

PRIMARY MEDICAL SERVICES (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament's Standing Orders, the following documents are published to accompany the Primary Medical Services (Scotland) Bill introduced in the Scottish Parliament on 23 June 2003:

- Explanatory Notes;
- a Financial Memorandum;
- an Executive Statement on legislative competence; and
- the Presiding Officer's Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 4-PM.

EXPLANATORY NOTES

INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Executive in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL – AN OVERVIEW

4. The purpose of the Bill is to make the necessary legislative changes to allow implementation of the new general medical services contract (GMS contract) for providers of primary medical services. These changes involve restructuring the existing regime under the National Health Service (Scotland) Act (“the 1978 Act”) and the National Health Service (Primary Care) Act 1997 (“the 1997 Act”) for the provision of personal and general medical services by Health Boards. Although these services are in substance the same, they are given different labels at present in the legislation according to what arrangements are made to provide them. Arrangements for the provision of personal medical services (PMS) are made under section 17C of the 1978 Act. Arrangements for the provision of general medical services (GMS) are made under section 19 of that Act. The Bill brings all of these services under a single label – primary medical services. (The restructuring of the existing regime is achieved by textual amendment of the 1978 Act. Accordingly, references in the new sections of that Act to anything being “prescribed” mean prescribed by regulations made by the Scottish Ministers, which will be subject to annulment in pursuance of a resolution of the Parliament. Where changes may be anticipated prospectively to the text of relevant sections of the 1978 Act, the reader should assume that the changes have been made for the purpose of this Bill. These changes are made by the National Health Service (Primary Care) Act 1997 (c.46); the Community Care and Health (Scotland) Act 2002 (asp 5); the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4); and Article 10(4) of The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (S.I. 2003/1250)).

5. The Bill is in two main parts (Provision of primary medical services and General) and 9 sections with a schedule. The sections are—

- Health Board duties;
- Section 17C arrangements;
- Pilot schemes;
- General medical services contracts;
- Persons performing primary medical services;
- Assistance and support;
- Ancillary provisions;

- Modification of enactments;
- Commencement and short title.

PART 1: PROVISION OF PRIMARY MEDICAL SERVICES

Section 1 – Health Boards’ duties: provision of primary medical services

6. This section inserts a new section 2C into the 1978 Act. This new section places a duty on Health Boards to provide or secure the provision of primary medical services for persons in their area.

7. Subsection (1) of the new section requires a Health Board to provide primary medical services or to secure the provision of those services by others. This gives Boards a new ability to provide services themselves, in contrast to current legislation which only permits them to secure provision by others. The subsection also introduces the concept of “primary medical services”.

8. Subsection (2) of the new section enables a Health Board securing the provision of primary medical services by others to do so by means of such arrangements as they think fit. The main arrangements available will be arrangements under section 17C, or GMS contracts under new section 17J which replaces the current section 19 GMS arrangements. An alternative option would be for a Health Board to contract with a private provider. Such a contract would not be a contract under section 17C or new section 17J. The Scottish Ministers intend to use powers of direction to ensure that monies allocated to Health Boards for GMS contracts and section 17C arrangements was not used to fund contracts with private providers.

9. Subsection (3) of the new section places a duty on Health Boards to publish prescribed information about the primary medical services which they secure the provision of by others or provide themselves.

10. Subsection (4) of the new section creates an obligation on Health Boards to co-operate with each other in discharging their duties under new section 2C. This has particular relevance when considering patients who may live in one Health Board’s area but seek services from a practice based in a neighbouring Health Board’s area. This specific duty of co-operation is in addition to the existing general duty on Health Boards and others under section 13 of the 1978 Act to co-operate with one another in exercising their functions in order to secure and advance the health of the people of Scotland.

11. Subsection (5) of the new section allows regulations to be made that will define “primary medical services” for the purposes of the 1978 Act. The regulations will set out types of services which are and which are not primary medical services for this purpose.

12. Subsection (6) of the new section allows the regulations made under subsection (5) to describe services by reference to the manner or circumstances in which they are delivered. This is intended to include categorising services by the times of day during which they are to be provided. The intention is to use this power to bring to an end GPs’ 24 hour responsibility for

their patients and allow them to opt out of providing care to patients between the hours of 6.30pm to 8am on weekdays and the whole of weekends, Bank Holidays and Public Holidays.

