into effect. This must be either three or six months from the notice date

(vii) when responding to the notice (within no more than 28 days), the Health Board cannot refuse the opt-out request. For notices given before 1st October 2004, it can however set a different target date for the opt-out to take effect. This can be any day from the date specified by the contractor up to 1st January 2005. For notices given after 1st October 2004, the Health Board must specify the date given by the contractor in its opt-out notice (that is, 3 or 6 months from the date of the notice)

(viii) the Health Board must do its best to put in place the necessary arrangements for the contractor to opt out by that target date. Where this is not possible the Health Board can, if necessary, extend the period to 9 months or until 1st January 2005, whichever is the later by following the procedure in the Contract Regulations. This means that all contractors who wish to opt out by 1st January 2005 should do so immediately after they have signed their GMS contracts, in writing by 1st April 2004. The nine month rule means that, for example, a contractor that gives notice on 1st May 2004 may not be able to opt out until 1st February 2005, if the Health Board is unable to secure alternative provision before then

(ix) the Health Board can only refuse or further delay opt-out in exceptional circumstances, for example if the contractor’s location is so remote or isolated that there is no realistic alternative to the contractor continuing to provide its own out-of-hours services. SEHD will be performance managing Health Board progress towards effective re-provision within these timescales
nothing in the opt-out procedures prevents Health Boards and contractors at any time agreeing a different date for the opt-out to take effect.

(iii) Sub-contracting and transfer of responsibility

2.64 Sub-contracting of out-of-hours services is subject to specific rules:

(i) contractors who provide out-of-hours services will normally have to obtain permission from Health Boards before they sub-contract those services to other out-of-hours providers. Health Boards will be able to withhold (or subsequently withdraw) this permission if they are not satisfied that the terms of the contract (including, from 1st January 2005, the national quality standards) will be met.

(ii) contractors who want to sub-contract will need formally to apply in writing for permission, giving details of the provider and the proposed arrangements. This does not apply to occasional, short-term arrangements, nor to sub-contracts to locum doctors, informal rotas or to other GMS practices or Section 17C schemes that provide out-of-hours services. Health Boards will be expected to respond as soon as possible to a contractor’s request to sub-contract, and normally within 28 days.

(iii) where the contractor plans to sub-contract to a provider with which the Health Boards is familiar (for example an out-of-hours provider with which it has a contract itself) then this is likely to be largely a formality, unless there are concerns about the provider’s ability to cope with the additional workload.

(iv) where the provider is unfamiliar – or is one about which the Health Board has other concerns – the Health Boards will want to assure itself that the proposed provider will be able to deliver an appropriate service. The Health Board may, if necessary, request further information before making a decision, and it may also attach conditions to its approval.

2.65 The requirement to gain permission for sub-contracting applies from the date of the new contract, and therefore applies to contractors that are waiting to opt out. However, until 31 December 2004 contractors will continue to be able to transfer responsibility for out-of-hours services, so they will generally not need to sub-contract. During the transitional period the current arrangements for transfers will continue more or less as per the old GMS regulations.
Contractors will be able to continue to transfer responsibility for out-of-hours services to another provider in accordance with any arrangements approved by a PCT and in force at 31 March 2004 in relation to any of the GPs who make up the contractor. Contractors will also be able to apply for approval to make new transfer arrangements. The information they need to supply will be largely the same as under the old system, and the detail is set out in Schedule 7 to the Contract Regulations.

2.66 The effect of a transfer is that, whilst the service will still be provided under the contractor's GMS contract, the contractor will not be liable for any breaches of the terms of the contract by the other provider. Transfer is only available in respect of out-of-hours services automatically included in the GMS contract, not for any other out-of-hours services it may have voluntarily agreed to provide. As now, PCTs that are not satisfied that transfer arrangements are (or continue to be) satisfactory will be able to refuse or withdraw permission as necessary. If contractors disagree with these decisions, they will be able use the contract dispute resolution procedure to challenge them (rather than appealing to the Scottish Ministers as at present). Where PCT decisions under the old Terms of Service are already the subject of an appeal at 31 March 2004, the appeals process will continue unless the parties agree otherwise, and the decision will be treated as if it had been made under the dispute resolution procedure.

2.67 Until 31 December 2004, if transfer arrangements end for whatever reason, the contractor will continue to be responsible for making alternative arrangements. However, PCTs should also have contingency arrangements in place for considering what support, if any, they should provide to contractors in this situation. 2.68 All transfer arrangements will end automatically on 31 December 2004. Contractors which still have transfer arrangements in place on 31 December 2004 will automatically be treated as having permission to convert the arrangement into a sub-contract.

