



National Audit Office

NHS Pay Modernisation: New Contracts for General Practice Services in England

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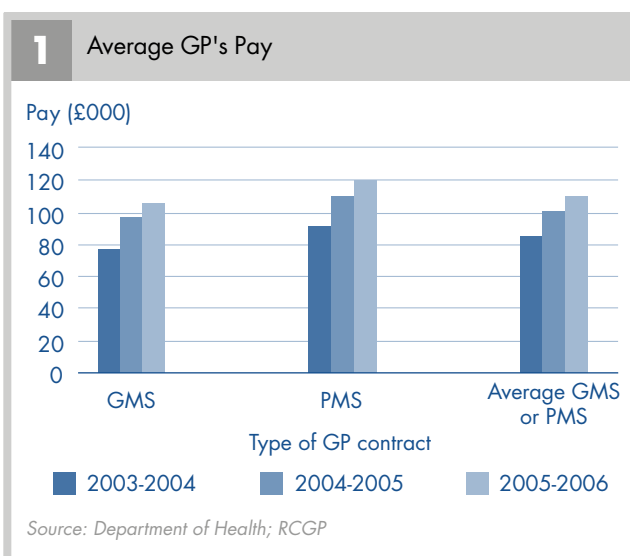
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KEY FACTS

Key facts about General Practice in England

- Each year general medical practices provide some 290 million consultations, an average of five consultations per person registered.
- The new contract changed the basis for commissioning primary care services. Instead of contracting with individual General Practitioners (GPs), Primary Care Trusts (PCTs) commission services from some 8,325 GP practices.
- The new contract was implemented fully in April 2004 but increased spending on GP services commenced in April 2003.
- Around 33,000 GPs, by headcount, equivalent to around 31,000 whole time equivalents (based on a 40 hour week) work in GP practices, each looking after around 1,600 patients on average.
- GPs can work as single handed practitioners, as one of a number of partners within a practice, or as a salaried employee of a contractor. The majority of GPs (approximately 85 per cent) are independent contractors who operate under a practice-based contract arrangement.
- Approximately 40 per cent of GPs are female, and 27 per cent of all GPs work part-time.
- Since April 2003, most GP services have been commissioned using nationally agreed General Medical Service (GMS) contracts (c. 62 per cent) or locally negotiated Personal Medical Service (PMS) contracts (c. 37 per cent).
- Since April 2004, PCTs have two other ways of commissioning GP services. From other healthcare providers: Alternative Provider Medical Services (APMS) or by delivering GP services themselves: Primary Care Trust Medical Services (PCTMS). Both are aimed at improving access to GP services.
- There are 23,797 nurses employed by GP practices (equivalent to 14,616 full time nurses) and the percentage of consultations they carry out is 34 per cent.
- In 2006-07, GP services cost £7.7 billion or almost 10 per cent of all NHS expenditure.
- Between 2002-03 and 2005-06 the average pay of a GMS and PMS practice partner in England increased from £72,011 in 2002-03 to £113,614 in 2005-06^a (**Figure 1**).
- In 2005-06, average net income of salaried GPs is £46,905^b, a three per cent rise since 2003-04. As the average number of hours worked by a salaried GP is 23.8 hours per week this suggests an average salary of £74,000 per annum.
- As part of the new contracting arrangements the Department removed GPs' responsibility for out-of-hours care (the period from 6.30pm to 8.00am). By January 2005, fewer than 10 per cent of GP practices delivered out-of-hours care under the nGMS contract.



^a Pay data for 2005-06 is used as it is based on tax returns which are reported a year in arrears.
^b Average Salary is based on part-time and full-time salaries and therefore does not represent an average full-time salary in the United Kingdom. Salaried GPs are more likely to work part-time hours than GP Partners and worked an overall average of 23.8 hours per week.

SUMMARY

- 1 Primary Care Trusts (PCTs) have a statutory responsibility to ensure that their local population has access to primary healthcare services, free at the point of need. Traditionally, primary care services are provided by general practitioners (GPs), working as either a single handed practitioner or as part of a larger practice, who offer the first point of contact or “gateway” to the NHS; treating and advising on a range of illnesses or referring patients on to specialist care where necessary. In 2006-07, there were around 290 million primary care patient consultations at a cost to the NHS of £7.7 billion.
- 2 *The NHS Plan (2000)* emphasised that the development of primary care services was key to the modernisation of the NHS. The Plan set out the Department’s aim to make primary care more easily accessible, offer patients more choice, and move more services from secondary into primary provision. It acknowledged that these objectives could not easily be achieved under existing contractual options and that the NHS needed “more, better paid staff, working differently”.¹
- 3 The Plan highlighted the need to modernise the contractual relationship between the NHS and GPs and increase the number of GPs working in the NHS (2,000 more GPs and 450 more GPs in training by 2004). The Plan was published against a background of GP unrest with a number of surveys finding that: GPs workload was unsustainable; morale was endemically low; and there was a recruitment crisis as new doctors opted to avoid the long hours and inflexibility associated with general practice.
- 4 Before 1998, most GPs worked under a nationally negotiated General Medical Services (GMS) contract. Under this contract, GPs were contracted individually by the Secretary of State to provide GP services based on the number of patients registered and claims for each piece of work carried out. Funding therefore followed the individual GP, not patient needs. In 1998, the Department piloted the Personal Medical Services (PMS) contract which enabled GP practices to negotiate greater flexibility through local contracts with their PCT based on meeting set quality standards and the particular needs of their local population. Implementation of PMS aimed to improve GP services in under-doctored areas including providing funds to increase the numbers and types of healthcare staff working in PMS practices.
- 5 By 2001 there was broad agreement between the Department and the GP’s representative body, the British Medical Association (BMA), that the national GMS contract was not adequate to deliver the type of primary care needed in the twenty-first century. There were funding inequalities between practices in different parts of England and services were not flexible enough to meet local needs. GPs reported feeling unable to control and manage their workload effectively and that the contract led to extended hours of work. The Department and the BMA agreed that the PMS contract provided a model to help shape the design of a new contract but that a new national contract (new GMS contract) was needed which would incentivise GPs to work in a general practice and improve access to primary care. The Department decided to retain the PMS contract.

6 The Department also agreed two other contract options. Alternative Provider Medical Services (APMS) enable providers other than existing GP partnerships to provide primary care services in the most poorly served areas, thereby improving access. In a few instances Primary Care Trusts also provide GP services under a Primary Care Trust Medical Services (PCTMS) contracts with GPs.

7 Our study examined the negotiation and implementation of the new GMS contract and how well it is working in practice, including the extent to which the new contracting regimes have achieved the benefits intended by the Department. Our methodology is detailed in Appendix 2. We use April 2003 as the baseline for the new contract as this is when the increased funding for the contract was introduced although the contract was not fully implemented until April 2004.

Key Findings

The terms of the agreement

8 In 2001, the Department and the other UK Health Departments gave the NHS Confederation, the employers' representative body, a mandate to act on their behalf in negotiating a new contract with the BMA. The Department set minimum levels for its increased spending in primary medical services and representatives attended the joint negotiation meetings. Negotiations were lengthy and an original agreement reached in late 2002 was rejected by doctors who believed that under the new proposed Global Sum allocation formula a substantial proportion would lose out financially. In addition GPs believed that the new formula which was based on population statistics as well as list size of the practice would create instability in funding for GPs increased spending in primary medical services.

9 In June 2003, the negotiating parties agreed the terms of a new contract, following the Department's concession to provide a Minimum Practice Income Guarantee. The allocation formula was also changed so that it was based on practice list sizes and not census population estimates. The Minimum Practice Income Guarantee was seen as a transitional arrangement based on historic funding for core services. The new GMS practice based contract was implemented from April 2004 (**Figure 2**).

10 Under the new contract GP practices are required to provide essential services but are able to opt-in to providing enhanced services and out-of-hours urgent care services. The Department passed responsibility for commissioning enhanced and out-of-hours services to PCTs. The change in responsibility for out of hours care was a key part of the BMA's negotiating mandate and reflected the belief of 83 per cent of doctors that they should be able to choose not to provide out-of-hours care.² In 2006, we examined the implications of this decision and identified shortcomings in the initial commissioning process. We found that the costs exceeded estimates and out of hours providers, although beginning to deliver satisfactory standards, were not yet meeting the national quality requirements.³ Our focus in this report is on the new contract, commenting on out-of-hours where relevant.

How much has the new contract cost?

11 The Department intended from the outset to increase spending on GP's services and in its business case to the Treasury proposed to increase spending from £4.9 billion^c in 2002-03 to £6.9 billion in 2005-06. The contract, however, has cost more than the Department budgeted for in setting the financial envelope for the contract negotiations. In the first three years of the contract PCTs spent £1.76 billion or 9.4 per cent more than the minimum that the Department committed to spend (Gross Investment Guarantee). When the Department increased the amount of money available for GP's services in 2004-05 and 2005-06, the NHS spent £406 million or 2.8 per cent more than the Department had allocated (**Figure 3**).

12 The main causes of the overspending in the first two years was a significant underestimate of achievement levels on the Quality and Outcomes Framework (QOF)^d and the additional cost of providing out-of-hours care. There was also a considerable overspend on Primary Care Organisation Administered funds which covers items of miscellaneous expenditure on the GP contract such as locum costs and seniority payments.

13 Part of the reason for overspending on the QOF is that the Department reallocated funding initially assigned to fund QOF to the global sum, in order to fund the Minimum Practice Income Guarantee. It therefore revised its predictions of achievement under the QOF. Following implementation however, QOF achievements exceeded these revised estimates.

^c For GIG monitoring purposes an extra £0.2 billion was added to the 2002-03 baseline figure, bringing it to £5.1 billion, to allow compatibility/comparability with the 0.2 billion expected spend on Enhanced Services in each of the GIG years.

^d The quality outcomes framework is the quality incentive scheme where GPs are paid based on achievement or delivery of services against a set criteria. QOF scores are audited by the PCT.

2 Summary of the new negotiated GMS contract

Contract held between PCT	Old General Medical Services contract	New General Medical Services contract
	Individual GP	GP Practice
Funding for core services	Individual GP patient list provides a small fee per patient registered and a fee for each item of service provided. There was also a Basic Practice Allowance.	Each practice receives its main funding for the provision of essential services via a "global sum" based on the weighted needs of the practice's pooled patient list. The global sum payment is based on a national allocation formula, calculated according to lists size and adjusted for the age and needs of the local population. This is supplemented by a Minimum Practice Income Guarantee which was negotiated to ensure that practice funding was not reduced in the first few years of the contract.
Service delivery	GPs can claim for a limited range of additional services.	Flexible structure allows practices and Primary Care Trust to opt in to provide a portfolio of enhanced services, which can be innovative or tailored to meet specific patient need.
Out of hours	GPs responsible for out of hours service but many delegated this to other providers.	The new contract defined "core hours" (8am to 6.30pm) as when practices are responsible for providing a full range of primary medical care services. Responsibility for out-of-hours urgent care was removed. Practices can opt to provide out-of-hours urgent care under a separate contract (defined as Monday to Friday 6.30pm to 8am, weekends and bank holidays).
Quality rewards	Some small sums available for quality rewards for example some payments for cervical cytology. There was also a range of quality schemes in the later years of old GMS, including 'Investing in Primary Care' schemes.	Practices are financially incentivised for delivering measurable levels of quality in patient care, via the evidence-based Quality and Outcomes Framework (QOF). Between 10–15 per cent of the new money tied to the contract is available to reward practices for providing higher quality services.
Staffing	Funding follows GP, so no incentive to develop other staff.	Encourages development of different skill mix within a practice by linking some funding to activity carried out by nurses and other practice staff (through the Quality and Outcome Framework).

Source: Department of Health

3 Spending compared to allocation and the Gross Investment Guarantee¹ in the first two years²

	2003-04 £ million	2004-05 £ million	2005-06 £ million	Additional cost of the new contract £ million
Gross Investment Guarantee	5,611	6,211	6,918	–
Department's Allocation	n/a	6,802	7,483	–
Actual Spend by PCTs	5,811	6,957	7,734	–
Difference between spend and Gross Investment Guarantee	200	746	816	1,762
Difference between spend and allocation	n/a	155	251	406

Source: Department of Health

NOTES

1 The money Government promised to spend on GP services as part of the new contract negotiations.

2 Spend recorded for 2003-04 as the agreed increase in funding was from April 2003. Full implementation of the contract was not until April 2004.

14 Elements of the contract are negotiated annually between BMA and NHS Employers (part of the NHS Confederation) for example the QOF and enhanced services. Aspects of the contract were amended through negotiation in 2006-07. For 2006-07, the Department allocated £7.9 billion to PCTs, which represented a small increase in the level of overall spending compared to 2005-06. However, in our focus groups, GPs told us they perceived this as a “pay freeze”. In the event PCTs spent £110 million less on GP services than the £7.9 billion allocated by the Department. Whilst expenditure on QOF and out of hours was more than allocated, PCTs spent less than their allocation on premises, enhanced services, and PMS contracts.

How much are GPs now earning as a result of the new contract?

15 All GPs, including the 37 per cent of GPs who remained on PMS contracts, have experienced a significant increase in their incomes following the introduction of the new GMS contract. Whilst this was one of the stated intentions in the NHS Plan and in the negotiations, the extent of the increases has been higher than anticipated. This is largely as a result of higher than expected levels of achievement, and therefore payments, on the QOF and the higher costs associated with paying the Minimum Practice Income Guarantee.

16 Ultimately, individual GP practices are responsible for agreeing the levels of income that are paid to their partners and salaried doctors, based on the practice income earned under the contract, after deducting expenses and pay of other practice employees. If a practice is more efficient or reduces its operating costs it will have more money to distribute as GP income and there is no guidance provided on the appropriate level of pay taken by GP partners as pay. There is therefore wide variation in the amount of money taken by GP partners as pay. Since the introduction of the new contract the percentage of practice income taken as pay has increased.

17 In the first three years, pre-tax take home pay for GPs in England (including income from NHS and private sources) increased by 58 per cent (from £72,011 in 2002-03 to £113,614 in 2005-06). The average pay for a GMS partner increased to £110,054 and a PMS partner to £121,375. This excludes the amount of money surrendered in opting out of providing out of hours care.

Practice nurses and salaried GPs, who form part of the practice team, have not benefited to the same extent with pay rises largely in line or indeed below inflation.⁴

18 The average pay of a salaried GP is £46,905 and has only risen by 3 per cent since the new contract was introduced.^e This figure does not, however, represent the average full time salary as many salaried GPs work only part-time hours. The results of a workload survey published in July 2007 by the Information Centre for Health and Social Care indicated that the average salaried GP works 23.8 hours per week. This suggests that a full time salaried GP receives around £74,000 per annum.

Has the new contract benefited the NHS?

19 The Department, in its 2002 business case to the Treasury, detailed some 13 benefits that it expected the new contract to deliver. Following negotiation the Department sent out a letter to PCTs explaining what tests it should apply to test the benefits of the contract (Appendix 4). For the purpose of this report we compare the progress in achieving the expected benefits against the Department’s business case. We found that there has been good progress in some areas and in others it is too early to tell. However, there are also some areas where there has been slower progress in delivering the intended benefits (**Figure 4 on pages 10 and 11**) or the contract is not designed to deliver the benefits.

20 The Department’s business case noted that in return for increased pay, the numbers of doctors choosing to work in general practice should increase (by 1,950 whole time equivalents in the first three years), thereby improving access. Since March 2003 there have been improvements in the recruitment and retention of GPs and their numbers have increased from 26,833 to 30,931 (15.3 per cent increase in whole time equivalents since 2002-03). There are also fewer vacancies for GPs, including in deprived areas where recruitment has previously been a problem and few PCTs report any significant recruitment problems. Whilst recruitment has improved in terms of applicants per available job, the number of practice partnerships on offer has reduced with practices taking on a higher proportion of salaried GPs. In response to our survey, GPs told us that while their morale improved in 2005 it has subsequently decreased, partly as a result of negative publicity about pay increases but also the zero uplift in GP funding for 2006-07.⁵

^e This figure is for the UK as separate England data is not available.

21 The Department's Business case suggested there would be an increase in NHS productivity (1.5 per cent gain year-on-year). The Office of National Statistics (ONS) has subsequently developed new quality-adjusted productivity measures for health. These estimates suggest productivity has fallen in the NHS since 2003 even when quality adjustments are made to the output measure. The ONS has separated this measure to approximate for GP services and estimates that productivity has fallen by an average of 2.5 per cent per year in 2004 and 2005. Whilst this is only an approximation, this result is supported by our finding that the number of consultations carried out in GP practices has increased but at a much lower rate than the increase in costs. The Department has reservations about the methodology the ONS has used to arrive at the figures that purport to measure productivity change within primary care. The Department argues that the methodology used by the ONS misrepresents the position and that the general medical practice productivity has not fallen to the extent that the ONS figures suggest.

22 Whilst the total number of consultations carried out in GP practices has increased, the number of consultations that each GP carries out has reduced. The main reason for this change is that the total number, and overall proportion, of consultations carried out by practice nurses has increased. Nurses generally deal with more routine cases, enabling GPs to concentrate on the more complex cases, and as a result the average length of a GP consultation has increased. Whilst practice nurses are delivering an increased proportion of the practice's work, they believe that this has not been reflected in their pay. GPs are working, on average, almost seven hours less per week and their pay has significantly increased, suggesting individual GP productivity has reduced.

23 In each of the first three years GPs have achieved high scores in the QOF. In 2006-07 practices in England achieved an average of 954.5 points, 95.5 per cent of the 1,000 available. This compares with an average achievement of 96.2 per cent in 2005-06 and 91.3 per cent in 2004-05 against the 1,050 points then available. Early data suggests the introduction of the QOF has shown moderate improvements in outcomes for patient care in some long term conditions such as asthma and diabetes. At the same time some academic commentary highlights a risk that GPs may concentrate on QOF activity at the expense of other patient needs or that the QOF may at the margins have increased rather than addressed inequalities.^f It is therefore too early to conclude whether improvements in quality match or exceed the increased cost of the new contract.

^f British Medical Journal 2007, Iona Heath, Julia Hippisley-Cox, Liam Smeeth.

What benefits are still to be achieved?

24 The new contract has not yet led to a measurable improvement in moving services into deprived or under-doctored areas. One of the key aims of the new contract was to help recruitment of doctors into more deprived areas, but renegotiation of the contract to introduce the Minimum Practice Income Guarantee has meant that the redistribution of funding to the most deprived and under-doctored areas has to date been limited.

