‘Implementing the new GMS contract in Scotland’

6. Contracting process
6. CONTRACTING PROCESS

SUMMARY OF KEY POINTS

1. GMS contracts will be between practices (contractors) and Health Boards. There is a new standard GMS contract for Health Boards and contractors to use. This is being published separately in draft form with an explanatory note to assist in completing the contract. The standard contract reflects the Contract Regulations and means that Health Boards and contractors do not have to worry about producing their own contract. A revised version will be sent to Health Boards and contractors by 27 February 2004; that version will reflect changes made to the Contract Regulations, which will be laid in the Scottish Parliament in early March 2004.

2. Local discussions on the contract should be ongoing and provisional agreement reached by 27 February 2004. Health Boards will be responsible for completing the draft standard contract in the light of local discussions, and then sending this to all GMS contractors by 27 February 2004. The present GMS arrangements come to an end on 1st April so contractors need to sign a GMS contract or a default contract by 31st March 2004. Contractors also need to decide, by 27 February 2004, whether they want to become a Health Service Body and have the contract as a NHS one or instead have a private law contract.

3. The default contract will be published in mid-February 2004 and Health Boards will offer it to contractors by 27 February 2004 if provisional agreement on GMS contracts has not been reached. We do not anticipate many default contracts to be used as they are less flexible and of short-term duration.

4. The new contract provides new flexibility around how contractors are structured. They can be single-handers, partnerships, or a certain type of limited company. Contractors must also comply with conditions about suitability and confirm that they are doing so again by 27 February 2004.

5. Contractors and Health Boards will have access to formal dispute resolution procedures where local resolution proves impossible. Both sides will be under a legal obligation to make every reasonable effort at local dispute resolution before using the formal mechanism. There are also fixed national rules around contract termination, breaches and sanctions.
6. An annual contract return *pro forma* will be produced and a contract information system for Health Boards to use if they so wish.

Introduction

6.1 The old GMS was a set of statutory arrangements with individual GPs. The Primary Medical Services (Scotland) Act 2004 provides that new GMS:

(i) is a local contract between a Health Board and a GMS contractor

(ii) is subject to a standard set of national rules and procedures. These are contained in the National Health Service (General Medical Services Contracts)(Scotland) Regulations 2004 and the Scottish Statement of Financial Entitlements. Those documents describe and give effect to the agreements described in *Investing in General Practice* and the supplementary letters which were subsequently endorsed by the GP ballot. They are being published in draft to accompany this guidance and the Regulations will be made and laid in Scottish Parliament in early March 2004.

6.2 The national rules cover:

(i) the different types of services to be provided (described in chapter 2)

(ii) the entitlement of contractors to different payments (described in chapters 2 to 5, and summarised in chapter 5)

(iii) other statutory requirements (described mainly in chapters 2 and 3)

(iv) how the contractual process works: who can be a contractor, the formal dispute resolution procedure where the Health Board and contractor cannot reach local agreement, how contract conditions are enforced through breach and termination procedures, and the way in which contracts can be varied.

6.3 The Contract Regulations have in turn been translated into a standard NHS contract, *The Standard GMS Contract*. This document will be modified for use in Scotland and published in draft form for use by Health Boards and GMS contractors. The draft contract will be subject to marginal revision when the GMS Contract Regulations are finalised in February 2004. A revised version will be issued by the SEHD by 27 February 2004.
6.4 This chapter explains how the contractual processes work. Health Boards and contractors should note that, as is the case with other chapters, it is intended as guidance only; the chapter neither provides a detailed description of the Contract Regulations nor should be seen as a definitive statement of law. Health Boards and contractors should therefore read this chapter in conjunction with the Regulations and standard contract.

6.5 This chapter describes:

A. Local contracting
B. Contractor form & conditions
C. Disputes
D. Contract termination, breach and sanctions
E. Annual review and contract variations

Each is considered in turn.

A. Local contracting

6.6 This section explains:

(i) the contracting timetable

(ii) The Standard GMS Contract

(iii) NHS contracts and Health Service Body Status (Regulation 10)

(iv) pre-contract disputes (Regulation 9)

(v) the default contract

(vi) how contractors can move between GMS and Section 17C (PMS). This will be set out more fully in separate guidance on Section 17C arrangements.

