# Review of the new General Medical Services contract

Prepared for the Auditor General for Scotland
July 2008

# Auditor General for Scotland

The Auditor General for Scotland is the Parliament's watchdog for ensuring propriety and value for money in the spending of public funds.

He is responsible for investigating whether public spending bodies achieve the best possible value for money and adhere to the highest standards of financial management.

He is independent and not subject to the control of any member of the Scottish Government or the Parliament.

The Auditor General is responsible for securing the audit of the Scottish Government and most other public sector bodies except local authorities and fire and police boards.

The following bodies fall within the remit of the Auditor General:

- directorates of the Scottish Government
- government agencies, eg the Prison Service, Historic Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Enterprise.

**Note:**
Prior to September 2007 the Scottish Administration was generally referred to as the Scottish Executive. It is now called the Scottish Government. When dealing with the earlier period this report refers to the Scottish Executive. Recommendations for the future refer to the Scottish Government.

**Acknowledgements:**
Audit Scotland would like to thank the members of the study advisory group for their input and advice throughout the study (Appendix 1). We are grateful to the managers and staff within the NHS boards we visited as part of the review. Thanks also to ISD and PSD of NHS National Services Scotland for the data analysis carried out on our behalf.

Claire Sweeney, Amanda Taylor and Iain Armstrong produced this report, under the general direction of Angela Canning and Barbara Hurst.

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Government and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

# Contents

**Summary**
**Page 2**

Background

About the study
**Page 3**

Key messages

Key recommendations
**Page 4**

**Part 1. Setting the scene**
**Page 5**

Key messages

Previous GP contracts were not fit for purpose

The SEHD supported local implementation but released the final contract later than planned

NHS boards carried out local work to implement the contract
**Page 6**

The nGMS contract changes the way general practice is funded and services are delivered
**Page 7**

The nGMS contract is intended to deliver benefits to patients, GPs and the wider NHS

Recommendations
**Page 9**

**Part 2. Cost of the nGMS contract**
**Page 10**

Key messages

The cost of general medical services in Scotland has increased following the implementation of the nGMS contract

In the first three years of the contract, GP services cost £160 million more than was allocated
**Page 11**

The global sum has decreased in cost since 2004/05

The correction factor has limited the potential for the Scottish Government and NHS boards to target funding at deprived and remote communities

GP practices have achieved highly under the QOF but this was under-estimated by the SEHD
**Page 13**

NHS boards are investing in enhanced services
**Page 14**

There is variation in the cost per registered patient of nGMS practices across Scotland

The introduction of nGMS has affected other GP contracts

The net income of GPs who moved onto the nGMS contract increased by 38 per cent between 2003/04 and 2005/06
**Page 15**

Recommendations
**Page 17**

**Part 3. Impact of the nGMS contract on the NHS**
**Page 18**

Key messages

The nGMS contract is intended to deliver benefits to GPs and to the wider NHS

The nGMS contract provides the potential for services to be tailored to meet local needs
**Page 19**

Enhanced services offer the opportunity to provide services tailored to meet local needs

GP numbers have increased but lack of data prevents workforce planning at a national or local level
**Page 21**

Practice staff roles are changing under the new contract
**Page 22**

The impact of the new contract on other NHS services is not known
**Page 23**

Recommendations
**Page 24**

**Part 4. Benefits for patients**
**Page 25**

Key messages

Most NHS boards believe that patient care has improved as a result of the nGMS contract

Access to GP practices is not monitored under the new contract
**Page 26**

The QOF has improved some processes for patient care but a greater focus on outcomes is needed

There is limited evidence of improvements for all patients since the introduction of the nGMS contract
**Page 27**

Most practices carry out patient satisfaction surveys

Recommendations
**Page 29**

**Appendix 1. Advisory group members**
**Page 30**

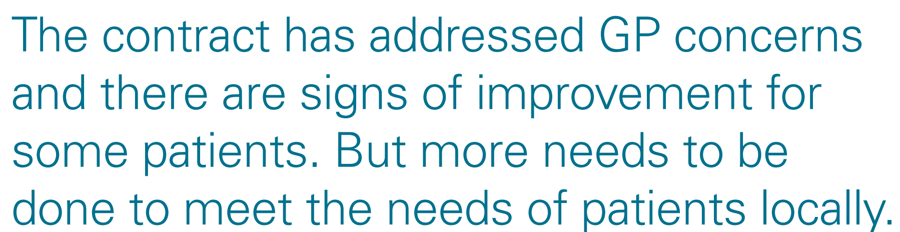
**Appendix 2. Details of QOF**
**Page 31**

**Appendix 3. QOF achievement and payments for nGMS practices in Scotland, 2004/05 to 2006/07**
**Page 34**

**Appendix 4. NHS board minimum required investment and actual expenditure on enhanced services**
**Page 35**

**Appendix 5. Self-assessment checklist for NHS boards**
**Page 36**

# Summary



The contract has addressed GP concerns and there are signs of improvement for some patients. But more needs to be done to meet the needs of patients locally.

## Background

**1.** General practitioners (GPs) are the first point of contact with the NHS for the majority of patients and, on average, patients see their GP three times a year.[1] Most GPs are independent contractors who provide services to the NHS. Very few are employed directly by an NHS board although this number is increasing. In 2007, there were 4,721 GPs and 1,030 GP practices across Scotland.[2] This report comments on changes to services provided by GPs and practice staff (commonly referred to as general medical services) under the new General Medical Services contract (nGMS contract).

**2.** The nGMS contract was introduced on 1 April 2004. It is a UK-wide contract with minor differences negotiated by each of the four UK health departments. Negotiations were carried out by the British Medical Association's General Practitioners' Committee and the NHS Confederation (representing the four UK health departments). It replaced a previous contract where GPs had to claim for payment in over 60 separate activities.

**3.** Following the introduction of the nGMS contract, there are now three contracts for general medical services in Scotland:

- The new General Medical Services (nGMS) contract – the nGMS contract is a nationally negotiated contract agreed between the NHS board and the GP practice while previous contracts were with individual GPs. By 2007 in Scotland 904 practices (88 per cent) had nGMS contracts.
- Personal Medical Services (PMS) – this contract is negotiated directly between the NHS board and individual GP practices with quality indicators and specific service requirements agreed between the practice and the NHS board. Following participation in a pilot programme prior to the introduction of the nGMS contract, nine per cent of GP practices in Scotland are on PMS contracts.
- NHS board direct provision – three per cent of GP practices are managed directly by the NHS board using salaried GPs.[3 4]

**4.** The cost of providing general medical services in Scotland through the three contracts has risen by 40 per cent over the last four years from £503.9 million in 2003/04 (the year prior to the introduction of the nGMS contract) to £706.1 million in 2006/07.[5 6] The average net income of nGMS GPs in Scotland increased by 38 per cent from £65,180 in 2003/04 to £90,127 in 2005/06.[7 8 9]

## About the study

**5.** In carrying out this study we:

- analysed central data on activity and cost from the Information Services Division (ISD) and Practitioner Services Division (PSD) of NHS National Services Scotland (NSS)
- collected and analysed additional data on activity and cost from all NHS boards
- interviewed staff and reviewed relevant documents from the Scottish Government Health Directorates (SGHD), the Scottish General Practitioners Committee (SGPC) of the British Medical Association (BMA), the Scottish Ambulance Service, NHS 24 and a sample of five NHS boards (NHS Dumfries and Galloway, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian and NHS Western Isles).[10]

**6.** We have previously produced a report commenting on out-of-hours services.[11] As out-of-hours provision is an integral part of the nGMS contract we refer to it in this report where necessary to provide a complete picture of the contract and its impact.

**7.** A separate document aimed at non-executive members of NHS boards accompanies this report. This document highlights issues that will support non-executives in exercising their scrutiny role.[12]

**8.** This report is structured in four main parts:

- Setting the scene, which provides contextual information on the nGMS contract and its stated aims (Part 1).
- Cost of the contract (Part 2).
- Impact of the contract on the NHS (Part 3).
- Benefits for patients (Part 4).

1 Information Services Division (ISD) Practice Team Information. http://www.isdscotland.org/isd/3675.html.
2 ISD workforce statistics, published 29 January 2008. http://www.isdscotland.org/workforce
3 *Information on Scottish GPs, Practices and their Populations*, ISD, published 29 January 2008. http://www.isdscotland.org/GPpracs&pops
4 nGMS, PMS and NHS board direct provision are commonly known as 17j, 17c and 2c respectively from definitions in the Primary Medical Services (Scotland) Act 2004.
5 *Gross Investment Guarantee (GIG) Monitoring Report – Final figures for 2003/04-2005/06*, NHS Information Centre, 2007.
6 *Primary Medical Services Payments for 2006/07: Scotland Audited Outturn*, NHS Information Centre Technical Steering Committee, 2008.
7 *GP Earnings and Expenses Enquiry 2003/04, Final Report*, NHS Information Centre, March 2006.
8 *GP Earnings and Expenses Enquiry 2005/06, Initial Report*, NHS Information Centre, October 2007.
9 GP income based on self-assessment income tax return to HM Revenue and Customs.
10 The Scottish Government is split into directorates. This new structure replaces the former departmental structure. Where appropriate we refer to the previous Scottish Executive Health Department (SEHD), rather than the current Scottish Government Health Directorates.
11 *Primary care out-of-hours services*, Audit Scotland, August 2007.
12 http://www.audit-scotland.gov.uk

**Key messages**

- The nGMS contract cost more than expected. In the first three years of the contract, general medical services cost £160.4 million more than the SEHD allocated to NHS boards for these services. The majority of the additional costs are due to the costs of implementing an incentive payment system for quality (the Quality and Outcomes Framework – QOF) and ensuring that no GP practice was financially disadvantaged by the new contract (the correction factor).

- The nGMS contract has the potential to develop general medical services for patients by introducing payments for improved or targeted services (known as enhanced services). NHS boards are spending more than the minimum required on these services. But shortfalls in funding could limit NHS boards' ability to further develop general medical services to meet the needs of their local population.

- There is a lack of basic management data on general practice. This makes it more difficult for the NHS to plan effectively and to carry out workforce planning. However, there is some evidence that the roles of practice staff are changing and that GPs are more satisfied with their income and working hours.

- Securing patient benefits from the nGMS contract will take time, but better monitoring, particularly of access to primary care, is required. However, there is evidence of some improvement, for example, the QOF is helping to provide consistency of care through better monitoring of patients with certain long-term conditions.

**Key recommendations**

The Scottish Government should:

- collect robust data before implementing major schemes so that it can base decisions on accurate information

- review the impact of the nGMS contract on referrals and prescribing rates in clinical areas covered by the QOF to inform the future development of the nGMS contract

- collect monitoring data on the effect of recent changes on the workload of NHS 24 and the Scottish Ambulance Service

- continue to improve the contribution of QOF to patient care and to achieve value for money by moving from a focus on processes to a greater focus on outcomes.

The Scottish Government and NHS boards should:

- monitor the investment by NHS boards in enhanced services to make sure that they achieve value for money and meet local needs

- collect comprehensive data on GP and GP practice staff numbers to support workforce planning at a national and local level.

# Part 1. Setting the scene

The nGMS contract has made fundamental changes to how general practice is funded and how services are delivered.

**Key messages**

- The nGMS contract is a UK-wide contract which has made fundamental changes to the way in which general practice is funded and services delivered. It aims to: better reward GP practices for providing a specified range of services; give NHS boards the mechanism to plan general medical services more effectively; improve recruitment and retention of GPs; and provide patients with higher quality care and better access to services.
- NHS boards were successful in implementing the nGMS contract to an extremely tight timescale, following the late publication of the contract by the SEHD. The SEHD, however, provided ongoing support for NHS boards prior to implementation of the contract.