25 There are wide variations in the way that the contracts are performance managed by Primary Care Trusts, and the way Strategic Health Authorities monitor PCTs. The definition of the essential services provided by GPs is interpreted differently by PCTs and as a result some PCTs pay additional money for services (as enhanced services) which are provided as part of essential services in other areas. The re-organisation of PCTs in October 2006 has highlighted a number of these anomalies, arising in neighbouring PCTs, which are only now being addressed.

26 Enhanced services offer great potential for reconfiguring services to better meet local need, but at the moment this potential remains only partly fulfilled. Over the two year period 2004-05 to 2005-06 just over half (53 per cent) of PCTs did not spend to the minimum level set by the Department on Enhanced Services. By 2006-07, 69 per cent of PCTs had not spent to the minimum, partly because of cost overspends on items such as the QOF and lack of capacity to commission in PCTs. Some PCTs have, however, been able to manage these costs within budget and 45 per cent of PCTs spent more than they were allocated for enhanced services.

27 Many PCTs lack the advanced commissioning skills needed to identify and analyse local health needs and negotiate appropriate services with local providers. The new contract gives PCTs the option to negotiate with individual GPs or use alternative providers where standard GP practices are unable or unwilling to offer a particular enhanced service. A small number of PCTs are now starting to make more effective use of APMS to address this issue (see Case Study on page 37). This has increased flexibility and helped improve services in some under-served areas, but there are many PCTs that have not made use of these contracts.

4 National Audit Office's assessment of the progress made against the benefits the Department of Health listed in its business case to HM Treasury

	Expected Benefits	Progress to date
Increasing NHS Productivity	Gross productivity gains (above a do-nothing scenario) of 1.5 per cent in the first year, rising to 4.5 per cent within three years and continuing for up to eight years.	Progress has not been demonstrated. Estimates of NHS productivity produced by the Office for National Statistics suggest productivity has fallen since the new contract was introduced in 2003. Estimates for family health services suggest a fall in productivity (adjusted for quality) of 2.8 per cent between 2003 and 2004; and 2.2 per cent between 2004 and 2005. There are no quality adjusted productivity estimates for 2006 but non-adjusted productivity measures show an improvement in productivity between 2005 and 2006. Proxy indicators such as activity show that the number of patients seen at GP practices has increased at a much lower rate than costs (paragraphs 3.2–3.8).
Re-designing the services around patients	Basing allocations on the need of the local population with flexibility to shape services around local needs. Greater freedoms for patients to see their GP of choice and choose their own length of consultation. Patient satisfaction will be measured and rewarded.	Progress has not yet been demonstrated. The Minimum Income Practice Guarantee assured historical funding for GP practices (paragraph 1.14) and did not re-direct funding to deprived areas. Academic commentary and other statistics (such as mortality data) suggest QOF has not yet addressed inequalities. QOF performance is only slightly lower in deprived areas but is more pronounced in indicators such as supporting patients with mental health problems. Progress has been made on aspects of access but there is still scope for improvement. 88 per cent of patients are able to book an appointment with their GP of choice and average length of GP consultations has increased. ¹ However, the '24/48' target has created some perverse incentives with some GP practices not allowing patients to book appointments more than 48 hours in advance. QOF includes points for measuring satisfaction but does not reward GPs for high satisfaction. Current patient satisfaction remains in line with satisfaction rates recorded prior to implementation (paragraphs 3.22–3.27).
Designing the right jobs	Incentivise and provide resources for the modernisation of infrastructure supporting the delivery of primary care, including modern and fit-for-purpose premises. Continued improvements in skill mix in practices, encouraging the roles of nurse practitioners and health care assistants.	Some progress has been made in providing extra resources for premises although the new GMS contract has no specific mechanism in place to incentivise practices to improve GP premises. The Department provided more money to spend on premises, PCTs spent less than the Department allocated (figures 13 and 14). Some progress has been made on changing skill mix but the impact on value for money or patient care is not yet clear. The number of consultations and extent of work carried out by nurses has grown and nurses are carrying out an increasing percentage of routine work previously undertaken by GPs including a large proportion of QOF work. This leaves GPs free to see more complex cases. Practice staff report that morale has been affected by the increase in their workload and that they have not seen the same financial rewards as GP partners (paragraphs 3.11–3.13).
High quality care and linking pay and performance	The quality and outcomes framework will place greater emphasis on rewarding high quality services, rewarding outputs and quality rather than inputs. Local flexibility to further reward high performers. Promote a culture of clinical governance ³ and service improvement by explicitly rewarding GP time commitment on clinical governance, accreditation and CPD.	Some progress has been made in introducing a unique system of linking funding and quality through the QOF but there remains room for improving its design to reflect outcomes. It is too early to say conclusively if the QOF has led to improved outcomes for patients but some evidence exists to suggest that modest improvement has been made in controlling asthma and diabetes. ² The quality and outcome framework primarily measures processes of care but these inputs are linked to clinical evidence that they will result in improved patient outcomes. There is no clear strategy for the development of the QOF and there is room for more local flexibility (paragraphs 3.14–3.17). Some progress has been made in incentivising GPs to improve clinical governance through the QOF. GPs spend more time on clinical governance and CPD which is incentivised in the QOF. However, the NAO Report "Progress in implementing clinical governance in primary care" noted that whilst GPs have systems and processes for clinical governance in place these are not as extensive as at PCT level. ⁴ In addition the absence of contracts for some practice staff undermines one of the principles of clinical governance.

4 National Audit Office's assessment of the progress made against the benefits the Department of Health listed in its business case to HM Treasury *continued*

	Expected Benefits <i>continued</i>	Progress to date <i>continued</i>
Reduced administration	Less complex system for fees and allowances.	Some progress has been made by introducing a less complex system of fees. However the majority of GPs and PCTs still believe the new contract has not reduced administration (76 per cent of GPs and 58 per cent of PCTs), largely because of the need to manage the QOF and a portfolio of Enhanced Services.
Extending the range of patient services	Reducing the pressure on secondary care services and allow for greater continuity of patient care through further development of GP specialist services.	Some progress has been made in delivering new services. The new contract gives PCTs the necessary levers to commission locally enhanced services that would have been previously delivered in secondary care, although not all PCTs have yet realised the full benefits of enhanced services (paragraph 4.23). The introduction of the new contracts has coincided with an increase in emergency hospital admissions which is not necessarily attributable to the new contract (a rise of 36.2 per cent of total admissions since 2002-03). See Figure 25.
Overall measure of participation	Addressing funding inequalities will mean practices are more likely to offer a fuller range of services and reduce the need for patients to travel to hospital for diagnostic tests and treatment.	Some progress has been made and the new contract offers the chance for GPs to offer wider range of services away from hospital for example Dermatology. However, few PCTs have maximised the opportunity to commission more locally enhanced services based on patient need (paragraphs 4.23–4.30).
Recruitment and retention	Increase the number of full-time equivalent GPs by 300 in the first year of the contract and by 550 within three years.	Good progress has been made. The number of GPs has increased by 2,623 (full time equivalents) in the first three years of the contract. There are a number of other Departmental initiatives which may have contributed to the increase in GPs and therefore it is not clear how much the new contract has contributed to this improvement (paragraphs 3.9–3.10).
Better staff satisfaction and morale	Introduce a much more progressive career structure for GPs, involving a three-tier system, reflecting intensity of work, maturity and experience. Introduce a return to work package and review pension arrangements to provide better reward for NHS commitments in the later years of working life.	Good progress has been made on increasing the number of GPs. It is, however, too early to say if the new contract has helped retention. Under the new contract investment in the seniority payments scheme increased by 30 per cent and pensions have been reviewed to ensure that contributions are reflected and uprated in future years (the dynamising factor). However, some GPs report that it is becoming more difficult for young GPs to become partners.
	Increase employment options for GPs, for example job-share, or time working from home.	Some progress has been made but increases in satisfaction of GPs have not been sustainable. GP satisfaction increased up to 2005 and the removal of out-of-hours was important factor in improving GP satisfaction. Employment options for GPs have increased which is reflected in the increase in the number of part-time GPs. However, 2007 surveys show that staff satisfaction of GPs has deteriorated (paragraphs 3.30–3.31).

Source: Department of Health; and National Audit Office

NOTES

1 Department of Health Survey 2007.

2 New England Journal of Medicine 2007, Roland et al.

3 Clinical Governance is the framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care.

4 NAO Report: *Improving Quality and Safety – Progress in Implementing Clinical Governance in Primary Care* (HC 100 Session 2006-07) noted that as the primary purpose of QOF was to link remuneration to evidence of the quality of service, and in 2006, each practice on average achieved 96 per cent of the points available – or 1,011 out of a possible 1,050, we found that their further analysis did not yield useful comparative data for assessing progress in implementing clinical governance. We concluded that the QOF measures did not yield useful comparative data for assessing progress in implementing clinical governance.

Overall conclusions

28 The new contract for GPs has cost more than the Department intended but has started to deliver some of the benefits that the Department intended. Recruitment and retention has improved, services provided in GP practices have been extended and PCTs have the contractual tools to be able to commission local services. The introduction of the QOF improves consistency of care, for example in identifying and treating long term conditions. The contract also rewards clinical practice where evidence suggests intervention should lead to improved health outcomes. However, the new contract has not improved productivity even when outputs have been adjusted to account for quality. National statistics show productivity has fallen since the new contract was implemented. This conclusion is supported by comparing costs to activity, which shows that whilst consultations with patients have increased these are not in proportion with the increase in costs. GPs are being paid more but are working less hours.

29 A new contract for GPs was needed and the terms negotiated provide PCTs the levers to be able to commission services with GPs in a way that more closely aligns to patient needs. The contract has given GP practices more control and management of its workload by removing responsibility for providing services over and above what are considered to be essential services. PCTs now have the responsibility for commissioning out of hours and other enhanced services. However, in the first two years of the new contract, the higher than expected cost of the new GMS and PMS contracts has limited the opportunities to develop local enhanced services and other flexibilities envisaged by the new contract.

30 In the first two years some PCTs have not made use of all the contractual levers in the new contract. For example money earmarked for enhanced services has not been spent as intended, partly because of overspend which have occurred in other areas of the contract and PCTs inability to implement effective local commissioning. The introduction of the Minimum Practice Income Guarantee led to money being moved away from budgets allocated to the QOF and contributed to the overspend on GP services. The addition of the Minimum Practice Income Guarantee has also meant that money has not flowed into the most deprived areas and some areas remain under-doctored. In addition, continuing problems with access to services out of hours have been highlighted in the Lord Darzi review. The costs of the contract to the NHS were stabilised in 2006-07.

Recommendations

a *Issue: The new contract costs more than the Department expected and PCTs spent more on the new contract than was allocated. In particular the cost of the Quality Outcome Framework (QOF), Out of Hours and Primary Care Administered Funds cost more than the Department estimated. **The Department and NHS Employers should** fully cost future amendments to the contracts and where possible should pilot major changes before they are implemented in the NHS.*

b *Issue: The Department does not have a clear strategy for the QOF for future years, and the QOF largely concentrates on indicators which are easy to measure. The QOF is also voluntary for GPs yet is negotiated nationally with the BMA and does not necessarily reflect the health needs of a local population. **The Department should** develop a long term strategy to support yearly negotiations on the QOF and develop the QOF based on patient needs and in a transparent way. The QOF strategy should be based more on outcomes and should also include an element of cost effectiveness. The value of QOF points should not be made solely on the basis of an estimate of practice workload.*

c *Issue: The revisions to the framework in 2006-07 have set the bar higher and have led to stable, rather than increasing scores in the QOF. There is still a wide range of reporting of exceptions (patients that are not considered for counting under the QOF). However, in order to continue to make improvements in quality **the Department should** reduce the level of exceptions allowed under the QOF and move towards a more outcome-based approach. PCTs should also ensure that they compare exception reporting between practices to help inform their audit of the QOF scores. **The Department should** agree to allocate a proportion of the QOF indicators for local negotiation at Strategic Health Authority or Primary Care Trust (PCT) level. To facilitate further improvements in quality **the Department should** consider the case for time-limiting QOF points.*

d *Issue: The introduction of the Minimum Practice Income Guarantee meant the allocation formula for GPs practices did not help redistribute funding to areas with the highest need and correction factor payments continue to absorb significant proportions of available resources. This has meant PCTs have not been able to coherently address historic funding issues and as a result money has not been moved to areas with the highest need (typically under-doctored areas). The introduction of the Minimum Practice Income Guarantee also meant that the money available for quality incentives or enhanced services was reduced. **The Department should consider** phasing out the Minimum Practice Income Guarantee and moving the money into funding quality incentives and/or essential services.*

e *Issue: PCTs have not made the most of the levers within the contract to improve access to GP services. People in areas of deprivation have more difficulty accessing GP services than the rest of the population and are more likely to be under-doctored. Some patients also report the need for extended access to GP services which are more suitable to their needs, for example through week-end and/or evening surgeries. PCTs should undertake a consistent assessment of the demand for GP services including type of local services needed and where provision fails to match demand. PCTs should then consider how best to meet this demand using locally enhanced services or APMS contracts based on Department toolkits for commissioning.*

f *Issue: PCTs have not spent the money allocated to them for providing locally enhanced services and have not developed services effectively around local patient needs. Some PCTs lack the capacity to be able to commission these services effectively (they do not have the information or the right number and level of skilled staff). PCTs should, under the World Class Commissioning initiative, review the number and skills of staff they employ to commission and performance manage GP services with the aim of improving local commissioning. PCTs should improve their understanding of local health needs and use enhanced services to meet local patient needs in line with best practice being developed by the Department.⁵*

g *Issue: PCTs do not have effective performance measurement frameworks in place to be able to monitor the delivery of GP services. In particular there is inconsistency in monitoring of essential services. PCTs should adopt a performance management framework that monitors all aspects of their contracts and tackles poor performance. Locally PCTs should clarify what standards of 'essential services' and level of quality they expect from practices for the global sum funding they receive. To determine probity of reporting of QOF measures by GP practices PCTs should develop a risk-based approach to monitoring.*

h *Issue: Some practice staff who are not GPs do not have appropriate contracts of employment, which is not consistent with good clinical governance. The nGMS contract is with a GP practice but mainly refers to the terms and conditions of individual GPs. PCTs should obtain assurance that all staff in GP practices have appropriate contracts of employment as part of their contractual obligations.*

g The Department is promoting improvements in commissioning through its World Class Commissioning Programme.

PART ONE

New approaches for contracting with GPs were needed

General practice is a crucial part of the health service, providing a first point of contact for most patients

1.1 All UK residents are entitled to the services of an NHS General Practitioner (GP) free at the point of need, and for most people, their GP is the first point of contact with the NHS. GPs have overall responsibility for the management of patient healthcare, including the diagnosis and treatment of health problems and referring patients for specialist treatment where necessary. Most practices also employ practice nurses and, in some cases, other health professionals, such as midwives. Practices may also run a range of clinics and services such as baby clinics, asthma services or physiotherapy. Primary Care Trusts (PCT) have a statutory duty for ensuring that health services are provided to meet the needs of their local population. This part of the report looks at the rationale behind the negotiated nGMS contract.

The Department of Health believed that the old contract for GPs could not deliver the changes needed in primary care

1.2 In 2000, the Department had articulated a number of policy objectives for primary care that it believed could not easily be implemented under the existing arrangements for contracting with GPs. In particular, the Department's NHS Plan 2000 set out a vision for:

- a greater range of primary care services, moving some activities out of hospitals;
- improved patient access to primary care services and improved choice in healthcare;
- a new primary care contracting system that would allow greater local flexibility; and
- employment contracts with increased emphasis on performance-based rewards.

1.3 At the same time as the Department identified that the future role of general practice needed to be expanded the British Medical Association (BMA) believed that general practice was in crisis. A BMA survey in 2001 had found that two-thirds of GPs felt that morale was 'low' or 'very low' and a quarter were considering leaving general practice. The survey identified long hours and low pay, relative to hospital consultants, which deterred trainee doctors from choosing general practice.⁶

1.4 The number of applicants for each GP vacancy was falling and more than two-thirds of practices reported difficulties in filling vacancies.⁷ The Department acknowledged that general practice had become an unattractive option for many doctors, and there were limited possibilities of incentivising service improvements under the existing contract. The Department recognised the nature of the GP workforce was changing and doctors wanted a better work-life balance.

1.5 At the time, the majority of GPs were employed under the 1990 General Medical Services (GMS) contract, which had been largely unchanged since 1966. The GMS contract was a nationally negotiated agreement held between the Secretary of State and each individual GP as independent contractors. It was based on a set of regulations, known as the 'Red Book', through which GPs could claim funding for each item of service performed and a set fee for patients registered. This meant that the funding followed the doctor, rather than the patients' needs, and it provided little incentive to develop the role of other general practice staff such as practice nurses.

1.6 In 1998, the Department introduced a new locally negotiated Primary Medical Services (PMS) contract as a pilot to try to address the issue of under-doctored areas and to encourage the greater use of practice nurses and other staff by offering additional funding for GP practices. Evaluation of the PMS contracts found that they can act as a catalyst of change and innovation and help improve services but could not provide the answer to every problem in primary care.⁸

1.7 By 2001 the Department of Health and the British Medical Association were in agreement that the existing national contract was not satisfactory. Most GPs were not happy with their working conditions, and the Department had a long term ambition of delivering more services for patients within general practice. At this point the Department and the doctors' representative, the British Medical Association, began discussion about a new contract for GPs.

1.8 The negotiators drew on the experience from the locally negotiated Personal Medical Services (PMS) pilots and key elements were used as a basis for a new national contract. The Department and BMA did not believe that the full roll-out of PMS was appropriate as the implementation of local contracts would lack consistency and therefore not be appropriate for tackling national issues.

About the study

1.9 We examined the negotiation and implementation of the new GMS contract and reviewed how well it is working in practice. Where appropriate we examine how the contracts such as PMS are operating but our focus is on the new GMS contract. We consider whether the contract has achieved the benefits intended by the Department. We looked at the benefits of the new contract for patients and the NHS.

