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Review of the new General Medical Services Contract in Wales



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Summary

- 1** Across the United Kingdom (UK), General Practitioners (GPs) provide primary medical care to patients and act as gatekeepers to other National Health Service (NHS) services. Over 90 per cent of patient contacts with the NHS are in primary care, and GPs are an essential part of the NHS.
- 2** The NHS in Wales' strategic drive is towards world-class services managed efficiently, and providing effective care. The Welsh Assembly Government (the Assembly Government) 10 year strategy for health, Designed for Life, sets out the vision of the Assembly Government for achieving this, and places emphasis on local services. Effective primary care services are an essential part of this vision.
- 3** Leading up to 2002, there was widespread concern amongst GPs about both their workload and the sustainability of their services. There was a real risk that some GPs would opt out of the NHS, which was already suffering from recruitment and retention problems. The new General Medical Services (GMS) contract was introduced from April 2003¹. It replaced the previous contract and changed the basis on which GPs' income is calculated. However, concerns have arisen about the cost of the contract, and its impact on services with the implication that it may not be providing value for money for the people of Wales.
- 4** We set out to answer the question: Is the new GMS contract working in Wales? The framework is in place, but to demonstrate value for money, further changes are needed to deliver benefits to patients as well as GPs from the increased expenditure.

The new contract provides a framework which can accommodate the competing requirements of GPs, patients and commissioners

- 5** The new GMS contract was negotiated between the British Medical Association (BMA) and the NHS Confederation on behalf of the four UK health departments. The legislation supporting the contract came into effect on 1 April 2004. Wales benefited from the contract across the four countries within the UK, because separate negotiations would have duplicated resources, and potentially fragmented the national workforce. The contract needed to meet competing expectations from stakeholders, namely, patients and taxpayers, GPs, the Assembly Government and commissioners (those who purchase the service) on behalf of patients.

¹ See Appendix 2 for details of what services are covered by the new GMS contract.



- 6 There was general agreement between GPs, the wider NHS and Government that previous arrangements had not supported the drive towards wider and better primary care services. Medical evidence from national and international studies showed that GPs could do many things, that would over time, lead to improvements in both individual patient and public health.

The new contract has brought significant benefits for GPs

- 7 The contract delivers most GP requirements. GPs wanted to improve their work-life balance, be able to opt in and out of services as they choose, and to be paid equivalent to their colleagues following similar medical careers.
- 8 By 2005/2006, under the new GMS contract, GP salaries had risen by 25 per cent and, at the same time, their average weekly working hours had reduced by around 10 per cent. Practice expenditure has not increased significantly, but practices are able to choose whether or not to provide additional services.
- 9 For the first time in the UK, the contract sets measurable standards for primary care services. Practice performance is now measured and paid for through a points system, known as the Quality and Outcomes Framework (QOF). Payments for achieving these standards now represent a significant source of additional income for many practices.
- 10 These changes mean that general practice is now a more attractive option and, for the first time in many years, trainee schemes are oversubscribed and vacancy levels are falling.

Benefits to patients are more limited in the short term

- 11 The contract has some benefits for patients. Patients wanted continuity of service and continued access to GPs on the NHS. The contract rewards practices for providing prompt access to primary care. Service continuity has been achieved and most practices are claiming the payments for achieving access standards. However, access is not always being measured or validated, despite the Assembly Government guidance indicating that achievement of access standards does need to be established to claim the payment.
- 12 The new QOF system has resulted in more activities, more focused activities and more recording of activity. This has changed the way primary care practices provide services in some areas, and has ensured more patients receive care of an acceptable standard. In parts of Wales, attention to QOF monitoring has allowed GPs to show how high their standards already were.
- 13 Patients are also now more likely to be asked by their GPs for their opinions about the quality of the service they are getting. This is an important change, and in many practices this has resulted in changes to waiting rooms, and access arrangements. Wider patient involvement will impact on service development. Unfortunately, this valuable opportunity to collate patient views and use them to inform service developments is mainly restricted to practices, and not shared with the wider NHS.

14 Although the extension of preventative services and management of chronic disease in primary care practices, for example, the regular checking of blood pressure and diabetes monitoring, should help patients' long-term health. Many of these health gains will not be measurable for several years.

Commissioners are able to tailor services to meet identified priorities

15 Commissioners wanted to ensure continuity in primary care services, prevent GPs from leaving the NHS and be able to better influence the future direction and quality of primary care services. Commissioners have achieved service continuity, and increased their capacity to influence and manage primary care services in ways which were not available before.

16 Enhanced Services (ES) are additional services provided by practices to their (and sometimes other practices') patients. Enhanced services offer the prospect of moving care for some conditions closer to patients, and closing gaps in services. The ability to commission services from primary care which are flexible, local and responsive is an important part of the new contract. Services are provided to agreed standards and can be very varied, covering national priorities to local innovations. This flexibility in the contract allows the NHS to develop local services supporting Designed for Life and planned redesign of services.

17 Many Local Health Boards (LHBs) have only managed to commission national enhanced services (UK-wide) or those directed by the Assembly Government across Wales. There are a number of reasons for this, both strategic and operational. These include the Assembly Government directing a large number of enhanced services: the lack of a robust framework allowing disinvestment from secondary care to free up resources to invest in primary and community care: and individual LHBs unable to find additional funding or interest from GPs to provide Local Enhanced Services (LES). Consequently, it is difficult at present to arrive at a considered and robust conclusion on the effectiveness of the new contract in changing the balance of care in Wales from acute services to those delivered in the community.

Changes are needed to realise the new contract's full benefits

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



The contract itself requires some further adjustments

- 19** Contract governance has not been helped by ambiguity in parts of the national contract and limited definition of core services. While too tight a definition will restrict innovation and development of primary care services, the lack of definition is allowing significant differences in what are considered to be core services. In some areas, these differences have resulted in GPs getting additional income for continuing to provide services which they previously provided.
- 20** The contract is held by the practice not individual GPs, and payment is made to the practice for the services it contracts to provide. Income is calculated using the Carr-Hill formula, and is based on calculated need rather than historical investment. This Global Sum (GS) is an important change which allows practices to decide more flexibly how to provide services, and directs money to areas of greatest health need. However, unadjusted, this formula would result in the majority of practices having a lower baseline income (without QOF and Enhanced Services) than under the previous contract.
- 21** A Minimum Practice Income Guarantee (MPIG) protects practices from the re-distributive effects of this formula by boosting their GS to pre-contract levels. However, this is now having unintended consequences, such as attracting GPs to vacancies in better-off areas rather than to the areas with the greatest need. Hence, the MPIG is undermining the intention to redistribute resources based on need.

- 22** The QOF was initially set at achievable levels to ensure practices chose to take part (participation is not compulsory). In 2006/2007 the QOF rules were adjusted by negotiation: some relatively easier points were dropped, and new harder-to-achieve standards set. This recycling of points represents a gradual evolution of the framework and establishes a precedent for the gradual raising of standards over time. Such evolution is consistent with high standards of performance management and the drive across the public sector to improve services over time.

The way in which the contract is managed in Wales must be improved

- 23** Good governance demands that systems are in place to account for public money and promote improvement in services. The QOF in the new contract is a 'high-trust' contract, with the expectation that all parties act in good faith from a position of high professional standards.
- 24** This still means, however, that reasonable checks are required to provide assurance. The new contract involves considerable sums of public money ie, £423 million in 2005/2006. In that year, LHBs across Wales paid practices £65 million for QOF achievements alone. Expenditure on this scale necessarily requires reasonable levels of checks by service commissioners and their auditors on QOF claims. Whilst the contract is intended to be flexible and locally adaptable, it is essential that a baseline standard of accountability and consistency is reached in Wales, otherwise variation will not be driven

by local needs. Distortion or unfairness in resources may follow. Despite guidance from the Assembly Government across Wales we found:

- a** the five per cent random checks agreed nationally, and undertaken in England, are not routinely happening in Wales;
- b** variation exists in the depth and rigour applied to checking QOF points at practice level;
- c** numbers of patients excluded from QOF scores are higher than in other parts of the UK, and vary inexplicably between LHBs; and
- d** the evidence supporting access-standard achievement varies in robustness.

25 Performance management provides a rounded view of a system, organisation or practice. It enables fair comparison between practices (scrutiny) and facilitates improvement in services over time (measurement). The QOF, enhanced services and clinical governance frameworks provide the basis for such a system in primary care. Some LHBs are already realising the benefits of integrating governance in this way, allowing them to manage practices with a lighter touch or focus on practices needing extra support.

26 Most of the estates funding stream under the new contract is for rent and maintenance costs for primary care buildings. Alongside the new GMS contract, the Assembly Government promised significant additional funding to support development and encourage modernisation of the primary care estate. Despite providing resources to help not all LHBs were able to quickly agree estate strategies with the Assembly Government, although all are now agreed. Hence, release

of this money has been significantly slower than expected and this has impacted on the ability of primary care in some areas to change and expand.

27 Prior to the new contract, there was little formal idea of what services were needed Out of Hours (OOH), what was being provided OOH and what the total service cost was. One important outcome of the introduction of the new GP contract was to move the responsibility for providing services outside normal working hours from GP practices to LHBs from October 2004. Local Health Board OOH service specifications are now legally binding contracts with OOH providers. However, services are configured differently and are not easy to compare between LHBs.

Uncertainty on QOF made accurate forecasting of likely costs difficult and budgets were revised

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



QOF cost significantly more than expected

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

Practices were able to respond very quickly to the new opportunities

30 In the early days of the contract, there were concerns that GPs would not participate in QOF because it was voluntary. There was also uncertainty about the scale of the likely payments through QOF. Negotiators warned that practices would struggle to meet QOF expectations. In reality, practices scored more highly through QOF than had originally been expected. In 2005/2006, QOF payments across Wales totalled £65 million, equivalent to 16 per cent of the total cost of the contract.

Although GMS proportion of healthcare costs is stable, in the first year savings from drugs budgets funded QOF, and LHBs were unable to use these savings for local service development

31 The overall proportion of expenditure on primary care services in Wales remains stable as other health expenditure has risen at a similar rate. However, viewed from the perspective of financial commitment, the high QOF scores resulted in unexpected pressure on budgets at LHB level. Although the full

additional cost was eventually met by revised allocations from the Assembly Government, this had to be managed at LHB level. Despite this transfer, resources were less generally available to start new services, and in 2004/2005 savings from drugs budgets had to be used to pay for QOF in some LHBs, before allocations were revised.

Recommendations

32 The long-term impact of the new contract will be beneficial if the system is effectively policed, and if enhanced services are used to their potential.

The contract itself

33 These recommendations are for the Assembly Government and NHS Employers (who negotiate the contract on behalf of the four UK health departments).

i Core services have a loose definition. This is resulting in variation across Wales, and means some GPs are getting paid again for things that were included in their MPIG and GS. **Some further strategic discussion on the content of core services is necessary.** We do not believe a tight or comprehensive definition is desirable or, in a world of rapidly changing medical practice, practicable. However, it is essential that duplication in payments is eradicated, and a method agreed to resolve differences amicably between commissioners and practices. An agreed set of principles should set the framework enabling local resolution. We have set out in **Box 1** a starting point for this debate.

Box 1: Starting point for discussion of standards

Starting point for discussion of standards:

Payment for items of service previously provided and included in MPIG should never be extra and, if the service changes, then funding should reflect the change.

Is the practice best placed to perform this function?

Would the reasonable patient expect this to form part of practice services?

- ii The MPIG was deemed necessary to get wide acceptance of the new contract. The majority of practices in Wales get an MPIG payment and this is preventing redistribution of funds through the Carr-Hill Formula. Minimum Practice Income Guarantee has served its purpose by protecting practice income while the new contract became embedded, and was never intended to be a long term income stream. However, this is unfair both to GPs and patients in more deprived areas, and is now impeding further changes and should be phased out. This must not occur in isolation, as it could still destabilise many practices, and these practices should be encouraged to increase their income by adopting new services. **Minimum Practice Income Guarantee funding should be eroded as quickly as is practicable to establish a single formula payment** and will allow the re-distribution of health resources according to need, rather than historical investment and be fairer to both GPs and patients.
- iii The initial QOF targets were not as challenging as first anticipated for most practices. Negotiators acknowledge that this was to ensure practices and GPs accepted the contract and the principle of payment for achieving standards. **The level of difficulty for achieving QOF points has already been, and must be further raised over time.** In accordance with the 2006/2007 revisions to the GMS contract, this evolutionary raising of the standards set by QOF is accepted, reflects cost improvement processes across the NHS, and supports continuous improvement in services.
- iv It is widely acknowledged among health professionals that the current QOF points measure the process of care. **Quality and Outcomes Framework points should increasingly reflect outcomes** for patients such as complication rates or hospital admissions, rather than steps in the process of care. This change of focus can be incorporated into a regular renegotiation of QOF points.



Contract management

- 34 Consistency of contract governance varies across Wales. This must be resolved in the short term.

Quality and Outcomes Framework

- v There are, at present, only limited deterrents to those practices which might be inclined to inflate their QOF claims. This poses a significant risk that practices will start to manipulate QOF figures and that the intended benefits to patients will not be realised. Sixty-five million pounds is paid out through QOF or typically between £2 million and £5 million per LHB. As QOF accounts for a larger proportion of GMS monies, the potential losses through inadequate claim checking by LHBs become significant. **The Assembly Government must issue guidance on the interpretation and resourcing of 'light-touch' assurance, and LHBs must introduce routine detailed checks of QOF of five per cent of practices in this financial year.**
- vi LHBs vary unacceptably in how they monitor the contract. Quality and Outcomes Framework visits range from thorough and supportively challenging, to inadequately documented and sketchy. **All LHBs must adopt best practice in contract governance in 2007.**
- vii Audit trails must be clear, so that anyone reading files following practice QOF visits could reasonably be expected to reach the same conclusions on practice achievements as the QOF assessors. Promoting and adopting

good practice is not always easy. **From 2007 LHBs need to exchange assessors to:**

- a **promote swapping and sharing of ideas; and**
 - b **enable more rigorous challenge.**
- viii There are some examples of integrated governance, where assessment visits are developing into a balanced assessment of practice performance. This enables a holistic view of services and reflects developments across Wales in performance management. Building on progress already made, **LHBs must develop integrated governance in primary care** by including other areas in QOF visits, such as clinical governance and comparative performance information (eg, prescribing and referrals).

Enhanced services

- ix Enhanced services are one obvious route to supporting and driving changes in health services. They allow both the Assembly Government and LHBs to develop quality services at a local level. Although most LHBs have lists of innovative ideas for enhanced services, mainly collected from their own GPs, very few LES schemes have actually got off the ground. Some LHBs have struggled to engage sufficient GPs. The Assembly Government and LHBs must give fresh emphasis and encouragement to designing and commissioning enhanced services which address genuine local needs. **The Assembly Government and LHBs must work together to develop a**

framework to encourage dis-investment in secondary care to free-up resources to improve primary and community services by the end of 2007. This will give LHBs the leverage and space in budgets to redistribute resources, allowing the development of more locally tailored services driven by local needs.

- x** Health commissioners are in the process of redesigning services. To achieve the intended outcomes primary and community services will need to provide more care, closer to home. LHBs can encourage GPs to take on these roles through enhanced services. **LHBs should work together to agree and commission enhanced services which support their redesign plans and Designed for Life.**
- xi** Across the UK GP practices are collecting the views of patients, but in many cases this valuable information stays within the practice. **GPs and LHBs must work together to collect this information and use it to inform wider service developments.** This will help to increase public and patient involvement in NHS services and inform future service needs. **The Assembly Government can support this by developing specific tools and supporting analysis.**

Estates

- xii** Much of the promised spend on primary care estates is yet to be committed. Several LHBs have struggled to provide agreed plans to the Assembly Government. Consequently, there have been delays for a few GPs in moving or expanding their premises to provide extra services (typically, enhanced services) during normal working hours.

