PRIMARY MEDICAL SERVICES (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Primary Medical Services (Scotland) Bill introduced in the Scottish Parliament on 23 June 2003. It has been prepared by the Scottish Executive to satisfy Rule 9.3.3(c) of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Executive and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 4–EN.

POLICY OBJECTIVES OF THE BILL – BACKGROUND

2. The overarching policy objective of this Bill is to make the necessary legislative changes to allow implementation of the new contract for providers of general medical services (GMS). It amends the provisions of the National Health Service (Scotland) Act 1978 relating to the arrangements currently made by Health Boards with medical practitioners for the provision of general medical services (GMS) and personal medical services (PMS). In relation to PMS the contract holder can be someone other than a medical practitioner, although there must be a medical practitioner as one of the performers. Currently the arrangements for PMS contracting are delegated from Boards to Primary Care Trusts (PCTs) except in the cases where there is no PCT.

3. At its heart, the new contract will enable the development of a new contractual arrangement between NHS Boards and their constituent GP practices. The Executive sees this as a mutually supportive relationship, building on the spirit of partnership and collaboration that is key to Scotland’s approach to healthcare delivery and NHS modernisation. Partnership working has been well-established at the heart of Scotland’s programme of health service reform for a number of years and there is a clear commitment on all sides to build on this strong partnership ethos in taking NHSScotland forward into the 21st century.

4. This contract builds on the principles of reform in partnership with NHS staff groups. It will be accompanied by substantial additional resources for the development of primary care services. The contract will link investment to the specific health needs of local communities and practice populations, rather than simple payments for services and allowances to doctors. Changes to legislation as a result of the contract will encourage the development of teamwork by all primary care staff including nurses and other health professionals making full use of their skills. There will be more scope for providing high quality care in local GP practices which hitherto has only been available at hospital. The Bill and the contract which underpins it will
help the Executive to achieve the policy intention of improving the primary care experience for staff, patients and carers and the NHS as a whole.

POLICY OBJECTIVES OF THE BILL – SPECIFICS

Duties on Health Boards

5. Current legislation places Health Boards under a duty to secure services often referred to as ‘personal medical services’. This terminology has become confused with the development of the local alternatives to GMS, also referred to as personal medical services or PMS. The Bill creates a new terminology for the over-arching duty: primary medical services. Boards will be able to discharge this duty by providing such services directly or by means of arrangements for provision by others according to which is the most appropriate to local circumstances.

6. At present, the Scottish Ministers have an over-arching duty to secure the provision of a comprehensive health service. Health Boards have a more detailed duty to secure the provision of services to patients within their area who wish to avail themselves of such services. A Health Board has no power under existing legislation to provide general medical services itself except in very exceptional circumstances.

7. The Executive believes that this is unnecessarily restricting. It prevents Health Boards from employing salaried general practitioners (GPs) if they believe that is the most appropriate and cost effective way to provide services to the patients. One of the aims in negotiating the new contract has been to remove the barrier against Health Boards directly providing services which, in our view, hinders integration between acute services, primary care services and social care services, and thereby militates against patient’s interests, which lie in less rigid demarcation. It also blocks a career option that might appeal to many GPs.

8. It is the Executive’s intention to allow Health Boards both to secure and to provide services. This will allow boards to take a more holistic view of local needs and the most appropriate provision of the range of services required. It will help integration between types of care where it can be shown that this is in the best interests of the patients and NHS. It will also provide an alternative career path for individual doctors who want to practice family medicine but do not wish to take on the responsibilities that come with independent contractor status.

Personal medical services

9. The negotiated new contract is for providers of GMS. However, the changes in legislation required to effect these changes have implications for legislative and contractual arrangements for what are known as ‘personal medical services’ (PMS).