1.10 We surveyed 1,800 GPs and 138 Primary Care Trusts, interviewed 11 Primary Care Trusts and five Strategic Health Authorities, held two focus groups with GPs and practice managers and visited a number of other GP surgeries, and analysed existing data. Responses from individual PCTs in the survey were not individually audited and some variations in results may be as a result of PCTs interpreting data differently. We spoke to a number of key stakeholders such as the BMA and the NHS Confederation. The NAO used data from existing surveys to analyse patient satisfaction. A full description of our methodology can be found at Appendix 2. We use April 2003 as the baseline for the new contract as this is when the increased funding for the contract was introduced although the contract was not fully implemented until April 2004.

1.11 One of the features of the new GMS contract was that GPs were no longer expected to be responsible for providing out-of-hours care and responsibility was passed over to the PCT. Out-of-hours care was reviewed by the National Audit Office in 2006 and we will refer to those findings which were relevant.³

The contract was negotiated by the NHS Confederation on behalf of the four home countries

1.12 The Department delegated negotiation of the new contract to the NHS Confederation. The NHS Confederation was mandated to negotiate on behalf of the four UK health departments with the British Medical Association (BMA) (**Figure 5 overleaf**). The four departments modelled the financial assumptions on costs and agreed the financial envelope. The negotiation process was lengthy and took place between 2001 and June 2003.

1.13 The negotiated contract comprised of a core set of essential services and extra payments for additional services which GPs could choose if they wanted to provide. The Department removed the GPs' responsibility for providing care outside of core hours, allowing them the option to provide this care if they wished. The Department also agreed that more money for GP services would be linked to achievement of quality standards by the practice. The parties agreed the contract would be with the GPs' practice not the individual GP. GPs would then be paid by the practice as a salary or in the case of GPs who are partners in a practice (around 70 per cent of GPs) a share of the practice profits after it has paid its expenses.

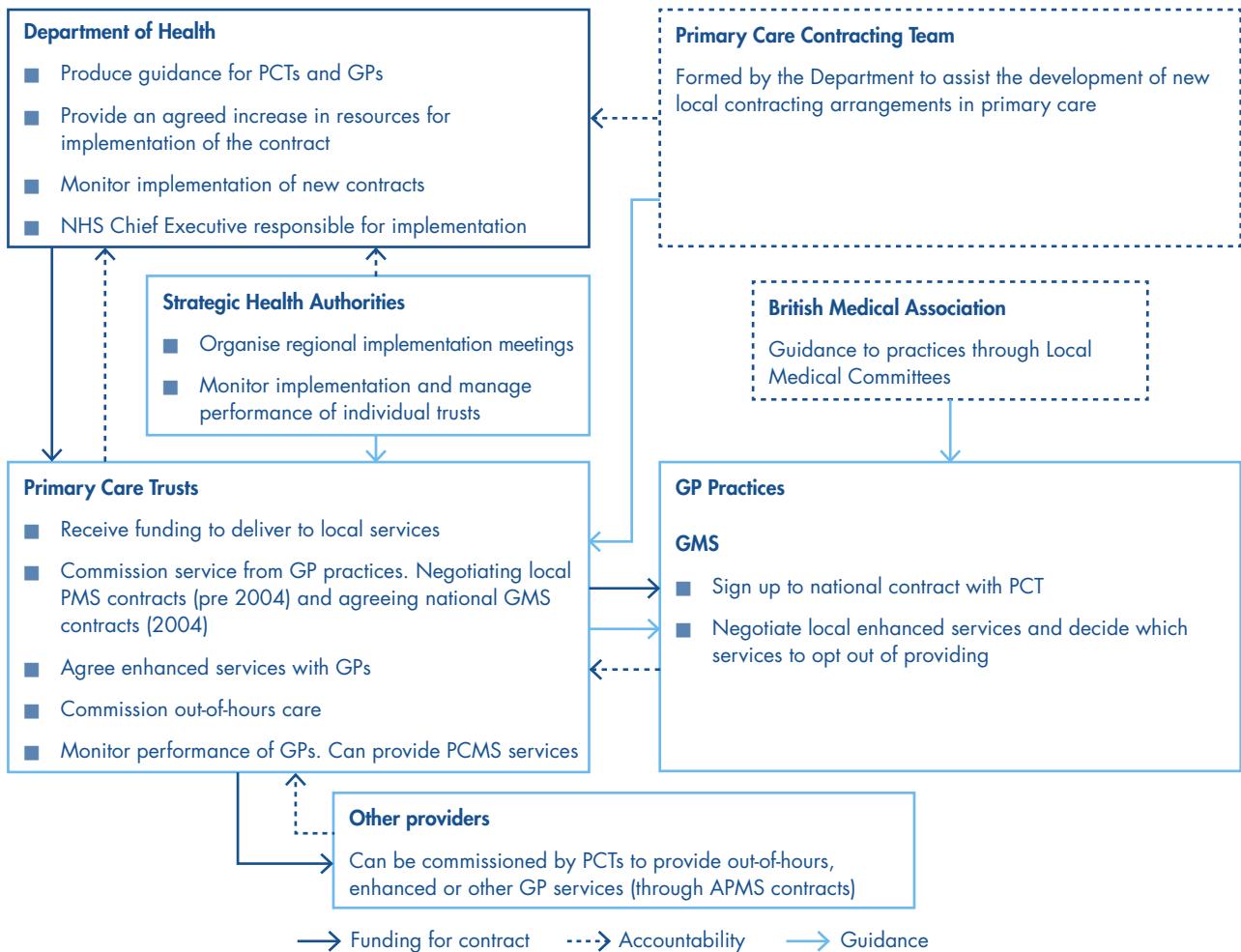
1.14 Negotiations stalled in 2002 when the allocation formula proposed by the Department meant that a large number of doctors (more than 80 per cent) would have a reduced income for providing core services. The Department therefore agreed with the BMA that doctors would have transitory protection of their income while the new contracts were embedded. This promise was termed the Minimum Practice Income Guarantee. The British Medical Association members voted to accept a new contract in June 2003 which guaranteed an increase in money available for general practice.

5 Roles and responsibilities for negotiating and implementing the nGMS Contract

Contract Negotiation for nGMS – August 2001 – December 2003



Implementation – nGMS December 2003 – March 2004 and beyond



Source: National Audit Office

NOTE

The Department agrees that GPs could still work under PMS contracts and 37 per cent of GPs have remained on PMS contracts.

1.15 The new contract was agreed for all four home countries but implemented separately by the relevant health departments in England, Wales, Northern Ireland and Scotland with some minor differences in the final terms and conditions (see Appendix 3). The new contract comprised of five main areas of expenditure for PCTs:

- Global sum (paragraphs 1.18–1.19)
- Quality Outcome Framework (paragraphs 1.20–1.23)
- Enhanced Services (paragraphs 1.24–1.25)
- Out of Hours (paragraph 1.26)

1.16 Other funding was made available for increased expenditure on information technology, premises, pensions, payments to recognise seniority, and help recruitment and retention.

The new contract makes significant changes to the way general practice is funded and services are delivered

1.17 In April 2004 PCTs were responsible for implementing the new contracting regime for GPs, replacing the old nationally negotiated GMS contract. The PMS contract was retained and subject to some of the new features of GMS. Thirty seven per cent of GPs remain on PMS contracts. At the same time another contracting route Alternative Provider Medical Services and Primary Care Trust Medical Services, where a PCT provides its own GP services, were introduced to enable new primary care medical providers to deliver primary care in under-doctored areas. See **Figure 6** for a summary of the main contracting routes.

Funding essential service in general practice: the “Global Sum”

1.18 A key aim of the new General Medical Services contract was to make the funding system for GP practices more equitable. The business case developed by the Department for the Treasury identified the need to direct more funding at practices where workload was higher, typically because the area was more deprived and the needs greater.

1.19 Under the new contract the core funding for GP practices is allocated through the Global Sum to provide the essential services expected from general practice. Essential services are broadly defined as for ‘treating those who are sick or believe themselves to be sick’ but interpretation is broad and varies nationally. Allocations for a practice are determined through the Carr-Hill^h formula which aimed to link funding to patient needs. It is calculated based on a practice’s population size and the following characteristics:

- Patient sex and age;
- Nursing and residential home status;
- Morbidity and mortality;
- Newly registered patients;
- Unavoidable costs of rurality;
- Unavoidable higher costs of living (mainly in the south east of England).

Over 90 per cent of practices receive Minimum Practice Income Guarantee payments and as such their Global Sum payments are based on their historic income rather than on the allocation formula.

6 Main contracting options for general practice services

- **General Medical Services** – GP practices contract with their PCTs on a nationally negotiated basis. Two thirds of GPs operate under General Medical Services contracts.
- **Personal Medical Services** – GP practices contract with their PCTs on a locally negotiated basis, with quality indicators and specific service requirements agreed between the practice and PCT. One third of GPs operate under Personal Medical Services contracts.
- **Alternative Provider Medical Services (APMS)** – enables PCTs to contract with providers other than standard GP practices for the provision of GP services. There are only a small number of APMS contracts in England, mainly held with private healthcare companies. APMS was introduced in 2004 as a means of improving access to GP services in the most poorly served areas.
- **Primary Care Trust Medical Services (PCTMS)** – enables PCTs to run GP practices directly. PCTMS was introduced in 2004 so that PCTs could take on the running of GP practices, for example where there is a need for extended primary care services, but a lack of providers.

Source: Department of Health

^h Formula to adjust funding of a practice to align with the needs of their patients, developed by Professor Roy Carr-Hill.

The Quality and Outcomes Framework

1.20 One of the Department's key aims in developing the new General Medical Services contract was to introduce better measures of performance and quality in primary care. Prior to 2004, funding for general practice was based primarily on quantity of services delivered, with almost no funding linked to performance or quality. As part of the new contract, the Department developed a Quality and Outcomes Framework (QOF) which awards funding where practices can demonstrate they have achieved certain quality measures (**Figure 7**).

1.21 The QOF is recognised by international research as being a unique approach to measuring and incentivising quality in healthcare.⁹ It enables PCTs, Government and patients to see how practices are performing. It incentivises good quality practice through a system of

financial reward. It also provides a data-set on prevalence of a number of common conditions, not previously available, which is an important resource for healthcare planning and research. Although participation is voluntary, nearly all practices take part (both those under GMS and PMS contracts).

1.22 The QOF was designed for the Department by a group of academic and health experts commissioned by the negotiating parties. Most of the indicators chosen were based on clinical evidence that an input or intervention leads to improved health outcomes. The disease areas were chosen on the basis of high prevalence or significance in terms of their impact, and a detailed rationale provided for each. The final form of the framework was subject to negotiation (and remains a subject of annual renegotiation) between the BMA and NHS Employers on the basis of the expert analysis. Although the QOF is voluntary, the Department negotiates with the BMA to encourage participation in the QOF.

1.23 Scores on the QOF are recorded by practices through an electronic management system (QMAS) and evidence of performance is supplied to the PCT in an agreed format. The assessment of QOF scores was agreed through the negotiation to be on a 'high-trust model'. The 'high trust model' meant that PCTs scrutiny of the recorded QOF scores was expected to be proportionate. The indicative scores for a practice are then verified by the PCTs through a more in-depth audit. PCTs are responsible for formally auditing a five per cent sample of practices submitting their QOF scores. The approach to auditing the QOF scores varies between PCTs.

7 Details of the Quality and Outcomes Framework

The Quality and Outcomes Framework consists of four main areas, or domains:

- clinical domain: 80 indicators across 19 clinical areas such as coronary heart disease, asthma and hypertension
- organisational domain: 43 indicators across five organisational areas such as records and information and practice management
- patient care experience domain: four indicators that relate to length of consultations and to patient surveys
- additional services domain: eight indicators across four service areas such as child health surveillance and contraceptive services.

A total of 1,000 points are available across these four domains, of which the majority – 655 points – are in the clinical domain. Each point is worth £125.

Points are awarded where practices can demonstrate that they have fulfilled a number of key stages in the management of chronic disease, for a proportion of the relevant population (usually between 40 per cent and 90 per cent). For example, for hypertension practices can receive:

- nine points for maintaining a register of patients with the condition;
- up to 20 points for diagnosis and initial management (for example, recording smoking status);
- up to 76 points for ongoing management of the condition (for example, taking regular blood pressure checks and trying to control blood pressure in hypertension to levels suggested by clinical evidence).

Source: Department of Health

Enhanced Services

1.24 The introduction of enhanced services is an important step in the development and expansion of primary care. Under the new GMS contract, all GP practices must provide essential services, but can negotiate the provision of a range of other services with their PCT. These 'enhanced services' are defined by the Department as ones that go beyond the normal daily activities of general practice, and which may require specialist skills. Additional resourcing is available for enhanced services for example care for drug misusers or homeless people. Such services may not be needed everywhere, or may need different approaches in different areas. Under the new contract, these enhanced services can fall into one of three categories: Directed Enhanced Services, National Enhanced Services or Local Enhanced Services (**Figure 8**).

1.25 PCTs are obliged to commission adequate services for their local populations, including relevant enhanced services based on assessment of local needs. The Department set PCTs a spending ‘floor’ for enhanced services which they must meet, but can exceed. The system of enhanced services formalises the provision of a range of services which previously may have been provided in an ad hoc way – perhaps by a GP without specific funding, or within secondary settings.

Out of Hours

1.26 Many General Practitioners (GPs) had already used powers granted in the mid-1990s to delegate out-of-hours provision to a third party. The new GMS contract removed the GPs’ responsibility for organising out-of-hours care entirely. Where GPs chose not to provide out-of-hours care they would need to give-up an average of £6,000 per annum to pass on responsibility for out-of-hours care to the PCT. However, during the negotiations, the Department estimated the average cost was £9,500 per GP. The National Audit Office reviewed these arrangements in May 2006 and found that the actual average annual cost of providing out-of-hours services in the first year was £13,000 per GP.³

8 Key Enhanced Services

Directed Enhanced Services: PCTs are obliged to achieve coverage of these services for their patients, though no individual practice is obliged to participate. Standards and prices are set nationally. They include Government priorities such as the development of patient access, but also basic and universally needed services such as child immunisation.

National Enhanced Services: PCTs can choose to commission these services, according to local needs, but in line with nationally set standards and prices. They include commonly needed services such as minor injury treatment.

Local Enhanced Services: PCTs have the freedom to design, negotiate and commission any other services they believe are needed in their area. Examples could include services for asylum seekers or people with learning difficulties. In some cases the National Enhanced Service standards are used with adjustments to meet local needs, but otherwise standards and prices are negotiated locally.

Source: Department of Health

Expected benefits of the new contract

1.27 The Department had clear expectations that the new contract would deliver specific benefits to GPs, patients and the NHS as a whole. These were principally set out in a strategic sense in the NHS Plan 2000; more explicitly in 2002 in the Department’s business case to Treasury (**Figure 9 overleaf** and Figure 4); and in 2004, following negotiations, in a letter to PCTs (Appendix 4). The business case set out the Department’s expectations about the costs of the new contracts and the intended participation (increased commitment of GPs to general practice) and productivity benefits. The Department expected that the new contract would yield a 1.5 per cent productivity gain in each of the first three years of the new contract.¹⁰

1.28 The introduction of the new GMS contract was accompanied by a promise by the Department to doctors to increase expenditure on primary care, called the “Gross Investment Guarantee”. The Gross Investment Guarantee committed Government to spend at least £5.6 billion on GP services in 2003-04, £6.2 billion in 2004-05 and £6.9 billion in 2005-06. In 2004 the chief negotiator communicated the tests for judging achievement of the benefits from the contract (Appendix 4). A timeline of key contract changes is set out in **Figure 10 overleaf**.

The rest of the report looks at:

- The implementation of the nGMS contract and costs of GP contracts (part 2);
- The benefits of the new contracts (part 3);
- Making the most of the new contracts (part 4).

9 The Department's expectations about the nGMS contract as expressed in its Business Case to HM Treasury¹



For GPs:

- Greater job satisfaction and moral
- Reduced administrative burden
- Improved recruitment and retention (more flexible career structure and greater control over workload)



For patients:

- Re-design of services around patients
- More choice and better access to services
- More flexible services, better meeting local needs
- Better quality services as a result of the Quality and Outcomes Framework
- Extending the range of patient-services



For the NHS:

- Increased productivity
- Improvement of skill mix in GP practices. Greater use of practice nurses, nurse practitioners and other healthcare staff.
- Improvement in GP premises and infrastructure (IT)
- Improvement in Clinical Governance
- Reduced pressure on secondary care through the development of GP specialist services

Source: Department of Health

NOTE

¹ Thirteen key benefits were expressed in the Department's Business Case and were described in other words in other documents.

10 Timeline for key contract changes

1990	Previous contract introduced, setting out more specific direction for GPs and establishing the 'Red Book' as the basis for remuneration.
April 1998	PMS pilot contracts introduced to try and address a shortage of GPs in some deprived areas, and to allow local flexibility to deliver services where needed.
July 2000	NHS Plan published, setting out aims to revise GP contract, shift more services into primary care, and improve access and choice for patients. Aimed to increase the number of GPs by 2,000.
2001	Eighty six per cent support for a new contract among GPs in a BMA ballot. Negotiations for a new contract begin.
February 2003	New contract offer sent to BMA.
April 2003	Gross Investment Guarantee funding starts
April 2003	Minimum Practice Income Guarantee negotiated.
June 2003	BMA votes to accept new contract with Minimum Practice Income Guarantee.
December 2003	Guidelines for new GMS contract issued to PCTs.
April 2004	New General Medical Services contract comes into force.

Source: Department of Health and British Medical Association

PART TWO

Implementation and cost of the new contracts

2.1 The introduction of the new GMS contract changes the responsibilities and relationships between the PCT and the GP. The contract established incentives for practices to deliver GP services to set standards of quality yet can be adapted to meet local needs. The implementation of the new contracts places greater responsibility on PCTs to commissionⁱ services based on the need of the local population in a more flexible and responsive manner. In this relationship GP practices or other providers act as contractors within the NHS.

2.2 Before the new contract was introduced 33 per cent of GPs practiced under PMS contracts and all but approximately two per cent of GPs continued with their contracts. The QOF and enhanced services are relevant to both contracts and this part of the report examines how effectively PCTs implemented the nGMS contract and the costs incurred in implementing both GMS and PMS contracts.

Implementation of the new contracts

2.3 PCTs consider that they were given the appropriate guidance by the Department to enable them to implement the contracts effectively but many PCTs felt that the implementation of the new contract was rushed (54 per cent of PCTs). The nGMS guidelines were issued in December 2003 for implementation in April 2004; part of this guidance was to aid financial planning. The Department gave PCTs a computer tool to aid their financial planning but the model contained errors. This tool was amended because of errors in February 2004, so PCTs had to revise their financial plans and this created time pressure on PCTs to complete their implementation plans. Fifty-three per cent of PCTs also felt that the Department did not adequately communicate the expected benefits of the new contract which would have enabled them to make more out of the contracts.

