‘Implementing the new GMS contract in Scotland’

4. Modernising Infrastructure
4. MODERNISING INFRASTRUCTURE

SUMMARY OF KEY POINTS

1. Contract implementation requires effective support strategies to develop human resources and modernise infrastructure.

2. The existing medical and supplementary lists will be replaced by the single Primary Medical Services Performers List on 1st April 2004. The Department will publish guidance on the transition in March 2004.

3. The contract is designed to support increases in primary care capacity and changes in skill-mix. Health Boards will want to ascertain contractors’ intentions in relation to employment of new staff whilst discussing contract changes, so that this can be reflected in workforce planning.

4. Work/life balance will be improved through the out-of-hours changes. Recruitment and retention will continue to be supported through the Retainer Scheme and Golden Hellos (which will be reviewed during 2004/05). The move to a practice basis for contracting will help make full use of the talents of the primary care team. Health Boards will want to work with contractors during 2004 to implement Agenda for Change principles. Practice management has a critically important function under the new contract and Health Boards will want to review their support arrangements for practice managers during 2004.

5. New pensions flexibilities to support portfolio working were introduced in November 2003. Regulations to implement the other pensions changes set out in Investing in Primary Care will come into force later in 2004 and will be accompanied by guidance. Health Boards and contractors will need to agree an amount of notional superannuable earnings by April 2004. This will be retained from the global sum for employer contributions, and the amount will be revised up or down in the light of actual superannuable earnings.

6. Premises payments to contractors will be set out in separate Directions, which the Department will publish in March 2004. New standards, set out in Investing in Primary Care, will come into effect from 1st April 2004.
Introduction

4.1 The GMS contract is primarily about the services to be delivered to patients (chapter 2), the quality standards for those services (chapter 3), and the supporting investment (chapter 5). But effective implementation also requires effective support strategies to develop human resources and modernise infrastructure. This chapter considers:

A. Human resources
B. Premises
C. Information management and technology

A. Human resources

4.2 Primary care professionals need to be eligible to perform services; they need to be recruited and retained; their ongoing development needs to be supported during their working lives; and they deserve adequate pensions when they retire. This section considers:

(i) primary medical services performers list
(ii) increasing workforce capacity
(iii) ongoing support and development
(iv) pensions.

Each is considered in turn.

(i) Primary medical services performers list

4.3 Chapter 7 of Investing in General Practice stated that the current medical, supplementary and PMS services lists would be rationalised into a single primary medical services performers list. This was enabled by the Primary Medical Services (Scotland) Act 2004. It will come into force on 1st April 2004 through the NHS (Primary Medical Services Performers’ Lists)(Scotland) Regulations 2004.

4.4 Listing is mandatory for individual qualified doctors who personally perform NHS primary medical services for patients, or who intend to perform such services. There are a few exceptions: such as a medical practitioner, who is
provisionally registered under section 15 (provisional registration), 15A (provisional registration for EEA nationals) or 21 (provisional registration) of the Medical Act 1983 may perform medical services where those services are performed in the course of the practitioner’s employment in a resident medical capacity in an approved medical practice; and a limited easement which applies to GP registrars for the first two months of their training period. Providers of the services are not entitled to be listed unless they personally perform, or intend to perform, the services.

**Transitional arrangements**

4.5 The arrangements will:

(i) ensure that the migration of doctors from existing lists to the new medical performer lists proceeds smoothly. In most cases this will be straightforward. Doctors included on one of the existing lists will transfer automatically on 1st April 2004. This will also apply to doctors who are suspended on 31st March 2004. Some GPs are currently listed on more than one medical list. This will change from 1st April; from this date they will only appear on one list, that of the Health Board in whose area the greatest number of their patients reside. Where there is doubt the relevant Health Boards will need to decide, taking account (but not being bound by) representations from the affected GP. This will not affect the right of GPs to work in any Health Board area

(ii) make transitional provision for the treatment of any doctors in relation to whom issues are being dealt with under the medical, supplementary medical and services list provisions on or before 31 March 2004. These will be dealt with under the medical performer list provisions from 1 April 2004. Any action that had been taken under the old lists is deemed to have been taken under the performer list regulations. Special arrangements again need to be made for those doctors who change Health Board on 1 April 2004