10. PMS is the system for the delivery of personal medical services introduced by the National Health Service (Primary Care) Act 1997 (“the 1997 Act”). PMS was conceived to operate in parallel with general medical services (GMS). It is the intention to continue to allow both schemes to operate in parallel.
11. The intention was to provide for increased flexibility to promote innovative and locally responsive measures of delivery of primary medical services. In particular PMS allows services to be agreed upon and priced locally, rather than nationally predetermined - as is the case under GMS. The 1997 Act extends to Scotland as well as England and Wales and allows for the development of “pilot” schemes which operate over a period of usually 3 years, during which time they are the subject of a review by the Scottish Ministers to determine if they can become “permanent” schemes. Provision for the “permanent” PMS regime in Scotland is made by amendment of the National Health Service (Scotland) Act 1978 (“the 1978 Act”). The Act defines a PMS pilot scheme as one or more agreements made by a Primary Care Trust or Island NHS Board for the provision of personal medical services. The 1978 Act provides for permanent schemes only in Scotland, but the arrangements relating to pilot schemes (1997 Act) are common to both sides of the border, with separate regulatory arrangements.

12. The Executive does not intend to make significant changes to PMS. The policy intention is to allow PMS to continue as an alternative scheme to GMS, offering the opportunity to agree locally flexible contracts where the health board and practice think that this offers the best option for those who provide primary care services, their patients and local communities – for example to ensure service sustainability. Most of the changes in the Bill are technical changes as a consequence of the decision described in paragraph 5 of this policy memorandum to create a new duty on health boards to secure or provide “primary medical services”.

13. Some changes in the Bill go further than amendments to terminology. The GMS sections of the Bill will allow the Scottish Ministers to introduce regulations to define who may enter into a GMS contract. These changes will also be brought in for providers of PMS. The policy intention is to create further parallels between the two systems with the aim of ensuring that anyone who provides PMS or GMS is a fit person to do so. This will deliver the commitment in the Partnership for Care\(^1\) White Paper to ensure that the public is confident that health services are as safe and effective as possible.

14. At present, doctors entering into PMS arrangements can do so on a “pilot” basis. There is also the option of direct entry into a “permanent” contract, however all PMS schemes in Scotland have commenced as pilots. The concept of pilots was created under the 1997 Act to allow all concerned to test out the new procedures. PMS arrangements have become well established in Scotland and the policy intention is to move to the next stage in the process: substantive PMS schemes. A number of pilot PMS schemes in Scotland have already become substantive schemes. The Bill therefore repeals the pilot schemes. This will not affect those currently in pilots as transitional arrangements will apply until the end of the agreed term for these schemes. It will not tie GPs or health boards into permanent schemes; instead the intention is that both parties to the contract will be able to set whatever contract length is most appropriate for them. Those exploring a new way of working may wish to set a short term to allow them a formal review at the end of that period; those with more experience of how the pilot schemes worked may wish to agree a longer term. This is consistent with the underlying policy of PMS contracts: that both parties have the local flexibility to make an agreement tailored for specific local need.

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\(^1\) Partnership For Care: Scotland’s Health White Paper, published February 2003. Available from The Stationery Office Bookshop, 71 Lothian Road, Edinburgh, EH3 9AZ (Tel: 0870 606 55 66) or online at www.scotland.gov.uk
General medical services contracts

15. The policy intention is to introduce the legislative changes required to allow full implementation of the new GMS contract as negotiated by the General Practitioners Committee (GPC), NHS Confederation and the four UK Health Departments.

16. The contract will, for the first time, be between the GP practice and the Health Board. Remuneration will also be at a practice, rather than a GP, level. This is a change from the present arrangements where the contract (which is, in essence, a set of arrangements governed by regulations) is between Ministers and individual GPs, although, in practical terms, many individual GPs practice in partnership and in group practice with other GPs. The formal requirement to make arrangements with individual medical practitioners is also seen to militate against the development of an integrated primary health care team with nurses, therapists and other practitioners, possibly from both the primary and specialist care settings, working in partnership and taking on responsibilities previously undertaken by general medical practitioners. The scope to provide a salaried GP service is also currently limited, as the statutory framework does not readily provide for a conventional employment contract. Independent medical practitioners therefore have a near monopoly on service delivery, inhibiting a flexibility and diversity of approach which may be more responsive to the widely varying needs of local patient populations and of practitioners. Furthermore, the business of declaring a GP vacancy and filling it is overly bureaucratic.