2.4 Sixty-one per cent of PCTs believe that they did not have adequate resources to implement the new contracts and feel that their capacity to manage the contracts since the implementation has been stretched.¹¹ PCTs felt they lack the necessary resources (staff and budgets) to make the most out of the new contracts, for example in developing local enhanced service (see Part 4).

Elements of the contract remain open for renegotiation

2.5 Other elements of the contract have been amended through negotiation for 2006-07, for example the QOF and enhanced services. The contract allows such amendments to be negotiated on an annual basis. These amendments are negotiated between the BMA and NHS Employers which is part of the NHS Confederation.

Costs of the New Contract

2.6 Prior to the implementation of the new GMS contract expenditure on primary care had been rising steadily since 1994 and in real terms had risen by 75.4 per cent^j between 1994 and 2004 (**Figure 11 overleaf**). In 2002-03, the comparable expenditure on GMS and PMS contracts was £4.9 billion with £2.9 billion spent on GMS contracts, £1.2 billion on PMS contracts and £0.8 billion on GP dispensing.

2.7 The Gross Investment Guarantee set out the minimum that the Department had promised doctors it would spend on GP services. The Gross Investment Guarantee (GIG) committed the Government to spend at least £5.6 billion in 2003-04, £6.2 billion in 2004-05 and £6.9 billion in 2005-06. For 2006-07, the Gross Investment Guarantee was removed and allocations were based on a zero percent uplift on the 2005-06 figure.^k

ⁱ Commissioning refers to the means by which PCTs secure services on behalf of the local population.
^j Department of Health Annual Report 2006 (Figures were converted using 2005 GDP deflator).
^k Department of Health.

In the first three years GPs services cost £1.76 billion more than was expected when the contract was negotiated

2.8 In each of the first three years the cost of the new contract has been above the level set out by the Gross Investment Guarantee. Cumulatively the contract has cost the NHS £1.76 billion or 9.4 per cent above the Gross Investment Guarantee in the first three years of the contract (**Figure 12**). Expenditure has also exceeded the level that the Department allocated to the NHS to spend on GP services.

2.9 Whilst the Gross Investment Guarantee was set at £6.21 billion for 2004-05 the Department allocated £6.80 billion to PCTs^l, but the NHS spent £6.96 million.

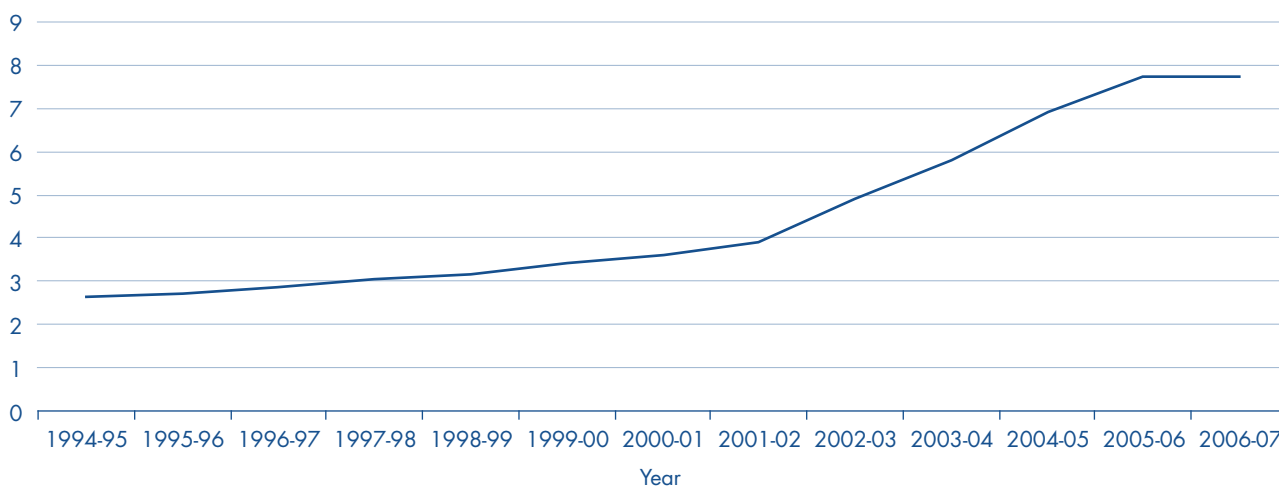
In 2005-06 the GIG was £6.92 billion, the allocation was £7.48 billion but the NHS spent £7.73 billion. In both of these years PCTs spent more than allocated by the Department on GP services and in total the NHS spent £406 million (2.8 per cent) more than it was allocated by the Department for GP services.

2.10 The main reason for this overspend has been the QOF, the cost of out-of-hours care (**Figure 13**), and PCT^m Administered Funds. PCT administered funds includes payments made to GP practices for locum services and other miscellaneous expenditure incurred by PCTs in contracting with GPs. Some PCTs were able to manage these costs without incurring an overspend against their budget.

11 Expenditure on GP Services between 1994 and 2007

This figure shows the increasing cost of providing GP services since 1994, with an increase in the rate since 2002 and a stabilisation of the cost in 2006.

£ billion



Source: Department of Health

12 Expenditure against the Gross Investment Guarantee, 2003-2006

	2003-04 £ million	2004-05 £ million	2005-06 £ million	Total £ million
Gross Investment Guarantee	5,611	6,211	6,918	18,740
Expenditure by PCTs on GP services	5,811	6,957	7,734	20,502
Expenditure compared to Gross Investment Guarantee	+200	+746	+816	1,762

Source: Information Centre

^l PCTs were allocated more than the Gross Investment Guarantee to cover increased costs of employer's pension contributions.
^m Actual term used by the Department is Primary Care Organisation Administered funds.

2.11 The initial overspend on the QOF occurred because practices scored much more highly on the framework than the Department had predicted – 91 per cent against estimates of 75 per cent. Expenditure on the QOF equates to an average income per practice of £74,300 in 2004-05 (around one third of average total earnings) and £126,000 in 2005-06.ⁿ

2.12 The QOF was not piloted before it was introduced, so the Department had limited information on which to base its estimates. However, the BMA told us that it warned the Department that achievement would be much higher.¹² In addition, Departmental documents suggest that the Department was aware that the estimates were low, but chose to retain them in order to release money in its budget to pay for the Minimum Practice Income Guarantee.¹³ When the contract was implemented the majority of practices were, and remain, eligible for the Minimum Practice Income Guarantee. In 2006-07 the Minimum Practice Income Guarantee cost each PCT an average of almost £2.1 million. Nationally, the total cost of the Minimum Practice Income Guarantee is around £330 million per year.

Expenditure on GP services has been controlled in 2006-07

2.13 In 2006-07, the allocation to PCTs for GPs services was not increased and the Gross Investment Guarantee ceased to apply. In this year, the Department allocated £7.9 billion but PCTs actually spent £110 million less on GP services. The main areas where PCTs spent less than their allocation was on premises, enhanced services and PMS (**Figure 14 overleaf**). PCTs still spent more than their allocation on QOF and out-of-hours.

Spending on GP Services varies nationally

2.14 The amount of money that a PCT spends on GP services per patient varies nationally. In 2006-07 PCTs spent an average of £128 per patient on commissioning primary care through GP contracts but this can vary between £99 and £222 per patient (**Figure 15 overleaf**).

2.15 Using population data at super area output level^o, in more deprived areas there are fewer doctors per head of population. In addition single handed practices are more likely to be located in deprived areas and fewer training practices (**Figure 16 overleaf**). At PCT level these differences are not as apparent.

13 Biggest areas where expenditure has exceeded allocation

2004-05	Allocation £ million	Spend £ million	Spend above allocation £ million	2005-06	Allocation £ million	Spend £ million	Spend above allocation £ million
GMS Contracts	1,934	1,959	25	GMS Contracts	1,846	1,967	121
PMS Contracts	2,213	2,012	-201	PMS Contracts	2,189	2,025	-164
Quality Outcome Framework	504	659	155	Quality Outcome Framework	927	1,095	168
Enhanced Services	601	588	-13	Enhanced Services	676	655	-21
PCO Administered funds	89	197	108	PCO Administered funds	94	195	102
Premises	386	370	-16	Premises	452	420	-32
Information Technology	64	66	2	Information Technology	65	68	3
Out of Hours	105	209	104	Out of Hours	302	380	78
Other	59	43	-16	Other	50	48	-3
Dispensing	847	854	7	Primary Care Support Scheme	1	0	1
Total	6,802	6,957	155	Dispensing	883	883	0
				Total	7,485	7,736	253

Difference in allocation in the first two years £251+£155 = 406

Source: Department of Health

ⁿ Calculated from QOF data.

^o Super Output Areas (SOAs) are a new geographic hierarchy designed to improve the reporting of small area statistics in England and Wales, describing statistics for areas of a similar size.

14 Breakdown of expenditure in England in 2006-07¹

2006-07	Allocation £ million	Spend £ million	Spend above allocation £ million
GMS Contracts	1,858	1,980	122
PMS Contracts	2,208	2,071	-137
Quality Outcome Framework	979	1,040	61
Enhanced Services	890	748	-142
PCO Administered funds	166	231	65
Premises	550	437	-113
Information Technology	84	65	-19
Out of Hours	288	342	54
Other	30	29	-1
Dispensing	814	814	0
Total	7,867	7,757	-110

Source: Department of Health

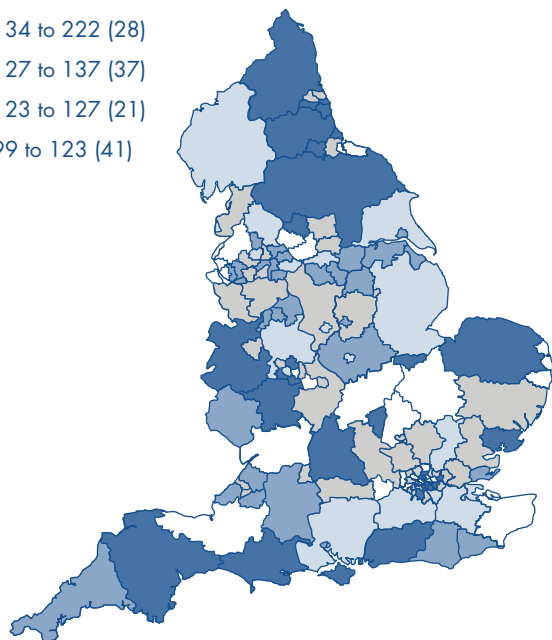
NOTE

1 PCTs' final summarised audited accounts 2006-07.

15 The average spend per patient by Primary Care Trusts in 2006-07

Average spend per patient, as at 31 March 2007

- 134 to 222 (28)
- 127 to 137 (37)
- 123 to 127 (21)
- 99 to 123 (41)



Source: National Audit Office (white denotes no data supplied to NAO)

16 Characteristics of general practice based on their location described by super output area census data for deprivation (2005-06)

	Least deprived quintile	Most deprived quintile
Number of Practices	1,228	2,373
GPs (FTEs)	4,660	6,342
List size per GP	2,063	2,284
Single-handed practice	13.4%	35.1%
Training practice	38.2%	19.1%

Source: Ashworth et al, British Journal of General Practice; DOH; and Census data 2004

Average Pay of GP Partners has increased by 58 per cent in three years

2.16 Part of the Department's aim in introducing the new GMS contract was to make general practice a more attractive career option for doctors. This meant increasing average pay, to bring it more closely in line with the pay received by hospital consultants. There was an expectation set out in the pay modernisation business case that career pay for GPs would increase by 15 per cent on the new contract. Under the new contract pay is difficult to control as it is determined by GP practices as independent contractors. GP partners are paid based on a share of the practice profits and salaried GPs pay is determined by the GP partnership. The Department cannot determine pay through the normal processes of negotiation leading to an agreed pay scale.

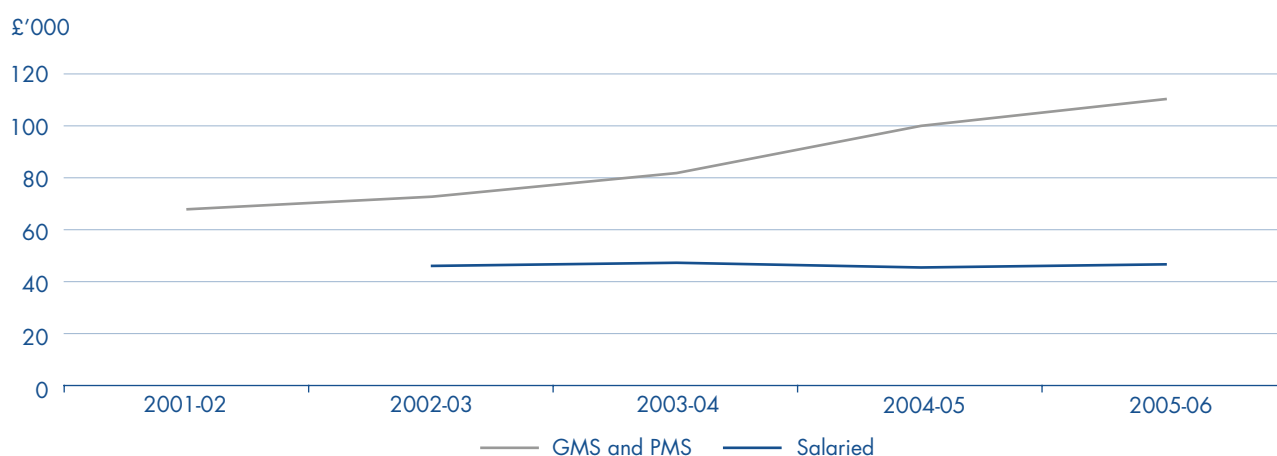
2.17 The way they expected pay to rise was to increase the amount spent on GP services which would allow GPs to earn more through incentives and efficiency alongside the delivery of more services. **Figure 17** shows the increase in average pay for GP partners and salaried GPs. The first year of the contract saw the average pay for GP partners rise by 18 per cent. In the second year it rose 23 per cent, with a further increase of almost 10 per cent in 2005-06.¹⁴

2.18 The large increases in average pay for GP partners have arisen largely from a combination of increased practice income and a smaller increase in the expenses paid out by each practice. Expenses are the amount that the practice costs to run, for example salaries for practice nurses and administration costs. Whilst pay for GP partners has increased, data from HMRC's tax self-assessment database states the average salary for a GP employed by a practice (approximately 20 per cent of all GPs) has only increased by 3 per cent in the first two years of the contract.

2.19 Total income per GP partner (excluding expenses) rose from £184,085 to £257,564, or around 40 per cent between 2002-03 and 2005-06. The average practice was able to reduce the proportion of total earnings required to cover expenses from 60 per cent in 2002-03 to 55 per cent in 2005-06. There is variation in the amount of money used by GP practices to cover practice expenses, for example some GP partnerships employ less staff working or work as single-handed practitioners. It is not known whether this reduction in expenses is due to GP efficiency or reduction in spending in the practice by GPs but we know that the average practice nurse income has reduced in real terms and salaried GPs' income has only increased by a small percentage. The income data used for GPs also includes income from private work (which makes up only a small amount of GP income equating to less than 5 per cent).

17 Average Pay of GP Partners and Salaried GPs 2001-02 to 2005-06

This figure shows the increase in average pay for GP partners and a stabilisation of average pay for salaried GPs. The average pay for salaried GPs does not represent the average full time salary.



Source: Information Centre (2006-07 data is unavailable as data is calculated based on Income Tax returns which are calculated a year in arrears)

2.20 Although rises in GP pay in the first two years of the new contract were significant, since then there has been no increase in the funding terms of the contract in a bid by the Department to claw back some of the high expenditure on the new contract and also as a result of the Doctors' and Dentists' Pay Review Body recommending a zero increase for contractor/partner GP pay in 2007-08. In a recent opinion survey by the British Medical Association two thirds of GPs reported that their personal income had stayed the same or decreased in 2006-07. Two thirds expected a decrease in income in 2007-08 but official figures will not be available until Autumn 2008.

Comparison of the Primary Care Service Contracts – GMS and PMS

2.21 As locally negotiated contracts PMS contracts naturally vary in what services are delivered between and within PCTs. The PCT negotiates what essential services the GP practice will provide and the practice remains eligible for additional funding from the QOF and from enhanced services. As PCTs aimed to increase the number of staff working in primary care PMS contracts commonly contain defined amounts of money to pay for on-going staff costs linked to inflation.

2.22 PMS GP partners appear to generate more income than GMS GP partners (Figure 18) but tend to serve larger populations and may have more GPs per head of population. For example, on average PMS practices have 16 per cent bigger list sizes than GMS practices (average list size of a PMS and GMS practice is 7,098 and 6,130 respectively¹⁵). The contracts are also not directly comparable as PMS contracts are locally negotiated and it is not clear what services they contain. Factors which vary between practices under different contracting routes include staffing, specification of essential services, use of enhanced services, list size per GP, contractual conditions and population characteristics.

2.23 The average net incomes for GPs vary considerably between GMS and PMS practices (Figure 18). PMS net income was 15.3 per cent higher than GMS in 2003-04, 11.3 per cent higher than in 2004-05 and 10.2 per cent higher than in 2005-06. Therefore the gap between PMS and GMS doctors partners income has narrowed.

Lack of staff and information affects the ability of PCTs to commission effectively

2.24 When the new GMS contract was introduced in 2004 there were 303 primary care trusts by October 2006. This was reduced to 152 through a national reorganisation which merged many PCTs. The merger of the PCTs has created some pressures in managing the new contracts, PCTs report that as a consequence of the mergers the number of staff managing contracts has reduced.

2.25 PCTs felt they had too low a number of staff working in primary care commissioning particularly where staff do not have wide experience in commissioning services or have not been involved at a senior level in managing general practice. In addition, PCTs report that their capacity has been stretched by managing two large contract reforms for dentists and GPs in the last three years. Our survey found that on average each PCT employs six people to work on primary care services to manage an average of £44 million.

