Key messages

Review of the new General Medical Services contract

Prepared for the Auditor General for Scotland
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Auditor General for Scotland

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Note:
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Key messages

Background

1. General practitioners (GPs) are the first point of contact with the NHS for the majority of patients and, on average, patients see their GP three times a year.[1] In 2007, there were 4,721 GPs and 1,030 GP practices across Scotland.[2] Most GPs are independent contractors who provide services to the NHS.

2. The new General Medical Services (nGMS) contract was introduced on 1 April 2004 as previous contracts were considered no longer fit for purpose. It is a UK-wide contract with minor differences negotiated by each of the four UK health departments. The British Medical Association's (BMA) General Practitioners' Committee and the NHS Confederation (representing the four UK health departments) carried out negotiations.

3. The main aims of the nGMS contract are to:

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

4. The nGMS contract is a contract between the NHS board and the GP practice. Previous GP contracts were with individual GPs. By 2007 in Scotland 904 practices (88 per cent) had nGMS contracts. There are also two other contracts for general medical services in Scotland: GP practices directly managed by the NHS board; and Primary Medical Services practices which specifically agree the detail of the contract with their NHS board.

5. The cost of providing general medical services in Scotland has risen by 40 per cent over the last four years.[3 4] The average net income of nGMS GPs in Scotland increased by 38 per cent from £65,180 in 2003/04 to £90,127 in 2005/06.[5 6 7]

The study

6. Audit Scotland has reviewed how the nGMS contract has been implemented in Scotland. We examined a range of issues, including:

- the approach taken by the Scottish Executive Health Department (SEHD) and NHS boards to plan and implement the nGMS contract
- the cost of the nGMS contract
- the effect of the new contract on patients, GPs and the wider NHS
- arrangements for monitoring and managing the nGMS contract.

Key messages

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

7. From 2003/04 to 2006/07, the cost of general medical services rose by 40 per cent – from £503.9 million to £706.1 million.[8 9] This compares with a 27.6 per cent increase in the net operating expenditure of the NHS in Scotland over the same period.[10] The greatest rise in spending was between 2003/04 (the year before the introduction of the nGMS contract) and 2004/05 (Exhibit 1, overleaf).

8. From 2004/05 to 2006/07, NHS boards have spent £160.4 million more on general medical services than the funding allocated by the SEHD. This additional cost has been funded from NHS boards' unified budgets (Exhibit 1, overleaf).

1 Information Services Division (ISD) Practice Team Information. http://www.isdscotland.org/isd/3675.html
2 ISD workforce statistics, published 29 January 2008. http://www.isdscotland.org/workforce
3 *Gross Investment Guarantee (GIG) Monitoring Report – Final figures for 2003/04-2005/06*, NHS Information Centre, 2007.
4 *Primary Medical Services Payments for 2006/07: Scotland Audited Outturn*, NHS Information Centre Technical Steering Committee, 2008.
5 *GP Earning and Expenses Enquiry 2003/04, Final Report*, NHS Information Centre, March 2006.
6 *GP Earnings and Expenses Enquiry 2005/06, Initial Report*, NHS Information Centre, October 2007.
7 GP income based on self-assessment income tax return to HM Revenue and Customs.
8 *Gross Investment Guarantee (GIG) Monitoring Report – Final figures for 2003/04-2005/06*, The NHS Information Centre, 2007.
9 *Primary Medical Services Payments for 2006/07: Scotland Audited Outturn*, NHS Information Centre Technical Steering Committee, 2008.
10 *The Costs Book*, ISD, 2003/04 and 2006/07.

Exhibit 1

Cost of general medical services

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

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

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

9. The nGMS contract is made up of a number of different elements (Exhibit 2). Core funding is allocated through the **global sum** to provide the essential services expected of general practice. As part of contract negotiations a **correction factor** was agreed to ensure that no practice was disadvantaged as a result of the introduction of the contract. In practice this meant that the core GP income remained based on historical income, which has limited NHS boards' ability to target funding at deprived, rural or remote areas.[11]

10. The nGMS contract has cost more than expected. This is partly due to a lack of data on activity and costs of general medical services. Funding available for the incentive payment system for quality (the **Quality and Outcomes Framework – QOF**) was reduced during negotiations to help fund the correction factor within the overall funding arrangements. GPs also went on to attain higher levels under the QOF than the SEHD had expected or funded.

