



House of Commons
Committee of Public Accounts

**NHS Pay Modernisation:
New contracts for
General Practice
services in England**

Forty-first Report of Session 2007–08

*Report, together with formal minutes, oral and
written evidence*

*Ordered by The House of Commons
to be printed 23 June 2008*

HC 463
Published on 9 October 2008
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

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Summary

For most people their General Practitioner (GP) is the first point of contact with the National Health Service (NHS). Around 33,000 GPs hold some 290 million consultations each year, with GP services costing some £7.7 billion, almost 10% of all NHS expenditure. In 2000, the Department of Health (the Department) determined that many of its planned improvements in primary care were unlikely to be achieved without a new contract for general practice. Fully implemented in April 2004, the new contract is intended to attract more doctors into general practice through better pay and improved conditions. The NHS is expected to benefit by linking GPs' pay to their clinical performance and by improved accessibility to services through more flexible working.¹

The NHS has realised some but not of all the benefits from the new contract. Over the first three years, the contract cost £1.8 billion more than originally expected because the Department underestimated the cost of delivering services such as out-of-hours care. The level of GP performance, as measured by the Quality and Outcomes Framework, also exceeded estimates and led to additional expenditure. The Department believes the cost of the contract is now under closer control and that by the end of 2008 it will have recovered any overspend.

The Department has succeeded in increasing the number of GPs working in the NHS above the target it set itself: more than 4,000 additional GPs from March 2003, an increase of 15%. It has also been successful in introducing a pay for performance system which has increased the consistency of care for long term conditions. The new contract has helped increase the breadth of services provided in primary care, but has had less success in improving access to primary care, particularly in more deprived areas.

GP partners have benefited most from the new contract, with an average pay increase of 58% and decreased working hours. Other staff, such as practice nurses and salaried GPs, have had only small pay rises despite taking on a larger proportion of the workload in general practice. GP productivity has actually decreased, on average, by 2.5% per year in the first two years of the contract.

Primary Care Trusts have lacked the capacity and capability to commission local services effectively and have not used the contract in a way that fully realises its benefits. They have spent more than they were allocated, but failed to use the contract to provide more convenient opening hours and more general practice services in deprived areas. The Department has now issued central directions to Primary Care Trusts to tackle these issues.

On the basis of a Report by the Comptroller and Auditor General,² we examined the contract negotiation, the cost implications, and the extent to which the expected benefits for patients and the NHS are being realised. We took evidence from witnesses from the Department and the NHS.

1 Department of Health, *NHS Plan 2000*

2 C&AG's Report, *NHS Pay Modernisation: New contracts for General Practice Services in England*, HC (2007–08) 307

Conclusions and Recommendations

- 1. The new contract cost some £1.8 billion more than planned.** Incomplete data on the cost of services provided by GPs led the Department to underestimate expenditure in the first three years of the contract. While Primary Care Trusts' funding was increased, they still spent £406 million more than allocated, largely because of the additional cost of providing out-of-hours care and higher than expected levels of payments to GPs under the pay for performance system. Where practicable, major changes should be piloted before they are implemented so that costs can be determined with greater accuracy.
- 2. Since March 2003, 4,098 more GPs are working in primary care, an increase of 15.3%.** There are also fewer vacancies for GPs, including in some deprived areas where recruitment has previously been a problem.
- 3. General practice productivity has decreased annually by an average of 2.5%.** The contract was expected to deliver 1.5% productivity gains year-on-year. The Office of National Statistics' method for estimating productivity is, however, not accepted by the Department as sufficiently robust. An agreed method for measuring productivity in primary care should be developed, which has the support of the NHS, the Department, the Treasury and the Office of National Statistics. More specifically, the Department needs to set a clear strategy and timetable for Primary Care Trusts to report to Strategic Health Authorities on how their GP practices have improved productivity.
- 4. Many Primary Care Trusts do not yet have the capability to make the best use of the contract to maximise the benefits for patients.** The contract allows Primary Care Trusts to negotiate with GPs the provision of a range of enhanced services specifically intended to meet local needs. Very few Trusts have so far done this, and over a half have not spent to even the minimum level set by the Department for enhanced services. Primary Care Trusts should use the standards developed as part of the Department's World Class Commissioning programme to benchmark their commissioning performance and identify priority areas requiring improvement.
- 5. The contract has yet to lead to a measurable improvement in services for deprived areas.** The needs-based funding formula is intended to reduce inequality in service provision. The Minimum Practice Income Guarantee has, however, significantly reduced its redistributive impact, and failed to address historic funding issues. The Department should consider replacing the Minimum Practice Income Guarantee with a redesigned global sum allocation in order to move more money into areas of greatest need.
- 6. Access to general practice services has not improved significantly since the new contract, although the Department is taking action to address this lack of improvement.** Having to arrange to visit a GP in normal working hours is a significant cost to the economy in terms of lost output. The Department has included as part of future Directed Enhanced Services the requirement that GPs open for longer hours. For this to be effective, Primary Care Trusts need to commission services that are more clearly linked to local needs, underpinned by a performance management framework

that enables them to monitor how well GP practices meet this and other requirements. They must also tackle poor performance as necessary.

7. **The Quality and Outcomes Framework links GP pay to the quality of patient care they deliver but requires further enhancement.** The Framework concentrates largely on indicators that are easy to measure, and as such there is a tendency for it to reflect GP workload, rather than improvements in population health. The Department should (i) develop the Framework so that it is better aligned to national health priorities; (ii) give more weight to achieving health outcomes, rather than clinical practices which are easy to measure; and (iii) allow Primary Care Trusts some discretion to agree the content of the Framework to reflect local priorities.
8. **GP partners' pay has increased by an average of 58% since March 2003 compared to 15% originally expected.** Higher pay has helped improve recruitment and retention, but not all practice staff have benefited to the same extent as GP partners. Salaried GPs and practice nurses have only had inflationary rises in pay over the same period and some practice nurses do not have appropriate contracts of employment. Primary Care Trusts need to require practices, as part of their GMS contracts, to have appropriate contracts of employment in place for all staff and advise practices on appropriate pay rates. Primary Care Trusts should also, as part of the contract, require GP partners to provide annual feedback on how they have used NHS funding to improve practice productivity.

1 Negotiation and cost of the new contract for general practice services

1. By 2001, there was broad agreement between the Department and the representative body for General Practitioners (GPs), the British Medical Association (BMA), that the existing national contract was not satisfactory. Most GPs were not happy with their working conditions. There were funding inequalities between practices in different parts of England, and services were not flexible enough to meet local needs. At the same time, the Department considered that its strategy for improving primary care, for example, by providing more care close to home, was unlikely to be achieved through the existing contractual arrangements.³

2. The specific aims of the new contract for GPs were set out in a business case that the Department provided to the HM Treasury in 2002.⁴ The Department expected the new contract to have benefits for the patient, the NHS and for doctors. Key objectives were: to increase productivity against a falling trend, extend patient services, improve access to services for patients, improve recruitment and retention, and to deliver better care by paying doctors based on the quality of services they provide.⁵

3. The new national General Medical Services (nGMS) contract was negotiated by the NHS Confederation, on behalf of the Department, with the BMA. The negotiations commenced in August 2001 and doctors voted to accept the negotiated deal nearly two years later in June 2003. The new contract was fully implemented in April 2004, and additional funds were released to finance preparations for the new contract in April 2003.⁶

4. The new contract has changed the way basic services provided by GP practices are funded. Whereas previously they were paid for specific items of service they provided, money is now allocated to each practice on the basis of its population needs.⁷ The introduction of an allocation formula is intended to make funding for GP services more equitable by shifting more money to areas of greatest need and attracting more GPs to work in them. The effectiveness of the allocation funding system was, however, diminished by the Department's late concession to guarantee the existing income of some GP practices.⁸ This was agreed when many doctors realised that their basic funding under the new contract would be lower than in previous years, although this conclusion failed to take into account new payments that were to be made available under the new pay for performance system, the Quality and Outcome Framework. The minimum income practice guarantee was only meant to provide transitional stability to general practice but it has remained part of the funding to general practice.⁹

3 Qq 2, 8, 12, 24, 163; C&AG's Report, paras 1.2–1.3

4 C&AG's Report, paras 1.27, Figure 9

5 Qq 8, 42; C&AG's Report, Figure 9

6 C&AG's Report, paras 1.12–1.14

7 Q 58; C&AG's Report, paras 1.5, 1.19

8 Q 13

9 Q 13

Figure 1: Comparison of the terms of the old GMS contract and new nGMS contract

OLD GMS CONTRACT	NEW GMS CONTRACT
CONTRACT	
1966 to April 2004. Contract between individual GP and Health Authority. Based on National terms and conditions.	April 2004 onwards Funding for preparation released in April 2003 but fully implemented from April 2004. Contract between GP practice and Primary Care Trust. Based on national terms and conditions.
FUNDING FOR ESSENTIAL SERVICES	
Fee per item of service and small capitation fee based on the number of patients registered per GP.	Global sum is paid to each practice for essential services based on an allocation formula (adjusted to protect historic income).
ENHANCED SERVICES	
Limited amount of money could be claimed by the individual GP for providing additional services.	Primary Care Trusts are set a minimum amount of funding which has to be spent on providing new services. GP practices can opt to provide these for additional payment. Some nationally directed services but most negotiated locally based on patients' needs.
QUALITY PAYMENTS	
Small amount of money available for quality schemes.	A large proportion of funding is made available to pay for performance of the GP practice. The Quality and Outcome Framework rewards practices for achieving quality standards. Participation in the Framework is voluntary, but virtually all practices participate
HOURS OF WORK	
GPs responsible for 24 hour care of patients which included seeing patients outside of core hours. In 1992, GPs worked an average of 43.1 hours per week.	Practices can opt out of 24 hour, 7 days per week responsibility for patient care. Core responsibility 8.00 a.m. to 6.30 p.m. Monday – Friday excluding bank holidays. In 2006, GPs worked an average of 36.3 hours per week. Primary Care Trusts responsible for commissioning all other 'Out of Hours' service provision if practices choose to 'opt-out'
PATIENT LISTS	
GPs maintain individual lists. Money follows the individual GP.	Pooled list for practices.

Source: C&AG's Report, Figures 2 and 6

5. Before the new contract was implemented, funding for GP services was not cash limited, but was on a fee per service basis. In 2002–03, £4.9 billion was being spent on GP services. During the negotiation of the contract, the Department agreed to increase spending in this area and, in the "Gross Investment Guarantee", set what it estimated that the contract would cost. This agreement detailed the minimum expenditure on GP services in England for three years. The Gross Investment Guarantee committed the Government to spend £5.6 billion in 2003–04, £6.2 billion in 2004–05 and £6.9 billion in 2005–06 (a 41% increase from 2002–03).¹⁰

6. In April 2002, the Department estimated that the new contract would add £18.7 billion to the cost of primary care in the first three years. The Department had, however, to provide

10 C&AG's Report, para 1.28

£20.5 billion to fund the new contract, £1.8 billion more than the Department had estimated (Figure 2), and £406 million more than funded.¹¹

Figure 2: The difference from the estimate between the cost and funding of the new contract

	2003–04 £million	2004–05 £million	2005–06 £million	TOTAL £million
1. Department's estimate of the additional cost of the new contract (Gross Investment Guarantee)	£5,611	£6,211	£6,918	£18,740
2. Actual funding allocated to Primary Care Trusts	N/A ^a	£6,802	£7,483	N/A
3. Actual spend by Primary Care Trusts	£5,811	£6,957	£7,734	£20,502
Difference between estimated spend and actual spend (1–3)	£200	£746	£816	£1,762
Difference between funding allocation and actual spend (2–3)	N/A	£155	£251	£406
KEY AREAS WHERE PRIMARY CARE TRUSTS SPENT MORE THAN THEY WERE ALLOCATED (£MILLION):^a				
Quality and Outcomes Framework	N/A	£155	£168	£323
Out of Hours	N/A	£104	£78	£182
GMS Contract (essential services)	N/A	£25	£121	£146

^a There were some areas where Primary Care Trusts underspent their allocation, for example on Personal Medical Services contracts (these were piloted in 1998 and which 30% of practices have opted to use rather than GMS)¹²

Source: C&AG's Report, Figures 3, 12, 13 and 14

7. Following the first year of the contract, the Department realised that it had miscalculated the cost of the new contract and increased the amount of money it allocated to Primary Care Trusts.¹³ In the first three years of the contract, despite raising the allocation to Primary Care Trusts by £1,156 million above the Gross Investment Guarantee, Trusts spent an additional £606 million more on GP services. The additional money for the new contract had to be found within the existing Primary Care Trusts' budgets. Whilst the contract might have placed financial pressures on some Primary Care Trusts, many managed their financial affairs adequately.¹⁴

8. The Department believes that the overspend for the new contract was only £406 million more than expected and that the additional costs were not attributable to the new contract but represent the Department's lack of understanding about what GP services were being paid for by Primary Care Trusts.¹⁵ The two areas of greatest overspend were payments for the Quality

11 Qq 2, 56, 127

12 C&AG's Report, paras 1.6–1.9, 2.2; Figures 13, 14

13 Qq 128–134

14 Qq 93–100

15 Qq 2, 29, 56, 93, 96, 127

and Outcome framework and out-of-hours, both of which are directly attributable to the new contract. The Department underestimated the cost of out-of-hours and also underestimated the level of achievement on the Quality and Outcome Framework.¹⁶ It considers that the costs of the contract are now under control and reports that, by the end of 2008, the overspend will have been recovered through Primary Care Trusts spending less than their allocated funding.

9. In the first three years of the contract, GP partners have benefited from an average of 58% increase in pay, compared to the Department's expectation that it would increase by 15%.¹⁷ The average pay of GP partners increased from £73,000 in 2002–03 to £114,000 in 2005–06.¹⁸ Not all GPs have benefited to the same extent from the new contract. The average rise in salary for salaried GPs over the same period of time was closer to 3%.¹⁹ Whilst pay has increased, the average number of hours worked by a GP has decreased by seven hours per week.²⁰ The BMA reports that morale of GPs has also decreased because of critical media coverage and because of the belief that their core values were undermined by the emphasis on cost cutting and quantity rather than quality of care.²¹

10. The pay of GP partners is based on the practice income once all the relevant expenses, such as practice nurse salaries, have been paid. In negotiating the new contract, the Department placed no cap on the proportion of income GPs could take as profit.²² The Department believe that it was not appropriate to cap profit as GP practices are small independent businesses and that the amount that GPs take as profit is for practice partners to determine.²³

16 Qq 22, 48, 79, 147, 148

17 Qq 3–4, 6, 58, 101

18 C&AG's Report, paras 2.16–2.19, 3.7; Figure 17

19 Qq 3, 62–63, 109, 115, 117

20 Q 7

21 Q 47; C&AG's Report, paras 3.30–3.31

22 Qq 59–61, 123–124

23 Qq 59, 47

2 The benefits of the new contract

11. In its business case to HM Treasury, the Department set out its expectations of the new contract's benefits for patients, the NHS and for GPs. The overall aim of the contract is to attract more doctors to general practice, particularly in more deprived areas. GPs would have greater job satisfaction and a reduced administrative burden; patients would have more choice and better access to a wider range of services; and the NHS would see an improvement in skill mix in GP practices and reduced pressure on secondary care through the development of GP specialist services. In securing the increased funding for primary care, the Department expected that the NHS would see measurable improvements in productivity.²⁴

12. The Department's planning assumption was that productivity in delivering primary care would increase annually by 1.5%. The Office of National Statistics (ONS) productivity measure, used at the time, showed that overall NHS productivity had been falling by 0.5% year on year from 1997 to the end of 2004. In 2006, the ONS introduced a revised output measure which adjusted NHS outputs, such as the number of consultations, to take into account the quality of care provided. The quality adjustment takes into account, amongst other factors, health gain and patient satisfaction.²⁵ The quality adjustment was developed in consultation with the Department.