17. The policy intention is to introduce a new system whereby the skills and services of the whole of the health care team are taken into account when a contract is drawn up. This allows the contract to take an integrated approach to care and deliver the full range of services for patients. It will allow practices to expand into areas previously seen as outwith the direct remit of a GP. This can include providing nurse-led services or specialised services which have previously been provided in a secondary care setting.

18. Giving the responsibility for holding contracts to Health Boards accords with the Executive’s policy intention to devolve responsibility from the central to the local level. The White Paper Partnership for Care explicitly rejects a command and control approach and emphasises the importance of giving local systems the tools and freedom to redesign services and lead change. The transfer of responsibility for contracts from the Scottish Ministers to Health Boards fits with that overarching policy objective.

19. The practice based contract devolves responsibility for determining staffing levels even further, down to the practice. At present, the Scottish Medical Practices Committee (SMPC), constituted under the National Health Service (Scotland) Act 1978, has the final say in whether and by whom a GP vacancy can be filled. This is bureaucratic, time-consuming and prevents health boards and practices from taking decisions based on local understanding of local needs. It has long been recognised that local health care systems should have the responsibility for determining local staffing levels. Accordingly the Scottish Executive brought forward proposals to abolish the SMPC as part of the Public Appointments and Public Bodies etc. (Scotland) Act 2003. A date for abolition has not yet been set but it is anticipated that abolition will follow the introduction of the new contract.
20. Under the new contract, a practice’s funding will depend on the needs of its patients. Practices will have an income largely based on this. This income will not, as now, be reduced if a GP leaves. Once the new contract has been implemented and the powers to abolish the SMPC have been put into effect, it will be for practices themselves to determine how this income should be spent to meet local service needs. They can, if they so choose, employ doctors but they also have the freedom to employ nurses or other health care professionals if they believe that this is the most appropriate way for them to meet their contractual obligations to the Health Board.

21. Although each contract will be negotiated at a local level between the practice and the Health Board, it is the Executive’s intention to have a degree of uniformity to reflect the fact that the principles of the new contract have been agreed at a UK level. The Bill creates powers to introduce secondary legislation on a range of issues including who can hold a contract; mandatory contractual terms; the types of services to be provided and the manner in which they are to be provided. The intention behind the regulation making powers is to ensure that practices and Health Boards maintain a base level of quality and organisation wherever in Scotland they happen to be. The Scottish Ministers will retain the overall responsibility for ensuring that a comprehensive health service exists in Scotland. This Bill will ensure that they can discharge this over-arching duty through setting the parameters within which Health Boards must work.

Key regulation making powers

Categorisation of services

22. Under current arrangements, GPs are, through the GMS regulations, required to provide the whole range of general medical services without defining any limits to these services. This is burdensome on GPs, and restricts their ability to manage workload and select their own work patterns, and can lead to difficulties in recruitment. “General medical services” are not clearly defined from a medical standpoint and have expanded incrementally as a result of a gradual shift of services from the hospital sector and developments in medical technology. There is a perception that this has added to GPs’ workload without bringing any commensurate recognition for it.

23. The Bill will bring in powers to create a new set of GMS regulations which will, inter alia, set out definitions for “essential”, “additional” and “enhanced” services. The intention is that—

- all practices will provide essential services (the ongoing care of people who are or who believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable);
- practices will normally also provide the full range of additional services (such as child health surveillance and contraceptive services) but can opt out of this provision in accordance with fixed rules; and
- practices will be able to opt into “enhanced services”, which will be commissioned by the health board and delivered by selected practices within a Board’s area.

