



House of Commons
Committee of Public Accounts

**The Provision of Out-of-
Hours Care in England**

Sixteenth Report of Session 2006–07

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

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The Committee of Public Accounts

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Summary

Approximately 9 million patients receive urgent primary out-of-hours care in England every year. The term out-of-hours care refers to care delivered between 6:30 pm and 8:00 am on weekdays and at all times during weekends and public holidays.

Prior to April 2004 GPs were responsible for the provision of this care, but most provided the service either by pooling their responsibility through a GP co-operative or delegating it to a commercial deputising service. Responsibility for this service had become unpopular with GPs and there were rising levels of complaints from patients. With effect from April 2004 the Department of Health gave GPs the chance to opt out of personal responsibility for the service under a new General Medical Services contract agreed with the medical profession. Where a GP opted out, he or she gave up an average of £6,000 per year and the local Primary Care Trust took over responsibility for the out-of hours service for the GP's patients.

On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department on three main issues: the Department's preparation for the new out-of-hours service; the performance of the new service; and its costs.¹

We found that preparations for the new service were shambolic, both at the national and local level. The Department took part in the negotiation of the new General Medical Services contract only as an observer, and only the doctors did well out of the deal on out-of-hours costs. The Department also failed to explain whether the service should be for urgent care or all unscheduled health needs.

The new service is undoubtedly now starting to improve. But actual performance against the key access targets is still not good enough. The percentage of providers meeting the requirements for call answering, definitive clinical assessment and consultation times is extremely low. For example only 2% could report that they complied with one standard. Some providers were simply unable to report at all. The cost of the new out-of-hours service has also been some £70 million a year higher than foreseen.

Conclusions and recommendations

1. **The Department of Health (the Department) failed to make clear whether it regarded out-of-hours care as an urgent or unscheduled service.** It was therefore difficult for Primary Care Trusts to plan or commission services according to the type and volume of demand for out-of-hours care. The Department needs to decide which kind of service it wants to provide, and give Primary Care Trusts a definitive statement so that they can plan or commission services for the future.
2. **The new contract allowed GPs to opt out of responsibility for the out-of-hours service at an average cost of £6,000, less than half of the cost to the Primary Care Trust of providing the service.** This sum was the outcome of a negotiation which was not rigorously conducted by the Department, and which was based on a serious under-estimate of Primary Care Trusts' likely costs. In future negotiations the Department needs to improve value for money for the taxpayer by being a lot better informed on the likely impact of decisions under consideration.
3. **By acting as an 'observer' in the new General Medical Services contract negotiations, the Department was poorly placed to achieve the best outcome for taxpayers.** Although the Department ultimately approved the outcome of negotiations, their importance meant that it was not enough for the Department simply to observe the negotiations that were being conducted by the NHS Confederation. To reflect its accountability for the cost, the Department should be a principal in future contract negotiations.
4. **Inadequate performance measurement means that some Primary Care Trusts do not know how good a service they are providing for their patients.** Two thirds of Primary Care Trusts taking on out-of-hours services in 2004 found that management information on the service either did not exist or was of poor quality. Primary Care Trusts should report their performance against all of the Quality Requirements.
5. **Quality Requirements relating to access are of most interest to patients, but performance against them is poor.** Fewer than half of all Primary Care Trusts are meeting the required standard on measures of speed of access to advice and treatment because of the combination of inadequate performance measurement and poor performance. Primary Care Trusts should improve their performance against all these measures, with priority given to Quality Requirements (9a, 10a, 12a and 12b) relating to emergency and urgent cases. They should, for example, plan out-of-hours staffing levels to match the peaks and troughs of demand.
6. **Primary Care Trusts remain unclear whether they and their providers should aim for 95% or 100% compliance with the Quality Requirements.** In order for Primary Care Trusts to know on what basis to commission and performance manage services, the Department needs to make clear what level of compliance is acceptable.
7. **It did not occur to the Department that ending GPs' Saturday morning surgeries would reduce the service at a key time of the week for patients.** The Department should encourage Primary Care Trusts to use the contractual arrangements for

primary care at their disposal to re-instate Saturday morning surgeries where there is the demand for them.

8. **The £70 million gap between departmental allocations for out-of-hours services and actual expenditure has forced many Primary Care Trusts to incur further deficits or raid other parts of their budgets in order to maintain a safe out-of-hours service for their patients.** The Department should rigorously evaluate the financial impacts of proposed initiatives in advance, for example by forecasting the likely impact on pay rates that might be caused by changes in a service, so that they do not unintentionally lead to deficits or adversely affect other services provided by Primary Care Trusts.
9. **Comparisons between Primary Care Trusts suggest that many could reduce their out-of-hours costs without diminishing quality.** If every Primary Care Trust provided its service at the same cost as the most cost-effective in their classification £134 million could be saved, while £53 million could be saved if the most expensive 50% of Primary Care Trusts reached the average performance level in each category.² The Department should set a timetable for Primary Care Trusts to benchmark their services against their peers, require Strategic Health Authorities to report on their performance, and hold to account Primary Care Trusts whose costs remain seriously out of line.