13. Subsection (7) of the new section provides that while Health Boards are exercising their own statutory functions to provide or secure the provision of primary medical services, they are also to be regarded in law as exercising functions of the Scottish Ministers. This (along with subsection (3) of section 1 of the Bill) brings forward the existing link to the Scottish Ministers from section 18 of the 1978 Act.

Section 2 – Provision of primary medical services: section 17C arrangements

14. This section makes the changes which are necessary to the main sections in the 1978 Act on section 17C arrangements - sections 17C, 17D, 17E and 17H. (More minor changes to related sections – sections 17EA, 17EB, 17F and 17I – are contained in the schedule, and related pilot schemes under the 1997 Act for personal medical services are dealt with in sections 3 and 7 of the Bill and in the schedule).

15. Subsection (2) continues the re-labelling of “personal medical services” as “primary medical services”. It also repeals section 17C(3)(a) of the 1978 Act which provides that a Health Board’s duty to make GMS arrangements under section 19 does not apply to a person who is covered by section 17C arrangements. This express exclusion from the duty is no longer needed in light of new section 2C.

16. Subsection (3) amends section 17D of the 1978 Act. It sets out the categories of persons who are eligible to enter into section 17C arrangements. The amendments reflect the need to be consistent with the terminology in other new sections of the Bill, including the creation in section 2C of the “primary medical services” duty on Health Boards and the descriptions in section 17J to 17O of new GMS contracts. The subsection also ensures that a person is eligible to enter into section 17C arrangements only if the person is on the new list for performers of primary medical services required under new section 17P (section 5 of the Bill).

17. Subsection (4) expands the regulation making powers contained in section 17E of the 1978 Act. It is intended that under section 17E regulations, performers of primary medical services under section 17C arrangements will have to demonstrate that they have a prescribed level of qualification and experience as part of their eligibility to provide such services. It is also intended that the regulations will set out the circumstances in which a provider of primary medical services under such arrangements can or must accept a patient and end the provider’s responsibility to a patient. These new regulation making powers bring section 17C arrangements into line with those governing the new GMS contract. New section 17E(3C) enables the regulations to set out circumstances under which a person who is a party to section 17C arrangements will be able to request a Health Board to replace those arrangements with a new GMS contract.

18. Subsection (5) repeals section 17H of the 1978 Act. That section ensures that all GPs have the opportunity to participate with the arrangements for vaccinations and immunisations. Under the new arrangements, the provision of immunisations and vaccinations will be part of the services to be provided in the section 17C arrangements themselves.

Section 3 – Revocation of power to make pilot schemes

19. Under current powers, section 17C arrangements can be set up either as pilot schemes under the 1997 Act, or as permanent schemes under section 17C of the 1978 Act. For pilot schemes a business case must be approved by the local Health Board, then approved by the Scottish Ministers. Permanent schemes are approved at Health Board level only. This section prevents the creation of new pilot schemes for the provision of personal medical services after the date on which it comes into force. (Existing pilot schemes for the provision of such services are not affected by the section. An order made under section 7 of the Bill will contain an express saving for such schemes to ensure that there is no doubt on this point. Such schemes will run their course: the order will make appropriate provision to ensure that they still work.)

Section 4 – Provision of primary medical services: general medical services contracts

20. This section inserts new sections 17J to 17O into the 1978 Act (in place of the existing sections on GMS arrangements). The new sections govern the terms and content of the new GMS contracts and who may provide or perform primary medical services under the contracts. They contain broad regulation making powers which will be used to set out the detail of the rights and obligations under the new contracts.

21. New section 17J refers to the general content of the contract.

22. Subsection (1) allows a Health Board to enter into a GMS contract with a contractor to provide primary medical services in accordance with the provisions of Part I of the 1978 Act.

23. Subsection (3) sets out broad parameters for services to be provided under the contract, the remuneration for their provision and other matters. Health Boards and contractors are free to agree the terms of the contract – subject to any restrictions on this freedom contained in Part I of the 1978 Act (restrictions set out in new sections 17K to 17O and in regulations under new section 17J and those sections).

24. Subsection (4) also allows the contract to cover a wide range of services, such as those which have previously been provided in an acute care setting and to include patients who may live outwith the Health Board area in which the contractor is based.