To resolve this, LHBs and the Assembly Government must ensure that:

- a Premises are used more flexibly - eg, providing services in the evenings,** such as enhanced services. These innovations may have additional benefits such as improving access for disadvantaged groups.
- b** The planning and development of appropriate primary care premises is central to implementing health, social care and well-being strategies across Wales. All strategies will be reviewed for the five year period from 2008 and **all LHBs should ensure that their primary care estates strategy is reviewed alongside their health, social care and well-being strategy.** This ensures that the appropriate premises are being developed for the delivery of services in primary care over the next five year period.



Out of Hours services

- xiii** Out of Hours costs frequently fund different services, and are difficult to compare. More analysis is needed on the links between standards, operational arrangements and costs. The Assembly Government has already commissioned some research from the University of Wales on the quality of OOH services, which is due to be published in 2007. For the past 12 months, the six LHBs in North Wales have been working with the Assembly Government to develop and pilot a revised and more well-defined set of OOH quality standards; further guidance will be published by the Assembly Government in 2007.
- The Assembly Government must set up a framework to ensure all aspects of OOH services are measured and reported in a consistent way across Wales.** This will allow effective comparison of services both between areas and against quality criteria.
- xiv** When OOH contracts were introduced, many bidders were inexperienced and choice was limited to a small number of providers. As new contracts are negotiated in 2007, those LHBs where there is a limited market providing competition must consider other cost saving strategies including:
- a** **Change the call receiving and triage system.** All other things being equal, the more work that can be done by telephone, the lower the cost of the OOH service should be. Although care must be taken to ensure quality standards are met.
 - b** **Redesign the service in conjunction with the wider health economy.** In many areas, and particularly in rural areas, the need to see someone before they can get themselves to their own doctor presents a complex series of options. Understanding the practicalities of the various options is best done through computer-based analysis and modelling of demand rates, distances, responses and costs. The impact of changes in OOH must be understood and the best solution for the whole unscheduled care system sought.
 - c** Altering pay and skill mix. Trying to negotiate a reduction in payments would risk disruption to services, but **LHBs should seek to limit future increases.**

Part 1 - The new contract provides a framework which can accommodate the competing requirements of GPs, patients and commissioners

- 1.1** The new GMS contract was introduced from April 2003. It was agreed by the Government and the NHS Confederation, with the BMA negotiating on behalf of GPs. It replaced the previous contract based on the 'Red Book' and changed both the basis on which GPs are paid and their incentives.
- 1.2** Negotiating a new GMS contract provided an opportunity for stakeholders to achieve some important changes to primary care services. Specifically:
- patient needs could be built into the contract, such as improved access to primary care services and improved care for people with chronic conditions;
 - GPs could gain control over both their workload and remuneration; and
 - Government and LHBs could support NHS Wales' strategic drive towards providing world-class services managed efficiently, and providing effective care.
- 1.3** LHBs were relatively new organisations when they became responsible for managing the new contract, and were struggling with a massive agenda, including deficits in many parts of Wales. The Wanless report had been published the previous year and *Designed for Life* was published in 2004. Capacity to manage change was stretched and the pace of change continues with new contracts for Dentists, Pharmacy and Ophthalmics following on from GMS. Many LHBs delegated much of

the contract implementation to relatively junior staff with experience of managing the old 'Red Book' contract. Given this background, it is unsurprising that we found considerable variation across Wales.

The new contract has brought significant benefits for GPs

- 1.4** A survey of GPs in England in 2000 found that high levels of job dissatisfaction correlated strongly with the desire to leave general practice. Dissatisfaction related to long working hours but also to a dislike of the NHS reforms that were introduced from 1990. In 2001, a BMA ballot found that 86 per cent of GPs would consider resigning from their current NHS contract if a satisfactory new contract could not be secured by the BMA².
- 1.5** Recent research³ has looked at GP satisfaction before the introduction of the contract. It found that GPs were apprehensive about the new contract before implementation. Since then improvements have occurred both in pay levels and hours of work.

² British Medical Association 2006. *General Practice: basic facts*.

³ Sibbald, B, Bojke, C and Gravelle, H. National survey of job satisfaction and retirement intentions among general practitioners in England. *British Medical Journal*, 326; 22-25. 4 January 2003.



GP pay has increased faster than practice expenditure

1.6 In February 2006, HM Treasury published a Freedom of Information disclosure comparing GP salaries in the UK with those in other countries. According to Inland Revenue surveys, average earnings increased from £78,437 in 2003/2004 to £97,768 in 2005/2006, an increase of 25 per cent⁴. Using 2004 estimates, HM Treasury estimated that GPs in the UK earned more than in any other European country. The expenses to earning ratio (the percentage of GPs' earnings accounted for by tax-allowable allowances) decreased by four per cent, meaning GPs income increased more than expenses over the same period.

1.7 Making comparisons with hospital consultants is difficult, as consultants have access to private work which can increase their income by at least 50 per cent over the amount they are paid by the NHS and are also able to attract higher remuneration through an 'awards' system. Data from a series of local Audit Commission in Wales reviews of the consultant contract in 2005 suggested a typical consultant in Wales earns an average NHS salary of £110,000 (range £83,000 to £150,000) for a planned 37.5 hours per week. GP pay and hours are now more comparable to those of hospital consultants.

GPs now have better control over their working lives

1.8 The ballot by the BMA in 2001 proved to be a catalyst to spur on the development of a contract that would be acceptable to both GPs and NHS Employers.

1.9 General Practitioners were keen to negotiate a new contract because they had concerns over their heavy workload and 24-hour responsibility for all patients on their list. This meant that they could be out all night on call and then have to work the next morning in surgery. The new contract has transferred responsibility for OOH services (including Saturday morning surgeries in most cases) from GPs to LHBs, enabling an average reduction in GP hours of around 10 per cent.

1.10 General Practitioners also wanted to choose what services to provide outside of the core care for patients who are ill, or believe themselves to be ill, and to develop special interests.

1.11 Finally, many GPs wanted to be able to change the way in which services are delivered so that other members of the healthcare team can take greater responsibility for delivering patient care. The new contract allows any approved health professional to be the lead partner in a practice, opening the prospect of nurse-led primary care services in the future.

Recruitment and retention have improved in most parts of Wales

1.12 Despite salary improvements and the overall reduction in working hours, in 2006 practice data showed that vacancy rates are higher in Wales than in England. Vacancy rates are lower than they have been for many years, but there has been less progress in reducing vacancies in Wales⁵ (see [Figure 1](#)). North Wales is experiencing the highest vacancy levels - double the average for Wales - and shows the only increase in vacancies for the three regions.

⁴ HM Treasury. International comparisons of GP and nurses pay. Freedom of Information disclosure. February 2006.

⁵ Three-month vacancies are vacancies that practices were actively trying to fill at 31 March 2006 which had lasted for three months or more. Three-month vacancy rates are three-month vacancies expressed as a percentage of two-month vacancies plus staff in post. Figures are based on returns from 23 per cent of Welsh practices and 13 per cent of English practices.

Figure 1: Estimated GP practice vacancies per 100,000 patients in Wales

GPs	Estimated three-month vacancy rate		
	2005	2006	Change in percentage points 2005/2006
England	1.4%	0.7%	-0.7%
Wales of which, by Government Office Region	2.1%	1.8%	-0.2%
Mid and West Wales	1.0%	0.6%	-0.4%
South-East Wales	3.0%	2.1%	-0.9%
North Wales	2.1%	3.6%	1.5%

Source: Department of Health, Information Centre. GP practice vacancies survey 2006: England and Wales

1.13 The Assembly Government has been working on recruitment and retention problems for some years. Although some changes were introduced (such as the Golden Hello Scheme, which rewarded doctors taking up posts in deprived areas), these did not have the desired effect of attracting GPs to posts that were hard to fill, and subsequently, were dropped. Hence, the Assembly Government asked LHBs to develop their own recruitment and retention plans by the end of March 2006⁶. These plans reflect local circumstances and contain a number of different solutions. Local Health Boards are improving their monitoring of the problem and are working together with other organisations in their health community. An example of these local initiatives is the Primary Care Support Unit (PCSU) in the South Wales valleys, established in 2000 to provide support to GPs and directly employ primary care staff in an area that has found it very difficult to recruit staff (see **Case Study A**).

Case Study A: The Rhondda Cynon Taff Primary Care Support Unit

The PCSU was established in 2000 as the Cynon Valley PCSU. Although the work of the PCSU remains focused within the Cynon Valley, it is increasingly operating within the Rhondda and Taff Ely areas. The aims of the PCSU are to:

- support GPs and practice nurses in personal and professional development;
- develop chronic-disease services in primary care settings;
- develop clinics for children and women; and
- attract new GPs by providing a supported environment and improved working conditions.

In April 2007, the PCSU employed 34 GPs (around 20 Whole Time Equivalent (WTE)) and nine nurses either in managed practices or in surgeries with a mix of independent and salaried practitioners. Good links between the LHB and Cardiff University's GP Training Scheme have made employment in Rhondda Cynon Taff an attractive option for salaried GPs. A recent advert for a salaried GP in the area attracted 15 applications.

The PCSU acts as a 'bridge' for some GPs on their way to independent practice, while for other GPs and nurses, it is a permanent provider of secure employment. It provides opportunities for professionals to find out more about the way the local health economy operates without having to make a full commitment to independent practice.

Source: Wales Audit Office local performance audit work

⁶ Welsh Assembly Government. Recruitment and retention of General Practitioners. Welsh Health Circular, WHC (2005) 042: 19 April 2005.



Box 2: The Quality and Outcomes Framework rewards GP practices for activity in three domains

The QOF formally came into operation in April 2004 and is one of the underlying elements of the new contracting arrangements in primary care. The QOF is divided into four domains through which practices are assessed and rewarded:

- a clinical domain - practices are rewarded in line with the quality of clinical care they provide within specified disease areas, and according to the existence of several specific clinical policies;
- an organisational domain - practices are rewarded for, amongst other things, the quality of the information they keep about their patients, their practice education and training facilities, and the systems they use to control and manage the use of prescription medicines;
- a patient experience domain - practices are rewarded for how well they accommodate the preferences of their patients; and
- additional services - such as cervical screening, child health surveillance, maternity and contraceptive services.

Source: Wales Audit Office: Briefing paper

1.14 Partly because of these initiatives, and the recent improvements to GPs' pay and perceived status, GP training schemes are now oversubscribed for the first time in many years. Other information shows that many GPs are delaying their retirement, which will allow time for new GPs to be trained and become established. Many of these changes are connected to the new contract.

Practices are now rewarded for achieving measurable standards

1.15 General Practitioner practice performance is now measured and paid for through a points system, known as the QOF. Practices are rewarded for achieving points for undertaking evidence-based activities, which are often

Case Study B: The financial value of Quality and Outcomes Framework remuneration

The Vale of Glamorgan LHB serves a resident population of around 120,000. There are 17 primary care practices within the LHB's operational area; none of these is single-handed and there are no LHB-managed practices. QOF ratings in 2005/2006 in the Vale of Glamorgan practices were generally strong: three practices were within the 900-1000 range, 12 scored between 1000 and 1049, and two gained the maximum 1050 points. The average score was 1015. In 2005/2006 total payments through the QOF system to practices in the Vale of Glamorgan LHB amounted to £2.54 million - an average of around £150,000 per practice.

measures of care processes, designed to improve the quality of care for patients, and ultimately patient outcomes. The new system has resulted in more activities, more focused activities and more recording of activity. **Box 2** explains the structure of the QOF.

1.16 The QOF points are valuable to practices, worth on average £124.60 each point in 2005/2006. Consequently, practices have worked hard to demonstrate achievement. See **Case Study B** for an example of the value of QOF to practices.

1.17 Not all of this increase in activity is funded by practices themselves, and other parts of the health service are helping practices to achieve QOF points. Before GMS there was a large variation in general practice behaviour, especially around testing and monitoring patients for chronic conditions such as diabetes, heart disease and stroke. Some practices undertook regular testing and monitoring, whilst others used diagnostic services less. Quality and Outcomes Framework encourages all practices to test their patients regularly, and to screen patients. This, combined with strong guidelines from National Service Frameworks (NSFs) drove a rapid increase in tests from GPs in some areas. Although this increase in testing was

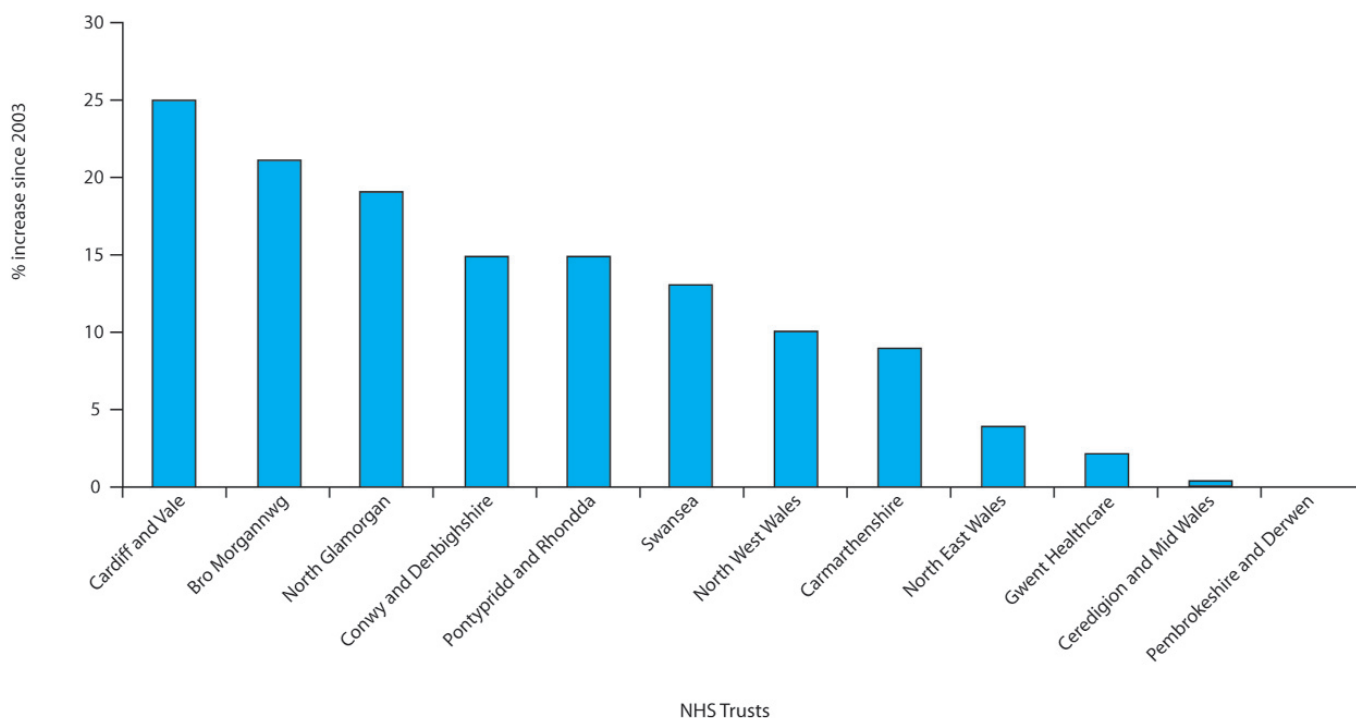
expected to happen eventually, as different practices caught-up with 'best-practice,' the rapid increase surprised many, and the costs are borne by the wider health community.

1.18 Good examples of this change in behaviour are two biochemistry tests: Glycosylated Haemoglobin or HBA1c (a measure of diabetes control) and cholesterol levels (high cholesterol contributes to heart disease, stroke and other vascular diseases). The numbers of biochemistry tests have increased significantly between 2003 and 2005 across most of Wales, measured by the

Acute Hospital Portfolio (AHP)⁷ data collection. The rate of increase has been greater in some areas than others, and this appears to correlate with those areas where, historically, primary care services used diagnostic support services less. For example, **Figure 2** shows that in some urban communities, the proportion of biochemistry tests requested by GPs rose more quickly than in rural services where, historically, primary care requested a larger proportion of tests. Recent research⁸ on Haemoglobin A1C shows diabetic control has improved since the introduction of QOF.

Figure 2: Increases in biochemistry tests between 2003 and 2005

Whilst tests have risen overall, the percentage from GPs has risen most in areas with lower baselines.