(iii) ensure that relevant decisions that were taken under the provisions of the existing regulations continue to have effect (or equivalent effect) once the performer list regulations come into force.
Under new GMS, questions arising from the operation of contracts with providers will be dealt with using the contract disputes mechanisms described in chapter 6. Questions relating to the suitability, efficiency or probity of individual doctors who are performing primary medical services will be dealt with by using regulations made under section 17P of the 1978 NHS (Scotland) Act (the NHS (Primary Medical Services Performers Lists) (Scotland) Regulations 2004).

(ii) Increasing workforce capacity

The Department’s workforce strategy can be summarised as more staff, working differently. The new contract will support an expansion of workforce capacity and changes in skill-mix. This requires effective workforce planning as well as ways of supporting the recruitment and retention of GPs and other primary care professionals.

Workforce planning

Contractors will have freedom to spend their overall budget as they see fit. They will be rewarded for the outcomes they deliver under the quality and outcomes framework, rather than be constrained in relation to specific input conditions such as those that existed under old GMS, through for example the GP basic practice allowance. This autonomy and flexibility, combined with the increased investment described in chapter 5, and the change in out-of-hours arrangements described in chapter 2, are likely to lead to increases in primary care workforce capacity and changes in skill-mix.

Health Boards are advised to consider the workforce planning implications of the new contract, the changes to PMS (Section 17C arrangements) described in February 2004 guidance, and the new Health Board direct provision and alternative provider delivery routes described in chapter 2. They will want to ascertain the intentions of their contractors about, for example, plans to recruit additional staff to support the implementation of the quality and outcomes framework. Health Boards will then want to ensure that this information is fed into their local and regional workforce planning networks and that it forms part of local and regional workforce plans which set out arrangements for building capacity and developing skills within the workforce. This in turn will form part of the national picture and national workforce plan for NHSScotland.

Recruitment and retention

This will be supported by:
(i) the out-of-hours changes. GPs and other primary care professionals can expect a better work/life balance. The transfer of responsibility by the end of December 2004 for out of hours to the Health Board will make general practice a more attractive place to work. Contractors will also benefit from the new ability to manage workload through the ability to opt-out of certain additional services and the new procedures to reduce assignments to contractors with closed lists.

(ii) increased investment in primary care which will support workforce expansion. The devolution of primary care funding to Health Boards, combined with the introduction of the Health Board provider and alternative provider routes, gives Health Boards the ability to develop new services in areas that have historically been under-doctored, and the ability to develop innovative ways of employing GPs, nurses and practice managers to support GMS and Section 17C providers.

(iii) new opportunities for GPs to become salaried to GMS contractors, to Health Boards and to out-of-hours providers, where this better suits their particular circumstances. This is supported by the introduction of the model salaried contract which includes a pay range and flexibility for Health Boards and contractors to offer salaries commensurate with local labour market conditions. Details are set out in Supplementary Documents.

(iv) new opportunities for nurses, allied health professionals, practice managers and others (including consultants) through (a) the introduction of a practice-based contract, (b) the delivery of a wider range of services through the enhanced services route, and (c) delivery of better chronic disease management and organisational standards through the quality and outcomes framework. In a way that is similar to Section 17C arrangements, it will be possible to have nurse-managed, or therapist-managed GMS services. Practice staff will also be supported through the introduction of the principles underpinning Agenda for Change, if approved at ballot. Whilst Agenda for Change is not mandatory for non-NHS employees, GMS contractors, as part of the broader “NHS family” will be expected to implement its principles and will want to work closely with their Health Boards on this, particularly in relation to the effective use of the Job Evaluation Scheme and the Knowledge and Skills Framework or equivalents.

(v) the continuation of specific supply-side incentives: golden hellos in 2004/05 and the retainer scheme. These remain as entitlements in the
2004/05 Statement of Financial Entitlements (SFE). The golden hello scheme was introduced in Scotland in 2001 as a time-limited measure to improve conversion rates of GP registrars and to improve recruitment in rural and remote and historically under-doctored areas. Its efficacy in achieving these objectives will be reviewed during 2004/05. The four UK Health Departments and/or their agents will consult the GPC on these proposals

(vi) ongoing development and support to improve working lives, which is considered further below.