2 C&AG's Report, paras 4.19, 4.20

1 The Department of Health's preparation for the new service

1. Each year, approximately 9 million patients receive urgent primary out-of-hours care in England. The term 'out-of-hours' refers to care delivered between 6:30 pm and 8:00 am on weekdays and at all times during weekends and public and bank holidays.³

2. Out-of-hours services are provided by a range of organisations, including in-house Primary Care Trust teams, GP co-operatives, mutual organisations⁴, commercial deputising services, ambulance services and NHS Direct. Treatment options include advice over the telephone, face-to-face clinical assessments at out-of-hours clinics, and home visits. These services are provided by a range of professionals, including doctors, nurses, paramedics and emergency care practitioners, depending on clinical need and the nature of the service. All services must meet a series of standards, known as Quality Requirements, mandated by the Department of Health. The Quality Requirements cover response times, clinical audit, organisational elements, information flows and patient feedback.⁵ More frequent users of the service include women, those with one or more children under 16 in their household and those aged between 35 and 54.⁶ A survey of Primary Care Trusts by the National Audit Office during 2005–06 showed likely spending in 2005–06 of £392 million compared with a budget of £322 million.

3. Prior to April 2004 GPs were responsible for the provision of out-of-hours services, but most provided the service either by pooling their responsibility through a GP co-operative or by employing a commercial deputising service. During the last decade, responsibility for this service became increasingly unpopular with GPs and the number of complaints from patients rose. In the new General Medical Services contract that came into effect in 2004 the Department therefore gave GPs the chance to opt out of personal responsibility for providing the service. Where GPs opted out, responsibility passed to the local Primary Care Trust, although many GPs remained involved in the delivery of out-of-hours care, working for Primary Care Trusts or for service providers appointed by Primary Care Trusts. The new contract allowed GPs to opt out of their out-of-hours responsibilities from 1 April 2004. If Primary Care Trusts were not ready to take on responsibility at that point, they could defer the transfer until a final deadline of 1 January 2005.⁷

Support to Primary Care Trusts

4. The Department provided a range of guidance for Primary Care Trusts before the handover of the service. For example, new guidance was published in 2003, an Exemplar Programme was created to pilot new ways of working, 11 regional centres were established

3 C&AG's Report, para 1.1

4 Mutual organisations are GP co-operatives organised on a community ownership model—C&AG's Report, para 5.1 and Figure 12

5 C&AG's Report, para 1.6 and Appendix 5

6 C&AG's Report, para 3.19

7 C&AG's Report, paras 1.2, 1.3, 1.8, 5.6

to spread good practice, and a template to aid performance monitoring and reporting was distributed around providers. Despite the range of guidance provided, however, many Primary Care Trusts encountered difficulties in establishing new services because of time constraints and a lack of information to inform the planning of services. Many providers had difficulties in using the template designed to aid performance monitoring and reporting, and only 25 Primary Care Trusts actually used it. In light of this experience, the Department decided to re-examine common reporting processes. Although variable outcomes are likely in a system with 300 Primary Care Trusts, the Department accepted that it should have provided more practical support to all Primary Care Trusts.⁸

5. A key difficulty for Primary Care Trusts in their preparation for the handover was ongoing confusion over whether the new service should provide ‘unscheduled’ care to treat all patients that required attention, or restrict access to ‘urgent’ cases and ask all others to see a GP in-hours the next day. The Department wanted the public to be able to choose which service they want to use, and its aim during the handover was not to restrict access for patients but to advise them on how they could receive the most appropriate care or advice. It had not defined whether out-of-hours should be urgent or unscheduled, either at the time of the handover or in the contract negotiations, but has since recognised that it needed to do so.⁹

The shape of the new service

6. The handover resulted in the service being delivered by a range of providers from both private and public sectors. The Department was keen to encourage plurality of provision; it saw an important ongoing role for the voluntary, private and independent sectors as well as the NHS, and wanted everyone so far as possible to be able to participate. The Department was also keen to encourage greater movement towards the integration of all unscheduled and urgent care services, including Accident & Emergency, out-of-hours services, district nursing and ambulance services.¹⁰

7. Primary Care Trusts were not required to run competitive tenders, and only 39% did so. The price of the service being paid by Primary Care Trusts that tendered was only 29 pence per head of population lower than that paid by those who did not tender, and quality standards did not vary at all. In many instances the specifications had been written by providers, however, and there was a favouring of local co-operatives. The Department’s view was that more competition was needed.¹¹