(i) Timetable

6.7 The statutory arrangements governing old GMS come to an end on 31st March 2004. All GPs who currently provide services under section 19 (of the NHS (Scotland) Act 1978) arrangements and who wish to continue to provide GMS services from 1st April will, from 1st April 2004, need to be party to a GMS contract (or if necessary a default contract) if they are to continue to provide
GMS. NHS Boards will also be able to enter into agreements with a range of providers under Section 17C arrangements (formerly Personal Medical Services – “PMS”). NHS Boards will have arrangements in place to discuss future plans with existing PMS providers, including a move to a Section 17C agreement.

6.8 Health Boards and contractors should be engaged in ongoing discussions now with a view to agreeing provisional contracts by 27 February 2004. This deadline is important, as it should allow sufficient time for any remaining issues to be resolved during March 2004. If provisional agreement is not reached by 27 February, Health Boards will need to offer potential contractors the default contract as an alternative. The default contract is intended to be a contingency measure to be used in the unlikely event that Health Boards and contractors cannot agree the major elements of the new GMS contract in time. It is a short-term measure that will not offer the same flexibility as the GMS contract and is likely to be used only in exceptional cases.

Transitional arrangements will protect the position of GMS GPs whose names are included in the medical list on 31st March 2004. Existing GMS GPs will have a right to become GMS contractors if they wish, and Health Boards must offer either a new GMS contract or a default contract to be agreed and signed by 31st March 2004. Where existing GPs sign a default contract they will continue to have a right to a full GMS contract. Further guidance on the transitional arrangements will be issued by March 2004 alongside Transitional Regulations.

(ii) The Standard GMS Contract

6.9 The draft Standard GMS Contract for use in Scotland has been agreed by SEHD and SGPC as part of the UK negotiations. This is a standard contract that contains all the requirements set out in the GMS Regulations. It is accompanied by a covering explanatory note that explains what both sides need to do. Health Boards should use the contract and bear in mind the instructions in the explanatory note when negotiating their local GMS contracts. Using the standard contract will significantly reduce the workload involved in the contracting process. It means that both sides will not have to worry about whether the legal mechanisms in their local contract are right. They can focus instead on the important matters of what services will be provided, the quality of care, and finance. The text of the standard contract has been drafted by Counsel and has been agreed between Departmental solicitors and solicitors acting for the GPC.
6.10 Health Boards are responsible for producing completed drafts of the standard contract. They should send these to all their contractors by the end of February 2004, with relevant sections completed to reflect the provisional agreements reached. Health Boards will also need to take on board any changes to the standard contract agreed nationally during February.

(iii) NHS contracts and Health Service Body status

6.11 The Primary Medical Services (Scotland) Act 2004 provides that a GMS contract may be treated as a NHS contract. An NHS contract is an arrangement between one Health Service Body and another for the provision of goods and services. All NHS Boards in Scotland are Health Service Bodies. Where the contract is an NHS contract disputes about the terms of a contract are dealt with through the NHS disputes resolution procedures rather than through the courts, thus potentially reducing bureaucracy and cost for both sides. It should also be noted that contractors with private law contracts would be able to choose to use the NHS dispute procedure instead of the Courts should they so wish to do so.

6.12 For a GMS contract to become a NHS contract the provider will need to elect to become a Health Service Body. Potential GMS providers will therefore need to give written notice to the Health Board to this effect. This should be done by 27 February 2004. Health Service Body status would then commence from 1st April 2004 (assuming that the contract has been agreed on or before that date).

6.13 The choice of being or not being a Health Service Body is entirely a matter for the GMS contractor. The Health Board should not attempt to force such status onto, or deny such status to, a GMS contractor. Key points to note about Health Service Body status are:

(i) if a GMS provider becomes a Health Service Body, it may enter into other NHS contracts with another Health Service Body

(ii) becoming a Health Service Body does not affect other contracts the provider may have entered into before Health Service Body status takes effect. If for any reason the GMS contract is terminated, the contractor stops being a Health Service Body, unless it already holds a separate NHS contract in which case it can continue to be a Health Service Body for the purpose of that contract

(iii) partnership changes do not affect Health Service Body status
(iv) contractors can at any time seek to vary their contract to remove or include provision that it is to be considered a Health Service Body.