2.26 A number of NAO reports and a report by the Audit Commission have highlighted the importance of strengthening commissioning by PCTs. To commission effectively PCTs need to have good information about local needs, and sufficient staff to be able to identify the way to secure services that meet local needs and offer good value for money.¹⁶ The Department has recognised that commissioning is an area for improvement for PCTs and is promoting an initiative to improve commissioning.¹⁷

Mergers of PCTs have highlighted inconsistency in the implementation of the nGMS contract

2.27 When PCTs were merged in October 2006 the management of the GP contracts in many PCT areas changed. When negotiated contracts were scrutinised some PCTs identified inconsistencies in the funding of the nationally negotiated nGMS contract. In particular, the reorganisation highlighted some variance in the interpretation of essential services paid for under the global sum. The difficulty in interpreting what services are paid for under the global sum is due to the wide definition of essential services. The lack of definition has meant that some practices are being paid extra to deliver an enhanced service that would be defined by other PCTs as part of essential service and already paid for under the global sum. This has been shown to be a particular issues with PMS practices, 19 per cent of PCTs have found services which are eligible for specific payments through the PMS contracts are also included as an enhanced service or part of the QOF.

18 Comparison of the average net incomes of GMS and PMS partners in England

This figure shows that the average pay of partners in PMS practices is higher than in GMS practices but this gap is decreasing.

	GMS £	PMS £	Average GMS or PMS £	PMS premium over GMS Percentage
2003-2004	80,421	92,778	84,795	15.3
2004-2005	99,795	111,099	103,564	11.3
2005-2006	110,054	121,375	113,614	10.2

Source: Information Centre (2007) GP Earnings and Expenses Enquiry

PART THREE

Benefits Delivered to the NHS

3.1 In 2002, the Department set out the benefits that were expected from the new contract in its NHS Pay Modernisation Business Case (see Figure 4). In particular the Department expected that implementation of the new contract would improve productivity and participation of GPs within the NHS. The over-arching aim was to deliver increased access and better quality services to patients. In this part we report on the extent of progress against these stated objectives:

- Improve productivity (paragraphs 3.2–3.8)
- Improve recruitment and retention (paragraphs 3.9–3.10)
- Increase skill mix (paragraphs 3.11–3.13)
- Improve quality of care (paragraphs 3.14–3.17)
- Increase the flexibility of services provided in general practice (paragraph 3.18–3.21)
- Improve patient satisfaction and access (paragraphs 3.22–3.27)
- Increase entrepreneurial culture in primary care (paragraphs 3.28–3.29)
- Improve GP satisfaction (paragraphs 3.30–3.31)

Effect of the New Contract on Patients

Productivity

3.2 The Department expected the nGMS contract would lead to year-on-year productivity gains. Productivity is the relationship between inputs and outcomes, so alongside increased spending the Department expected returns which had greater benefit than the amount of money put into the new contract. In the business case sent to HM Treasury, the Department emphasised the importance of productivity in determining the volume and quality of care provided and set out its assumption that the contract would produce gross productivity gains (above a do-nothing scenario) of 1.5 per cent in the first year,

rising to 4.5 per cent within three years and continuing for up to eight years. At the time the contract was developed the Department did not define how productivity would be measured.

3.3 A crude measure of productivity for GP services can be estimated by comparing the number of consultations carried out at a GP practice with the input cost. When we compare the number of consultations before and after the new contract there is not a proportional increase in activity in GP practices (see Figure 19 overleaf) compared with the greater rise in costs.

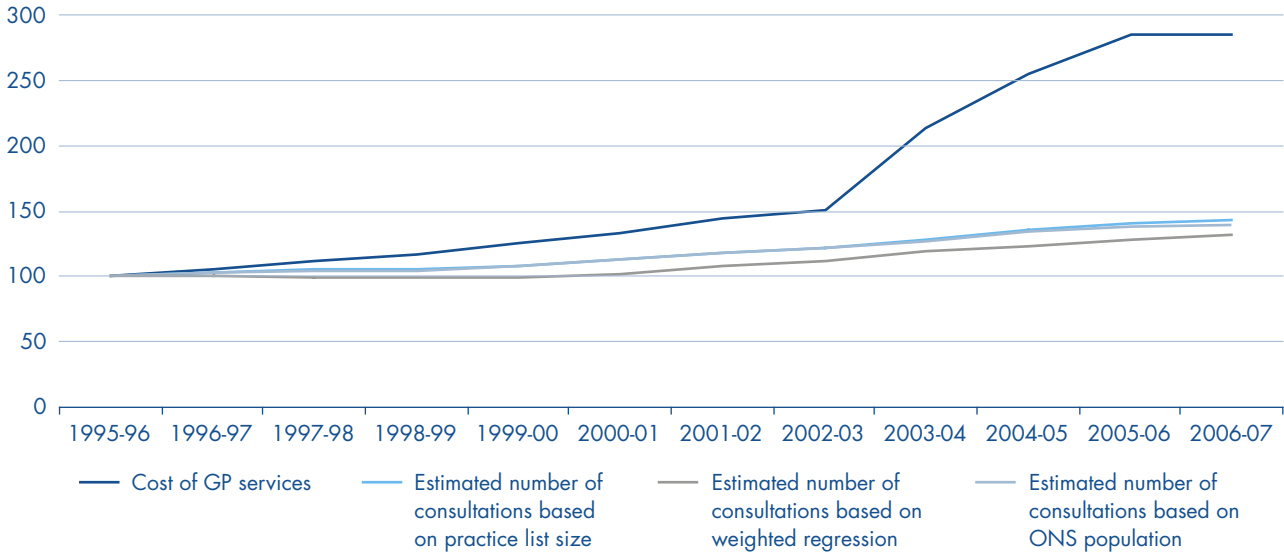
3.4 The Office for National Statistics (ONS) has developed new measures of productivity for the whole of the NHS that included measures of quality within its calculations to make specific adjustments for the outcomes of primary care; assessment of patient experience; waiting times; and the health gains following treatment in hospital. The quality adjusted figures are available from 2001 to 2005 only. The ONS estimates for the whole of the NHS productivity decreased 2.3 per cent between 2002 and 2003; decreased by 0.9 per cent between 2003 and 2004; and decreased by 1.8 per cent from 2004 to 2005 (Figure 20 overleaf). Data is not yet available for 2006 but without quality adjustment from 2005 to 2006, productivity fell less quickly, by 0.2 per cent.

3.5 The ONS is able to disaggregate these figures to estimate the productivity in primary care with an adjustment for quality. Whilst this estimate includes other services such as dentistry and optometry, the majority of the input and output measures are based around GP services. Using this estimate, productivity increased by 1.2 per cent between 2002 and 2003. It then decreased by 2.8 per cent from 2003 to 2004; and decreased by 2.2 per cent from 2004 to 2005 (see Figure 20). The ONS warns that productivity estimates should be interpreted alongside other evidence and this change represents only the first two years of the contract.¹⁸

19 Increase in patients seen in GP services compared to increase in costs of GP services

This figure shows that by all methods of estimation the number of consultations carried out in GP practices in England has increased. The cost of GP services in England has increased at a greater rate than the number of consultations. Weighted regression refers to the method of estimating based on the assumption that there is no uniform distribution of users of GP services.

Index, normalised at 100 for 1995-96

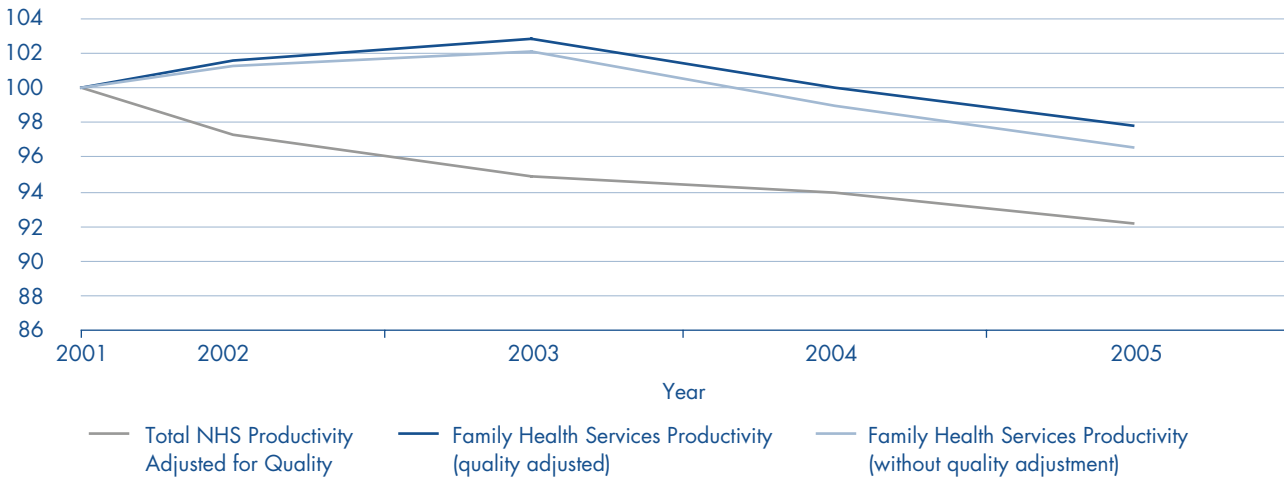


Source: Information Centre and QResearch

20 Productivity index from 2001 to 2005

This figure shows that productivity in primary care increased from 2002 to 2003 but reduced from 2003 (with or without an adjustment for quality), the year the contract was introduced. This can be explained by the fact that the cost of GP services has increased at a higher rate than the increase in the measured outputs from GP services. It also shows there has been a decrease in total NHS productivity over the same period. The Department has reservations about the methodology ONS has used to arrive at the figures that purport to measure productivity change within primary care. The Department argue that the methodology used by ONS misrepresents the position and that general medical practice productivity has not fallen to the extent that ONS figures suggest.

Productivity 2001=100 per cent



Source: Office for National Statistics 2008

GP workload

3.6 A survey of the workload in general practice was carried out in 2006, the first time since 1992. The workload of GPs in 2006 was compared with those in 1992. However this comparison should be treated with caution as the changes in workload may not be due to the new contract as much has changed since 1992. A more recent survey carried out by the National Primary Care Research and Development Centre also comments on workload.

3.7 Using the comparison between 1992 and 2006, and when out of hours work is removed from the analysis, there is little difference between the average hours worked by a GP. GPs worked an average of 35.9 hours per week in 1992-93, and 36.3 hours in 2006-07. When out of hours is included in the comparison GPs are now working 7.2 hours per week less than in 1992. These figures cover both part time and full time GPs. Other research compared workloads in 2004 and 2005, and found that the mean reported hours worked per week by full time GPs had also fallen from 44.5 to 40.8 hours.¹⁹

3.8 Whilst the overall number of consultations with patients has increased the average number of patients seen per week by individual GPs has dropped from 122 in 1992-93 to 88 in 2006-07. Based on these patient figures, the estimated length of a GP consultation appears to have increased from 8.4 minutes to 11.7 minutes (although this does not take into account interruptions between patients or other delays). Similarly, fewer patients are seen per GP in clinics, a fall from 12 to 8 between 1992-93 and 2006-07.

Participation – recruitment and retention has improved

3.9 When the contract was negotiated, surveys carried out by the BMA suggested one of the biggest factors affecting GPs' morale was the long and unsocial hours caused by providing care outside of normal working hours (out of hours care). Long hours alongside lower pay made general practice an unpopular choice for new doctors. The new contract offered all practices the option to opt out of providing out of hours care in return for a financial penalty. The new contract was expected to address these issues. A breakdown of the GP workforce is set out in **Figure 21**.

3.10 The new GMS contract may have contributed to the increase in the number of GPs employed (see **Figure 22 overleaf**). However there are other Government initiatives that may have contributed to the increase in GPs, for example the increase in doctors in training and the increased number of overseas doctors working in England. From 2003 to 2006 there was a 11.8 per cent rise in the number of GPs, to more than 33,091

(headcount) by October 2006. Since March 2003, the number of wholetime equivalent GPs has increased from 26,833 to 30,931. The number of GPs wanting to work in general practice has also increased since 2003 as evidenced by the reduced vacancy rates (vacancies that have taken longer than 3 months to fill) from 3.1 per cent in 2004 to 0.8 per cent in 2007. Recruitment has improved in terms of applicants per available job but the number of partnerships on offer has reduced as practices take on a higher proportion of salaried GPs. Only a small proportion of PCTs report a problem recruiting or retaining GPs, with the remaining problems tended to be in the more deprived areas.

Skill mix has been enhanced

3.11 By changing the PMS and GMS contracts from individual contracts of employment with a PCT to a commissioned contract between a PCT and practice, there was an expectation that GP services could be improved by changing the staffing in general practice. It was hoped that the new contract would see more health professionals, such as nurses, working in general practice to carry out more straightforward treatments which in turn would leave more time for GPs to see the more complex cases.

3.12 The contract has been successful in increasing the number of nurses working in general practice. From 2004 to 2006, the number of nurses working in general practice is estimated to have increased by 7.7 per cent from 13,563 in 2004 to 14,616 in 2006 although numbers have been increasing steadily since 1992. Healthcare assistants are also playing an increasing role in delivering care within general practice.

21 Breakdown of the GP workforce 2005-06

		Male	Female
Types of GP (headcount, unless stated otherwise)			
All GPs (including registrars)	35,302		
All GPs (FTE)	29,248		
GMS and PMS (excluding registrars)	32,738 (92.7%)	19,598 (59.9%)	13,140 (40.1%)
Registrars	2,564 (7.3%)		
Working patterns (of non-registrar GPs)			
Part Time	8,725 (26.7%)	2,273 (11.6%)	6,452 (49.1%)

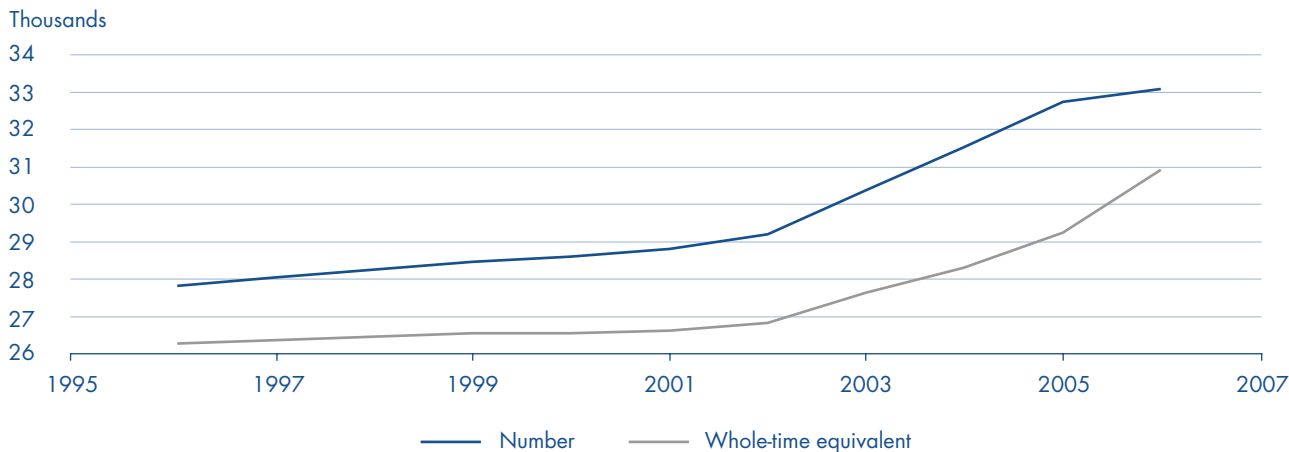
Source: Information Centre

3.13 Based on the national workload survey the proportion of consultations undertaken by practice nurses has increased from 21 per cent to 34 per cent between 1995 and 2006. On average, a practice nurse performs 60 consultations per week, compared to 87 for GP partners (**Figure 23**). The majority of PCTs agree that skill

mix has improved and this appears more pronounced under PMS contracts (65.2 per cent for GMS contracts and 79.5 per cent for PMS contracts) and that there are better opportunities for practice nurses and Healthcare Assistants to develop their roles (68.2 per cent for GMS and 81.2 per cent for PMS).

22 The number of GPs working in the NHS in England (1996 and 2006)

This figure shows that the number of GPs employed in England has increased since 1996 but increased at a greater rate from 2002.

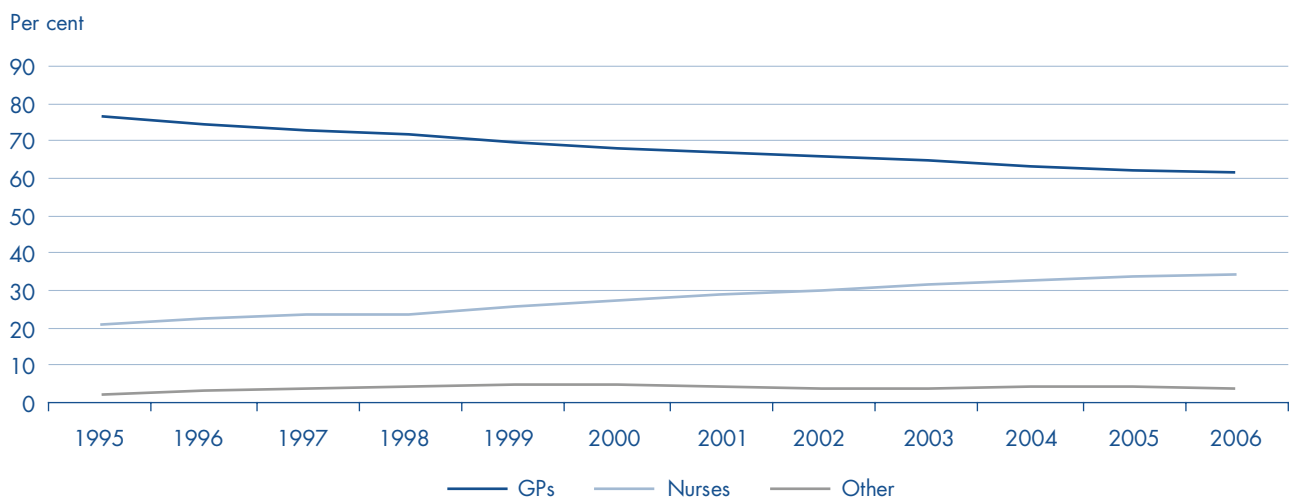


Source: Department of Health

23 GP consultations have decreased yet nurse led consultations have increased but this was happening before the contract was introduced

This figure shows that the proportion of consultations carried out by GPs has decreased whilst the proportion carried out by nurses has increased.

