‘Implementing the new GMS contract in Scotland’

5. Financing Primary Medical Services
5. FINANCING PRIMARY MEDICAL SERVICES

SUMMARY OF KEY POINTS

1. Investment in primary medical services will increase by an unprecedented level of at least 33% between 2003/04 and 2005/06 in Scotland. The Gross Investment Guarantee mechanism will ensure delivery.

2. GMS contractors will be entitled to payments set out in the 2004/05 Statement of Financial Entitlements (SFE), which replaces the Red Book. Contractors are encouraged to submit claims under the Red Book by the end of March 2004.

3. The final version of the SFE in Scotland was published under the cover of NHS Circular PCA(M)(2004)13 on 11 May 2004 with effect from 1st April 2004. Most GMS funding will be non-discretionary.

4. Responsibility for the bulk of the contract funding will lie with Health Boards. The old GMS non-cash limited arrangements were replaced from April 2004 by cash-limited allocations from the Department to Health Boards. Health Boards were notified of a single actual allocation for primary medical services including Section 17C, in draft form in April 2004 and final form in May 2004. The allocations identify for each Health Board a floor level of spending on enhanced services that cannot be breached but can be exceeded. The allocations also include funding for the Quality Aspiration payments. The remaining funding for the balance in relation to Quality Achievement payments will be held centrally and allocated at a later date during the financial year 2004/05.

5. The allocations include funding an increase in the global sum price to reflect the increase in employers’ superannuation contributions.

6. The existing restrictions on spending the Out-of-Hours Development Fund will be lifted.

7. Funding for existing, agreed and new premises spend will be allocated directly to Health Boards in the Primary Medical Services allocation for 2004-05. The Funding for IM&T is also allocated directly to Health Boards in the Primary Medical Services allocation for 2004-05.

8. Introduction of the new GMS contract will be monitored and performance
managed as set out in the Implementation Schedule in Section 7 of this guidance.

9. Financial reporting will need to reflect the new arrangements. SEHD with PSD and NHS Boards will review monitoring returns and financial information requirements for the new system by June 2004. The joint DH/BMA/NHSC Technical Steering Committee (TSC) will also monitor spend.

Introduction

5.1 The new GMS contract is supported by an unprecedented level of new investment in primary care services, new mechanisms for Health Boards to fund contractors and for the Department to fund Health Boards, and new information flows.

5.2 This chapter describes how the new financial arrangements will work:

A. Gross Investment Guarantee
B. Contractor entitlements
C. Allocations to PCTs
E. Financial monitoring and management

Each is considered in turn.

A. Gross Investment Guarantee

5.3 UK spend on primary medical services will rise by 33% between 2002/03 and 2005/06, from £6.1 billion in 2002/03 to £8 billion. This will be delivered through the Gross Investment Guarantee (GIG) mechanism. The UK GIG total is the aggregate of the national GIGs in England, Scotland, Wales and Northern Ireland. In Scotland resources are expected to rise from £433m in 2002/03 to £575m in 2005/06. This includes funds for Section 17C.

5.4 £559.2 million of resources are being allocated to Health Boards in the 2004-05 Primary Medical Services allocations. This is summarised in Annex A to this Section. This total allocation is comprised of the following elements:

(i) £510.7m identified as the GMS Funding Envelope figure for 2004-05
(ii) An additional £32m (transferred from HM Treasury) identified as the funding required to meet the increased employers’ superannuation contributions (to the 14% level) for GPs and practice staff, and an estimate of the amount needed to cover the additional superannuation contribution (at 14%) anticipated as a result of new income generated under the new contract.

(iii) An additional £16.5m of funding to further support delivery of Primary Medical Services in 2004-05

5.5 Any in-year financial pressures will need to be effectively managed by Health Boards from within their overall resource envelope. In-year financial pressures will not lead to in-year changes to contractor entitlements. Paragraph 5.7 of Investing in General Practice also made clear that “to ensure delivery of the GIG the pricing of the contract could be adjusted”. Were the need to arise for such adjustments to be made, the four UK Health Departments and/or their agents would be required to consult the General Practitioners Committee before making changes to the Statement of Financial Entitlements for subsequent years.

