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THE GP CONTRACT MADE EASY – GETTING PAID

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About the author

Rodger Charlton BA MB ChB MPhil MD FRCGP FRNZCGP DFFP FSOMW qualified from Birmingham in 1983. During vocational training in Nottingham he completed an MPhil thesis in medical ethics. Shortly afterwards he became a GP principal in Derby in a five-doctor partnership and part-time lecturer in general practice at Nottingham University. In 1991–92, he was a visiting fellow at the Department of General Practice, University of Otago Medical School, New Zealand, researching into the perceived needs of undergraduates in palliative medicine education. This formed the basis of his MD thesis. He also worked as a GP in New Zealand gaining his MRNZCGP in 1992.

In 1994 he was appointed as a senior lecturer in primary healthcare at the Postgraduate School of Medicine, Keele University, and in 1995 he took over a single-handed general practice in Hampton-in-Arden, close to the Warwickshire border. In 1997 he became a GP trainer and in 1998 he became editor of the Royal College of General Practitioners (RCGP) *Members' Reference Book* (MRB) for two years. He is now the editor of RCGP publications excluding the journal and MRB which is now produced quarterly as the TNG (*The New Generalist*).

His research interests and published papers are in palliative care, bereavement and meningococcal disease, but there is a strong focus on research in education and professional development in primary care. In September 2000 he was appointed as senior lecturer in continuing professional development at Warwick University and in January 2003 he became the Director of GP Undergraduate Medical Education at Warwick Medical School. He received the John Fry Award of the RCGP in April 2001 for being a GP who has 'promoted the discipline of general practice through research and publishing as a practising GP'.

In November 2003 he was awarded a fellowship of the Society of Medical Writers (SOMW) of which he became the chairman in April 2004. He maintains an interest in postgraduate education by being a GP and primary care trust (PCT) tutor and helping GPs move through the recent changes in relation to the Postgraduate Education Allowance (PGEA), personal development plans (PDPs) and appraisal. He has now become a GP Appraiser.

Rodger has been a GP principal for 16 years and during this time has acquired knowledge in the day-to-day running of a GP practice. During his five years as a solo practitioner until he went into partnership in September 2000, he had to get to grips with practice management and how a GP and GP practice gets paid and the many associated issues. This has remained an interest since then particularly with the advent of the new GP contract (nGMS contract, also called GMS II). As well as being an academic GP he remains a practical 'hands on' GP both in patient care and the running of a practice with his GP partner, Ryan Prince.

To all general practitioners that this text may be a help to them as they cope with further change.

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Introduction

In June 2003, GPs (family doctors) in the UK overwhelmingly (80%) supported a new contract which has been hailed by some as the biggest change in their employment terms since the NHS was founded in 1948. As well as being paid for 'essential' services which are the 'core' activity of a GP's daily work, GPs would be paid for quality of care in relation to chronic disease and the organisation of care. In addition, it has been recognised that this new contract could enable GPs to provide and be paid for 'enhanced services' traditionally confined to hospitals and so formalise the concept of GPs with Special Interests (GPswSIs).

Although there may be some differences in process in each of the four countries of the UK, the principles of the new contract apply to all. GP practices have been busy preparing for 1 April 2004. Across the four countries of the UK, nearly 100% of practices signed up to the contract, with only eight default contracts in England and none in the other three countries.

One of the problems with the 'new contract' is that there are still a lot of unknowns and ongoing changes, particularly in interpretation and putting the theoretical proposals into practice. I recently received an email from a colleague in France who told me how she kept hearing about the NHS's 'new GP contract', but could not find a simple description of what it was. I was asked if I could tell her in a few words what it was all about, what were the main changes and how it differed from the 1990 contract. As I grappled with this question I was stimulated to answer the question and so write this book and in particular to detail its implications financially to GPs.

Why did the new contract come about?