Note
Pembrokeshire and Derwen NHS Trust did not submit data in 2003 for this indicator, so in effect, all trusts in Wales have seen increased GP testing since the new contract was implemented.

Source: Acute Hospital Portfolio 2003 and 2005 data

⁷ The AHP is a UK-wide benchmarking tool run by the Healthcare Commission for assessing key areas of acute hospital activity.

⁸ M. C. Gulliford, M. Ashworth, D. Robotham, A. Mohiddin 'Achievement of metabolic targets for diabetes by English primary care practices under a new system of incentives' Diabetic Medicine.



Benefits to patients are more limited in the short term

1.19 Patients were not directly involved in the negotiations for the new contract, and their collective views were not sought before implementation. Despite this, the contract has many potential benefits for patients, and research supports many of the points negotiated on their behalf. Patients want continued access to GPs on the NHS, and their views are now collected at practice level. However, the other expected benefits to patients are from improved outcomes and more consistent standards of care due to QOF, and these have longer timeframes.

Patients can expect to see their GP promptly

1.20 Research shows that, ideally, patients want rapid access to a GP of their choice. In reality, when patients have urgent problems they are content to see any primary care practitioner at short notice. But if they are older, sicker and consulting more frequently, they prefer continuity of service with someone they have built up a relationship with⁹.

1.21 Promoting better access to GPs is one of the key components of the new contract. Practices were expected to design systems which enabled patients to access a member of the Primary Care Team within 24 hours or much sooner in an emergency. This consisted of two parts in Wales:

- a self-declaration as part of the QOF system accounting for 50 points, worth on average £6,000 per practice; and
- a Directed Enhanced Service (DES) for access, a mandatory scheme for all LHBs, to prepare for meeting the access targets, accounting for around £5,000 per practice.

Case Study C: Neath Port Talbot 'Mystery Shopping' audit of access standards

The LHB wanted to test practices implementation of their access policies under QOF. So LHB carried out 'mystery shopping' phone calls, to see how easy it is to get appointments straightaway or within two weeks. The LHB has said that it will continue to run 'mystery shopping' exercises to monitor the DES for 2006/2007. This shows a commitment by the LHB to verifying spending in a key risk area.

Source: Wales Audit Office local performance audit work

1.22 Achievement of the Service Access Standard depended on how 'access' is interpreted. Guidance suggests that access will normally mean having an opportunity to see, in person, a doctor or a nurse, but that telephone consultations can be used as an alternative for many patients. Some LHBs, such as Neath Port Talbot, conducted audits to ensure practices were meeting this standard, (see [Case Study C](#)).

1.23 From April 2006, the access standards were tightened and changed from a self-declaration forming part of the QOF points to a DES (see [Box 3](#)). Under QOF the access standard was checked as part of the QOF visit, but now practices are required to demonstrate externally to the post-payment verification teams that they meet the standards.

1.24 So far, over 90 per cent of practices in Wales have claimed payment from LHBs for meeting the Welsh Access target. Across Wales the total cost is in excess of £2.5 million¹⁰. This level of expenditure warrants a rigorous approach. One potential audit tool is outlined in [Case Study D](#).

⁹ Guthrie, B. and Wyke, S. Personal continuity and access in UK general practice: a qualitative study of general practitioners' and patients' perceptions of when and how they matter. *BioMed Central Family Practice* 2006, 7:11, 24 February 2006.

¹⁰ Each practice received an average of around £11,500 in 2005/2006 to £13,000 in 2006/2007.

Case Study D: An audit of the 2006 access standards

The 2006/2007 access will be rewarded entirely through a single DES, rather than as before, partly through a DES and partly through QOF. These changes provide the LHB with an opportunity to introduce new methods to check the suitability of practice access plans against these new access criteria, and to stipulate what evidence it will expect to receive from practices showing that their plans are working. The LHB decided to proactively check access plans against a list of questions and use a tool at the start of the year to check:

- Does the plan correctly state the three different access targets for 2006/2007 (within 24 hours, within two weeks (unnamed practitioner), within four weeks (named GP))?
- Does the plan say how many patients are currently being seen at the practice?
- Does the plan say how many patients are being helped through telephone advice from the practice?
- Does the plan offer any evidence to suggest that the number of contacts is increasing?
- Does the plan provide any evidence of attempts to reduce the number of contacts or ideas for how to do so in the future?
- Does the plan summarise the expected numbers of contacts in each of the following groups: urgent, bookable (unnamed) within two weeks, bookable (named) within four weeks?
- Does the plan give plausible explanations of how the practice will work with its patients to enable the targets to be met for each type of access?

The tool measures actual appointment availability against the new access standards at a specific point in time. As well as measuring and recording the achievement of access standards, it also helps practices plan and ensure they have a good balance between urgent and planned appointments. We have included the tool in Appendix 4.

Source: *Wales Audit Office local performance audit work*

1.25 The required evidence to support practice claims on access standards has varied across Wales. In Wrexham, the Performance Management Team asked all practices to audit their compliance with the 2005/2006 targets before claims were approved for payment via the Business Services Centre (BSC). In Cardiff, concerns about the ability of patients to access GP appointments led the LHB to agree to pilot an assessment tool developed with the Wales Audit Office and Practice Managers, to support practices in measuring their ability to meet the 2006 access targets. We understand from the Local Medical Committee (LMC) and Assembly Government that this was outside the specification of the DES. However, LHBs need to consider how they are able to demonstrate good use of public money in making payments without proper evidence that the required service standards are being met by practices.

Box 3: The Directed Enhanced Service for access to primary care in Wales was revised in 2006/2007

In recognition that the single and simple 'urgent' target does not provide the best access opportunities for all patients, the Access Standard has been altered for 2006/2007. In the new scheme there are three separate targets relating to access for patients:

- the first target, for 24-hour access, is retained with the same definition;
- a second target, to provide an opportunity to pre-book an appointment up to two weeks in advance, has been introduced; and
- a third target, to pre-book an appointment with a named GP of the patient's choice within four weeks, has also been added.

There is also new guidance on providing access for people with disabilities, including those with hearing and visual deficiencies, and for making sure that practice telephone systems are adequate, at all times, to cater for patient demand.

Source: *Wales Audit Office*

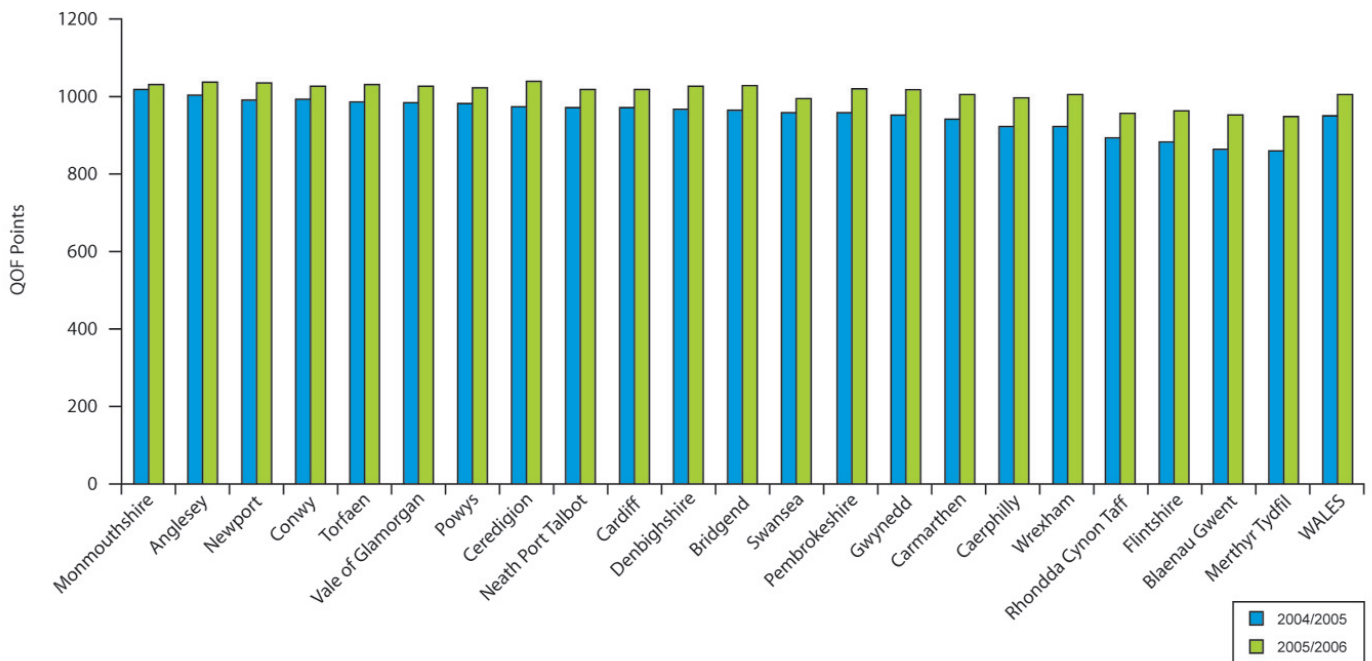


Patients can expect to get services provided to consistent standards

1.26 The QOF provides a template to specify and check the standards of primary care services. In areas where standards of primary care have not been of a generally high quality, the introduction of QOF has, in effect, provided commissioners with a checklist which they can use with practices to identify scope for service improvement. In other parts of Wales, the QOF monitoring system has enabled primary care practices to demonstrate how high their standards already were, and at the same time, identify and adopt other areas of good practice so that they can further improve their level of patient care.

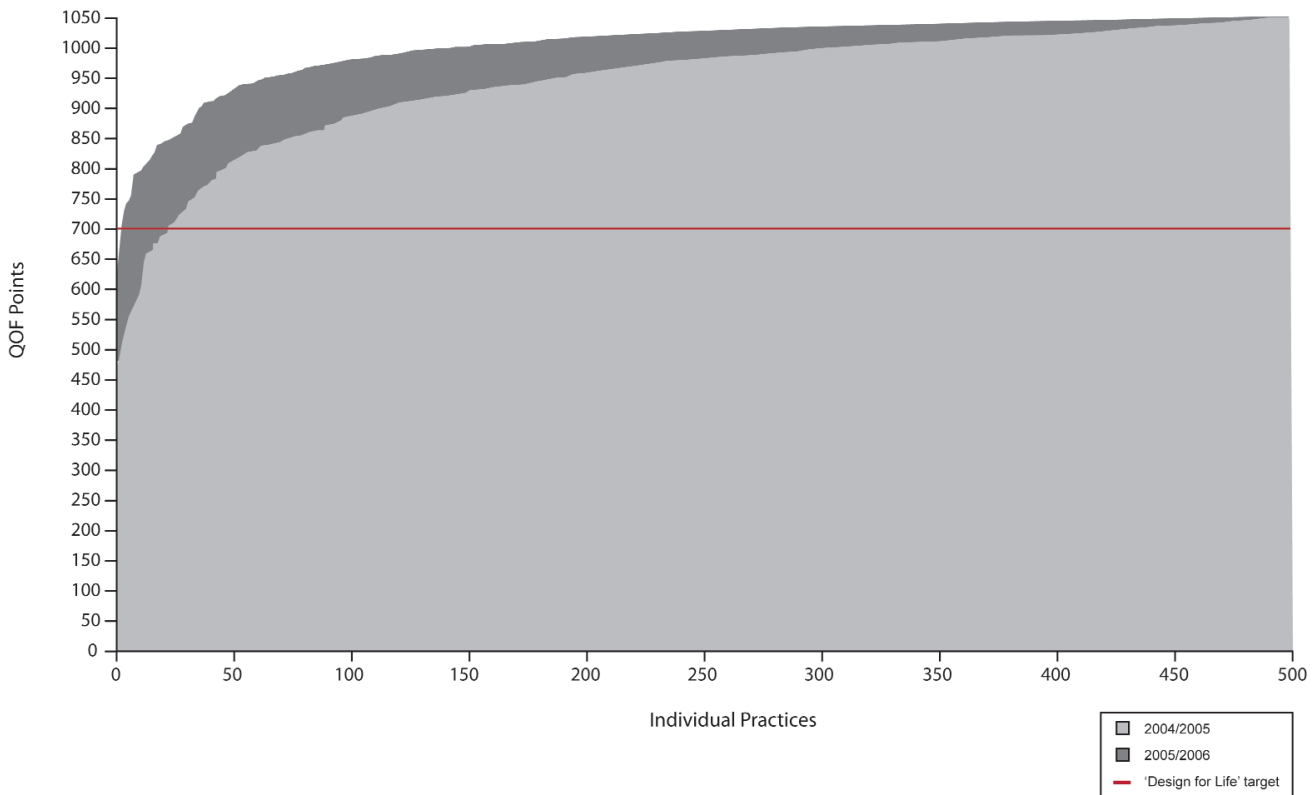
1.27 Areas which historically have been considered to have had less-developed primary care services and/or were 'under doctored' have seen the greatest improvements in QOF point scores. Many of these areas were in the South Wales valley communities, and these practices have used the extra support and money to invest in improving services. **Figure 3** shows that Merthyr Tydfil, Blaenau Gwent and Rhondda Cynon Taff (RCT) LHBs have made significant improvements in care processes, recording and therefore in QOF points. Other areas, such as Anglesey and Monmouthshire, were able to score very highly on QOF almost immediately, and have shown only limited further increases.

Figure 3: Average Quality and Outcomes Framework score by LHB



Source: Wales Audit Office analysis of Assembly Government Quality and Outcomes Framework data

Figure 4: Change in Quality and Outcomes Framework points between years: Practice Total QOF Points 2004/2005 and 2005/2006



Source: Wales Audit Office analysis of Welsh Assembly Government Quality and Outcomes Framework data

1.28 Nearly all practices in Wales had achieved over 700 points by March 2006 and therefore met the Designed for Life target (Figure 4). The remaining practices were working with LHBs to improve scores, and despite changes to the QOF points system, most expect to achieve 700 points by April 2007. This means that all practices in Wales are now able to demonstrate they are meeting acceptable standards.

Patients' views are starting to influence practice developments

1.29 National Health Service Confederation research across England and Wales shows patients are generally satisfied with the care they receive from their GPs. Eighty-one per cent saying they are satisfied with the service they have received, a rate which is higher than for all other NHS services¹¹.

¹¹ NHS Confederation. Lost in translation: why are patients more satisfied with the NHS than the public? 2006.



Case Study E: Vale of Glamorgan LHB

The Patient and Public Liaison Officer at the Vale of Glamorgan LHB visited GP practices (with their consent) and sat in waiting rooms talking to patients. This allowed the LHB to select a random sample of patients to be sent questionnaires to their own homes. The questionnaires found:

- patients are generally happy with the quality of their GP practice;
- patients generally want more time for individual consultations; and
- access is important.

Individual feedback to practices allowed practices to tackle any problems identified. Practices overall felt that this visit was very helpful.

Source: Wales Audit Office local performance audit work

1.30 Community Health Councils (CHCs) indicate patients' perceptions of the changes to the GMS contract are limited to changes they can see, such as access to a doctor, either during normal working hours or in the evening, at night or at weekends. Other changes are unlikely to have noticeably affected patients, and few will know about QOF.

1.31 All practices are encouraged to survey their patients for their views, and are rewarded under QOF for doing this. This can take the form of a paper survey, usually administered by the practice, or practices can adopt other approaches. Most practices keep this valuable information on patients' views within the practice and few LHBs have full access to this information; practices are under no obligation to share it. Recent research¹² using one of the commonly used questionnaires shows that patients think that some aspects of their care are better. Specifically, access to appointments, the GP consultation itself, and practice services.

¹² CFEP-UK surveys, Innovation Centre University of Exeter, 2007.

Case Study F: Clwyd Community Health Council

Clwyd CHC placed advertisements in local papers asking patients for their views on the changes to GP services since the new contract was introduced. Most complaints were either about the impact of OOH changes, or about access to GP appointments following the introduction of new appointment systems.

Some of the key points made were:

1. Access standards:

- many patients were unable to pre-book to see the same GP each time;
- some vulnerable patients struggled to get appointments at all;
- little allowance is made for patients in difficult situations, such as single parents with more than one child or carers; and
- 'system stacked up against people who work', that is, they generally favour those with most time in the mornings, and disadvantage those working or with children of school age.