5.6 Future increases in resources beyond 2005/06 would lead to increases in both the GIG and the SFE entitlements. These will be considered as part of future negotiations between the four Health Departments or their agents and the GPC.

B. Contractor entitlements

5.7 This section:

(i) describes arrangements for making outstanding Red Book payments

(ii) summarises the Statement of Financial Entitlements

(iii) describes general conditions attached to SFE payments.

5.8 GMS GPs were entitled to a number of payments under the old Red Book arrangements that come to an end on 31st March 2004. The principle of entitlement continues in new GMS, but on the basis of a contractor practice rather than an individual GP. The new Statement of Financial Entitlements (SFE) gives contractors certainty about the minimum level of key resources they will receive that year. Health Boards will have no discretion over (i) whether to make most SFE payments (an obvious exception being the Prolonged Study Leave payments which require Health Board approval) or
(ii) the value of those payments. Discretionary funds will also be available to practices, for example those that successfully compete for provision of enhanced services. Contractors will also be entitled to receive pensions entitlements under separate pensions regulations.

(i) Completing final payments under the Red Book

5.9 Health Boards and Practitioner Services Division (PSD) of the Common Services Agency (CSA) have been encouraging GMS GPs to submit by the end of March 2004 all claims for services undertaken in the financial year 2003/04 and prior years. This is to enable prompt payment by Health Boards, and to improve contractors’ cash-flow.

5.10 When completing their 2003/04 Statutory Accounts Health Boards should make adequate year-end provision for sums outstanding to practices for services provided before 1st April 2004. This will have implications for in-year cash and resource management and is considered further in paragraph 5.67. Any under-statement of year-end creditors will need to be managed in 2004/05 by the Health Board. There will be no additional resource cover from the Department.

(ii) SFE entitlements

5.11 Health Boards and contractors are encouraged to read the Scottish SFE issued separately. The first SFE covers 2004/05 only and a revised SFE for subsequent years will be published, following consultation, before April 2005. We anticipate that this will include a schedule of payments to be revised annually, to avoid the need for updating the whole SFE each year thereafter.

5.12 Table 14 summarises the entitlements:

**TABLE 14 - CONTRACTOR ENTITLEMENTS**

<table>
<thead>
<tr>
<th>Entitlement</th>
<th>Description of key aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Global sum</td>
<td>1. New entitlement that subsumes some existing payments relating to running costs of the practice</td>
</tr>
<tr>
<td></td>
<td>2. Based on the global sum the Scottish allocation formula which reflects patient need and contractor costs, allocates each practice its share of the Scotland-wide global sum</td>
</tr>
<tr>
<td></td>
<td>3. This corresponds to an average of approximately £58 per registered patient.</td>
</tr>
<tr>
<td></td>
<td>4. An off-formula Temporary Patients Adjustment, calculated on a rolling 5-year historic average.</td>
</tr>
<tr>
<td></td>
<td>5. Calculated quarterly, paid by end of each month</td>
</tr>
</tbody>
</table>