(iv) Pre-contract disputes

6.14 One of the main reasons why the process of agreeing provisional contracts could be delayed beyond 27 February 2004 is a pre-contract dispute. The new arrangements have been designed to keep these disputes to a minimum:

(i) disputes over aspiration levels should be resolved in line with the guidance in chapter 3

(ii) disputes about what additional services should be provided will be minimised because the formal opt-out rules and procedures do not start until 1st April 2004

(iii) disputes about open or closed list status should be minimised because contractors will have recourse to the new procedures from 1st April 2004

(iv) disputes about what enhanced services are to be provided will be minimised because the SFE makes clear what enhanced services contractors have a right to provide (quality information and childhood vaccinations and immunisations if they are also providing the additional service). Other enhanced services are commissioned from contractors at the discretion of the Health Board

(iv) disputes about premises, IM&T funding and Health Board-administered funding items should similarly be kept to a minimum because the SFE and premises Directions are clear about contractor entitlements.

It does not make sense for concerns about the interim global sum or MPIG figures to delay the contract being signed. The SGPC and the SEHD strongly advise contractors and Health Boards to defer potential disputes on the global sum and MPIG until actual figures are known. It is important for Health Boards and contractors to note that by signing the contract, neither side is indicating its agreement to the final global sum and MPIG payments.

6.15 Despite these considerations, if in the course of negotiations intending to lead to a GMS contract, the prospective parties are unable to reach agreement on a particular term, either party may refer the dispute for consideration and determination by the Scottish Ministers.
6.16 All such disputes will be considered and determined in accordance with the procedure set out in regulations 9 and paragraphs 97(3) to 98(12) of Schedule 5 to the GMS Contract Regulations. This pre-contract dispute mechanism will take effect from the date that the Contract Regulations take effect, which is expected to be 1 April 2004. In some cases the parties may wish to make use of the local implementation protocol agreed between the NHS Confederation, GPC and four UK Health Departments, however this may not be appropriate for routine local issues. A copy of the protocol is attached at annex A to this section.

(v) Default contract

6.17 If agreement is not reached and new GMS contracts are not signed by Health Boards and contractors by 31st March 2004, no payments can be made to GPs and services cannot be provided to patients. GMS GPs would also lose their transitional rights to a new GMS contract (unless there are exceptional circumstances or where the Health Board incorrectly refuses to offer a new GMS contract). For these reasons SEHD and the SGPC advise that Health Boards and GMS providers should all sign GMS contracts before 31st March 2004. The contracts will then be able to come into force on 1st April. It is important to note, however, that this does not mean that Health Boards cannot offer GMS contracts after this date should they so wish.

6.18 The default contract will be available to allow payments to continue until a new GMS contract is signed. It will also need to be agreed to and signed by both parties. The default contract is being developed at UK national negotiations, and will be published in England by mid February 2004 and in Scotland by the end of February. The principle underlying its development is that its terms are black and white and not open to discussion. It will be based on The Standard GMS Contract but will not offer the same flexibility to either party and will be a short-term contract of fixed duration. We do not envisage that the default contract will need to be used other than in exceptional cases.

(vi) Movement between GMS contracts and Section 17C agreements

6.19 Under the terms of the National Health Service (Primary Care) Act 1997 a “right of return” to the Medical List was possible for doctors who had been given approval to do so. This right can be exercised by those individuals before 31 March 2004. Thereafter all doctors who perform primary medical services will be included in the Primary Medical Services Performers List.
(described in Section 4 of this guidance). However it will be possible for a Section 17C provider to move to a GMS contract, assuming they meet the requirements of the GMS provider regulations.

6.20 It will also be possible for GMS providers to move to, or hold, a Section 17C agreement with the approval of the NHS Board.

B. Contractor form and conditions

6.21 This section sets out who can be a GMS provider, the constitution of a GMS provider, and conditions that need to be met by GMS providers. Full details of the conditions applying to GMS providers are set out in Regulations 4 and 5 of the GMS Contract (Scotland) Regulations. The conditions apply to individuals, partnerships and contractor bodies. They cover such areas as qualifications, career, employment status, criminal history, and financial status. These conditions are intended to prevent unsuitable individuals such as murderers or undischarged bankrupts from contracting to provide GMS.