## Previous GP contracts were not fit for purpose

**9.** Before the nGMS contract, GPs in the UK were employed under the 1990 National General Medical Services contract, which had remained relatively unchanged since 1966. Both the BMA and the Royal College of General Practitioners (RCGP) believed that the 1990 contract was no longer fit for purpose for a number of reasons:

- A quarter of GPs were considering a career break from general practice, giving unsustainable workload as the main reason.
- The old contract allowed little flexibility about the services a GP practice could provide.
- The contract lacked quality measures and the allocation of resources did not reflect patients' needs.
- Payments did not address the additional costs of providing services in remote or deprived areas.[13]

**10.** The negotiation of the nGMS contract by the BMA's General Practitioners' Committee and the NHS Confederation was a lengthy process lasting from 2001 to June 2003. It was made more complicated by the lack of available data on general medical services.

## The SEHD supported local implementation but released the final contract later than planned

### The SEHD did not allow sufficient time for NHS boards to agree and sign the new contract with GP practices

**11.** The SEHD provided an implementation schedule to NHS boards on 19 January 2004 setting out its plan to publish the draft nGMS contract on 31 January 2004 and when it would need to be signed off by GP practices and NHS boards.[14] New contracts had to be agreed and signed by individual GP practices prior to introducing the new contract on 1 April 2004.

**12.** The SEHD did not publish the draft nGMS contract until 12 March 2004. This meant that NHS boards had less than three weeks to reach agreement and sign off contracts with individual GP practices. Given this extremely tight timescale, NHS boards did well to achieve contract agreement and sign-off with GP practices.

### The SEHD established national working groups to support nGMS implementation

**13.** The SEHD set up a series of national working groups to address key areas of concern prior to the introduction of the contract (quality, out-of-hours, human resources, premises, information management and technology, finance and service redesign). A national reference group that included representatives from all NHS boards (usually nGMS leads or primary care medical directors) was also set up to oversee the process.[15]

**14.** The national working groups provided support to the NHS boards which helped them to implement the new contract despite the tight timetable. The Scottish Ambulance Service and NHS 24 also attended these groups. Four of the five sample NHS boards found the level of support provided through the national workgroups appropriate to help with implementation of the new contract.

## NHS boards carried out local work to implement the contract

**15.** In order to implement the contract, NHS boards engaged with GP practices and developed service and financial plans. Four of the five sample NHS boards had nGMS implementation plans and steering groups. NHS Western Isles did not have an implementation plan or steering group but set up a working group to monitor the implementation of the nGMS contract. However, the steering groups and subgroups tended not to involve patients or representatives from secondary care. Better engagement with secondary care would have strengthened planning for the nGMS contract. Local support by NHS boards for implementing the new contract included newsletters and road shows for GPs and practice staff, and mentoring in new IT systems.

13 *National Survey of GP Opinion*, BMA, 2001.
14 *New GMS contract – implementation schedule of key tasks, milestones and responsibilities*, PCA(M)(2004)3, SEHD, 2004.
15 Primary care is the term for the health services that play a central role in the local community: general medical, pharmaceutical, dental and ophthalmic services.

**16.** The role of Community Health Partnerships (CHPs) in the management of general medical services is continuing to develop. The SEHD issued statutory guidance on the role of CHPs to all NHS boards in October 2004.[16 17] This guidance stated that the partnerships would evolve according to local circumstances but it set out minimum requirements for devolving appropriate resources and responsibilities for decision-making. This guidance expected that CHPs would:

- deliver services more innovatively and effectively by bringing together those who provide community-based health and social care
- shape services to meet local needs by directly influencing NHS board planning, priority setting and resource allocation
- integrate health services, both within the community and with specialist services, underpinned by service redesign, clinical networks and by appropriate contractual, financial and planning mechanisms
- improve the health of local communities, tackle inequalities and promote policies that address poverty and deprivation by working within community planning frameworks
- lead the implementation and monitoring of child health surveillance and relevant aspects of screening of children
- promote involvement of, and partnership with, staff whether employed by or contracted to the NHS
- secure effective public, patient and carer involvement by building on existing or developing new mechanisms.

**17.** To date, most NHS boards have retained responsibility for budgets and decision-making relating to general medical services, with CHPs largely involved in more operational matters such as monitoring enhanced services and overseeing quality review visits. As CHPs develop, the five sample NHS boards plan to devolve more responsibility to CHPs. For example, NHS Greater Glasgow and Clyde has increased the number of people it employs with the knowledge and experience of primary care contracting to support transferring this responsibility to CHPs. CHPs within the five sample boards are involved in planning and delivering services to meet the needs of the local population to some degree, and full responsibility for general medical services has been delegated to the CHPs in NHS Grampian.

## The nGMS contract changes the way general practice is funded and services are delivered

**18.** A key aim of the nGMS contract was to make the funding system for GP practices more equitable. In particular, it aimed to direct more funding to practices where workload was highest; such as in practices working in deprived areas where health needs are greater. In Scotland, there was also a perceived need to target more funding at practices in remote and rural areas.

**19.** The contract is made up of a number of different elements (Exhibit 1, overleaf). Core funding is allocated through the **global sum** to provide the essential services expected of general practice. As part of contract negotiations a **correction factor** was agreed and added to the global sum to ensure that no practice was disadvantaged as a result of the introduction of the contract. In practice this meant that the core GP income remained based on historical income, which has limited NHS boards' ability to target funding at deprived, rural or remote areas.[18]

**20.** Another aim of the contract was to introduce better measures of performance and quality in primary care. Prior to 2004, funding for general practice was based primarily on the number of GPs with almost no funding linked to performance or quality. Under the new contract, a **Quality and Outcomes Framework (QOF)** has been introduced which awards funding where practices can demonstrate that they have achieved certain quality measures (Exhibit 2, page 9).

**21.** The introduction of **enhanced services** is an important lever for developing services in primary care. Under the nGMS contract, NHS boards can negotiate with GP practices for the provision of services which are considered to be in addition to the range of essential services already being delivered. NHS boards can commission these services from other providers, not only GPs. These enhanced services may require specialist expertise and fall into one of three categories:

- directed, which NHS boards have to provide for patients within the area, for example, child immunisation
- national, which NHS boards may choose to have provided, for example, drugs misuse services
- local, which are locally designed based on local need such as services for asylum seekers.

Further details are available in Part 3.

16 Community Health Partnerships, Statutory Guidance, October 2004, SEHD.
17 CHPs were created to help facilitate moving services from acute to community settings. All NHS boards have created CHPs with different types of arrangements with councils being developed; for example, some CHPs have also incorporated social care into the arrangement making Community Health and Care Partnerships.
18 The global sum and correction factor together are known as the Minimum Practice Income Guarantee (MPIG).

## Exhibit 1

Components of the nGMS contract

There are several components of the nGMS contract which determine GP practice income.

### Services

**Essential services**
Treatment of those who are ill or believe themselves to be ill.

**Additional services**
Additional services are those that a practice is expected to provide for the local population. These are: cervical screening, contraceptive services, vaccinations and immunisations, childhood vaccinations and immunisations, child health surveillance, maternity medical services and minor surgery.

**Enhanced services**
Enhanced services are either medical services that are not included as essential or additional services, or they are essential or additional services provided to an enhanced level of service provision. GP practices can choose to provide enhanced services if commissioned by an NHS board. Enhanced services are either:

- Directed – NHS board must deliver these services and provide them to a UK or Scottish specification.
- National – NHS board chooses to provide service to UK defined specification.
- Local – NHS board designs and specifies service to meet local need.

**Quality and Outcomes Framework (QOF)**
The QOF is a quality incentive scheme for GP practices. It offers financial rewards for achieving quality and activity targets by awarding points linked to four areas: clinical, organisational, additional services and patient experience (Appendix 2).

**Potential reductions in practice income**
If GP practices decide not to provide additional services their global sum payment is reduced by a set amount. For example, a practice opting out of providing maternity medical services will have its global sum reduced by 2.1 per cent.

### Practice income

The **global sum** is a needs-based calculation for each practice to cover essential and additional services.

The **correction factor** acts as a safety net and protects the elements of GP income which were paid under the old contract so no practice loses core income under the nGMS contract.

Payment rates for national and directed enhanced services are set nationally.

Payment rates for local enhanced services are set locally by NHS boards.

**QOF payments** are calculated based on achievement but are weighted by population and disease prevalence.

Source: Audit Scotland, 2008

## Exhibit 2[1]

Quality and Outcomes Framework

The 2006/07 Quality and Outcomes Framework consists of four main areas, or domains.

**QOF 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 holistic care payment is also available based on achievement across the clinical domain. 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 on average £124.64. Points are awarded where practices can demonstrate that they have fulfilled a number of key stages in the management of chronic disease, for a per cent of the relevant population (usually between 40 and 90 per cent). For example, for the management of patients with hypertension, practices can receive:

- six points for maintaining a register of patients with hypertension
- up to 76 points for ongoing management of the condition (eg, taking regular blood pressure checks and trying to control blood pressure in hypertension to levels suggested by clinical evidence).

Note: 1. See Appendix 2 for further details of the QOF and variations in QOF from 2004/05 to 2006/07.
Source: Audit Scotland, 2008

**22.** Under the nGMS contract GP practices can opt out of providing some services, including out-of-hours services. Prior to the introduction of nGMS many GPs had already delegated out-of-hours provision to a third party, typically an out-of-hours co-operative.[19] The new contract transferred responsibility for out-of-hours provision from GPs to NHS boards unless GPs chose to continue providing this cover. If GP practices opted out of providing out-of-hours services under the nGMS contract then they had to give up an average of six per cent of their global sum per year.

### The nGMS contract is intended to deliver benefits to patients, GPs and the wider NHS

**23.** The nGMS contract aims to give GP practices greater flexibility in the choice of services they provide, and NHS boards and CHPs a greater role in the planning and delivery of general medical services.

**24.** The objectives of the new contract were to:

- reduce GPs' personal and practice workload, making it more manageable
- appropriately reward GPs for the work they carry out
- address problems in recruiting GPs, particularly in more rural areas
- deliver more services in primary care, closer to patients' homes.

**25.** Progress against these objectives is set out in Parts 3 and 4 of this report.

### Recommendations

- The Scottish Government should collect robust data before implementing major schemes so that it can base decisions on accurate information.
- The Scottish Government and NHS boards should ensure that all relevant groups are involved in planning for major service changes.
- NHS boards should monitor the effectiveness of CHPs in taking over responsibility for general medical services.

19 *Primary care out-of-hours services*, Audit Scotland, August 2007.

# Part 2. Cost of the nGMS contract

The cost of general medical services has increased following implementation of the nGMS contract.

**Key messages**

- The cost of providing general medical services in Scotland has risen by 40 per cent over the last four years from £503.9 million in 2003/04 (the year prior to implementing the nGMS contract) to £706.1 million in 2006/07. The nGMS contract cost more than expected. In the first three years of the contract general medical services cost £160.4 million more than the SEHD allocated to NHS boards. The majority of the additional costs are due to the costs of the Quality and Outcomes Framework (QOF) and the correction factor.
- The QOF was not piloted before it was introduced and the UK health departments under-estimated how well GP practices would achieve against the QOF, leading to a £43.6 million shortfall in 2004/05. This has affected the overall cost of implementing the nGMS contract, and NHS boards have had to meet the associated additional costs from their unified budgets.[20]
- Although the nGMS contract was intended to target resources at areas with higher levels of deprivation or rurality than others, guaranteeing previous practice income levels through the correction factor has prevented this from happening.
- The nGMS contract has the potential to develop general medical services for patients by introducing payments for improved or targeted services (known as enhanced services). NHS boards are spending more than the minimum required on these services. But shortfalls in funding could limit NHS boards' ability to further develop general medical services to meet the needs of their local population.