8. Out-of-hours providers have increasingly used nurses and other health professionals to work with GPs in out-of-hours services. The increased use of nurses has been seen as a way of making services more cost-effective. Whilst GPs remain essential, nurses can handle many aspects of out-of-hours care.¹²

8 C&AG’s Report, paras 2.2, 2.7, 3.28; Qq 97–9

9 C&AG’s Report, para 2.3–2.5; Qq 16–17, 22–24

10 C&AG’s Report, paras 1.6, 5.1; Figure 12, 13; Qq 124, 185–187

11 C&AG’s Report, paras 2.15, 2.16; Qq 182–184

12 Q 190

2 The performance of the new out-of-hours service

Performance against the Quality Requirements

9. Before April 2004, Primary Care Trusts did not deliver or manage out-of-hours services. When taking on this responsibility in 2004, two-thirds found that the management information they could obtain on the service was of poor quality or simply not available. The Department's management information arrangements therefore started from a very poor information base, although the Department has since been expanding its information base to help inform how the service will be taken forward in the future.¹³

10. In 2000, the Department commissioned a review of out-of-hours care, known as the 'Carson Review'. The review identified ways of assuring quality in out-of-hours services and made 22 recommendations to improve those services, all of which were accepted by the Department. Recommendation 21 stated that by April 2001 out-of-hours providers should start to report on performance against quality standards, but only some did, and those that did report did not do so in a consistent way.¹⁴

11. New standards were introduced from January 2005, when out-of-hours providers were required to meet national Quality Requirements established by the Department. The Quality Requirements were widely agreed by providers and commissioners to be an improvement on their predecessors. There was, however, confusion over whether providers and commissioners should aim for 100% compliance with the Quality Requirements or whether a lower level of compliance, such as 95%, could suffice, which the Department intended to clarify.¹⁵

12. Actual performance against the Quality Requirements was poor, and reporting against the targets incomplete. For example, a third of Primary Care Trusts were unable to say what their performance had been against the target to start a definitive clinical assessment within 20 minutes following an urgent phone call and fewer than 10% of Primary Care Trusts were able to say that they had fully met the target. Some Primary Care Trusts lacked equipment to monitor their performance, for example, in handling telephone calls, although the IT equipment needed to do so exists and could have been obtained.¹⁶

13. **Figure 1** sets out the performance of all Primary Care Trusts against those Quality Requirements relating to access to advice and treatment. The Department accepted that there was a need to improve in three main areas: in making a clinical assessment; in call handling; and in face-to-face consultation. The Department expected Primary Care Trusts to address areas where their performance fell short of the targets, and local Strategic Health

13 C&AG's Report, para 2.1; Qq 14, 65–7

14 C&AG's Report, para 1.5; Qq 75–6

15 C&AG's Report, para 3.4; Qq 106, 19–121, 207

16 Qq 106–108, 114–115

Authorities were responsible for investigating Primary Care Trusts that did not do so. The Department also intended to review the Quality Requirements.¹⁷

Figure 1: Performance against the Quality Requirements

Quality Requirements	Percentage Meeting Requirement at 100%
8c Answer calls within 60 seconds of message	2
8d Answer calls within 30 seconds if no message	5
9a Start definitive clinical assessment for urgent calls within 20 minutes	8
9b Start definitive clinical assessment for other calls within 60 minutes	9
9c Where no prioritisation system, start definitive clinical assessment within 20 minutes	13
10a Start definitive clinical assessment for urgent arrivals within 20 minutes	23
10b Start definitive clinical assessment for other arrivals within 60 minutes	19
10c Where no prioritisation system, start definitive clinical assessment within 20 minutes	19
12a Emergency face-to-face consultation at centre within 1 hour	15
12b Urgent face-to-face consultation at centre within 2 hours	15
12c Less urgent face-to-face consultation at centre within 6 hours	24
12d Emergency face-to-face consultation at home within 1 hour	21
12e Urgent face-to-face consultation at home within 2 hours	13
12f Less urgent face-to-face consultation at home within 6 hours	24

14. The high numbers of Primary Care Trusts unable to measure or report performance has made effective performance management difficult, and the inability to provide data remained a key problem for Primary Care Trusts. Some Primary Care Trusts have had problems with their IT systems, especially call management technology. However, technology to address this latter challenge existed and could be rolled out wherever financial constraints allowed. Some Primary Care Trusts struggled with definitions of key terms, including the concept of definitive clinical assessment, which the Department had committed itself to clarifying.¹⁸