Ongoing support and development

4.11 Ways in which Health Boards will be able to help provide ongoing support and development include through:

(i) application of the Department’s Workforce Strategy, including “Careers for Health”, the Staff Governance Standard and PIN guidelines. Specialist interest development is a key aspect and will be supported through the commissioning of more specialised services using the enhanced services budget

(ii) Health Boards will want to encourage and support GMS contractors (particularly larger practices) to apply the principles of the Staff Governance Standard and to pursue PIN guidelines. This will help support recruitment and retention, job satisfaction, and also contribute towards achieving points in the organisational standards within the quality and outcomes framework (eg education and training and patient communication)

(iii) supporting the appraisal of all staff. Guidance entitled “GP Appraisal: A Brief Guide” was issued to all GPs in March 2003 and covers the preparation for, and conduct of, the appraisal process.

(iv) provision of locum support and partial reimbursement for locum costs where necessary for maternity, paternity, adoptive leave, sickness leave, to cover for suspended doctors, or for the prolonged study leave scheme. Details of minimum requirements are included in the draft Statement of Financial Entitlements. The costs will be funded from the Health Board-administered budget described in Chapter 5. Health Boards will also be under a new legal obligation from 1st April 2004 to develop and seek to agree with the LMC a policy for locum cover and payment arrangements. This should include what proportion of the
maximum funding would be available to those with a less than full working commitment. This is because the existing Red Book rules on that point have been simplified to allow greater local flexibility. Health Boards may wish to use the 37.5 hours in the model salaried GP contract as a guide to full-time working. The Department advises that Health Boards should develop policies and consult LMCs during March 2004.

(v) the Directed Enhanced Service for those patients who threaten violence or commit violent acts, which Health Boards must commission and which will ensure that all Health Boards have secure facilities available to see violent patients.

(vi) new pension flexibilities to support portfolio careers. These are described later in this section.

(vii) supporting practice management. Practice managers will have an increasingly important role as they become the experts in the operation of the new contract, including all the new mechanisms outlined in this guidance. Health Boards are advised to review their support arrangements for practice management during 2004.

(viii) supporting practice nurses. The Scottish Executive is developing a framework for nursing in general practice in partnership with professional bodies, to be published in the summer of 2004. This will provide both a structure to support the development of practice nursing roles and a set of governance standards drawn from the GMS contract which will support practices in being good employers of nurses.

(ix) providing the same access to childcare arrangements in primary care as exist for Board staff working elsewhere in the NHS.

**Employment law**

4.12 GMS contractors are obliged to:

(i) provide written terms and conditions of service in contracts

(ii) not unfairly dismiss an employee

(iii) allow for ante-natal care, maternity leave, paternity leave, adoption leave, and parental leave, if their employees satisfy the relevant entitlement conditions under employment legislation for those types of
leave. Additionally, employees have common law rights to a reasonable amount of time off, where necessary, to care for dependants. Employees of contractors will, if they qualify, be entitled to statutory sick pay from the contractor for 28 weeks of absence on account of sickness in any three years

(iv) not discriminate on the grounds of gender, marital status, race, colour, disability or Trade Union membership (additionally, as a matter of policy, we expect GMS providers not to discriminate on the grounds of age, religion, creed or sexual orientation)

(v) not to make deductions from wages without agreement

(vi) consult fully and make appropriate payments in a redundancy situation

(vii) recognise the rights of staff transferred from another NHS employer, and

(viii) comply with the Public Interest Disclosure Act 1998 which gives full protection of the law to all self-employed NHS professionals who act in the public interest. In Scotland, guidance is supplied in the PIN Guideline “Dealing with Employee Concerns” which contains a model Freedom of Speech Policy.