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

12. The average cost per registered patient of nGMS practices varies across Scotland and has increased from £112.24 per annum in 2004/05 to £123.12 per annum in 2006/07 in cash terms (Exhibit 3, page 4).[12]

13. Average costs tend to be higher in remote and rural areas, with the island boards having the highest costs.

14. Under the nGMS contract GP practices must provide essential services to patients but can choose to opt out of providing certain other services including out-of-hours services. Prior to the introduction of nGMS many GPs had already delegated out-of-hours provision to a third party, typically an out-of-hours co-operative.[13] The out-of-hours opt out has added to cost pressures for NHS boards, which have to find other ways of delivering the service, particularly those in remote or rural areas. This is the subject of a previous Audit Scotland report.[14]

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

15. Delivering improved services for patients was one of the key aims of the contract, specifically the aim of having more services delivered in primary care and closer to the patient's home. Eleven NHS boards believe that patient care within the board has improved as a result of the nGMS contract.

11 The global sum and correction factor together are known as the Minimum Practice Income Guarantee (MPIG).
12 Registered patient populations are from Community Health Index (CHI) extract, Practitioner Services Division (PSD).
13 *Primary care out-of-hours services*, Audit Scotland, August 2007.
14 Ibid.

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

17. Achievement of the 48-hour access target is not being measured. To meet the requirements of the 48-hour access target, GP practices must demonstrate that they have arrangements in place which support achievement of the target. They do not need to demonstrate that they are actually achieving the target. Better monitoring of access to general practice is required.

18. The new contract was intended to introduce better measures of performance and quality in primary care. Prior to 2004, funding for general practice was based primarily on the number of GPs with almost no funding linked to performance or quality. Under nGMS the QOF awards funding where practices can demonstrate that they have achieved certain quality measures.

Exhibit 2

Components of the nGMS contract

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

Services		Practice income
Essential services Treatment of those who are ill or believe themselves to be ill. **Additional services** Additional services are those that a practice is expected to provide for the local population. These are: cervical screening, contraceptive services, vaccinations and immunisations, childhood vaccinations and immunisations, child health surveillance, maternity medical services and minor surgery.	→	The **global sum** is a needs-based calculation for each practice to cover essential and additional services. The **correction factor** acts as a safety net and protects the elements of GP income which were paid under the old contract so no practice loses core income under the nGMS contract.
Enhanced services Enhanced services are either medical services that are not included as essential or additional services, or they are essential or additional services provided to an enhanced level of service provision. GP practices can choose to provide enhanced services if commissioned by an NHS board. Enhanced services are either: • Directed – NHS board must deliver these services and provide them to a UK or Scottish specification. • National – NHS board chooses to provide service to UK defined specification. • Local – NHS board designs and specifies service to meet local need.	→	Payment rates for national and directed enhanced services are set nationally. Payment rates for local enhanced services are set locally by NHS boards.
Quality and Outcomes Framework (QOF) The QOF is a quality incentive scheme for GP practices. It offers financial rewards for achieving quality and activity targets by awarding points linked to four areas: clinical, organisational, additional services and patient experience.	→	**QOF payments** are calculated based on achievement but are weighted by population and disease prevalence.
Potential reductions in practice income If GP practices decide not to provide additional services their global sum payment is reduced by a set amount. For example, a practice opting out of providing maternity medical services will have its global sum reduced by 2.1 per cent.	←	

Source: Audit Scotland, 2008

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

20. Although achievement of QOF indicators is likely to lead to long-term health improvements, it is too early to show demonstrable benefits in health from the QOF. However, academic research has shown that achievement of quality indicators (eg, to reduce cholesterol) will improve the health of practice populations if the quality of care is maintained.[15]

21. The QOF and the mechanisms GP practices have had to put in place to deliver it have had a positive impact on some other conditions that are not part of the QOF. This includes the recording of alcohol status which, although not part of QOF, is also being recorded more routinely.[16]

22. The average nGMS practice achievement in Scotland for QOF has risen from 92.5 per cent of points available in 2004/05 to 97.1 per cent in 2006/07. Achievement peaked at 97.7 per cent in 2005/06, but decreased in 2006/07 due to changes in the indicators and points available.[17] There is scope for the UK health departments and the BMA to renegotiate the indicators annually and this is essential to ensure value for money in the future.

Exhibit 3

Average costs per nGMS practice registered patient

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

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

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

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

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

24. The introduction of enhanced services is an important lever for developing services in primary care. Under the nGMS contract, NHS boards can negotiate with GP practices for the provision of services which are considered to be in addition to the range of essential services already being delivered. These enhanced services may require specialist expertise and fall into one of three categories: directed, national or local.