Percentage of consultations undertaken by healthcare professionals, 1995-2006



Source: Department of Health

It is too early to tell if the overall quality of care is improving

3.14 The new QOF element of the contract introduced a system of incentivising GPs based on achievement of quality standards. These quality standards are based on clinical evidence that an output can lead to long term improvements in patient outcomes i.e. better health. Since the introduction of the contract GPs have achieved very high QOF scores and in the first year of operation (2004-05), practices scored an average of 91 per cent of the available points. This rose to 96 per cent in 2005-06. In 2006-07 a number of changes were made to the QOF framework, with some new indicators added and achievement thresholds raised for others. Average practice scores remained high (95.5 per cent). Two thirds of GPs in our survey agreed that the Quality and Outcomes Framework had increased consistency in the quality of care.

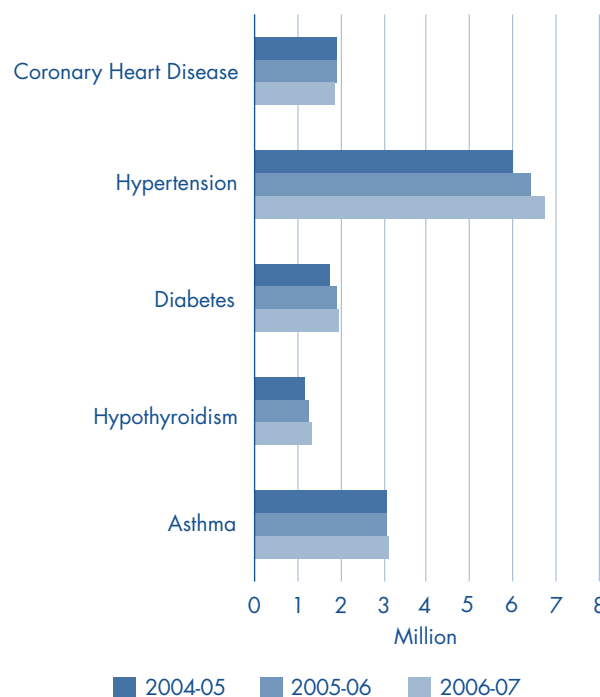
3.15 Various academic studies show that the QOF appears to have driven up quality in general practice in several respects. Since the introduction of QOF, there has been an increase in the diagnosis of a number of diseases (**Figure 24**). While this may be linked to increased prevalence, it more likely suggests that the use of the framework is encouraging practices to be more systematic in investigating and recording new cases. For example, the diagnosis of hypertension has risen from 11.3 per cent to 12.5 per cent between 2004-05 and 2006-07, equivalent to an extra 740,000 cases.

3.16 In the short period of time since the introduction of the contract it is difficult to make clear judgements about the impact of the QOF on health outcomes as many impacts will not be measurable for some years. Many of the QOF indicators are based around processes rather than outcomes although carrying out these processes is likely to lead to health improvements as shown by clinical evidence. There is, however, a lack of baseline data on conditions covered under the QOF. An academic study by University of York found that most points earned were not linked to population health gain, and rather reflected workload.²⁰ Another academic study by Manchester University found that quality improvements had occurred in three disease areas it reviewed, which were Coronary Heart Disease, Asthma and Type II Diabetes. The study found that these improvements had already been underway prior to 2003 but the introduction of the QOF had made a moderate impact on Asthma and Diabetes.

3.17 The QOF increases the consistency in the management of chronic disease across practices and therefore may have had a positive effect in ensuring that patients receive similar care wherever they live. However, it is not clear the extent to which the QOF has succeeded in addressing health inequalities. While the total QOF scores of practices in the most and least deprived areas show little difference, on certain specific indicators, such as those relating to Mental Health, practices in the most deprived areas perform less well than the least deprived areas.²¹

24 Diagnosis of some diseases has increased as a result of the introduction of the QOF

This figure shows that the diagnoses of hypertension, diabetes, hyperthyroidism and asthma have increased since the contract was introduced. The diagnosis of coronary heart disease has decreased.



Source: QOF data, Information Centre 2004-07

The impact of the GP contract on secondary care is mixed but enhanced services have increased the breadth of services delivered by GPs

3.18 The introduction of the new contracts has coincided with an increase in emergency hospital admissions. In 2002-03, there were 4.0 million emergency admissions^p (34.6 per cent of total admissions), rising to 4.2 million in 2003-04 and 4.7 million by 2006-07 (35.5 and 36.2 per cent of total admissions respectively)^q. **Figure 25** highlights this increase in emergency admissions against an already rising trend. The quality of care within primary care and the access to out-of-hours services may affect the number of emergency admissions. However, there are many other factors that can affect these figures such as levels of violence in society, the age of the population, the level of provision of crisis resolution services, and the reduction in waiting in Accident and Emergency.

3.19 The new contracts include levers to move some activity from the acute, hospital sector to GP practices. For example, where appropriate, PCTs are able to commission practices to deliver a clinical service beyond the normal scope of general practice, such as dermatological care; undertake advanced procedures; or develop services. These services are often undertaken by GPs with a Special Interest (GPwSIs) or, more recently, Practitioners^r with a Special Interest (PwSIs), who have to evidence that they

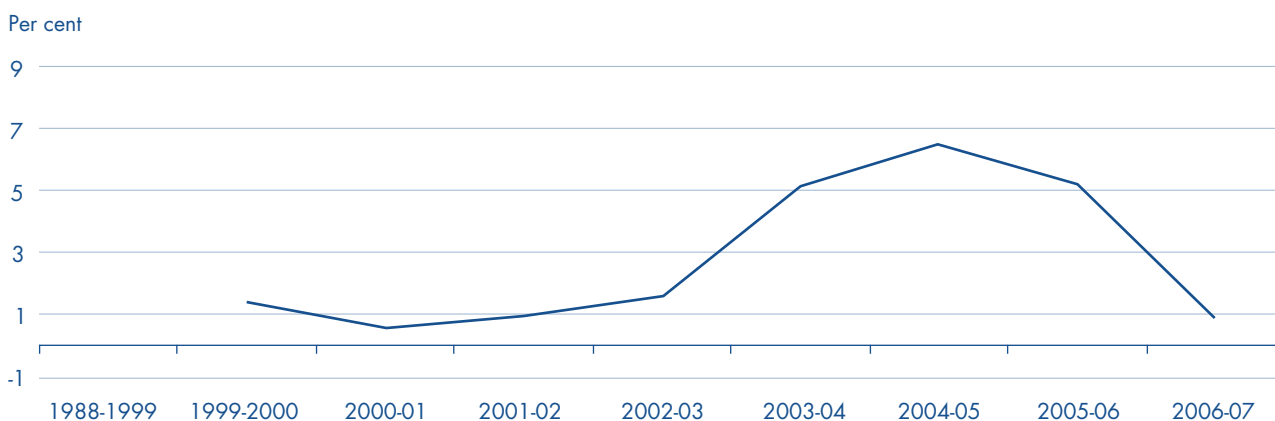
have the necessary competencies for the role^s and receive appropriate accreditation from the PCT, with support of the local acute sector. On average, respondents to our survey had nine GPwSIs and two PwSIs working within their PCT.

3.20 The new contract aimed to improve the breadth of services provided in primary care to be achieved by PCTs commissioning enhanced services. The ability to commission enhanced services can lead to the development of more specialised services that might previously have taken place in a secondary care setting. This flexibility is an important aspect of the new contract and has the potential to improve the local sensitivity of primary health services.

3.21 In our survey of PCTs, 78 per cent believed that the new GMS contract had made it easier for PCTs to develop services tailored to the needs of their own populations, and facilitated the expansion of primary care services. Our survey showed that all PCTs had commissioned enhanced services and the audited figures show a total cost in England of £749 million in 2006-07. Many of these enhanced services are in areas where there are local rather than national problems for example drug and substance misuse (see **Figure 26**). In contrast enhanced services for national issues such as care for people with long-term mental health problems are not commonly commissioned by PCTs.

25 Change in emergency admissions as a percentage increase on previous year

This figure shows that in every year since 1999 emergency admissions have increased but the rate of increase was greater between 2002-03 and 2004-05.



Source: Hospital Episode Statistics

p Emergency admissions: indicated as emergency on the Hospital Episode Statistics (HES) database using codes 21 to 24 or 28).
q Source: Hospital Episode Statistics.
r Non-GP grade primary care workers, e.g. practice nurses.
s Typically, a GPwSI will have an appropriate diploma.

Patient satisfaction and access have not improved significantly

3.22 Patient surveys consistently show that people are generally satisfied with the service they receive from their GP practice. A Department-sponsored survey found that by 2006 overall satisfaction levels with the services from a GP practice had increased by only one percentage point to 74 per cent. The new contract does not appear to have had a big impact on patient satisfaction: in general, patients trust and respect their GPs, regardless of contract arrangements.²² Satisfaction with the out-of-hours service has however decreased.

3.23 Patients are generally satisfied with access to their GP. Access means ability to see a GP at a time which is convenient to them. A Patient Survey carried out by the Department in 2006 shows an improved level of satisfaction with access since 2002. Eighty-six per cent of patients were able to make an appointment within 48 hours, compared to 80 per cent in 2003.²³ The majority of PCTs believe that access has improved under the new GMS contract (NAO Survey, 64.6 per cent).

3.24 Some ethnic minority groups have more difficulty in accessing primary care services. There are significant disparities between ethnic groups in relation to their ability to access primary care, with Bangladeshi and Pakistani patients finding access most problematic. For example, only 70 per cent of Bangladeshi patients reported that they were able to book an appointment within 48 hours (compared to 86 per cent of all patients); and only 67 per cent of Bangladeshi patients were satisfied with telephone access (compared to 86 per cent of all patients).

3.25 In 2005-06 almost 98 per cent of practices were found to have achieved the target to give access to a GP or health professionals within 48 hours or 24 hours respectively.²⁴ However, there has been criticism of the way that PCTs were asked to measure and record this target²⁵. PCTs would phone a GP practice on a set day and ask if there were appointments available within 48 hours without further checks. Subsequent measures, using different methods, have yielded rather lower success rates, suggesting that this was not a robust measure. Achievement is now measured through a patient survey.

3.26 The 24/48 hour access target has created perverse incentives, encouraging practices to focus on providing appointments quickly. Patients who wanted to book some way in advance sometimes found that their practice would not allow them to do so. According to a 2006 survey, one third of patients could not make an appointment more than three days in advance; although this had dropped slightly to 25 per cent by 2007. As part of a Directed Enhanced Service practices must now achieve not only the 48 hour target, but also offer advance appointments, a good standard of telephone access, and the opportunity for patients to see a doctor of their choice.²³

3.27 The Department and some other stakeholders, such as the Confederation of British Industry (CBI) believe that access to GPs services needs to be improved. The CBI have analysed data which they believe shows that businesses lose 28 million working hours, which equates to £1 billion a year, because employees have little choice but to schedule GP visits in working hours.²⁶ The CBI suggests that GPs need to be more flexible about the way that they provide their services. In addition, the interim report by Lord Ara Darzi has found that many patients are concerned about access to GP services.²⁷ He believes that the NHS needs at least 100 more GP practices in under-doctored areas to help reduce health inequalities.

26 Commissioning of Enhanced Services

Local Enhanced Services

In 2006-07:

- 84 per cent of PCTs commissioned enhanced services for drug and substance misusers
- 59 per cent for homeless people
- 52 per cent for people who find it difficult to access GP services
- 50 per cent for asylum seekers
- 26 per cent for people with learning disabilities
- 24 per cent for young people
- 21 per cent for minority ethnic groups
- 19 per cent for people with long term mental health problems

Source: National Audit Office

An entrepreneurial culture has been developed

3.28 The introduction of contracts that allows GPs to decide which services to provide and which to opt out of, other than those deemed as essential, erodes the monopoly that previously existed within primary care. If a local GP is not prepared to provide enhanced services then the PCT is free to commission the services from other providers which in most cases is another GP already working in the locality, but can also include the private sector. This has helped achieve one of the aims of the contract which was to incentivise those GPs that wanted to provide new services and for PCT to be able to commission services based on local need.

3.29 In some areas PCTs are competitively tendering the provision of GP services using the Alternative Provider Medical Services (APMS) contracts. The competitive process allows the PCT to commission services based on local need, for example to increase access in deprived areas. Competitive tendering gives the PCT the opportunity to demonstrate value for money and tightly manage contracts around their own specifications and service standards.

GP satisfaction has not significantly increased as a result of the contract

3.30 GP satisfaction increased in the first two years of the contract but appears not to have been sustainable. A long term GP satisfaction survey found that GPs satisfaction had improved in the first year of the contract (mean overall job satisfaction increased from 4.58 out of 7 in 2004 to 5.17 in 2005). The NAO survey in 2007 and focus groups found that GP satisfaction has not been maintained. In the NAO survey GPs rated their satisfaction around various attributes of their job. Only 31 per cent of GPs in our survey expressed some level of satisfaction with their work and 41 per cent of GPs expressing varying degrees of dissatisfaction with their work. The majority of GPs in the NAO survey believed that the new GMS contract is an improvement on the old contract (60 per cent), but their personal satisfaction with their role was not so strong.

3.31 There could be factors apart from the contract which may have affected morale of GPs. From our focus groups and survey we found the initial optimism about the contract appears to have evaporated, and some groups of GPs, such as salaried GPs, express lower levels of satisfaction. The BMA carried out a large survey of 11,000 GPs which found that the level of job satisfaction of GPs was being affected by fears over the private sector involvement in primary care and a belief that the core values of general practice are being undermined by an emphasis on cost-cutting and quantity of care rather than quality.²⁸

PART FOUR

Making the most out of the new contracts

4.1 As discussed in part three of this report, whilst the new contracts have achieved some of the benefits of implementing the new contracts for general practice some have yet to be fully realised. There are, however, a variety of levers and mechanisms within the new contract which should over time enable the NHS to make more out of the new contracts, but only if they are effectively managed. This section of the report looks at how the NHS can improve the contracting arrangements with GPs, including the use of other contracts, and highlights examples where such improvements are already happening.

Quality and Outcome Framework has not focused enough on health outcomes

4.2 Various interpretations of achievements under the QOF have been published.²⁹ The strong performance on the QOF demonstrates the high standards of care that exist in most practices in England but may suggest that the requirements of the QOF may not have been sufficiently challenging. Indeed the BMA and NHS Employers's review of the QOF in 2006-07 raised the threshold for some clinical indicators to incentivise improved performance.

4.3 In the early years of the contract the Department has focused on the building blocks to good clinical outcomes. Although these contain a high proportion of measures for simple administration and recording for example, in some areas points are awarded for having a policy (for example, on equal opportunities) without any standards set for what the policy should contain or how it is implemented. Subsequent reviews of the QOF in 2006-07 attempted to address some these issues and 138 points have been removed and new measures added to the clinical domain. Eighteen per cent of QOF points remain within the organisational domain.

4.4 A further criticism by some health commentators is that the QOF has concentrated on negotiating clinical activities that are easily measured.²⁹ The QOF framework at present largely rewards outputs that are expected to lead to good outcomes rather than actual outcome measures, for example measuring the percentage of heart disease patients that have received treatment rather than a reduction in patients that have a heart failure.

4.5 One of the potential risks of the QOF is that it may divert a clinicians' attention away from clinical areas that are not measured. Seventy-five per cent of GPs believed that they spend more time on areas which attract QOF points and 67 per cent less time on areas which were less likely to be rewarded under QOF.³⁰ Support groups which have interests in specific diseases have lobbied to have measures in the QOF which would promote improvement of particular conditions.

4.6 While the QOF is largely based around major diseases there is no overall strategy for the QOF. The rationale for conditions can be justified on an individual basis but clinical indicators are not chosen based on prioritised health needs. There is a possibility that in the future the QOF could be based on local needs and locally developed. There are no national barriers to local development as the QOF is voluntary for GP practices and therefore QOF measures do not necessarily need to be nationally negotiated but could be developed by individual PCTs to reflect local health needs. The National Primary Care Research Centre and Development Centre recently made recommendations on the development of the QOF (see Appendix 5).

4.7 The QOF measurement and recording system was always expected to place high trust in GPs. However, suspicion of gaming remains within the profession³¹ as there is a wide range in the numbers of patients that GPs exempt for counting under the QOF (exception reporting).^t PCTs were obliged to visit all practices in the first year of the framework, with visits becoming less frequent in subsequent years for practices where no concerns were apparent. In addition, PCTs must carry out pre-payment verification checks on all practices and carry out a random counter-fraud check on five per cent of practices. We found that PCTs are completing these checks, and in most cases are visiting one third of practices each year and completing a paper review or self-assessment for all practices annually. 77 per cent of PCTs in our survey felt that the audit processes were robust.

4.8 PCTs in our survey were not, however, so sure that the procedures for exception reporting were robust, with only 52 per cent agreeing that they were. Exception reporting is a system which allows practices to exclude patients from the calculation of points where there is a valid reason why the patient cannot be treated (for example, because they refuse to attend an appointment, or are allergic to the relevant medication). Excluding patients in this way can have the effect of increasing scores. In 2005-06, exception reporting rates were relatively low, at 5.5 per cent, but varied considerably between different indicators.

4.9 At present, PCTs must find ways to balance the need for rigorous checks against the desire for a 'light touch' monitoring programme (especially given the high administrative burden that many felt the QOF had imposed). We found that, in general, appropriate checks are taking place but more could be done to carry out risk-based checks by analysing the QOF data. For example, in our survey, 84 per cent of PCTs said that they intended to benchmark exception reporting rates, in addition to existing checks, in order to help them spot any anomalous patterns.

The new contract has not yet fully realised its aim of improving primary care provision in deprived areas.

4.10 The new contract aimed to address the shortfalls in provision of primary care in more deprived areas. It is widely accepted that deprivation is a key determinant of health, and that primary care provision has tended to be lower in more deprived areas. One common measure of this is the number of GPs per head. Several studies have shown that the more deprived PCTs have fewer GPs per capita, on average, than the least deprived.³²

4.11 Recruitment of GPs in deprived areas has improved, although the situation is still worse in deprived compared to more affluent areas.³³ In 2006, three-month vacancy rates had dropped from 3.6 per cent to 1.2 per cent in the 10 per cent most deprived areas, compared with a fall from 1.2 per cent to 0.7 per cent in the least deprived.³⁴ This reflects a general increase in numbers of doctors choosing general practice because of improved conditions and career prospects. GPs in our survey who worked in areas they defined as deprived were, however, considerably less satisfied with their jobs than those that worked in affluent areas. This suggests that recruitment may continue to be difficult in more deprived areas.