(iv) Pensions

4.13 General practitioners have been included in the NHS Superannuation Scheme in Scotland (NHS Scheme) since it was established in 1948. They automatically become members unless they decide to opt out. As with other scheme members, their own contributions are based on 6% of their pensionable earnings, and from 1st April 2004 the Health Board which is treated as their employer, contributes an amount equal to 14% of their pensionable earnings. Chapter 5 describes how the increase in contributions will be funded by an increase in the global sum. It will also be possible for certain Out-of-Hours providers who satisfy specific eligibility criteria, to be able to apply for approval as an employing authority for the purposes of the NHS Scheme. Further guidance on this matter is issued by the Scottish Public Pensions Agency (SPPA) and is available at [http://www.scotland.gov.uk/sppa/nhs/circ504.pdf](http://www.scotland.gov.uk/sppa/nhs/circ504.pdf)
Calculation of Pensionable Pay

4.14 Chapter 5 of *Investing in General Practice* explained how the definition of NHS pensionable earnings will be broadened. In broad terms pensionable earnings will include all fees and regular remuneration, net of expenses and overtime, paid to practitioners in respect of the provision of primary medical services, and any other services that are treated as NHS work, but excludes all income derived from work undertaken on behalf of a commercial organisation. It will also include profits, net of expenses, for the practitioner in providing clinical placements for students undertaking a recognised course of healthcare learning and development. The Scottish Public Pensions Agency is working towards changing the NHS Scheme to reflect the new definition for pensionable earnings. To this effect, amendment Regulations should be in force before the Scottish Parliament goes into recess on 28th June 2004. The Regulations will be accompanied by an information circular which will be discussed with SGPC. This circular will also set out the detail of the other pensions changes described in this section.

4.15 Future contributions paid by general practitioners as employees, and the employer’s contribution paid on their behalf, will be assessed on practice profits. An estimated sum will normally be retained at Health Board level from the global sum and paid to the Scottish Public Pensions Agency monthly. For this year, as an interim measure, Practitioner Services Division (PSD) of the Common Services Agency (CSA) has estimated the practice liability for pension contributions. This has been calculated as 15% of the practice Global Sum allocation. On an all-Scotland basis this rate recovers an amount equivalent to the level of contributions paid last year, uprated to allow for the increased employers contribution rate from 5.5% to 14%. As this is an estimate, this method will be reviewed during the year and may be subject to revision to enable greater accuracy in matching deductions with practice liabilities. At the end of the year the practice accountants will produce a certificate of NHS profits in a specified form, yet to be devised, to be signed by GPs. The completed certificates will need to be agreed with the Health Board and forwarded to the Scottish Public Pensions Agency with any balance of payments. This will also inform the calculation of the uprating factor and also the final calculation of seniority pay. In future working commitment in relation to seniority will be calculated on the basis of average superannuable earnings.
Uprating factor

4.16 In the new contract, the uprating factor is based on the actual growth in GP pensionable earnings across the UK compared with the previous year. This will be adjusted by the Joint Health Departments/NHSC/GPC Technical Steering Committee to take account of the shift to less than full-time working. The exact figures cannot be known until after the end of the financial year, so the TSC will estimate an interim award to mitigate any short-term loss in benefits for newly retired doctors while the actual uprating factor for the year is assessed. The interim reward will be set at a level that avoids the need to make subsequent reductions or reclamation of pension or lump sum.

Admission of non-GP partners to the NHS Scheme

4.17 The existing right of non-GP practitioners in section 17C to join the scheme is being extended to non-GP partners in GMS practices from 1st April 2004. They will be admitted on an officer basis; their eventual benefits will be assessed on the basis of final year salary, on the same basis of calculation as other officer members of the NHS Scheme. Their contributions will be assessed on profit share. Non-GP partners will have no redundancy rights under the NHS Compensation Scheme although they will have access to the NHS Injury Benefits Scheme.