Access to the service for patients

15. Saturday mornings were the time of peak demand for out-of-hours services, making it frequently difficult to meet access targets. There was also a peak on Sunday mornings. GPs had been allowed to opt out of these busy sessions as part of the new General Medical Services negotiations because of the aim of improving the recruitment and retention of GPs. However, the recent primary care White Paper suggested that more people wanted Saturday morning clinics and indicated that the Department would be introducing arrangements for Saturday morning and other evening clinics. Although some Primary Care Trusts found it difficult to meet Saturday morning access targets for out-of-hours care, those that made the right arrangements and planned appropriately did not.¹⁹

17 C&AG's Report, Figure 3; Qq 14, 78, 106, 116–118, 121

18 Qq 107–08, 116; C&AG's Report, para 3.8

19 C&AG's Report, para 3.15; Department of Health, *Our Health, Our Care, Our Say*, Cm 6737, January 2006; C&AG's Report, Appendix 2; Qq 31, 110–111

16. Four out of five respondents to the NAO's survey of users of the out-of-hours service said they were satisfied with the quality of their care. The Department considered these findings to be a reasonable reflection of its own assessment of the patient experience. Although the number of complaints has gone down since the introduction of the new service, the Department wanted to improve further on this performance.²⁰

3 The costs of the new out-of-hours service

The new General Medical Services contract negotiations

17. The new General Medical Services contract was negotiated during 2002 and 2003. The formal negotiations were conducted between the NHS Confederation, the NHS employers' organisation, and the GP Committee of the British Medical Association. In conducting the negotiations on behalf of the Department, the NHS Confederation received a mandate from the Government setting out parameters for the negotiation, in terms including outcomes or services to be provided, and resources. The actual outcomes of the negotiations came from the ebb and flow of discussions between the parties. However, the Department was an observer to the negotiations and approved the outcome reached.²¹

18. The new contract allowed GPs to opt out of responsibility for the out-of-hours service, at an average cost to them of £6,000 a year. The figure of £6,000 came from the negotiations and was not designed to reflect the full cost of providing the service. Since 1995 out-of-hours services have received additional central funding from an out-of-hours development fund, which in 2005–06 totalled £92 million. During 2005–06 the Department augmented its initial out-of-hours funding of an average of £9,500 per GP, including the £6,000 forgone by GPs, to an average of £10,700 after introducing new arrangements for commissioning NHS Direct.²²

19. The Department believed that new arrangements were good value for money because the contract was designed to secure better recruitment, retention and working arrangements for doctors. In the past three years GP numbers have increased by 3,000.²³

Breakdown of actual costs for the new service

20. The Department's allocation of funds to Primary Care Trusts for the new out-of-hours service took into account both the £6,000 forgone by GPs and the development funds previously provided to Primary Care Trusts. The figure of £6,000 for the opt-out sum had been widely used in the media and some Primary Care Trusts did not understand the difference between this amount and the initial out-of-hours funding sum of £9,500, despite the Department's programme to educate them.²⁴

21. The total allocated by the Department to Primary Care Trusts for out-of-hours in 2005–06 was £322 million. However, the National Audit Office's survey of Primary Care Trusts in September and October 2005 showed likely actual spending in 2005–06 of £392 million, £70 million over the allocated amount.²⁵

21 Qq 40–45; Ev 21

22 C&AG's Report, paras 1.8, 4.10 and 4.12; Qq 43, 218–226

23 C&AG's Report, para 1.8; Qq 31–42, 112

24 C&AG's Report, para 4.6; Qq 14, 151–157

25 C&AG's Report, para 4.10, 4.12

22. The Department told us that Primary Care Trusts' outturn spending on out-of-hours services in 2004–05 was around £100 million more than allocated, and that in addition Primary Care Trusts spent around £150 million more than allocated on paying GPs under the new Quality and Outcomes Framework. The Department expected the outturn for 2005–06 to be broadly similar. However, increased allocations to Primary Care Trusts meant that the shortfall in funding that Primary Care Trusts needed to manage in 2004–05 was limited to £155 million. Altogether, spending was forecast to have risen by between 40 and 50% over the three years 2002–03 to 2005–6.²⁶

The prospects for making savings

23. The amount Primary Care Trusts reported that they spend per head of population on out-of-hours services varied widely between Primary Care Trusts. There was no correlation between cost and the quality of the service but some link to how rural or urban the Primary Care Trust was. If all Primary Care Trusts with a cost above the median for their type of area could reduce their cost per head to that of the median the result would be a reduction in total cost of some £53 million a year.²⁷