2. OOH:

- some patients are using A&E departments inappropriately as walk-in centres for treatment as the alternative to the GP OOH service;
- the service is not patient orientated; and
- patients need to travel further to access services than they did before.

Source: Wales Audit Office local performance audit work

1.32 Some LHBs have tried to support practices and gain wider insights into patients' views using various approaches from collation of patient complaints to actively seeking patients' views in different areas. Two examples of how patient consultation is carried out in Wales are:

- the Vale of Glamorgan LHB used their Patient and Public Liaison Officer to visit individual practices (**Case Study E**); and
- Clwyd CHC placed advertisements in the local press to ask patients for their views on the new contract, as well as analysing complaints and comments received from patients about GP services (**Case Study F**).

1.33 More could be done to use patients' views to inform the wider development of NHS services. The opportunity presented by regular surveys of patients' views to increase knowledge of what patients want should be used more widely to inform planning and needs assessment. This would support the wider involvement of patients in the design of services.

It is too early to show the expected benefits to patients' health

1.34 One specific objective of the new contract was to improve the systems of care for people with chronic diseases. For example, practices are now rewarded directly for identifying patients with diabetes, and for monitoring and treating this condition. Rewards are also offered to practices that screen, register and treat patients with high blood pressure (or hypertension). Recording of activity has improved, with examples of practices changing the way in which they use 'Read codes' (a method of recording clinical activity), and standardising coding to ensure all patients in a particular category are captured and recorded.

1.35 The QOF is also a population-based Disease Management Programme which, as one doctor pointed out, is in conflict with the patient-centred ethos of the individual consultation¹³. The increase in regular checks for patients with chronic diseases, whilst improving patient care, may be less situated to their own personal convenience because their conditions are now more closely managed.

1.36 Clinical research on chronic diseases has been extensive and both NHS Employers and the BMA used this knowledge base when developing the clinical indicators for QOF. This type of research has been extensively reviewed by the National Institute for Clinical Excellence (NICE), the King's Fund¹⁴ and teams developing NSFs on diabetes, Coronary Heart Disease (CHD) and others¹⁵. Although there has been some criticism that indicators do not always reflect the latest and most challenging targets, given the nature of QOF (that targets are practice population-based and that changes are through negotiation) it is unsurprising that sometimes compromises have crept in or recent changes in best practice are not reflected in QOF targets. For example, in the 2003/2004, QOF points were awarded for having disease registers for patients with CHD. Many GPs argued that this was good practice and that every practice should have been doing this before QOF. These points have now been 'recycled' from April 2006, and the target cholesterol level for patients with CHD reduced to reflect more up-to-date guidelines.

1.37 The incentives given to primary care practices to increase monitoring and treatment of conditions have inevitably led to cost increases. For example, the focus on monitoring patients with hypertension has contributed to the increase in the costs of prescription drugs to treat the disease. Similarly, the increased focus on kidney conditions in primary care is likely to increase the demand, and therefore the cost, of providing various pathology and specialist services in the short term.

¹³ Lipman, Toby. So how was it for you? A year of the GMS Contract: Into the sunlit uplands? *British Journal of General Practice*, May 2005.

¹⁴ King's Fund, a health research charity.

¹⁵ Scottish Intercollegiate (SIGN).



Case Study G: Rhondda Cynon Taff changes to diabetes care

Given the high rates of the condition in Rhondda Cynon Taff, diabetes is a priority area for improving patient care. Patients living in the two Rhondda Valleys now have the option of going to a diabetes review clinic run by an LHB-salaried GP and nurse specialists at Llwynypia Hospital. Nurses employed by the LHB have also advised some practices on how to run their own clinics for patients with diabetes.

Some service shifts have already occurred between secondary and primary care and further shifts are likely. These schemes have been actively encouraged and supported by the consultant diabetologists employed by the Pontypridd and Rhondda NHS Trust, as part of their overall vision to provide more community-based (as opposed to hospital-based) diabetes care.

Source: Wales Audit Office local performance audit work

- 1.38** The principal rationale of these changes, however, has not been cost minimisation but to help patients to live longer, and to improve the quality of their additional years. Chronic disease management has, in the past, been shared between hospital and primary care services. It is likely that this sharing will be retained, but that the more routine elements of care will in future be handled in general practice, leaving secondary-care specialists with more time to manage more complex cases. The increase in treatment for most people closer to where they live should be a welcome improvement. **Case Study G** gives an example of the move of services for patients with diabetes from secondary care to primary care.

- 1.39** It remains unclear whether the increase in the volume and costs of primary care activity will be matched by a reduction in the volume and cost of activity in secondary care. Or whether hospital specialists will, in future, be kept equally busy providing more and better services to those patients who are more ill and more dependent¹⁶.

Commissioners are able to tailor services to meet identified priorities

- 1.40** The Assembly Government no longer holds direct responsibility for primary care services, as the contracts are now held by the LHB. Under the new GMS contract, LHBs are responsible for managing and commissioning primary care services from GPs and other primary care professionals. If the contract is working for commissioners we would expect some early benefits to be apparent. Consequently, local commissioners' ability to both manage and tailor local services to meet identified local needs is potentially an important advantage (not available under the previous contract). Nationally, LHBs now have the ability to plug known gaps in services, such as drugs and alcohol services, and in future to support Designed for Life by expanding services closer to patients' homes.

¹⁶ McElduff, P et.al. Will changes in primary care improve health outcomes? Modelling the impact of financial incentives introduced to improve quality of care in the UK. *Quality and Safety in Health Care*. June 2004. 13 (3): 191.

Case Study H: Caerphilly LHB has an Enhanced Services Group

Caerphilly LHB has established a group of officers (the Enhanced Services Group) to encourage bids from practices for further LES work. The group has developed a flow chart to assess proposals for LES funding, starting with a statement of the expected benefits that the proposed scheme will provide for the practice's patients. One of the guiding principles of the Caerphilly system is that priority is given to schemes that broaden the range of services provided in primary care.

Source: Wales Audit Office local performance audit work

The contract allows development of new services in primary care

- 1.41** Commissioners wanted to ensure continuity in primary care services, prevent GPs from leaving the NHS, and to be able to better influence the future direction and quality of primary care services. They now have the tools with which to tailor local services to meet identified priorities but not all have yet made optimum use of them.
- 1.42** The new contract is different from the previous system of paying GPs which was based on a system of allowances, items of service and recompense for investment. The new system is based on four main funding streams:
- the GS which provides a basic practice income and is underpinned by the MPIG;
 - the QOF which is a points-based system, where extra practice income depends on the score achieved;
 - enhanced services which can be national, directed or locally agreed; and
 - a bundle of LHB discretionary funding including OOH (which funds providers separately for offering a primary care service throughout the weekend, and during the evening and night on weekdays), premises, IT and others.

Case Study I: Local Enhanced Service for dermatology

One important initiative currently being piloted by a GP jointly employed by Rhondda Cynon Taff LHB and the North Glamorgan Trust is a Dermatology 'Telemedicine' Service for six GP practices - three in Rhondda Cynon Taff and three in Merthyr Tydfil LHB. These practices have been provided with digital cameras, and GPs in the pilot practices can e-mail photographs of skin conditions to the co-ordinating GP specialist who can then advise the GPs on the best course of action for individual patients. In effect, the GP is acting as an expert filter to sift potential dermatology referrals.

The operation of this filter has resulted in more basic care for dermatology being delivered by GPs, and more rapid treatment in secondary care for those who most need hospital support.

The Consultant Dermatologist at the North Glamorgan NHS Trust has supported initiatives to develop dermatology services in primary care. It enables the Trust to concentrate on patients with more complex and challenging dermatological problems and, in the short term, to reduce its waiting list and waiting times.

Source: Wales Audit Office local performance audit work

- 1.43** Commissioners, both locally and at Assembly Government level, have achieved the ability to manage and influence primary care services in ways which were not available before. The new contract's structure also allows LHBs and the Assembly Government flexibility in encouraging innovative services via the enhanced services route (Case Study H).

Commissioners are starting to use these new powers locally and nationally

- 1.44** Enhanced services are additional services provided by practices to their (and sometimes other practices') patients. Enhanced services offer the prospect of moving care for some conditions closer to patients, and plugging gaps in services. The ability to commission services from primary care which are flexible, local and responsive is an important part of the new contract.



- 1.45** Directed Enhanced Services are services which all LHBs have to provide. LHBs have to ensure that all patients are able to access these services. Many of these services have been negotiated at an all-Wales level. One example is childhood immunisation.
- 1.46** National Enhanced Services (NESs) are not required services but are considered important for primary care to deliver. Many are based on nationally agreed service specifications. Examples include Intra Uterine Contraceptive Devices (IUCD) and anticoagulant testing and monitoring.
- 1.47** Local Enhanced Services give LHBs the opportunity to encourage innovative local services to address significant local health needs. Local Enhanced Services can be developed to meet any priority which was not easy under the old contract. Some services offered by GPs with special interests - for example, the dermatology service shared between Rhondda Cynon Taf and Merthyr Tydfil LHBs - are funded as LES (Case Study I). A list of LESs is included in Appendix 5.
- 1.48** The general tendency of the new contract is to encourage more work to be done by local primary care staff, and to provide opportunities for high-quality services closer to where patients live. But there are other areas where increased clinical safety concerns and the introduction of new guidance for practitioners will make it less likely that some specific services will continue to be provided in primary care - a clear example is the IUCD or 'coil' fitting¹⁷ service. Using the guidance that practitioners need to fit on average at least one IUCD a month to maintain skills, practices in many LHBs - and particularly rural practices - will have insufficient IUCD work to justify IUCD accreditation. It means in future that women will have to travel to specialist clinics for the service. One example of the impact of this change is on IUCD services in Wrexham (Case Study J).
- 1.49** The Assembly Government has used the enhanced services route to introduce new services across the whole of Wales. These new services are aimed at perceived service gaps at national level. Funding is agreed nationally and is available as part of an LHB's allocation and all LHBs are expected to spend this 'minimum floor.'
- 1.50** Each LHB has a ring-fenced budget to fund enhanced services, but not all LHBs have spent their full allocation on enhanced services, and only a few LHBs have deliberately commissioned above their allocated floor. Although there were some notable exceptions, the ring-fenced enhanced services budget in many LHBs were significantly underspent in 2004/2005, but across Wales the floor was reached.
- 1.51** Local Enhanced Services have also not developed quickly. Four of the 22 LHBs did not commission any LES in 2004/2005, and only £3 million was spent in total to commission LES. This is not because LHBs and their practices were short of ideas. For example, in Torfaen LHB there have been bids to develop primary care physiotherapy services. Such initiatives would have transferred care closer to where people live if they had been commissioned.

¹⁷ Although general guidance on IUCD competence has been available for some time - for instance as published by the BMA in January 2004 and by NICE in October 2005 - policy guidance was not circulated in Wales until January 2006.

Case Study J: Wrexham LHB has commissioned enhanced services under block contracts

Wrexham LHB asked practices to contract to provide enhanced services (national, directed and local) under block contracts. This meant that each practice had to estimate how many of each procedure or service they would perform in the financial year. The LHB then paid for this level of service in 12 equal instalments. At the end of the financial year, performance against contract was agreed (and checked by the BSC's Post Payment Verification Team), and the next year's contract level adjusted accordingly. This transferred the risk of overperformance (more procedures than planned) to the practices from the LHB, and ensured that enhanced services remained within budget. The practices benefited from regular income and the ability to plan their work across the whole year. Those practices which underperformed were allowed to keep the excess, but the following year had their contracted activity level and payment adjusted to reflect this.

Wrexham combined this approach with a firm line that all practices providing enhanced services must be able to demonstrate the quality and safety of these services. So in Wrexham:

- For coil fitting they have withdrawn accreditation from practices with smaller numbers, and concentrated the services to ensure there is one practice in each locality able to provide the service to sufficient numbers of women.
- They used the guidelines agreed across North Wales to accredit practices providing drugs and alcohol services.
- They are providing funding for GPs to take post-graduate training in areas where they wish to commission other enhanced services, such as dermatology and orthopaedics. Only those practices with a trained GP (GP with Special Interest (GPwSI)) will be commissioned to provide these services, and they have sufficient interest from GPs for one practice in each locality, to ensure equity across Wrexham County.
- As further money becomes available they hope to expand this approach to chronic diseases such as diabetes.

The LHB also believed that this robust approach to enhanced services has enabled it to maintain open lists across the county. Practices which close lists are not eligible to apply for accreditation for enhanced services, on the grounds that this places unnecessary further strain on a stretched practice team.

Source: Wales Audit Office local performance audit work

1.52 Part of the problem of deciding whether to commission an LES is forecasting how much will be spent by practices on national and directed enhanced services. In common with those in other LHBs, Rhondda Cynon Taff practices did not reach their planned enhanced-service activity targets in 2004/2005 or in 2005/2006. The requirement to set aside funding to match the high expectations of GPs across the LHB in the first two years, in effect meant that the LHB could not finance various other specific schemes suggested by some of its practices. For example, in 2004/2005 there were bids from practices to provide enhanced services for patients with multiple sclerosis, for care of the homeless and some specific sexual health services. In the first year of the contract, the LHB was left with about £300,000 of unspent money at the year end, and in the second

year £200,000. With the benefit of hindsight, the LHB could have used this to fund other enhanced services. Now it has enhanced services activity data from the first two years, the LHB is in a better negotiating position with its practices to make sure that their intentions in relation to enhanced services delivery (and consequently their funding) are realistic.

- 1.53** There are three issues underlying this problem; two of which are best considered local and the other is more strategic.
- a The first local issue is the accreditation requirement. Practices have to be accredited to provide enhanced services. Some LHBs, such as Ceredigion, initially adopted the generally permissive line that GPs who had previously offered equivalent services (for example minor surgery and



coil fitting) under the 'Red Book' arrangement would be allowed to continue to offer these services under the new contract. Other LHBs, for example Wrexham (**Case Study J**), adopted a stricter and more cautious approach, and required all their practices to apply for new accreditation. In some cases, such as in Caerphilly, this led to delays in providing enhanced services at the beginning of the year and resulted in some practices failing to meet their planned targets.

- b** The second local issue is the complicated billing systems for enhanced services. Billing and payment mechanisms variously involve links between practices, the LHB and the BSC. In the first year of the contract, practices were told to send invoices for some enhanced services direct to the BSC (some on paper and others through computer file), and send requests for payments for other services to their LHB.
- c** The final and more strategic issue is whether busy, and increasingly high-earning, GPs are likely to take on further enhanced services work. While there is a core of entrepreneurial practitioners who are interested in any opportunities to increase their services and their income, there is another group of GPs who are more inclined to maintain or even reduce their activity (and their working hours) rather than take on more.

Part 2 - Changes are needed to realise the new contract's full benefits

2.1 The new GMS contract is working well in most parts of Wales, however, there remain anomalies arising both from the contract itself, and the way in which the contract is managed. These are resulting in unfairness in payments between practices providing the same service in different LHB areas and, if allowed to continue, may undermine the expected benefits in improvements to both individual patients and public health in general.

The contract itself requires some further adjustments

2.2 The contract is held by the practice rather than individual GPs and payment is made by the LHB to the practice for the services it contracts to provide. This is an important change which allows practices to decide more flexibly how to provide services, and gives them:

- an incentive to change the way services are provided, for example, practice nurses can deliver care for patients with long-term conditions, and health care assistants can take blood or provide basic wound care (which happened only sporadically before);
- the opportunity to opt in or out of providing additional services; and
- the ability to opt out of providing all OOH care for their patients, while giving them the option to opt in as a contractor and get paid the market rate.

The poor definition of core services is causing some problems at local level

2.3 The contract itself defines core services as 'to provide primary care services to patients who are, or who think they may be ill' (see [Appendix 2](#)). This loose definition was deliberate and intended to allow innovation in primary care and flexibility over time. The non-restrictive nature of the definition supports both of these intentions.

