DRAFT
DELIVERING INVESTMENT IN GENERAL PRACTICE

Implementing the new GMS contract in Wales

January 2004
FOREWORD

LHBs and practices are facing the best opportunity to reshape primary care services and improve general practice since the inception of the NHS.

Delivering Investment in General Practice – Implementing the new GMS contract is the product of negotiations between the GPC, the NHS Confederation and the 4 UK Health Departments and has been agreed by all parties. It fleshes out the detail of the contract document Investing in General Practice and sets out how implementation needs to be taken forward. It needs to be read in conjunction with the Contract Regulations, the Standard GMS Contract published, and the draft Statement of Financial Entitlements, which will be published in Wales in January 2004. These documents will be agreed by the NHS Confederation and the GPC and they provide the further information that LHBs and practices will need to implement the new contract.

We have worked in partnership at national level. The Welsh Assembly Government is 100% committed to effective and timely implementation. The NHS, through the NHS Confederation, and the profession, through the GPC, have together developed the vision and the contractual mechanisms. It is now for LHBs and practices to work in partnership locally to make that vision a reality.

The local contracting process and its ongoing review mechanisms will fundamentally change the current relationship between LHBs and practices, enabling them to work together much more closely and more effectively. The contract is not just about a legal agreement. It must be about a relationship based on mutual trust, respect and support.

The investment underpinning the new contract will see significant extra resources going into primary care. This was made clear when LHBs were notified of their primary care allocations in December 2003. Primary care will benefit from an unprecedented level of new investment – an increase of over 33% between 2003/04 and 2005/6. The Welsh Assembly Government has committed this money because it recognises that investment in primary care and general practice is an essential part of our programme to modernise the whole NHS. The allocations will also identify a local floor for expenditure on enhanced services that LHBs can exceed but not underspend. LHBs should see enhanced services as an opportunity to think strategically about how health care is delivered locally, in a way that improves convenience and choice for their populations. They must commission the six Directed Enhanced Services, and it will be for LHBs to decide how, when and from whom they commission other enhanced services.
The out-of-hours changes are an essential part of our strategy to make general practice a more attractive place to work. The changes were first mooted in April 2002 and LHBs are already advanced in planning new patterns of service delivery. The Welsh Assembly Government expects every LHB to be taking on this responsibility by the end of December 2004 and Regional Offices will be performance-managing this process. The changes also provide a unique opportunity for LHBs to develop a more integrated approach to delivering unscheduled care across the whole NHS; and patients will benefit from all providers delivering according to clear national minimum standards.

The new contract, above all else, is a strategic tool to improve the quality and range of services for patients; to give LHBs the ability to shape services, increase primary care capacity to meet local needs, and tackle wider problems across the whole NHS; and to revitalise general practice and make it a more attractive and family-friendly place to work, utilising the full talents of the primary care team.

Without doubt the timescale for delivery is challenging. But it is also fully achievable. Critical steps include LHBs calculating indicative budgets for contractors; LHBs planning the provision of out-of-hours, additional and enhanced services as part of a coherent strategy, and working with contractors to reach provisional agreement on local contracts by the end of February 2004; and then LHBs and contractors signing the new contracts by no later than the end of March 2004.

Implementing the new contract is without doubt one of the biggest and most important opportunities and challenges facing LHBs in the first half of 2004. We must make every effort to get this right. We will be working to ensure that implementation happens on time and effectively across every LHB.

We do not pretend that the new contract will provide instant answers for all the different issues that LHBs and practices are facing. But it gives you, LHBs and practices, the new freedoms you sought in order to improve patient care. And these are backed by substantial investment. It is now up to you to be ambitious, to be bold, and to be innovative, as together you make it work.
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1. EXECUTIVE SUMMARY

Chapter 2 - Flexible provision of services

1.1 LHBs will be under a new duty to secure the provision of primary medical services from 1st April 2004. They will have greater flexibility over how and from whom they commission primary medical services, using three routes: GMS, alternative providers (eg the voluntary sector, commercial providers, NHS trusts, or other LHBs), or direct LHB provision. Guidance on the alternative provider and LHB provider routes will be published in March 2004. The new commissioning arrangements will support an expansion of primary care capacity, including delivery of a wider range of services. This will help reduce pressures on the acute sector, and improve convenience and choice for patients.

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

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

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

1.5 List-based general practice remains at the heart of the new contract. Patients register with a contractor for essential services. They can choose which practitioner to see, subject to the practitioner’s availability and the appropriateness and reasonableness of the request. Patient choice of contractor will be assisted by patient leaflets, which contractors should review before 1st April 2004, and a new LHB Guide to Primary Care Services. The
Assembly will begin consultation on the contents of the guide during January/February 2004.

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

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

1.8 The formal procedure for contractors to opt out from additional services starts on 1st April 2004. LHBs can choose to agree opt-outs before then when agreeing contracts. When opt-outs are being considered, the simplest and least bureaucratic approach is for LHBs and contractors to reach local agreement without using the formal procedure. LHBs will want to review the sufficiency of their commissioning of additional services by the end of January 2004.