25. New section 17K makes it compulsory for a GMS contract to require the contractor to provide primary medical services of such descriptions as may be set out in regulations under the section. The regulations may describe services by reference to the manner or circumstances in which they are provided. The intention is to set out in the regulations those services referred to in the new GMS contract as essential services.

26. New section 17L sets out the persons with whom a Health Board may enter into a GMS contract. Subsection (1) allows a Health Board to enter into a GMS contract with a medical practitioner, or where prescribed conditions are satisfied a partnership or a company limited by shares. The nature of the prescribed conditions are set out in subsections (2) and (3). There may be a change in the membership of a partnership, and subsection (4) enables regulations to set out what effect such a change is to have on the GMS contract. The intention is to allow the

membership of the partnership to change without requiring a new contract to be entered into merely because such a change in membership has taken place.

27. New section 17M deals with payments to be made under GMS contracts.

28. Subsection (1) enables the Scottish Ministers to give directions as to payments to be made under the contracts. This follows current practice of using direction making powers to ensure that Health Boards make payments which adhere to Scotland wide rates and levels.

29. Subsection (2) makes it compulsory for a GMS contract to require payments to be made under it in accordance with the directions then in force.

30. Subsection (3) gives particular examples of the factors that may be taken into account in giving directions.

31. Subsection (4) requires the Scottish Ministers to consult before giving any direction under subsection (1).

32. New section 17N provides a broad regulation making power to impose further requirements that must be included in all GMS contracts. It is anticipated that the regulations will cover such issues as: the manner in which and the standards to which services are to be provided; the persons who may perform services; contract variation and enforcement; and the adjudication of disputes.

33. Subsection (3) provides for regulations made under subsection (2)(c) to set out prescribed circumstances in which a contractor must accept a person as a patient to whom services are to be provided and in which a contractor may decline to accept a person as a patient or may terminate responsibility under the GMS contract for the patient.

34. Subsection (4) provides for regulations made under subsection (2)(e) to include provision as to the circumstances in which a Health Board may vary the terms of a GMS contract and for suspension or termination of any duty under the contract to provide services of a prescribed description.

35. Subsection (5) provides for regulations made under subsection (4)(b) to prescribe services by reference to the manner or circumstances in which they are provided.

36. Subsection (6) provides for all GMS contracts to require the contractors under them to comply with any directions given by the Scottish Ministers for the purposes of section 17N as to the drugs, medicines or other substances which may or may not be ordered for patients in the provision of primary medical services under the contracts.

37. New section 17O essentially does two things.

38. Subsection (1) creates the regulation making power to set national procedures for internal dispute resolution for the terms of proposed GMS contracts. Participation in dispute resolution is optional but the existence of the procedures at Health Board level is mandatory. The regulations may provide for the proposed terms to be referred to the Scottish Ministers and for the Scottish Ministers, or a person appointed by them, to determine what the terms of the contract should be.

39. Subsection (2) creates the regulation making power to enable the parties to a GMS contract to opt instead to have the contract treated as “an NHS contract” entered into under existing section 17A for any purposes of that section. NHS contracts, which are agreements between health service bodies, are not regarded for any purpose as giving rise to contractual rights or liabilities, and the effect is that NHS contracts are not enforceable in the courts. Section 17A provides for either party to an NHS contract to refer any matter in dispute to the Scottish Ministers for determination. It also provides for any determination made by the Scottish Ministers to contain directions (including directions about payments) and places a duty on the parties to the NHS contract to comply with any such directions. Opting into section 17A in this way also gives a party to a GMS contract who is not a health service body the opportunity to enter into other contracts with other health service bodies under that section for the supply of goods and services to or by those health service bodies.

40. Where a practice opts for its GMS contract to be an ordinary contract at law, it will have the option of asking the courts to resolve any resultant contractual disputes.

Section 5 – Persons performing primary medical services

41. This section inserts new section 17P into the 1978 Act. The new section inserts into the 1978 Act regulation making powers governing the ways in which persons performing primary medical services are listed. The regulations will prevent health care professionals from performing primary medical services for Health Boards unless their name appears on a list held by the Health Board in whose area they will work. (Health care professionals will not have to be included in these lists to perform services privately). For example, where a Health Board employs a salaried GP to perform primary medical services directly by the Board (A) or where a practice (which includes a GP) undertakes to provide primary medical services under a GMS contract or section 17C arrangements (B), the doctors performing primary medical services in both (A) and (B) will need to have their name included on that Health Board’s list.