4.12 Lord Darzi's interim report found that, in 2006, there was still a close correlation between the PCT areas with the lowest life expectancy, and those with the fewest GPs per head. Lord Darzi states in the report that, 'our current GP system has actually led to a larger inequality in the distribution of GPs across the country over the past two decades'.

4.13 Elements of the new contract have not necessarily supported practices in deprived areas. The development of a new, needs-based funding formula was the key element of the new contract aimed at reducing inequality of provision. However, the introduction of the Minimum Practice Income Guarantee significantly reduced the redistributive impact of the formula by maintaining income at pre-2004 levels.

4.14 In the NAO survey, some PCTs and SHAs commented that the design of the QOF would not encourage practices to try and include the most hard-to-reach patients because no further points are received once a practice has achieved 90 per cent coverage. The final 10 per cent, likely to be the most challenging, has no incentive attached. In our survey, GPs were evenly divided on whether the framework had helped to address health inequalities.

4.15 Opinion among PCTs is divided on whether deprived populations are better served as a result of the new GMS contract: 30 per cent thought they were and 21 per cent thought they were not, but 37 per cent were not yet sure. Only 14 per cent thought that there was a fairer distribution of GPs between deprived and affluent areas, with more than a third disagreeing with this statement. GPs also expressed a range of opinions in our survey, but 40 per cent believed that aspects of the contract had not helped tackle inequalities.

^t GPs are able to exclude some patients from QoF measurements for example when a patient has a side-effect to a medication or does not attend a review.

Improving Access to GP Services

4.16 Efforts to incentivise improved access through the new contract have had mixed success. Improving access to GP services was a key aim of the new contract. Despite this aim, the core GMS contract lacks specific incentives to improve patient access and indeed the notion of Saturday surgeries for emergency appointments was scrapped. The Department did, however, introduce a Directed Enhanced Service for access which rewarded GPs for meeting the '24/48 hour' access target.

4.17 The Department has acknowledged the need to extend accessibility of GP services, and following the publication of Lord Darzi's interim report, the Department has announced its intention to provide £250 million to fund 113 new GP practices in the areas with poorest provision. This money will also pay for a new GP led walk-in health centre in each PCT in the country. In addition there is an aim to ensure that half of surgeries are open at weekends or after work, and SHAs are currently working with their PCTs on how this might be delivered.

4.18 The new contract does, however, allow PCTs to commission services to address problems with access to general practice. In terms of providing more convenient access to a GP, the new contract has reduced the times that a patient can make an appointment with a GP, as Saturday surgeries do not form part of a standard contract. This issue could be addressed by negotiating locally enhanced services with a practice to help provide some flexible surgeries for example in the evening or on Saturday morning. Effective rostering of GPs and their staff by a GP practice could ensure that extended hours do not mean longer working hours for individual staff (see Case Study 1).

4.19 In terms of improving the amount of general practice available in an area, PCTs can use APMS contracting routes to be able to attract new general practice into an under-doctored area through the procurement route. There are several examples which exist where APMS has been used to improve the provision of GP practice. To date, limited use has been made of this facility: only 39 'alternative provider' contracts have been let, and almost 80 per cent of PCT have not used them at all (see Case Study 2).³⁵

CASE STUDY 1

Extending Access

Based on patient's views, a PMS practice in Kingston decided to extend the hours available for appointments. By the beginning of 2007 the GP practice believed that the ability of the practice to offer access was about to fail and patients were blocking the phone systems due to limited hours of availability. The practice determined that in order to manage the requirements for access they needed to extend hours of availability.

The practice now offers services to patients from 8am to 8pm weekdays, when the full complement of services within the medical centre is available for patients. Saturday services run between 9am to 12.30pm and they offer a two-doctor, one-nurse, booked and open access service. The PCT did not provide additional funding for this change.

The implications of this are that the doctors, nurses and healthcare assistants are now working shifts during the day. The practice has also employed an extra part-time PMS doctor to handle late evenings as this was a portion of the day that was proving difficult to cover.

The practice believes it now works far more smoothly. Patients know they can be seen on the same day at any time between 8am and 8pm. The telephone systems are now operating more effectively. Doctors report that there is a difference in the way consultations are being conducted. The lack of pressure associated with a more managed reception and a less crowded environment is feeding through to better and more productive consultations. Patient satisfaction has also improved.

Source: Kingston PCT

4.20 Some patients have difficulty registering with a GP and the new contract has not improved the access to register with a GP. Two per cent of practices report having "closed lists" meaning that they are not registering new patients and up to 10 per cent are operating 'open but full' lists meaning that they are not registering new patients while avoiding the consequences of a "closed list". However, practices may have good reasons to declare its list closed or full, e.g. they may have temporary capacity problems or have reached maximum patient capacity. These issues can be addressed by:

- Providing incentives to open lists through removal of Minimum Practice Income Guarantee which would place more emphasis on income based on list size
- Providing incentives to practices for taking on larger list sizes without comprising access

Improving Performance Management of the Contracts

4.21 Whilst monitoring and auditing of the QOF element is relatively consistent, PCTs report that monitoring of the essential services element of the new contract is more difficult. This was demonstrated within our survey of PCTs which showed broad variations in the way that PCTs manage the performance of the new contracts. Our survey found that whilst 80 per cent of PCTs monitored the performance and services offered by the global sum, 52 per cent of PCTs said that they had not developed any systems for monitoring performance consistently. Our visits highlighted broad variations in the way that PCTs manage the essential services part of the GP contracts. As the payment under the Global Sum for essential services represents the largest part of the contracts and services delivered to patients it is important that standards are monitored and there are mechanisms in place to do this systematically.

CASE STUDY 2

Use of APMS

Barking and Dagenham PCT is using support from APMS contracts to help it create the new capacity it will need to meet the demands of its growing population.

The Thames Gateway development is expected to swell the PCT's population by 40-50,000 over the next 11 years, while over the same period, the area's GP numbers are expected to fall due to retirement.

To pre-empt this, the PCT wants to open a new primary care centre close to Dagenham's main shopping centre. This is a new building, funded through the NHS LIFT project, and houses a GP practice and walk-in service.

Around 7,000 patients will eventually register with the new practice while the walk-in service is expected to have around 36,500 attendances a year. It will provide nurse-led care and advise with GP support to anyone who needs it – including those registered elsewhere - from early in the morning until 10pm, Monday to Friday, and 9am to 6pm at weekends and public holidays.

As well as improving access to primary care, the new centre is also expected to improve access to urgent care through its provision for minor injury and illness. This is particularly important as there are no accident and emergency departments within the boundaries of the PCT.

Source: Barking and Dagenham PCT

4.22 The PCTs that have developed performance management systems are more easily able to demonstrate consistency in the services that are being provided and be able to tackle poor performance where it arises (see Case Study 3). In our survey 37 PCTs had used remedial notices to compel improvement in at least one practice's performance although very few contracts are terminated. However few contracts are terminated by PCTs, in total only 18 contracts were terminated in 2006-07 (NAO Survey). Without adequate performance management it is difficult for the PCT to demonstrate that it is receiving value for money from the essential services it has commissioned. By tackling poor performance PCTs are more easily able to hone their services to meet local need and commission more effectively.

CASE STUDY 3

Tower Hamlets – Use of Performance Management in Managing Essential Services

Tower Hamlets PCT has developed a balanced scorecard, for assessing the performance of all Practices in delivering the essential services. It uses a systematic approach to assess each practice based on defined criteria in the balanced scorecard and categorises them on the basis of performance. The PCT aims to raise the standard of all practices and has an agreed range of interventions to support improvement.

The assessment is carried out by the PCT who collect a variety of information about practices and collates this into an initial assessment. The PCT then visits the practice to validate and then complete the assessment. The PCT aims to ensure that the completion of the balanced scorecard assessment is not onerous, and that it is achieved relatively quickly, with little Practice effort required.

The PCT then reports back to the Practice and, where applicable, agree a series of improvement milestones with Practices that are struggling, especially focussing on areas that are scored in the lowest level of achievement, i.e. below acceptable minimum standards of practice. The PCT will make a full range of supportive interventions available in such cases.

In cases where the PCT's facilitative approach results in either lack of cooperation for improvement or lack of progress, then the PCT will use its commissioning powers to require improvement. This will include use of remedial notices, and eventually, removal of the contract where there is clear documented evidence of lack of improvement to basic standards. It should be noted however, that the PCT's overall aim is the improvement of existing contracts in order to ensure that contractual remedy is used as a last resort i.e. only when development support has been documented not to achieve improvement.

Source: Tower Hamlets PCT

Improving commissioning of enhanced services

4.23 There have been some clear successes in providing improved care for patients through enhanced services, but so far their potential benefits have not been fully realised. There is a wide variation in spending on enhanced services by PCTs and many PCTs have failed to spend money on locally enhanced services to the level the Department expected. One of the main areas where PCTs have not fully spent the money allocated to them by the Department is on locally enhanced services.

4.24 The Department put in place a minimum level of expenditure that they expected PCTs to spend during the first three years of the contract, the “enhanced services floor”. In each of the first three years PCTs have not spent to the enhanced services floor. Fifty per cent of PCTs failed to spend to their minimum allocation in 2004-05, 47 per cent in 2005-06, and 71 per cent in 2006-07.

4.25 Taking into account PCTs which had spent more than the enhanced services floor, nationally there was an under-spend in enhanced services worth £13 million in 2004-05 and £21 million in 2005-06. The failure to spend to the enhanced services floor may have been caused by over-spending on other areas of the contract such as the QOF. In 2006-07 spending had decreased on enhanced services to such an extent that there was an under-spend of £142 million against the enhanced services floor.

4.26 PCTs told us that they felt that some of the Directed Enhanced Services had not worked well. Rather than address the need for locally flexible services, Directed Enhanced Services provide a way for the Department to ensure coverage of certain key activities. In practice this has meant both vital services such as child immunisation, and new initiatives such as improving access to GPs where an incentive is required to ensure participation.

4.27 PCTs said that the Directed Enhanced Services were too rigid, did not allow for local flexibility and in some cases were poorly designed. For example one PCT said that they had already negotiated a Local Enhanced Service on Access when a new Directed Enhanced Service was introduced. They were forced to abandon the local version in favour of the Directed, even though they had negotiated a stricter agreement on more favourable financial terms. As the contract develops PCT should be encouraged to spend more money locally.

4.28 Many PCTs lack good quality information on local health needs to be able to maximise the benefits of the contract. As a result, many PCTs and Strategic Health Authorities told us that there was an insufficiently strategic approach to commissioning. In some cases, PCTs tended to follow patterns of historical provision rather than try and reconfigure services in more efficient ways.³⁶ This can be illustrated by the similarity of the enhanced services provided by PCTs nationally. The lack of variance suggests that PCTs are not fully adapting their commissioning of services to meet local needs. PCTs could improve the quality of the information they collect on local patient needs to enable them to negotiate locally enhanced services more effectively based on the needs of their community.

4.29 Improving the commissioning of GP services is essential to make sure that the most is made from the new contracts. PCTs need to ensure that they have sufficient numbers of staff with experience of commissioning services and budgets for GP services are based on local need. GPs are also starting to commission service under Practice Based Commissioning and will also need to ensure they have the information and skills to commission effectively. The Department has acknowledged that commissioning across the NHS could be improved and has developed its World Class Commissioning Programme in response.

4.30 The World Class Commissioning project provides an assurance framework that SHAs will be able to use to assess PCT commissioning and to drive improvement in commissioning. The assurance framework will ensure that strategic plans produced by PCTs have a direct link to local needs. Some good practice guidance also exists to help PCTs improve the commissioning of specific enhanced services. The NHS Primary Care Contracting Team have developed some Primary Care Service Frameworks to support PCTs in commissioning new Local Enhanced Services for example in Sexual Health. The Department of Health are also promoting improved commissioning through its World Class Commissioning project.

Relationships between GPs and the PCT are changing

4.31 Since 2004, partly as a result of the changing staffing and partly as a result of the increased emphasis on demonstrating value for money of the contracts, there has been a changing relationship between PCTs and GP practices. In the past, the PCTs' role was more supportive of the individual GP and local GP practices. The move towards commissioning services with defined quality measures has required PCTs to be more involved in managing the performance of a practice under its contracted terms. As a result the relationship between GPs and PCTs is changing, and both sides report that "goodwill" is reducing. Some GPs feel that PCTs are becoming less supportive and some PCTs feel that GPs are less willing to provide services without financial incentives.

Practice staff under the new contract

4.32 The new GMS contract aimed to extend the use of other staff in the GP practice, but does not stipulate how they should be employed. This has resulted in variation in how practice staff are employed and treated. Practice nurses carry out a significant proportion of the QOF work and locally enhanced services. In the focus groups carried out with approximately 100 practice nurses in London the NAO found nurses' morale is being affected by the new contract.

4.33 Nurses believed that they had an increased workload which has helped increase GPs income without getting any personal reward. The NHS Working in Partnership Programme recently highlighted that GPs fail to reward nurses for their work on the QOF. Some of the practice nurses reported that they were working without contracts and only a minority were on NHS 'Agenda for Change' contracts. The Department has carried out some work to develop guidelines on Agenda for Staff for practice staff but the use of these contracts is discretionary for GP practices. There was also wide variability reported in the investment that had been made in training practice staff.

Out of Hours

4.34 The Department established national Quality Requirements for out-of-hours providers in January 2005. However, a Committee of Public Accounts report in 2007 found that "actual performance against the Quality Requirements was poor, and reporting against the targets incomplete. For example, a third of Primary Care Trusts were unable to say what their performance had been against the target to start a definitive clinical assessment within 20 minutes following an urgent phone call, and fewer than 10 per cent of Primary Care Trusts were able to say that they had fully met the target".³⁷ Whilst low in number, there has since been an increase in serious complaints about out-of-hours care. In 2006, 182 serious complaints were dealt with by the Medical Defence Union, compared to 120 in 2002.

APPENDIX ONE

Chronology of Events

Date	Event
1911	The National Insurance Act provides partial state-funded primary care; practices are paid through a 'pool' payment, with the total money available for the pool determined by Whitehall.
1948	NHS provides universal state-funded primary care; practices still paid through the pool, based on patient headcount.
1951	The pool payments are rebased upon payments per doctor rather than per patient.
1965	Morale amongst GPs reaches such a low that the majority of GPs (~18,000) hand in their undated resignations. The Doctors' Charter is drawn up by the profession as a list of demands arising from poor morale (reflected in poor recruitment and retention). It proposed better remuneration for out-of-hours work, funding for improvements to general practice premises, a reduction in the maximum size of the patient list and other beneficial reforms to pay and workload.
1966	A new contract – the "New Deal" – is negotiated between the BMA and the DHSS. The 'pool' system remained, despite calls for payment based on items of service. The 1966 Pay Review body recommended an increase of 33 per cent but much of this was lost due to economic crisis. Practices started to be reimbursed automatically for their expenses. The contract is based on a trust of the profession by Government, with quality control left to doctors themselves, and the nature of primary care remaining vague in the 1966 contract. A guarantee of minimum practice income is introduced.
1990	A new contract is introduced which builds specific direction about primary care services into practice contracts and which many doctors see as degrading their professional autonomy. The 'Statement of Fees and Allowances' (red book) becomes the basis of GP's remuneration. Jane Lewis argues ³⁸ that this contract represented the end of the 'gentlemen's agreement' between GPs and the Department, and the beginning of the current Government approach of using financial incentives and specific contractual clauses to achieve quality primary care, based on a view of GPs as 'self-interested individuals who would respond rationally to economic incentives'. Target incentives are provided, e.g. for childhood immunisation and population-wide preventative measures.
1 January 1996	DH publishes "Choice and opportunity – primary care: the future" in the last days of the Major government, establishing a policy context for PMS contracts.
1 April 1998	Statutory Instrument 1998/665 provides a legal basis for GPs operating under Personal Medical Services (PMS) contracts.
1 July 2000	The NHS Plan is published, setting out the Government's stall. The NHS pay system needs modernising in order to reflect the actual output of staff rather than their job titles, and the Government is prepared to 'invest in pay' (p52). It commits to improving retention and recruitment by modernising pay and improving conditions (principally through the Improving Working Lives initiative, which amongst other things commits the NHS to promoting flexible working conditions). 2,000 more GPs are promised by 2004 (p74) and the Plan recognises that the Red Book pay system is too focused on patient numbers and quantity of services, and should be replaced by a quality-based framework. The PMS is upheld as an example to follow, and a major expansion is to be encouraged. Bringing PMS and nGMS under the same contractual framework will be 'the most significant change to the way GPs work for the NHS since 1948' (p76).
9 February 2001	Dr. John Chrisholm (then chair of BMA) expresses anger over the below inflation Apr 2001 pay award for GPs.