(iv) Commissioning alternative out-of-hours services

2.69 By 1st January 2005 it is expected that all Health Boards will be fully responsible for securing out-of-hours services for their local populations. Each Health Board is actively planning for future provision of OOH services. The funding arrangements are further described in chapter 5.

2.70 The new Health Board responsibility is a major opportunity to shape and deliver better quality more integrated services; it is not just an operational challenge. In planning provision, Health Boards will wish to take a strategic
view looking across the delivery of primary, acute and emergency services. All the OOH services will need to meet the National Quality Standards for Scotland.

2.71 GMS contractors, including those who have opted out of out-of-hours, can at any time approach the Health Board with a view to providing out-of-hours services to their own patients or those of other contractors. Health Boards should consider such requests within the context of their overall strategy for out-of-hours services. When agreeing that the contractor will provide such services, the contractor and the Health Board will also need to agree the terms on which the arrangement can be ended (which can, but need not, be the same as the opt-out procedures).

2.72 Contractors that opt out still have an interest in the out-of-hours services that are provided to their patients, as well as a responsibility to help ensure that their patients receive seamless care. Health Boards will want to keep contractors informed of the out-of-hours services available to their patients, including any proposed changes.

2.73 All GMS contracts will include a term requiring contractors to co-operate with other people who provide out-of-hours services to their patients. Co-operation might include providing and receiving information about patients, although members of the contractor cannot be required to make themselves available during the out-of-hours period. There will need, for example, to be a system in place for the transmission of information to providers about patients with special needs (including violent and vulnerable patients, and those who are terminally ill) and for contractors in turn to receive timely details of the out-of-hours care provided to their patients. Contractors which opt out, or otherwise stop providing services, will also be required to provide any information reasonably requested by the Health Board or the alternative provider which is to take over the service.

2.74 It is vital that patients are fully informed of how to access out-of-hours services. Health Boards will want to have developed plans for effective public engagement well in advance of opt-outs taking effect. They may wish to develop these as part of the wider process of planning, by January 2004, community engagement on the new contract generally. Patients will benefit from more integrated services, all of which, for the first time, will have to meet the OOH national standards from 1st January 2005. GPs will benefit from a better work/life balance. The change will help improve recruitment and retention of GPs and enable primary care capacity to be expanded. The change will also enable GPs to focus on delivering better quality services in hours.
2.75 All GMS contacts will include a term requiring contractors to include information about how to access out-of-hours services in their practice leaflets. Contractors which do not provide out-of-hours services must also take reasonable steps to ensure that patients who contact the practice by telephone during the out-of-hours period get accurate information about how to obtain out-of-hours services. Contractors with clear telephone messages, or whose calls are transferred automatically to out-of-hours providers, will also be able to gain points in the organisational domain of the quality and outcomes framework.

F. Enhanced Services

2.76 Enhanced services represent a major new opportunity for Health Boards to expand the range of primary care services and they will want to consider this when they draw up their local health plans. Commissioning Enhanced Services can improve choice and convenience for patients and deliver value for money for the NHS. It is a key tool for Health Boards to use to help improve secondary care access through reducing pressures on out-patient and in-patient hospital departments. This section describes:

(i) definition and monitoring arrangements

(ii) preferred provider status

(iii) commissioning other enhanced services.

Each is considered in turn.

(i) Definition and monitoring arrangements

2.77 Health Boards will be placed under a duty through directions to commission all five current Directed Enhanced Services (DES) to meet the needs of their population. In line with paragraph 2.13 of Investing in General Practice, the Contract Regulations define enhanced services as follows:

(a) “medical services other than essential services, additional services or out of hours services; or

(b) essential services, additional services or out of hours services or an element of such a service that a contractor agrees under the contract to provide in accordance with specifications set out in a plan, which requires of the contractor an enhanced level of service provision to that which it needs generally to provide in relation to that service or element of service”.

53
The Contract Regulations allow the medical services to be of any type, in any setting, and to extend beyond the scope of primary medical services. There is no legal constraint as to what types of NHS medical services a Health Board can commission through the four provider routes described in section A of this chapter. This will give Health Boards a broad ability to develop more integrated services across the primary, secondary and acute sectors.