## The cost of general medical services in Scotland has increased following the implementation of the nGMS contract

**26.** Expenditure on primary care had been rising steadily since 1994 and in real terms had risen from £354.3 million to £519.0 million between 1993/1994 and 2003/04, an increase of 46 per cent.[21 22 23]

**27.** From 2003/04 to 2006/07 the cost of primary care rose by 40 per cent – from £503.9 million to £706.1 million in cash terms.[24 25] This compares with a 27.6 per cent increase in the net operating expenditure on the NHS in Scotland over the same period.[26] In 2003/04, the allocations included £22.9 million targeted to support the introduction of the new contract.[27] The greatest rise in spending (24.7 per cent) was between 2003/04 (the year before the introduction of the nGMS contract) and 2004/05.

## In the first three years of the contract, GP services cost £160 million more than was allocated

**28.** From 2004/05 to 2006/07 NHS boards have spent £160.4 million more on general medical services than the funding allocated by the SEHD. This additional cost has been funded from NHS boards' unified budgets (Exhibit 3, overleaf).

**29.** The SEHD published allocation letters late in the financial planning cycle: in May 2004 for the financial year 2004/05; June 2005 for 2005/06; and March 2006 for 2006/07.[28] In two of these years this was after the financial year had started, restricting NHS boards' ability to plan effectively.

### The cost of the nGMS contract has risen, largely due to implementing the Quality and Outcomes Framework

**30.** The cost of providing general medical services through nGMS practices has risen by ten per cent over the first three years of the contract – 2004/05 to 2006/07. The biggest increase was between the first two years of the contract and was largely due to the increased cost of implementing the QOF (Exhibit 4, overleaf).

**31.** This analysis excludes the cost of providing out-of-hours services, which is covered by our previous report.[29] We found that 95 per cent of GP practices in Scotland had opted out of providing out-of-hours care. The opt out has added to cost pressures for NHS boards with out-of-hours costs rising from £35 million in 2004/05 (part year) to estimated costs of £68 million in 2006/07.[30]

20 2004/05 Primary Medical Services Forecast Expenditure, SEHD and *Gross Investment Guarantee (GIG) Monitoring Report, Final figures for 2003/04-2005/06*, NHS Information Centre, 2007.
21 1993/94 expenditure adjusted to 2003/04 prices using the HM Treasury GDP deflator.
22 *The Costs Book*, ISD.
23 Note that the figures collected in 1993/94 were not collected on a consistent basis with those collected in 2003/04 but they are included here as a high-level comparison. These differ slightly from figures reported in the accounts.
24 *Gross Investment Guarantee (GIG) Monitoring Report – Final figures for 2003/04-2005/06*, NHS Information Centre, 2007.
25 *Primary medical Services Payments for 2006/07: Scotland Audited Outturn*, NHS Information Centre Technical Steering Committee, 2008.
26 *The Costs Book*, Information Services Division (ISD), 2003/04 and 2006/07.
27 *General Medical Services Allocations for 2003-04*, SEHD, September 2003.
28 SEHD Primary Medical Services Allocations, 2004/05 to 2006/07.
29 *Primary care out-of-hours services*, Audit Scotland, August 2007.
30 Ibid.

## Exhibit 3
Cost of general medical services

General medical services have cost more than was either estimated or allocated since 2003/04.

| | 2003/04 Year before nGMS | 2004/05 | 2005/06 | 2006/07 | Totals 2004/05 to 2006/07 |
|---|---|---|---|---|---|
| | £ million | £ million | £ million | £ million | £ million |
| Estimated spend | | 595.8[1] | 684.5[2] | 653.1[3] | 1,933.4 |
| NHS board allocation | 445.1 | 559.2 | 655.7 | 655.2 | 1,870.1 |
| Actual NHS board spend | 503.9 | 628.4 | 696.0 | 706.1 | 2,030.5 |
| Difference between NHS board allocation and NHS board spend | 58.8 | 69.2 | 40.3 | 50.9 | 160.4 |
| Difference between estimated spend and actual NHS board spend | | 32.6 | 11.5 | 53.0 | 97.1 |

Notes: 1. Estimated as at September 2004. 2. Estimated as at July 2005. 3. Estimated as at July 2006.
Source: SEHD Primary Medical Services Allocations, 2004/05 to 2006/07. Unified board summary accounts, 2004/05 to 2006/07, SEHD. Primary Medical Services forecast expenditure, 2004/05 to 2006/07, SEHD. *Gross Investment Guarantee (GIG) Monitoring Report – Final figures for 2003/04-2005/06*, NHS Information Centre, 2007.

## Exhibit 4
nGMS component costs from 2004/05 to 2006/07 in Scotland

Component costs are increasing but the global sum has reduced since 2004/05.

| | 2004/05 | 2005/06 | 2006/07 | Percentage increase 2004/05 to 2006/07 |
|---|---|---|---|---|
| | £000 | £000 | £000 | % |
| Global sum | 287,674 | 272,348 | 270,347 | -6.0 |
| The correction factor | 55,306 | 59,089 | 57,709 | 4.3 |
| **Total global sum and correction factor** | **342,980** | **331,437** | **328,056** | **-4.4** |
| **Quality and Outcomes Framework** | **71,579** | **123,281** | **115,487** | **61.3** |
| Directed enhanced services | 21,339 | 19,628 | 28,097 | 31.7 |
| National enhanced services | 8,554 | 11,504 | 12,020 | 40.5 |
| Local enhanced services | 9,746 | 8,506 | 11,272 | 15.7 |
| **Total enhanced services** | **39,639** | **39,638** | **51,389** | **29.6** |
| **Board administered funds** | **27,745** | **28,537** | **31,466** | **13.4** |
| **Premises** | **46,341** | **50,594** | **52,808** | **14.0** |
| **Information management and technology** | **7,507** | **7,206** | **7,200** | **-4.1** |
| **Out-of-hours development fund[1]** | **7,064** | **14,276** | **11,443** | **62.0** |
| Total nGMS | 542,855 | 594,969 | 597,849 | 10.1 |

Note: 1. This exhibit shows only a proportion of out-of-hours cost, the out-of-hours development fund. The full costs are detailed within the Audit Scotland report *Primary care out-of-hours services*, August 2007.
Source: Unified board summary accounts, 2004/05 to 2006/07, SEHD

**The global sum has decreased in cost since 2004/05**

**32.** The global sum is distributed to GP practices using a weighted capitation formula – the Scottish Allocation Formula (SAF). This formula aims to reflect the distinctive needs of the Scottish population and the additional cost of providing general medical services in the remote regions and deprived areas of Scotland. The SAF was introduced to provide an equitable distribution of resources in Scotland, based on the cost of providing services to populations where deprivation and morbidity is higher or where access to services is difficult (remote and island areas). However, the correction factor has prevented the SAF from redistributing resources to areas of greatest deprivation or remoteness.

**33.** The global sum has reduced slightly over time, by six per cent. This is because GPs were able to opt out of providing out-of-hours services part way through 2004/05 and gave up on average six per cent of their global sum.

**The correction factor has limited the potential for the Scottish Government and NHS boards to target funding at deprived and remote communities**

**34.** As part of the contract negotiations, it was agreed that the core GP practice income would not reduce under the new contract. A correction factor was therefore introduced. The correction factor relates only to the global sum, and not the additional payments for QOF or enhanced services. The global sum and correction factor relate to an average of 54.9 per cent of the cost of nGMS practices.

**35.** Ninety-four per cent of GP practices in Scotland received the correction factor when it was introduced in 2004.[31] This has subsequently reduced slightly to around 90 per cent of GP practices.[32] The cost of the correction factor has changed over time and this is due to new practices being created. If a GP practice closes and a new one is created, or a new practice opens, the correction factor would not apply. This is because the correction factor protects historical income, which would not apply to a new practice.

**36.** The correction factor has cancelled out any effect that the SAF might have had in allocating a greater proportion of available resources to GP practices in deprived and remote areas where the costs of primary care services are higher. In particular, there is no evidence to show that the new contract has increased the number of GPs in areas that had a lower proportion of doctors per head of population compared to other areas.

**GP practices have achieved highly under the QOF but this was under-estimated by the SEHD**

**37.** The QOF was not piloted or tested before it was introduced. This was a serious omission as experience of previous incentive schemes for GPs indicated that achievement levels would be high.[33] In addition, the funding available for the QOF was reduced during negotiations to help fund the correction factor within the overall funding arrangements.

**38.** The SEHD originally estimated that 80 per cent of GP practices would achieve 80 per cent of the quality points available. This was a significant underestimate as actual achievement against QOF in the first year of the contract was an average of 92.5 per cent across nGMS practices in Scotland. In subsequent years this high achievement continued with averages of 97.7 per cent in 2005/06 and 97.1 per cent in 2006/07.[34] Practices with larger lists and higher disease prevalence are more likely to record higher total achievements.[35] Exhibit 5 (overleaf) shows an example of how GP practices are paid through QOF.

**39.** Expenditure on QOF therefore has been a significant part of the overall contract. For nGMS practices only, QOF payments rose from £71.6 million in 2004/05 to £115.5 million in 2006/07 (although costs peaked in 2005/06 at £123.3 million) (Exhibit 4).

**40.** QOF payments for all practices (nGMS and other contracts) rose from £77.1 million in 2004/05 to £128.3 million in 2006/07.

The increased value of QOF points has contributed to the overall increase in QOF costs

**41.** As well as increased achievement against the QOF adding to the cost, the large increase in the costs of the QOF between 2004/05 and 2005/06 was also due in part to the change in value of QOF points agreed during negotiations. For a practice with average list size and disease prevalence, the value of a QOF point rose from £77.50 to £124.64 over these two years.[36] Appendix 3 provides a summary of QOF achievements and payments by NHS board area for 2004/05 – 2006/07. Part 4 considers the implications of the introduction of a quality-based payments system for patients.

31 Parliamentary Question S2W-11040 on Thursday 21 October 2004. http://www.scottish.parliament.uk/business/pqa/wa-04/wa1021.htm
32 *Breakdown of health improvement and PMS funding*, NHS Scotland resource allocation committee, January 2006.
33 *Quality and Outcomes Framework, So what are we to do?* TJ Roscoe, *British Medical Journal* 2007; 335: 1170 (8 December).
34 *General practice – quality and outcomes framework*, ISD 2008.
35 Audit Scotland fieldwork based on ISD data, 2008.
36 See Appendix 2 for a more detailed explanation of QOF points.

## Exhibit 5

QOF payments example

GP practices can receive various payments through the QOF.

Overall payments

In 2006/07, an average payment of £124.64 was made for each point achieved.

An average-sized GP practice with 5,284 registered patients in an area with average disease prevalence had the potential to earn up to £124,640 through the QOF. It is important to note that each practice will receive very different QOF payments due to a number of factors including practice list size and disease prevalence.

| QOF area | Points available | Calculation | Payable |
|---|---|---|---|
| Clinical domain | 655 | 655 x £124.64 | £81,639.20 |
| Organisational domain | 181 | 181 x £124.64 | £22,559.84 |
| Patient experience domain | 108 | 108 x £124.64 | £13,461.12 |
| Additional services domain | 36 | 36 x £124.64 | £4,487.04 |
| Additional payments for holistic care | 20 | 20 x £124.64 | £2,492.80 |
| | | Total payable | £124,640.00 |

In comparison the same GP practice in 2004/05 could potentially have earned £81,375.

Example of specific QOF payments

Using asthma as an example, a GP practice could earn up to:

- 4 points for keeping a record of all patients suffering from asthma
- 6 points for recording the smoking status in the previous 15 months of asthma patients aged between 14 and 19
- 15 points for new diagnoses of asthma in patients aged eight and over
- 20 points for reviewing an asthma patient within a 15-month period.

Therefore an average-sized GP practice with 5,284 registered patients in an area with average deprivation could potentially earn £5,608.80 by achieving all of the criteria for indicators relating to asthma.
(4 x £124.64) + (6 x £124.64) + (15 x £124.64) + (20 x £124.64) = £5,608.80

Source: Audit Scotland, 2008

**42.** Practices covering deprived areas are achieving similar QOF points to those practices covering more affluent areas. This is despite it being harder for practices in deprived areas to achieve QOF points.[37] Nine out of the 14 NHS boards do not believe that, when compared to the 1990 contract, the nGMS contract has helped ensure that there is a fair distribution of primary care resources between deprived and affluent areas.