42. The new section (taken with the repeal by the schedule of the relevant sections of the 1978 Act) replaces the existing system of listing which created three lists in each Health Board area: the medical list for principal GPs; the supplementary list for non-principal GPs; and the services lists for providers under section 17C arrangements.

43. The amalgamation of the lists into a single list for each Health Board area is a technical consequence of the creation in new section 2C of a duty on Health Boards to provide or secure the provision of primary medical services and of new section 17L which allows Health Boards to enter into GMS contracts with a partnership or company.

44. Under new section 2C, GMS contracts and section 17C arrangements will be two ways in which Health Boards will be able to discharge their duty to provide or secure the provision of

primary medical services. Bringing the two options together under one duty ends the need to have separate listing arrangements for those who provide these services.

45. Section 17L ends the distinction between GP principals (those GPs who make direct arrangements with Health Boards to provide GMS) and non-principals (those GPs who assist principal practitioners but do not have their own arrangement with the Health Board), and it is therefore no longer appropriate to distinguish between them for listing purposes.

46. Section 17P also sets out the particular issues that may be included in the regulations (subsection (2)). These include, for example, how the list will be drawn up and maintained; what criteria an individual will have to meet to qualify to be on the list; the process by which decisions on applications will be made; mandatory grounds under which a Health Board would have to reject an application and discretionary grounds under which they may reject an application.

Section 6 – Assistance and support

47. This section inserts new section 17Q into the 1978 Act. The new section enables a Health Board to provide assistance and support (including financial assistance) to those providing, or proposing to provide, primary medical services under a GMS contract or section 17C arrangements. The terms on which such assistance and support are given, including terms as to payment, are a matter for the Health Board.

PART 2: GENERAL

Section 7 – Ancillary provision

48. This section enables the Scottish Ministers by order to make incidental and other ancillary provision for the purposes of the Bill or in consequence of it. It is intended to use the power, for instance, to make an express saving provision for existing pilot schemes under the 1997 Act for personal medical services, and to make appropriate provision to secure that such schemes continue to work. (See the entry above for section 3 of the Bill.) It is also intended to use the power to make appropriate provision to ensure that existing GP practices providing general medical services under section 19 arrangements have an automatic right to transfer to a new general medical services contract

Section 8 – Modification of enactments

49. The amendments and repeals in the schedule which is introduced by this section are consequential on the provisions of the Bill.

Section 9 – Commencement and short title

50. This section allows the Scottish Ministers to bring the provisions of the Bill (apart from sections 7 and 9) into force by commencement order. Different dates may be appointed in the order for different provisions. The section is in the usual terms.

FINANCIAL MEMORANDUM

INTRODUCTION

51. The Bill is the vehicle through which the Executive will implement the new GMS contract for providers of primary medical services which has been negotiated at a UK level by the General Practitioners Committee (GPC) of the BMA, the NHS Confederation and the four UK Health Departments.

COSTS ON THE SCOTTISH ADMINISTRATION

Current arrangements for GMS funding

52. Nearly all GPs are paid by the NHS as independent, self-employed contractors. They are entitled to payments in respect of patients registered and work carried out. The payments they receive cover both their expenses in providing GMS and a net income for doing so. Most of the fees paid to GPs are set out at a UK level. Annual uplifts are considered by the GB wide Doctors' and Dentists' Review Body (DDRB) who then make recommendations for decision by the English, Scottish and Welsh administrations. Other fees, such as the GP appraisal fees and sliding scale payments for influenza immunisations are set at a Scottish level.

53. GPs do not receive a salary but are paid through a system of payments designed to deliver certain levels of gross and net income for the average GP. A GP may claim reimbursement of certain practice expenses and a range of fees and allowances. These are prescribed in the Statement of Fees and Allowances.

54. Expenditure on GMS is non-discretionary, that is, demand led and met by Health Boards. The Scottish Executive Health Department (SEHD) receives funds for the provision of GMS through the spending review process. It then issues allocations to Health Boards, based on indicative spend. GPs submit regular claims for their expenses, fees and allowances. The required resources are then drawn down (by the Common Services Agency on Health Boards' behalf) from the SEHD to enable payments to be made.