| See Part 1 of the Scottish SFE and Annex B of the Scottish SFE | |
| See Part 1 of the Scottish SFE and Annex B of the Scottish SFE | |
| **2** | MPIG  
See Part 1 of the Scottish SFE and Annex D of the Scottish SFE | 1. Based on comparison on 1st April 2004 of initial global sum (adjusted for historic opt-outs) with uplifted historic income from relevant fees and allowances between 1st July 2002 and 30th June 2003  
2. Adjusted for GP vacancies, practice mergers and splits, and also changes in list size between 1st July 2003 and 31st March 2004  
3. Fixed amount, but uplifted in line with the global sum uplift  
4. Paid to qualifying contractors in addition to the monthly global sum  
5. A separate calculation of GSE and MPIG for current Inducement Practitioners is set out at Annex D Part 2 to the Scottish SFE |
| --- | --- | --- |
| **3** | Quality preparation (QPREP)  
See chapter 3 of the guidance and Part 2 of the SFE | 1. £3250 for a contractor with average national list size of registered patients, for practice to decide how to support preparation required for implementing contract  
2. 2004/05 is the second and final year of QPREP  
3. Paid as a lump sum in April 2004 subject to agreeing aspiration points |
| **4** | Quality aspiration  
See chapter 3 of the guidance and Part 2 of the SFE | 1. For 2004/05, one third of anticipated achievement points agreed with Health Board, at £75 per point for a contractor with average Scottish list size of registered patients  
2. New method from 2005/06 based on 60% of previous year achievement points, uprated to 2005/06 price and adjusted for prevalence  
3. Paid at end of every month |
| **5** | Quality achievement  
See chapter 3 of the guidance, and Part 2 of the SFE | 1. Achievement payment is the difference between the total QOF entitlement and aspiration payments made  
2. Total QOF entitlement is the achievement points multiplied by £75 per point in 2004/05 for a contractor with average Scottish list size of registered patients  
3. For each disease area, pounds per point are multiplied by the Adjusted Disease Prevalence Factor to reflect differential workload  
4. For the additional services domain, pounds per point are adjusted to reflect the relative contractor target population  
5. 2004/05 achievement paid as a lump sum by end of April 2005 |
| **6** | DES - Quality Information Preparation (QuIP)  
See chapter 3 of the guidance Part 3 of the SFE | 1. Must be offered by Health Boards to all contractors that agree a QuIP plan.  
2. Provides a contribution to the costs of summarising and maintaining summaries of patient records  
3. Price must be between £1000-£5000 per contractor with an average national list size of patients  
4. 2004/5 QuIP must be paid by end of April 2004 for plans agreed on or before 1st April. For plans agreed after 1st April, payment is made when the next global sum monthly payment falls due  
5. 2004/05 is second and final year of QuIP |
| 7 | DES - Childhood vaccinations and immunisations (CVI)  
See Part 3 of the SFE | 1. From April 2004, Health Boards must offer CVI DES to all contractors which do not opt out of providing the vaccinations and immunisation additional service.  
2. Existing arrangements are rolled forward from the Red Book. For achieving the 70% and 90% targets for both 2 and 5 year olds average payments of £897 and £2691 will be paid per quarter. These amounts are adjusted by determining the proportion of children immunised against those on the Childhood Vaccinations and Immunisations Register and comparing this with the average number of children per 5000 population  
3. Informed dissent does not apply  
4. Payments are made quarterly |
| 8 | Locum payments  
See Part 4 of the SFE | 1. Existing Red Book arrangements are simplified for locum cover for GP partners for:  
(a) sickness leave  
(b) adoptive leave  
(c) paternity leave  
(d) maternity leave  
(e) suspended doctors  
(f) prolonged study leave  
2. Health Boards must develop local policies on paying locum reimbursement and seek to agree these with the GP Sub Committee of the AMC. The policies must include how less than full-working commitment would be treated, using the salaried GP employment contract hours as a guide  
3. Link to years of service ends but list size criteria remain  
4. Maximum amount payable is £948.33 per week for a full-time GP  
5. Payments must be made within 14 days of claims being submitted |
| 9 | Seniority payments  
See Part 4 of the SFE | 1. The new payments scale in the 2003/04 scheme is further enhanced in 2004/05  
2. Entitlement will be based on superannuable earnings of GP providers. Health Boards and contractors will need to agree notional superannuable earnings to produce an indicative seniority payment. This will subsequently be adjusted upwards or downwards once year-end certificates of superannuable earnings have been agreed in the following year  
3. The retention incentive payment scheme ends from 31st March 2004. If a GP’s seniority entitlement in each year from 2004/05 is less than the sum of the old seniority amount in 2002/03 and retention incentive payment scheme income in 2003/04, the difference is made up  
4. Payments must be made by the end of each month |
| 10 | Golden Hello Scheme  
See Part 4 of the SFE | 1. The existing scheme is rolled forward from the Red Book  
2. Working commitment is determined by the proportion of hours worked compared with the 37.5 hours specified in the model contract for salaried GPs |
3. Arrangements whereby eligible GPs are entitled to additional payments for eligible practices in remote and rural or deprived areas remain in place.  
4. The scheme will be reviewed and is expected to change in 2005/06.