There are many possible reasons, but one that politicians often quote is that an increase in pay and the ability to opt out of out-of-hours care would stop GPs leaving the profession. In addition, it would help to recruit newly qualified GPs to take up the increasing number of vacancies and encourage junior doctors to consider general practice as a career. The previous health secretary, Alan Milburn, delegated the responsibility for negotiating the new contract to the NHS Confederation, the representative body for health service managers, because government talks through the Department of Health with the British Medical Association (BMA) reached a deadlock over nearly a three-year period. The General Practitioners Committee (GPC) of the BMA, the professional body for all UK doctors, has represented and continues to represent GPs in the negotiations.

Which GPs will the contract affect?

The new contract (GMS2) covers the 36 000 GPs who work under the General Medical Services (GMS1) contract and the approximately 25% of GPs who work under the Personal Medical Services (PMS) scheme. However, the implications are

different for PMS practices as they have contracts negotiated locally with commissioning health bodies such as primary care trusts (PCTs). Nevertheless there is likely to be considerable convergence with GMS2 practices, particularly in terms of quality targets.

It has been said that the new contract will succeed or fail depending on the future partnerships of GPs, GP practices and primary care organisations (PCOs) – PCTs in England and Health Boards in Scotland.

Patients

The government and negotiators hope that patient care will improve as a result. This is unknown because a pivotal change will be that patients will no longer be registered with an individual GP, but a GP practice. Patients are likely to see a greater range of primary care practitioners and not just a general practitioner. This could be a healthcare assistant, a practice nurse, a nurse practitioner, one of many other healthcare practitioners or a general practitioner. Some have argued that this could be the end of the traditional doctor–patient relationship, continuity of care and the personal doctor. Furthermore, as many GPs opt out of out-of-hours care as a result of the new contract, this will further fragment continuity of care.

What will happen to the term, 'GP principal'?

If GPs are no longer responsible for individually registered patients, but the practice is, what will happen to the concept of a GP principal? Will GPs become consultants in primary care? GP practices may choose to just provide essential care for patients who are acutely or chronically sick, or offer a wider range of services, such as contraception, vaccination, minor surgery, and the management of more complex medical conditions such as multiple sclerosis or epilepsy. It is anticipated that quality of care through a national framework of standards (quality indicators) will be an important focus for GP practices. GPs (principals and non-principals) have been transferred from the supplementary lists of PCOs to lists of 'Medical Performers'. (Any doctor who wishes to perform General Medical Services or Personal Medical Services will have to be included in a PCO Medical Performers list from 1 April 2004.) The terms 'principal' and 'non-principal' are being used less frequently and all are GPs whether that is as partners, salaried doctors or working on a sessional/locum basis. However, in view of readers' familiarity with and the transition in the use of this terminology, the term 'GP principal' is still used during this book.

The role of PCOs

The new contract provides increased scope for collaborative working between practices working in the desired 'clusters' of the new contract, across primary care, as well as with secondary care and social services. But what if GPs decide to opt out of providing 24-hour care, immunisations, contraceptive care or chronic disease management? PCOs will take on the responsibility and commissioning costs for providing alternative providers and instead of much of a patient's care being available in a single practice, they may have to travel to different practices for different services.

The future of primary care

Ultimately this has the potential to fragment primary care and its co-ordination under the original gatekeeper – the GP. In an attempt to increase patient choice, patients may be able to register with more than one practice. This may be required, for example, as the place they live may be very far away from where they work. Quality of care may be compromised as the necessary patient records may not be available in the absence of a universally shared patient-held NHS electronic record. However, concurrent information technology (IT) changes predicted in the NHS may overcome this difficulty.

Payments

This book does not attempt to address the pros and cons of the new contract, but rather how to continue quality of patient care and survive financially under the many logistical unknowns of the new contract. Politicians are of the opinion that payment for quality services by demonstrating evidence of achieving defined indicators and providing enhanced services should encourage the provision of a wider range of services within primary care. It is thought that most GPs' NHS income will rise over the next three years, but the amount will be substantially less than the 50% pay rise mooted when the concept of the new contract was launched in February 2003.

Those practices who provide a wider range of services and meet defined high standards should see a considerable rise in profits. This book aims to instruct GPs and practice managers how to achieve this rise.