Date <i>continued</i>	Event <i>continued</i>
May 2001	BMA ballots GPs on whether they would, in principle, be prepared to accept a new contract. 86 per cent of respondents vote yes.
6 July 2001	Then Secretary of State, Alan Milburn announces that the GP contract negotiations will take place with the NHS, not the Department.
August 2001	Negotiations between the BMA and NHS Confederation begin on the terms for a new contract.
1 June 2002	A paper evaluating the PMS pilots are published.
26 February 2003	nGMS contract 'offer' published – letter from Mike Farrar (NHS Confederation) to John Chrisholm (BMA).
20 March 2003	Ballot papers sent to all UK GPs asking if the nGMS contract is acceptable.
11 April 2003	nGMS ballot closes.
17 April 2003	Joint letter from BMA and NHS Confederation to GPs announcing Minimum Practice Income Guarantee.
30 May 2003	BMA issues guidance to GPs on Minimum Practice Income Guarantee.
5 June 2003	DH issues guidance on implications of nGMS contract for PMS practices.
20 June 2003	British Medical Association votes to accept nGMS contract.
23 December 2003	nGMS guidelines published (main guidance; annex B; annex C).
25 February 2004	Amendments to annex C of nGMS guidance published, ironing out some bugs in the indicative contractor budget spreadsheet, which was designed to help GPs judge how much they would receive under QOF etc.
1 March 2004	Statutory Instrument 2004/291 comes into force, enabling the nGMS contract.
1 April 2004	Initial nGMS contract comes into force, along with revised PMS contracts.
14 October 2004	<i>National Quality Requirements in the Delivery of Out of Hours Services</i> published (subsequently superseded).
15 November 2004	Statutory Instrument 2004/2694 comes into force, giving legal status to the new DoH quality requirements (above).
14 April 2005	Statutory Instrument 2005/893 comes into force, making a few small amendments to the main SI, including banning the use of national and premium-rate numbers and providing for the introduction of electronic prescription.
1 July 2005	Information Centre publish statistics on GPs' 2002-03 GP Earnings and Expenses.
12 October 2005	NHS Confederation issues guidance on establishing the accuracy of QOF data.
29 November 2005	Information Centre publish statistics on GPs' 2003-04 GP Earnings and Expenses with supporting material.
20 December 2005	Barbara Hakin, lead negotiator for NHS Employers on the GMS contract, sends guidance on the financial implications of the 2006-07 contract changes to PCT and SHA chief executives.
14 March 2006	Guidance on 2006-07 PMS contracts issued to PCTs.
1 April 2006	Revised nGMS and PMS contracts for 2006-07 become effective.
4 April 2006	Directions issued from DH to PCTs requiring them to review the financial provisions of PMS contracts for 2006-07.
20 July 2006	<i>National Quality Requirements in the Delivery of Out of Hours Services</i> updated to reflect NAO recommendations. Statutory basis remains SI 2004/291 as amended by SI 2004/2694.
29 November 2006	Information Centre publish statistics on GPs' 2004-05 GP Earnings and Expenses.
19 January 2007	SoS Hewitt says 'I think if we anticipated this business of GPs taking a higher share of income in profits we would have wanted to do something to try to ensure that the ratio of profits to the total income stayed the same'. Widely reported as a desire to 'cap' GP earnings.
1 February 2007	BBC Radio 4 broadcasts an edition of 'The Investigation' in which Dr. Simon Fradd, a member of the negotiating team for the 2004 contract, reveals that the BMA was stunned to be offered such a generous package.
1 April 2007	Revised nGMS and PMS contracts for 2007-08 become effective.
31 May 2007	Results from Department's GP survey due to become available (guidelines, including timetable).
July 2007	Information Centre will receive results of their GP workload study.

APPENDIX TWO

Methodology

We designed this study to examine whether the new contracting regime for General Practitioners in England had delivered the benefits expected by the Department of Health. Our study methodology involved the collection and analysis of primary data on the experiences of GPs in working under the new contract; the experiences of Primary Care Trusts and Strategic Health Authorities in implementing and managing the new contracts; and the views of stakeholders and experts on the impact of the new contract. We carried out secondary analysis of a range of data including that relating to pay, workload, patient experience and costs. We also reviewed relevant literature. Details of the main aspects of our methodology are set out below.

Survey of GPs

We commissioned doctors.net to carry out a survey of 1,800 GPs in England. This took place in July 2007. Participants were asked to complete an online questionnaire which explored their views on:

- Their overall job satisfaction, and satisfaction with key elements of working life such as pay, level of responsibility, and workload
- The impact of the new contract on patient care
- The impact of the Quality and Outcomes Framework on workload, working practices and quality of care

Respondents were broadly representative of all GPs in England in terms of geographical spread, contract type (PMS or GMS), GP status (e.g. partner, registrar) and gender.

Survey of PCTs

We carried out a survey of Primary Care Trusts in England. An electronic survey was sent to all 152 PCTs in July 2007, of whom 134 submitted a response. As well as exploring PCTs' views on the impact of the new contract on areas such as recruitment and patient care, the survey gathered quantitative data on a range of topics including funding allocations and expenditure, contract types and enhanced services commissioning. This enabled us to analyse the patterns of expenditure and care across England, as well as providing an overall picture of the impact of the new contract. The financial results from the survey have not been subject to audit and therefore some of the information may be subject to variation due to the different interpretation of the survey guidance, by individual organisations.

Interviews – Primary Care Trusts and Strategic Health Authorities

We visited thirteen Primary Care Trusts and five Strategic Health Authorities to carry out in-depth interviews. These interviews enabled us to explore in more detail some of the issues tackled in the survey, and also to hear about the particular experiences of implementing the contract on the ground. The trusts and authorities that we visited reflected a range of circumstances, including rural, urban, more and less deprived areas across England.

Surveys of Patients

We analysed data from the Department of Health's and Picker Institute's surveys of patient satisfaction.

Visits – GP surgeries

We visited four GP surgeries to meet GPs and other practice staff and discuss the practical implications of implementing the new contracts. These visits enabled us to see how management systems work in practice and to hear examples of the benefits and problems involved in implementing the new contract. We used this information in conjunction with the nationally representative data collected through the GP survey.

GP focus groups

We carried out two focus groups with GPs and practice managers, one in Kingston, south west London, and one in Grimsby. A total of 13 participants were involved in these groups. The focus groups provided an opportunity for structured discussion on workload, impact on patient care, enhanced services, the Quality and Outcomes Framework, and relationships with Primary Care Trusts. We used this information in conjunction with data gathered through the GP survey, as a means of providing specific examples to illustrate the representative data collected in the survey.

Practice nurse workshop

We ran a workshop with approximately 100 practice nurses as part of the 2007 Practice Nurse Conference. The workshop involved discussion about the impact of the new contracts on nurses' workload and patient care. It provided a useful insight into the role of non-GP staff in implementing the new contracts.

Stakeholder interviews and expert panel

We interviewed a range of key stakeholders to discuss their role in the negotiation and implementation of the new contract (where appropriate), their views on its impact and costs and benefits. We also held an expert panel meeting during the planning stage of the study, where we were able to draw on the specialist knowledge of a range of academic experts and practitioners to inform our approach. We are grateful to all those who contributed.

Those who participated in the interviews and expert panel:

- Dr Laurence Buckman, British Medical Association General Practitioners' Committee
- Maggie Marum and Eric McCullough, National Association of Primary Care
- Michael Dixon, NHS Alliance
- Philip Grant and Chris Dowse, NHS Employers
- Professors Martin Roland and Hugh Gravelle, the National Primary Care Research and Development Centre, Universities of Manchester and York
- Dr Mark Ashworth, GP and Honorary Senior Lecturer, Department of General Practice and Primary Care, King's College London
- Mike Farrar, Chief Executive of NHS North West and formerly Chief Negotiator, NHS Confederation
- Jan Aps, Audit Commission
- Professor Julia Hippisley-Cox, QResearch – University of Nottingham
- Richard Armstrong, Elizabeth Scott, Andrew Clapperton, David Stevens, Department of Health
- Mark Wilson, NHS Primary Care Contracting
- Sarah Furniss, NHS Warwickshire
- Julia Griffith, Bath and North East Somerset Primary Care Trust

Literature review and data analysis

We carried out a detailed review of existing literature, research and data on general practice, primary care management and the new contract. In particular we collated data on the overall cost of the new contract; GP pay and workload; recruitment and retention; QOF performance and impact on quality of care; patient satisfaction and access.

APPENDIX THREE

Comparison of the implementation within the Home Countries

The differences in terms of the contracts in England, Wales and Scotland

The new GMS contract was negotiated between the British Medical Association (BMA) and the NHS Confederation on behalf of the four UK health departments. The legislation supporting the contract came into effect on 1 April 2004.

The GMS contract is UK-wide and, as such, there are actually very few differences between the contract in England, Wales and Scotland. There are however a few noteworthy differences.

Scotland has retained its own global sum allocation formula, the Scottish Allocation Formula (SAF), which is different from the rest of the UK. The requirement for the SAF is that it better reflects the pattern of need and the additional cost of providing primary health care services in the remote regions of Scotland. Northern Ireland also has its own slightly revised GMS Global Sum formula.

Furthermore, in Scotland, funding for dispensing services is outside the funding for primary medical services. In England this is included within the primary medical services funding envelope.

As part of the revisions to the GMS contract in 2006-07 there was further movement towards country-specific contracts in terms of the different Direct Enhanced Services (DESs) which were introduced in each of the four countries. Each country agreed to implement different DESs to meet their own specific priorities. However, the other parts of the contract remained UK-wide.

It is also worth noting that there are numerous implementation differences (e.g. premises and appeal arrangements) that exist between the countries but the fundamental principles of the contract are no different.

Differences in net income between countries

Home Country Region	Net Income £		
	2003-04	2004-05	2005-06
England	85,000	104,000	114,000
Wales	74,000	92,000	102,000
Scotland	66,000	83,000	91,000
N Ireland	68,000	91,000	99,000

Source: NHS information centre – annual survey of GP earnings and expenses (rounded to the nearest £1,000)

Summary of review of the implementation of the new GMS contract in Wales

The new GMS contract for GPs in Wales became available on 1 April 2004. The report examining the implementation of this contract was published by the Wales Audit Office in August 2007.

Although the contract is working well in most parts of Wales, and despite the benefits to GPs already identified, there are some problems arising from the contract itself and contract governance has not always been robust. Systems used to oversee the delivery of services and the more general assessment of practice performance vary in thoroughness and effectiveness. This could undermine the progress made on quality and the expected benefits to health may not be realised.

In Wales the Gross Investment Guarantee (GIG) was agreed at 38 per cent above expenditure under the contract's 'Red Book' system. In the first year QOF costs rose more quickly than forecast, revised budgets were agreed with Ministers, and funding identified for future years. Most of the extra cost is due to practices scoring on QOF at a much higher rate than anticipated. These higher costs were met in the short term by re-assigning savings from drugs budgets, and in the long term by revised allocations from the Assembly Government. However, these cost pressures meant that generally money was less available to spend on other potential developments in primary and community services.

In 2002-2003, the year before the new contract was introduced, £293 million was spent under the old 'Red Book' GMS system. Negotiators agreed to increase spending on GMS by at least 33 per cent in Wales by 2005-2006. A revised figure of 38 per cent or £405 million was agreed by Ministers, but £17 million more than GIG was spent in 2005-2006. This represents a 44 per cent increase since 2002-2003 on primary care spending. The largest contributor to the additional cost is GPs higher than anticipated performance on QOF.

APPENDIX FOUR

Letter to the NHS by Mike Farrar setting out the benefits of the new contract

Press release: NHS Confederation sets key tests for success of GMS contract for PCTs and GP practices

09 Feb 2004

The chair of the NHS Confederation's negotiating team for the GMS contract, Mike Farrar, today has written to PCT Chief Executives in England setting key tests to judge the success of the GMS contract for both PCTs and GP Practices.

The letter had been sent on the back of the final financial allocations received by PCTs. The tests have also been designed to ensure that the GMS contract delivers real benefits to NHS patients, practices and PCTs by fundamentally rethinking how services are developed.

The tests for the GMS contract ask PCTs:

- Are you replacing the out-of-hours service or **reforming the emergency care system**?
- Are you supporting the effective use of the quality frameworks to **manage chronic disease**?
- Are you using the enhanced services and the floor to **reconfigure services** or are you treating them as a cross to bear?
- Are you using patient feedback and the flexibility in the new contract to **advance patient choice** and to improve the patient experience?

- Are you using the practice-based contracts and new roles of the PCT to develop opportunities around **skill mix**?
- Are you using the contract as a lever for **recruitment and retention** and for improving morale?
- Are you using the flexibilities in PMS and PCTMS to tackle **specific local issues**?
- Are you developing the **entrepreneurial culture** in primary care?
- Are you using contracts as a lever for **modernising services** or as a payment mechanism for GPs?

Mike Farrar, Chair of the NHS Confederation negotiating team, said: 'Achieving the above will deliver a renaissance in primary care, a key objective at the heart of the new GMS contract negotiations'.

Mike Farrar also said that the success of the contract will be based on close working relationships: 'The NHS Confederation fully supports the deal as negotiated with the BMA and set out in the contract documentation. We believe that the new contract can only be successful if it is supported by open discussions between PCTs and practices and to this end believe that good relations should be fostered between commissioners and contractors.'

APPENDIX FIVE

Recommendations for Improving the Quality and Outcome Framework made by the National Primary Care Research and Development Centre

- New indicators could be swapped in and out on a three to four year cycle
- Progressive targets could be reviewed when most practices are meeting the target
- Pilots for any new indicators included in revisions
- No increase in overall QOF-dependent income
- Payment formula needs to be changed to encourage rather than discourage case-finding in areas of high morbidity
- Exception reporting should be retained but monitored carefully by PCTs. If exception reporting is allowed the upper target should be 100 per cent
- Rethink needed for organisational domain in the QOF, focusing on aspects that are most likely to improve individual patient care
- A single national patient questionnaire, administered by post to patients that have recently consulted GP
- PCTs should be given the opportunity to use some local QOF variants with indicators drawn from piloted national sets.

Source: National Primary Care Research and Development Centre

GLOSSARY

24/48 hour target		The target simply means that all patients should be seen by a GP within two working days or a primary care professional within one working day if they wish to do so.
Access		The legal right every patient has to obtain health information about themselves.
Accident and Emergency	A&E	Hospital departments that assess and treat people with serious injuries and those in need of emergency treatment.
Alternative Primary Medical Services contract	APMS	Contractual route through which PCTs can contract with a wide range of providers to deliver primary medical services that are tailored to local needs. It is one of four contracting routes, which collectively provide a strategic framework for PCTs to plan, commission and develop high quality primary medical services.
British Medical Association	BMA	Professional association that represents UK doctors and acts as an independent trade union, scientific and educational body, and publisher.
Carr-Hill formula		Formula used to derive practices' baseline income.
Commissioning		The processes local authorities and primary care trusts (PCTs) undertake to make sure that services funded by them meet the needs of the patient.
Directed Enhanced Services	DES	Directed Enhanced Services (DES) must be provided by the PCT for its population, eg. the childhood immunisations programme. See <i>Enhanced Services</i> .
Emergency Admissions		When a patient goes into hospital at short notice, also known as urgent admission and unplanned care.
Enhanced Services		Enhanced services are services not provided through essential or additional services, or essential and additional services delivered to a higher specified standard. They were negotiated into the GMS contract as a key tool to help PCTs reduce demand on secondary care. Their main purposes are to expand the range of local services to meet local need, improve convenience and choice, and ensure value for money.

Enhanced Services Floor		The minimum level of resources that PCTs are expected to spend on primary care service providers, in particular GMS practices and existing and future PMS practices.
Essential Services		Under the new contract the core funding for GP practices is allocated through the <i>global sum</i> to provide the essential services expected from general practice. Essential services are broadly defined as for 'treating those who are sick or believe themselves to be sick' but interpretation is broad and varies nationally. Allocations for a practice are determined through the <i>Carr-Hill formula</i> which aimed to link funding to patient needs.
General Medical Services contract	GMS	Contract that is the mechanism for providing funding to individual GP practices. It has two elements of funding – a basic payment for every practice, and further payments for specified quality measures and outcomes.
General Practitioner with a Special Interest	GPwSI	GPs that supplement their generalist role by delivering a clinical service beyond the normal scope of general practice. See also Practitioners with Special Interests (PwSI).
Gross Investment Guarantee	GIG	The level of investment in GPs promised by Government in negotiating the contract.
Local Enhanced Services	LES	Locally developed services designed to meet local health needs. See <i>Enhanced Services</i> .
Minimum Practice Income Guarantee	MPIG	The guarantee made by the government to protect historical income of GPs in the first years of the new GMS contract.
National Enhanced Services	NES	Services commissioned to meet local need to national specifications and benchmark pricing. Other examples of NES are enhanced care of the homeless, more specialised services for multiple sclerosis and specialised care of patients with depression. See <i>Enhanced Services</i> .
New General Medical Services contract	nGMS	The new General Medical Service contract was designed to improve the way that Primary Care services were funded, and to allow practices greater flexibility to determine the range of services they wish to provide, including through opting out of additional services and out-of-hours care.
NHS Confederation		The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS.
NHS Employers		NHS Employers represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work.
NHS Plan (2000)		A government plan for the NHS that set out a 10 year programme of investment and reform.
Out of Hours	OoH	GPs can choose not to provide 24-hour care for their patients. The Out of Hours period is 6.30pm to 8am on weekdays and all weekends and bank holidays. During this time, PCTs are responsible for providing GP services for local people.

Practice Based Commissioning	PBC	PBC engages practices and other primary care professionals in the commissioning of services.
Practitioner with a Special Interest	PwSI	A PwSI specialises in a particular type of care in addition to their normal role.
PCO Administered funds		PCO-administered funds can support a number of different entitlements, including seniority payments, the retainer, returner, golden hello and flexible career schemes and locum allowances; and are mainly allocated on the basis of historic baselines.
Primary Care		The collective term for all services which are people's first point of contact with the NHS, eg GPs, dentists.
Primary Care Contracting Team		Formed by the Department of Health to assist the development of new local contracting arrangements in primary care.
Primary Care Support Scheme		Support provided by <i>Primary Care Contracting Team</i> offered to PCTs for <i>commissioning</i> their <i>enhanced services</i> .
Primary Care Trust	PCT	NHS bodies with responsibility for delivering health care services and health improvements to their local areas.
Primary Care Trust Medical Services contract	PCTMS	PCTs are able to provide services themselves by directly employing staff, under the PCTMS route. The PCT may wish to employ full time staff to provide a full range of services, or employ staff on a sessional or part time basis.
Primary Medical Services contract	PMS	The PMS contract was introduced in 1998 as a local alternative to the national GMS contract. PMS contracts are voluntary, locally negotiated contracts between PCTs and the PMS Provider, enabling, for example, flexible provision of services in accordance with specific local circumstances.
Quality Outcomes Framework	QOF	Part of the contract primary care trusts (PCTs) have with GPs. It is nationally negotiated and rewards best practice and improved quality of services.
(GP) Registrars		Doctors training to be general practitioners.
Secondary Care		The collective term for services to which a patient is referred to by a consultant. Usually this refers to NHS hospitals in the NHS offering specialised medical services and care.
Special Primary Medical Services contract	SPMS	Specialist PMS (SPMS) is a PMS model of delivery that does not require the provider to have a registered list of patients, the involvement of a GP or the provision of essential primary care services. Though in that regard SPMS and APMS are similar. What makes SPMS different is that it can only be provided by those who would otherwise qualify to hold a PMS agreement, as in Section 28D of the 1977 Act and Part 2 of the PMS Regulations.
Strategic Health Authority	SHA	The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans, and that primary care trusts (PCTs) are performing well.

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