**43.** GP practices in very remote areas do not always achieve as many QOF points overall as those in urban areas. Remote practices with a low practice population may have the capacity within the practice to meet all QOF targets but may not be able to achieve all of the points available. For example, they may not have any patients eligible to be included on certain QOF registers and so cannot achieve points in those areas.[38] Practices in remote areas may also find it difficult to meet some organisational elements of the QOF.

### NHS boards are investing in enhanced services

**44.** Enhanced services are a key mechanism for NHS boards to improve the planning and coverage of general medical services through the new contract. The SEHD put in place a minimum level of expenditure that it expected NHS boards to spend on enhanced services in the first three years of the contract (Appendix 4). Across Scotland, spending has exceeded this minimum level, increasing from £45.6 million in 2004/05 to £57.1 million in 2006/07. This indicates that many boards are beginning to introduce a range of enhanced services.

37 *Practice size and quality attainment under the new GMS contract: a cross-sectional analysis*, Wang, O'Donnell, Mackay, Watt, *British Journal of General Practice* 56(532): 830–835, November 2006.
38 Audit Scotland fieldwork based on ISD data, 2008.

**45.** On average, NHS boards have invested 31 per cent above the minimum allocation on enhanced services in 2004/05, 27 per cent in 2005/06 and 32 per cent in 2006/07. However, this disguises significant variation among NHS boards (Appendix 4).

### There is variation in the cost per registered patient of nGMS practices across Scotland

**46.** The average cost per registered patient of nGMS practices in Scotland has increased from £112.24 per annum in 2004/05 to £123.12 per annum in 2006/07 in cash terms.[39] Average costs tend to be higher in remote and rural areas, with the island boards having the highest costs (Exhibit 6).

### The introduction of nGMS has affected other GP contracts

**47.** Overall the rate of increase in spending on general medical services is slowing down after the initial large increases at the time of the introduction of the nGMS contract. Because GPs have been able to opt out of providing some services (such as out-of-hours), NHS boards have increased the use of salaried GPs to help to deliver out-of-hours services (Exhibit 7).

### The net income of GPs who moved onto the nGMS contract increased by 38 per cent between 2003/04 and 2005/06

**48.** All GPs who moved onto nGMS contracts had a significant increase in their incomes following the introduction of the nGMS contract.[40] This was one of the stated aims of the contract but the extent of the increases has been higher than anticipated. This is largely as a result of higher than expected levels of achievement against the QOF.

## Exhibit 6

**Average costs per nGMS practice-registered patient**

Average costs vary across Scotland, and rural and remote boards tend to have the higher costs.

| | 2004/05 £ | 2005/06 £ | 2006/07 £ |
|---|---|---|---|
| NHS Ayrshire and Arran | 106.66 | 120.01 | 118.79 |
| NHS Borders | 111.34 | 118.73 | 119.47 |
| NHS Dumfries and Galloway | 118.35 | 125.44 | 130.48 |
| NHS Fife | 110.44 | 122.95 | 123.13 |
| NHS Forth Valley | 104.43 | 115.34 | 116.43 |
| NHS Grampian | 117.40 | 124.44 | 128.60 |
| NHS Greater Glasgow and Clyde | 109.67 | 121.89 | 115.70 |
| NHS Highland | 158.72 | 165.80 | 163.41 |
| NHS Lanarkshire | 94.45 | 104.57 | 103.83 |
| NHS Lothian | 113.82 | 129.07 | 130.66 |
| NHS Shetland | 194.93 | 240.85 | 274.40 |
| NHS Tayside | 119.75 | 123.82 | 125.34 |
| NHS Western Isles | 261.89 | 261.17 | 283.44 |
| **Scotland** | **112.24** | **122.68** | **123.12** |

Note: NHS Orkney has been excluded due to inaccuracies in the data.
Source: Registered patient populations are from Community Health Index (CHI) extract.
Unified board summary accounts, 2004/05 to 2006/07, SEHD.

## Exhibit 7

**Spend on general medical services**

The rate of increase in spending on general medical services is slowing down.

| Contract type | 2004/05 | 2005/06 | 2006/07 | Increase from 2004/05 to 2005/06 | Increase from 2005/06 to 2006/07 |
|---|---|---|---|---|---|
| | £ millions | £ millions | £ millions | % | % |
| nGMS | 542.9 | 595.0 | 597.8 | 9.6 | 0.05 |
| Personal Medical Services | 68.2 | 73.7 | 75.5 | 8.1 | 2.4 |
| NHS board direct provision | 17.4 | 27.3 | 32.7 | 56.9 | 19.8 |
| **Total cost per year** | **628.4** | **696.0** | **706.1** | **10.8** | **1.5** |

Source: Unified board summary accounts, 2004/05 to 2006/07, SEHD

39 Registered patient populations are from Community Health Index (CHI) extract, Practitioner Services Division (PSD).
40 This relates to GMS contract holders or providers, previously known as principle GPs.

**49.** The average net income of GPs who moved onto nGMS contracts in Scotland has increased by 38 per cent from £65,180 in 2003/04 to £90,127 in 2005/06.[41] This is lower than for nGMS GPs in England, Wales and Northern Ireland, partly as a result of the lower average practice list size in Scotland.

**50.** nGMS GP net income increased by 38 per cent between 2003/04 and 2005/06. During the same period nGMS GPs in Scotland have increased re-investment in their practices by an average of £6,860 per GP practice between 2003/04 and 2005/06 – an 8.5 per cent increase.[42] In 2003/04, GPs reinvested 55.2 per cent of their income and in 2005/06 they reinvested 49.2 per cent.

**51.** nGMS GPs in Scotland take a lower income than GPs in the rest of the UK and GP earnings account for a higher percentage of the practice income.

**52.** Salaried GP income in the UK has not risen at the same rate since the implementation of the contract – average pay has risen by only three per cent from £45,560 in 2004/05 to £46,905 in 2005/06. This does not reflect an average full-time salary, however, as many salaried GPs work part-time hours only.

## Exhibit 8

nGMS GP income

nGMS GP income is lower in Scotland due to lower list sizes.[1]

| | 2003/04 £ | | 2004/05 £ | | 2005/06 £ | |
|---|---|---|---|---|---|---|
| | Gross income | Net income | Gross income | Net income | Gross income | Net income |
| Scotland | 145,537 | 65,180 | 168,031 | 81,863 | 177,345 | 90,127 |
| England | 200,407 | 80,421 | 229,592 | 99,795 | 245,440 | 110,054 |
| Wales | 186,755 | 73,983 | 210,184 | 91,693 | 224,210 | 102,194 |
| Northern Ireland | 140,243 | 67,564 | 173,091 | 91,151 | 185,205 | 98,656 |

Note: 1. Net income equals gross earnings minus expenses and is pre tax. GP expenses include the following costs: employee, premises, business, interest, car and travel, net capital allowance, depreciation, and other.
Source: *GP Earnings and Expenses Enquiries 2003/04, 2004/05 and 2005/06*, NHS Information Centre

## Exhibit 9

nGMS GP expenses, gross income and reinvestment 2003/04, 2004/05 and 2005/06

The percentage reinvested over time has reduced.

| | 2003/04 £ | | | 2004/05 £ | | | 2005/06 £ | | |
|---|---|---|---|---|---|---|---|---|---|
| | GP Expenses | Gross income | Per cent re-invested | GP Expenses | Gross income | Per cent re-invested | GP Expenses | Gross income | Per cent re-invested |
| Scotland | 80,358 | 145,537 | 55.2 | 86,168 | 168,031 | 51.3 | 87,218 | 177,345 | 49.2 |
| England | 119,987 | 200,407 | 59.9 | 129,797 | 229,592 | 56.5 | 135,386 | 245,440 | 55.2 |
| Northern Ireland | 72,679 | 140,243 | 51.8 | 81,940 | 173,091 | 47.3 | 86,549 | 185,205 | 46.7 |
| Wales | 112,772 | 186,755 | 60.4 | 118,491 | 210,184 | 56.4 | 122,016 | 224,210 | 54.4 |
| UK | 111,509 | 188,632 | 59.1 | 120,775 | 217,097 | 55.6 | 125,723 | 232,035 | 54.2 |

Source: *GP Earnings and Expenses Enquiries 2003/04, 2004/05 and 2005/06*, NHS Information Centre

41 *GP Earnings and Expenses Enquiries 2003/04, 2004/05 and 2005/06*, NHS Information Centre.
42 Ibid.

**Recommendations**

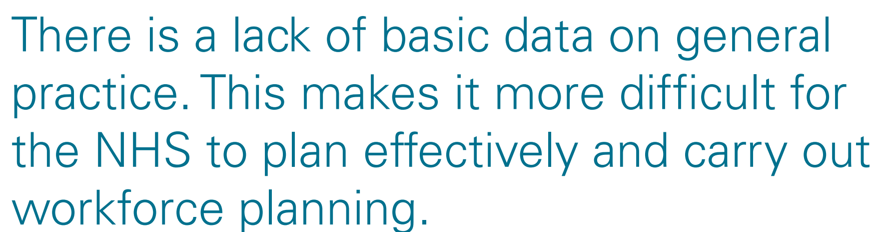
The Scottish Government should ensure that:

- funding allocation letters to NHS boards are issued before the financial year begins
- the nGMS contract is used to improve primary care services in deprived and remote areas.

The Scottish Government and NHS boards should:

- monitor the investment by NHS boards in enhanced services to make sure that they achieve value for money and meet local needs.

# Part 3. Impact of the nGMS contract on the NHS



There is a lack of basic data on general practice. This makes it more difficult for the NHS to plan effectively and carry out workforce planning.

## Key messages

- There is a lack of basic management data on general practice. This makes it more difficult for the NHS to plan effectively and to carry out workforce planning. However, there is some evidence that the roles of practice staff are changing and that GPs are more satisfied with their income and working hours.
- NHS boards and GPs are working flexibly together using enhanced services to deliver general medical services based on the needs of the local population. Shortfalls in funding may limit the continued development of enhanced services.

## The nGMS contract is intended to deliver benefits to GPs and to the wider NHS

**53.** The nGMS contract has given GP practices and NHS boards greater flexibility in the choice of services that are provided. It provides NHS boards and CHPs with the potential to take a greater role both in the planning and delivery of general medical services.

**54.** The SEHD set out the anticipated benefits of the new contract in guidance issued to NHS boards (Exhibit 10, overleaf).[43] This guidance provided information to NHS boards on the technicalities of the new contract but did not provide clear and measurable performance measures.

## The nGMS contract provides the potential for services to be tailored to meet local needs

**55.** The nGMS contract has the potential to help the NHS tailor services to meet the needs of the local population. Twelve out of the 14 NHS boards believe the nGMS contract has made it easier to develop tailored services. The contract specifies services that the NHS must deliver to patients, and other services that can be delivered based on local need. The nGMS contract provides NHS boards with more flexibility in the way in which services can be delivered. For example, they can ask a small number of GP practices to deliver specialist care to all patients in the area or deliver some services themselves. Although this has begun to result in a change to the way services are delivered, there is scope to develop this further.

**56.** NHS boards regularly assess the needs of the local population to decide what services should be delivered. NHS boards produce a Local Delivery Plan (LDP) which includes an assessment of local need and in some areas NHS boards also use the LDP to help inform which primary medical services to invest in.

**57.** Enhanced services offer the NHS flexibility in which services to provide to patients. These services can be either directed, national or local. (Exhibit 11, page 21).

### Directed enhanced services

**58.** As part of the nGMS contract four directed enhanced services were introduced in 2004 (Exhibit 12, page 21). The provision of these directed enhanced services has not changed significantly in the first three years of the new contract. For 2006/07, an additional four directed enhanced services were introduced with specific funding available (shown in bold in Exhibit 12).