Practical points
Throughout the book will be sections provided entitled, 'Practical points', which will emphasise these issues and so alert GPs and practice managers to areas that relate to practice income and thus where practice performance can be improved.

Sources for the book

This book is based on information gained from the following sources:

- *New GMS Contract 2003: Investing in General Practice.* BMA Publication.
- *New GMS Contract 2003: Investing in General Practice. Supporting Documentation.* BMA Publication.
- Lilley R (2003) *The New GP Contract: how to make the most of it.* Radcliffe Medical Press, Oxford.
- Spooner A (2004) *Quality in the New GP Contract.* Radcliffe Medical Press, Oxford.
- Various websites including the BMA website: www.bma.org.uk.
- *British Medical Journal.*

- Commentaries from the medical press including *Pulse, Doctor, General Practitioner, Registrar Update*, Department of Health's (DoH) *GP Bulletin, MedEconomics, Guidelines in Practice* and associated supplements.
- Mailings from the author's local PCT, Solihull, West Midlands.
- The 'LMC Live' website: www.lmclive.co.uk.

Interpretation

The writing of this book and in particular the content has provided a considerable challenge to the author. This is for several reasons and one that has posed the most difficulty has been the initial commentary on the new contract and then further development on different aspects of the new contract. A great amount of material has been read in an attempt to understand the many available sources. Interpretations have been made to make the subject digestible and readable. Although reference has been made to specific documents, the most helpful information to interpret these lengthy documents has come from professional magazines including *Doctor, GP* and *Pulse* and also Internet searches under subject headings. There was very little information provided in peer-reviewed medical journals that the author was able to use to guide the content of this book.

In relation to payments, local variations and different regulations for each of the four countries of the UK, these interpretations *may not be absolute*. It is therefore strongly recommended that if the reader is in doubt they should seek further advice as detailed below.

Future changes

For all of us the new contract is a new area and a huge change from the 1990 GP contract. Furthermore, each individual GP practice has received an individual version of the new contract and so there are differences in localities as well as the four countries of the UK.

After publication

When this book goes into print, further developments, revisions and interpretations of aspects of the new contract will be made and the reader should bear this in mind. Similarly, this book does not purport to be an absolute authority or tablet of stone in relation to the new contract; some interpretations by the author may be open to criticism and similarly there may be some errors.

Further information

It is suggested that when a reader has a query or concern about any issue raised in this book and how it applies to their practice, they should seek clarification from their local PCO in the first instance. If they are unhappy with the advice provided by the PCO, then they should refer to the BMA's publications detailed previously or their website for the very latest information regarding the new contract and associated negotiations which can change quickly as the new contract is implemented. Alternatively, one can seek advice from the BMA, if they are a BMA member. This

may be by telephone or by email and failing this a Local Medical Committee (LMC) representative may also be able to give practical and helpful advice.

Having made this statement, it is hoped that this book will be both a useful guide to a complex and very different contract to the previous 1990 GP contract and so be a useful source of reference as one seeks a way through the nGMS contract maze.

Role of the GPC of the BMA

In the BMA *Contract News* (April 2004), Dr John Chisholm, Chairman of the GPC, writes, '*The contract is not perfect and we are by no means complacent*'. He goes on to say, '*The contract is an evolving contract and its development is an ongoing process.*' He emphasises how the GPC will continue to work on the problems and concerns that arise as a result of the implementation of the new contract and as progress and developments occur that these will be posted on their website: www.bma.org.uk/gp contract.

Book as a resource

It is hoped that the book is a valuable resource in a contract that has been thrust on busy GPs who have yet another change to cope with as they try and meet the needs of their patients and practices in many different community settings.

Rodger Charlton
November 2004

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CHAPTER 1

Getting paid under the 1990 contract

Before a doctor enters general practice, they will be accustomed to receiving a salary and a payslip detailing deductions for tax and national insurance. This is referred to as the PAYE (Pay-As-You-Earn) method of income tax collection. However, most GPs are self-employed, although salaried GP posts are becoming more common. So, if you start as a GP principal it takes quite an adjustment to receiving a cheque of differing amounts each month according to the profits of the practice which is a small 'business'. The cheque is a gross payment and it is advisable to save 40% in a high interest savings account for a tax bill which is in arrears and also for national insurance payments. The local PCO or Health Board deducts a proportion of your payments as superannuation and so a monthly contribution towards your eventual pension.