6.22 A contract may only be entered into with a contractor which satisfies the conditions set out in section 17L of the Primary Medical Services (Scotland) Act 2004 and regulations 4 and 5 of the GMS Contract (Scotland) Regulations. After the contract has been entered into the GMS contractor is responsible for ensuring continuing compliance with the conditions set out in regulations 4 and 5 of the GMS Contract (Scotland) Regulations. The contractor can be made up of individual providers who do not have to perform clinical services under that contract, although many will do that as well. However, the provider conditions in no way operate as a substitute, in whole or in part, to those set out in the National Health Service (Primary Medical Services Performers’ Lists)(Scotland) Regulations 2004 which apply in full to all GPs performing clinical services under the GMS contract.

Who can be a GMS provider

6.23 The contract provides considerable new flexibility about how GMS providers are constituted. GMS contracts may be entered into with any of the following:

(i) single-handed GPs
(ii) partnerships that include at least one GP
(iii) certain types of company limited by shares
It will be possible in GMS, as it is in PMS, for there to be a nurse-managed (or therapist-managed) service.

**Single-handed GPs**

6.24 Where a GMS contract is made with an individual medical practitioner, that practitioner’s name must be included in the General Practitioner Register set up under the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. It is possible that the GMS Contract Regulations and this guidance may come into operation before the coming into force of this Order. In this case the condition may be treated as being satisfied if the medical practitioner is suitably experienced within the meaning of section 31(2) of the 1977 NHS Act, section 21(2) of the 1978 NHS (Scotland) Act, or Article 8(2) of the Health and Personal Social Services (Northern Ireland) Order 1978.

**Partnerships**

6.25 Where the contract is with one or more individuals practising in partnership at least one of the partners must be a medical practitioner whose name is included in the GP register (or is suitably experienced). Other individual partners can be other health professionals, including practice nurses, dentists, consultants together with other persons such as practice managers, who could be offered partnership shares and help deliver enhanced services in a primary care setting. Contractors will want to consider whether they want to take advantage of this new flexibility before signing GMS contracts or thereafter, and when bidding for enhanced services.

6.26 The GMS contract can be continued with the partnership “as it is from time to time constituted”. This delivers the concept of a rolling contract set out in Chapter 7 of *Investing in General Practice*. Routine changes in the partnership will not therefore affect the contract. However, if in the reasonable opinion of the Health Board, the change in membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Health Board to perform its obligations, the Health Board may serve notice terminating the contract. The contract requires the Health Board to be given a written notice of any changes (see paragraph 82 & 101 of Schedule 5 to the GMS Regulations). Where there is a change in the partnership the GMS contract may need to be varied to reflect the change in contractor status. Provisions covering a change in a partnership or change in status from individual medical practitioner to partnership and vice versa can be found at paragraphs 101 – 102 of Schedule 5.


**Companies limited by shares**

6.27 The ownership rules for GMS companies are that:

(i) all shares in such a company must be legally and beneficially owned by a person who could lawfully enter into a GMS contract as an individual or as part of a partnership

(ii) at least one share must be legally and beneficially owned by a medical practitioner whose name is included in the GP Register (or is suitably experienced)

(iii) any other shares owned by a medical practitioner must be so owned by a medical practitioner whose name is included in the GP Register or who is employed by a Health Board, a Local Health Board, a NHS trust (including an NHS Trust in Scotland), a NHS foundation trust, a Health Board, or a Health and Social Services Trust

6.28 The contract will require that the GMS provider inform the Health Board immediately if there is any change in the ownership of the shares or any other event occurs that would prevent the company from continuing its business.

**Conditions relating to all GMS contracts**

6.29 A GMS contract cannot be entered into if the provider conditions are not satisfied, so Health Boards should ensure that any potential GMS contractor confirms in writing that it satisfies all of these conditions. Contractors are encouraged to write to the Health Board to confirm this at the same time as they apply for Health Service Body status, that is by 27 February 2004. The new contractual arrangements are intended to be a high trust system. Health Boards should therefore consider carefully whether they require any additional information to support this statement. Where the individual is a GP, Health Boards will already have received much of this information in response to enquiries made under the NHS (Primary Medical Services Performers’ Lists) (Scotland) Regulations 2004

6.30 Where a Health Board is of the view that the conditions for entering into a contract are not met it should notify in writing the person or persons intending to enter into the contract of its views. Where the prospective contractor is a company limited by shares, the Health Board should at the same time inform any shareholder, director or company secretary where that person is the
subject of the Health Board’s decision because it is him or her that has failed to meet the conditions. Any person refused a contract on these grounds may appeal to the Scottish Ministers concerning the Health Board's decision that the provider conditions have not been met by writing to the Scottish Ministers within 28 days beginning on the day that the Health Board served notice

6.31 GMS contractors must give notice to the Health Board in writing that any new partner joining the partnership after the GMS contract has been signed meets these conditions. Again it is for the Health Board to decide the extent to which it seeks to verify this statement. The Health Board may serve notice terminating the contract immediately if any of these conditions is broken.