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| 11 | **Retainer Scheme**  
Sees Part 4 of the SFE | 1. Health Boards must pay to contractors £57.33 for each full session undertaken by a member of the Doctors’ Retainer Scheme up to four sessions a week provided that the sessions have been arranged with the Director of Postgraduate GP Education.  
2. Payments must be made by the end of the month in which the sessions were worked. |
| 12 | **Dispensing**  
Sees Part 4 of the SFE | The existing arrangements are rolled forward from the Red Book. |
| 13 | **Existing premises costs**  
See chapter 4 of the guidance, Part 5 of the SFE and separate Directions | Existing payments for premises are brought forward from the Red Book to reflect the new GMS funding arrangements. |
| 14 | **IT minor upgrades and maintenance**  
See chapter 4 of the guidance and Part 5 of the SFE | NHS Boards, rather than contractors, are responsible for the purchase, maintenance, future upgrades and running costs of integrated IM&T systems and are developing processes to provide a robust underpinning infrastructure to support the ongoing development of GP computing. |

(iii) **Conditions attached to SFE payments**

5.13 Specific conditions are attached to each entitlement and these are described in the SFE. A broad summary is:

(i) contractors must make available to the Health Board any information which the Health Board does not have and needs

(ii) information supplied by the contractor must be accurate to the best of its knowledge. This includes information used for capitation-based payments on the size of the contractor’s registered patient list held by Practitioners Services Division (PSD) of the Common Services Agency (CSA). Contractors must ensure that they provide full, accurate and timely information to registration systems and will as a result be co-operating with list cleaning exercises undertaken by Health Boards

(iii) sums are generally payable only in respect of the duration of the contract, so if a contract starts or ends in year the full annual payment is reduced according to the number of days for which the contract has run.
(iv) breach of the SFE conditions is treated as a breach of contract and is subject to the rules set out in chapter 6 of this guidance.

(v) Health Boards and contractors are obliged to co-operate with investigations by authorities such as auditors and counter-fraud services.

C. Allocations to Health Boards

5.14 This section gives an overview of the Primary Medical Services allocations to Health Boards for 2004-05. It describes:

(i) Global sum and MPIG funds

(ii) Out-of-hours funds

(iii) Enhanced services funds

(iv) Quality funds

(v) NHS Board-administered funds

(vi) Premises funds

(vii) IT funds

(viii) Section 17C (PMS) funds.

Introduction

5.15 The Primary Medical Services (Scotland) Act 2004 places Health Boards under a new duty to provide or secure the provision of primary medical services. The Primary Medical Services allocation for 2004-05 funds delivery of these services through a range of contractual options: General Medical Services (GMS) Section 17C schemes (formerly Personal Medical Services (PMS)) Health Board Medical Services (HBMS) Health Board Direct Provision

5.16 Under new GMS arrangements Health Boards will receive cash-limited allocations rather than be reimbursed for the expenses they incur as a result
of paying entitlements to contractors. This means that the previous GMS non-discretionary arrangements will cease. Health Boards will manage the resources for Primary Medical services with those in the unified allocation to meet national and local service targets and will continue to have a responsibility to live within their overall resource allocation. The allocations will identify notional amounts for each funding element, except for enhanced services, which will have a local funding floor that cannot be breached but can be exceeded.