24. If a practice does decide to opt out of additional services, patients will retain the right to receive these services and the duty to ensure that this happens will fall on the Health Board. This
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categorisation of services will give practices more ability to control their workload and to specialise in particular areas should they so choose. It also ensures that patients will continue to be able to access the full range of services.

Who can hold a contract

25. The Bill has the effect of creating the power to prescribe those who can enter into a contract. The policy intention is to ensure that those being given a contract are fit and competent people to carry out this sensitive and important work. This is in the public interest and is essential to retaining public confidence in the provision of family health services.

Others

26. The Bill also includes powers to give directions as to payments; and other mandatory terms, such as out-of-hours transfer of responsibilities; and opting out of additional services.

Disputes

27. It is inevitable that the negotiation and implementation of any contract has the potential to give rise to disagreements between the parties to the contract. The Executive intends to bring forward regulations which will set out a process for dispute resolution. The policy intention is that the vast majority of disagreements will be resolved by discussion and good working relationships at a local level. However, it is essential that all parties have access to a fair and independent dispute resolution system. In keeping with the concept of a national contract, the Executive believes that the process should be a common one across Scotland. This will ensure that any dispute follows a single, easily understood procedure and adheres to the principles of the European Convention on Human Rights.

Listing arrangements

28. Under current arrangements, GPs who provide or assist in the provision of GMS must be on a list held by the health board in whose area they work. There are two different lists: a medical list for principal practitioners (those medical practitioners who make direct arrangements with Health Boards to provide GMS); and supplementary lists for those GPs who assist principal practitioners but do not have their own arrangement with the Health Board. This latter category include locums and GPs employed by principal practitioners.

29. The purpose of the lists is to tie GPs into terms and conditions of service and to ensure that disciplinary action can be taken against them if they are found to be in breach of these conditions.

30. At present, doctors providing PMS only have to appear on a list if they also assist in the provision of GMS. However, the Community Care and Health (Scotland) Act 2002 contained powers to create a list for PMS doctors, to be known as the services lists. These powers have not yet been taken up.

31. The policy intention behind having three different lists was to recognise the different situations pertaining to principal practitioners, non-principals and PMS providers. The move to a
practice-based contract effectively brings to an end much of the distinction between the terms and conditions required for each category of GP. The creation of overarching “primary medical services” ends some of the administrative and managerial differences between GMS and PMS doctors. The Executive therefore intends that there should be a single list maintained by each Health Board for all the doctors providing primary medical services, whether they are principals or non-principals and whether they are providing them by way of the new GMS contract or PMS arrangements. The Bill will empower the Scottish Ministers to provide by regulations that a health care professional of a prescribed description may not perform any primary medical service for which a Health Board is responsible unless the person is included in a list maintained under the regulations by that Health Board.

32. GPs currently on the medical and supplementary lists should notice little change under the new arrangements. While PMS doctors are not currently required to have their names on a list, there has been an expectation of the creation of PMS lists since the consultation paper Supplementary medical lists for non-principal general practitioners was issued as part of the consultation exercise which preceded the Community Care and Health (Scotland) Act 2002.

ALTERNATIVE APPROACHES

33. The proposals contained with the Bill are the result of almost two years’ negotiation with the GPC and NHS Confederation on a UK wide basis. They reflect the UK agreement on the way forward for GMS.

34. There are two alternative options: to implement only certain sections of the UK deal; or to move away from the UK deal and begin negotiations on a purely Scottish contract. The Executive rejects both approaches.

35. Although health and the pay and conditions of workers within the NHS are devolved matters, the Executive believes that a UK wide approach has much to commend it. It ensures consistency across the UK so that a contract between a Health Board and a practice has the same core roles and responsibilities regardless of the geographic area. A UK-wide contract and UK pay scales avoid fragmentation and prevent one part of the country from distorting the labour market. A consistency of approach across the UK to pay and terms and conditions also helps to reinforce the concept of a UK NHS.