C. Dispute resolution

6.32 The new GMS contract contains comprehensive dispute resolution procedures. These can cover issues ranging from decisions about contractual sanctions and termination through to matters such as remuneration, list closure, practice area, patient assignment, and opt-outs. As a rule of thumb virtually all disputes will be capable of being referred for adjudication. Dispute resolution does not apply to complaints made under the NHS complaints system as set out in the GMS Contract Regulations.

6.33 It is expected that most contractual disputes can be resolved as part of the normal contractual relationship. Use of the formal dispute resolution procedures will usually represent a failure of that relationship and should be avoided where possible. Health Boards and GMS contractors should make every reasonable effort to communicate and co-operate with each other in an attempt to resolve any disputes locally before considering referring the dispute for determination in accordance with the dispute resolution procedure, or to the Courts. This is a requirement under the contract. Reaching local solutions will make best use of the resources available for the local population, will help to develop a partnership approach between contractor and Health Board, and will avoid additional bureaucracy and cost for both parties. Local resolution might involve, where necessary, board level involvement in conciliation meetings and neither side should be afraid to use appropriately skilled and qualified advisers. In addition both the Health Board and the GMS contractor may, if either so wishes, invite the GP Sub Committee of the Area Medical Committee to participate in any discussions. If no solution can be found locally it will be open to either part to the dispute to refer a matter to dispute resolution.
6.34 Any dispute arising out of, or in connection with, the Contract, except matters dealt with under the complaints procedure, may be referred for consideration and determination to the Scottish Ministers. In such cases the NHS dispute resolution procedure applies as set out in paragraphs 97 and 98 of Schedule 5 to the GMS Contract (Scotland) Regulations 2004.

6.35 In the particular cases of disputes arising in relation to: list closures; patient assignment to closed lists and; opt out of additional or out-of-hours services, then the matter is to be dealt with initially by an assessment panel, as described in Section 2 of this guidance.

6.36 Disputes where the contractor is not a NHS body can be referred to either the Scottish Ministers or a competent court. Where the contractor wishes to follow the NHS process it should express that choice in writing. Any such dispute should follow the procedure set out for NHS contracts. It is important to note that the resulting determination will be binding on both parties.

D. Contract termination, breach and sanctions

6.37 This section explains the rules concerning contract (i) termination, (ii) breach, and (iii) sanctions.

(i) Termination

6.38 Provision for the termination of GMS contracts is set out in part 8 of Schedule 5 to the GMS Regulations. A Health Board may serve notice terminating the contract immediately if the contractor no longer satisfies the contractor conditions. See paragraphs 106 to 110 of Schedule 5 of the GMS Contract (Scotland) Regulations.

6.39 In operating this provision the Health Board should note that:

(i) where the contractor holding a GMS contract changes so that it no longer includes a medical practitioner who is on the General Practitioner Register, the Health Board will need to review the viability of the contract

(ii) where the medical practitioner was a sole practitioner the Health Board must issue a notice terminating the contract forthwith – there is no longer anyone with whom the Health Board is in contract
where the medical practitioner was part of a partnership, for example with a nurse and/or a practice manager, the Health Board may issue a notice terminating the contract forthwith. However, where the loss of the medical practitioner was sudden and there had been no reasonable opportunity for the remaining partners to regularise their affairs the Health Board may decide to allow the contract to continue for up to six months. This will either allow the Health Board to bring matters to an orderly conclusion or allow the remaining partners to recruit a suitable medical practitioner. In reaching such a decision the Health Board is recommended to take into account the best interests of the contractor’s patients.