13. ONS found that in the first two years of the contract, productivity of family health services, which directly relates to primary care, reduced on average by 2.5% per year. Whilst outputs have increased, the large amount of additional funding put into general practice means that the overall level of productivity has decreased (**Figure 3**). Thus, the quality of service and the total number of people seen by a health professional in general practice has increased, but the cost of the new services has increased at a greater rate.²⁶

14. Although the Department worked with the ONS to develop a quality adjusted methodology of estimating health service productivity, it does not believe that it is meaningful for general practitioner services, or takes into account the complexities of delivering primary care. The Department also believes that the measure does not take account of other benefits that were achieved through the contract such as improving treatment and health outcomes for people with long term conditions.²⁷ The Department and HM Treasury are continuing to work with the ONS on improving the quality adjusted measure of productivity.²⁸

24 C&AG's Report, paras 1.2, 1.27; Figure 9

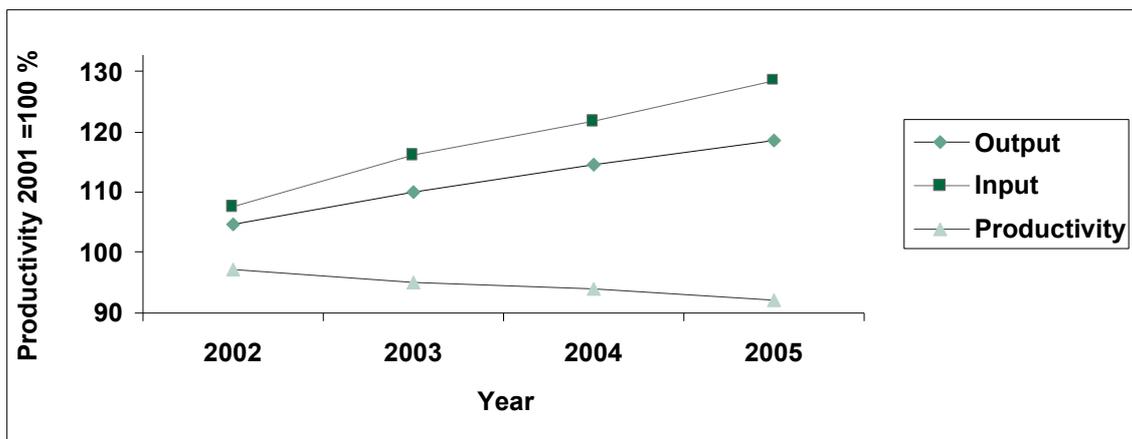
25 C&AG's Report, paras 3.2–3.4

26 Q 5; C&AG's Report, para 3.5; Figure 20

27 Q 6

28 Office for National Statistics, *Public Service Productivity: Health Care*, January 2008

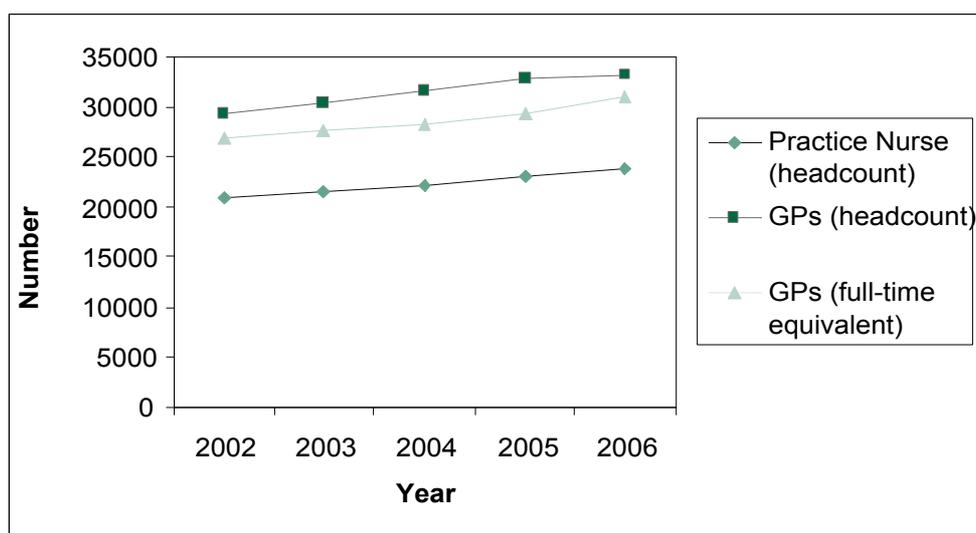
Figure 3: Productivity change for family health services from 2002–2005 including an adjustment for the quality of outputs



Source: C&AG's Report, Figure 20, and Office of National Statistics Public Service Productivity: Health Care, January 2008

15. The new contract has contributed to the increase in the number of doctors working in general practice.²⁹ From 2003 to 2006, the number of full-time equivalent GPs working in England has increased from 30,358 to 33,091, exceeding the Department's expectations of increased numbers of doctors (Figure 4). The Department considers that the contract played a large part in achieving this increase, but it is likely that other initiatives, such as overseas recruitment, will have contributed to the rise in the number of GPs. GPs are mainly being recruited as salaried GPs as the opportunities for being a partner in a GP practices have reduced.³⁰ Whilst the total number of doctors has increased, there are still too few per head of population in the most deprived areas.³¹

Figure 4: Rise in the number of GPs and practice nurses



Source: C&AG's Report, Figure 22 and 23, and data on nurses from Department's Workforce census 2007

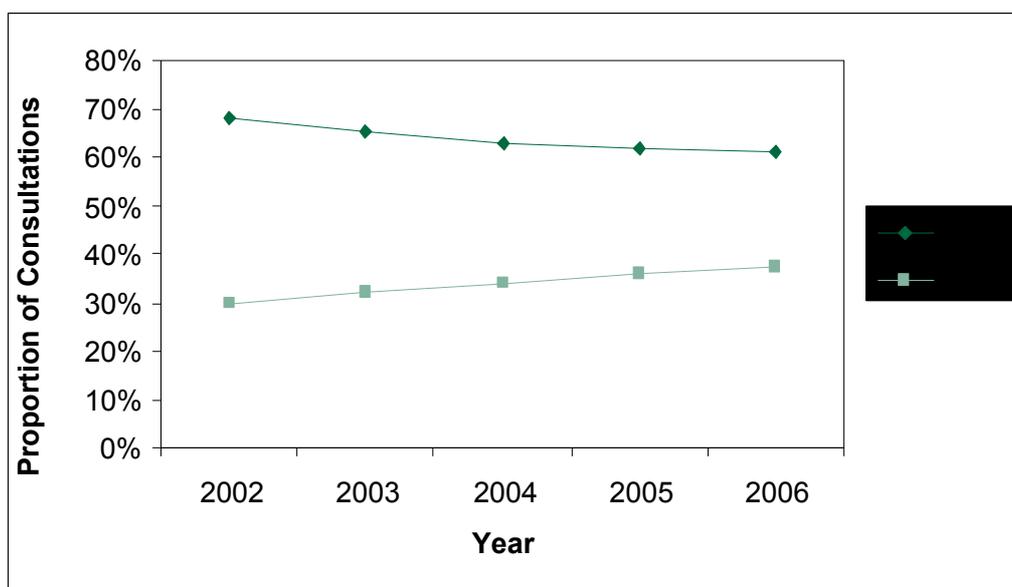
29 Q 9

30 Qq 64, 82

31 Q 14

16. Since the new contract has been introduced, nurses are carrying out an increased proportion of consultations (**Figure 5**). They carry out routine consultations, such as asthma and diabetes reviews, and this development has helped GPs to release time to deal with more complex cases.³² This is evidenced by the increase in the average length of a GP consultation, which has risen from 8.4 minutes in 1992 to 11.7 minutes in 2006.³³

Figure 5: Change in the proportion of consultations undertaken by GPs and nurses



Source: C&AG's Report, Figure 23

17. The implementation of the pay-for-performance system, the Quality and Outcomes Framework, is internationally recognised as innovative, directly linking doctors' pay to the quality of service that they have provided.³⁴ The system pays GPs based on the points earned for meeting various quality criteria for treating specific conditions, for example, managing the blood pressure of patients with hypertension. The Framework has had an impact in improving the consistency of care, particularly for managing long term conditions such as hypertension, diabetes and asthma and has contributed toward saving lives.³⁵

18. In the first three years of the contract, GP practices have universally achieved high scores in the Quality and Outcomes Framework. The average GP practice earned 91% of the points available in the first year, increasing to 95.5% in 2006–07 suggesting that the bar was set too low and was too easy for doctors to meet.³⁶ Indeed, the level of performance was much higher than the estimate that the Department had used to determine the level of funding the new contract would need.³⁷ The British Medical Association claims that it

32 Qq 26, 62, 65–67

33 Q 27

34 Q 8

35 Q 22; C&AG's Report, paras 3.14–3.17

36 Qq 19, 20

37 Qq 19, 75

predicted that the performance of GPs under the Framework would be higher than the Department had estimated, and there is evidence that the Department reduced its estimation of performance under the Framework when budgeting for the increased cost due to the minimum income practice income guarantee (see paragraph 4 above). The Department considers that the reliability of the costing assumptions underpinning the new contract would have been better if it had had more reliable and complete information on GPs' workload and other activity.³⁸

19. The Department negotiates the Quality and Outcome Framework annually and considers that it has now made the Framework more stringent, following criticism that too many points were awarded for activity that GPs were already carrying out before the Framework was introduced.³⁹ The annual negotiation is based on a combination of submissions from lay people and interest groups and Departmental priorities, which are then assessed by an independent academic panel. The academic panel assesses the cost effectiveness and the evidence base for each proposed indicator. There is, however, no overall strategy for the Framework. Also, the Quality and Outcomes Framework is developed on a national basis and, therefore, does not prioritise or reflect local health inequalities and local needs.⁴⁰

20. To claim money under the Framework, GPs need to reach targets for providing a service to a specific proportion of its population. GPs are able to exclude some of their patients when recording their performance where there is a valid reason, for example, a patient refuses to attend an appointment. Primary Care Trusts are responsible for monitoring the level of exception reporting, but could not assure that the procedures were robust. The Department considers that exception reporting is necessary to avoid a situation where doctors might coerce patients into treatment, but that Primary Care Trusts should be tracking performance to identify and address outliers.⁴¹

38 Qq 75, 147–148; C&AG's Report, para 2.12

39 Qq 75–76

40 Q 46

41 Qq 44–45; C&AG's Report, para 4.8

3 Getting more out of the new contract

21. The new contract has not yet delivered all the benefits that the Department expected it to achieve.⁴² In particular, the contract has been less successful in redirecting funds to areas with the greatest need and has had mixed success in incentivising improved access to general practice services. Whilst recruitment of GPs in deprived areas has improved, it is still worse when compared to more affluent areas.⁴³ The average expenditure on general practice care in relation to need is lower in some of the most deprived areas of the country (**Figure 6**). For many patients, the contract actually led to a decrease in GP provision through the removal of the GP's responsibility for out-of-hours care, loss of Saturday surgeries and reducing the times that a patient can make an appointment.⁴⁴

22. The new contract successfully increased the types of services that are available in general practice, but has not yet led to the development of as many new services as the Department had expected. Many of the new services reflect national directions, rather than services responding to specific local needs. In 2006–07, 71% of Primary Care Trusts did not spend their allocation for locally enhanced services. These allocations were expected to be the minimum level that a Trust would spend on enhanced services.⁴⁵

23. One of the key objectives of the new contract was to increase access to GP services but efforts to improve access have been mixed. The contract allows Primary Care Trusts to increase provision of GP care by negotiating locally with GPs to extend hours using local enhanced services payments, or to commission new general practice services through competitive tendering. These options have not been used effectively by Primary Care Trusts in commissioning services to address local need.⁴⁶

24. As part of the new contract, the Department negotiated a national enhanced service to incentivise GPs to offer appointments to patients within 48 hours. Currently, 90% of patients are seen within this target. However, this has also had a perverse effect for patients, as GPs reduced the amount of appointments that were available to be booked in advance. The Department has now allocated some of the points available under the Quality and Outcome Framework to measure patient satisfaction against this access target. In addition, the inconvenience of not being able to see a doctor in the evening or at weekends has been highlighted as an issue in patient surveys.⁴⁷ The Department has responded to patients' concerns about being unable to see a doctor in the evening and at weekends by issuing a national directive to extend opening hours using directed enhanced services.⁴⁸

42 C&AG's Report, Figure 4

43 C&AG's Report, paras 2.15, 4.10–4.11, 4.16

44 C&AG's Report, paras 4.16, 4.18

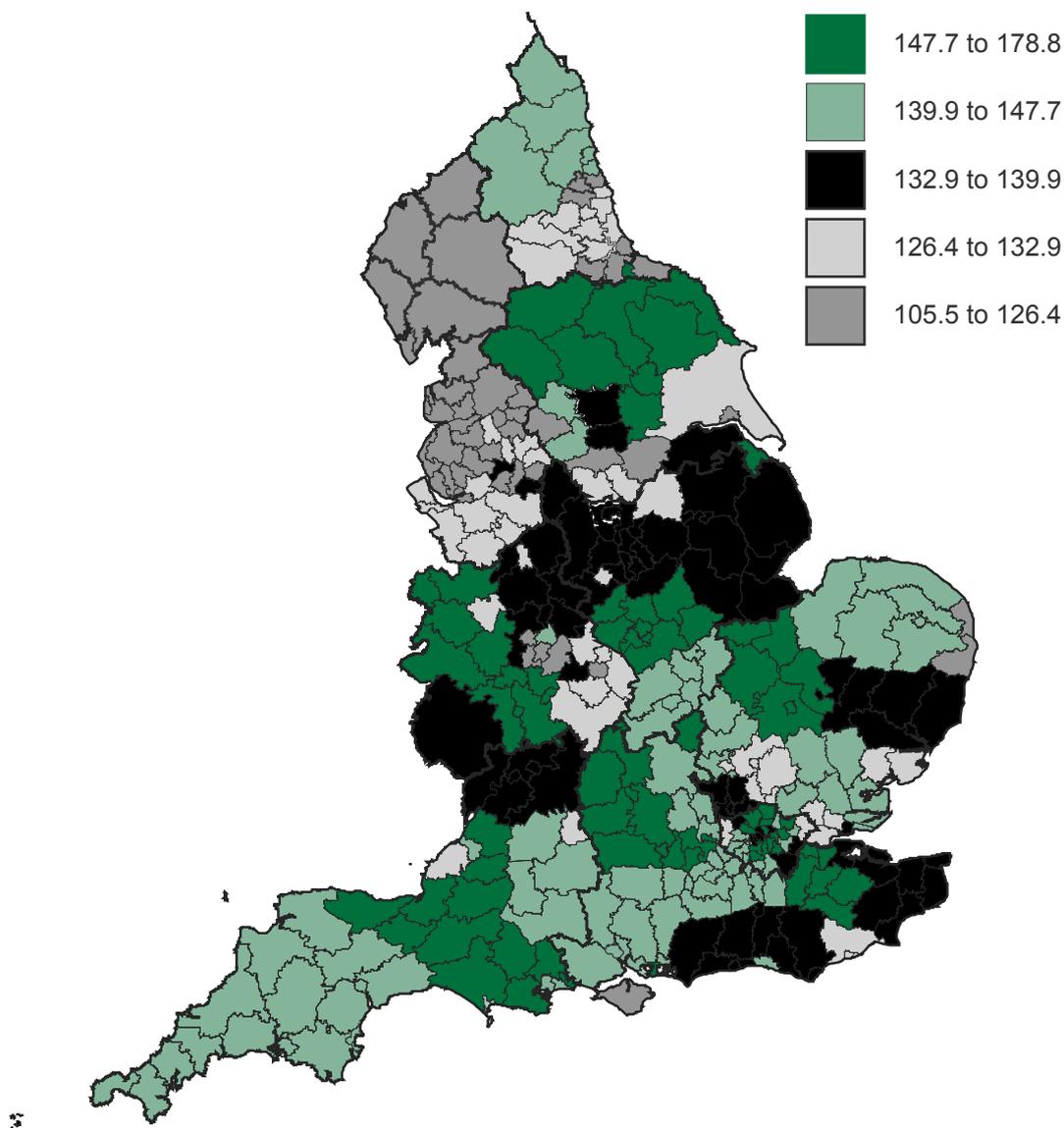
45 C&AG's Report, para 4.24

46 C&AG's Report, paras 4.10–4.15

47 Q 18

48 Qq 18, 51, 71, 81, 155

Figure 6: Average GP expenditure per head of population adjusted for need



Source: C&AG's Report, Para 2.14 and Department of Health PFR1 Data Returns 2006–07