24. The Department intended to ask each Primary Care Trust to look at its costs in the light of best practices, using cost benchmarks. It was up to individual Primary Care Trusts to find these efficiencies and it was therefore not possible to put a precise figure on what savings could be made, but if Primary Care Trusts matched their benchmarks it would make a big difference. One important factor was the rates of pay agreed locally for GPs working in the out-of-hours service. For example, for one type of shift these varied between £19 and £114, and it was evident that in some cases GPs had driven a hard bargain. To support Primary Care Trusts in realising savings, the Department wrote to Primary Care Trusts on the day of publication of the National Audit Office report asking them each to review their position relative to others. Subsequently, the Department also reviewed its guidance on commissioning with the help of the National Audit Office, and hosted a conference with the National Audit Office for Primary Care Trusts and providers.²⁸ Looking forward, the forthcoming White Paper on urgent care represents one of many opportunities the Department has to make practical improvements to the out-of-hours service by implementing some of the Committee's recommendations.

26 Ev 20

27 C&AG's Report, Figures 1, 2; para 4.20

28 Qq 163–178; Ev 27

Formal Minutes

TUESDAY 27 FEBRUARY 2007

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Annette Brooke
Mr David Curry
Mr Philip Dunne
Helen Goodman

Mr Sadiq Khan
Mr Austin Mitchell
Dr John Pugh
Mr Don Touhig
Mr Alan Williams

Draft Report

A draft Report (The Provision of Out-of-Hours Care 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 24 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the sixteenth 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 until Wednesday 28 February at 3.30 pm.]

Witnesses

Monday 22 May 2006

Sir Ian Carruthers, OBE, Acting NHS Chief Executive, **Professor David Colin-Thomé**, National Clinical Director of Primary Care, **Mr Gary Belfield**, Head of Primary Care, Department of Health

Ev 1

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Oral evidence

Taken before the Committee of Public Accounts

on Monday 22 May 2006

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Greg Clark
Mr David Curry
Mr Ian Davidson

Mr Sadiq Khan
Mr Austin Mitchell
Mr Alan Williams

Sir John Bourn KCB, Comptroller and Auditor General, was in attendance, and **Mr Chris Shapcott**, Director, Health & PFI/PPP VFM, National Audit Office, was in attendance and gave evidence.

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

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

THE PROVISION OF OUT-OF-HOURS CARE IN ENGLAND (HC 1041)

Witnesses: **Sir Ian Carruthers, OBE**, Acting NHS Chief Executive, **Professor David Colin-Thomé**, National Clinical Director of Primary Care, **Mr Gary Belfield**, Head of Primary Care, Department of Health, gave evidence.

Q1 Chairman: Good afternoon. Welcome to the Committee of Public Accounts which today is considering the Comptroller and Auditor General's Report on *The Provision of Out-of-Hours Care in England*. We welcome Sir Ian Carruthers, acting NHS Chief Executive, Professor David Colin-Thomé, National Clinical Director of Primary Care, and Mr Gary Belfield, Head of Primary Care. Sir Ian, perhaps we can start by looking at the cost of all this. If you want the reference, this is dealt with on page 49, starting at paragraph 4.11. Why did the out-of-hours services in 2005–06 cost £70 million more than you had expected and allocated?

Sir Ian Carruthers: First, I think that the cost of the service was based on taking the £6,000 sums from the 30,000 GPs, which is £180 million, and supplementing it by further sums which represented the true cost. That was another £92 million and further sums were added to that. As outlined in the Report, one of the main driving factors was general practitioners' salaries. They were set locally and were variable, as the table in the Report says. The second matter that many PCTs cited was the additional cost of the quality monitoring arrangements. It is clear from the Report, however, that while the cost is greater there is much room for improvement. We are already acting on some of that, and many have already taken action to reduce that cost.

Q2 Chairman: The average opt-out sum of £6,000 was very low, was it not? PCTs are now spending an average of £13,000 on this service, are they not?

Sir Ian Carruthers: Yes. It is important to recognise that the £6,000 was a notional amount of income deducted from the income of general practitioners

who wished to opt out of the service and was part of the contract discussion. The actual cost estimate at the time for each GP was somewhere between £7,000 and £14,000 and because the data was not there the median was taken.

Q3 Chairman: The truth is that once again GPs have done extremely well out of this, have they not? Was it Aneurin Bevan who said that he could get through any reform by stuffing doctors' mouths with gold? That is precisely what you have done, is it not?

Sir Ian Carruthers: It is very clear that at the time this was part of the GPs' contract. It is fair to say that when we look at the contract it brought many benefits. The quality of the service has improved with the GP contract.

Q4 Chairman: It is patchy at best?

Sir Ian Carruthers: I think the contract itself has led to that.

Q5 Chairman: If as you claim it has improved why does it say in paragraphs 3.10 to 3.14 on pages 21 to 11 that so few PCTs are unable to say they are meeting the quality requirements set by the Department?