1.9 Where the LHB has agreed and has satisfied itself that a safe service can be provided in line with their out of hours plans, contractors can opt out of out-of-hours from 1st April 2004 onwards. Contractors will have the automatic right to opt out from 1st January 2005, except in very exceptional circumstances that the Assembly has approved, in consultation with LMCs and GPC Wales. LHBs will be expected to take on their full commissioning responsibility by this date, although it is anticipated that in most cases this will occur by mutual agreement in advance of this period. Delivery against this objective will be monitored by the Assembly, together with the monitoring of the implementation of other areas of the GMS contract. LHBs will have to submit their plans for the provision of out of hours services by the end of January 2004 and these plans will be used as a basis for the performance monitoring of LHBs. It is important that all LHBs fully engage with local partners and the local community in the development of these plans. Once the new contracts have been signed, contractors wishing to opt out of out of hours should submit notices to their respective LHBs by 1st April 2004.
1.10 The new out-of-hours commissioning responsibility is an opportunity to ensure a more structured delivery of all aspects of unscheduled care services. LHBs are expected to demonstrate a clear vision of this service provision in their plans and key milestones for new service models. Patients will benefit from both a more integrated approach to service delivery and quality standards applied to the new services.

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

1.12 LHBs will be notified of local enhanced services expenditure floors in their final financial allocations, which they can exceed but not underspend. They are expected to draw up initial commissioning plans during February 2004. LHBs must seek to obtain LMC agreement that the enhanced services they propose to commission count within the definition of enhanced services for financial monitoring purposes.

**Chapter 3 - Improving quality**

1.13 Contractors will be subject to statutory requirements relating to quality including a new duty of clinical governance.

1.14 The Quality and Outcomes Framework (QOF) is a voluntary system of financial incentives. It is not about achieving targets or LHB performance management but rewarding contractors for good practice through participation in an annual quality improvement cycle.

1.15 Preparatory funding is available through the Quality Information Preparation payment (QuP DES) and the Quality Preparation Payment (QPREP). For the year 2004/05 these will normally be paid by the end of April 2004.

1.16 Monthly aspiration payments provide in-year funding. The aspiration level then has to be agreed with the LHB. Provided the level is realistic the LHB would normally agree it without seeking further information.
1.17 In 2005/06 a new aspiration method will be used, based on 60% of the achievement points in 2004/05, uprated to the 2005/06 price, adjusted by 2004/05 prevalence. This method will improve contractors’ cash-flow and will be used in future years.

1.18 The new disease prevalence factor will provide higher rewards for those contractors with highest workload, whilst providing some protection for those with lowest prevalence. It will adjust the pounds per point in the different clinical disease areas. Achievement in the additional services domain will also recognise workload, through comparing contractor target populations with the average national target populations, and adjusting pounds per point accordingly.

1.19 Contractors will need to ensure that data on quality achievement are properly recorded utilising the correct Read Codes. Contractors will be supported in this task by the “nGMS Contract Release” software. LHBs will also have a version of this software and will be provided with monthly information for financial planning purposes.

1.20 Between October and January each year, LHBs will conduct annual quality reviews of all contractors. Further guidance will be published on how this will work, following completion of a research study and discussions with GPC. LHBs will need to produce a schedule of visits by 31 August 2004.

1.21 During visits, LHBs will need to ensure that the information supplied by the contractor is accurate. Where there are concerns, an action plan should be agreed and delivered to ensure that achievement payments can be made on time. Achievement payments for 2004/05 will normally be made by the end of April 2005.

1.22 The QOF is intended as a high trust system. To underpin this and ensure fairness, mechanisms will be put in place to prevent any potential abuse and fraud eg through inaccurate disease registers or inaccurate exception reporting.

1.23 The QOF will need to be updated. The review process will be in place by the end of 2004. The review will also consider all aspects of the prevalence adjustment arrangements.

Chapter 4 - Modernising infrastructure

1.24 Contract implementation requires effective support strategies to develop human resources and modernise infrastructure.
1.25 The existing medical, supplementary and services lists will be replaced by the single Primary Medical Services Performers List on 1st April 2004. The Assembly will publish guidance on the transition in March 2004. As from August 2002 the Assembly has required that all applicants supply an enhanced criminal records certificate. The Services & Tribunal Regulations will also be replaced, from 1st April, by the new contract mechanisms.

1.26 The contract is designed to support increases in primary care capacity and changes in skill-mix. LHBs 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.

1.27 Work/life balance will be improved through the out-of-hours changes. Recruitment and retention will continue to be supported through schemes such as 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. LHBs 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 LHBs will want to review their support arrangements for practice managers during 2004.

1.28 New pensions flexibilities to support portfolio working were introduced in October 2003. Regulations to implement the other pensions changes set out in Investing in Primary Care will come into force in April 2004. Guidance will be produced in March 2004. LHBs 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.

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

1.30 Contractors are entitled through the Statement of Financial Entitlements to full funding of the costs as specified in WHC (2004) 008.