### National enhanced services

**59.** National enhanced services are services that NHS boards may choose to offer to patients if there is a local need. These are delivered to a national specification. Since implementing the nGMS contract there have been minor changes in the number of GP practices delivering national enhanced services (Exhibit 13, page 22). These services can be delivered in other ways and in some cases NHS boards have decided that a smaller number of practices could deliver certain services in the NHS board area, or that the NHS board themselves could deliver the service. For example, NHS Lanarkshire has changed how it provides services for patients suffering from drug or alcohol misuse. These services used to be provided by a combination of direct NHS board provision and 40 GP practices, but now the NHS board provides all of these services to patients.

### Local enhanced services

**60.** Local enhanced services are services designed specifically to meet a local need. Seventy-two local enhanced services were implemented across Scotland between 2004/05 and 2006/07.[44] The majority of local enhanced services cover similar areas to the national and directed enhanced services (for example, immunisation and sexual health services). Other local enhanced services are specific to local population needs and some NHS boards are using enhanced services to provide services to disadvantaged patient groups. For example, NHS Greater Glasgow and Clyde has implemented a local enhanced service for asylum seekers and refugees.

43 *Implementing the nGMS contract in Scotland*, NHS Scotland, February 2004.
44 Audit Scotland fieldwork.

**Exhibit 10**

Expected benefits

Progress in achieving the benefits expected from the nGMS contract.

| Expected benefits | Progress |
|---|---|
| Expansion of general medical services | **Some progress.** The enhanced service programme has allowed NHS boards to expand the services provided through primary care. There is scope for this to continue to develop. |
| Improvements in recruitment and retention of staff | **Some progress.** The number of GPs in Scotland has increased from 4,456 in 2004 to 4,721 in 2007. Lack of data means it is not possible to say how many of these are part or full-time GPs but the data that do exist suggest there have been increases in GP numbers.[1]<br><br>There is a lack of comprehensive data on GP and practice staff numbers, roles and workload. The Scottish Government collects some workforce data through the annual Primary Care Workforce Survey. This is a voluntary survey, therefore the data available depend upon the number of GP practices submitting data. In 2007/08, 69 per cent of practices asked to participate in this survey completed a return.<br><br>The average net income of GPs who moved onto nGMS contracts increased by 38 per cent from 2003/04 to 2005/06.[2] |
| Control of GP workload<br><br>Increased flexibility in employment opportunities for GPs | **Some progress.** The opportunity for GPs to opt out of out-of-hours working has improved work/life balance.[3] There is some evidence from sample NHS boards that there is increased use of salaried GPs in nGMS practices.<br><br>This has reduced the number of hours per week GP partners are working on average by three (excluding previous out-of-hours commitment).[4] |
| Flexibility in the structure of the practice<br><br>Increase primary care capacity and skill mix | **Some progress.** The changing roles within GP practices has increased the potential for flexible working. There is some evidence that practice nurses are becoming much more involved in the regular treatment of patients with certain conditions. |
| Reduced pressure on the acute sector | **Limited progress.** There are a number of case studies that demonstrate that a small number of services have moved from secondary to primary care. However, there is no evidence of resources following the patients. |
| Reforming emergency care | **Limited progress.** NHS boards have concentrated on maintaining services rather than reforming unscheduled care services.[5] |
| Greater flexibility in commissioning of general medical services | **Some progress.** There are some examples of NHS boards introducing board managed services. However, the majority of services are still provided through GP practices. NHS boards have not commissioned services from commercial providers in Scotland, although this has happened in England. |
| Allocation of resources based upon patient need (deprived and remote areas)<br><br>Reduce inequalities across Scotland | **No progress.** Funding for essential and additional services is not distributed in relation to where the cost of providing general medical services is higher, eg deprived and remote areas.<br><br>The QOF has ensured a minimum quality standard of service provision across Scotland. Remote practices are not always able to achieve as well as urban practices in the QOF as they have fewer patients and may not always have patients eligible for monitoring through individual QOF indicators. |

Notes:
1. ISD workforce statistics, published 29 January 2008. http://www.isdscotland.org/workforce
2. *GP Earnings and Expenses Enquiries 2003/04, 2004/05 and 2005/06*, NHS Information Centre.
3. *Primary care out-of-hours services*, Audit Scotland, August 2007.
4. *Changes in job satisfaction, work commitments and attitudes to workload following contractual reform*, French, Geue, Ikenwilo, Needham, Rooke, Skatun, Sutton, December 2006.
5. *Primary care out-of-hours services*, Audit Scotland, August 2007.

Source: Audit Scotland, 2008

## Exhibit 11

Enhanced services

There are three types of enhanced service.

**Directed enhanced services:** NHS boards have to achieve coverage of these services for their population, though no individual practice is obliged to participate. Standards and prices are set nationally. They include national priorities such as patient access, and universal services such as child immunisation.

**National enhanced services:** NHS boards can choose to have these services provided, according to local needs, but in line with nationally set standards and specifications, including cost. They include commonly required services such as services for drugs misuse.

**Local enhanced services:** NHS boards have the freedom to design and negotiate any other services they believe are needed in their area. Examples could include specific services for asylum seekers or enhanced services to care homes. In some cases the national enhanced service standards are used with adjustments to meet local needs, in which case standards and specifications are negotiated locally.

Source: Audit Scotland, 2008

## Exhibit 12

Directed enhanced services

New directed enhanced services were introduced in April 2006 for one year.

| | Percentage of GP practices across Scotland providing services | | |
|---|---|---|---|
| | 2004/05 | 2005/06 | 2006/07 |
| **Services introduced in April 2004** | | | |
| Childhood vaccinations & immunisations | 97.9 | 97.0 | 97.7 |
| Violent patients | 10.3 | 10.3 | 11.1 |
| Influenza immunisations | 97.7 | 96.7 | 95.6 |
| Minor surgery | 87.7 | 85.6 | 88.4 |
| **Services introduced in April 2006 for one year** | | | |
| Cardiovascular risk registers for patients aged 45-64 | | | 97.4 |
| Services for adults with learning disabilities | | | 92.2 |
| Services for carers | | | 90.6 |
| Cancer referrals audit | | | 95.4 |

Source: Audit Scotland NHS board data request 2008

**61.** Local enhanced service provision in Scotland was extended in 2007/08 through the Scottish Enhanced Service Programme for Primary and Community Care.[45] An additional £19.5 million was distributed to NHS boards to implement a minimum of three new local enhanced services between 2007/08 and 2008/09. NHS boards were required to choose these from nine proposed by the Scottish Government.[46] There was also the opportunity to develop an additional local specific enhanced service within the funding available.[47]

### Enhanced services offer the opportunity to provide services tailored to meet local needs

**62.** Different approaches to the delivery of some enhanced services by NHS boards and GP practices have been required where there are local concerns such as insufficient funding for an enhanced service. For example, GP practices in NHS Western Isles agreed to provide the alcohol national enhanced service as a locally enhanced service on the basis of a set fee per practice rather than a set fee per patient, to help contain costs.

**63.** Four out of the five sample NHS boards used the new enhanced services model to build on and help implement their existing board strategy for general medical services. For example, NHS Greater Glasgow and Clyde used components of the QOF and enhanced services to meet the strategic aims of its chronic disease management programme.

### GP numbers have increased but lack of data prevents workforce planning at a national or local level

**64.** The number of GPs in Scotland has risen from 4,456 in 2004 to 4,721 in 2007.[48] However, since the

45 *Scottish enhanced services programme for primary and community care*, PCA(M)(2007)10, SEHD, August 2007.
46 Three of these services are developments of the one-year directed enhanced services implemented in 2006/07 – services for carers, cancer referral audit and services for adults with learning disabilities.
47 The programme proposed the following services as national priorities, the number of NHS boards which have provided these services are shown in brackets): services for adults with learning disabilities (11), alcohol screening and brief interventions (5), care for adults with diabetes (7), cancer and urgent referral audit (9), services for carers (7), COPD-pulmonary rehabilitation (11), falls prevention and bone health (7), childhood obesity services (1), flexible GP appointment sessions (0).
48 ISD workforce statistics, published 29 January 2008. http://www.isdscotland.org/workforce

## Exhibit 13

National enhanced services in Scotland

There are minor changes in the percentage of GP practices providing national enhanced services.

| Service | Percentage of GP practices across Scotland providing service | | |
|---|---|---|---|
| | 2004/05 | 2005/06 | 2006/07 |
| Patients suffering from alcohol or drug misuse[1] | 43.7 | 39.1 | 40.4 |
| Anti-coagulation monitoring | 81.0 | 73.3 | 68.7 |
| Intra-uterine Contraceptive Device (IUCD) fittings | 63.3 | 63.1 | 62.3 |
| Specialised care of patients with depression | 7.0 | 6.9 | 8.5 |
| Provision of immediate care and first response care | 8.0 | 8.6 | 9.3 |
| Enhanced care for the homeless | 4.3 | 4.9 | 5.1 |
| Intrapartum care | 2.7 | 2.4 | 1.5 |
| Minor injury services | 24.7 | 31.5 | 30.7 |
| Specialised sexual health services | 0.6 | 1.0 | 1.3 |
| Specialised services for patients with MS | 5.0 | 4.8 | 5.7 |
| Near-patient testing | 89.2 | 86.9 | 88.1 |

Note: 1. Refers to two separate NES
Source: Audit Scotland, 2008

implementation of the new contract there is a lack of comprehensive data on staff numbers, workload and activity in GP practices. The NHS does not know the number of GPs, full or part-time, by NHS board. The Scottish Government collects some workforce data through the annual Primary Care Workforce Survey. This is a voluntary survey, therefore the data quality depends upon the number of GP practices submitting data. In 2006/07, 69 per cent of practices asked to participate in the survey completed a return. GPs and the Scottish Government must work together to improve these data.

**65.** The lack of data on GP practice staff does not allow robust workforce planning at a national or local NHS board level. However, we do know that the new contract has addressed the issues that previously caused most dissatisfaction to GPs. Satisfaction levels increased from 56 per cent in 2001 to 75 per cent in 2006, with the main reasons given as better pay and working hours.[49]

**66.** Only three NHS boards (NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde and NHS Shetland) routinely collect and monitor information on recruitment and retention in primary care. NHS Shetland collects this for NHS board managed practices only.

**67.** The number of salaried GPs in Scotland, either within GP practices or employed by NHS boards (including those just carrying out out-of-hours services) has increased by 117 per cent since the implementation of the nGMS contract, from 188 in 2004 to 408 in 2007.[50] The use of salaried GPs has provided flexibility in providing services to remote, rural and deprived areas.

### Practice staff roles are changing under the new contract

**68.** Although there are limited monitoring data at a national level, there are signs that the nGMS contract is beginning to change the way that people work within GP practices. Since the introduction of the new contract fewer GPs in Scotland have concerns about staffing levels in their practices. In 2002, 75 per cent stated they had insufficient staff to allow delegation of some tasks from GPs to others in the practice. By 2006, this had reduced to 53 per cent.[51]

#### Practice nurses are helping to meet the requirements of QOF

**69.** ISD collects practice team information (PTI) from a small sample of practices in Scotland, 45 practices in 2006/07. These practices are broadly, but not completely, representative of the Scottish population in terms of age, gender and urban/rural mix. They give an indication of what is happening within practices, in the absence of more comprehensive data. PTI data suggest that practice nurses are undertaking

49 *Changes in job satisfaction, work commitments and attitudes to workload following contractual reform*, French, Geue, Ikenwilo, Needham, Rooke, Skatun, Sutton, December 2006.
50 ISD workforce statistics, published 29 January 2008. http://www.isdscotland.org/workforce
51 *Changes in job satisfaction, work commitments and attitudes to workload following contractual reform*, French, Geue, Ikenwilo, Needham, Rooke, Skatun, Sutton, December 2006.

an increasing number of consultations with patients. Practice nurses carried out 32.6 per cent of all GP practice consultations (practice nurses and GPs) in 2006/07 compared to 29 per cent in 2003/04 (Exhibit 14).

