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

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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

	Old General Medical Services contract	New General Medical Services contract
Contract held between PCT	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 Guarantee[1] in the first two years[2]

	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.

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.

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

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.	**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.
	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 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).
	Incentivise and provide resources for the modernisation of infrastructure supporting the delivery of primary care, including modern and fit-for-purpose premises.	**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).
Designing the right jobs	Continued improvements in skill mix in practices, encouraging the roles of nurse practitioners and health care assistants.	**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.	**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).
	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 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 *continued*	**Progress to date** *continued*
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.
	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).
Overall measure of participation	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).
Recruitment and retention	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.
Better staff satisfaction and morale	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 overspends 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.[g]

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.