6.40 If it exercises its discretion in this the Health Board ought to:

(i) consult with the GP Subcommittee of the AMC immediately

(ii) appoint one or more suitable medical practitioners to support the practice under its powers to provide support and assistance (the Health Board may charge for this service)

(iii) complete all processes within a period of no more than six months

(iv) terminate the contract after six months if the contractor still does not include a medical practitioner whose name is included in the General Practitioner Register (or a practitioner who is suitably experienced).

6.41 Although in most circumstances a GMS contract cannot be terminated simply because there is a change in the structure of the partnership (for example the acquisition or loss of partners) the Health Board does have the ability to terminate a contract following such changes in two specific circumstances:

(i) if the Health Board considers, in its reasonable opinion, that the change in the partnership is such that it is likely to have a serious impact on the ability of the contractor or the Health Board to perform its obligations under the contract it may serve notice terminating the contract forthwith or from such other date as it might indicate. Any such notice should specify why the Health Board has chosen this course of action and should, where practical, follow consultation with the GP Subcommittee (or a notification to the GP sub committee where this is not practical)

(ii) a change in the structure of the partnership might be sudden and/or acrimonious. In these circumstances (which include a two-partner
practice splitting and not indicating which partner should continue with the contract) the Health Board may be unable to determine which of the remaining partners has the right to retain the GMS contract. It would be unreasonable for the Health Board to be involved in any practice dispute, or to take sides. In these circumstances the Health Board may serve notice terminating the contract forthwith or from such other date as it might indicate. Any such notice should specify why the Health Board has chosen this course of action and should, where practical, follow consultation with the GP sub committee (or a notification to the GP sub committee where this is not practical).

6.42 Where a Health Board takes such action it will need to take steps to secure the provision of patient services. It is normally expected that in these circumstances the Health Board will wish to enter into short-term temporary contracts (for no more than 12 months) with any of the parties to the old GMS contract who wish to continue to provide GMS services and who meet the GMS provider conditions. The Health Board could make alternative arrangements if for example the temporary contracts required the provision of new practice premises, or if the granting of temporary contracts would otherwise be to the detriment of NHS efficiency.

6.43 It is similarly envisaged that at the end of temporary contracts, the temporary contractor(s) would normally be offered a permanent contract or, where they agree, be allowed to continue to provide services under a wider GMS contract with other persons, for example by merging with a neighbouring practice.

6.44 Health Boards should:

(i) consult with the GP sub committee before refusing the holder of a temporary contract a permanent contract

(ii) ensure patient representatives are appraised of all decisions to terminate a contract in these circumstances, and to ensure that individual patients are aware of the choices available to them.

6.45 Notwithstanding the above paragraphs, a Health Board may serve notice in writing terminating a contract immediately, or from such other date as may be specified if:

(i) the Health Board considers that the contractor has breached the contract and as a result of that breach the safety of the contractor’s patients is at serious risk
(ii) if the contractor’s financial situation is such that the Health Board considers that the Health Board is at risk of material financial loss.

6.48 Contractors must provide six months notice before they withdraw from the contract, although this is reduced to three months in the case of a single-handed practitioner. By mutual agreement these periods can be changed. The different treatment of single-handers reflects the fact it is easier to find alternative provision for a small contractor than if a large contractor stops providing services.

**Remedial and breach notices**

6.49 Where it believes that a contractor is in default of its obligations under its contract the Health Board can either issue a breach notice or a remedial notice (see paragraph 111 of Schedule 5):

(i) if a contractor breaches any of the terms of the contract and the breach is capable of remedy, the Health Board may give notice to the contractor requiring it to remedy the breach. A breach capable of remedy might be a failure to provide a practice leaflet or to make arrangements for a home visiting service. This remedial notice will specify the details of the breach, the steps to be taken to remedy the breach, and the period within which those steps must be taken

(ii) where a contractor has breached the terms of the contract and the breach is not capable of remedy, for example a one-off act such as a failure to visit a particular patient, the Health Board may serve notice on the contractor requiring the contractor not to repeat the breach.

6.50 If, following a breach notice or a remedial notice, the contractor repeats the breach, or otherwise breaches the contract resulting in another breach or remedial notice, the Health Board may give notice terminating the contract from such date as may be specified.