Sir Ian Carruthers: I think we need to go back to the time before the arrangements were introduced when there was a widespread belief that to continue as we were was not sustainable. There were many complaints; it was a burden to GPs; the Ombudsman—

Q6 Chairman: We used to have family doctors; we knew our GPs. It was a vocation. If you were ill very occasionally he would be prepared to come out.

Now they are not prepared to do it. If GPs did not want to do it they were quite capable of making their own arrangements, but, no, you had to step in. The result is that the taxpayer has to pay the price for it in a botched scheme. The scheme is costing us £70 million more a year. Very few PCTs can say whether they are meeting the quality requirements. To sum it up, it has been a costly mess, has it not? Our family doctor does not come to see us at night time.

Sir Ian Carruthers: As I said before, the previous arrangements were not sustainable. The quality standards are more exacting than those previously outlined. Looking at the National Audit Office Report, when compared with other comparators in the UK we fare well, as we do internationally. Our cost is lower per head than in Northern Ireland and Wales, but the support highlights that there are difficulties with standards. There are definitional problems as well as some difficulty in introducing the changes.

Q7 Chairman: What is the average GP earning at the moment in London?

Sir Ian Carruthers: I do not know what the average GP in London is earning.

Q8 Chairman: What is the national figure?

Sir Ian Carruthers: I will ask my colleague Professor Colin-Thomé who is a GP. He may declare his own earnings, but at least he will know.

Q9 Chairman: It is now virtually impossible to earn less than £100,000 a year as a GP, is it not?

Professor Colin-Thomé: I think the average is between £95,000 and £100,000.

Q10 Chairman: With some earning considerably more?

Professor Colin-Thomé: Yes, but a few are earning less. The average is about £100,000 which is approximately equivalent to our hospital colleagues.

Q11 Chairman: We read press reports that the cost of the new GPs' contract has been about £300 million. Is that right?

Professor Colin-Thomé: In terms of spending over the estimate?

Q12 Chairman: Yes.

Professor Colin-Thomé: It is about £250 million.

Q13 Chairman: You are now confirming that officially on behalf of the Department?

Professor Colin-Thomé: It is about £250 million, a significant amount of which arose because GPs did better on quality and outcomes which benefited patients hugely.

Q14 Chairman: Sir Ian, what about the management of information? If you look at pages 24 to 25, paragraphs 3.28 to 3.30, there are various gaps in the management information that is available to you, so how can you assess the quality and consistency of this service?

Sir Ian Carruthers: Obviously, it is difficult to do. There was no management information before. There are difficulties with the Adastra system in that we need common reports and nomenclature, as mentioned in the Report. This is one of the actions being taken to see how this can be improved. These arrangements started from a very poor information base and as time goes on we are able to collect more information which will inform how we take out of hours forward in the future.

Q15 Chairman: I should like a note on the full cost of GP contracts, and I should like it to be signed by you as the Accounting Officer, please.¹ If we look at paragraph 4.13 on page 29 it says: "Even for those PCTs who foresaw the need to top up the Department's allocations, the financial impact of this increase in cost has been considerable." Sir Ian, what is the impact of this new contract on other services?

Sir Ian Carruthers: I think it is difficult to predict because the choices are made locally by primary care trusts. It is also important to recognise that during this time, and the two-year period before, there have been substantial increases in the amounts allocated; they have grown from £44 billion to £49 billion, and this year to £53.9 billion. The costs are difficult to predict because there were local choices. They may not have been made for reasons of reduction, but they would be priority choices. The costs that we have, which we feel are appropriate, are as in the Report.

Q16 Chairman: What is the actual standard of care that is supposed to be provided? This is dealt with in paragraphs 2.3 to 2.5 on pages 13 and 14. Are they supposed to meet simply urgent need, or is this a 24-hour seven-day NHS provision which is available to everybody? What can we as the public expect to receive? It is unclear from the Report.

Sir Ian Carruthers: Again, I think this is an area for further action. One of the matters which we shall be looking at following the recently produced White Paper is our urgent care strategy and how we define it. Broadly speaking, the approach taken at the present time is that members of the public are able to contact the out-of-hours services. They have a choice between A&E, out-of-hours services, walk-in centres and NHS Direct. What we aim to do is advise them on how they can receive the most appropriate care or advice.

Q17 Chairman: Precisely the point you make is dealt with on page 23 at paragraph 3.20. How are the public to know which is the right service for them when there are so many options available? Previously, they did the rather old-fashioned thing of ringing up their family doctor.