**70.** Practice nurses are employed directly by the GP practice and there is no national information available on staff remuneration within GP practices – not all practice nurses are covered by national pay agreements such as Agenda for Change.[52]

**71.** All nurses, including practice nurses, have to comply with a professional code of conduct, which has recently been updated. NHS Education for Scotland (NES) supports education and professional development for practice nurses but funding for training is restricted. In 2006/07, NES funded training grants for 30 new practice nurses in GP practices involved in the 'Keep Well' initiative.[53] Another 30 were offered to all other NHS boards in 2007/08. Each training grant is equivalent to £2,000 per practice nurse.

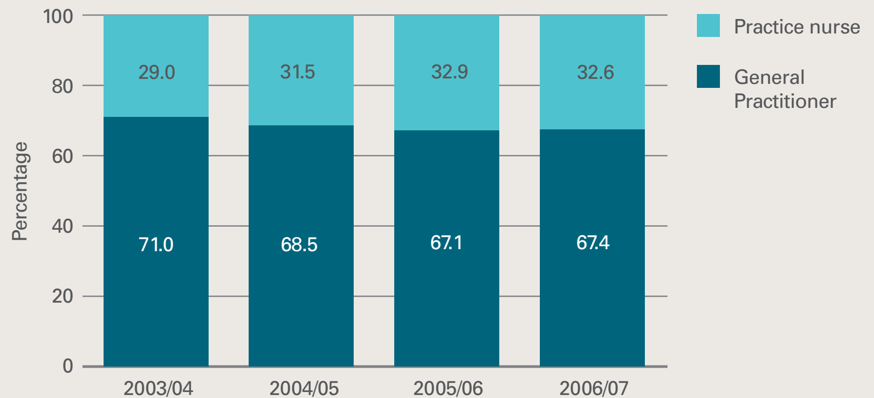
**72.** Based on PTI data, around 23 per cent of all consultations with a GP or practice nurse in Scotland in 2006/07 were for a QOF-related condition (Exhibit 15).[54]

**73.** The administrative role within GP practices has not decreased with the introduction of the nGMS contract but the focus of the role has changed; for example, data entry and recording of patient contacts are required to meet the QOF criteria. All sample NHS boards have suggested that there has been a change in the role of practice manager to business manager, and in some cases practice managers have become partners. Practice managers have been supported by the NHS network and learning programme to develop the required skills.

## Exhibit 14

General Practioner and practice nurse contacts

The percentage of consultations with a practice nurse has increased.[1]



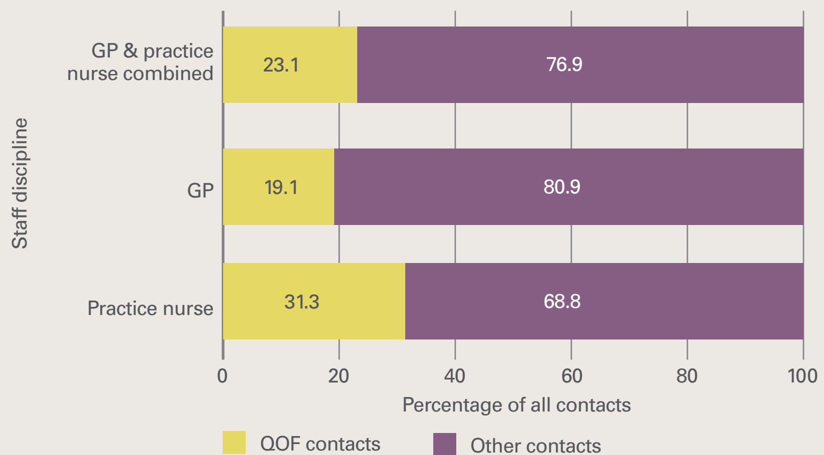

Note: 1. Based on data submitted by the following numbers of PTI practices: 45 in 2003/04, 44 in 2004/05, 44 in 2005/06 and 45 in 2006/07. http://www.isdscotland.org/pti

Source: ISD PTI Data

## Exhibit 15

QOF related practice consultations

Nearly a third of practice nurse consultations relate to QOF clinical areas.




Source: ISD Practice Team Information data for 2006/07; http://www.isdscotland.org/pti

### The impact of the new contract on other NHS services is not known

**74.** There is no regular monitoring of the impact of the nGMS contract on hospitals; for example, whether referrals to specialist services have increased. This makes planning and the re-allocation of resources harder to manage.

**75.** The SEHD produced a work plan in 2004, which highlighted that it would review the impact of the nGMS contract on referrals, but this has not yet been done.[55] However, some NHS boards are looking at the impact of the nGMS contract on local hospital services. For example, NHS Grampian has implemented a local enhanced service for referral management

52 Agenda for Change is a new contract that covers most NHS staff and aims to harmonise pay scales and terms and conditions throughout the NHS. It was introduced in April 2004.
53 The 'Keep Well' initiative is a free health check for people aged 45-64 in certain areas of Scotland.
54 Note that defining workload due to QOF-related conditions is complex and does not result in absolute figures. It is also different from workload strictly due to achieving QOF targets.
55 *Implementation of the nGMS Contract Workplan 2004/05*, SEHD, 2004.

and is analysing planned referrals to ensure they are made appropriately.

**76.** As a result of the contract some services are now undertaken in GP practices that were previously carried out in hospital, for example, anti-coagulation testing and review of patients with type II diabetes. Although NHS boards are redesigning services to provide more locally based care the analysis of total costs of the NHS shows that resources are not shifting towards primary care in line with planned changes.[56]

**77.** All sample NHS boards review prescribing in primary care and note higher levels of prescribing since the implementation of the nGMS contract and the QOF. This is not necessarily a negative indicator but without better monitoring it is not possible to judge the appropriateness of this rise.

**78.** Only one out of the five sample NHS boards, NHS Grampian, had reviewed laboratory test requests from GP practices since the implementation of the nGMS contract. Its data showed that although the volume of test requests had risen, there was no evidence that this was due to the nGMS contract. Laboratory test requests from GPs increased by 15.9 per cent between 2003/04 and 2004/05, compared to a 13.5 per cent increase between 2002/03 and 2003/04 prior to the introduction of the contract.[57]

**79.** The implementation of the nGMS contract has reportedly affected the activity of the Scottish Ambulance Service and NHS 24. The Scottish Ambulance Service and NHS 24 were involved in the implementation workgroups primarily concerned with the impact of GPs opting out of out-of-hours care. However, the impact of the nGMS contract does not just change out-of-hours working, it also changes the way GP practices work during the day. These changes may also have led to pressures on NHS 24 and the Scottish Ambulance Service and these factors were not fully considered. There are conflicting views about the effect of the nGMS contract on the workload of NHS 24 and the Scottish Ambulance Service, but with a lack of information it is difficult to confirm what this has been. The Scottish Government has established a Demand Management Group to clarify the position and identify actions needed.

**80.** Five out of the 14 NHS boards have implemented local enhanced services to improve GP services for people living in care homes.[58] However, both the Care Commission and Help the Aged have raised concerns about the lack of GP services to care homes in some areas indicating that this may be an area which all NHS boards should review.[59] The use of enhanced services can mean that some areas receive a better service dependent on resources being made available.

**Recommendations**

The Scottish Government should:

- review the impact of the nGMS contract on referrals and prescribing rates in clinical areas covered by the QOF to inform the future development of the nGMS contract
- collect monitoring data on the effect of recent changes on the workload of NHS 24 and the Scottish Ambulance Service
- measure anticipated benefits of the nGMS contract.

The Scottish Government and NHS boards should:

- collect comprehensive data on GP and GP practice staff numbers to support workforce planning at a national and local level
- ensure that people living in care homes have access to high quality GP services.

56 *Overview of Scotland's health and NHS performance in 2006/07*, Audit Scotland, December 2007.
57 *Effect of the nGMS contract on laboratory test ordering, audit of Scottish Laboratories*, Aberdeen Royal Infirmary, March 2006.
58 These NHS boards are NHS Ayrshire and Arran, NHS Grampian, NHS Highland, NHS Lothian and NHS Orkney.
59 *My home life*, Help the Aged, 2007.

# Part 4. Benefits for patients

Securing patient benefits from the nGMS contract will take time but there is evidence of better monitoring of patients with certain conditions.

**Key messages**

- The nGMS contract has the potential to improve general medical services for patients and most NHS boards believe that it has. More work is now needed to demonstrate improvements in access and health outcomes.
- Securing patient benefits from the nGMS contract will take time. However, there is evidence of some improvement; for example, the QOF is helping to provide consistency of care through better monitoring of patients with certain long-term conditions.

## Most NHS boards believe that patient care has improved as a result of the nGMS contract

**81.** Delivering improved services for patients was one of the key aims of the contract, specifically the aim of having more services delivered in primary care and closer to the patient's home (Exhibit 16). Eleven NHS boards believe that patient care within the board has improved as a result of the nGMS contract. Two NHS boards believe it is too soon to tell, and one NHS board did not express an opinion.

## Access to GP practices is not monitored under the new contract

**82.** Access to GP practices is a high priority for patients. The target is that all patients should have contact with a healthcare professional in the practice team within 48 hours. This should not prevent the patient requesting an appointment with a specific healthcare professional if they wish to, but this is not guaranteed to take place within 48 hours. Only four of the 14 NHS boards think that access to GPs has improved due to the nGMS contract.

**83.** Achievement of the 48-hour access target is not being measured. To meet the requirements of the 48-hour access target, GP practices must demonstrate they have arrangements in place which support achievement of the target. They do not need to demonstrate that they are actually achieving the target. The achievement of this was high for the first two years of the contract (96.8 per cent in 2004/05 and 99.4 per cent in 2005/06).[60]

**Exhibit 16**

Limited progress has been made in achieving patient benefits expected from nGMS

| Expected benefits | Progress |
|---|---|
| Improve convenience choice, and access for patients | **Limited progress has been made.**<br>The number of services provided through GP practices has increased as the number of enhanced services commissioned by NHS boards increase.<br>Access to general medical services is monitored as to whether systems are in place to achieve the 48-hour target rather than achievement of the target itself.<br>In March 2008, GPs agreed in principle to extend practice opening hours by an average of 2.75 hours per week outside the core service hours (0800 to 1830, Monday to Friday). The impact this will have on access, convenience and patient satisfaction will require monitoring and evaluation. |
| Quality framework to manage chronic disease | **Some progress has been made.**<br>The QOF has improved the recording and monitoring of patients with some specific diseases. Estimates suggest 23 per cent of face-to-face consultations in GP practices relate to QOF. |

Source: *Implementing the new GMS contract in Scotland*, SEHD/NHS Scotland, February 2004. *Delivering the benefits of pay modernisation in NHS Scotland*, NHS HDL(2005)28, SEHD, July 2005. *Primary Medical Services – Strategic Tests*, NHS Scotland, September 2007.

60 In 2006/07, the access target moved from a QOF indicator to a directed enhanced service but kept the same criteria in Scotland.

## Good practice example

GP practices can take part in the Scottish Primary Care Collaborative (SPCC) to improve access to general medical services.

Practices participating in SPCC have reduced the average waiting time to see a GP from 4.67 days to 1.45 days.[61] They have achieved this by reviewing demand patterns for appointment times and managing clinics and staff working hours (including leave requests and study time) more effectively. The average time for an appointment with a member of the nursing team improved by 54 per cent despite nurse caseloads becoming more complex.[62]

**84.** One of the requirements of the QOF is that routine consultations booked with GPs will not be less than ten minutes. Average consultation times with GPs in the UK have increased from 8.4 minutes in 1992/93 to 11.7 minutes in 2006/07 after the introduction of the contract.[63]

**85.** In 2008, as part of QOF renegotiations, it was agreed that GP practices would survey patients to see how satisfied they are with the time taken to get an appointment. The details of the survey are not yet available. The Scottish Government is planning a national patient access survey which will provide data on patient experience. The survey will look at how easy patients find it to access a member of the practice team within 48 hours and whether they are able to book ahead up to a fortnight in advance. These survey data are designed to inform the points a practice can gain under QOF.

