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DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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From the Secretary of State for ~~Social Services~~ XXXXXXXXXXXX Health

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Michael Morris Esq MP

13 JUNE 1989

Dear Michael.

Thank you for your letter of 21 March about our proposals for a New Contract for general practitioners.

I agree with you that general practice in this country provides a good service and that most GPs are highly conscientious people. The intention of our reforms is to make the service even better and ensure that doctors who perform well are paid appropriately. The New Contract proposals will encourage all GPs to offer the services their patients need and want. Patients will have greater choice and doctors will have a remuneration system which is fairer and more closely related to their performance. There has been no major reform of the family doctor service for over 20 years, and it is clearly time for some important changes to be made.

As you will know, after over 12 months of discussions, we have now reached agreement with the General Medical Services Committee's (GMSC) Negotiators on all the main outstanding issues in the New Contract, and the Negotiators will be commending the New Contract proposals to the profession for acceptance. I attach for information the full text of the agreement. I will, of course, bear in mind the points you make as we are amending Regulations and the Statement of Fees and Allowances are drafted.

In the meantime I would like to comment on some of the issues you raise.

With targets of 50 per cent and 80 per cent for cervical cytology and of 70 per cent and 90 per cent for childhood immunisation being set, I do not believe that GPs will be unable to reach these, especially the lower ones. Specifically, the work done by DHA clinics will be taken into account when calculating the level of coverage on the GP's list.

E.R.

Basic Practice Allowance - this is said to recognise a GP's basic commitment to the NHS and to cover certain standing expenses. As you will see from the agreement one of the main criteria for the assessment of entitlement will be retained, namely that entitlement to Basic Practice Allowance will continue to be based on average, rather than personal list size.

Home Visits - The requirement on doctors to be available in their surgeries for consultations and clinics is to be 26 hours a week over five days (although, in certain circumstances, and with the agreement of the FPC, this can be reduced to four days). This will include home visits. The point of this requirement is to make sure that patients can expect to see the doctor with whom they are registered throughout the week. The original figure of 20 hours was set with regard to the average time currently spent in surgery by GPs. The average time spent on all general medical services work is closer to 40 hours a week.

I cannot agree that doctors' current income should be guaranteed. The actual work undertaken by different GPs varies enormously, though under the current system this difference is not always reflected in their income. It is only reasonable that the remuneration should be redistributed and that those GPs who lag behind in providing services should be encouraged to improve.

Our aim is to build upon the excellent service provided by many doctors, so that the standards of the best practices are achieved throughout the service. I am confident that when the final details of the new measures are confirmed GPs will respond constructively to the new and challenging opportunities they present.

I am copying this letter to the Prime Minister.

I hope this is helpful.

KENNETH CLARKE

Kenneth Clarke, Secretary of State for Health, and David Mellor, Minister for Health met Dr Wilson, Chairman of the GMSC and his Negotiating colleagues on 4 May. The purpose of the meeting was to discuss the new contract for family doctors.

Agreement was reached on all the major outstanding issues. These were:

1. Prevention Targets. Payments will be made for two levels of achievement:

- for childhood immunisation a higher level of payment will be made to GPs who achieve 90% coverage. A lower payment will be made for reaching 70% cover. The differential will be 3:1;

- for screening for cervical cancer the upper level will be 80% and the lower level will be 50%; the same differential applying.

2. Night visits. It was agreed that a two level fee will be introduced for night visits on the ratio of 3:1. The higher level will be paid where the visit is made by a doctor from the patient's own practice or from a small rota of local GPs (up to a maximum of ten practitioners).

3. Minor surgery. So that patients will benefit fully from the new arrangements for more minor surgery in the GP's premises, individual operations up to a total of five will be allowed to count towards entitlement to a monthly sessional payment.

4. Availability to patients. To optimise the time that GPs are available to patients, the GPs' terms of service will be amended to require GPs to be available for 26 hours on average over 5 days each week. This will include availability in surgery, health promotion clinics and for home visits. In recognition of the work that some GPs do elsewhere on health related activities in the public service, this commitment can be reduced to four days subject to agreement with the Family Practitioner Committee.

5. Rural Practice. It was agreed that the present system of rural practice payments needed to be updated. Work on revising the scheme will be taken out of the present negotiation and considered by the Central Advisory Committee on Rural Practice Payments.

6. Seniority Payments. This allowance will be retained but will be reduced by the value of the new postgraduate education allowance. This change will reflect the fact that under the new arrangements all GPs who are entitled to seniority payments will be entitled to this new allowance (provided they meet the necessary training requirements).

7. Basic Practice Allowance. This allowance will be reduced as a proportion of GPs' income. The payment will be made on a proportionate basis for all patients up to 1200. GPs with fewer than 400 patients will not be entitled to BPA. This is a change from the original proposal that the limits should be 500-1500 and will be consistent with proposals in Scotland.

Another change to the original proposals for BPA will be that one of the main criteria for assessing entitlement will be retained, namely that entitlement to BPA will be based on average list size within the partnership.

8. Funds for practice teams and premises. The Secretary of State confirmed that commitments entered into under the existing arrangements for the direct reimbursement of staff, premises, and premises improvements will be honoured.

9. Areas of Deprivation. The Health Departments will consult the GPs' representatives about the detailed arrangements for distributing the new capitation payments to GPs serving deprived areas.

10. The Secretary of State and the Negotiators also agreed to submit joint evidence to the Doctors and Dentists Review Body about pricing the new contract in such a way as to meet the Government's policy objective for the General Medical Services in that the joint

evidence would refer to the professions acceptance of the Government's intention that the proportion of the remuneration GPs arising from capitation* based payments will reach 60% from 1 April 1990.

11. Finally, the Negotiators undertook to commend this agreement to the profession for implementation with effect from 1 April 1990; and that (i) evidence be prepared for the DDRB to price the new proposals and (ii) draft amendments to the Statement of Fees and Allowances and Regulations be prepared for consultation with representatives of the profession.

KENNETH CLARKE
Secretary of State for Health

DR MICHAEL WILSON
Chairman, General Medical Services Committee

* Under the new contract capitation will include: standard capitation fees (as currently understood) together with the new capitation fees for registrations, child health surveillance and the deprivation supplement but exclude Basic Practice Allowance and contraceptive payments.