25. Under the new contract, access to a GP outside of normal hours is the responsibility of each Primary Care Trust, which is expected to commission sufficient out-of-hours services. A previous report by this Committee⁴⁹ highlighted that the Department underestimated the cost of out-of-hours care and that the quality of out-of-hours care is not consistent.⁵⁰ The Department now believes that the NHS has improved its monitoring and quality assurance of out-of-hours care. The Department does not believe that there is a relationship between a rise in emergency admissions and access to out-of-hours care, although the C&AG's Report showed that the number of emergency admissions has increased since the new contract was implemented.⁵¹

49 Committee of Public Accounts, Sixteenth Report of Session 2006-07: *The Provision of Out-of-Hours Care in England*, HC 360

50 Qq 30–35, 48

51 Qq 36–37, 80–81

26. Another factor that affects access is the location of general practices. More deprived areas tend to have the least number of doctors working in them per capita.⁵² Since the new contract has been introduced, there has been an increase in the number of doctors working in more deprived areas but still not enough to meet the under provision, nor to reduce the imbalance compared to affluent areas.⁵³ Primary Care Trusts had mechanisms within the new contract arrangements, such as the Alternative Provider Medical Services (APMS) contracts, to attract new general practices into under-doctored areas but had failed to use them to the extent that the Department expected.⁵⁴

27. In 2008, concerned at the lack of progress, the Department announced the provision of an additional £250 million which it expects most Primary Care Trusts to use to commission a new practice in their most deprived area. At least 100 new practices will be obtained through competitive tendering using APMS contracts, but this process will not exclude current GP practices from making bids to operate the service.⁵⁵

28. Indeed, the Department is investing some £1 billion over five years (including the £250 million in paragraph 27) to develop more accessible and responsive services. In London, following Lord Darzi's London review,⁵⁶ this involves the development of polyclinics that bring primary care and secondary care closer together. For the rest of the country, Primary Care Trusts are expected to commission new services using the best model of care that meets their local needs. As a minimum, the Department expects each Primary Care Trust to invest in a GP led health centre that will be open from 8am to 8pm. Polyclinics and health centres will introduce a range of services into primary care which are currently delivered in hospitals. This is an attempt to increase the access and breadth of services provided in primary care.⁵⁷

29. The lack of progress in increasing access to, and the provision of, new services in the areas of most need is largely explained by Primary Care Trusts not being sufficiently proficient in commissioning, as well as a lack of reliable information on which to base commissioning decisions. In addition, they lack sufficient people with the requisite skills to commission new services effectively. The reorganisation of Primary Care Trusts may help address this by enabling more experienced staff to be redeployed to areas of greater need. There is a risk, however, that such staff will initially have less detailed knowledge of local needs.⁵⁸ The Department is taking steps to tackle this through its World Class Commissioning initiative.

52 Q 14

53 Q 24

54 Qq 50–51, 74

55 Qq 17, 24, 74; Ev 22

56 Department of Health, *Healthcare for London: A Framework for Action*, July 2007

57 Qq 151–159; Ev 22

58 Qq 85, 86

Formal Minutes

Monday 23 June 2008

Members present:

Mr Edward Leigh, in the Chair.

Mr Richard Bacon

Mr Austin Mitchell

Mr Paul Burstow

Geraldine Smith

Mr Ian Davidson

Mr Don Touhig

Mr Philip. Dunne

Draft Report (*NHS Pay Modernisation: New contracts for General Practice services in England*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 29 read and agreed to.

Resolved, That the Report be the Forty-first Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 25 June at 3.30 pm.]

Witnesses

Wednesday 26 March 2008

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Mr David Nicholson, Chief Executive, **Professor David Colin-Thomé**,
National Director for Primary Care and Medical Adviser and
Mr Mark Britnell, Director General of Commissioning and System
Management, National Health Service

Ev 1

List of written evidence

- 1 British Medical Association
- 2 Department of Health

Ev 17

Ev 22

List of Reports from the Committee of Public Accounts 2007–08

First Report	Department for International Development: Tackling rural poverty in developing countries	HC 172 (Cm 7323)
Second Report	Department of Health: Prescribing costs in primary care	HC 173 (Cm 7323)
Third Report	Building for the future: Sustainable construction and refurbishment on the government estate	HC 174 (Cm 7323)
Fourth Report	Environment Agency: Building and maintaining river and coastal flood defences in England	HC 175 (Cm 7323)
Fifth Report	Evasion of Vehicle Excise Duty	HC 227
Sixth Report	Department of Health: Improving Services and Support for People with Dementia	HC 228 (Cm 7323)
Seventh Report	Excess Votes 2006–07	HC 299
Eighth Report	Tax Credits and PAYE	HC 300 (Cm 7365)
Ninth Report	Helping people from workless households into work	HC 301 (Cm 7364)
Tenth Report	Staying the course: the retention of students on higher education courses	HC 322 (Cm 7364)
Eleventh Report	The compensation scheme for former Icelandic water trawlermen	HC 71 (Cm 7364)
Twelfth Report	Coal Health Compensation Schemes	HC 305 (Cm 7364)
Thirteenth Report	Sustainable employment: supporting people to stay in work and advance	HC 131 (Cm 7364)
Fourteenth Report	The budget for the London 2012 Olympic and Paralympic Games	HC 85 (Cm 7365)
Fifteenth Report	The Pensions Regulator: Progress in establishing its new regulatory arrangements	HC 122 (Cm 7365)
Sixteenth Report	Government on the Internet: Progress in delivering information and services online	HC 143 (Cm 7366)
Seventeenth Report	Foreign and Commonwealth Office: Managing Risk in the Overseas Territories	HC 176 (Cm 7366)
Eighteenth Report	Improving corporate functions using shared services	HC 190 (Cm 7366)
Nineteenth Report	BBC Procurement	HC 221 (Cm 7366)
Twentieth Report	HM Revenue & Customs: Helping individuals understand and complete their tax forms	HC 47 (Cm 7366)
Twenty-first Report	The Carbon Trust: Accelerating the move to a low carbon economy	HC 157 (Cm 7366)
Twenty-second Report	Improving the efficiency of central government's use of office property	HC 229 (Cm 7366)
Twenty-third Report	Report on the NHS Summarised Accounts, 2006–07: Achieving financial balance	HC 267
Twenty-fourth Report	The privatisation of QinetiQ	HC 151
Twenty-fifth Report	The cancellation of Bicester Accommodation Centre	HC 316
Twenty-sixth Report	Caring for Vulnerable Babies: The reorganisation of neonatal services in England	HC 390
Twenty-seventh Report	DFID: Providing budget support to developing countries	HC 395
Twenty-eighth Report	Government preparations for digital switchover	HC 416
Twenty-ninth Report	A progress update in resolving the difficulties in administering the single payment scheme in England	HC 285
Thirtieth Report	Management of large business Corporation Tax	HC 302
Thirty-first Report	Progress in Tackling Benefit Fraud	HC 323
Thirty-second Report	Reducing the cost of complying with regulations: The delivery of the Administrative Burdens Reduction Programme, 2007	HC 363
Thirty-third Report	Ministry of Defence: Major Projects Report 2007	HC 433
Thirty-fourth Report	Increasing employment rates for ethnic minorities	HC 472
Thirty-fifth Report	Housing Market Renewal: Pathfinders	HC 106
Thirty-sixth Report	HM Treasury: Making Changes in Operational PFI Projects	HC 332
Thirty-seventh Report	Leaving the Services	HC 351
Thirty-eighth Report	Nuclear Decommissioning Authority—Taking forward decommissioning	HC 370

Thirty-ninth Report	Preparing to deliver the 14–19 education reforms in England	HC 413
Fortieth Report	DEFRA: Management of Expenditure	HC 447
Forty-first Report	NHS Pay Modernisations: New contracts for General Practice services in England	HC 463
First Special Report	The BBC's management of risk	HC 518 (Cm 7366)
Second Special Report	Evasion of Vehicle Excise Duty	HC 557 (Cm 7366)

Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 26 March 2008

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Angela Browning
Mr Paul Burstow
Mr Ian Davidson
Mr Philip Dunne

Mr Austin Mitchell
Dr John Pugh
Geraldine Smith
Phil Wilson

Mr Tim Burr, Comptroller and Auditor General, and **Ms Karen Taylor**, Director, Health Value for Money, National Audit Office, were in attendance and gave oral evidence.

Ms Paula Diggle, Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

NHS PAY MODERNISATION: NEW CONTRACTS FOR GENERAL PRACTICE SERVICES IN ENGLAND (HC 307)

Witnesses: **Mr David Nicholson**, Chief Executive, **Professor David Colin-Thomé**, National Director for Primary Care and Medical Adviser and **Mr Mark Britnell**, Director General of Commissioning and System Management, National Health Service, gave evidence.

Q1 Chairman: Good afternoon, welcome to the Committee of Public Accounts. I apologise for the earlier time; it is so we do not clash with the visit of President Sarkozy to the House of Commons and the House of Lords. We have a very important and interesting session this afternoon. We are considering the Comptroller and Auditor General's Report *NHS Pay Modernisation: New Contracts for General Practice Services in England*. We welcome back Mr David Nicholson, who is the Chief Executive and Accounting Officer of the National Health Service. You are very welcome. Perhaps you would introduce your colleagues for us.

Mr Nicholson: Mark Britnell, who is the Director General of Commissioning and Professor David Colin-Thomé who is the National Director for Primary Care.

Q2 Chairman: We always try to get a balanced point of view so I have to congratulate you on at least making an attempt to get a better quality outcome for patients from seeing their GP. However, there are various aspects of this which worry a value-for-money committee. We can see this laid out for the benefit of members of the Committee in figure 4 on page 10. This is the "National Audit Office's assessment of the progress made against the benefits the Department of Health listed in its business case". What we see there and in fact what shouts out to us throughout the Report is that you spent £1.8 billion more than expected but people still cannot see a GP when they need to. Why is this?

Mr Nicholson: I would say two things about that. First of all on the £1.8 billion, of course the National Audit Office reflects this, but £1.4 billion of that was

not actually extra money paid by the taxpayer for the contract it was based on a miscalculation, an estimate of the amount of money we already paid. If you take that against both ends of the argument, £1.4 billion was not extra money paid to general practice over what we had expected. The issue was just over £400 million.

Q3 Chairman: Remind us of the percentage increase—not for salaried GPs as I know their salaries only increased by 3%—for GPs. It is about 56% is it not?

Mr Nicholson: Absolutely.

Q4 Chairman: Quite a high increase.

Mr Nicholson: It is.

Q5 Chairman: Remind us what the productivity increase has been? There has actually been a decrease of 2.5% has there not?

Mr Nicholson: One of the issues around productivity, as you will know from previous Committee of Public Accounts hearings—

Q6 Chairman: But that is right, is it not? A 56% increase in their salaries and a 2.5% decrease in their productivity. That is right, is it not?

Mr Nicholson: The Office of National Statistics have calculated 2.5% but that does not take account of the complexities of delivering primary care and all the other significant benefits that we got through the contract. It is essentially a measure of the number of people divided by the amount of activity, the number of patients seen. In modern primary care it is much more complicated than just how many

patients GPs see and much better for patients. Patients now see a whole variety of professionals in primary care, nurses, podiatrists, dieticians, a whole range of people as part of this service.

Q7 Chairman: You set the bar so low in terms of meeting the quality and outcomes framework, the QOF, that the GPs get 96% of the available points. Doctors are doing seven hours less work a week on average, there is no real Saturday or evening service, it is still difficult to book an appointment in advance. The trouble is that you rushed this, did you not? The PCTs did not have the resources available and the BMA took you for a ride. That is the honest truth, is it not?

Mr Nicholson: I do not think any of those things are—

Q8 Chairman: What I said is not right, is it? What I said about the extra cost, the decline in productivity, their meeting 96% of the quality outcomes, the fact they are doing seven fewer hours a week on average, none of that is right, is it?

Mr Nicholson: No, the judgment you made at the end about it being rushed is not correct. We set out to change completely the nature and the way general practice is remunerated in this country, something which had been continuing since 1948, getting a GP contract which was ready for the NHS we were trying to build for the future. The QOF was a really important part of that. For the first time we could connect the GPs' pay to performance and in particular clinical performance; a fantastic opportunity for us to take services forward. No doubt during this hearing we will talk about some of those benefits. We completely changed the way in which general practice is funded, much more focused on the health needs of the population, and we managed to allow GPs to expand considerably the services that they did. This was against a background of general practice which was demoralised, we had large numbers of vacancies, we were having real difficulty recruiting people into general practice and, as no doubt many of you remember, general practices at the time were threatening to resign en masse from the National Health Service.

Q9 Chairman: Can you please look at Figure 22 on page 30 "The number of GPs working in the NHS in England"? I hear plenty of threats of resignation: I do not see that actually manifesting itself according to that figure. I see the number of GPs rising continuously according to this Report which you have agreed.

Mr Nicholson: Absolutely; that is the case.

Q10 Chairman: So you were led astray by a very powerful lobby and threats.

Mr Nicholson: No; no.

Q11 Chairman: Give your answer then.

Mr Nicholson: I am sorry, none of those things was the case.

Q12 Chairman: Look at the figure.

Mr Nicholson: It was success; that was part of what we were trying to do. The whole point of the new contract was to get us to a place where we could recruit more general practitioners, where we could keep more general practitioners in primary care and expand the nature and range of services that we provided. It seems to me that is a success measure of the contract.

Q13 Chairman: There is no point repeating these points; other members can come in if they wish to. Will you please look in rather more detail at paragraph 4.13? When are you going to reverse this very late decision to guarantee the historic income of GPs, which has prevented redistribution of income to deprived areas?

Mr Nicholson: It was a really important decision when it was taken. As no doubt members will remember, when the GP contract was originally formulated and GPs looked at what the implication of going to a needs-based funding formula would be, it became very clear that a large number of practices would be destabilised by moving in one step to a needs-based formula. So MPIG, the minimum practice income guarantee, was implemented in order to stabilise general practice at a time when we were going through a massive change in terms of the nature of services that we provided. We are now past that stage and there are two issues which are really important to us for the future. One is how we can get from a position where the funding of primary care gets much better to a place which reflects the health needs of the population. Second is how we can make it much easier for patients to move between general practices as a matter of choice and how we can build incentives for practices to make sure they keep their patients. In order to do that you clearly have to tackle the issue of the minimum practice income guarantee, but you need to do it in a way that on the one hand you do not completely destabilise existing general practice, but on the other hand you have the opportunity to move relatively quickly to that position. We are now entering negotiations because the position I have just described is also the position of the British Medical Association and we will be working with them over the next few months to see how we can take this particular issue forward.

Q14 Chairman: Fair enough, but paragraph 4.10 tells us that deprived areas are still under-doctored, are they not? "Several studies have shown that the more deprived PCTs have fewer GPs per capita, on average, than the least deprived." This is a National Health Service publicly-owned body.

Mr Nicholson: That is true.

Q15 Chairman: So why has this contract failed to deliver an improvement?

Mr Nicholson: It has given us the opportunity to take this forward and that is precisely what we are trying to do.

Q16 Chairman: To take it forward.

Mr Nicholson: Absolutely.

Q17 Chairman: What have you achieved?

Mr Nicholson: By the end of this year we will be in a position where we will put into place 100 new practices across the country in those deprived areas. The number of doctors is not the only issue. It is the number of nurses, the number of physiotherapists, the number of dieticians; the whole primary care team needs to be developed in these areas. What the contract enables us to do—and this is what we are doing this year—is to attack this particular issue.

Q18 Chairman: So doctors are working fewer hours and the NHS has to pay extra to provide out-of-hours care. Are we, the taxpayer, paying twice?

Mr Nicholson: No. One of the aims of the contract, and we made it very clear at the beginning of the contract, was to better and more fairly remunerate GPs. One of the issues which particularly affected GP morale and which GPs were very concerned about was the whole issue of out-of-hours care. As part of that most of the reduction in GPs' hours has come from a reduction in their working out of hours and we put in place a new out-of-hours scheme which we have described to the Committee before. This was funded by taking money from and resource from existing general practice, but also adding to it top-ups from the Department of Health. We found that the issue for us was that whilst we have gone very quickly to providing a service which is quick for patients, so now nine out of ten patients can be seen within 48 hours, we have lost something in relation to convenience and that is why we are tackling this particular issue around out of hours, evenings and weekends and that is why we are implementing the proposals that we negotiated with the GPC.

Q19 Chairman: Others can come back on the lack of an evening service if they wish to. Let us now look at the quality and outcomes framework in more detail, particularly paragraph 4.2. Achievement of this framework is obviously far too easy—96% of doctors achieved the available points. Why is this? Why did you not have a more demanding assessment? There are various case studies at the back of the Report. Some PCTs, which were perhaps better resourced, better managed, more skilful, do seem to have achieved some improved outcomes but the picture is very mixed. Generally it appears to be too easy; doctors met these outcomes too easily.