2.4 There are understandable reasons for this deliberate ambiguity. Too tight a definition may result in GPs reverting to 'item of service' mentality and expecting to be paid for everything they do. The starting position of practices varies considerably and individual contract negotiations may produce different results. This usually happened when a practice was paid to deliver a service under the old regime and they continue to do that because the funding is still reflected in their MPIG/Correction Factor. The contract was intended to be flexible, not one size fits all.

2.5 However, because core services are not defined, and the services provided by practices under the old contract reflected GPs' interests, and historic investment, problems have arisen in parts of Wales. Inconsistencies are emerging between LHBs which are not always based on clinical or service needs. What is and what is not included in the core contract varies and is left for local negotiators in LHBs and Local Medical Committees (local GP advisory groups) to determine (see [Case Study K](#) for detailed examples).



Case Study K: Examples of variation in what is provided as an essential service across Wales

Blood-taking services

Historically, some practices were allocated extra money for providing phlebotomy services to their patients, either as part of the fund-holding allocation or by approval for extra nursing staff. Since the new GMS, some practices have insisted that this constitutes an enhanced service and want extra money to continue to provide these services. In some LHBs this has been paid, others, such as Caerphilly, have not paid again.

Physiotherapy services in practices

Historically, many fund-holding GPs bought additional physiotherapy time for their patients, to provide quick and reliable access to services. When fund-holding stopped, these practices were paid an allowance for continuing to provide these services. These allowances were absorbed into the practices' MPIG. In Wrexham LHB, a strategic decision was made to continue such services as a LES, and the LHB negotiated an amount of income which reflected historical allowances for those practices which had provided the service under fund-holding, ensuring no duplication of payments.

Source: Wales Audit Office local performance audit work

2.6 While we do not believe a tight or comprehensive definition is desirable, or in a world of rapidly changing medical practice, practicable, it is essential that duplication in payments is eradicated, and a set of standards agreed to resolve differences between commissioners and practices.

The Carr-Hill formula is not working as intended

2.7 The GS was intended to replace most of the old contract's system of 'Red Book' payments, based on items of service or allowances, and which generally reflected the level of investment in practices by their GPs.

The GS was intended to reflect genuine levels of need and deprivation, and is based on the Carr-Hill formula. As such, the intention politically was for the new formula to be redistributive (Box 4).

2.8 Some Welsh GPs criticise the Carr-Hill formula, because few practices in Wales gained from the GS formula (over 90 per cent were losers). Others suggest that it is the way that the formula is applied that causes problems, as the same issue arises in other parts of the UK. Generally, stakeholders agree that the principles behind Carr-Hill are sound, and changes suggested by the

Box 4: Carr-Hill resource allocation formula

1. This formula is used to allocate the GS and related payments, on the basis of the practice population, weighted for factors that influence relative needs and costs, including:

- an adjustment for the age and sex structure of the population, including patients in nursing and residential homes;
- an adjustment for the additional needs of the population, relating to morbidity and mortality;
- an adjustment for list turnover; and
- adjustments for the unavoidable costs of delivering services to the population, including a staff market forces factor and rurality.

2. The formula differs from those previously developed for resource allocation purposes in two key respects. First, the majority of the formula is applied to the four countries within the UK. Secondly, the formula is applied to practice populations, rather than LHB populations.

3. Hence, the formula expresses relative need in cost terms. It is based on the age-sex profile for each practice, it estimates the additional resource implications of additional needs, and then adjusts for other factors that affect the cost of delivering services.

Source: NHS Employers and Department of Health 'Investing in General Practice'

Formula Review Group are being debated. NHS Employers, the BMA and the Department of Health (on behalf of the four UK health departments) are currently in the final stages of reviewing the impact of the Carr-Hill formula and the GS.

The Minimum Practice Income Guarantee has served its intended purpose

2.9 During the contract negotiations, it became clear that most GP practices' GS income would be lower than their equivalent income under the old contract's arrangements. To ensure acceptance of the new Contract, the MPIG was agreed, which protects the minimum income for each practice at 2002/2003 levels. Currently, over 90 per cent of Welsh practices are on MPIG which now needs to be eroded as quickly as practicable.

2.10 The use of MPIG means that resources are not being redistributed according to need. Those practices (generally in more affluent areas) that started from a higher baseline are able to continue to improve rapidly, while practices requiring additional investment in terms of staff, premises or equipment to improve or expand services, have less room for manoeuvre.

2.11 The MPIG has several other unintended consequences:

- Independent practice in more affluent areas is often still more attractive financially than in deprived areas. Practice income is protected even when a GP retires from a partnership.
- New practices do not attract MPIG, so starting from scratch is less financially attractive. Consequently, the intention to increase the number of practices in deprived areas, by making practices there

more rewarding, is not happening. As has the intention that GPs would follow population moves to new housing estates, because, without MPIG, GS is not guaranteeing enough income to make new practices attractive.

- MPIG is constant even if list size changes. This reduces the incentive for practices to expand, either to accommodate patient preference or because of population movements - perhaps a new housing estate. A new patient is worth around £54, but an existing patient attracts a GS payment with MPIG averaging £66.
- Practices which may have had an untypical year in 2002/2003 (a vacancy or extra training and development budgets) have this anomaly built into their MPIG, so some practices are either 'short' or 'gainers' under MPIG.

The Quality and Outcomes Framework represents the first stage of an evolutionary process

2.12 The QOF provides a template to specify and check the standards of primary care services. The QOF is a new system for rewarding practices. It is believed to be unique to the UK and other countries are known to be interested in whether or not it works. In areas where standards of primary care have not been of a generally high quality, the introduction of QOF has, in effect, provided a checklist to identify scope for service improvement. In other parts of Wales, the QOF monitoring system has enabled primary care practices to demonstrate how high their standards already were, and at the same time, identify and adopt other areas of good practice so that they can further improve.



2.13 The QOF is based on clinical evidence of the factors that improve patient outcomes. It also rewards those practices which consult effectively with their patients, offer good access arrangements, and genuinely function as good employers. We found evidence to suggest that practices in some parts of Wales were originally stronger in relation to what was expected of them clinically, than in terms of what might have been expected of them managerially. For example, practices with a strong clinical focus have been fully rewarded through QOF for their diabetes screening and for advising their patients on how to stop smoking. They have often found it harder to demonstrate that they have a system for recording the training needs of their nurses, or are demonstrating good employment practice by having appropriate policies and procedures in place.

2.14 The QOF standards were initially set to attract participation in this voluntary framework. This is understandable, but the level of achievement has significant implications which we will discuss in Part 3.

2.15 In 2006/2007, the QOF points were changed through negotiation, and some relatively simpler points were 'recycled' into more challenging standards. Examples are given in **Figure 5**, but overall eight new clinical indicators were introduced. This represents a positive evolution of the system and, over time, this process should result in a more challenging framework, which encourages practices to continually improve their services.

2.16 Although there has been some criticism of the QOF system – some have suggested that it is too easy to score highly, while others have indicated that it creates a 'tick box' mentality – there is broad agreement that it is a step in the right direction. It provides a useful framework for LHBs when setting standards, and is now generally respected and accepted by most GPs and practice staff. The principle of directly rewarding doctors for the quality of services, as opposed to the number of contacts, is unique. Clinical practice has changed, and changes to QOF domains in 2006 will drive further improvements.

Figure 5: Some examples in changes to QOF points

Original QOF point	Replacement after 31 March 2006
Stroke 1: The practice can produce a register of patients with stroke or TIA. 2 points	Stroke 11: The percentage of new patients with stroke who have been referred for further investigation. 2 points (payment staged 40-80 per cent)
Chronic Obstructive Pulmonary Disease (COPD) 2: The practice can produce a register of patients with COPD. 3 points	COPD 9. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing. 10 points (payment staged 40-80 per cent)
Organisational domain: many changes including deletion of records 1,2,4,5,6,7,10,12,14 and 16. Mainly concerned with ensuring practices have good basic systems.	Clinical domain points for achieving clinical targets for: <ul style="list-style-type: none"> ■ atrial fibrillation; ■ dementia; ■ depression; and ■ various other points.

Source: NHS Employers 'Revisions to the GMS contract 2006/2007'

2.17 The current set of standards that most QOF points measure are for the process of care, which clinical evidence suggests in time will improve patient outcomes. Over time, as the points are recycled and patient outcomes become more widely measurable, more outcome measures should also be included in the QOF.

The way in which the contract is managed in Wales must be improved

2.18 Local Health Boards were relatively new organisations when they took on responsibility for the new contract and faced a challenging agenda. Local Health Boards have had to work hard to establish working relationships with their practices. They are still, in many cases, collaborating closely with struggling practices to improve their performance, and their QOF scores.

2.19 Good governance demands that systems are in place to account for public money and promote improvement in services. Taxpayers can then be reasonably assured that when a practice is paid for achieving a standard or providing a service, then that service or standard has been achieved.

2.20 Within the new GMS contract, QOF is 'high-trust'. There is an expectation that all parties are acting in good faith, from a position of high-professional standards. This does not mean that a reasonable amount of checking could not take place, and in parts of the UK this has happened. Other such high-trust arrangements are operated by government¹⁸ and all include an element of checking to provide assurance.

2.21 Across Wales there are considerable variations in how Assembly Government guidance is implemented; the management style of LHBs, and their relative success at local negotiations results in:

- inconsistent arrangements to verify access payments;
- apparent duplicate payments for services already included in MPIG; and
- LESs not developing quickly or consistently.

2.22 This variation cannot be explained by local circumstances alone, and frequently reflects the interests and capacity of LHB management teams. Local Health Boards with strong experienced financial management are relatively more successful in reducing duplication. Local Health Boards with strong clinical governance teams are relatively more successful in ensuring stronger checks and balances on enhanced services.

Box 5: Support from the Assembly Government for QOF

The Assembly Government took a number of steps to support LHBs in making their QOF checks more robust, including:

- providing LHBs with data on clinical domains of QOF for practices that were more than two standard deviations away from the norm, enabling them to identify outlying practices;
- notifying LHBs where there had been significant change in practice disease prevalence in the last two months of the year;
- commissioning a report from Cardiff University to provide a detailed analysis of the validity and robustness of the clinical information that underpins the clinical domain of the QOF; and
- LHBs have been able to view anonymised QOF clinical data for the past 2 years during practice visits.

¹⁸ Income tax self-assessment and VAT collection. For VAT, businesses self-assess and declare the amount payable, knowing that HM Customs and Revenue can inspect at any time, and that a random sample of 10 per cent of businesses are inspected every year.



Case Study L: Caerphilly LHB first year QOF visit system

To confirm what practices had achieved, and therefore what could be rewarded, the LHB visited (and in seven cases revisited to ensure suggested changes had been implemented) each of its 31 practices. Visits were carried out by a team of typically three or four drawn from a group of LHB employees, CHC representatives, and GP clinicians. A senior nurse also attended the majority of the practice visits.

The visit teams recognised that the fundamental idea of the QOF scoring system was to encourage primary care practices to improve their services to patients. The LHB sent a letter ahead of the visits telling practices that:

'A key aim of the assessment is to enable practices to identify their future support needs. The Primary Care Resource Team are keen to work with practices supporting them in areas identified in the [QOF] verification process. The Primary Care Resource Team can facilitate practices in the achievement of their QOF aspirations through: production of a coherent Practice Development Plan; achievement of effective chronic disease management including establishment of clinics and disease registers; effective medicines management; clinical audit; and facilitation of organisational standards including records management, education and training and workshop reviews'.

The seven revisits were conducted in February and March 2005. These second visits were undertaken primarily to check clinical data quality. This involved the LHB seeking permission from patients using the seven practices to check a sample of patient files and records.

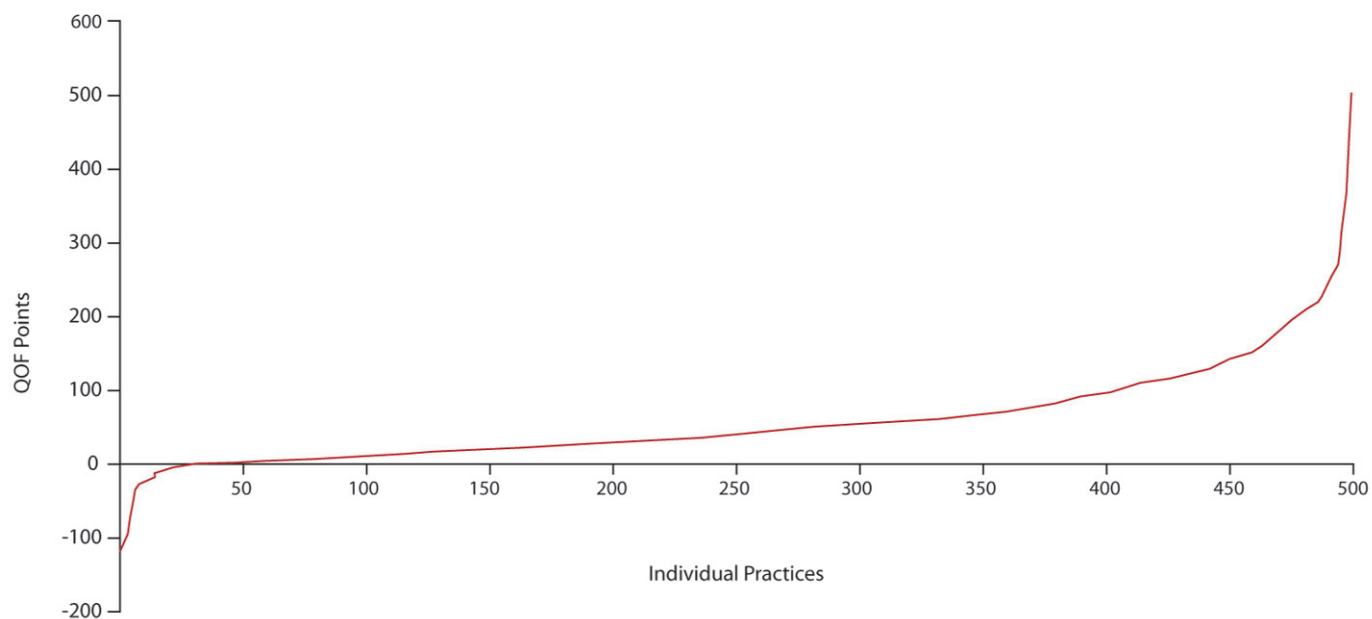
Although the significant shift in scores during the year in Caerphilly probably reflects initially modest aspirations in several practices, there is also evidence that the average increase in the median score from an aspirational value of 785/1050 to an agreed out-turn of 966/1050 reflected genuine within-year service improvements. These in turn resulted partly from adoption of advice provided during team visits and in their reports.

Source: Wales Audit Office local performance audit work

Better assurance is needed on the Quality and Outcomes Framework

- 2.23** Some LHBs have built upon comprehensive guidance issued by the Assembly Government to check thoroughly QOF payments. Caerphilly LHB is a good example and its system is shown in [Case Study L](#). [Box 5](#) shows the support offered by the Assembly Government to LHBs.
- 2.24** The systems used in some other LHBs have been more superficial, and post-visit record keeping and reporting has not always been of the highest standard. In these cases, records were not sufficient to allow the auditor to arrive at the same conclusion as the QOF visit team. There is no implication that the decisions made were wrong but without sufficient audit trails there can be no certainty that decisions were correct.
- 2.25** Other LHBs have deducted points from some practices, showing that robust challenging discussions have occurred and points removed. Such changes have mainly been in the management domains, where practices have lost points for not being able to demonstrate on visits that policies and procedures were being used. [Figure 6](#) shows that in some cases significant changes in scores occurred between the second and third years.
- 2.26** A number of alterations have been made to the QOF system for 2006/2007 and it remains important that LHBs check how practices are operating, verify a sample of QOF claims and remunerate practices correctly. The difficulty facing QOF visit teams is that they need to accommodate the 'high-trust' nature of the contract and therefore that monitoring should be 'light touch', and at the same time act as guardians of the public purse.

Figure 6: Changes in practice QOF scores across Wales between 2004/2005 and 2005/2006



Source: Wales Audit Office analysis of Quality and Outcomes Framework data

2.27 Manipulation of QOF scores is possible within the clinical domain of QOF. Practices can potentially manipulate two things to get more money: exception reporting and disease prevalence.