### Opening hours

**86.** The NHS across the UK has asked GP practices to extend their opening hours beyond the core period to improve access for patients. In March 2008, 93 per cent of GPs in Scotland voted to accept the option to extend GP practice opening hours beyond core hours (0800 to 1830, Monday to Friday) by half an hour per 1,000 patients on the practice list per week. On average this equates to opening the practice for an additional 2.75 hours per week. The vote, however, does not mean that all GP practices will decide to extend their opening hours although it gives them the option. The Scottish Government hopes that these extended hours will help people who work during the day to access GP practices for routine appointments at a convenient time.

### The QOF has improved some processes for patient care but a greater focus on outcomes is needed

**87.** The QOF forms a significant part of the nGMS contract and introduces a system for ensuring consistency in certain primary care services for patients. It has led to better monitoring of some conditions, specifically long-term conditions such as diabetes. It has also brought the performance against QOF indicators of a few poorer performing practices up to the level of the rest.

**88.** The average nGMS practice achievement in Scotland for QOF has risen from 92.5 per cent of points available in 2004/05 to 97.1 per cent in 2006/07 (Exhibit 17, overleaf). Achievement peaked at 97.7 per cent in 2005/06, but decreased in 2006/07 due to changes in the indicators and points available.[64] There is scope for the UK health departments and the BMA to renegotiate the indicators annually and this is essential to ensure value for money in the future. The National Primary Care Research and Development Centre recently made a number of recommendations on the future development of the QOF, including more progressive targets, the piloting of new indicators before they are introduced, recycling of indicators on three to four-year cycle and that there should be no overall increase in QOF income.[65]

**89.** The QOF has helped NHS boards to identify underperformance, allowing them to put in place initiatives to improve performance. For example, NHS Lanarkshire identified underachievement in a specific indicator in 2004/05 and implemented a spirometry service and delivered training to improve performance.[66]

### There is limited evidence of improvements for all patients since the introduction of the nGMS contract

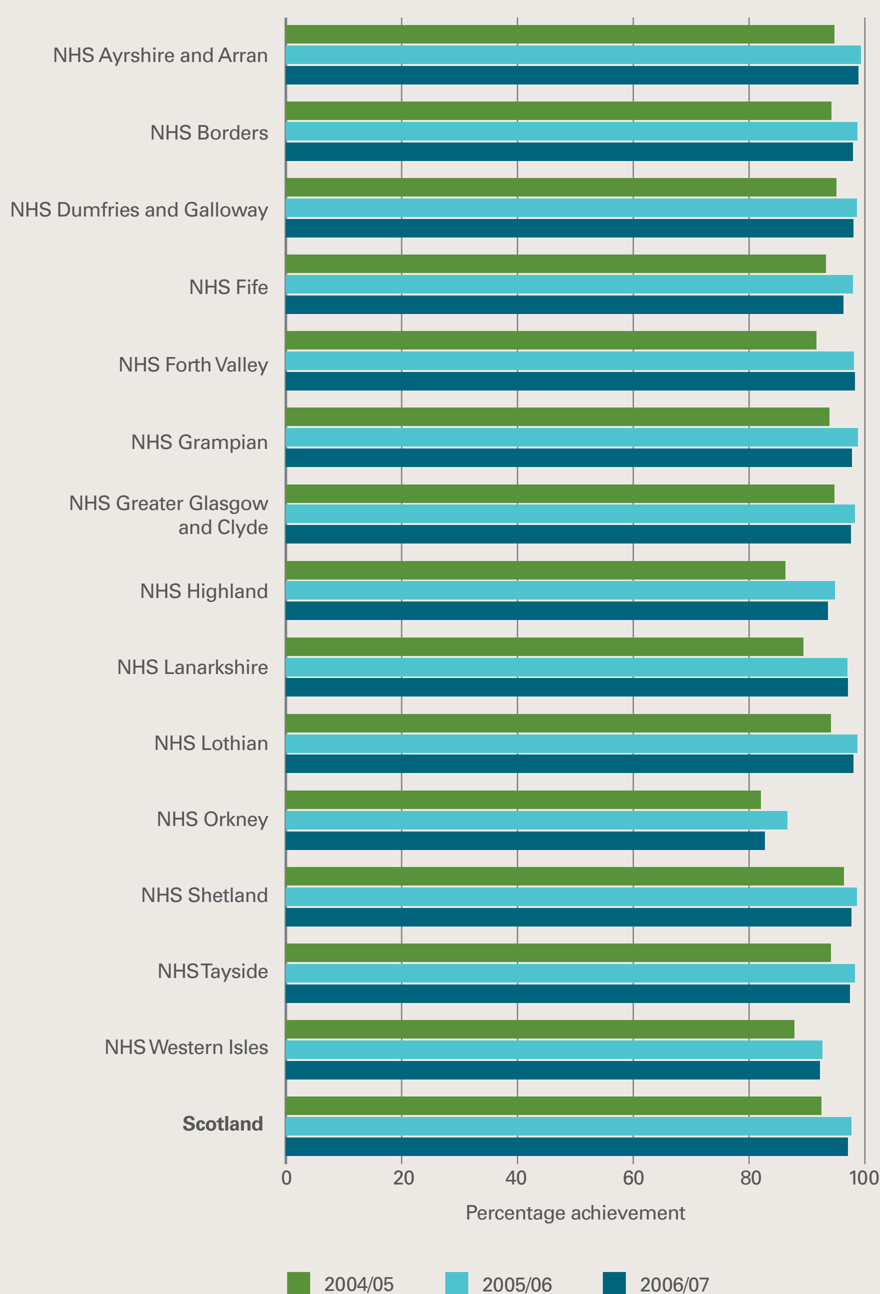
**90.** Although achievement of QOF indicators is likely to lead to long-term health improvements, it is too early to show demonstrable benefits in health from the QOF. However, academic research has shown that achievement of quality indicators (eg, to reduce cholesterol) will improve the health of practice populations if the quality of care is maintained.[67]

**91.** Prevalence data supporting the QOF identified 558,376 patients in Scotland suffering from hypertension in 2004/05. Research by the BMA suggests that by lowering blood pressure and controlling hypertension effectively in these patients over a

61 Based on 178 practices that have completed the access programme in 24 months (from September 2003 to September 2005).
62 *The Scottish Primary Care Collaborative*, Scottish Government Health Delivery Directorate, January 2008.
63 *2006/07 UK General Practice Workload Survey*, NHS Information Centre, 2007.
64 ISD QOF web pages, http://www.isdscotland.org/qof
65 http://www.npcrdc.ac.uk/Quality_and_Outcomes_Framework_QOF_.htm
66 Spirometry is a test that can help diagnose various lung conditions, most commonly COPD (Chronic Obstructive Pulmonary Disease). Spirometry is also used to monitor the severity of certain lung conditions, and how they respond to treatment.
67 *Will changes in primary care improve health outcomes? Modelling the impact of financial incentives introduced to improve quality of care in the UK*, McElduff, Lyratzopoulos, Edwards, Heller, Shekelle and Roland, Quality and Safety in Health Care, 13:191-197, 2004.

## Exhibit 17

Overall percentage quality and outcomes achievement for nGMS practices by NHS board




Source: ISD QOF web pages, http://www.isdscotland.org/qof

five-year period, 820 cardiovascular events (heart attacks/strokes) will be prevented.[68]

**92.** The QOF and the mechanisms GP practices have had to put in place to deliver it appear to have had a positive impact on other conditions that are not part of the QOF. This includes the recording of alcohol status, which although not part of the QOF is also being recorded more routinely.[69]

**93.** GP practices are able to exclude some patients from the QOF measurements, for example, when a patient has a side effect to a medication or does not attend a review appointment. This is known as exception reporting. Exception reporting by GP practices is monitored as part of the QOF review process carried out by each NHS board largely through reviewing documentation and carrying out practice visits.

**94.** Some research studies have shown that exception reporting has been used appropriately for specific groups of patients, for example, stroke patients.[70] However, other research studies indicate that approximately ten per cent of patients are inappropriately excluded from QOF measurements.[71] There is a risk that certain groups of patients may be excluded due to exception reporting such as those patients who find it difficult to attend GP appointments. Reductions in exception reporting would ensure that all patients benefit from the QOF and this should be kept under review.

68 *Will changes in primary care improve health outcomes? Modelling the impact of financial incentives introduced to improve quality of care in the UK*, McElduff, Lyratzopoulos, Edwards, Heller, Shekelle and Roland, Quality and Safety in Health Care, 13:191-197, 2004.
69 *Measuring quality in primary medical services using data from Spice*, R Elder, M Kirkpatrick, W Ramsey, M MacLeod, B Guthrie, M Sutton, G Watt, NHS QIS, NHS NSS, July 2007.
70 *Are different groups of patients with stroke more likely to be excluded from the new UK general medical services contract? A cross-sectional retrospective analysis of a large primary care population*, Simpson, Hannaford, McGovern, Taylor, Green, Lefevre, Williams, 1471-2296, September 2007.
71 *Doctor behaviour under a pay for performance contract: evidence from the quality and outcomes framework*, Centre for Health Economics, University of York, May 2007.

### Most practices carry out patient satisfaction surveys

**95.** To achieve QOF points for patient experience GP practices need to undertake a patient survey each year, produce an action plan and report the results of the survey. Achievement of patient experience indicators in the QOF was initially high and has remained high (94.1 per cent in 2004/05, 97.7 per cent in 2005/06 and 98 per cent in 2006/07).

**96.** Ten out of the 14 NHS boards monitor patient satisfaction with nGMS services from data collected by GP practices. Although there is local monitoring, patient satisfaction with their GP practice is not monitored at a national level. The Scottish Government is working with GPs and NHS boards to develop a national survey of patients to monitor levels of satisfaction with GP services. The survey will be available from April 2009.

### Recommendations

The Scottish Government should:

- continue to improve the contribution of QOF to patient care and to achieve value for money by moving from a focus on processes to a greater focus on outcomes
- monitor demand for emergency care, with the Scottish Ambulance Service and NHS 24, and consider the impact of extended GP practice opening hours on these services.

NHS boards should:

- continue to monitor levels of GP exception reporting to ensure that specific groups of people are not excluded inappropriately.

# Appendix 1.

## Advisory group members

| Member | Organisation |
| --- | --- |
| Jane Cantrell, Programme Director, NMAHP | NHS Education for Scotland |
| Gareth Davies, Primary Care Medical Director | NHS Forth Valley |
| Dr Nadine Harrison, Senior Medical Officer | Primary Care Division, Scottish Government |
| Robert Kemp, Director of Finance | NHS Borders |
| Dr Julie Kidd, Principal Information Analyst, Primary Medical Services | Information Services Division (ISD) NHS National Services Scotland |
| Ian McDonald, Associate Director of Finance | NHS Tayside |
| Dr Dean Marshall, GP and Chairman, Scottish General Practitioners Committee | British Medical Association |
| Duncan Miller, General Manager, Primary Care Contracts, and GMS Lead | NHS Lothian |
| Mark O'Donnell, General Manager Planning and Performance | Scottish Ambulance Service |
| Nigel Small, Community Health Partnership Manager | South East Highland Community Health Partnership |
| Professor Matt Sutton, Professor of Health Economics | Health Methodology Research Group, University of Manchester |
| Dr Steven Wilson, Performance Assessment Team Manager | NHS Quality Improvement Scotland |

Note: Members of the advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

# Appendix 2.

## Details of QOF

| Clinical | | Organisational | Additional services | Patient experience |
|---|---|---|---|---|
| 2004/05 | Additional in 2006/07 | | | |
| Coronary heart disease | Heart failure | Records and information | Cervical screening | Length of consultations |
| Stroke/transient ischemic attack* | Palliative care | Information for patients | Child health surveillance | Patient survey |
| Hypertension | Dementia | Education and training | Maternity services | |
| Diabetes* | Depression | Practice management | Contraceptive services | |
| Chronic obstructive pulmonary disease* | Chronic kidney disease | Medicines management | | |
| Epilepsy | Atrial fibrillation | | | |
| Hypothyroidism | Obesity | | | |
| Cancer* | Learning disabilities | | | |
| Mental health* | | | | |
| Asthma* | | | | |
| Smoking* | | | | |

Note: Categories marked * have had points and indicators amended in 2006/07.
Source: nGMS Contract 2004 and Revision to the GMS Contract 2006/07, Delivering Investment in General Practice, Scottish Guidance, SEHD

### Description of QOF points

In 2004/05 and 2005/06, practices could score up to a maximum of 1,050 points across 146 indicators. For 2006/07, this was revised to a maximum of 1,000 points across 135 indicators. The distribution of points by domain and year are laid out in more detail in the following tables, while the domains and additional points are expanded on in further text overleaf.