55. A number of GPs are not covered by these arrangements. They are known as "non-principal GPs" and assist principal practitioners but do not have their own arrangement with the Health Board. They work either as employees of GP principals or as locums. They are paid directly by the employing GP.

New arrangements

56. Under the new contract as implemented by the Bill and its consequential regulations, funding will continue to flow from the Executive to GPs via the Health Boards. However, the Bill will lead to a change in the basis for payments with remuneration going to the practice rather than, as at present, to an individual GP. A further, more fundamental, change is that Board allocations to practices will be distributed according to patient need instead of through the current system of payment per GP.

57. The key financial change brought about by the new GMS contract is the cash limiting of what is currently non cash limited spend on Part II GMS. In 2002-03, Scottish spend on GMS was £433m. The introduction of a gross investment guarantee (GIG) and the contractual change making the contract between the practice and the Health Board will in effect transfer GMS Part II funding onto the same footing as Health Boards' Part I Hospital and Community Health Services (HCHS) expenditure.

58. The new contract will be accompanied by an unprecedented investment in primary care over a three year period, increasing spend by 33% to a total of £575m in 2005-06. This total figure (the GIG) is a guaranteed amount agreed between the 4 Health Departments, the NHS Confederation and the BMA. Spending within the GIG will largely be determined by policy decisions made by the Executive and not by external factors. Sufficient provision to meet the increase was identified during the 2002 spending review.

59. GMS will be divided into five main funding streams—

- global sum payments;
- quality payments;
- enhanced services;
- Health Board administered funds; and
- minimum practice income guarantee (MPIG).

60. Once the quality framework is fully implemented in 2005-06, the overall expenditure will be spread across the funding streams as follows—

- global sum – 49%
- quality payments – 18%
- enhanced services – 8%
- Health Board administered – 21%
- MPIG – 4%.

61. Of these funding streams, the global sum, quality payments and MPIG are guaranteed to practices and cannot be changed by the Health Board. Income from the global sum and, if required, the MPIG will flow directly to practices. Income from the quality framework will be determined by the number of points scored by the practice against an objective set of measures.

62. Health Boards have discretion in how the enhanced services and Board administered lines are spent. However, minimum floors have be set for how much must be spent on enhanced services; Boards can increase this but cannot go below it.

63. Under the terms of the new contract, the method for distributing the reimbursements outlined in the current Statement of Fees and Allowances (also known as the “Red Book”) will be replaced by the Scottish Allocation Formula (SAF) which will provide the mechanism for

allocating the global sum payments according to patient need and will also inform payments made for quality, enhanced services and Health Board administered functions.

Scottish Allocation Formula (SAF) and global sum

64. The SAF is a resource allocation formula that will allocate resources to practices on the basis of the relative needs of their patients and the associated workload for GPs. The SAF will be responsible for the allocation of a global sum to each practice. Although funding for the global sum will flow through Health Boards, the amount for each practice is guaranteed and cannot be altered by the Board.

65. In addition to being the mechanism for allocating resources to practices, the SAF will also be used to allocate some of the other funding streams to Boards. Health Board administered funding (which is explained more fully in paragraphs 81 to 84) and enhanced services (paragraphs 76 to 80) are also allocated using the formula, but at Board rather than practice level.

66. The SAF determines how the global sum for Scotland is distributed between GP practices; it does not inform the total size of the Scottish budget for the global sum. The SAF is a population based formula, at GP practice level, with a series of “weightings” to reflect the relative needs of GMS patients and the additional costs of providing an adequate service in remote and rural areas of Scotland.

67. The components of the SAF are the GP practice population (total practice list size) adjusted for “weightings” to reflect—

- the age and sex structure of the practice population (demography);
- the additional need of the practice population (morbidity and deprivation);
- the rurality and remoteness of the practice population.

68. There are other weights - set at a UK level - to reflect nursing and residential home patients, new registrations and staff costs, but these combined have for most practices a relatively minor effect compared with the above set of “weightings”.

69. Moving to global sum payments is contingent upon the passing of the Bill. If the Bill is accepted by the Parliament, Scottish spending on the global sum will be £280m per annum in 2004-05 and 2005-06 (the first two years of the new contract).