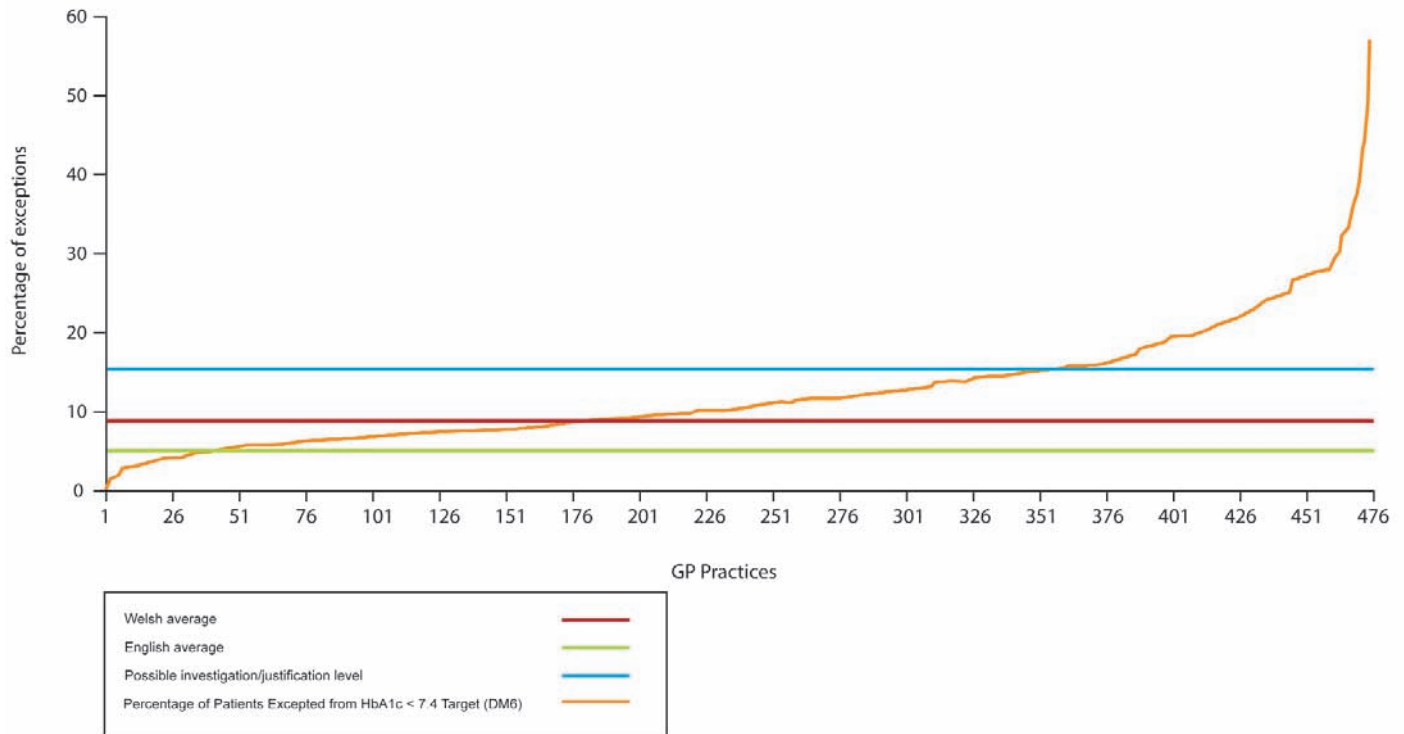
2.28 Exception reporting is easily done and can bring high rewards. Practice points scores depend on the percentage of patients on a disease register to reach an agreed treatment level. Practices are allowed to exclude patients from registers under defined circumstances. For example, the patient cannot tolerate the medication or they are terminally ill, or they refuse to attend for appointments. Excluding these patients increases the likelihood of high scoring with more 'compliant' patients.

2.29 In England where random checks occur in five per cent of practices, the average rate of exception reporting is five per cent. This is slightly higher in deprived areas and levels of over 15 per cent trigger further investigation by QOF review teams. Figure 7 shows that the Welsh average is higher than this at nine per cent, and a significant number of practices are exceeding 20 per cent. Whilst there are many clinically-valid reasons for exclusion, this warrants investigation at practice level to ensure all exclusions meet clinical protocols.

2.30 Where practices are not on maximum QOF points, reporting unusually high prevalence by adding patients to the register unnecessarily provides limited extra reward for significant extra work. Consequently, it is unlikely that GPs would choose to inflate prevalence. However, where practices are on maximum



Figure 7: Chart showing exception reporting – percentage of patients excepted from HbA1c<7.4 target (DM6)



Source: Wales Audit Office analysis of Quality and Outcomes Framework data

points increases in prevalence do increase practice income¹⁹. Hence there is an incentive to ‘case find’ and increase prevalence. In Wales, many screening programmes are managed centrally, so patients are screened independently. This means that patients put on registers mistakenly, are quickly detected and removed.

2.31 Outside the clinical areas of QOF, many of the management and employment QOF points simply require the practice to have a policy. These may be copied from another practice, or not in day-to-day use. Some LHBs, for example Wrexham and Torfaen, have facilitated practice managers' groups to share the best examples. Local Health Boards

encouraged all practices to actively use the policies by asking randomly-selected staff about them during QOF visits. Other LHBs have only required sight of the policy.

2.32 Quality and Outcomes Framework visits now form the basis of a governance framework for primary care. In some LHBs, for example Pembrokeshire (**Case Study M**), QOF visits are increasingly being referred to as practice development visits. This development allows LHBs and practices to work together to proportionately support and manage primary care.

¹⁹ Doctor Behaviour Under a Pay for Performance Contract: Evidence from the Quality and Outcomes Framework. CHE Research paper 28. The University of York, Centre for Health Economics.

Case Study M: Pembrokeshire LHB's integrated visit framework

Pembrokeshire LHB took a different approach to QOF visits in the first two years. They felt that they had already established a number of mechanisms pre-contract which they could build on, for example, the CHC had to undertake the patient experience survey so they could tag on the patient experience indicators. The Medical Director and clinical governance officers were already undertaking clinical governance visits, so they tagged on the clinical indicators. The Prescribing Advisor was undertaking prescribing visits so she tagged on the Medicines Management (MM) indicators and the Primary Care Manager was undertaking visits with the practice managers so she tagged on the practice management indicators.

The visits were scheduled per quarter, so each practice would have four visits over the year. This process has lots of benefits in terms of building on the processes that they already had in place rather than developing a new one. However, over time, the clinical visits and the prescribing visits had a number of overlaps. The LHB is revisiting the QOF mechanism to a team approach once a year, involving a team of GPs from within Pembrokeshire to be trained and engaged in the process. This was implemented in October 2006.

Source: Wales Audit Office local performance audit work

The promised improvement in the primary care estate has been slow to materialise

2.33 Traditionally, most GPs in the UK have owned their own premises. However, the economics of the property market in parts of Wales, plus changing demographics of the workforce and the expected increase in salaried practitioners, means that decreasing numbers of GPs now want to own their own practice buildings. Flexibilities to support GPs who own their own properties were first introduced in 2001 and were augmented after the introduction of the new GMS contract²⁰. These changed the priority in Wales for developing practices from GPs to the strategic level, by linking health need to premises development.

2.34 Maintenance and rent costs represent the majority of estates costs in the new GMS contract, and capital funding for new schemes, improvements and expansion is funded separately. Many practices which own their own premises are refunded a notional rent for NHS use of the premises. Increases in funding in the GMS contract for premises are dependent on agreement for capital funding via estates strategies, when ongoing maintenance costs are transferred to the GMS budget.

2.35 All LHBs have been developing detailed primary care estate strategies since 2003 when the Assembly Government gave them £30,000 towards development costs and provided them with a list of consultants and guidance. Assembly Government officials checked all submitted strategies for consistency with policy direction, with regional offices, and with Welsh Health Estates for technical aspects. The LHBs then received feedback on which aspects of their strategy they needed to address in the short, medium and long term. Some LHBs faced significant delays in finalising their strategies, they reported several problems including:

- Stakeholders not being able to come to an agreement on the content of the strategy.
- Local Health Boards reported problems with the quality of consultants used from the Assembly Government's list.
- Conversely, the Assembly Government reported that some LHBs did not engage fully with consultants, probably due to capacity issues. This contributed to delays because consultants did not have the necessary local knowledge and contacts to ensure good local strategies.

²⁰ Welsh Assembly Government. Premises Flexibility Schemes - incorporating all premises flexibilities. WHC (2004) 006. 23 January 2004.



- Other LHBs reported difficulties in agreeing primary care resource centres with local stakeholders, and believe they have relatively satisfactory group practice premises which require extensions for expansion. Hence, they would like more flexible access to development funds.

2.36 Until their strategies were finalised, these LHBs were unable to submit bids for development of premises, which caused delays to the modernisation of the estate in a few areas. However, the Primary Care Estates Forum does consider urgent applications for funding, outside of approved strategies, which should mitigate this problem.

2.37 In 2006/2007 £3 million funding was made available for revenue schemes and improvement grants, and bids from LHBs were considered by the Assembly Government. In 2005/2006 the fund was £12.7 million (including £9 million re-provided from previous years). Just over £8 million of this was allocated in 2005/2006, but the unallocated money, approximately £4 million, was not re-provided in the following year.

2.38 Fifteen schemes for new developments and three for temporary accommodation from 10 LHBs were approved by the end of October 2006. The Primary Care Estates Forum also provided improvement grants for 23 GP practices valued at £466,000 by October 2006. Schemes funded (at up to 66 per cent of the total cost) range from upgrading telephone systems to building refurbishments and improvements to the security of buildings.

2.39 Only one scheme was funded in full for the entire capital bid (at a cost of £4.9 million) because the Assembly Government wanted to learn from this development and support the LHB in an unfamiliar area. Assembly Government officials said that no further bids for full capital funding would be approved until this one has been completed and evaluated.

2.40 The other schemes are third-party development schemes which are owned by the GPs or by a developer who designs and maintains the property and charges rent over a long-term lease period (usually 20 years). Setup costs (such as stamp duty, legal fees and surveyors) are also funded by the Assembly Government. The total estimated capital value of all the new premises is £37 million. Based on the recurrent costs for 2008/2009, the Assembly Government will be paying £2 million a year in rent and maintenance. Over the period of 20 years this will amount to some £41.6 million.

Out of Hours services differ in configuration and integration with other parts of the NHS services

2.41 Out of Hours services are now more closely monitored by NHS commissioners than before, with formal contracts agreed across Wales. Local Health Boards are now more aware of the standard of service they, and their residents, are receiving from their contracted OOH providers. A good example of the change in management of OOH is the arrangement with MorfaDoc which supplies OOH services to Conwy and Denbighshire ([Case Study N](#)).

2.42 In our report on Cardiff OOH services published in 2005, we looked at the commissioning of Cardiff's OOH service in some detail. We made recommendations to both the Assembly Government and LHBs:

- that further guidance and some tools should be provided from the centre;
- LHBs should ensure that delegation arrangements are clear and all decisions are properly documented when awarding tenders; and
- LHBs should ensure that they performance manage contracts effectively.

2.43 Our local work across Wales has shown that many LHBs had limited choice in providers when awarding the initial contracts. This limited choice of credible providers meant that in some cases LHBs felt they were unable to test the market effectively.

Case Study N: OOH provision in Conwy and Denbighshire

Conwy and Denbighshire LHBs work closely together on commissioning, clinical governance and prescribing, especially for primary care. The LHBs' Clinical Governance Framework is combined with analysis of activity data to form the basis of regular Performance Framework visits to MorfaDoc, their joint OOH provider. This robust contract management compares well with previous arrangements, and the LHBs are confident that patients are receiving a safer service, because:

- assessment and call handling procedures are robust;
- all participants are appropriately qualified and trained; and
- those patients who need medical attention are sent to A&E.

Source: Wales Audit Office local performance audit work

2.44 Under the new contracts, service standards are now set, measured and monitored, but not all quality standards are being met, and management information is often inadequate. Performance management by LHBs of service providers should improve this position, although faster progress is desirable. We will be keeping this area under review.

2.45 Commissioning and contracting OOH is difficult in an environment where there is little standardisation and no reliable benchmarking information available in Wales. For example, some OOH contracts, such as ShropDoc in Wrexham and Powys include triage by the provider while others, such as Gwynedd and Anglesey, have triage provided by NHS Direct Wales. Powys OOH service includes medical cover for its community hospitals, not covered by most services. Where services are based adjacent to A&E departments, such as in Bridgend and Carmarthen, they are integrated to different extents, and premises costs are variable depending upon who owns the building.

2.46 As a starting point to understanding costs, the service provided OOH should not exceed the standards of the service provided within normal primary care operating hours. Out of Hours service suppliers should not, for example, routinely provide patients with better access to medical advice and care than they might expect to receive from their own GP practice. For example in Ceredigion, there are some incidents of patients calling the OOH service to order repeat prescriptions rather than to wait until their own GP practice opens. This is an inappropriate and wasteful use of the service.



- 2.47** Secondly, OOH services are intended to provide an emergency service for patients who are too ill to wait for their practice to open. It is generally more resource effective to advise patients by telephone or to see patients in treatment centres before seeing them in their own homes.
- 2.48** The OOH services should be patient focused and capable of directing patients to the most appropriate care. More research is required before definitive guidance can be issued on how these services should be provided. In some parts of Wales, providers are developing innovative ways of working, such as the Paramedic Practitioner in Pembrokeshire.
- 2.49** The figures for 2005/2006 show that the significance of the OOH budget varies between LHBs (see [Appendix 3](#)). Services provided outside normal operating hours generally account for around seven per cent of all new GMS spend, but the percentage is higher in rural areas. The spend per head is even more variable; it averages around £11 per resident per year across Wales, but is less than that in Cardiff (under £7 per resident per year), and more than twice as high in Ceredigion (over £20). In Ceredigion, the cost of answering and dealing with the 13,000 calls taken by the OOH provider in 2005/2006 amounted to £1.6 million - an average cost per call handled of between £120 and £125.
- 2.50** The true cost of an OOH service has to be judged more widely than as a single heading within the new GMS. This is because the behaviour of those who operate OOH services influences other operational health areas. For example, what might at first appear an expensive service, could in the long run, if it results in fewer emergency hospital admissions, be more cost effective (and more popular with residents) than an apparently cheaper OOH service run by more cautious operators. Further research will be available in 2007, which should aid further understanding of OOH.
- 2.51** Before renewing contracts, OOH providers and LHBs must work with secondary care and the Ambulance Service to understand the whole unscheduled care process. Apparent savings in OOH, may lead to increased A&E admissions, and the benefits of whole system approaches have been demonstrated by Welsh Emergency Access Collaborative projects and the Modernisation Agency in England. This, however, is a long-term solution, and requires effective joint working between primary care hospital trusts, the Ambulance Service, and LHBs.