Sir Ian Carruthers: I am sure that many people actually do that now and they are put through to the services, but we want the public to be able to choose what they feel is appropriate to their circumstances. Through telephone and other

¹ Ev 20-21

Sir Ian Carruthers, OBE, Professor David Colin-Thomé, Mr Gary Belfield and Mr Chris Shapcott

consultation assessment processes we will provide them with advice and support to get them to the right place. Everyone who needs it will see a doctor. We do not want to restrict the public, because for them when they are ill (deleted repetition “when they are ill”) they want access to the best information. We should develop an integrated system, which is one of our aims, as it would develop the existing arrangements.

Q18 Greg Clark: Sir Ian, perhaps we can start with a very basic question. This is a hearing on the provision of out-of-hours care in England. Is the out-of-hours provision supposed to be an urgent or unscheduled care service?

Sir Ian Carruthers: As I said before, there is a view which says that the Department of Health should define it.

Q19 Greg Clark: What is your view?

Sir Ian Carruthers: I can express only a personal view. I have said that this is one of the issues on which we shall take action.

Q20 Greg Clark: To be clear, the Department does not have a view as to whether the out-of-hours service is urgent or unscheduled provision?

Sir Ian Carruthers: At this stage we have not defined whether it is “urgent”. Generally, people understand “urgent” to mean care and treatment given there and then with an appointment maybe the next day.

Q21 Greg Clark: How could you negotiate a contract with GPs when you were not even aware whether or not this was a service dealing with urgent or unscheduled care, since clearly one will be used far more than the other?

Sir Ian Carruthers: The contract was based on a broader range of issues, which was to say that when people needed out-of-hours care they could access it by a range of different routes. The precise definitions of those two areas were not undertaken.

Q22 Greg Clark: You are the Accounting Officer of the Department and I know that you had predecessors, but if the Department was about to negotiate a contract why did it not decide that issue then rather than start to think about it now?

Sir Ian Carruthers: What we are saying is that we now recognise that it is an issue.

Q23 Greg Clark: But the specific question is: why did the Department not decide this before negotiating the contract?

Sir Ian Carruthers: I cannot answer that. What we are saying is that we recognise this is an issue to be addressed.

Q24 Greg Clark: Do you concede that it was wrong and you should have settled it before?

Sir Ian Carruthers: I am not saying it was wrong or right. The out-of-hours service was about replicating what was there previously. We have now got into definitional issues which we have indicated will be taken forward as part of the White Paper.

Q25 Greg Clark: These are not semantic issues, because the Report makes clear that commissioners and providers would like the Department to decide which kind of service they should provide. It is so basic it is scarcely believable that we are discussing it.

Sir Ian Carruthers: From the point of view of the public, they want the ability to obtain access either to advice and information or the services they need.

Q26 Greg Clark: I think that is rather obvious for a committee that is looking at value for money. Of course we want to give the public what they want, but in order to provide value for money it is essential to know what the contract is about and what it provides?

Sir Ian Carruthers: Yes, but value for money is about balancing two things, the actual sums involved and the service, and the view was taken not to restrict the service.

Q27 Greg Clark: Does the contract with GPs represent value for money?

Sir Ian Carruthers: Do you mean the GMS contract or the out-of-hours contract?

Q28 Greg Clark: The element relating to the buy-out of out-of-hours services. Is it good value for money?

Sir Ian Carruthers: I think that it was—

Q29 Greg Clark: In your view—yes or no—is it good value for money?

Sir Ian Carruthers: The answer is yes. The £6,000 deduction from income very much helped to improve some of the issues which were the nub of the contract and were about recruitment, retention, and different working practices and improved service quality.

Q30 Greg Clark: But we know from Sir John’s Report that doctors accepted a £6,000 reduction in income but the actual cost of providing the service was £13,000.

Sir Ian Carruthers: Yes.

Q31 Greg Clark: Yet this was good value for money?

Sir Ian Carruthers: It was good value for money in the context of negotiating the overall contract, because it was designed to secure the better recruitment, retention and working arrangements for doctors. Many doctors who have now had the contract adjustment come back and contribute to the out of hours service.

Q32 Greg Clark: So, this was a good deal?

Sir Ian Carruthers: In the overall context of the contract one can say that.

Q33 Greg Clark: The fact that 90% of doctors signed up delighted to be able to swap £13,000 worth of activity for £6,000 worth of sacrifice is coincidence?

Sir Ian Carruthers: Yes. It is important to see this in the wider context of the GMS contract. The contract also put in place a number of other matters, albeit

incentivised, to improve the quality of care. It is difficult to pick on one specific issue when it is part of a package of changes which have been agreed.

Q34 Greg Clark: You said that this contract was a good deal, but you expected that its cost would be £9,500. The Report said that you funded the system to the tune of that amount and yet it turned out to be £13,000. Is it still good value for money even though it is £3,500 more than you expected?