5.17 The principle of contractor entitlement, combined with different levels of historic spend in Health Boards for different funding streams, means that there can be no overall primary medical services allocation formula and target progression applied to the totality of those funds. Such an approach would not target resources with sufficient accuracy. For this reason a tailored approach is to be taken to allocating each of the main funding sources.

(i) **Global sum and MPIG funds**

5.18 The Global Sum allocation covers the payments Health Boards will make to GMS practices as a contribution towards contractors’ costs in delivering essential and additional services, including staff costs, under the new contract. It also covers part of the baseline funding for Section 17C schemes (see also NHS Board Administered Funds) which Boards will use towards meeting the agreement value of locally negotiated Section 17C schemes. The Global Sum is calculated at practice level using the Scottish Allocation Formula (SAF). The calculation will be revised quarterly, based on quarterly changes to the registered practice list size, and a proportion paid monthly to practices. The Global Sum allocation at Board level is an aggregate figure for practices in the Board area which will change to match actual practice allocations through the year.

Any practice’s global sum which is less than it received in global sum equivalent fees and allowances is entitled to a minimum practice income guarantee (MPIG) payment. The allocation of MPIG funds at Health Board level comprises the payments that Boards will make to GMS practices to deliver this income guarantee through the “correction factor” payments to practices. The allocations are based on a data set supplied by PSD at January 2004. Boards will be required to manage any variations, due to changes in the data set since January 2004, within their overall resource allocation.
In some cases funding for GMS practices has been historically vired from the Unified Budget into GMS. For the purpose of calculating the Global Sum Equivalent and MPIG requirements at NHS Board level, this funding will have been identified and removed from the GSE calculation. The Scottish Executive Health Department and the Scottish General Practitioners Committee have agreed a set of guiding principles which can be used in future decision-making around how this funding is played back in as the new GMS contract is fully introduced. These principles are:

- Current funding arrangements should not be withdrawn from a practice unilaterally
- Instances of possible double funding should be discussed, clarified and agreed between the practice and the Board
- Where instances of double funding have been established and agreed between the practice and the Board, alternative options for the redeployment of these funds within the practice should be explored and agreed between the practice and the Board
- Thereafter, alternative options for the redeployment of these funds on local primary care priorities will be explored and agreed between the GP Subcommittee of the AMC and the Board
- Where no agreements can be reached either on the existence of double funding and/or on the redeployment of these resources, new GMS contract dispute resolution procedures will apply.

5.19 Health Boards should note that global sum and MPIG funding includes the staff element of GMS cash-limited resources.

5.20 The Global Sum allocation contains an additional £32m (transferred from HM Treasury) identified as the funding required to meet the increased employers’ superannuation contributions (to the 14% level) for GPs and practice staff, and an estimate of the amount needed to cover the additional superannuation contribution (at 14%) anticipated as a result of new income generated under the new contract.

(ii) Out-of-hours funds

5.21 When determining how to secure integrated out-of-hours (OOH) services, Health Boards will need to consider all the resources available to them in the unified budget (eg resources used for emergency care networks) and elsewhere.

5.22 Additionally, they will have access to two specific sources of funding:
(i) allocations to Health Boards from the Out of Hours Development Fund (OOHDF) are to be increased from £6.3m in 2003/04 to £6.8m in 2004/05 and £10m in 2005/06.

(ii) these resources will be supplemented by 6% of global sums (not global sums plus MPIGs) of contractors that opt out.

5.23 The OOHDF allocation in 2004-05 is based on the allocations for 2003-04, with a 7.9% uplift applied. The OOHDF will remain for use on out-of-hours primary medical services (however provided), but the detailed rules on its use contained in the Statement of Fees and Allowances will no longer apply.