Part 3 - Uncertainty on QOF made accurate forecasting of likely costs difficult and budgets were revised

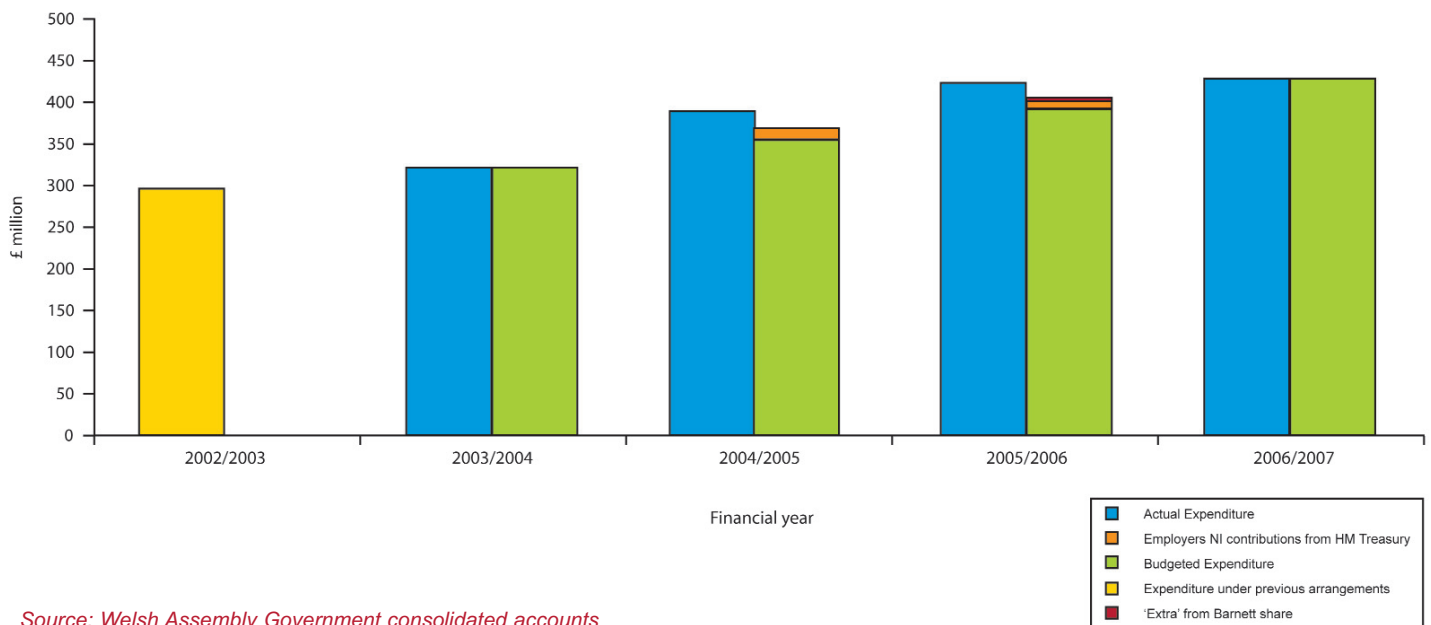
3.1 Expenditure on GMS in Wales can be readily identified from the whole of government accounts. Clarity on what was initially planned, and when and how budgets were revised is harder to see.

3.2 Assembly Government officials have told us that value for money was one of their key, yet unstated objectives. This was against a background of GPs claiming that they were not adequately paid for what they were doing and that they were being asked to do new work without the necessary resources.

3.3 During the final stages of contract negotiations the four UK countries agreed to increase investment in primary care services by a minimum of 33 per cent over the three years 2003/2004 to 2005/2006²¹. The Wales GIG was formally agreed at 38 per cent.

3.4 Easy comparison between the old and new contract expenditure is complicated because dispensing doctors' costs (drugs and fees) were not included in the figure for 2002/2003. They are now included in the allocations for the new contract, and to simplify interpretation we have included this budget in the previous GMS spend.

Figure 8: Expenditure on General Medical Services since 2002



Source: Welsh Assembly Government consolidated accounts

²¹ Investing in General Practice: The New General Medical Services Contract. NHS Employers 2003.



QOF cost significantly more than expected

- 3.5** A 33 per cent increase in expenditure on 2002/2003 levels would have been £390 million (Figure 8). However, a figure of 38 per cent was agreed for Wales, giving a GIG minimum investment of £406 million by 2005/2006. This higher figure was to allow for extra funding from HM Treasury to cover the seven per cent increase in employers contributions for pensions and to reflect the increased profit premium. For 2004/2005, the budgets for LHBs were issued in two stages, with the QOF allocation being finalised in April 2005 when the scale of achievement of practices on QOF was known.
- 3.6** Actual expenditure in 2005/2006 was £424 million, representing an increase of 44 per cent over the agreed minimum additional investment. So Wales has spent four per cent or £17 million more than the revised GIG (see Appendix 6).
- 3.7** Assembly Government officials and others on the negotiating team, have been working to ensure that future expenditure is capped and efficiency savings implemented. The 2007/2008 uplift in GMS is zero per cent.
- 3.8** There are a number of reasons why the contract cost more than initially planned. We believe that at least some of these factors should have been predictable, and consequently managed more actively.
- 3.9** The biggest single element in the cost of the new contract is the GS payment, but this is decreasing as a proportion, because quality payments have grown in significance. QOF payments are the single biggest reason for the increased contract cost.
- 3.10** Although OOH services have attracted considerable attention, they represent only a small part of the cost increase of the whole contract (eight per cent in 2005/2006). Initially practices gave up £6,000 per GP per year for withdrawing from OOH cover. This £6,000 was re-allocated to LHBs, but the true cost of providing these services was considerably more. To reflect this, in 2005/2006 the

Figure 9: General Medical Services in Wales between 2002 and 2007

Year	GIG £m	Budgeted expenditure £m	Actual Expenditure £m	Timeline
2002/2003			293	Old contract
2003/2004	323	323	323	New contract GS with MPIG
2004/2005	369	387	392	QOF ES and OOH start
2005/2006	406 ¹	415	424 ²	QOF £'s per point increased
2006/2007		433	433 ³	

Notes

- ¹ A 33 per cent increase would have amounted to £390 million.
² £424 million amounts to a 44 per cent increase.
³ From LHB audited accounts.

Assembly Government allocated approximately £16,500 per GP to LHBs. The true cost of providing this service, again exceeded initial expectations, and budgets were revised.

Practices were able to respond very quickly to the new opportunities

3.11 Before the contract was implemented, there were uncertainties about what the impact of QOF would be both clinically and financially across the UK. This was the first time any major healthcare system had systematically rewarded practices on the basis of quality of care to patients. The QOF system, which links clinical achievement to practice remuneration, is a key factor in determining overall practice remuneration and contract costs. The contract was negotiated by the NHS Confederation with health departments as observers. There was a project management structure in place, stakeholder meetings and a direct link between LHBs and the NHS Confederation.

3.12 In 2003, most reviews²² discuss the risk of non-engagement and under achievement on planned investments. Consequently, performance management focused on increasing engagement and supporting GPs in maximising income. Whilst this was appropriate in some parts of Wales, such as the South Wales Valleys, it has made it harder in other parts of Wales, such as North West Wales, to control and accurately predict costs.

3.13 The estimate of around 700 QOF points came from UK negotiations and was supported by expert medical advice. Despite this, it is our view that in Wales, predicting the risk of many practices over achieving on QOF scores could have been possible because:

- some practices were already participating in quality development schemes, such as the Royal College of General Practitioners Quality Team Development and Practice Accreditation Scheme, and many QOF indicators were derived from this and other schemes;
- generally, there is a good history of GPs rapidly taking-up opportunities to earn more money, such as fund-holding;
- Health Social Care and Well-Being strategies across Wales emphasise and invest in better chronic condition management services, especially in primary care (many LHB had supported GPs in constructing registers); and
- the Assembly Government's strategic investment in primary care computing (the Foundation Program for Primary Care IT) ensured all Welsh GPs were able to record and evidence their achievement of QOF targets.

3.14 Clearly there were no guarantees that any of this investment would result in quality improvements. In fact, in Wales, the quality of general practice in the most deprived areas has been stubbornly low for decades. The work of Professor Julian Tudor-Hart²³ on the Inverse Care Law clearly demonstrates this. In 2002/2003 much of the evidence pointed to the fact that it was going to be extremely difficult to drive up quality in the most deprived areas.

²² ACiW briefing paper. Welsh Roadshows, NHS Employers literature.

²³ The Inverse Care Law. Julian Tudor Hart. The Lancet: Saturday 27 February 1971.

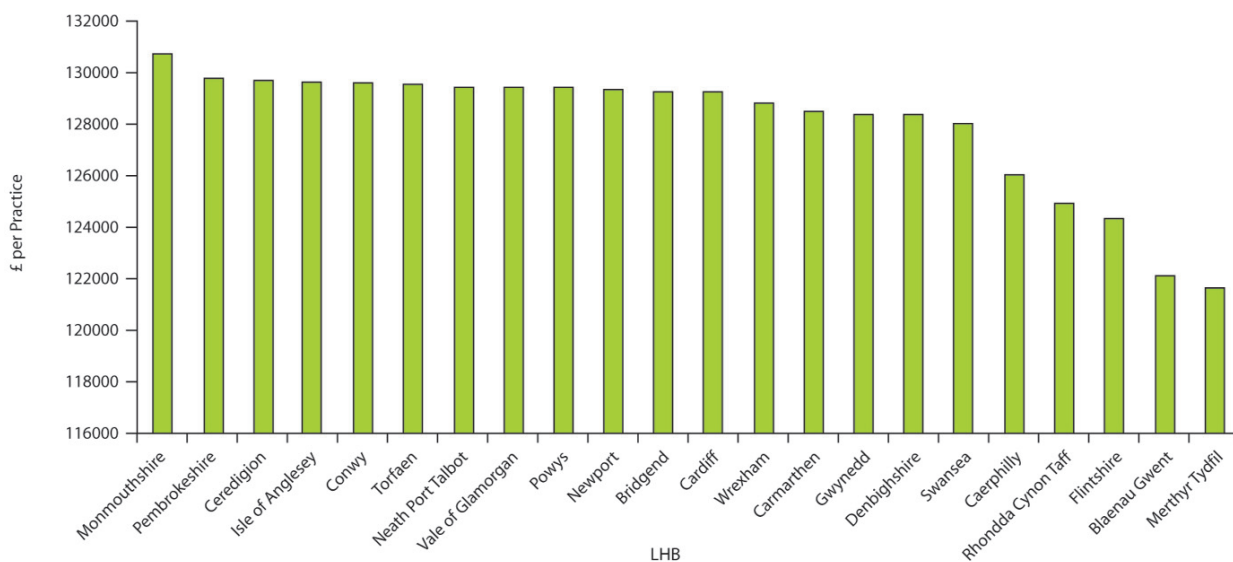


3.15 By 2005/2006, QOF payments across Wales totalled £65 million equivalent to about one-sixth of the total cost of the contract. It was planned that practices would achieve an average of 700 points by April 2006, but by 2006 the average was 943.

3.16 In the first years of the new contract, the maximum points score achievable through QOF was 1050. In 2004/2005, a point was worth £75 for a practice with an average weighted population of 1,800 per GP. In 2005/2006, the value of a point rose to £125. This 66 per cent increase was agreed at the negotiations to make uptake of QOF attractive for practices. The value of a point in each practice depends, amongst other things, on the size of the practice population and the observed levels of disease within the local population (prevalence).

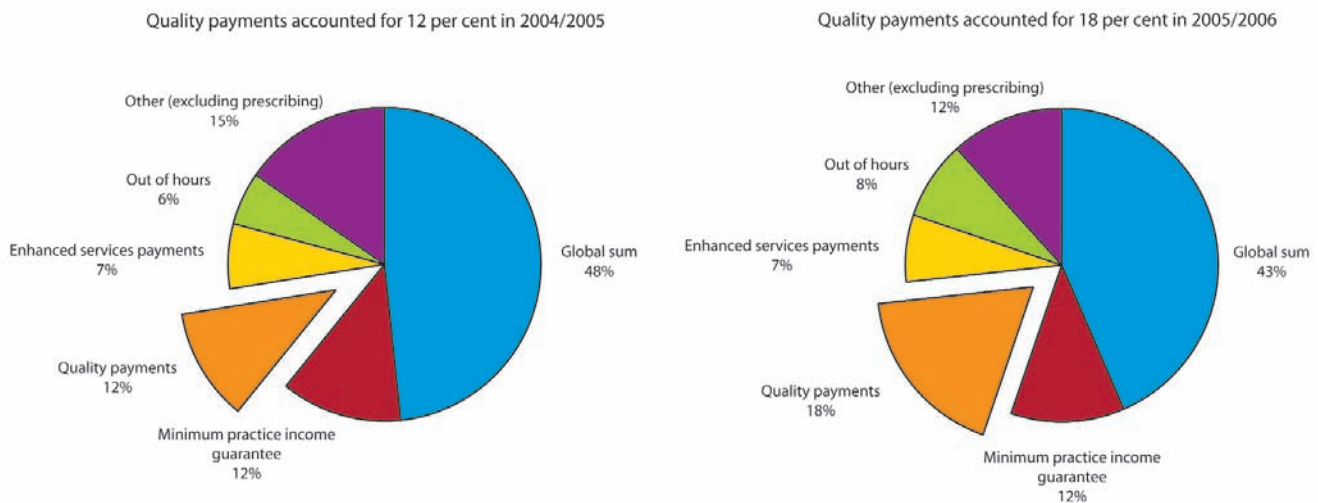
3.17 The other issue raised by GPs in Wales, is that QOF income within the clinical domain, is based upon calculations that use Welsh specific practice prevalence (amount of ill health) and not UK-wide figures. In general, the average levels of prevalence for Wales within the clinical areas are higher than in England. Although, on average there is a higher prevalence of disease in Wales than England, there are also higher levels of multiple disease, which along with other factors, such as practice list size, are included in the formula. The issue is further complicated by differences in data collection systems and clinical systems technical handling of Read codes. So despite different levels of payment for a given level of prevalence, the extent of the income differential is likely to be lower than the raw prevalence figures would suggest. Consequently, a Welsh practice receives slightly less income than an identical practice in England for the same level of prevalence.

Figure 10: Median Quality and Outcomes Framework practice payments across Wales



Source: Welsh Assembly Government consolidated accounts data

Figure 11: Money spent on Quality and Outcomes Framework as percentage of total new General Medical Services spend



Source: LHB consolidated accounts data

- 3.18** Across Wales, QOF represents a valuable source of income for most practices, and considerable value to some practices with lower baseline incomes (Figure 10).
- 3.19** Each LHB spends between £2 million and £5 million on QOF annually. If practices had achieved their expected scores of 700 points, then expenditure would have been significantly lower, between £1.5 million and £4 million per LHB by April 2006.
- 3.20** Figure 11 show the significance of QOF payments overall. The increase between the two years stems from two changes - the increase in the value of a QOF point (£75 to £125) accounts for the main part, but most practices also raised their points score between the two years.
- 3.21** Viewed from the perspective of service delivery, the high achievement on QOF should be welcomed. It indicates that most practices in Wales believed in the concept of QOF and also saw it as a means to boost practice income.
- 3.22** The high achievements show that most practices already had sound infrastructures including, for example, trained and active practice nurses and reasonable systems for offering good access. Computer systems and data reporting systems were also readily available in Wales. The Foundation Program for Primary Care IT had ensured that Welsh GPs were properly equipped with appropriate computer systems even if some still needed guidance on how best to use them. Many practices were also encouraged by QOF rewards to use questionnaires to find out what their patients most wanted from them.



Although GMS proportion of healthcare costs is stable, in the first year savings from drugs budgets funded QOF, and LHBs were unable to use these savings for local service development

3.23 Primary care expenditure has remained stable as a proportion of healthcare spending, as although spend on GMS has risen, other health spending has also risen. Consequently, GMS reflects a similar proportion of total healthcare expenditure in 2006/2007 to that in 2002/2003.

3.24 Unexpected cost pressures, resulting from practices achieving higher-than-anticipated QOF scores, and additional OOH costs, have resulted in pressure on LHB budgets. This has been managed at LHB level, and the full additional cost met by revised out-turn allocations by the Assembly Government. In contrast, the NHS in England is reporting an overspend of £300 million, mainly reported to be due to overspend on GMS²⁴. In Wales, recent written responses to Assembly Government members²⁵ indicate that £17 million more than budgeted was spent on GMS. Allocations overall in Wales are set by the Barnett formula and have not changed. This means that money could not be spent on other NHS developments as it had been allocated to GMS.

3.25 In practice, at Assembly Government level, this left officials and ministers with little room for manoeuvre on NHS spending. At LHB level, for example, it meant that savings achieved from prescribing budgets within a year were not available to start new services. Development monies were also absorbed in many LHBs. Whilst most areas have been able to manage this, it does mean that other important developments in community services have not happened yet, and that budget pressures in other parts of the NHS have not been funded by commissioners. Consequently, some projects across Wales which aim to re-design care, provide better services closer to patients' homes, and better care in hospitals, are unable to attract pump-priming funding.