Mr Nicholson: I shall ask David to talk a little about some of the outcomes in relation to what you have described. This was a groundbreaking set of proposals which we put in place as part of the contract.

Q20 Chairman: I have already given you credit for trying.

Mr Nicholson: Thank you. Nowhere else in the world have they got something quite like this and this is a really important part of the contractual arrangements for us. It is absolutely true that we judged that general practice might get in the region

of 750 points and, to be frank, in the negotiations and discussions we had various views were expressed from 500 points right the way through to 1,000. The critical thing for us, to be honest, was how we could move the middle group of GPs' average performance forward; there were always general practices at the top end of performance. I think QOF has proved a very powerful way of moving that average performance up.

Q21 Chairman: If you look at paragraph 4.4 you will see that you are basing QOF on things which are easily measured rather than making patients healthier, for instance it throws doubt on the number of heart disease patients who have received treatment.

Professor Colin-Thomé: I disagree that it was easy. Most of us thought that we would get about 750 points and even a practice like mine, which had a track record of doing a lot of chronic disease work, estimated we would get 90% rather than the nearly 99% we got. That took a lot of hard work. The thing that QOF does is raise the average up and it meant that general practice had to get itself prepared by having systems in place to identify patients who were not diagnosed and patients to follow up. That took a lot of work; it was not about being cleverer. On the issues about the processes, some of those processes are absolutely crucial. One of the processes mentioned is about measuring blood pressure. About 30% of us have raised blood pressure. If you can reduce the level of people with existing high blood pressure, you would save a significant amount of ill health.

Q22 Chairman: I am in danger of getting high blood pressure.

Professor Colin-Thomé: The issue is that that will lead to an outcome by measuring the ones who are not diagnosed as having high blood pressure. On outcomes there is also good evidence that on things like heart disease we have shaped outcomes. There is a guestimate that we could save something like 400 lives per 100,000 patients. That is what we can do with QOF and it has already demonstrated it.

Chairman: That is what we are all about: saving lives.

Q23 Phil Wilson: How much is the improved recruitment and retention of GPs down to the contract when you consider that the number of overseas doctors has increased and the number of doctors that are in training has increased as well. How much of that increase do you reckon is actually due to the new contract?

Mr Nicholson: We think the bulk of the improvement in retention and recruitment of GPs is down to the contract. It was absolutely the case that lots of GPs were planning early retirement as part of their contractual arrangements. We were getting a position where, certainly in the year or so coming up to the introduction of the contract, it was commonplace to have one or no applicants for GP appointments. The contract transformed both of those things. We found that more GPs were

prepared to stay on longer on the one hand and it was becoming a much more attractive career option for doctors coming out of training to the extent that there are now lots of applicants for most GP appointments when they come up. As part of the contract we had a significant expansion of the number of salaried GPs as well and you can see that developing something between 3,000 and 4,000 extra during that period.

Q24 Phil Wilson: On deprived areas again, towards the end paragraph 3.10 talks about difficulty in attracting GPs to more deprived areas; even though other PCTs are complaining about the increase in the number of GPs in general it is these specific areas, where you probably will have the most issues around public health, et cetera, that need the GPs. Is this a problem which has persisted over the years? How do we get round the problem?

Professor Colin-Thomé: It has persisted since the inception of the Health Service; more socially deprived areas have been relatively under-doctored for lots of reasons, some of them more difficult to recruit general practice and the patients had more problems and therefore needed extra staffing so it was lack of resources. We have increased the number of GPs in those deprived areas from the contract. What we have not done is tackle the difference. That is why our new policy is to get extra practices specifically into socially deprived areas. We have tried loads of things over the last sixty years to try to redress this without any success, whereas the focus we have with these 113 new practices we are going to get will make a difference and bring a lot more doctors and nurses into those areas. It is a very focused bit of work and maybe we should have done that 20 or 30 years ago, but we did not.

Q25 Phil Wilson: So you are saying that the contracts are helping to solve the problem.

Professor Colin-Thomé: It has increased the numbers but it has not closed the gap yet.

Q26 Phil Wilson: Figure 23 on page 20 shows an increased proportion of consultations being carried out by practice nurses whilst the number of consultations taken by doctors is actually decreasing. What monitoring is there of this development to ensure that patients receive appropriate levels of care and nurses are rewarded accordingly.

Professor Colin-Thomé: Two things on that. One is that most of those extra appointments done by practice nurses are reviews of people with chronic disease which the contract has generated because that is part of the quality contract of QOF, the quality and outcomes framework. There is in fact international evidence that nurses are sometimes better at doing regular reviews than doctors. That is practice based, the practices have to make sure that quality is there and they will suffer any consequence of litigation, whatever. Practice nurses have to be trained and part of the QOF was to make certain the quality of the team was better. One of the attractions of QOF was that you have to have proper induction

and training programmes; that was one of the indicators in the organisational framework. A lot of that work by nurses is the review work for people with existing diseases.

Q27 Phil Wilson: The new contract seems to increase the time GPs spend with individuals who are high risk patients, for example. Is this something you would expect to see extended?

Professor Colin-Thomé: Yes and that is partly because of the consequence of taking some of those reviews away from doctors, who were doing those as well in the old days, so they could concentrate on the people with more complex problems. About a quarter of a million patients really have lots of illnesses in the one person, as it were, and are getting older and they are the ones we want to focus our attention on quite a lot because they may not have had the maximal care they could have in the past.

Q28 Phil Wilson: The new contract has enabled GPs to offer a greater breadth of services and increased the consistency of care of long-term conditions. Have you seen a reduction in the number of emergency admissions because of this?

Professor Colin-Thomé: No. Emergency admissions have gone up and went up before the new contract but the amount of time people stay in hospital has gone down significantly. Even if people are being admitted, they are ready to be discharged back to general practice much faster and part of that is because we have better systems in place to review patients in primary care now. If you look at the emergency admissions, what they do not tackle in the report is the emergency bed days, the length of time people stay, which have come down quite considerably. That is almost all a consequence of care of long-term conditions.

Q29 Dr Pugh: Figure 12 is "Expenditure against the Gross Investment Guarantee" and what it seems to show is an overshoot of £200 million in 2003-04, an overshoot in 2004-05 of £746 million and an overshoot in 2005-06 of £816 million and the trend is up, in other words the gap between what you are expecting to spend and what you do actually spend. Is there any reason to believe it will not continue to go up?

Mr Nicholson: Yes, there is. Those total figures were based on an estimate which proved to be incorrect and the real cumulative figure there is more like £400 million in real terms. What we have found in the two years since then is that that has been recovered by primary care trusts. You will see that over the two years to come after this we would expect a cumulative underspend of £400 million over those two years. We expected both to change and reverse.

Q30 Dr Pugh: Okay, but there might be a certain amount of shifting of costs. I note that you spent a lot more on out of hours; £78 million more than you expected to spend. I think it would be fair to say that not all the out-of-hours organisations set up performed adequately. One of the reasons for that

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might be that not enough money was transferred out of the doctors' contract for out-of-hours provision. Is that a reasonable assumption?

Mr Nicholson: We transferred £6,000 per GP out and we added to that.

Q31 Dr Pugh: Which probably did not approximate to the cost of the out-of-hours service.

Mr Nicholson: No; we knew that because the Department had always topped up the cost of out-of-hours nationally anyway.

Professor Colin-Thomé: In the past GPs did not get a fee for out of hours, it was at a marginal cost to their normal earnings. If we were going to have a separate service it had to be funded fully and that was an extra cost.

Q32 Dr Pugh: We needed to find another £78 million. The service provided then failed to satisfy the public right across the piece and my presumption is that many PCTs have put a lot more money into the out-of-hours contract since then. Am I correct?

Mr Nicholson: They put the amount of money that is described in the National Audit Office Report. It is absolutely true that we have implemented a whole series of schemes in relation to out of hours to improve our monitoring and the quality of it and the auditing of it. It is true, as part of that, that to improve some services PCTs may have put relatively small amounts of money to improve it, but we do not expect anything of that scale.

Q33 Dr Pugh: "Relatively small amounts".

Mr Nicholson: Yes.

Q34 Dr Pugh: You do not think an appreciable amount of money has been invested by PCTs across the country which will show up in later years' accounts.

Mr Nicholson: No.

Professor Colin-Thomé: One of the reasons we took out of hours, apart from the low morale, was that there were loads of complaints about the previous service and there had been reports and a quality paper published. So it was not as though there were some rosy past in out of hours; there had been lots of complaints about the former service.

Q35 Dr Pugh: I am familiar with local examples from my own constituency where extra money has been put in because it was thought that the service was not adequate as it stands and that is going on now, this year and not just immediately after the GP contract. I wondered whether that pattern was replicated across the country and you are saying that it is probably not.

Mr Nicholson: Yes.

Q36 Dr Pugh: Emergency admissions. On page 32 there is an alarming blip in emergency admissions more or less when the contract kicks in and the NAO are slightly struggling to come up with a true explanation of that. They mention a variety of factors there including apparently an increase in

violence in society round about 2003 peaking at round about 2005 and diminishing thereafter. What is the real explanation for that?

Professor Colin-Thomé: It predates the opting out of GPs from the 24-hour responsibility by a good year so that we cannot see any correlation with the out-of-hours work and the rise in emergency attendances.

Q37 Dr Pugh: So this is nothing to do with the GP contract.

Professor Colin-Thomé: That is what we think. It pre-dated, then it flattened, then it appeared to increase again and it has flattened out again. The GP contract happened after that. GPs were still working out of hours even when the numbers went up.

Q38 Dr Pugh: I accept that is an unfounded allegation put on you by the NAO which you are rebutting. Practice efficiency. I was surprised to learn that, if you do things to make your practice more efficient as a GP, the net effect of that is that you take home more salary. There is no sharing of the gains of efficiency at all. Am I right there?

Professor Colin-Thomé: The NAO report says that nurse pay has not gone up to the same degree as that for GPs, so in that respect you will be right.

Q39 Dr Pugh: If my practice becomes more efficient—I am a GP and I make it more efficient—the real beneficiary is me the GP not the NHS.

Professor Colin-Thomé: No, the NHS has benefited from you running a good practice and we have some measurements.

Q40 Dr Pugh: But there is no sharing of efficiency gains.

Professor Colin-Thomé: No. In many practices, like the one where I was, we actually used to give bonuses. We could not guarantee year on year a quality-of-outcomes result so many of us gave bonuses. I cannot substantiate how many did that.

Q41 Dr Pugh: Did you not think to cap efficiency gains? Did you not think to cap the amount doctors could take in efficiency gains from their practice that they could transfer into their salaries?

Mr Nicholson: They are small independent businesses at the end of the day. Whilst we are the major customer, they are still small independent businesses.

Q42 Dr Pugh: It is the entrepreneurial spirit, is it?

Mr Nicholson: There is something about that and the benefits that brings to patients overall. It is true that over the first two years

Q43 Dr Pugh: They benefit better from doctors who get better paid universally, do they? That is what you seem to be suggesting. Maybe it is true.

Mr Nicholson: What I am saying is that practices that are successful, which generate surpluses, do reinvest them in their practice, but it is true to say that over the first couple of years or so general practitioners did take more out of their income from

profit than they had in the past. The indications for this year and probably next year, given the settlements we had last year under the Doctors' and Dentists' Review Body, are that will return to more normal levels of profits.

Q44 Dr Pugh: May I touch briefly on the business of exception reporting which is mentioned on page 36, paragraph 4.8? I understand this to be a sort of gaming device which you can use to get more QOF points by excluding certain patients from your assessments where you can give a valid reason, because they refused to attend an appointment, are allergic and so on. We know this goes on and clearly the NAO picked up some of it. Are you confident that the procedures for tracking this and restraining this are in place? I would have thought it was extraordinarily difficult, no matter what the PCTs do, to track doctors not recording their patients.

Professor Colin-Thomé: There are several things. One is that you need to have exception reporting. Most contracts in other parts of the world which have not had that have found that doctors have sometimes coerced patients into treatment because of the incentives. So you do need exception reporting. There is a system whereby PCTs can track what percentage of exception reporting there is. So if there are significant outliers, as there are in some practices, that is for local management action to challenge that.

Q45 Dr Pugh: So 84% of PCTs said they intend to benchmark exception reporting rates and you are confident that they have the mechanism to do so.

Professor Colin-Thomé: Yes.

Q46 Dr Pugh: Do you regret in a sense, given the fact that you have not addressed as many of the health inequalities through this contract that you had hoped to do, that QOF points were not more locally determined, allowing people to deal with the local health problems they were presented with, which do vary from community to community?

Professor Colin-Thomé: Number one, we had to get the show on the road first of all and that is what we want to move towards in the next phases. In terms of health inequalities, the biggest causes of health inequalities and diseases are national issues about cardio-vascular disease and QOF gives quite big incentives to get the care of that better. If you look at the health inequalities issue, it is not local issues, it is things like cardio-vascular disease and diabetes which have a huge class gradient in severity as well as incidence and that is what we want to tackle straight away. We are in our next phase, looking at how we can get something local for particularly local issues, but those are national inequalities issues. The two biggest causes of inequality are cancer and heart disease.

Q47 Geraldine Smith: What concerns me is, if doctors are having it so good at the moment, why are they all so fed up? I have had lots of discussions with GPs recently and when the new contract was brought in I think there were some real reasons for

doing it and recruitment was one of them and morale was becoming very low then so you had to increase the earnings. Looking at the BMA, they talk about a doctor, when you take into account salaried GPs, just being on £88,000 a year on average. That does not sound extortionate to me. Since the contract has been brought in I notice that there has been no inflationary increase in the value of the contract since 2006. What is going to happen this year?

Mr Nicholson: That is a matter for the Doctors' and Dentists' Review Body which will be reporting soon. They will decide what that is. We put evidence and the BMA put evidence in and they make their judgments.

Q48 Geraldine Smith: Doctors tell me locally that one of the problems with the contract was that there was a significant underestimate of the additional cost of PCTs providing the out-of-hours service and they argued that it was because they did so much work that you were not aware of.

Mr Nicholson: Yes.

Professor Colin-Thomé: Because we were not paid a specific fee extra for out of hours when we had 24-hour responsibility and it was done at marginal cost in our existing money, when you costed it per hour of work then it appeared to be more expensive. I remember the NAO Report was saying also—and we have addressed this—that if the PCTs where the most was spent could get to the level of the ones who were more efficient, there would not have been anywhere near that significant difference. There was quite a variation between PCTs. We have addressed that through various techniques. We had to pay extra for out of hours because it was a new service in many respects.

Q49 Geraldine Smith: One of the things in my own area was that we do appear to have a very good service from our GPs in Morecambe and Lancaster and I have very few complaints from the public about the service they provide; quite the reverse. We are one of these under-doctored areas and the proposal is to bring a new practice forward. This has caused an awful lot of instability with local GPs. I would ask: why is there no flexibility, why is there a national diktat, why can local PCTs not decide which is the best way forward for them to address the problem of under-doctoring in their area?

Mr Britnell: I was up in your neck of the woods a couple of weeks ago—Blackpool; I did not get quite as far as Morecambe. The design of the new service is going to be very flexible. There is a core specification giving patients more access to GPs' services, but in terms of the total flexibility of the contracts which will be awarded, I would say that over 90% flexibility resides with the PCT. We are being quite prescriptive in access to GP-led health services because, as you rightly said, 84% of patients nationally think GPs provide good services. There are over 6.5 million patients up and down the country who would like hours extended to be more accessible and more responsive, so we have been very, very limited in our central prescription and local prescription is quite wide and varied.

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Q50 Geraldine Smith: That is not the impression I get from my primary care trust. Our local GPs are asking me, if they could meet the service specification being demanded of them, if they could do all the things required and address the problem of under-doctoring in this area then why can they not do it? Why is there a procurement process? Why is there going to be a new practice which could in effect destabilise them? I can see that in the inner cities there might be good reasons for doing it, but in areas such as my own there is a real need for flexibility. The PCT have told me that flexibility does not exist. Are you telling me that is wrong?

Mr Britnell: No, that is not the case. We are encouraging all sorts of people to tender for the services the PCTs will commission. We have set aside £1.25 billion over five years for the best of existing general practice, for new providers, for social enterprises and others to step forward and compete for the work which will be tendered. They have as great an opportunity as any other provider to tender for those services and if they are successful they indeed will provide those services.