### QOF – points and payments available to practices, 2004/05-2005/06

| | Number of indicators | Total points available | 2004/05 Pounds per point | 2005/06 Pounds per point |
|---|---|---|---|---|
| 1. Evidence-based indicators | | | | |
| • Clinical domain | 76 | 550 | Variable | Variable |
| • Organisational domain | 56 | 181 | £75 | £124.64 |
| • Patient experience domain | 4 | 100 | £75 | £124.64 |
| • Additional services domain | 10 | 36 | Variable | Variable |
| Subtotal evidence-based indicators | 146 | 870 | | |
| 2. Additional payment points | | | | |
| • Holistic care | 0 | 100 | £75 | £124.64 |
| • Quality practice | 0 | 30 | £75 | £124.64 |
| • Access bonus | 0 | 50 | £75 | £124.64 |
| Total | | 1,050 | | |

Source: ISD QOF web pages, http://www.isdscotland.org/qof

### QOF – points and payments available to practices, 2006/07

| | Number of indicators | Total points available | 2006/07 Pounds per point |
|---|---|---|---|
| 1. Evidence-based indicators | | | |
| • Clinical domain | 80 | 655 | Variable |
| • Organisational domain | 43 | 181 | £124.64 |
| • Patient experience domain | 4 | 108 | £124.64 |
| • Additional services domain | 8 | 36 | Variable |
| Subtotal evidence-based indicators | 135 | 980 | |
| 2. Additional payment points | | | |
| • Holistic care | 0 | 20 | £124.64 |
| Total | | 1,000 | |

Source: ISD QOF web pages, http://www.isdscotland.org/qof

Notes:

1. £75 per point was the initial amount for 2004/05 and excluded employers' superannuation payments. This was later raised to £77.50 per point, inclusive of superannuation. Payments for 2004/05 published on the ISD website are based on the initial £75.

2. £124.64 per point as applicable to 2005/06 and 2006/07 is inclusive of employers' superannuation payments.

3. Within the clinical domain, the baseline payment per point is adjusted up or down for each practice according to a 'prevalence rate' derived from the QOF register applicable to each individual indicator. QOF registers may relate to a single health condition, or group of health conditions, and may have specific restrictions on them, eg covering patients within a particular age range only.

4. Within the additional services domain, the baseline payment per point is adjusted up or down for each practice according to the number of patients within the target population for each additional service type, relative to the national average target population size for that additional service.

5. Holistic care payment points are awarded on the basis of overall achievement in the clinical domain.

6. Applicable only to the framework during 2004/05 and 2005/06, quality practice payment points were awarded on the basis of overall achievement in the organisational, patient experience and additional services domains.

7. Applicable only to the framework during 2004/05 and 2005/06, access bonus payment points rewarded sustainable achievement against the 48-hour access target; that is, access to a GP, nurse, or other health care professional within 48 hours. The access bonus was removed from the QOF at the end of March 2006. Instead, the requirement that practices demonstrate 48-hour access was formalised as a directed enhanced service.

8. All the payments in the four domains and additional payment point areas are added together to give the total 'raw' payment for the practice. This 'raw' payment is then adjusted up or down according to the list size of the practice (ie, the number of patients registered) relative to the national average size (set at 5,095 patients).

# Appendix 3.

## QOF achievement and payments for nGMS practices in Scotland, 2004/05 to 2006/07

| | Per cent achievement of QOF by nGMS practices | | | Average QOF payment per nGMS practice | | |
|---|---|---|---|---|---|---|
| | 2004/05 | 2005/06 | 2006/07 | 2004/05 | 2005/06 | 2006/07 |
| NHS Argyll and Clyde | 89.0 | 93.2[1]<br>97.8[2] | | £64,581 | £66,407[1]<br>£138,687[2] | |
| NHS Ayrshire and Arran | 94.7 | 99.3 | 98.9 | £102,843 | £176,511 | £174,124 |
| NHS Borders | 94.2 | 98.7 | 97.9 | £65,337 | £113,939 | £108,940 |
| NHS Dumfries and Galloway | 95.1 | 98.6 | 98.0 | £64,918 | £111,408 | £106,701 |
| NHS Fife | 93.3 | 97.9 | 96.3 | £87,403 | £152,798 | £143,809 |
| NHS Forth Valley | 91.6 | 98.1 | 98.3 | £78,901 | £139,728 | £133,677 |
| NHS Grampian | 93.9 | 98.8 | 97.8 | £94,028 | £165,665 | £159,575 |
| NHS Greater Glasgow and Clyde | 94.7 | 98.3 | 97.6 | £66,135 | £114,514 | £113,906 |
| NHS Highland | 86.3 | 94.8 | 93.6 | £47,370 | £89,363 | £78,676 |
| NHS Lanarkshire | 89.4 | 97.0 | 97.1 | £80,782 | £147,011 | £140,412 |
| NHS Lothian | 94.1 | 98.7 | 98.0 | £95,927 | £166,603 | £160,171 |
| NHS Orkney | 82.0 | 86.6 | 82.7 | £34,386 | £40,783 | £39,258 |
| NHS Shetland | 96.4 | 98.6 | 97.7 | £17,603 | £29,839 | £29,647 |
| NHS Tayside | 94.1 | 98.3 | 97.4 | £85,909 | £148,609 | £146,830 |
| NHS Western Isles | 87.8 | 92.7 | 92.2 | £16,448 | £28,079 | £26,278 |
| **Scotland** | **92.5** | **97.7** | **97.1** | **£76,435** | **£134,073** | **£128,745** |

Notes:
1. NHS Highland.
2. NHS Greater Glasgow.
In April 2006, NHS Greater Glasgow and NHS Highland took over responsibility for the former NHS Argyll and Clyde. Data for the former NHS Argyll and Clyde are presented here split into two parts for 2005/06, corresponding with the practices that from April 2006 come under the responsibility of NHS Highland and NHS Greater Glasgow boards.
The averages used here are the unweighted means.
Source: QMAS database, as at 25 August 2005, 9 August 2006, 1 August 2007, http://www.isdscotland.org/qof

# Appendix 4.

## NHS board minimum required investment and actual expenditure on enhanced services

| | 2004/05 | | | 2005/06 | | | 2006/07 | | |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | | | £000 | | | £000 | | |
| | Allocation | Expenditure | Per cent overspend | Allocation | Expenditure | Per cent overspend | Allocation | Expenditure | Per cent overspend |
| NHS Argyll and Clyde | 2,882 | 2,928 | 1.6 | 2,882 | 3,073 | 6.6 | | | |
| NHS Ayrshire and Arran | 2,523 | 3,890 | 54.2 | 2,523 | 4,124 | 63.5 | 3,145 | 5,607 | 78.3 |
| NHS Borders | 803 | 906 | 12.8 | 803 | 944 | 17.6 | 803 | 849 | 5.7 |
| NHS Dumfries and Galloway | 1,141 | 1,021 | -10.5 | 1,141 | 1,106 | -3.1 | 1,422 | 1,613 | 13.4 |
| NHS Fife | 2,164 | 2,667 | 23.2 | 2,164 | 2,209 | 2.1 | 2,697 | 2,706 | 0.3 |
| NHS Forth Valley | 1,877 | 2,220 | 18.3 | 1,877 | 2,211 | 17.8 | 2,340 | 2,991 | 27.8 |
| NHS Grampian | 3,458 | 5,003 | 44.7 | 3,458 | 4,821 | 39.4 | 4,310 | 6,640 | 54.1 |
| NHS Greater Glasgow and Clyde | 6,236 | 8,828 | 41.6 | 6,236 | 9,069 | 45.4 | 10,324 | 14,535 | 40.8 |
| NHS Highland | 2,010 | 2,829 | 40.7 | 2,010 | 3,312 | 64.8 | 3,547 | 5,472 | 54.3 |
| NHS Lanarkshire | 3,615 | 3,831 | 6.0 | 3,615 | 3,896 | 7.8 | 4,506 | 5,273 | 17.0 |
| NHS Lothian | 4,896 | 6,350 | 29.7 | 4,896 | 6,511 | 33.0 | 6,103 | 7,155 | 17.2 |
| NHS Orkney | 150 | 1,691 | 1,027.3 | 150 | 91 | -39.3 | 187 | 181 | -3.2 |
| NHS Shetland | 174 | 177 | 1.7 | 174 | 178 | 2.3 | 217 | 175 | -19.4 |
| NHS Tayside | 2,676 | 2,981 | 11.4 | 2,676 | 2,385 | -10.9 | 3,336 | 3,365 | 0.9 |
| NHS Western Isles | 293 | 242 | -17.4 | 293 | 239 | -18.4 | 365 | 572 | 56.7 |
| **Total** | **34,898** | **45,564** | **30.6** | **34,899** | **44,169** | **26.6** | **43,302** | **57,134** | **31.9** |

Note: In April 2006, NHS Greater Glasgow and NHS Highland took over responsibility for the former NHS Argyll and Clyde. Data shown for NHS Greater Glasgow and Clyde and NHS Highland in 2006/07 include allocations and expenditure for those practices formerly part of NHS Argyll and Clyde.
Source: Primary Medical Services Allocations for 2004/05, SEHD, May 2004; Primary Medical Services Allocations for 2005/06, SEHD, June 2005; PCA2005(M)14 NHS Board Funds – Enhanced Services Floor, SEHD, 2006. Unified board summary accounts, 2004/05 to 2006/07, Scottish Government Health Directorates.

# Appendix 5.

## Self-assessment checklist for NHS boards

The checklist sets out some high-level statements about the nGMS contract based on issues raised in this report. NHS boards (with their CHPs) should assess themselves against each of the statements and consider which statement most accurately reflects their current situation:

- Not in place and action needed.
- Not in place but action in hand.
- In place but needs improving.
- In place and working well.

This approach will enable boards to identify what action needs to be taken.

| Issue | Assessment of current position | | | | | Comment to support or explain your statement |
|---|---|---|---|---|---|---|
| | No – action needed | No – but action in hand | Yes – in place but needs improving | Yes – in place and working well | Not applicable | |
| We monitor the effectiveness of CHPs in taking over responsibility for general medical services | | | | | | |
| We monitor investment in enhanced services to make sure that we achieve value for money and meet local need | | | | | | |
| We collect comprehensive data on GP and GP practice staff numbers to support workforce planning at a national and local level | | | | | | |
| We have reviewed access to general medical services for people living in care homes and other residential homes to ensure that they have access to high quality GP services | | | | | | |
| We continue to monitor levels of GP exception reporting to ensure that specific groups of people are not excluded inappropriately | | | | | | |

# Review of the new General Medical Services contract

If you require this publication in an alternative format and/or language, please contact us to discuss your needs.

You can also download this document at:
**www.audit-scotland.gov.uk**

Audit Scotland, 110 George Street, Edinburgh EH2 4LH
T: 0845 146 1010 F: 0845 146 1009
**www.audit-scotland.gov.uk**

ISBN 978 1 906752 07 1 AGS/2008/7

This publication is printed on uncoated paper, made from 100% post consumer reclaimed material.