(iii) **Enhanced services funds**

5.24 The Enhanced Services allocation includes funding for some services that were previously funded from the GMS non-cash limited budget. This allocation forms the agreed 2004-05 Health Board Enhanced Services floor. The allocations have been calculated using the Scottish Allocation Formula at Health Board level.

5.25 Planned spend against the enhanced services floor must be discussed with the GP Subcommittee of the AMC. Spend against the floor will be monitored by TSC on the basis of the definition described in chapter 2.

(iv) **GMS quality funds**

5.26 Chapter 3 explained how GMS contractors will receive four types of quality payment: (i) quality preparation (QPREP), (ii) quality information preparation (QuIP), (iii) quality aspiration and (iv) quality achievement. These are all legal entitlements: in particular, Health Boards must fund contractors fully for whatever level of points they achieve on the QOF scorecard. Section 17C agreements will include a quality and outcomes framework which mirrors the GMS QOF; or where appropriate is negotiated and agreed locally in accordance with local circumstances. In either case, the overall quality points available should equate to a total of 1,050.

5.27 Allocations are made on the following basis:

(i) QuIP is an enhanced service funded from the Enhanced Services line of the GMS allocation
(ii) funds for Quality Preparation cover the one-year cost of paying all contractors for preparing implementation of the Quality and Outcomes Framework and are included within the Primary Medical Services allocations for 2004-05, on the basis of Health Board registered populations collected from PSD, as detailed in the SFE.

(iii) Quality Aspiration payments: These funds cover the Aspiration payments agreed between Health Boards and contractors, as detailed in the SFE. To ensure Health Boards have sufficient funds to cover these payments the allocation to boards is based on an assumption of all practices in the Board area requiring the maximum Aspiration payment level. Any surplus funding will be retained by the Board and the balance used towards meeting Quality Achievement payments, payable at 31 March 2005. From 2005/06 resources will be allocated on the new basis for calculating aspiration payments, once achievement payments have been confirmed by Health Boards.

(iv) Health Boards will be notified of the allocation of any remaining Quality funding in relation to Quality Achievement payments later in the year.

5.28 There is a cost to high quality primary care and higher than expected achievement against the QOF will require financial risk management across the NHS in Scotland. Boards should also note that high quality primary care, and in particular better chronic disease management, will over time help reduce avoidable A&E and outpatient attendances and hospital admissions, improve health outcomes and improve patient experience.

5.29 The Scottish Executive Health Department’s current estimate is that the Scotland GIG includes sufficient provision to support an average of 80% of practices achieving 80% of the quality points available. The method for monitoring, as closely as possible, the emerging levels of actual achievement against the new Quality and Outcomes Framework across Scotland will be developed with the GMS Contract Finance Working Group and the Quality Group and the information shared with Health Boards for the purposes of financial planning and financial risk management. The GMS Contract Finance Working Group will also consider the best approach to managing the financial risk associated with quality achievement and whether this is best managed at a local or national, Scotland-wide level.
(v) **NHS Board Administered funds**

5.30 The allocation of NHS Board Administered funds support a number of different entitlements, including (i) seniority, (ii) the retainer and golden hello schemes and (iii) locum allowances for maternity, paternity and adoptive leave, sickness, suspended doctors and prolonged study leave and are based on the historic level of these payments in each Board area.

5.31 The funding also covers direct provision of services by Health Boards where appropriate. The allocation takes account of the new arrangements for previous Inducement Practitioners and Associate GPs. This allocation additionally covers part of the baseline funding for Section 17C schemes which Health Boards should use towards meeting the agreement value of locally negotiated Section 17C schemes.

(vi) **Premises funds**

5.32 From 1 April 2004, all GP premises funding is to be met from a single funding stream. Funding is to increase from the £47.5m total recorded in 2003-04, to £55.5m in 2004-05.

5.33 Health Board’s progress on disbursing funds in line with their declaration of commitments on existing and new projects will be monitored and underspending against premises allocations may result in revisions to allocations for 2005-06.