6.51 Before issuing such a termination notice the Health Board should give careful consideration to the cumulative effect of any breaches. For example, a run of minor breaches over a short period or occasional breaches over a longer period ought not, in themselves, to lead to a termination. However, a persistent stream of minor breaches could justify termination if it was clear to the Health Board that the contractor was unwilling or unable to take steps to stem the flow. It is expected that each decision will be taken in the light of the contractor's individual circumstances. Circumstances that might be considered include the likelihood of temporary support from the Health Board being
helpful, practice workload and the views of patients. The GP sub committee should be consulted before the Health Board reaches a decision under these provisions. A notice terminating the contract should only be issued if the Health Board is satisfied that the cumulative effect is such that it would be prejudicial to the efficiency of patient services to allow the contract to continue.

6.52 If the contractor is in breach of any obligation under the contract, and a breach or remedial notice has been issued, the Health Board may consider withholding or deducting monies which would otherwise be payable under the contract, but only those monies payable in respect of the contractual obligation that has been breached.

6.53 The contractor may challenge any notice given by the Health Board under these provisions through the dispute resolution procedures. If the contractor does raise a dispute within the specified period given in the notice, the contract termination will not take effect until either (i) there has been an initial determination of the dispute by the relevant adjudication authority or competent court, or (ii) the contractor ceases to pursue the dispute, whichever is the sooner.

6.54 A Health Board may terminate the contract before the conclusion of the NHS dispute procedures if it is satisfied that it is necessary to do so to protect the safety of patients or to protect itself from material financial loss. However, in doing so the Health Board should exercise due care. On terminating a contract, the Health Board decision is still subject to challenge and if the resolution of the subsequent dispute were to find in favour of the contractor, the Health Board could be liable for damages as it would have wrongly deprived the contractor of its livelihood under a contract that was not limited as to its duration. The scope for damages could be very substantial. Health Boards would normally wish to seek legal advice before terminating a GMS contract to limit any risks that it might be exposed to.

**Contract sanctions**

6.55 Where a Health Board is entitled to serve notice terminating a contract it may instead impose one of the other available contract sanctions (see paragraph 113 – 114 of Schedule 5). These are:

(i) termination of specified obligations under the contract

(ii) suspension of specified obligations for a period of up to six months or
(iii) withholding or deducting monies otherwise payable under the contract.

6.56 The Health Board may not, however, terminate or suspend any obligation to provide, or any other obligation which relates to, essential services.

E. Contract review and variations

6.57 Chapter 7 of *Investing in General Practice* set out the principle of annual contract review. This is distinct from the quality review described in chapter 3, but it can be carried out at the same time if the contractor so wishes, to minimise disruption.

6.58 The contractor will be required to submit an annual return to the Health Board on a standard *pro forma*. This *pro forma* will include a number of pieces of information pre-completed by the Health Board, the accuracy of which the contractor should confirm. It will also include a declaration by the contractor that it is meeting all the statutory requirements under the contract. The *pro forma* will be developed and introduced during 2004 by agreement between SEHD and SGPC.

6.59 *Investing in General Practice* also made clear that Health Boards must not neglect the informal process of developing and maintaining, where appropriate, a sustained empathetic relationship with contractors, based on the principle of high trust and developing an understanding of the contractor’s needs, pressures and aspirations, which may change in year.

6.60 Paragraph 7.25 of *Investing in General Practice* gave a commitment that the annual review would be strongly evidence-based. To support this commitment, the SEHD plans to develop in consultation with the BMA a contract information system for Health Boards as part of UK agreements. The system might for example help Health Boards to:

(i) record basic data about contractors and aspects of the contractual process

(ii) support the completion of the annual contract review *pro forma* by contractors and inform discussions during the annual contract review

(iii) reduce to a minimum the need for Health Boards to request information from the contractor in year. Health Boards and contractors should also note that a code of practice on information requests will be produced in discussion with the GPC during spring 2004.
6.61 The information system specification has not been finalised but will draw on existing best practice in Health Boards. Health Boards will be encouraged to use this system but they will be free to make their own arrangements if they so wish.

6.62 Health Boards would also be expected to share this information to inform national monitoring of the contract by the SEHD, NHS Confederation, GPC and the TSC, and inform subsequent contract development. For example, if information were collected about the number of patient assignments, this could inform national (UK) consideration of whether the new arrangements are effective in achieving the UK aim of reducing the numbers of patients who were assigned.