What it means to be self-employed

GPs have always been self-employed practitioners, who mix their subcontracted work from the NHS with a small amount of private practice. When the NHS was set up in 1948 GPs kept their independence but agreed to register all patients and provide 24-hour care for them in return for contracted payments. In keeping with the ethos of the NHS, this established universal access to GPs for the first time in the UK. This chapter describes how GPs were paid on the basis, e.g., of the number of patients registered in their name and other payments for defined services until the advent of the 'new contract' of 1 April 2004. It is important to be conversant with the latest version of this, the '1990 contract', in order to understand the financial workings, the origins of payments and implications for the new contract. Many of the principles of being self-employed also apply to this new contract. This chapter is therefore devoted to the derivation of payments under the previous 1990 GP contract.

Gross payments

When a GP receives their first payment it seems a large amount when there have been no deductions and it is tempting to feel rich and spend a lot. However, it is important to start saving for the tax bill, which may be 12 months in coming, as late payment or taking out a loan results in high interest payments. In order to try and reduce the tax bill, GPs are diligent about keeping receipts as some of their business expenses can be put against the tax bill, e.g., car, telephone and equipment bills. The end of each tax year is usually the beginning of April. This is when

a GP starts to complete their tax return form and calculate their tax bill (tax liability). It is also important to employ the services of an accountant (whose fees are tax deductible) to make these calculations. One's first impression might be that this is a lot of hassle, but financially there are benefits to being an independent contractor or self-employed. It also means that you are an employer as opposed to being employed and wholly and exclusive business expenses can legitimately reduce the tax bill.

How did GPs get paid under the 1990 contract?

In essence there were and still are two sources; General Medical Services (GMS) and Personal Medical Services (PMS) in addition to private fees. GMS and PMS payments are for providing NHS services to patients registered with individual GPs of the practice partnership. Private fees can be for seeing patients who wish to be seen privately, although this is relatively rare these days. Private fees are more commonly received for completing reports for insurance companies or solicitors and are not part of a GP's NHS service. In addition, GPs may charge for private sick notes, completing a holiday cancellation form, conducting a pre-employment medical or completing a cremation certificate. Also, some GPs act as occupational health physicians for local firms or as school medical officers to private schools. All these activities are sources of private income and could contribute up to 10% or more of a GP's income before they could affect cost or notional rent reimbursement on GP premises.

General Medical Services (GMS)

These were divided into three main areas:

- basic practice allowance and patient registration fees
- target payments
- item of service payments.

Full-time GPs received a basic practice allowance (BPA) for 1200 or more patients registered with them. If they had less than 1200 patients then the BPA was proportionately less. However, in addition to the BPA, the more patients that were registered with a GP, the greater the income through capitation fees. This was a set annual payment for providing care for patients 24 hours a day, 365 days a year. This payment was greater for patients over the ages of 65 and 75. However, with more patients came a greater workload and there was a ceiling number of registered patients after which there were no additional payments.

Target payments were for providing cervical cytology services to women between the ages of 25 and 64. Similarly, there were target payments for providing defined childhood vaccinations to infants and boosters to preschool children. For both groups there were lower and higher targets to achieve a lower and higher payment. In the case of cervical cytology 80% of women within the above age group had to have had a cervical smear in the preceding five years to achieve a higher payment and the only people exempt were those who had had a hysterectomy (lower target = 50%). In the case of vaccinations the target was 90% to achieve a higher payment (lower target = 70%). In both groups patients who

chose not to have a smear or have their child vaccinated would still count towards the target payment. Ways of exempting patients in the new contract will be discussed in a later chapter.