36. A Bill which implemented only part of the UK agreed proposals would also fundamentally move Scotland away from a UK position. The Executive’s policy position is that, as the contract has been accepted in a ballot of GPs across the UK, it should be available in full to GPs and medical practices across Scotland.

CONSULTATION

37. This Bill is different from many that come before the Parliament in that it is a legislative vehicle for a contract for the provision of services. The contract in question is the result of two years’ intense negotiations between the GPC, representing the interests of the profession, and the NHS Confederation acting on behalf of the four UK Health Departments.
38. The contract has twice been subject to a formal consultation with the profession. On 17 April 2002, the NHS Confederation and the UK General Practitioners Committee (GPC) agreed the framework for the new UK wide contract. The four UK Health Ministers agreed its principles. In a GPC ballot of GPs, 75.8% of those who responded agreed that the framework was an acceptable basis to continue negotiations on the detail and on pricing.

39. Negotiations were finally concluded with the publication of the new contract on 26 February 2003. The contract was put to a ballot of the 43,000 general practitioners across the United Kingdom and was accepted by the majority of those who voted.

40. The Executive has not carried out further consultation on the contents of this Bill. This reflects the unique position of the Bill. It implements a UK contract for the provision of services negotiated and accepted by both sides to the contract. It would be inappropriate to subject this to further consultation as any proposed changes stemming from the consultation exercise could not be incorporated into the Bill without breaching the negotiated agreement.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

41. The Bill’s provisions are not discriminatory on the basis of gender, race, disability, marital status, religion or sexual orientation.

Human rights

42. The Executive has studied the Bill and is satisfied that its provisions are compatible with the European Convention on Human Rights. This is due to the fact that the Bill is concerned with the arrangements for the delivery of primary medical services and replaces the existing arrangements for provision of general medical services and personal medical services made respectively under sections 19 and 17C of the 1978 Act. The Bill contains subordinate legislation making powers the Scottish Ministers intend to use to provide for transitional arrangements.

Island communities

43. The policy intention is that the Bill will apply to all parts of Scotland. However, during the negotiations on the contract, it was acknowledged that there are specific issues relating to remote and rural areas, including island communities.

44. It is the firm intention of the Executive that the new contract implemented by the Bill will improve life for GP practices in island communities and, as a consequence of this, the health care provided to those communities. As part of the UK negotiations, a sub-group, based in Scotland, was set up to look at rural issues. Many of its conclusions do not require statutory changes and will be taken forward as part of the implementation of the detail of the contract. However, creation in the Bill of new powers of Health Boards to provide services through, for example, employing salaried doctors, will help to support those areas where it may not be economically attractive for an independent contractor to operate a practice.
Local government

45. The Executive is satisfied that the Bill will not have an impact on local government. The lead on implementing the legislation will fall to Health Boards with central support and guidance provided by the Executive.

Sustainable development

46. The Executive has made clear that efforts to promote health, alongside programmes on social justice, education, crime and transport, are central to sustainable development. An important aspect of sustainable development is to ensure that people across Scotland have access to the same level of services. Access to NHS services is one of the keystones of the Partnership for Care White Paper.

47. The Bill and the contract which it implements is one of the means by which the Executive will ensure access to primary care. Around 90% of patients’ experiences of the NHS as a whole happen in the primary care setting. It is essential that general practice is an attractive career option for those considering a future in medicine. At the start of the current set of negotiations, GPs indicated that they were dissatisfied with many elements of the work including the control of workload, financial support and work/life balance. Rectifying this and improving the morale of the profession has obvious implications for the future of the GP workforce. The Bill is the means by which the Executive will implement the substantial package of investment and improvement in primary care that is embodied within the new contract. This will assist and underpin the sustainable development of primary care.
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