Q51 Geraldine Smith: The problem is the timescale. With timescale contracts have to be in by December. Why the massive rush? If you rush things through you are in danger of making mistakes.

Mr Nicholson: Part of the issue is, in defence of national action—I normally spend most of my time defending local action—people could have done this before but they have not; for a whole variety of reasons people have not done it. We have not made these improvements and in a sense that is why we are saying, being slightly more prescriptive now than we have been in the past, that they must do it and we are saying they must do it to this particular timetable. To be frank, we and the population, I am sure, are fed up of waiting for improvements to primary care services. That is why we are being quite prescriptive about driving it. Mark is absolutely right: if local general practice can provide a service to specification required in the way it was required they will be very competitive and I am sure the PCT will be as free to pick them as anybody else. There will certainly be no pressure on them to go outside of the existing NHS or general practice to do that.

Mr Britnell: It is an opportunity for those who want to provide even better services to provide better services. Looking at the previous initiatives, arguably from 1911 with the National Insurance Act, but I will not bore you by going that far back, looking at the Fairness in Primary Care initiatives our analysis is that there are three or four reasons why PCTs did not get to the hard-to-reach communities: capability, capacity and also cash. What we have been trying to do over the last seven or eight months since the publication of Darzi back in October of last year is work on capability, capacity and also on cash, which is why the extra £1.25 billion over five years is a real increase in spending for PCTs. We make it very clear to PCTs that they can decide as commissioners—and we may come onto this later on—what else they want to put in the specifications. We think we have listened to

local people, we have looked at the national GP survey, the biggest one in the world, and there are 6.5 million people up and down the country who want extended hours, better access and responsiveness. Therefore the core national prescription is just looking at access to services at the weekend and also in the evening. Anything else PCTs want to do locally is an absolute matter for them.

Q52 Geraldine Smith: So basically you are telling me that GPs could work together, could say they can solve this problem by working together, we could put in a case for that to happen and the PCT will look on it favourably.

Mr Britnell: Yes. One of the issues raised in this report is in Chapter 4 which talks about PCTs having to develop competence and confidence to be commissioners. What we are doing now is giving them national support and encouragement to commission services for their resident population and that means that people who want to design and procure better services have the opportunity also to provide those services as well with their existing GPs or others.

Q53 Geraldine Smith: Just one other thing, the 48-hour target. A very well respected GP in my area, for whom I have a lot of time, complained to me about this. He said that by having this target it means that the doctors who have appointments booked ahead where people want to ring and book an appointment a few days in advance to see their doctor are being held back in order to meet those targets, so half the appointments are gone. It means there is very little flexibility within the system and they are having to tell people who want to make an appointment to ring back the following morning at 8am and it is causing jams on the phone lines; 4,000 in one day. Is this a national problem? Is it happening in other areas? I notice that one quarter of patients could not make an appointment to see a GP more than three days in advance and that is often a complaint.

Professor Colin-Thomé: And yet three quarters did. Many practices have actually tackled both by having emergency access for people who need it as well as forward booking. That is the idea; that is our policy and most manage to do that. Some of it is planning your workflows during the week and so on and using other persons in the team and using phone calls and all sorts of things to patients. Arguably three quarters managed to do both.

Q54 Geraldine Smith: A fair point.

Mr Nicholson: I do think though that our first priority was speed, it was not convenience. Now we are into convenience and how we can make services much more convenient. There are lots of examples around the country where people have managed to get over this and sort it out really well.

Q55 Geraldine Smith: Would you say the increased access is demand-led or clinically-led?

Professor Colin-Thomé: It is patients; it is their Health Service. We have not been as good. People who like GPs the most are often the elderly with complex problems who see us a lot. What we have not done as well with are sometimes younger people with kids and so on and it is to meet some of those needs that we need to increase hours and that came from patient surveys. It is for patients who need to have a better range of services.

Q56 Mr Mitchell: The cost was £1.76 billion higher than the estimate and the statement we have here from the BMA tells us what a good job doctors are doing, indeed so they should be if they are 58% better off. What does this reflect: the superior negotiating skills of the BMA or the incompetence of the Department?

Mr Nicholson: What I say again is that the actual overspend was £400 million not £1.8 billion.

Q57 Mr Mitchell: It is still big.

Mr Nicholson: It is still big.

Q58 Mr Mitchell: I do not suppose you envisaged a 58% increase in the pay of partners.

Mr Nicholson: In a sense part of the issue was that the existing contract was so complicated and so difficult to deal with and, interestingly, was not for the most part, until relatively recently, cash limited at all. There was no cash limit at all, it was incredibly complicated and moving to a new contract was bound to be difficult. It is true that we were really clear at the beginning that we wanted to boost GPs' pay as a part of it and we wanted to link GPs' pay to performance and we were successful in doing that. As David has pointed out, you are driving increased pay through more QOF points and it seems to be a really good way of doing it. We can demonstrate, as David has, some of the clinical benefits and outcomes you can get from driving GPs' pay in that kind of way. The framework is a good one.

Q59 Mr Mitchell: I accept that things have improved; I am sensible of the improvement in the service I get from my own doctor. There still is an inequitable situation within practices in the sense that the partners are creaming it off, taking it in profit and the rest of the practice is being worked harder and paid less. Why did you not cap the profits of partners?

Mr Nicholson: They are small independent businesses and that seems to me a really important part of what general practice is.

Q60 Mr Mitchell: What, making a profit?

Mr Nicholson: Absolutely.

Q61 Mr Mitchell: It is creamed off.

Mr Nicholson: There is no doubt that in the two years since the contract the amount, as a proportion, which the GPs take in as profit has gone up. We are confident that over this year and next year that will go down to historic levels, so we think that the split

will be in the future what it has been in the past and it does not take into account all the benefits to patients that we have got out of the contract.

Q62 Mr Mitchell: It points out in paragraph 2.18 that they are making more profit because expenses are down and that means they are exploiting the rest of the people in the practice: the income of salaried doctors has gone up 3%, the practice nurses are working harder, they are being exploited so the practice can make a profit.

Mr Nicholson: They are improving productivity. It seems to me a perfectly reasonable thing for a small business to do.

Q63 Mr Mitchell: Is it?

Mr Nicholson: Absolutely. They are also improving services for patients at the same time. It seems to me that both practices and patients gain from that.

Professor Colin-Thomé: You might want to quibble about the percentage of extra money but if you are running a practice—to introduce a bit of history—in times when it has not been as good the partners would not get any gain at all, whereas the salaried employees like nurses would, because they were on a salary. If you are running a business, sometimes there are vagaries as to how much earnings are. Two years after the contract deliberately put more resource into primary care for the reasons we gave, to get more GPs and so on, but running the business is not an easy pattern, it is not always profit. In the past we have had staff who decided not to be partners when offered.

Q64 Mr Mitchell: They want to be partners, do they not? They want the status of being a partner.

Professor Colin-Thomé: Not all do. Quite a lot of doctors want to be salaried nowadays without the responsibility because if you are a partner you have to run the practice and take responsibility for all the actions of the practice rather than just your own. Many doctors prefer to be a salaried doctor now rather than take the responsibilities.

Q65 Mr Mitchell: Let us take the position of the practice nurses. They are taking more appointments, dealing with more patients and their pay has not increased anything like it. They have a grievance, do they not?

Professor Colin-Thomé: No, but we did increase the numbers to cope with that.

Q66 Mr Mitchell: The numbers, yes.

Professor Colin-Thomé: The numbers of practice nurses are much higher. The figure about nurse pay, as the NAO would admit, was done on a sample at a conference so we do not have detailed figures about their poor pay increase. It was not a very systematic review. Most of us have increased the number of practice nurses for the work rather than making their existing ones work that much harder and many of us also gave them bonuses but we could not guarantee the year-on-year. We have had a continuing increase in nurses.

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Q67 Mr Mitchell: Is it a good thing that practice nurses are doing more of the appointments?

Professor Colin-Thomé: It is for the reviews. There is a lot of evidence from international work that if you have a chronic disease like diabetes the systematic review is done better by nurses than doctors; doctors are better at handling more and differential problems.

Q68 Mr Mitchell: I take that point. Why, if the contract was so good, do you now have to bribe practices into staying open longer, which is what you have been doing?

Mr Nicholson: We are not actually bribing them.

Q69 Mr Mitchell: You are offering to pay more if they work longer hours.

Mr Nicholson: No, we are recycling money we already give them for other things into this area. We currently give them money for choose-and-book and the access which we expect them now to deliver and we are moving that money over to pay them to open for extra hours. It is recycling money: it is not extra money we are giving them to do it.

Q70 Mr Mitchell: It is still more money for them, is it not, to work longer hours which they should be working anyway?

Professor Colin-Thomé: No.

Mr Nicholson: No, they are losing money out of one part of the contract and they have to earn it in another part.

Q71 Mr Mitchell: It struck me, going round talking to doctors when this proposal for longer and longer hours was put up, that they did not want it, they did not feel it was necessary. They were prepared to accept it because they were getting more money but the chief opposition came from the practice nurses and the other staff who wanted more time at home with the kids. They were the ones being exploited and they were the main opposition to longer hours.

Mr Britnell: I understand some of the concerns. Just a quick point on the progressive nature of the contract. As we have already said, through pay and prices and also recycling money both in QOF and also in access, we have over the last two or three years started to make the contract in a global sense much more efficient and effective. As Mr Nicholson has said, you will see over the next period of time, the next couple of years, how the contract is working more progressively. While this Committee is absolutely right to point out in the first two years the performance of the contract, we are confident that the mechanisms in place through QOF especially but not exclusively, are starting to make the contract work much more efficiently in the interests of patients. Specifically in terms of the points you raise, we have worked very hard with the GPC, with the profession, with the Royal College of General Practitioners and others in primary care and I cannot find anybody who does not believe that extended hours are a better thing for patients. That

is why, in the recent GPC ballot 92% of GPs expressed a preference for option A, which was extended hours which come out of existing money.

Q72 Mr Mitchell: Let me stop you there because I want to move on to another issue. You obviously hoped and we would have wanted you to improve the number of doctors and the quality of service in the deprived areas, of which Grimsby is certainly one. Why has there been no improvement?

Professor Colin-Thomé: Previous incentives just have not worked. We had all sorts of inducements for people.

Q73 Mr Mitchell: What is the problem? Are they not paid enough?

Professor Colin-Thomé: I used to work in a socially deprived area myself. It is partly that you did not get any extra resources in the old contract. In the new contract you do, but it is still not focused enough on the underprivileged areas. The money followed the doctor and it was often nicer to work in posher parts of the country and that is why we lost out. The contract could redress that, but it has not been focused enough so we are tweaking it now to make it even more focused and producing more practices in there as well.

Q74 Mr Mitchell: Are there not levers in the contract for the PCTs to lever more people into deprived areas? Why are you now having to put up another £250 million under the Darzi proposal to establish 113 more practices in deprived areas? Why?

Mr Britnell: When we looked at Fairness in Primary Care which had patchy success, it was a combination of capability, capacity and cash. Our strategy this time is to move quickly, because we should have addressed this issue some time ago, by putting extra cash in over five years, £1.25 billion, and helping PCTs commission services. We are looking at the primary and community care strategy which was part of Lord Darzi's work in the Next Stage Review. We are looking at other issues which actually stop patients moving around more quickly, where commissioners and PCTs want to commission new services. We are looking at that matter.

Mr Mitchell: Could you tell us in a written answer where the money is going to go and what I am going to get out of it?¹

Chairman: Send us a note.

Q75 Angela Browning: Is it not the case that when the Government first set up the new GP contract they really failed to understand the quality of the service which was already being provided and therefore the QOF resulted in them reaching their targets relatively easily because they were being paid extra money for pre-existing activity? Is that not one of the problems in terms of delivering good value for money under the new contract?

Mr Nicholson: There is no doubt that one of the real issues was that we did not really know very much about what was happening generally. The nature of

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the contract was such that it was extraordinarily difficult to be able to identify what the quality of a particular general practice was, the quality of the services it was providing, because there simply was not the information. The contract itself was so Byzantine that it was difficult to get to the bottom of it; that is absolutely true. It was very difficult to get a handle on what the existing quality was. What we were doing then in those negotiations was using the best information that we had to make the judgements that we made. Even the best practices had to improve themselves to deliver QOF, to be much more systematic and very often outcomes are driven by the way a practice is organised, by the nature in which patients are followed up, by the way in which services are wrapped round their individual need. That is quite tough and quite hard work and lots of practices, even the best ones, had to do things to make that happen. Whether it was going to be 75% or 85% or 60% was a matter of judgment at the end of the day and the best people we got to look at it thought it might be 75%. It proved to be a very effective way of driving improvement in primary care because the general practitioners got hold of the issue and drove it very quickly. As you have seen by the results, there has been a massive shift in terms of QOF points.

Q76 Angela Browning: Do you feel you have now got your benchmark, given that you did not have the necessary information to start off with?

Mr Nicholson: Yes, we have much more information now about the quality of primary care and we are in a much better position now to drive things on. What we have done already is to look at new clinical domains for which we can develop quality and outcomes frameworks. The whole quality and outcomes framework is based on continuous improvement, so it is not that you get your quality points and you will get them for ever by just doing the same thing. We will constantly, year on year now, be looking to ratchet up quality and improvement as part of the QOF scheme.

Professor Colin-Thomé: In fact in 2006–07 we did that; we took 138 of the existing points saying we could move on and brought seven more clinical areas into the contract and increased the minimum that you had to hit to get the threshold. So already there was a continuous quality improvement approach.

Q77 Angela Browning: Thank you; you have led me very neatly into my next question which is about omissions and that is things which were not actually included initially in terms of the GP contract and you have mentioned seven clinical areas which you have just added. What is the criterion for deciding what you add?

Professor Colin-Thomé: People put in their submissions and it could be lay people, it could be interest groups. We have an independent academic unit which assesses the cost effectiveness and the evidence base. Even though there are many worthy causes, there is no evidence base that actually seeing

the doctor will make any difference. So this academic unit makes the decision as to the effectiveness and the cost effectiveness of the submissions people put in.

Q78 Angela Browning: Thank you for that. I do not want to go too deeply into this because I want to go on to something else. There are certain things that GP practices can do within the practice but they are also a very important referral gatekeeper to other services, other disciplines. Is that primary role as gatekeeper still there in terms of them referring on across the piece rather than the specialisms that might be developed because of the QOFs?

Professor Colin-Thomé: Yes, most general practitioners are proud to be generalists, that is you can serve the individual patient and their varying needs rather than one special area. That gatekeeper function is an essential part of general practice and with practice-based commissioning we are going to reinforce that gatekeeper function so that more care can be done in community settings.

Q79 Angela Browning: Could we move in a similar vein on to the question of the GP out-of-hours service where we notice on page 6 in the general point under paragraph 10 it says “We found that the costs exceeded estimates and out of hours providers, although beginning to deliver satisfactory standards, were not yet meeting the national quality requirements”. Clearly we have heard various reasons as to why there were problems with the out-of-hours service. I have heard some of them from my own constituents and as a generality I would say, from my constituency, a lot of problems are around matters to do with the elderly who very often are a big call on out-of-hours services. What are these national quality requirements that they are not meeting and how are you addressing that?

Professor Colin-Thomé: They were mainly on speed. I do not have them all in my head I must admit. They are on how quickly you access the phone, how quickly you respond to an urgent appointment, how quickly you actually visit and so on. It was on access. Part of the quality requirements were also that you could see a GP, if there were a need for it, you could get a home visit, if there were a need for it and the PCT has to audit their services. There were also some very quick access ones which I do not have in my head and they did not meet all those. However, there was no evidence that clinical care was bad, it was more on speed of access and that is what we are going to improve. Since that last NAO report we have set in process a benchmarking system and an audit system which makes it easier for PCTs to assess their success against these criteria.

Q80 Angela Browning: Have you done any analysis into the fact that there is this identified problem of speed of access, that people would short-circuit the system and go straight to casualty and other hospital services.

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Professor Colin-Thomé: There is no evidence that the increase in A&E attendances came after the GP contract; that was going up for some reason before and actually has tailed off. That did not seem to be cause and effect is all I can say.

Q81 Angela Browning: There is obviously a cost factor there in terms of the hospitals and their A&E departments.