70. Expenditure estimates for the global sum are based on a read-across from the existing relevant fees and allowances, uprated for inflation. The SAF will be used to allocate this sum to practices. The budget cannot be overspent as the Scottish global sum is fixed for the current spending review period.

Quality payments

71. The new contract will include an evidence-based quality and outcomes framework to reward practices on the basis of the quality of care delivered to patients. The framework is

outwith the confines of the Bill but has implications for how the overall contract is funded. It is not mandatory for practices to participate in the quality framework but the expectation is that almost all practices will be involved.

72. Practices will receive a number of points according to their performance against a set of key quality indicators. The maximum number of available points is 1050. The financial worth of each point will, in part, be determined by a weighting based on prevalence. Prevalence can be defined as the number of patients with a specific disease in the population at any given time. It is usually expressed as a rate x number of patients per 1000 population or x percent of the population. Prevalence will vary from area to area depending on the profile of the population. The weighting will be set at the end 2004-05 (the first year of the quality framework) and will be based on prevalence data recorded at practice level and collated from the disease registers which each practice will set up in 2004-05 as part of the implementation of the quality framework. Although the funding for quality will flow from Boards to practices, Boards will have no powers to vary locally either the number of points available or their worth. The introduction of an adjustment for prevalence means that individual practices will not be able to accurately calculate their final payment for quality points until the overall prevalence is known. Prevalence will only impact on the amount each practice receives through quality: the size of the Scottish pot will not change.

73. In addition to the money secured through quality, there is funding of £8m to be allocated to practices in 2003-04 to assist them to prepare for the quality framework by, for example, collecting initial data to establish their current position in the framework.

74. Expenditure on quality will begin at £8m in 2003-04, all of which will be spent on quality preparation payments. This will rise rapidly to £64m the following year and £100m in 2005-06. Expenditure is low in the first year, as the quality framework does not become operational until 2004-05. Spend is projected to rise rapidly in the first two years of the framework's full operation for two reasons: the amount a quality point is worth rises in the second year; and it is anticipated that the number of points achieved by practices will increase as they become familiar with the new ways of working and begin to score more highly.

75. The estimated expenditure on quality is based on quality preparation payments for 2003-04 and quality points thereafter. Quality preparation is based on a predetermined level of expenditure divided between practices. The quality points element of the spend is predicated on an estimate that 90% of practices will achieve 90% of the available points each year. There is a slight risk that practices will score higher, but as it will take practices some time to become accustomed to the framework and for data to be recorded, the risk of the cost estimates being exceeded in the first three years of the contract is viewed as minimal.

Enhanced services

76. Regulations made under the Bill will categorise services provided under GMS into essential, additional and enhanced. Essential and additional services will be funded through the global sum. Enhanced services will form a separate funding stream. Enhanced services will be defined as either essential or additional services delivered to a higher specified standard; more specialised services which might traditionally have been done in a secondary care setting;

schemes addressing a specific local need; or innovative pilots. Not all practices will provide the full range of enhanced services.

77. Enhanced services will be commissioned at Health Board level and Boards will be free to determine the range and extent of services that they think are required for local health needs. There are a small number of exceptions to this. All Boards will be obliged to secure “directed enhanced services” (DES) for: childhood immunisations; flu immunisations; violent patients; minor surgery and quality information preparation. England will have a further DES to ensure that practices meet their English access targets. In Scotland, achievement of the access targets will be rewarded through the quality payments.

78. Unlike the global sum and quality payments, enhanced services will not be a guaranteed source of income for all practices. Boards will be free to make decisions on the services which they choose to commission. However, in order to assist the bedding down of the new ways of working, each Health Board will have to earmark a minimum amount for enhanced services; they will be free to spend more than this but cannot earmark less.

79. The Scottish floor for enhanced services will rise from £12m in the first year of the contract to £44m in 2005-06. This will be allocated to Boards using the SAF. The rapid increase in resources reflects the commitment to funding the modernisation of primary care through the medium of the new contract.

80. Cost estimates for enhanced services are based on payments for existing services which have been redefined as enhanced services, such as flu immunisations, and a substantial input of new money. Boards are free to spend more than their allocated allocation on such services but would have to find these additional resources from within their unified budgets.

Health Board administered funds

81. Health Boards will receive a further allocation from the Executive to cover the following: premises, IT, seniority payments, recruitment and retention, locum allowances, a small number of allowances still paid on an individual GP basis, employers’ superannuation, maternity, paternity and adoptive leave and sick leave.