25. The SEHD put in place a minimum level of expenditure that it expected NHS boards to spend on enhanced services in the first three years of the

15 *Will changes in primary care improve health outcomes? Modelling the impact of financial incentives introduced to improve quality of care in the UK*, McElduff, Lyratzopoulos, Edwards, Heller, Shekelle and Roland, Quality and Safety in Health Care, 13:191-197, 2004.
16 *Measuring quality in primary medical services using data from Spice*, R Elder, M Kirkpatrick, W Ramsey, M MacLeod, B Guthrie, M Sutton, G Watt, NHS QIS, NHS NSS, July 2007.
17 ISD QOF web pages. http://www.isdscotland.org/qof

contract. Across Scotland, spending has exceeded this minimum level increasing from £45.6 million in 2004/05 to £57.1 million in 2006/07. This indicates that many NHS boards are beginning to introduce a range of enhanced services.

26. On average, NHS boards have invested 32 per cent above the minimum allocation on enhanced services in 2006/07.

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

27. The number of GPs in Scotland has risen from 4,456 in 2004 to 4,721 in 2007.[18] However, since the implementation of the new contract there is a lack of comprehensive data on staff numbers, workload and activity in GP practices. The NHS does not know the number of GPs, full or part-time, by NHS board. The Scottish Government collects some workforce data through the annual Primary Care Workforce Survey. This is a voluntary survey, therefore the data available depends upon the number of GP practices submitting data.

28. The lack of data on GP practice staff does not allow robust workforce planning at a national or local NHS board level. However, we do know that the new contract has addressed the issues that previously caused most dissatisfaction to GPs. Satisfaction levels increased from 56 per cent in 2001 to 75 per cent in 2006, with the main reasons given as better pay and working hours.[19]

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

30. The number of salaried GPs in Scotland, either within GP practices or employed by NHS boards (including those just carrying out out-of-hours services) has increased by 117 per cent since the implementation of the nGMS contract, from 188 in 2004 to 408 in 2007.[20] The use of salaried GPs has provided flexibility in providing services to remote, rural and deprived areas.

31. Although there are limited monitoring data at a national level, there are signs that the nGMS contract is beginning to change the way that people work within GP practices.

32. Information Services Division (ISD) collects practice team information (PTI) from a small sample of practices in Scotland (45 practices in 2006/07). These practices are broadly, but not completely, representative of the Scottish population in terms of age, gender, deprivation and urban/rural mix. They give an indication of what is happening within practices, in the absence of more comprehensive data. PTI data suggest that practice nurses are undertaking an increasing number of consultations with patients. Practice nurses carried out 32.6 per cent of all GP practice consultations (practice nurses and GPs) in 2006/07 compared to 29 per cent in 2003/4.[21]

33. National monitoring of the impact of the nGMS contract on other parts of the NHS, such as hospitals, needs to improve. Without this information, planning and the reallocation of resources is harder to manage.

34. The broader impact of the new contract is not fully understood, specifically the effect on the Scottish Ambulance Service and NHS 24. NHS 24 reports that it is experiencing peaks in unscheduled care activity in the early evening but the cause of this is not clear. The impact of changes to general medical services on the Scottish Ambulance Service and NHS 24 must be monitored, as there will potentially be an impact on the cost and activity of these services.

Key recommendations

The Scottish Government should:

- collect robust data before implementing major schemes so that it can base decisions on accurate information
- review the impact of the nGMS contract on referrals and prescribing rates in clinical areas covered by the QOF to inform the future development of the nGMS contract
- collect monitoring data on the effect of recent changes on the workload of NHS 24 and the Scottish Ambulance Service
- continue to improve the contribution of QOF to patient care and to achieve value for money by moving from a focus on processes to a greater focus on outcomes.

The Scottish Government and NHS boards should:

- monitor the investment by NHS boards in enhanced services to make sure that they achieve value for money and meet local needs
- collect comprehensive data on GP and GP practice staff numbers to support workforce planning at a national and local level.

18 ISD workforce statistics, published 29 January 2008. http://www.isdscotland.org/workforce
19 *Changes in job satisfaction, work commitments and attitudes to workload following contractual reform*, French, Geue, Ikenwilo, Needham, Rooke, Skatun, Sutton, December 2006.
20 ISD workforce statistics, published 29 January 2008. http://www.isdscotland.org/workforce
21 ISD Practice Team Information. http://www.isdscotland.org/pti

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