Flexibilities

4.18 The new contract introduces new flexibilities in the way that pensions are calculated for doctors who have worked in both general practice and other specialities. Doctors working in both general practice and hospital or community care, or who move between them, accrue benefits under both assessment regimes, and although the NHS Scheme legislates specifically for these circumstances, the results may not always be optimal. To support doctors who pursue portfolio careers, four new pension flexibilities have been introduced for those doctors retiring on or after 1 April 2003. These complement existing rights by broadening the range of methods used to calculate final benefits where there is a mixture of GP and non-GP accrual. All options will be tested at retirement and the most favourable will be applied. Doctors currently working in the NHS will benefit automatically from the new flexibilities, and the impact will extend to their full scheme membership, not just that from the effective date of the regulations. All pension benefits will be automatically safeguarded when doctors move between GP and non-GP work.
4.19 The amending regulations came into force on 29 November 2003, and have retrospective effect from 1 April 2003. The new flexibilities are:

(i) doctors who work for less than ten years in hospital or community care (known as officer service) or as a GP Registrar before becoming a Principal Practitioner will receive the most favourable of the following:
   (a) a separate pension for hospital work using the non-GP formula plus a separate GP pension
   (b) an addition to the practitioner pension pro rata to hospital work
   (c) a GP pension for all work

(ii) doctors who work in hospital or community care (known as officer service) for more than 10 years before becoming a Principal Practitioner will receive the most favourable of the following:
   (a) a separate pension for hospital work using the non-GP formula plus a separate GP pension
   (b) a GP pension for all work

(iii) doctors who work in general practice before moving to hospital or community care (known as officer service) will receive a separate non-GP pension and the more favourable of the following:
   (a) a GP pension plus pensions increases (linked to prices)
   (b) a GP pension increased by uprating factors linked to pay up to retirement

(iv) doctors who work in both general practice and hospital or community care (known as officer service) for more than one year at the same time will receive the more favourable of the following:
   (a) a separate pension for hospital work using the non-GP formula plus a separate GP pension
   (b) a GP pension for all work.

B. Premises

4.20 The contract allows Health Boards to agree to the extent of reasonable premises costs they incur and the nature and level of payments to be made. Where premises are used to provide services other than general medical services, payments will be reduced proportionately. Health Boards will need to comply with the payment arrangements, which will be set out in Directions to be published in April 2004. The new funding arrangements for Health Boards are described in chapter 5.
4.21 Contractors whose premises were approved for payment at 31 March 2004 need not seek confirmation of that approval in order to continue receiving payments calculated under the arrangements that existed on that date. The arrangements set out in the rest of this section will come into operation in respect of any changes made to existing premises, when new premises agreed in the contract are brought into use or any of the payment mechanisms outlined in this guidance are effected.

4.22 Health Boards should be satisfied that new premises development or refurbishment demonstrates value for money. In so doing, Health Boards, in consultation with the District Valuer, shall have regard to SEHD and NHSScotland Property and Environment Forum guidance and standards from time to time in force which will be available at www.show.scot.nhs.uk/gpweb. There may be occasions where, for example, because of the physical nature of the building/site, full compliance with published standards is not possible for an otherwise suitable site or building. In such cases, the Health Board should be satisfied that any reduction of or enhancement to those standards is reasonable and demonstrates value for money. Where a contractor does not agree with a Health Board decision not to accept premises or disputes the level of funding offered by the Health Board, the matter will be resolved through the dispute resolution arrangements described in chapter 6.

Minimum standards

4.23 Chapter 4 of Investing in Primary Care set new quality standards for premises to be used for the delivery of general medical services. It also set out actions to be taken should any premises not meet those standards. Details are available at www.show.scot.nhs.uk/gpweb.

Payments

4.24 This section sets out the arrangements by which recurrent payments for new or substantially refurbished premises should be calculated. Health Boards should seek advice from the District Valuer on matters relating to current market rent, open market valuation and permissible augmentations to current market rent payments to permit leasehold developments in areas with unsupportive property markets. Contractors may receive, at the Health Board’s discretion, payments towards for example, costs to improve practice premises, overcome barriers to capital investment or assist moves from poor premises into modern replacements. The main arrangements are set out in Table 12:
### TABLE 12 - PREMISES PAYMENTS