Item of service fees could be claimed for providing the following services:

- contraception advice
- inserting an intra-uterine device (IUD)
- administering certain vaccines, e.g., tetanus
- new patient registration health checks
- minor surgery and child health surveillance
- seeing temporary residents
- performing a night visit (for calls received and completed between the hours of 10pm and 8am)
- maternity care
- arresting a dental haemorrhage
- other areas to be listed in the next chapter where they form part of the Global Sum of the new contract.

Doctors who dispense vaccines and injectables or medication in rural areas could and still can attract certain fees through the Prescription Pricing Authority (PPA).

It can be seen from this information that a lot of data needed to be stored either manually or (more usually) on computer so that the necessary individual claims could be made. The new GP contract should reduce this clerical activity through the payment of a 'Global Sum', which is discussed in the next chapter. This reduction in clerical activity has already been achieved for PMS practices where income is based on the last GMS claims and associated uplifts with inflation and pay reviews and changes with a practice list size. Most claims were made in arrears and they could be claimed manually or through computer links with the local PCO or Health Board. A practice manager would play a vital role in the smooth running of this business side of a GP practice.

Other GMS income

For attending 30 hours per year of approved postgraduate educational activity in the three designated areas of health promotion, disease management and service management a fee of almost £3 000 could be claimed each year. This was paid quarterly upon production of certification of attendance and was called the Postgraduate Education Allowance (PGEA).

There were practice activities for which GPs received partial or full reimbursement. For example, for employed staff whose employment is approved and fell within the agreed staff budget, a reimbursement of 70% was usual. Reimbursement was available for the salary of a GP registrar as well as the payment of a small training grant and this will continue under the new contract. Payments for GPs under the 'GP retainer' scheme payments should also continue.

Partial reimbursement may also have been available for computer expenses, such as hardware and software and especially upgrades which will be a particular feature of the new contract. The changes regarding funding of IT will be discussed in a later chapter, but do not form part of what is called the 'Global Sum'.

Payments were also available for health promotion, chronic disease management – e.g., in diabetes and asthma – and locally defined quality initiatives.

One further incentive for new GPs joining a practice was the 'golden hello' scheme of a one-off payment of usually £5000. GPs will need to enquire of local PCOs whether this scheme will continue under the new contract.

Personal Medical Services (PMS)

PMS is very similar to GMS and many practices have converted to PMS subject to agreement with the local PCT. In PMS a budget is estimated on the basis of the previous year's GMS claim and altered according to patient list size. This avoided all the clerical work associated with making individual claims for the above. In addition, it was possible to negotiate 'PMS with growth' and so the creation of salaried nurse and GP posts to undertake new and locally agreed work for the practice in conjunction with the local PCO. The changes to PMS as a result of the new contract are discussed in depth in Chapter 8.

Payments relating to premises

There should initially be no change in the way that premises-related claims and reimbursements are dealt with under the new contract for:

- cost rent and notional rent payments
- hazardous waste
- rates.

General practice as a 'business'

Being a GP involves knowledge of medicine and developing skills in running a business. Usually, each partner in a practice looks after one area of practice income in liaison with the practice manager. It need not be a burden or daunting if it is well organised and efficient and a practice manager can undertake much of the work. Great satisfaction can be gained from achieving quality patient care and in the same way maximising income to which a GP is entitled. It allows for a degree of independence which employed hospital doctors do not have unless they are involved in private practice.

Why tell you all this?

First, it is to understand how the financial origins of the new contract have come about as it is from these figures that the Global Sum of the new contract (discussed in the next chapter) originates. Second, it is to appreciate that there are elements of the 1990 GMS contract that should in the author's interpretation continue as they are paid mainly three months in arrears for work undertaken prior to 1 April 2004. This is detailed in the Appendix. Individual practices will need to discuss and negotiate such potential claims with their local PCO. If a practice is in doubt they should seek advice from their LMC or the GPC of the BMA.

Practical point
Income from the '1990 contract' should not stop on 1 April 2004. Some of it should continue as many of the payments are in arrears and practice managers should ensure that these continue to be paid or have been settled by 1 April 2004. Under the 1990 GMS contract the old regulations allowed for claims to be submitted for up to six years. However, the limit for submitting these claims may be reduced to six months at a PCO's discretion.