2.78 However, for the purposes of financial monitoring, the definition of enhanced services is drawn more tightly than the legal definition. Health Boards will be notified of their enhanced services expenditure floor level in the February 2004 allocations, which they will be expected to meet but can exceed. Health Boards will need to consider carefully what constitutes an enhanced service for the purpose of accurate financial monitoring. This will be undertaken at national level by the joint BMA/NHS Confederation/Health Departments Technical Steering Committee. Whilst a precise national definition would not be sufficiently sensitive to local issues, Health Boards and contractors should bear in mind that, generally speaking, the following spend would count towards the floor:

(i) commissioning, or direct Health Board provision, of Directed, National or Locally Enhanced Services from any provider, not just GMS and Section 17C schemes.

(ii) services provided within Section 17C schemes

(iii) if the Health Board proposed, for example, to re-commission a service that had previously been placed with a NHS trust it would count towards the floor, regardless of the outcome of the contest, but only providing that:

(a) it was contestable for GMS and Section 17C contractors

(b) it is a service that might reasonably be provided by GMS and Section 17C contractors, for example because looking across the UK there are other such contractors delivering similar services.

2.79 The following would not count:

(i) spend on primary medical services that is funded through other routes described in chapter 5, such as primary care administered funding, spend on essential services (including greenfield and brownfield sites), and spend on any additional or out-of-hours services (except where
spend is for the purpose of delivering services to a higher standard than that normally required)

(ii) baseline spend on services provided through Health Boards or other providers, for example an accident and emergency-based minor injuries service commissioned from an acute hospital, or existing services delivered by GPs in community hospitals or as clinical assistants. These baseline services cannot be included for as long as the existing contracts are simply rolled forward.

2.80 Health Boards are expected to draw up initial plans for commissioning of enhanced services to meet, or exceed, their local floor on 27 February 2004. These should include proposals for commissioning the five DESs. The GP subcommittee of AMC should be consulted about the proposed level of spend, and the Health Board should seek to obtain GP subcommittee of the AMC agreement that the proposed services count within the above definition for financial monitoring purposes. Where there is a dispute over what counts towards the floor, the GP subcommittee of the AMC and Health Board should seek to resolve this locally in the first instance. Disputes over what counts towards the floor should not delay the commissioning of the service. Where a dispute remains unresolved, the Health Board would need to indicate in its financial returns to the SEHD that the level of spend is disputed. The TSC would then in turn note that some of the funding within its assessment of spend is disputed. It is important that Health Boards keep copies of correspondence with GP subcommittees of AMCs; they may need to send these to the SEHD to inform the TSC’s monitoring of the Gross Investment Guarantee, which is described in chapter 5.

(ii) Preferred provider status

2.81 GMS contractors have preferred provider status for two DESs: quality information preparation and childhood vaccinations and immunisation target payments if that contractor is providing the additional service. Health Boards must offer these services to GMS contractors, using the DES specifications and prices which are set out in the SFE. They will want to do so, and reach agreement with contractors, before GMS contracts are provisionally agreed by 27 February 2004. Contractors do not have preferred provider status for other enhanced services newly commissioned by the Health Board but pre-existing arrangements for enhanced services would continue for the duration of those contracts.

(iii) Health Board commissioning of other enhanced services
2.82 Health Boards will be under a legal obligation to commission services for violent patients, influenza immunisations, and minor surgery (all from 1st April 2004). These can be commissioned from any provider, or the Health Board can provide the service itself. However, it is likely that Health Boards will in most instances want to commission these services from the patients’ own GMS contractors and Section 17C providers, to ensure continuity of care.

2.83 The main purpose of enhanced services is to expand the range of local services to meet local need, improve convenience and choice and ensure value for money. Before making commissioning decisions Health Boards are advised to bear in mind what contractors are legally obliged to provide under the definitions of essential and additional services set out in sections B and D of this chapter.

2.84 The Health Board commissions enhanced services as primary medical services; they only become GMS services when they are provided as part of a GMS contract. The Health Board has discretion to draw up specifications on the basis of local need and it can also decide when it wants to commission most enhanced services. For example, a Health Board could choose to commission minor surgery from a Section 17C or commercial contractor using a different specification and at a different price from the GMS NES specification. Nonetheless, Health Boards may wish to be guided by the twelve GMS Nationally Enhanced Specifications in the Supplementary Documents. GMS contractors may expect, and may only be willing, to offer enhanced services on the basis of the GMS NES specifications and prices. Commissioning decisions are entirely a matter of local negotiation (and the contract dispute resolution procedure described in chapter 6 does not apply); Health Boards will want to make commissioning decisions on the basis of quality, accessibility, choice, and value for money. Health Boards will also want to consider the duration of such contracts.