Professor Colin-Thomé: Yes. What I can say is that in the areas which often surround hospitals, some of the more socially deprived areas, there are insufficient doctors and nurses in primary care and that is why we got this big push. Just having primary care there, even without QOF does seem to produce better health outcomes for our population and that is why we are so keen to do that. It is often areas around hospitals which attract people who have not been able to access their traditional general practice and that is why we have more practices coming in and extending their hours.

Q82 Angela Browning: I want to move on to PCTs but first very briefly, in the NAO Report there is reference to a concern they have picked up about younger GPs not being amenable or looking to become partners for various reasons. That does not auger very well for the future.

Professor Colin-Thomé: Yes, it does. The difference in being a partner is that he or she has to run the practice as an organisation and many GPs say they do not want to do that, they just want to be a GP. So it does not auger badly for having GPs, but it does say that the management of the practice is less popular and that might mean you have to have different people managing it rather than GP partners. Certainly in our practice there are many partners coming in now, even if they are partners, who do not want, for instance, to take their share of owning the property. So there is a shift in attitude.

Q83 Angela Browning: Is this purely a financial business commercial thing? The reason I am asking this is because I am just wondering about the fact that there are lots more part-time GPs and therefore if you are a part-time GP you may be less inclined to seek a partnership?

Professor Colin-Thomé: Yes. I do not have any detailed figures on that but certainly I have practised where several of us became part-time or were part-time and they all were partners. It is a choice, but if you are a partner you have to run the business as well as be a good doctor and that is an added responsibility and some do not want to do that.

Q84 Angela Browning: But we do need to ensure that there are people capable and qualified as managers. Are you addressing that in your future planning?

Professor Colin-Thomé: Yes and part of our strategy for the future which we are doing with the Lord Darzi work is addressing some of those issues.

Q85 Angela Browning: I want to move on, if I may, to pages 12 and 13 of the NAO Report which are specifically to do with PCTs. On those two pages

there is a long list, a very long list, a to h, with recommendations of what PCTs should be doing in terms of their role in all of this. It does seem an exceptionally long list and it covers a multitude of disciplines and I wonder, before you answer, whether the restructuring of PCTs around the country has had anything to do with this.

Mr Nicholson: One of the reasons we went for restructuring was that it was pretty obvious to us that it was unlikely that we could deliver the level and quality of people in 303 organisations across the country. We had to improve the quality of our commissioning in primary care and primary care trusts.

Q86 Angela Browning: May I just stop you there? I am sorry to interrupt but you say that it was impossible for you to do this. Surely when you had smaller PCTs they would have had a much better handle on local needs, local practices and local demographics of populations. I speak from the County of Devon where we now have one PCT. I have to say that if you look at the geography of the County of Devon with two moors in it plus big cities like Exeter, Plymouth, et cetera, I would have thought you would have benefited from the experience of people running smaller areas within a PCT region.

Mr Nicholson: There is no doubt that small PCTs geographically focused could get lots more information and knowledge about local circumstances; it is absolutely true. The issue for us is what they would do with it when they had that information. What was pretty clear to us was that PCTs were not strong enough, did not have the depth of expertise, the depth of analysis, the depth of understanding and the commissioning ability, commissioning capacity to drive the change that we needed to do. That is one of the arguments around going from 303 to 152. We think that having bigger PCTs with more concentrated managerial and analytical ability, coupled with practice-based commissioning, which does give you that local experience, is the best balance. We have put quite a lot of effort now into making sure that our PCTs can commission and deal with these issues and Mark has been leading that.

Q87 Mr Davidson: I and my colleagues would agree with the objectives and see them as laudable but what I am not entirely clear about is the competence with which all of this was handled. On page 42 we have a timeline of much of what was done. Just at the bottom, on 19 January, the Secretary of State made a statement "I think if we anticipated this business of GPs taking a higher share of income in profits we would have wanted to do something to try to ensure that the ratio of profits to the total income stayed the same". Then on 1 February we have one of the BMA negotiators saying that the BMA were astonished to be offered such a generous package. That does look rather as though the union basically took the management to the cleaners, does it not? Is that basically correct?

Mr Nicholson: What I would say about the contract is that—

Q88 Mr Davidson: A simple yes or no would be sufficient.

Mr Nicholson: No.

Q89 Mr Davidson: Do you know whether the BMA negotiators got a bonus from their colleagues?

Mr Nicholson: I do not know the answer to that.

Professor Colin-Thomé: It is unlikely.

Q90 Mr Davidson: They possibly should have, should they not really?

Professor Colin-Thomé: I think Simon Fradd's view was a minority view in the BMA.

Q91 Mr Davidson: It is a minority now I suspect; a minority on the basis that he should not have said it.

Professor Colin-Thomé: That may be one interpretation but I think it is a different interpretation.

Q92 Mr Davidson: Am I right in thinking that this has been a private company, as it were, with a limited income and not having access to the bottomless pit of government funding this deal would have bankrupted the NHS?

Mr Nicholson: No.

Q93 Mr Davidson: How much was the overspend?

Mr Nicholson: It was £400 million and we have got it back over the last years or we think we have got it back.

Q94 Mr Davidson: But not at the time.

Mr Nicholson: No.

Q95 Mr Davidson: Companies who get bankrupted do not generally get away with it by saying they will be all right in a while. They are bankrupt at the time. Somebody had to bail you out basically.

Mr Nicholson: No, we sorted the issue out ourselves. Over the last three years the NHS has moved from deficit to surplus. Not only have we paid back our deficit, we have also produced a surplus.

Q96 Mr Davidson: Let me be clear then. You already actually had that £1.78 billion or £400 million, the figure being in dispute. You had it in your back pocket ready, so you could have paid more to the doctors. You actually had that money for this deal, did you, or was it money you had to take from somewhere else?

Mr Nicholson: We had to take it out of somewhere else. It did not bankrupt us.

Q97 Mr Davidson: It would have bankrupted you if you had not had that money floating about.

Mr Nicholson: We did not take the view, nor is there any evidence that we thought there was a bottomless pit of taxpayers' money when we went into this.

Q98 Mr Davidson: Where did the money come from then? Which other services suffered?

Mr Nicholson: The NHS had a deficit of £250 million in one year and £500 million in the other.

Q99 Mr Davidson: Fine, so you were bailed out.

Mr Nicholson: No, we were not bailed out.

Q100 Mr Davidson: You ran a deficit then.

Mr Nicholson: We had to pay that back. The NHS has paid it back. It has not been bailed out.

Q101 Mr Davidson: You ran a deficit. The thing that strikes me about this is that it makes much clearer to us than perhaps it was before the whole idea of GP services essentially being already privatised. They are run as private companies, they are run as small businesses and in line with most small businesses they have a role of profit maximisation. Maybe I am just old-fashioned with ideas of public service and so on, but the way this has developed has certainly shaken that. May I just clarify paragraph 2.16 on page 25? I want to pick up some of the same points as Mr Mitchell in relation to salaries "an expectation set out in the pay modernisation business case that career pay for GPs would increase by 15% on the new contract". Was that 15% a year every year? Maybe the NAO can tell me.

Professor Colin-Thomé: We did intend to give general practice more resources.

Q102 Mr Davidson: No, I know that. Is this 15% each year or 15% over a three-year period?

Ms Taylor: I am told it is across their career; it was career earnings.

Q103 Mr Davidson: Goodness me, that is interesting. The plan was then that the career pay for GPs across a long period would increase by 15% yet in the next paragraph we see that partners got 18% the first year, 23% the second year, almost 10% the next year. That does not seem to have been well planned, does it?

Mr Nicholson: The plan at the beginning was to increase the earnings of the practices by 36% over the three years.

Q104 Mr Davidson: It is 15% here. You have agreed this, so this must be right.

Mr Nicholson: Yes.

Q105 Mr Davidson: You both agreed this.

Mr Nicholson: Yes, but the difference is between pay and income because it is a contract for service.

Q106 Mr Davidson: Of course it is; that is right. That is very helpful. The pay of GPs who are partners is determined by themselves.

Mr Nicholson: Yes.

Professor Colin-Thomé: Yes.

Q107 Mr Davidson: So there is a big bucket of profits and they can just decide how much they want to take out of that themselves.

Mr Nicholson: They have to provide the service but they decide.

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Q108 Mr Davidson: Once the lorry comes and tips the money on the pavement they just decide how much they keep for themselves and how much they reinvest in the practice and how much they give to their staff, do they not?

Mr Nicholson: But they have to organise their staff in order to get the money in the first place.

Q109 Mr Davidson: I understand all that. Once they have done all that several lorries come in with the money and they tip it on the pavement. Can you just clarify for me why it is that they decided to take so much of the extra money for themselves and give so little to their staff? It seems here that salaried GPs, who presumably were also making a contribution, got 3% increases. It says here, and you have agreed this, that the average practice nurse income has gone down in real terms. The good professor is shaking his head but you agreed this at the time. If you did not agree this, you should have raised it at the time.

Professor Colin-Thomé: We did not disagree with the findings in the NAO Report but how we analyse the practice nursing one is not systematic enough.

Q110 Mr Davidson: You are either disputing this evidence or you are not.

Professor Colin-Thomé: We are not disputing the way they got to the evidence.

Q111 Mr Davidson: That is not our concern. We take this as being gospel and as being agreed by you, so if you do not agree with it you should have disagreed with it before. The evidence here is that nurses are now worse off in real terms, in the first two years salaried GPs got 1.5% and the partners filled their boots and every other orifice with gold and went off. Is that wrong, not morally but factually?

Mr Nicholson: For the two years after the contract, the proportion that the partners took as profit went up beyond what it historically had been. That is true.

Q112 Mr Davidson: Is it true also that their employees are not nearly as well off, that they had 1.5% in the first two years for salaried GPs and an average practice nurse's salary actually went down?

Mr Nicholson: Yes.

Q113 Mr Davidson: Does that seem fair to you? All these small businesses talk about their most important asset being their staff but for partner GPs the most important question is themselves really, is it not? They have taken all the share of the money for themselves.

Professor Colin-Thomé: No.

Q114 Mr Davidson: I recognise that the professor made a point about bonuses, but presumably bonuses are recognised within this since this is from the Inland Revenue statistics.

Mr Nicholson: What you have not taken into account, of course, is that the salaried GPs had a pay increase every year and that the nurses had a pay increase every year.

Q115 Mr Davidson: May I ask the NAO about that? It says here "the average salary for a GP employed by a practice . . . has only increased by 3% in the first two years". I assume that includes any other salary increases being offered because it is an absolute statement.

Ms Taylor: Yes, that is over the two years of the contract.

Q116 Mr Davidson: That includes any salary increases that were coming normally.

Ms Taylor: I think what you are trying to say is that they were having year-on-year increases and it has just continued.

Q117 Mr Davidson: Yes.

Ms Taylor: Which is true, but we are just measuring it against the years since the contract was implemented. In the years since it was implemented it was a 3% increase.

Q118 Mr Davidson: So as a result of these lorry loads of gold the GPs employed by the practices did not get anything they were not going to get anyway. Is that correct? We have just heard that basically 1.5% presumably was the salary increase.

Mr Nicholson: It is true that the GPs took a greater proportion of the income.

Q119 Mr Davidson: No, all of it; they took virtually all of it, did they not?

Mr Nicholson: No, not virtually all of it. No, they took a greater proportion of the income as profit. That is true.

Q120 Mr Davidson: The way in which the spoils have been divided is just a manifestation of sheer unadulterated greed, is it not?

Mr Nicholson: General practice is based on independent businesses. They are not private; they are part of the NHS.

Q121 Mr Davidson: What do you mean "they are not private"? Of course they are private.

Mr Nicholson: For example, GPs have access to the NHS pension scheme, so they are part of the system, although the practices are independent businesses.

Q122 Mr Davidson: Private.

Mr Nicholson: They are not outside of the NHS, they are an important part of it and there are lots of examples around the country where the kind of public service values that we would aspire to are absolutely aspired to by those practices.

Q123 Mr Davidson: This is still sheer, unadulterated, naked greed as far we can see, is it not? That is a reasonable assumption.

Mr Nicholson: No, I do not accept that it is unadulterated, naked greed.

Q124 Mr Davidson: Slightly adulterated naked greed.

Mr Nicholson: No, I do not agree.

Q125 Chairman: Three times now you have denied, to Mr Mitchell, to me and now to Mr Davidson, that this has cost us £1.7 billion more. Would you please look at page 7 and Figure 3? I must make this point. You have there on the first line that the Department originally thought it could deliver the contract for the amount shown under Gross Investment Guarantee. You see that listed there, do you not?

Mr Nicholson: Yes.

Q126 Chairman: We now find that is based on a wrong estimate and we see on the third line that the Actual Spend by PCTs was £1.762 billion higher than the guarantee. We can also see on the second line that in view of the higher spend the Department allocated more, but even that was overspent by £406 million.

Mr Nicholson: Yes.

Q127 Chairman: One can have as much smoke and mirrors as one likes about this but this figure seems to me to back up what the NAO have persistently told us, that this cost you £1.76 billion more than you expected. It is laid out there in Figure 3.

Mr Nicholson: It cost £1.8 billion more than we estimated. The estimate was based on incomplete information. It is not that we spent £1.8 billion more than the taxpayer was already spending. We spent £400 million more than the taxpayer was already spending.

Q128 Chairman: Who made the wrong estimate in the first place?

Mr Nicholson: Officials in the Department.

Q129 Chairman: You.

Mr Nicholson: Officials in the Department made the judgment but it is one of the arguments for having a new contract because it was almost impossible to get to the bottom of the old contract to understand what was happening until way after the event and that is why we got ourselves into this particular position here.

Q130 Mr Bacon: The Chairman has really asked my first question about this £1.7 billion. My first question was going to be: who is responsible for the miscalculation?

Mr Nicholson: I am the accounting officer.

Q131 Mr Bacon: But when the miscalculation was made were you the accounting officer?

Mr Nicholson: No.

Q132 Mr Bacon: Who was?

Mr Nicholson: Nigel Crisp.

Q133 Mr Bacon: When we look at Figure 12 on page 22, again a summary of the same figures as in Figure 3, we have the Gross Investment Guarantee and the Gross Investment Guarantee is described in paragraph 2.7 as "... the minimum that the Department had promised doctors it would spend

on GP services". That is what the Gross Investment Guarantee is "... the minimum that the Department had promised doctors it would spend on GP services". In Figure 12 we see that over the three years the Gross Investment Guarantee is £18.740 billion, whereas the amount actually spent was £20.502 billion, a difference of £1.762 billion. You seem to be saying that £1.4 billion or so of that £1.762 billion was being spent already. Is that what you are saying?

Mr Nicholson: Yes.

Professor Colin-Thomé: One of the things where we did not have a good grasp is that 40% of GPs are on a local contract called PMS. It was in those areas where we had difficulty in ascertaining how much had been spent on those contracts.

Q134 Mr Bacon: Why did you have difficulty?

Professor Colin-Thomé: Because they were dispersed around the country and we did not have a systematic way of picking that up until we did the review.

Q135 Mr Bacon: The PMS contract was via the PCTs presumably, was it?

Professor Colin-Thomé: Yes.

Q136 Mr Bacon: Simply because you had PCTs dispersed around the country you could not ask each PCT how much they were spending on their PMS contracts.

Professor Colin-Thomé: Yes. We did that then and that is when we came up with the correct answer; that is when we found the extra allocation of £1.4 million, because we realised we had spent it already.

Q137 Mr Bacon: Billion. People keep saying million when they mean billion.

Professor Colin-Thomé: Sorry, yes, £1.4 billion. We had spent that already on PMS.

Q138 Mr Bacon: The NHS spends, what is it now, about £90 billion a year? What is the budget of the NHS now?

Mr Nicholson: Yes, just over £90 billion.

Q139 Mr Bacon: Even for an organisation with £90 billion, £1.4 billion is quite a lot of money to lose, is it not?

Mr Nicholson: Yes. We did not lose it. It was being spent on primary care.

Q140 Mr Bacon: I use the word "lose" loosely. What I meant was that it was quite a lot of money to spend without realising that you were spending it.

Mr Nicholson: It was being spent on primary care services and, retrospectively, because of the nature of the old contract, it was impossible for us to get to the bottom of it in time for these particular discussions. We did subsequently and the new contract puts us in a position whereby we can identify what we are spending and where we are spending it.

Q141 Mr Bacon: From that point of view the new contract is better.

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Mr Nicholson: Yes.