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Description</th>
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<tr>
<td>1 <strong>Owner-occupier</strong>&lt;br&gt;<strong>Borrowing costs</strong></td>
<td>1. The appointment of a firm to undertake construction works should normally be subject to at least three written quotes following an open competitive tendering exercise. The GMS Contractor and the Health Board should agree which quote represents best value for money.&lt;br&gt;2. A prescribed percentage should be applied to the necessary level of loan incurred to meet the aggregated cost elements. Costs can include: site purchase, building works, reasonable professional fees agreed in advance with the Health Board, any rolled-up interest incurred on loans taken to procure the premises, necessary local authority and planning application fees, VAT where properly applied and any pre-agreed levels of furnishing, fitting and equipping.&lt;br&gt;3. The prescribed percentage for fixed interest rate loans is equivalent to the 20 high year gilt rate issued by the Bank of England plus 1.5%. Details of the Gilt rate are at Gilts Yield.&lt;br&gt;4. The variable prescribed percentage, which should be recalculated annually, is the Bank of England Base Interest Rate plus 1%. Details of Base Rates are at Base Rate.</td>
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<tr>
<td>2 <strong>Subsequent changes</strong></td>
<td>1. Borrowing cost payments arrangements may transfer when an outgoing practitioner sells his or her equity interest in the premises to an incoming practitioner at the outstanding level of borrowing required to purchase the premises.&lt;br&gt;2. Where the practitioner is financing the scheme wholly or mainly from his or her own money, ie any loan is for the lesser part of the total cost, the prescribed percentage will be that agreed by the Health Board as representing best value for money.&lt;br&gt;3. Contractors in receipt of a fixed interest rate loan should advise their Health Board of any change of lender or any reduction in the level of interest charged to their loan.&lt;br&gt;4. From 1 April 2004, where a practitioner changes lender and/or re-negotiates lower loan costs, the cost rent reimbursement level shall be recalculated using the appropriate prescribed percentage in force at the time that the changed loan arrangements came into effect.&lt;br&gt;5. From 1 April 2004, when a practitioner has repaid his or her loan, entitlement to borrowing cost payments shall cease and be replaced with notional rent payments.&lt;br&gt;6. Health Boards should also conduct an annual enquiry of Contractors to confirm what borrowing arrangements are in place. Health Boards should recover any overpayments made to practitioners after 1 April 2004.</td>
</tr>
<tr>
<td>3 <strong>Rental costs for leasehold premises</strong></td>
<td>1. Payments for all rented premises will initially be based on the current market rent (CMR) or the actual rent whichever is the less. The CMR will be set having regard to the terms of the lease on offer adjusted, if necessary, to a tenant’s internal repairing basis. The CMR will be reviewed to take account of periodic landlord reviews of the rent. The exception is where the landlord review results in no change to the rent charged or to the lease itself.&lt;br&gt;2. For leases where landlord reviews are linked to an index (for example, RPI), the level of rental payment will be adjusted in accordance with the arrangements set out in the lease. Health Boards should receive a copy of the</td>
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lease being offered and obtain advice from the District Valuer as to the appropriateness of the terms and the initial rent being offered.  
3. In all cases, VAT should be added where this is properly charged by the landlord.

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<tr>
<td>4</td>
<td><strong>Notional-rented premises</strong></td>
</tr>
<tr>
<td></td>
<td>1. Contractors which owner-occupy their premises may opt to change from payments based on their borrowing costs and receive a notional rent. Payments will be calculated using the current market rent (CMR) assumptions contained in the notional lease and be reviewed three-yearly after the first payment has been made. Only in the event of a change in the purpose for which the premises are to be used or as a result of further capital investment in the premises agreed in the contract will a subsequent assessment be made earlier than the normal three-yearly review date.</td>
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<td></td>
<td>2. Full notional rent will be equivalent to the current market rent assessment. Where NHS capital has contributed to the cost of the work completed the full notional rent will be abated in proportion to the total cost of the work carried out. On completion of the development, the abated notional rent payable should be calculated in accordance with the details to be found at <a href="http://www.show.scot.nhs.uk/gpweb">www.show.scot.nhs.uk/gpweb</a>. The abated notional rent will be paid to the Contractor for a period of 10 years, after which full notional rent will become payable.</td>
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| 5 | **Temporary premises costs** |
|   | Occasions arise whereby premises are to be wholly replaced on the existing site or extension work may require the practice to move to temporary premises. Where agreed in the contract, Health Boards may provide a grant and/or recurrent funding to meet associated set-up and rental costs. |