(vii) **Information technology funds**

5.34 The revenue allocations for IM&T have been calculated using the Scottish Allocation Formula at Health Board level. In addition a central retention of £0.5m in 2004-05 is being made to support ongoing investment plans.

5.35 Additional supporting capital allocations are being made outwith the funding envelope to support new investment in IT. In 2004-05, £2.2m has been allocated using the Scottish Allocation Formula at Health Board level. A further £1.5m in capital is being retained centrally to support nationally co-ordinated investment programmes.

(viii) **Section 17C schemes**

5.36 Previously PMS schemes received funding as a transfer from the GMS non-cash limited budget to the GMS cash limited budget. In the 2004-05 Primary Medical Services allocation, Health Boards receive funding to cover this
baseline level of funding for Section 17C schemes from Global Sum and NHS Board Administered Funds. In addition Boards should draw funding from all other funding streams (with the exception of the MPIG line) to contribute towards meeting the agreement value of locally negotiated Section 17C schemes.

E. Financial monitoring and management

5.37 This section considers financial monitoring and Health Board cash and resource management.

(i) Monitoring

5.38 National and local financial monitoring arrangements need to change to support the new GMS and Section 17C financial arrangements. Health Boards will need to provide SEHD with sufficient information not just to monitor expenditure against the resource limit but also to support the monitoring of the GIG and the local enhanced services floor. New arrangements will deliver all requirements through a single reporting system and Health Boards will be required to hold information on expenditure at a sufficiently detailed level to meet the new reporting requirements.

5.39 Health Board financial reporting will feed into national monitoring undertaken by the joint 4 UK Health Departments/NHSC/GPC Technical Steering Committee (TSC). The TSC will:

(i) source and review data for the financial allocation formula

(ii) monitor outcome against the Gross Investment Guarantee described in paragraphs 5.3-5.6, which replaces the old GMS concept of IANI

(iii) monitor and forecast total earnings, GP net incomes and expenses (which includes Section 17C and salaried doctors)

(iv) monitor outcome against the local Health Board-level enhanced services floor in line with the definition in chapter 2 and monitor overall expenditure on enhanced services

(v) monitor quality payments

(vi) adjust the proposed pensions dynamising factor to take account of the shift from full-time to part-time working.
The TSC will also undertake a continuous workload survey and monitor skill mix.

5.40 Copies of the new monitoring returns together with detailed guidance notes on the data requirements were issued to the Service during the week beginning 31 May 2004.

5.41 Health Boards will need to ensure that their ledger systems are suitably reconfigured in order to generate the relevant information.

(ii) **Health Board cash and resource management**

5.42 The new GMS contract will require Health Boards to change their cash and resource management arrangements. As section C of this chapter described, funds for primary medical services will now be allocated as a resource allocation together with a cash-financing requirement within which Health Boards have a statutory obligation to contain spending.

5.43 Health Boards / CSA  will also need to review treasury management processes to ensure that they can maintain effective in-year control over the requisitioning and reporting of cash payments. The new contract will change both the timing and the level of in-year cash payments to contractors. In addition, it will be necessary to manage the transition from the old payments regime to one that underpins the new contract. Health Boards will need to manage any excess creditors from within existing resource and cash allocations available in 2004/05.
ANNEX A

Primary Medical Services Allocations 2004/05 : Summary Table

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Sum</td>
<td>£319m</td>
</tr>
<tr>
<td>MPIG</td>
<td>£53.3m</td>
</tr>
<tr>
<td>Quality Payments</td>
<td>£55.8m</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>£34.9m</td>
</tr>
<tr>
<td>Premises</td>
<td>£55.8m</td>
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<tr>
<td>IT</td>
<td>£7.3m</td>
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<td>£26.3m</td>
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<tr>
<td>OOH Development Fund</td>
<td>£6.8m</td>
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<td><strong>TOTAL</strong></td>
<td><strong>£559.2m</strong></td>
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