3.26 This financial pressure has occurred at the same time as other guidance - particularly the NSFs - has encouraged primary care activity and spending. For example, the bill for statins has increased, partly because QOF has encouraged GPs to identify, register and test patients with heart conditions, but also because an NSF and NICE encourages most of these patients to be offered drug therapies. The encouragement through QOF to measure and record cholesterol levels in primary care has also led to increase in demand for secondary care pathology services.

3.27 In the long term, these and other similar primary care initiatives will benefit patients, but in the short-term they are putting increasing pressures on LHBs to establish realistic priorities to decide between conflicting claims for funding.

²⁴ Public Accounts Committee questions to NHS Chief Executive October 2006.

²⁵ Written Assembly Question from Welsh Conservative health spokesman Jonathan Morgan AM 21 February 2007.

Appendix 1 - Methodology

Our methodology involved:

- 1 A background literature review including external reviews, academic reports and other documents from a wide range of sources including the Assembly Government, NHS Employers, Department of Health, the British Medical Association and the Audit Commission. This, together with preliminary meetings with key Assembly Government officials and others, informed decisions about the scope of the study and the key questions we needed to answer.
- 2 An extensive programme of interviews and meetings with leading health service administrators and clinicians, as well as representatives of other organisations and interested parties in health and social care. This included:
 - key officials of the Assembly Government in the Health and Social Care Team and the statistical and Finance divisions;
 - directors and staff from LHBs from across Wales;
 - GPs from both GPC (Wales) the Welsh BMA negotiating committee, and across Wales; and
 - various academics, practice managers, and other individuals with an interest in primary care.

3 We collated and analysed relevant statistical data from a number of sources, of which the following were particularly important:

- annual accounts from individual LHBs and the Assembly Government;
- QOF data, both at LHB and practice level;
- surveys conducted in LHBs as part of our local work; and
- various other sources of data used by the study team included: Health Solutions Wales data analysed to support our review of Chronic Conditions in Wales; Office of National Statistics, and Wales Programme for Improvement; and the Healthcare

Site visits and local audit work

Clwyd CHC
GP practices in several LHBs including Cardiff, Wrexham, Powys and Torfaen
BSC (Mold) Post-Payment Verification Team
Internal Audit a number of locations, including Swansea and Mersey
Cardiff LHB
Caerphilly LHB
Ceredigion LHB
Conwy LHB
Gwynedd LHB
Neath Port Talbot LHB
Merthyr Tydfil LHB
Pembrokeshire LHB
Powys LHB
Rhondda Cynon Taff LHB
Torfaen LHB
Vale of Glamorgan LHB
Wrexham LHB
North Wales LMC
Cardiff University



Commission's Acute Hospital Portfolio Phase 6, which provided data on GP testing as part of the Pathology module.

- 4 We undertook detailed local audit work in 11 of the 22 LHBs across Wales, which covered the key issues identified nationally and, in many LHBs, went on to investigate in more detail specific issues of particular relevance. We selected LHBs on the basis of risk during our risk based planning cycle, and ensured national coverage by conducting further interviews and visits in a sample of LHBs without local audit work.
- 5 We informed our findings by analysing internal audit reports, and interviewing relevant NHS staff about the new contract, how it is working in practice and their attitudes to it.

Expert panel

- 6 We constituted a panel of experts to advise us during the course of the examination. The panel members sat in an individual, advisory capacity, and had no executive role in the Auditor General for Wales' examination. The panel advised us at key stages of the study. We held two meetings which discussed:
 - the study scope and methodology; and
 - our emerging findings.
- 7 Panel members also actively participated in the drawing conclusions stage of our reporting, and commented on drafts of the report.

- 8 We are grateful to the following members of our expert panel who provided helpful advice and gave freely of their expertise. These are listed in the following table.

Expert panel members

Abigail Harris	Vale of Glamorgan LHB
Prof Adrian Edwards	Cardiff University
Dr Andrew Dearden	BMA Wales
Dr Andrew Goodall	Neath Port Talbot LHB
David Carson	The Healthcare Foundation
Derek Fishwick	Assembly Government
Dr Ian M Millington	BMA Wales
Dr Kay Saunders	BMA Wales
Ian Jones	Assembly Government
Janette Fells	Flintshire LHB
Judith Paget	Caerphilly LHB
Mel Evans	Rhondda Cynon Taff LHB
Dr Peter Rutherford	North East Wales NHS Trust

Appendix 2 - What is included in the new General Medical Services contract?

Essential services:	<p>(i) management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable;</p> <p>(ii) general management of patients who are terminally ill; and</p> <p>(iii) management of chronic disease in the manner determined by the practice, in discussion with the patient.</p>
Additional services:	<p>(i) cervical screening;</p> <p>(ii) contraceptive services;</p> <p>(iii) vaccinations and immunisations;</p> <p>(iv) child health surveillance;</p> <p>(v) maternity services - excluding intra partum care (which will be an enhanced service); and</p> <p>(vi) the minor surgery procedures of curettage, cautery, cryocautery of warts and verrucae, and other skin lesions.</p>

To maintain the professional ethos of general practice, practices will be funded through essential and additional services to continue to provide continuous holistic treatment and care for all registered patients, including opportunistic health promotion and management of patients' appropriate continuing care after acute referrals. Breadth of care will also be rewarded through holistic care payments within the Quality Framework.

Source: NHS Confederation and British Medical Association. Investing in general practice - the new general medical services contract. February 2003.



Appendix 3 - Charts and tables

Money spent on the new General Medical Services Contract

	LHB	2005/2006 £,000's
1	Torfaen	11,457
2	Caerphilly	22,081
3	Newport	17,069
4	Blaenau Gwent	10,318
5	Monmouthshire	16,237
6	Cardiff	39,495
7	Merthyr Tydfil	7,899
8	Vale of Glamorgan	13,907
9	Rhondda Cynon Taff	30,778
10	Bridgend	18,028
11	Neath Port Talbot	16,041
12	Swansea	28,693
13	Carmarthenshire	21,955
14	Pembrokeshire	17,774
15	Ceredigion	13,822
16	Powys	26,539
17	Gwynedd	23,158
18	Conwy	16,149
19	Anglesey	11,976
20	Denbighshire	15,673
21	Wrexham	17,311
22	Flintshire	20,655
Total		418,263

Money spent on Quality and Outcomes Framework as percentage of total of new GMS spend

	Source	New contract 2004/2005 £ million	Percentage of total new GMS spend	2005/2006 £ million	Percentage of total new GMS spend
	Data from LHB consolidated accounts	40.5	10.4%	65.8	15.8%
1	Torfaen	1.27	12.4%	2.06	17.9%
2	Caerphilly	2.36	12.3%	3.86	17.5%
3	Newport	1.94	12.6%	3.12	18.3%
4	Blaenau Gwent	0.88	9.6%	1.55	15.0%
5	Monmouthshire	1.30	8.2%	1.84	11.3%
6	Cardiff	4.38	11.5%	7.15	17.8%
7	Merthyr Tydfil	0.69	9.3%	1.19	15.0%
8	Vale of Glamorgan	1.51	12.0%	2.54	18.3%
9	Rhondda Cynon Taff	3.08	10.7%	5.10	16.3%
10	Bridgend	2.01	12.1%	3.30	18.3%
11	Neath Port Talbot	1.91	13.1%	3.05	19.0%
12	Swansea	3.21	12.5%	5.13	17.9%
13	Carmarthenshire	2.30	11.6%	3.76	17.1%
14	Pembrokeshire	1.56	9.4%	2.46	13.8%
15	Ceredigion	1.27	9.9%	2.00	14.5%
16	Powys	1.83	6.9%	2.94	11.1%
17	Gwynedd	1.54	7.1%	2.72	11.7%
18	Conwy	1.56	10.2%	2.48	15.3%
19	Anglesey	0.92	8.0%	1.47	12.2%
20	Denbighshire	1.38	9.3%	2.22	14.2%
21	Wrexham	1.78	11.1%	2.93	16.9%
22	Flintshire	1.83	9.5%	2.96	14.3%



Money spent on Out of Hours

	Source	2005/2006 £,000's first full year	Percentage of total 2005/2006 new GMS spend	Resident Population	OOH spend per resident
	Data from LHB consolidated accounts (excludes Powys)	29,114	7.0%	2,827,092 (excludes Powys)	£10.30
1	Torfaen	872	7.6%	90,303	£9.66
2	Caerphilly	1,496	6.8%	170,238	£8.79
3	Newport	1,126	6.6%	139,573	£8.07
4	Blaenau Gwent	745	7.2%	68,413	£10.89
5	Monmouthshire	1,002	6.2%	87,704	£11.42
6	Cardiff	2,209	5.5%	319,702	£6.91
7	Merthyr Tydfil	754	9.5%	54,868	£13.74
8	Vale of Glamorgan	846	6.1%	122,932	£6.88
9	Rhondda Cynon Taff	2,441	7.8%	231,622	£10.54
10	Bridgend	1,166	6.5%	130,772	£8.92
11	Neath Port Talbot	1,031	6.4%	135,586	£7.59
12	Swansea	1,952	6.8%	226,369	£8.63
13	Carmarthenshire	2,053	9.4%	178,119	£11.53
14	Pembrokeshire	2,090	11.8%	117,490	£17.79
15	Ceredigion	1,596	11.5%	78,258	£20.38
16	Powys	not comparable	not comparable	131,498	not comparable
17	Gwynedd	2,183	9.4%	117,985	£18.50
18	Conwy	1,200	7.4%	111,521	£10.76
19	Anglesey	681	5.7%	68,934	£9.88
20	Denbighshire	1,016	6.5%	95,991	£11.05
21	Wrexham	1,449	8.4%	130,482	£11.10
22	Flintshire	1,206	5.8%	150,230	£8.03

Appendix 4 - Access monitoring forms

Practice access report at, time of day, month, year, Practice name

Number of consultations through practice on previous day

	Face-to-face	Telephone
GP		
Nurse		
Other health professional		

(Q1) How many unused urgent face-to-face GP slots for today (Wednesday 6) were still available when the practice closed last night?

(Q2) Are you confident that you have enough free slots in the next 24 hours to cope with likely urgent demands? (yes/no)

(Q3) If a patient were to ring in the next half-hour, could you offer a non-urgent bookable appointment for that patient to see a GP within the next two weeks? (yes/no)

(Q4) Likewise, but to see a nurse instead? (yes/no)

(Q5) Concentrating on up to five GPs (full time or part-time), show below whether you could offer a routine appointment within four weeks if a patient were to ask for one in the next half-hour:

Doctor (name)						
Yes/no	Yes	No	Yes	No	Yes	No
Working days to next appointment						

(Q6) Where you have indicated 'no' please advise if this is because the doctor is on holiday or absent for some other planned reason, or if they are working but don't have any routine bookable appointments left within the next four weeks, or because your system doesn't work four weeks ahead.

(Q7) Are there any unusual factors affecting the level of access this practice can expect to offer its patients in the next four weeks?



Appendix 5 - A snapshot of Enhanced Services provided by Welsh LHBs

This table illustrates some of the local enhanced services provided by LHBs across Wales as at 31 March 2006.

local enhanced service	Local Health Board
ADHD	Neath Port Talbot
Chronic disease	Merthyr Tydfil
Dermatology clinic	Wrexham
Drugs misuse services - enhanced specification ¹	Gwynedd and Wrexham
Extended diabetes care	Caerphilly
IUCD ¹	Merthyr Tydfil
Medicine management	Conwy
Minor injury	Gwynedd
Minor surgery ¹	Merthyr Tydfil
MMR ¹	Monmouth
MMR catch up ¹	Merthyr Tydfil
Near patient testing ¹	Cardiff
Nurse triage	Flintshire
Nursing homes	Cardiff, Merthyr Tydfil
Outbreak (mumps)	Gwynedd
Phlebotomy ¹	Merthyr Tydfil
Phlebotomy and investigation ¹	Neath Port Talbot
Physio (COPD)	Flintshire

Note

¹ Local adaptations of national service specifications.

local enhanced service	Local Health Board
Podiatry services	Wrexham
Ring pessaries	Neath Port Talbot
Shared care prescribing	Bridgend, Neath Port Talbot
Substance misuse	Rhondda Cynon Taff
Treatment rooms	Powys
Weight loss clinic	Wrexham
Wound care/minor injuries	Merthyr Tydfil
Wound management	Neath Port Talbot
Zolodex	Merthyr Tydfil, RCT and Monmouth

Source: Findings from the Wales Audit Office survey of LHBs as part of the chronic disease management review, 2006.



Appendix 6 - Welsh Gross Investment Guarantee

Envelope for Wales

2002/2003 out-turn	2002/2003 £
GMS Fees and Allowances	155,691,074
Quality Payments	-
Enhanced Primary Care Services	670,443.24
GMS Cash-limited payments (including IT, Premises)	84,932,979
OOH	4,021,603
Other (R&R)	603,000
Dispensing	47,364,407
Total	293,283,506

	2002/2003 £	2003/2004 £	2004/2005 £	2005/2006 £
Total spend 2002/2003	293,283,506	293,283,506	293,283,506	293,283,506
Extra spend Year 1		29,300,000	29,300,000	29,300,000
Extra spend Year 2			32,200,000	32,200,000
Extra spend Year 3				35,300,000
Sub Total		322,583,506	354,783,506	390,083,506
% uplift at sub total line		9.99	20.97	33.01
A: Additional Funding			12,300,000	12,300,000
B: Additional Funding			1,600,000	3,500,000
GIG total	293,283,506	322,583,506	368,683,506	405,883,506
% uplift at GIG total line		9.99	25.71	38.39

Notes on additional funding within the GIG:

A Seven per cent increase to employers contribution (increase of £50 to £54 per CWP) CWP at 1 April 2004 is 3,065,600 (3,065,600 x £4 = £12.3 million).

B Barnett share of England's £88 million increased profit premium - ie, 5.89 per cent England's split £28 million/£60 million for 2004/2005 and 2005/2006.

Wales GMS Funding

	2003/2004 £ million	2004/2005 £ million	2005/2006 £ million
Out-turn	322.6	391.6	423.6
Agreed minimum level of investment (GIG)	322.6	368.7	405.9
Additional investment above agreed minimum level of investment	0	22.9	17.7
Assembly Government GMS Budget	322.6	387.2	415.2
Overspend by LHBs against Assembly Government budget	0	4.4	8.4
% overspend by LHBs against Assembly Government budget	0	1.1	2.0



Appendix 7 - Glossary definition of terms commonly used in the context of General Medical Services contract

Abbreviation	Description
Blue book	Investing in General Practice - the new General Medical Services contract rules, terms and conditions published by the Department of Health on behalf of NHS Employers and the other UK health departments
BSC	Business Services Centre
Carr-Hill	Formula used to derive practice baseline income
CHC	Community Health Councils
CHD	Coronary Heart Disease
DES	Directed Enhanced service - enhanced services which the Assembly Government insist must be available to all patients within an LHB area. Provided by the patients own practice or another practice nearby
ES	Enhanced Services - services which a practice can chose not to provide
FRG	Formula Review Group - the group consisting of representatives from NHS Employers and British Medical Association (BMA) who reviewed and published recommendations on the Carr-Hill formula
GIG	Gross Investment Guarantee
GMS	General Medical Services contract
GPC	General Practitioners Committee - a part of the BMA. There is all UK group (GPC) and sub-groups for the separate administrations - eg, GPC (Wales)
GPWSI	GP with Special Interest
GS	Global Sum -The baseline income, calculated using the Carr-Hill formula
LES	Local Enhanced Service - an enhanced service negotiated locally (regionally or at LHB level), and paid for from local funds
LHB	Local Health Board
LMC	Local Medical Committee - local GP advisory forum
MPIG	Minimum Practice Income Guarantee- A supplement to ensure that practice baseline income was maintained
NES	National Enhanced service - enhanced service with nationally negotiated terms and conditions

Abbreviation	Description
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
OOH	Out of Hours
QOF	Quality and Outcomes Framework - an incentive scheme to encourage GPs and practices to provide high quality care
Read codes	These are the codes used to classify clinical work on computer systems
Red Book	Terms and conditions for the 'items of service' and allowances under the previous GMS Contract