82. Spend on premises will rise substantially under the new contract from £40m in 2003-04 (comprising £34m from the GMS cash-limited line and £6m of new investment) to £69m in 2005-06. This represents an increased investment in infrastructure that is essential to the delivery of high quality primary care services. The new funding will go towards both capital and revenue expenditure. IT spend will rise over the same period from £5.5m (comprising £2.5m from the GMS cash-limited line and £3m of new investment) to £11m and is essential to the delivery of the new GMS contract. It will cover the IT equipment costs as well as IT training costs for primary care staff. The substantial increase in resources for premises and IT reflect the commitment to improving the infrastructure of primary care to the benefit of GPs, their staff and their patients. The vast majority of this additional investment will be recurrent and expenditure is unlikely to reduce beyond 2005-06.

83. The remaining budget for Board administered funds will be £34m in 2004-05 and £36m in 2005-06. This budget will be allocated to Boards using the SAF to ensure that it reflects patient need and consequential workload at Board level.

84. Cost estimates for Board administered funds are based on a common UK definition of the relevant existing payments from fees and allowances, and substantial new levels of funding for premises and IT. The SAF will be used to allocate the Scottish sum to practices. The budget cannot be overspent as the Scottish figure is fixed for the current spending review period.

Minimum practice income guarantee

85. The contract will introduce a fundamental change in the basis of resource allocation. It is inevitable that this will have a redistributive effect with some practices gaining significantly and some losing. To avoid destabilising existing practices, the contract originally proposed a three year transitional protection scheme. However, distribution of individual practice-weighted populations by the BMA in mid-March led to significant concerns amongst many GPs over the potential reductions to their current income. As a result of these, transitional protection has been replaced by the MPIG.

86. Under the MPIG, practices that would otherwise lose out as a result of the introduction of the global sum arrangements will receive a guarantee that their global sum allocation will reflect at least their previous level of income from those aspects covered by the global sum. The MPIG only covers those elements of the current fees and allowances that read across directly into the global sum; other existing fees and allowances will reach GPs through the other funding flows.

87. The purpose of the MPIG is to ensure that the financial viability of practices is not endangered by the new funding mechanisms. The principle of the MPIG is permanent but the policy intention is that the vast majority of practices will quickly discover that, when they take account of all of the funding streams, the new contract will leave them, even without the MPIG, in a better financial position than the current Statement of Fees and Allowances at which point they will cease to be losers and will no longer require the MPIG.

88. Monies set aside for MPIG are £25m per annum in both in 2004-05 and 2005-06.

89. Cost estimates for the MPIG are based on detailed modelling work at practice level on the potential aggregate loss for those practices whose indicative allocations under the new contract are less than their global sum equivalent under the new contract. There is a small risk of error in the estimate as the financial information used is based on the most recent year for which full financial information is available and complete payment records are not available for every single current practice in Scotland. However, the data is sufficiently robust to make the risk minimal. In addition, the modelling work is based on deflated lists, while future indicative allocations will be based on registered lists (which have not been deflated for list inflation). This change could have a small impact on the size of the MPIG funding requirement. It should also be noted that a move to registered lists could reduce the need for MPIG.

Summary of costs

Expenditure Type	2002-03	2003-04	2004-05	2005-06
	£m	£m	£m	£m
GMS fees and allowances	325	336		
GMS cash limited payments (including IT, premises)	101	103		
Global sum payments			280	280
Quality payments		8	64	100
Enhanced primary care services		12	35	44
Premises		6	56	69
IT		3	11	11
Other Health Board/PCT administered funds			33	36
MPIG adjustment			25	25
Remote and rural	1	1		
Out of hours development fund	6	6	7	10
Total	433	475	511	575

90. Premises: In 2003-04, premises expenditure occurs in both the GMS-CL line (£34m) and more explicitly as new investment in the “premises” line (£6m) giving a total premises expenditure of £40m.

91. IT: In 2003-04, IT expenditure occurs in both the GMS-CL line (£2.5m) and more explicitly as new investment in the “IT” line (£3m) giving a total IT expenditure of £5.5m.

92. The out of hours development fund is shown separately as it will either go to Boards (in the event that practices opt out of providing out of hours cover) or to practices (if they are unable or unwilling to opt out).