Q142 Mr Bacon: So you are saying that you had managed to devise a set of contractual arrangements which made it impossible to keep track of where money was being spent.

Mr Nicholson: No.

Q143 Mr Bacon: What do you mean by “no”?

Mr Nicholson: The 1948 contract for general practice was incredibly complicated and it was only recently that it became cash limited. Up to then it was essentially—

Q144 Mr Bacon: Mr Davidson’s bottomless pit.

Mr Nicholson: We have changed that now. Now we are cash limited and we know what the resources are and we know what they are being spent on. That seems to me one of the great benefits of the implementation of the contract.

Q145 Mr Bacon: Yes, I just accepted a minute ago that the new contract is better now; I said that a minute ago. However, the previous system was one in which it was impossible to keep track of how much money was being spent.

Mr Nicholson: It was not impossible to keep track.

Q146 Mr Bacon: You said it was impossible to get to the bottom of.

Mr Nicholson: What happened was that in the timescale we had it was several months after the year end that we were able to get a position on what the money was being spent in a particular year. That is true.

Q147 Mr Bacon: May I ask about the QOF? Why did you ignore the BMA’s warning that your estimate of the number of points that GPs might achieve under the QOF was too low?

Professor Colin-Thomé: Hindsight is interesting. At the time I think the BMA’s position was that many practices would do much better than the average but the estimate from academics and people in the service was that on average we thought the practices would only get 75%. One issue in general practice which QOF has addressed is the variation in performance across practices. So when the BMA said that they warned us, in fact you look at their words they said they thought many practices would do better than that.

Q148 Mr Bacon: In paragraph 2.12 it says “. . . the BMA told us that it warned the Department that achievement would be much higher. In addition, Departmental documents suggest that the Department was aware that the estimates were low”.

Professor Colin-Thomé: At the time our best guestimates, which included what some BMA people were telling us and others, including academics, was that we thought 75% was a shot. However, this was a completely new system that nobody had tried in the world before and GPs did

better because they put more services in. At the time the best guess of all of us was that 75% was a reasonable estimate of what we would do.

Mr Nicholson: It is true that we did overspend the amount of money available to us, but, as I have said on two or three occasions, in the last two years we will have clawed that money back.

Mr Bacon: In conclusion just to say that last week I was off with flu and, lying in bed on Good Friday at about six or seven o’clock, despite my protestations my wife insisted on calling the doctor. At about 6.30 or seven o’clock Friday evening, within two hours of a phone call I had a GP at my bedside in my house. I think most of us think GPs do quite a good job.

Q149 Mr Dunne: Am I right in saying that the increase in GP pay rates since the period of this contract has been 0% for the last two rounds, the year we are about to start and the current year?

Mr Nicholson: Is this from the Doctors’ and Dentists’ Review Body awards? Yes, 0%.²

Q150 Mr Dunne: The introduction of Lord Darzi’s polyclinics is taking place now not just in London but across the country. Is that right?

Mr Nicholson: Yes.

Q151 Mr Dunne: Am I right in saying that each PCT has been encouraged to open one polyclinic in their area?

Mr Nicholson: The London review came up with a model around what was described in that review as a polyclinic, which is a combination of general practice and secondary care clinicians all working together in one organisation. That is not what we are saying should happen across the country as a whole. What we are saying across the country as a whole is that it is up to local circumstances to determine what model of care you have. So the idea that we have this model of a polyclinic which has been developed in London, which can be rolled out across the country is simply not the case. We have been really clear with the NHS about that. What we have said is that we expect a whole series of new health centres to be set up across the country. We have been pretty clear about some of the core bits of those health centres, open from eight until eight and GP-led, but over and above that we have said it is for local circumstances to decide what best fits into your pattern of care and pattern of service locally.

Q152 Mr Dunne: So you are requiring each PCT to invest in one new health centre per PCT, to be GP-led.

Mr Nicholson: Yes.

Q153 Mr Dunne: That is very similar to a polyclinic; it is just called a health centre.

Mr Nicholson: No, because a polyclinic in the London perspective talks about a whole range of different services which are supposed to be in it and talks about size. We have not talked about size in relation to these health centres at all.

² Information provided by witness: NHS Employers negotiated 0% in 2006-07, DDRB 0% in 2007-08

Q154 Mr Dunne: I accept that the polyclinics in an urban environment may well have advantages to concentrate service provision in a particular area. If you look at a rural environment, where many of the 152 PCTs which are not in urban areas are covering rural areas, this focus on a health centre per PCT is almost inevitably, and certainly in my area, going to lead to the development of a health centre in the largest urban area within the PCT area to the detriment of the existing GP practices elsewhere in the area because the funding is being creamed off to support the new health centre. Is that not the case?

Mr Britnell: No, that is not the case. There are two things it is very important for the Committee to realise. First of all, we are asking PCTs to commission services not centres. We are not asking them to build new bricks and mortar; it is up to them whether they need new bricks and mortar. We are asking PCTs to commission new services. The second issue is £1 billion over five years—I think I said £1.2 billion before—is new money going into the NHS to provide more accessible and responsive services. Thirdly, as a result of the primary and community care strategy, which unfortunately we have not had a chance to talk about today, we shall be looking at some issues which the NAO has raised with us, including MPIG and other matters, to make sure we get more accessible and responsive services for the patients we serve in the future.

Q155 Mr Dunne: They may be more accessible for the few who have the benefit of living nearby, but they will be much less accessible, if this is where the investment is going, for the majority of people where investment in the other GP services provided will be declining. I am interested to hear you talk about services rather than centres. I have a letter here from the Minister, Mr Bradshaw, which I received on 18 March, which talks about 152 GP-led health centres and he keeps referring to centres not services. Centres sound to me like premises and that is certainly how it is being interpreted by the PCT.

Mr Britnell: In the guidance that we have sent round to PCTs in terms of their local procurements, their local commissioning, we make it clear that PCTs have to commission new services. It is the case that some PCTs also want to develop new health centres; there is nothing wrong with that. Just to go back to your previous question, we are very clear that it is not a question of either/or. We are progressing the agenda on extended hours for all practices. Of course it is a matter for them whether they choose to extend their hours but we now have recycled money, thanks to the contract, to make sure that those practices which do want to provide more hours will be paid for doing just that whilst also putting in extra money to procure and commission new services, not only for GP-led health services, but wider services, whether in Morecambe Bay or somewhere else, basically looking at services that local people need.

Q156 Mr Dunne: On the subject of hours, which I am glad you raised, I can understand that the health centres may be fully staffed from eight to eight, as you are intending, but it is a small proportion. The

impression given by the Government and your Department is that ordinary GP services will be readily accessible to everyone: in fact they are bookable appointments only. In most cases, in the small practices which are not in a position to employ their staff for the extra hours because they do not have the funding to do that, it will be doctors' appointments only. So people will not be able to turn up, knock on the door and expect to be received because there will be no-one to let them in.

Mr Britnell: That is not the case at all. First of all, we have to make sure we are providing enhanced services for patients. We expect, as we said before in answer to a previous question, that GPs can combine their services to tender for new commissioned services. How they do that is a matter for them. I hope that nobody would think that actually providing new services for extended hours is a bad thing for patients. If it encourages professionals to think how they work together, then so be it.

Q157 Mr Dunne: It is not a bad thing for those patients who are able to book appointments and meet those appointments. However, for the general public to get the impression that extended hours are going to mean access when they are advertised as having appointments, but actually it is by appointment not by open access, is misleading.

Professor Colin-Thomé: On the health centre which is open eight to eight seven days a week, that is for booked and non-booked.

Q158 Mr Dunne: I accept that, but that is only 152 and there are 8,000 practices or more around the country where that will not apply.

Professor Colin-Thomé: It is a minimum. If practices want to open for extended hours and if it is a single-handed practice then many, as my father used to, will work with other doctors who can provide that range of services without doing it themselves. On some things you might want to compete and on other things you should collaborate. You cannot have it both ways. If you want to be small, that is great in one sense, but you cannot then provide an extended range of services. There are ways round that and many practices share that responsibility.

Mr Britnell: That is a matter for local PCT discretion, listening to what its population wants and then deciding what it wishes to commission.

Q159 Mr Davidson: It is a question again of dealing with areas of deprivation. It was stated that one of the objectives was to deal with the shortfall in areas of deprivation. Really, from the report we have here, it is clear that has not been achieved. Can you give us a note indicating what steps you intend to take to address that? Maybe you could just give us an indication now of when you expect that element of the contract will have been dealt with adequately.³

Mr Nicholson: There are two aspects to it: one is the 100 more GP practices in the deprived areas. We are working through a procurement process at the

³ Ev

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moment and we expect that to end in December, so we would expect those practices to come on stream in 2009. The second part is the reform of the minimum practice income guarantee which enables us to move money around and much more effectively fund areas of deprivation.

Q160 Geraldine Smith: On the point about the new practices you are talking about, can GPs not work together to provide that service?

Mr Nicholson: To the specification; absolutely. We have to be clear about what we expect.

Q161 Geraldine Smith: Who will help them? There is all the tendering process and things to be gone through.

Mr Nicholson: They are small businesses, they can use some of their profit.

Professor Colin-Thomé: If you want to be serious about going into new business, then you have to get a proper assessment and if you do not have the skills in-house, then you need to buy them in if you want to be a significant player. What we are saying is that instead of extending existing practices we want more choice for patients by having these new practices, even if existing practices are running them at a distance. They are separate practices to increase choice rather than expanding the existing practices.

Q162 Geraldine Smith: And even that could lead to over capacity.

Professor Colin-Thomé: It could do.

Mr Britnell: We made it very clear, and I am sure you will agree with this, that all of these newly commissioned services must be fair and transparent. That means that anybody who wishes to provide better services to the specification of the PCTs, taking into consideration local needs, will be able to apply and tender for those services. If existing GPs in your part of the world want to get together and put in a tender, then the PCT will evaluate which the better replies or returns are. We think this is a fair way to get competition but also collaboration in equal measure to provide patients with better services.

Professor Colin-Thomé: There is plenty of work to be done. When you say we will have too much capacity, there is lots of care needed. We could do extended hours of surgeries, more chronic disease work and more care which is done in hospitals can be done in primary care.

Q163 Chairman: Thank you very much Mr Nicholson. That concludes our inquiry. Obviously a new contract was needed but it did cost the Department £1.76 billion more than you intended and GPs generally are the real winners of this, although a new contract was needed. We thank you for your evidence today and we will report later.

Mr Nicholson: I should also say that patients have significantly benefited from the new contract.

Chairman: You got the last word in, well done Mr Nicholson. Thank you.

Memorandum submitted by the British Medical Association

THE VALUE OF GENERAL PRACTICE: THE FACTS

The new UK-wide GP contract was introduced in full in April 2004 following lengthy negotiations and full agreement by all parties—the Government, NHS Employers and the BMA's General Practitioners Committee. Since April 2004 GPs have been mainly working under two contracts; the nationally negotiated General Medical Services (GMS) contract or the locally negotiated Personal Medical Services (PMS) contract. The two contracts are broadly analogous in terms of how services are provided to patients. The National Audit Office (NAO) recently issued the report *NHS Pay Modernisation: New Contracts for General Practice Services in England*, a report on the GP contracts in England. This fact sheet has been produced by the General Practitioners Committee (GPC) of the British Medical Association (BMA) to clarify the facts about why and how the contract was introduced and the benefits to patient care it has delivered.

KEY MESSAGES

“Since 2004 more services are being provided in GP surgeries and practices are offering structured management of chronic diseases which has resulted in consistency of care throughout the UK”.

Dr Laurence Buckman, Chairman, General Practitioners Committee

- Benefits of the contract include better consistency and quality of care for patients and fewer problems with recruitment, retention and morale of GPs.
- Although GP earnings have increased under the contract, this was an intended consequence and the BMA predicted the level of increase.
- Since 2006–07 GPs have received no inflationary uplift to the contract and have taken on additional areas of work through changes to the QOF. Global sum payments have not increased since 2004.
- Since the introduction of the contract the number of consultations has gone up, the time spent with the patient has increased and the work GPs do is more complex.

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Why was the contract introduced?

The contract was brought in to address the severe shortage of GPs, to reduce the excessive hours they were working and to redress the pay imbalance—before 2004 the UK's GPs were among the worst paid in the developed world.

What are the key benefits of the contract?

- The NAO report (England) recognises that the new national GP contract is delivering benefits:
- Structured management of chronic diseases has resulted in consistency of care throughout the UK.
 - More services are being provided in GP surgeries.
 - Patient satisfaction with access has improved (84% of patients said they were satisfied with GP practice opening times in the 2007 national GP patient survey).
 - There are fewer problems in recruiting and retaining GPs.

How has the GP contract and QOF improved patient care?

The contract delivered benefits to patients through the improved monitoring and treatment of acute and chronic health problems and the development of nationally determined and locally appropriate enhanced services beyond those that GPs traditionally supplied. For the first time the contract linked increases in practice resources to delivering proven higher quality care for patients through the Quality and Outcomes Framework (QOF). The QOF provides a framework for processes that, if followed, will ensure a high quality service for patients. The NAO report asserted that the QOF has not focused enough on health outcomes although it is important to note that QOF was designed to incentivise GPs to do the work that would lead to improved health outcomes. A recent article in the BMJ supported the use of process measures to monitor the quality of clinical practice.¹

The clinical indicators, which include disease areas such as coronary heart disease, stroke, diabetes and asthma, draw on best research evidence and only those areas for which there is evidence to underpin their inclusion can be found in the QOF. The QOF is reviewed and updated as necessary in the light of changes to the evidence base and advances in healthcare. These decisions are based on a review of the quality framework by an appointed expert panel with input from the BMA and NHS Employers. In 2006 new areas of clinical work were introduced as a result of this process.

The BMA, during negotiations on revisions to the 2008–09 contract, was keen to build on the success of the QOF and had agreed, with advice from the expert panel, to give over 38.5 points in the QOF to introduce new clinical indicators, including peripheral arterial disease and osteoporosis, into the QOF. Unfortunately the Government rejected this proposal and imposed the use of all these freed up points to just two access targets, which are already within the contract.

GPs have exceeded the quality targets they have been set (although the BMA always predicted that this would be so) and this has resulted in higher pay. The QOF is an important aspect of the GP contract. Research from the National Primary Care Research and Development Centre has shown that “quality of care for asthma and diabetes showed more rapid improvement after the QOF” and that “patients with

¹ 2007;335:648–650 *BMJ* Richard J Lilford, Celia A Brown and Jon Nicholl. *Use of process measures to monitor the quality of clinical practice.*

controlled blood pressure increased from 48% in 1998 to 82% in 2005, and the percentage of patients with controlled cholesterol increased from 17% to 73% in the same period".² The QOF is well-respected worldwide and many other countries are monitoring its development closely.

How much does the average GP earn?

The most reliable indicator of GP income is the Information Centre's Earnings and Expenses Enquiry (EEQ). This recently estimated that, from all professional earnings sources (including NHS, private and out-of-hours work), self-employed, non-dispensing GPs working under the GMS contract earned an average net income of **£102,648** 2005–06. This is much less than the £250,000 widely quoted and misinterpreted by the media (this figure is often based on income before expenses have been deducted and applies to only a tiny minority of GPs working in exceptional circumstances). The figure is often inflated by other contractual arrangements, such as PMS and dispensing practices. It is therefore not reasonable to suggest that the nationally negotiated GMS contract changes are solely responsible for the increase in overall GP pay. This is a UK figure. It should be noted that the earnings of GPs differ significantly across the four countries.³ In addition, the earnings of salaried GPs are not included in this figure. On average, salaried GPs earn less than GP principals, partly as a result of reduced responsibilities, particularly those to do with running the practice as a business. When taking into account salaried GPs the average NHS GP earnings figure is currently approximately **£88,000**. It is anticipated that the EEQ figure will fall in 2007–08 and 2008–09 to reflect increases in practice expenses and lack of uplift to the contract.

How have GP earnings changed since the introduction of the new contract?

The NAO report stated that the average pay of GP partners increased by 58% in the first three years of the contract (this figure includes both GMS and PMS partners). This is broken down as 18% in 2003–04, 23% 2004–05, and 10% in 2005–06. It is important to recognise when referring to this pay increase figure that the rise in GP earnings was an intended consequence of the new contract with the explicit purpose of demonstrating high quality general practice, through the delivery of new work including the Quality and Outcomes Framework and enhanced services, and counteracting well-recognised recruitment, retention and morale problems. GP pay was falling behind pay rates for equivalent professionals and the contract was specifically designed to address this. The BMA was not surprised at the extent of the increases in GP income as the BMA repeatedly told the Government's negotiators what the rise would be.