| 6 | **Improvement grants** |
|   | At the Health Board’s discretion, contractors may receive a grant of between 33% and 66% towards costs incurred to improve their premises to provide GMS. Examples include reconfiguration of the internal layout, adding an extension, DDA compliance and improved security. |

| 7 | **Uplift to current market rents** |
|   | Current market rent levels in some areas of deprivation and rural or remote communities may be too low to provide sufficient returns to support new capital investment in practice premises or provide sufficient support for existing premises that meet minimum standards. Where this is the case, CMR may be augmented by the Health Board, at the time the initial lease is signed, in accordance with advice from the DV. The resulting level of reimbursement will remain in payment until it is overtaken by the naturally occurring current market rent, or as otherwise agreed at the time that the initial lease is signed. |

| 8 | **Notional rent and leasehold premises** |
|   | Notional rent may be paid in respect of tenant improvements agreed in the contract carried out by practitioners on their leasehold premises to the extent the improvement is not reflected in the rent charged by the landlord. |

<p>| 9 | <strong>Combined borrowing</strong> |
|   | Notional rent may be paid also to practitioners in addition to |</p>
<table>
<thead>
<tr>
<th>Cost and Notional Rent Payments</th>
<th>Borrowing cost payments when further capital investment still results in a CMR on the whole premises which is lower than the existing borrowing cost payments being made.</th>
</tr>
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<tbody>
<tr>
<td>1 0 Reconversion of former residential premises</td>
<td>Health Boards may award a grant to re-convert former residential premises to their former use.</td>
</tr>
<tr>
<td>1 1 Guaranteed minimum sale price for redundant owner-occupied premises</td>
<td>To overcome any lack of surety on the sale price of redundant practice premises, Health Boards may provide a grant to ensure a guaranteed minimum sale price to enable a contractor to move to modern alternative premises to improve the range of services provided to patients.</td>
</tr>
<tr>
<td>1 2 Legal and other professional fees for new purpose-built premises</td>
<td>Health Boards may agree to pay a grant towards legal and other professional fees incurred by Contractors who occupy new leasehold premises or new owner-occupied premises built or significantly improved under notional rented premises payment arrangements.</td>
</tr>
<tr>
<td>1 3 Reimbursement of equipment leasing costs in new leasehold premises</td>
<td>Health Boards may meet reasonable costs of lease arrangements to furnish, fit and equip new practice premises.</td>
</tr>
<tr>
<td>1 4 Grant to meet mortgage deficit and/or redemption Costs</td>
<td>Health Boards may meet all or a proportion of mortgage deficit and early redemption penalty costs in respect of contractors which move from old premises to modern alternatives.</td>
</tr>
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C. Information Management and Technology

4.25 The payment and information systems that are required to support the new contract are being developed by the Common Services Agency (CSA) in conjunction with the Department of Health GMS Payments Project. This is in parallel with an ongoing programme managed by the CSA’s new GMS contract co-ordinating team to roll out, in a way tailored to local circumstances, an updated technical platform that will enable the delivery of enhanced functionality to all Scottish practices. Full details of the national and local roll out programmes can be found at www.show.scot.nhs.uk/gmsimt/

Funding for maintenance and upgrades

4.26 Each NHS Board, as part of the nGMS IM&T planning process, will be formalising a series of processes to ensure that for all GP systems an appropriate hardware refresh system is in place, that mentoring/training services are available and that a support and maintenance arrangement following the national template is in place. These processes will, regardless of system, provide a robust underpinning infrastructure to support the on going development of GP computing. Desirable core elements for practice IT systems are listed in [http://www.dh.gov.uk/assetRoot/04/07/86/61/04078661.PDF]. Local NHS Board implementation plans will ensure, as funding permits, that all practices are appropriately equipped to meet the current and developing needs of practices in the light of the ongoing functionality enhancement agenda as agreed between SEHD and SGPC.