93. The £1m for remote and rural in years 2002 and 2003 is for existing payments aimed to assist practices in remote areas. Once the new contract is implemented, this money will move into Health Board administered funding.

These documents relate to the Primary Medical Services (Scotland) Bill (SP Bill 4) as introduced in the Scottish Parliament on 23 June 2003

94. The Bill will give the Scottish Ministers the power to issue directions in relation to payments to be made under the contract. These powers are described in paragraphs 27 to 31 of the Explanatory Notes which accompany the Bill. The powers will be used to implement the funding mechanisms set out in this memorandum.

95. The Executive considers that there is one potential risk around the budget set for quality payments. The proposed Scottish allocation of £64m in 2004-05 and £100m in 2005-06 are calculated on a pro rata basis on the assumption that 90% of the practices across the UK will achieve 90% of the total quality points available to them in both years. In principle there is however a possibility that 100% of practices could achieve 100% of the quality points in both of these years. Given the focus on complex evidence based care and the reporting requirements, it is considered unlikely that these levels will be achieved in the first two years of the scheme being in operation. The following tables set out the Executive's assessment of the potential risk.

2004/05	Percentage of Practices		
Percentage of Quality	80 per cent	90 per cent	100 per cent
60 per cent	38	43	48
80 per cent	51	58	64
90 per cent	58	65	72
100 per cent	64	72	80

2005/06	Percentage of Practices		
Percentage of Quality	80 per cent	90 per cent	100 per cent
60 per cent	62	69	77
80 per cent	82	93	103
90 per cent	93	104	116
100 per cent	103	116	129

All above figures are in £m

96. As a result of ongoing discussions on arrangements for implementation between the 4 UK Health Departments, the NHS Confederation and the BMA, there have been late changes to the distribution of resources within the GIG. This will require additional modelling to assess the impact on overall risk management within the GIG and work on this is in hand. Any significant changes at individual practice level will have to be reflected by changes in the level of payment

not the overall level of expenditure given that the agreement with the profession is that the GIG is cash limited at the agreed level of investment.

97. The 4 Health Departments are committed to undertaking a joint review of the allocation formula. The process will begin formally in October 2004. Decisions on the appropriate level of resources for the global sum payments beyond 2005-06 will be a matter for the next spending review informed by recommendations from the Doctors' and Dentists' Review Body and the Executive's policy priorities and developments.

COSTS ON LOCAL AUTHORITIES

98. The Bill has no financial implications for local authorities.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

99. The additional costs described above will flow from the Executive to practices through Boards. Boards will be fully covered by the increased resources available to the Executive set out in paragraph 58.

100. Health Boards will take on additional responsibilities for negotiating contracts with individual practices in their areas. This is likely to give rise to additional administrative costs at Board level. Although it is not the Executive's intention to increase Boards' allocations to cover these costs, it is providing a range of central support to assist Boards with this work.

101. In particular central resources of £3.5m will be allocated by the Scottish Executive Health Department to Boards during 2003-04 and 2004-05 to help them to build the necessary capacity to implement all strands of pay modernisation: Agenda for Change, the new consultants' contract and the new GMS contract.

102. This resources will be complemented by central support to be given to the delivery of pay modernisation led, in the case of the new GMS contract, by the recently appointed GMS Pay Modernisation Director.

EXECUTIVE STATEMENT ON LEGISLATIVE COMPETENCE

103. On 19 June 2003, the Minister for Health and Community Care (Malcolm Chisholm) made the following statement:

“In my view, the provisions of the Primary Medical Services (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

These documents relate to the Primary Medical Services (Scotland) Bill (SP Bill 4) as introduced in the Scottish Parliament on 23 June 2003

PRESIDING OFFICER'S STATEMENT ON LEGISLATIVE COMPETENCE

104. On 20 June 2003, the Presiding Officer (Mr George Reid) made the following statement:

“In my view, the provisions of the Primary Medical Services (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

*These documents relate to the Primary Medical Services (Scotland) Bill (SP Bill 4) as introduced
in the Scottish Parliament on 23 June 2003*

PRIMARY MEDICAL SERVICES (SCOTLAND) BILL

EXPLANATORY NOTES (AND OTHER ACCOMPANYING DOCUMENTS)

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