**Contract variations**

6.63 Once a GMS contract has been agreed and signed it will open to either party to seek to vary or amend the agreement. Any such variation or amendment must be agreed by both parties, other than variations made under the procedures for opting out of additional and out-of-hours services where special procedures apply. Save in certain limited cases (see paragraph 100 of Schedule 5) any variation or amendment will need to be set out in writing and signed by or on behalf of the Health Board and contractor.

**Variations without contractor consent**

6.64 However, the Health Board may vary the contract without the contractor’s consent where it is reasonably satisfied that it is necessary to do so to comply with the NHS (Scotland) Act 1978 or any Regulations or Directions made under that Act. In these circumstances the Health Board must notify the contractor in writing of the proposed variation and the date the variation is to take effect, which should where possible be at least 14 days after the date of the notification.

6.65 Such variations would only follow from the introduction of changes to the Regulations and directions, for example following national negotiations. Where such changes are made SEHD will produce amendments to *The Standard GMS Contract* for Health Boards and contractors to use. If the contractor is unhappy with a variation made in accordance with paragraph 9 of the Standard GMS Contract it has a right of appeal to the Scottish Ministers through the dispute resolution procedures set out in section D of this chapter. However, contractors should note that such appeals will in all probability fail if (i) the regulations or directions are not ultra vires and (ii) the Health Board has used standard amendments produced by the SEHD to *The Standard GMS
Contract. A matter referred for dispute under this provision shall not prevent the Health Board implementing the variation from the stated date pending the decision of the adjudicator.
ANNEX A

PROTOCOL FOR HANDLING LOCAL IMPLEMENTATION ISSUES

Introduction

A.1 The General Practitioners Committee, NHS Confederation and the four UK Departments of Health have agreed this protocol for dealing with problems that arise locally during the implementation phase of the new GMS contract.

A.2 The protocol:

sets out the minimum safeguard required to give the profession confidence in the implementation process

will apply until 1 April 2004. This will be an interim arrangement until the contract is implemented and the formal appeals mechanisms are in place. The contract regulations will provide for a formal pre-contract dispute mechanism.

applies to problems that arise both from PCOs and from Local Medical Committees, practices or GPs.

A.3 Three types of problems have been identified:

1. where there was a perception by Local Medical Committees or practices of a lack of action to implement the contract by the PCO / NHS Board.
2. misinterpretation of the contract
3. rumour that needs to be managed.

A.4 Any of these problems can arise because of innocent misunderstandings, sometimes following informal contacts between PCOs, LMCs/AMCs and practices. Nevertheless, dealing with these problems is important.

A.5 Where issues about PCO performance are raised, these will be taken forward with the Departments of Health.

Protocol

1. Wherever possible, solutions should be sought at local level. This avenue should be exhausted before other interventions are instigated.
A.6 Before the GPC raises a local implementation problem, the LMC/AMC, practice and/or GP concerned need to demonstrate that all reasonable avenues at local level to resolve the problem have been explored and exhausted with no satisfactory conclusion.

2. If a problem cannot be resolved at local level, the LMC/AMC, practice or GP should write to the GPC setting out the problem. The GPC will then take it to the relevant country’s Implementation Co-ordination Group, which includes a GPC representative.

A.7 If the LMC/AMC, practice or GP wishes the GPC to raise the issue at the relevant country’s Contract Implementation Co-ordination Group, then appropriate evidence, usually in writing must be produced to support the case.

A.8 In Scotland, any such issues will be raised by Scottish General Practitioners Committee with Scottish Executive Health Department for resolution, and issues will formally be discussed at the monthly SGPC-SEHD meetings. Similar mechanisms will be used by GPC Wales and Northern Ireland GPC.

3. Where the problem arises from a perceived lack of action by a PCO, a rumour or a misinterpretation of the contract by the PCO, the relevant national Implementation Co-ordination Group will raise it with the Health Department who will, in turn, raise this with the PCO as quickly as possible. The outcome will be reported to the next meeting of the Implementation Co-ordination Group.

4. Where the problem remains unresolved after one month of the GPC raising it, the GPC may publicise it or take other appropriate action.

5. Where the Departments of Health or NHS Confederation have evidence of LMCs, practices or GPs creating problems that have not been resolved by local action, the GPC will raise this directly or via the LMC as appropriate.

A.9 The above arrangements apply only when all local avenues have been exhausted.