Chapter 5 - Financing primary medical services

1.31 Investment in primary medical services will increase by an unprecedented level of at least 33% between 2003/04 and 2005/06. The Gross Investment Guarantee mechanism will ensure delivery.
1.32 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.

1.33 The draft SFE will be published separately. The final version will be published in February 2004 and will take effect from 1st April 2004. Most GMS funding will be non-discretionary.

1.34 Responsibility for the bulk of the contract funding will lie with LHBs. The old GMS non-cash limited arrangements will be replaced from April 2004 by cash-limited allocations from the Assembly to LHBs. In December 2003 LHBs were notified of - an initial allocation for primary medical services. This initial allocation included global sum equivalent historic spend, former cash limited funding and dispensing cost.

1.35 Further allocations will be made to LHBs before April 2004. These include funding an increase in the global sum price to reflect the increase in employers’ superannuation contributions; quality aspiration funding, funding for enhanced services, out of hours and IT maintenance. The allocation of funding for enhanced services will identify a spending floor that cannot be breached but may be exceeded. The remaining funding for quality achievement will be allocated in April 2004 on a cash-limited basis.

1.36 The existing restrictions on spending the Out-of-Hours Development Fund will be lifted, and the enlarged budget will be subject to a legal ring-fence from April 2004.

1.37 Funding for existing and agreed premises spend has been partly allocated directly to LHBs in the December 2003 allocation. Further funding for the remaining elements of agreed premises spend will be made in January 2004. Funding for new premises development will be held by the Assembly until new arrangements have been discussed with GPC Wales. Funding arrangements for IM&T have been specified within the IM&T Guidance in WHC (2004) 008. LHBs must adhere to this guidance and confirm local IM&T budget requirements for 2004/5 by 27th February 2004.

1.38 LHBs need to calculate indicative contractor budgets by the end of the first week in February 2004 and then agree these with contractors by the end of February 2004. It is essential that these deadlines are met, to enable contracts to be signed before 1st April 2004. The Assembly will be monitoring and performance-managing LHB delivery. To support LHBs in this task an indicative contractor budget spreadsheet has been developed and is attached.
with guidance notes at annex C. It is essential that LHBs start to complete the indicative contractor spreadsheet and share baseline data with contractors in January 2004 prior to receiving allocations.

1.39 The global sum and Minimum Practice Income Guarantee (MPIG) are key elements of contractor budgets. Initial estimates for all GMS contractors were issued in December 2003. LHBs will need to convert the data into more accurate indicative global sums and MPIGs in February. Annex B describes and illustrates the global sum and MPIG calculation method.

1.40 LHBs must ensure that indicative payments are made by the end of April 2004. The Exeter payments system will be revised by April 2004. LHBs will need to agree actual budgets with contractors by May 2004 and ensure that under- or over-spends arising since April 2004 are corrected by June 2004.

1.41 Financial reporting will need to reflect the new arrangements. The Assembly will be issuing revised guidance to LHBs on changes to the Financial Information System (FIS). The joint Four countries/BMA/NHSC Technical Steering Committee (TSC) will also monitor spend. LHBs will also need to review their ledger structure, treasury management and internal financial management arrangements to support the new monitoring requirements.

1.42 Finance directors need to read this chapter carefully, understand the radical nature of the changes to the LHB role in respect of primary medical services financial arrangements, and ensure that the milestones described in this chapter are met.

**Chapter 6 - Contracting process**

1.43 GMS contracts will be between practices (contractors) and LHBs. There is a new standard GMS contract for LHBs and contractors to use. This is being published separately in January 2004 with an explanatory note to assist in completing the contract. The standard contract reflects the Contract Regulations and means that LHBs and contractors do not have to worry about producing their own contract. A revised version will be sent to LHBs and contractors before the end of February 2004; that version will reflect changes made to the Contract Regulations, which will be laid before the Assembly in February 2004 and come into force by the end of February 2004.
1.44 Local discussions on the contract should be completed by the end of February 2004. LHBs will be responsible for completing the standard contract in the light of local discussions, and then sending this to all GMS contractors by the end of 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, in 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.

1.45 The default contract will be published in mid-February 2004 and LHBs should offer it to contractors by the end of February 2004 if provisional agreement on GMS contracts has not been reached. We do not expect any default contracts to be used as they are less flexible and of short-term duration.

1.46 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 the end of February 2004.

1.47 Contractors and LHBs 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.

Chapter 7 - Implementation

1.48 The implementation support programme includes: a training and development programme comprising 7 core skills workshops during February and March 2004; making available to all LHBs and practices hard copies of the key documents and CD ROMs in March 2004; software applications for implementation of the quality and outcomes framework; a communications toolkit for raising public and media awareness; support from the national GMS contract implementation project board and regional office OD managers; and a dedicated project website for access to information and other sources of support.

1.49 The nGMS project board will be assessing LHB delivery of implementation through a simple self-assessment reporting system at four points between January and April 2004. Engagement of LHB boards is essential.
1.50 A local dispute resolution process, operated by the Assembly’s Primary Care Division, will help support LHBs where local attempts have failed.