Since 2006 there has been no inflationary increase in the value of the contract and GPs have taken on more work through the QOF. In addition, practice expenses have continued to rise, so most GPs will actually have seen their real earnings, for an increased amount of work, fall over the past two years. This is not widely reflected in press reports as official figures reflecting what GPs earn now will not be published until Autumn 2009.

What will happen to GP pay in 2008?

The Doctors' and Dentists' Pay Review Body (DDRDB) recommended a zero increase for contractor/partner GP pay in 2007–08. In an opinion survey by the BMA two thirds of GPs reported that their personal income had stayed the same or decreased in 2006–07. Two thirds expected a decrease in income in 2007–08 but official figures will not be available until Autumn 2009.

In 2008–09 the Department continued to put pressure on GPs to work harder and longer within the current contract funding streams by introducing proposals for extended hours. The BMA could not agree to the Department's proposals which were inflexible to local patients' needs and so polled all GPs on the options available. The package that will be implemented for 2008–09 includes the provision of an additional three hours per week for the average 6,000 patient practice for the same level of funding, and harder-to-achieve access targets being introduced into the QOF. Any inflationary rise to the contract terms for 2008–09 will be determined by the DDRDB which has yet to issue its report.

What difference has the QOF made to GP income?

The negotiations on the contract were predicated on the overwhelming bulk of new money being delivered through performance-based income streams and 75% of new money was intended to be delivered via the QOF. Since the introduction of the new contract, most of the increase in practice income has indeed been channelled through the QOF as performance-related pay. As the GPC had anticipated, practices have attracted additional resources by demonstrating that they deliver high quality care and work across the range of specific areas identified by the Government. In 2006–09 practices in England demonstrated top

² November 2007, National Primary Care Research and Development Centre; *What should happen to the Quality and Outcomes Framework?*

³ Average net profit for contracted GPs in 2005–06 was **£113,614** in England, **£98,656** in Northern Ireland, **£90,619** in Scotland and **£102,194** in Wales.

quality services with an average of 955 out of the 1,000 points available. These achievements were significantly higher than the Government had anticipated and are a great tribute to the work of GPs and their staff.

Weren't GPs already doing much of the work in the QOF?

The Government wanted rises in GP incomes to be linked to demonstrating the delivery of high-quality care (see above). Of course, as all parties were aware, GP practices were already undertaking some of the work that now falls under the remit of the QOF. Much of this work had been transferred from secondary care with increasing specialisation in secondary care. Unfortunately the resources for the work remained in secondary care and GP practices were becoming increasingly stretched by providing the care without resources. While the Government seemed to doubt that GPs would do well in the QOF, the GPC stated that it not only expected most practices to earn 750 points, because they had been delivering quality work for years, but that it fully expected many to top 900 points. The introduction of the QOF has indeed incentivised GPs to employ extra staff and invest in even better services for patients. It has also provided practices with the resources to identify patients with certain conditions before these would otherwise have come to light. Both work that had been initiated prior to the new contract and work undertaken since the introduction of the QOF have contributed to GPs' excellent performance in this area and improvements in patient care.

What hours are GPs working now?

The average length of surgery consultations with GP partners has increased from 8.4 minutes in 1992–93 to 11.7 minutes in 2006–07. The length of appointments is one of the best determinants of quality of care. GPs are therefore working with greater intensity during the day, and offering a higher quality service than they have ever done. The Information Centre's 2006–07 UK General Practice Workload Survey showed that GP partners, who regard themselves as full time, work on average 44 hours a week. This figure does not include any out-of-hours work, which was included in the 1992–93 survey. Further studies have confirmed that at least 25% of GPs still do out-of-hours work, on top of this average figure. The out-of-hours work carried out by GPs now is also more intense as they are no longer "on call" but tend to work shifts seeing patients almost continuously. The report states: "Direct comparison of results with the 1992–93 GP workload survey is difficult. However, average weekly hours for GMS(PMS/PCTMS) activities, excluding out-of-hours work, are very similar".

Prior to April 2004 GPs were responsible for the provision of out-of-hours care. Under the new contract, practices were given the opportunity to transfer responsibility for out-of-hours provision to the PCO. This was for two reasons; to give doctors a reasonable balance between their profession and personal life and to allow PCTs to re-commission out-of-hours services using a mixture of new and existing providers.

Has productivity fallen since the new contract was implemented?

The NAO reports that National Statistics show productivity has fallen since the new contract was implemented. This conclusion is supported by comparing costs to activity, which shows that whilst consultations with patients have increased these are not in proportion with the increase in costs.

GP activity cannot be measured in this way. General practice has changed and primary care is now provided by a whole team working in the surgery. The number of consultations has gone up, the time spent with the patient has increased and the work GPs do is more complex. An increasing number of conditions that were once managed solely in hospital are now managed solely by GPs and their teams. The entire way GPs work has changed so it is meaningless to talk about productivity in the way the NAO has done. GP productivity should be measured in improvements in health, not the frequency of consultations—and the early evidence is that the contract is leading to improvements in clinical care. Care for patients with asthma and diabetes has improved, more cases of raised blood pressure are being picked up and while it is too early to give exact numbers, this will prevent many more serious problems like strokes or heart disease.

What improvements have been made to the contract since its introduction?

For the year 2006–07, in addition to receiving no inflationary uplift to the contract, the GPC agreed "efficiency" changes in the QOF, amounting to some 15%, and the introduction of additional areas of work, on the explicit and publicly agreed understanding that the Government's perceived value-for-money issues would not be revisited in future negotiations. This included the recycling of 138 points from the QOF into new areas of work that required practices to work harder—this included new targets for dementia, depression, chronic kidney disease, atrial fibrillation, obesity and learning disabilities. This work was undertaken by practices for no additional funding.

Is it true that GPs are now taking a greater proportion of gross income home as profit?

No. GPs are often cited as taking a greater proportion of practice income as personal profit and the Government has said it regrets the fact that GPs have not invested more of the increase in gross income in patient services. EEQ figures show a fall from 59.5% in 2003–04 to 54.2% in 2005–06. Although a small change in the earnings/expenses ratio had been anticipated during the new contract negotiations, these figures are generally misleading because raw figures conceal several changes in the way GPs are paid under the new contract including the fact that GPs are no longer responsible for certain elements of their business expenditure, including IT, and that fact that many partnerships were opened up to non-clinical members, many of whom were previously employed by the practice.

The suggested present level of expenses does, in any case, no more than take the percentage back to its level in 1990–91 when the previous contract came into being. It had reached its higher level as GPs were prepared to invest heavily in their practices even when gross incomes were rising more slowly.

Are GPs investing in practice staff?

Contrary to accusations, GPs have increased investment in their staff and practices since the introduction of the new contract. According to the EEQ average expenses rose from £120,064 to £129,926 between 2003–04 and 2004–05. The increase in staff costs in 2004–05 was 17%, a fairly significant increase. The areas where expenses grew slowly or fell were business expenses and car and travel costs together with depreciation on capital assets. GPs value their hardworking staff and have honoured the pay increases put forward by the national body that decides nurse pay. The BMA has always supported paying practice staff well.

Did the contract over-deliver funding to practices?

The main causes of the overspending in the first two years was a significant underestimate by the Government of achievement levels on the Quality and Outcomes Framework (QOF) and the additional cost to Primary Care Trusts of providing out-of-hours care. The BMA made the potential QOF scores quite clear on a number of occasions and the costs of providing out-of-hours services were also known at the time and were never planned to be covered completely by the removal of £6,000 from GPs. Government negotiators were fully aware that out-of-hours replacement costs would be about £13,000. The global sum payment, provided to practices to deliver basic general practice defined as essential services, was defunded to increase investment in the QOF. As a result the Minimum Practice Income Guarantee (MPIG) had to be created by funds taken from premises, QOF and PCO funds to ensure that practices would not be worse off under the new contract arrangements. Had more funding been put into essential services in the first place, as the BMA wanted, the MPIG would not have been necessary.

Does the Minimum Practice Income Guarantee (MPIG) add to health inequalities?

The introduction of the MPIG was deemed essential to the contract proceeding and the alternative would have seriously damaged the viability of 90% of GMS practices. MPIG is a recognition that many practices, with the support of their Health Authority, had invested to a greater extent in practice staff in order to provide a greater range of services. The MPIG has led to funding for the contract being based more on historic funding that would have been ideal. The BMA is keen to work with the government to address these health inequalities but it is too simplistic to suggest that removing MPIG from GMS practices would achieve this aim. If the MPIG were to be abandoned this would significantly destabilise many practices that are most dependent on it and who would be forced to make large numbers of their staff redundant thereby affecting patient services currently provided.

Are GPs still good value-for-money?

The UK Governments expressed some value-for-money concerns following the introduction of the new contract, even though it had been negotiated and agreed by all parties, including Treasury. Although GP income did rise as intended, following the introduction of the new contract, GPs remain excellent value-for-money. General practice delivers high quality services with fewer doctors per head of population than most of our European neighbours. The Personal Social Services Research Unit at the University of Kent has calculated that, in 2005–06, the unit cost of each face-to-face GP consultation was just £214. This figure compares very favourably with other NHS costs. Increasingly, GPs are providing services which used to be done in hospitals, eg minor surgery, diabetic care, preventive treatment of heart disease and strokes at a much lower cost to the commissioner. In the House of Commons on 28 November 2006, the Secretary of State for Health, Patricia Hewitt said that the new GP contract “has led to primary care services being rated as better in our country than in almost any other advanced country”.

General practitioners are represented by a UK-wide committee, the BMA's General Practitioners Committee (GPC), plus three national committees, which work alongside it. The committees represent all general practitioners whether or not they are members of the BMA.

March 2008

Supplementary memorandum submitted by the Department of Health

QUESTIONS 74 (MR AUSTIN MITCHELL) AND 159 (MR IAN DAVIDSON)

Improving GP services in deprived areas

Despite recent increases in the primary care workforce, there are still significant variations across the country. For example, the PCT with most GPs and nurses for its population (Cambridge PCT with 124 GPs and practice nurses per 100,000 weighted population) has almost twice those of the least (Barking and Dagenham which has 64 GPs and nurses per 100,000 weighted population).

Research (by U.S academic Barbara Starfield) has shown that increasing the number of primary care clinicians is the most effective way of improving the health of a population. Yet when we look at those parts of the country with worse health outcomes and high levels of deprivation, we find they have fewest primary care clinicians. This also means that GPs in deprived areas tend to be spread more thinly and be more stretched than colleagues elsewhere. Amongst other problems, this can make it difficult for patients to book convenient appointments. Where there are fewer GP practices, this also gives the local public less choice (or no choice) over which practice they register with.

This is not a new problem but one that has persisted since the inception of the NHS and one that has been the subject of many attempts by past Governments to attract more GPs to work in these areas.

The interim report of the NHS Next Stage Review, "*Our NHS, Our Future*", acknowledged these issues and committed to improving access to primary care for those living in more disadvantaged or deprived areas. This also means making services more personal and designing them to fit with people's often busy lives.

The interim report set out a number of commitments to make services more equitable and to ensure patients have real choice. These included a commitment to invest extra resources to bring new GP practices into the 25% of PCTs with the greatest need for extra primary care and to develop GP-led health centres in all PCTs.

NEW GP PRACTICES

We subsequently developed a set of criteria to identify the 25% of PCTs that should benefit from investment in new GP practices. The main criterion was the number of GPs and practice nurses per head of population, but the criteria also gave some weight to health outcomes and to patient satisfaction with access to GP services. These criteria were developed in consultation with SHAs and PCTs to help make sure that we targeted additional investment on those areas where it is most needed.

Annex A sets out the 38 PCTs (25% of all PCTs) identified as having the greatest needs. These PCTs will between them be procuring the hundred new GP practices to which the Government committed in the interim report.

These new practices will not only increase the availability of primary care services in places that need it most. They will also all have extended opening hours, wide practice boundaries to give the local public greater choice of which GP practice they register with, and will have a particular focus on reaching out to local communities to promote good health.

HEALTH CENTRES

The additional investment is also being used to enable all PCTs to develop additional primary care services for their area that will be based in GP-led health centres. These health centres will be open from 8.00 am till 8.00 pm, seven days a week. They will include GP services that offer both bookable appointments and walk-in services, both for patients who want to register with the health centre (as their local GP practice) and for patients who are registered with other GP practices but would benefit from also being able to use these new services (eg commuters). In most cases, these core GP services will be co-located and increasingly integrated with other community based services, such as pharmacy, urgent care, dental services, diagnostic facilities, and social care.

INVESTMENT

On 10 October the Secretary of State for Health announced a package of new financial investment to support PCTs in developing these new GP practices and health centres. Over the five years from 2008–09 to 2012–13, this investment will total over £1 billion (£60 million in 2008–09, £200 million in 2009–10 and £250 million annually thereafter).

LOCAL FLEXIBILITY

This investment is designed to help the NHS new services that are responsive to local needs, increase patient choice and promote innovation. The Department has established a small number of core features that we expect PCTs to reflect in their specifications for these new services.

In the case of GP practices, we would typically expect the practice to have the capacity to service a registered list of at least 6,000 patients, to offer extended opening hours, to have wide practice boundaries, to be fully engaged in practice based commissioning, and to plan to be a training practice.

In the case of health centres, we have indicated that the centres should be in easily accessible locations, be open from 8.00 am to 8.00 pm, seven days a week, provide services for both registered and non-registered patients, and offer both bookable GP appointments and walk-in services. We have also indicated that PCTs should maximise opportunities to integrate and co-locate these core GP services with other community based services such as pharmacy services, diagnostic services and social care.

Beyond these core requirements, it is for PCTs to develop the specifications for these services locally, in consultation with the public and with local clinicians. We are looking to PCTs to identify how best to use the investment to improve access to primary care, promote more integrated services for patients, and achieve a stronger focus on promoting health and reducing health inequalities.

OPEN AND TRANSPARENT PROCUREMENTS

We have asked PCTs to undertake open and transparent procurements for these new primary care services. This is to ensure that the fullest possible range of potential service providers are able to put forward innovative proposals, including existing GPs, voluntary and third sector organisations, and independent sector organisations. PCTs will award contracts to those providers who can offer both high quality services and value for money.

Annex A

<i>Rank</i>	<i>PCT</i>	<i>SHA</i>
1	Manchester PCT	North West SHA
2	Barking and Dagenham PCT	London SHA
3	Knowsley PCT	North West HSA
4	Sandwell PCT	West Midlands SHA
5	Wolverhampton City PCT	West Midlands SHA
6	Heywood, Middleton and Rochdale PCT	North West HSA
7	Liverpool PCT	North West SHA
8	Sunderland Teaching PCT	North East SHA
9	Birmingham East and North PCT	West Midlands SHA
10	Halton and St Helens PCT	North West SHA
11	Heart of Birmingham Teaching PCT	West Midlands SHA
12	Barnsley PCT	Yorkshire and The Humber SHA
13	Leciester City PCT	East Midlands SHA
14	Oldham PCT	North West HSA
15	Blackburn with Darwen PCT	North West SHA
16	Stoke on Trent PCT	West Midlands SHA
17	Hounslow PCT	London SHA
18	Hull PCT	Yorkshire and The Humber SHA
19	Nottingham City PCT	East Midlands SHA
20	Blackpool PCT	North West SHA
21	Ashton, Leigh and Wigan PCT	North West SHA
22	Dudley PCT	West Midlands SHA
23	Bolton PCT	NorthWest HSA
24	Greenwich Teaching PCT	London HSA
25	Sefton PCT	North West HSA
26	Medway Teaching PCT	South East Coast SHA
27	Salford PCT	North West SHA
28	Hartlepool PCT	North East SHA
29	Tameside and Glossop PCT	North West HSA
30	Walsall Teaching PCT	West Midlands SHA

<i>Rank</i>	<i>PCT</i>	<i>SHA</i>
31	Newcastle PCT	North East SHA
32	Redcar and Cleveland PCT	North East SHA
33	South Tyneside PCT	North East SHA
34	Calderdale PCT	Yorkshire and The Humber SHA
35	North Lancashire PCT	North West SHA
36	Luton Teaching PCT	East of England SHA
37	Havering PCT	London SHA
38	Hammersmith and Fulham PCT	London SHA