4.27 Each GP clinical system supplier has given an undertaking to the Department that each of their RFA Scotland accredited systems is being developed to meet the precise needs of the contract. Therefore, advice to NHS Boards and practices is not to make immediate changes to system supplier, unless there are pressing needs to do so which can be justified within a business case prepared in accordance with standard SEHD guidance on the preparation of business cases.

Clinical coding

4.28 Detailed specifications to enable suppliers to develop solutions to support the Quality and Outcome Framework have now been released. Contractors and Primary Care Trusts should not, therefore, develop local queries to support the Quality and Outcomes Framework with respect to quality points generation.
Contractors should not develop local Read Codes as these will result in a loss of earnings for contractors and poor quality data for Health Boards. An interim release of Read Codes was made on 1 October 2003 containing the new exception codes for the Quality and Outcomes Framework. This, together with the logical query specification and associated business rules, contains the complete set of Read Codes products. As the Quality and Outcome Framework requires an up-to-date set of Read Codes to be present in clinical systems for payment purposes, contractors will need to ensure that they are working with the correct versions at all times. Further information on Read Codes is available from the NHS IA (tel: 0121 3330333) or at http://www.nhsia.nhs.uk/terms/pages/default.asp.

Service Level Agreements

4.29 Chapter 4 of Investing in General Practice states that “a national template SLA will be developed to support the development of future primary care IT systems providing practices with assurances on training, maintenance and support. The national template will allow local enhancements and additions in line with national programmes”. A national template SLA for Scotland which takes into account the current relationships between practices, Health Boards and system suppliers as well as the emergence of national and local service providers has now been published and is available at www.show.scot.nhs.uk/gmsimt.

National Information Management and Payment Systems

4.30 Work is in hand on a UK-wide basis to define the functionality that will be required in GP clinical and Health Board systems to support Quality and Outcomes Framework Payments. GP clinical system suppliers have been fully informed of these developments and are currently working to develop the required enhancements to their systems.

4.31 A national testing and certification programme is being developed with the support of the profession and the NHS Confederation to ensure that the outputs from GP clinical systems for QOF payments are produced in compliance with national standards to apply on a UK-wide basis.

Training and support

4.32 A national GP IT mentoring programme has been put in place to raise practice awareness of the capabilities of their GP IT system and to guide ongoing
training activity and development of longer term Health Board training strategies that help practice staff to develop the skills that they need to make best use of clinical systems and information.

**Baseline Audits**

4.33 Baseline audits of GP IT in use across Scotland has been carried out to inform national and local development strategies

**Implementing the new GMS contract**

4.34 There are a number of actions that Health Boards and contractors should have in hand in implementing the contract:

(i) contractors may wish to review system management and information governance in the light of the “Good Practice Guidance” recently published by SEHD, BMA and Royal College of General Practitioners and available at [http://www.doh.gov.uk/pricare/computing/index.htm](http://www.doh.gov.uk/pricare/computing/index.htm) and the Scottish commentary thereon, available at [www.show.scot.nhs.uk/gmsimt/](http://www.show.scot.nhs.uk/gmsimt/). Contractors should also be aware that it is the intention that customised guidance for Scotland will be developed in parallel with any update of the Good Practice Guidance being produced by the Joint Computing Committee of GPC and RCGP in conjunction with the Department of Health to address any changes of circumstances in England.

(ii) contractors will want to set up and maintain disease registers in accordance with good practice guidance published at [http://www.nelh.nhs.uk/nsf/chd/sig/secondary/appendix1.htm](http://www.nelh.nhs.uk/nsf/chd/sig/secondary/appendix1.htm).

(iii) contractors must ensure that the correct clinical codes associated with the Quality and Outcomes Framework are being used. Detailed further information on the codes is at [http://www.doh.gov.uk/gmscontract/implementation.htm](http://www.doh.gov.uk/gmscontract/implementation.htm).

(iv) contractors may want to review existing templates and protocols with system suppliers to ensure that they meet the requirements of the new contract

(v) contractors may want to undertake training needs assessment as part of ongoing contractor development programmes.