Sir Ian Carruthers: We allocated in addition to the £6,000 income further sums which covered rurality. That covered the £3,500. The implementation of this was undertaken at local level by primary care trusts which agreed different salary rates.

Q35 Greg Clark: Whatever was spent on this would be value for money?

Sir Ian Carruthers: No.

Q36 Greg Clark: At what level would it stop being value for money?

Sir Ian Carruthers: I think that is a judgment given the local context.

Q37 Greg Clark: I am interested in your judgment, Sir Ian.

Sir Ian Carruthers: I would not make a judgment because this was handled at local level. One matter I want to raise is a point mentioned in the National Audit Office Report, namely that if everyone worked to the ability of the best a sum of money would be saved which would be less than the allocation, and if 50% of the providers worked to that standard we would virtually be back within budget.

Q38 Greg Clark: But 90% worked to it?

Sir Ian Carruthers: No; it is 50% refers to the out-of-hours providers in contract with the others, and the GP figure is the other one.

Q39 Greg Clark: Did the Department take an active role in these negotiations which clearly are so crucial to all our constituents and the finances of the NHS?

Sir Ian Carruthers: The Department set the framework. The negotiations were undertaken by local primary care trusts. As the Report says, that was done either through competitive means or otherwise.

Q40 Greg Clark: Please turn to page 10, paragraph 1.8. It says that the new GMS contract was negotiated between the NHS Confederation and the GP Committee of the BMA and the Department acted as an observer. With such a crucial contract, is it right that the Department should have acted merely as an observer?

Sir Ian Carruthers: This is similar to other negotiations—where the NHS Confederation, which is the NHS employer's organisation, undertook the negotiations on behalf of the Department.

Q41 Greg Clark: So, the Department was a passive recipient of whatever deal was brokered, despite the fact that it would be paying the bills?

Sir Ian Carruthers: No. The Department and in particular Ministers set out some parameters.

Q42 Greg Clark: The Ministers set out the parameters for the negotiations?

Sir Ian Carruthers: I am sure that they set out parameters.

Q43 Greg Clark: So, the deal whereby £6,000 was given up in return for £13,000 worth of costs has come from Ministers?

Sir Ian Carruthers: It came from the negotiation which in the end was agreed by government.

Q44 Greg Clark: To be clear, this was the negotiating parameter given by Ministers?

Sir Ian Carruthers: I am not actually saying that; I am saying that parameters were given.

Q45 Greg Clark: Who gave them?

Sir Ian Carruthers: Ministers gave them, but the real position is that in a negotiation there is ebb and flow and this was the final agreement which was endorsed.

Q46 Greg Clark: The flow seems to have been all one way. Did you take the same approach with the consultants' contract, for example, or was the Department merely an observer to that negotiation?

Sir Ian Carruthers: The consultants' contract, as you are probably aware, was agreed in discussion with the NHS.

Q47 Greg Clark: Was the Department of Health a participant or observer in that negotiation?

Sir Ian Carruthers: I will have to give you a note to clarify that.² I am not quite sure whether at that time we had also handed over these negotiations to the NHS employers.

Q48 Greg Clark: Perhaps you would let us know. What about the dentists' contract? Was the Department an observer or participant in those negotiations?

Sir Ian Carruthers: The present arrangement—I shall ask colleagues to comment in a moment—is that NHS employers—

Q49 Greg Clark: But was the Department an observer or participant in the negotiations over the dentists' contract?

Sir Ian Carruthers: I do not know. We will come back with a note on that.³

Q50 Greg Clark: You were a senior figure in the Department before you took on your present duties?

Sir Ian Carruthers: No, I was not. I have been there for only three months, but that does not mean we cannot get this information. I believe that these contracts were dealt with very much earlier.

² Ev 21

³ Ev 22

Q51 Greg Clark: Is it surprising that there has not been transferred to you an institutional memory as to whether you participate in these contracts or just accept what the parties agree with each other, no matter what the cost?

Sir Ian Carruthers: Both of those were settled some time ago, but we will have to come back with a note about the role of the Department in agreeing contracts.

Q52 Greg Clark: This contract has already overrun by £70 million, as we know. Who is to pay for that?

Sir Ian Carruthers: The allocations which are made to primary care trusts have increased substantially—on average it is 9% or more—over the year.

Q53 Greg Clark: Because of this?

Sir Ian Carruthers: Not because of this.

Q54 Greg Clark: That was increasing anyway. I want to know where the unforeseen £70 million is coming from. Is it coming from PCTs' own budgets or essentially is it being reimbursed?

Sir Ian Carruthers: From PCTs' own budgets.

Q55 Greg Clark: Therefore, it is squeezing out other patient activity in which they would otherwise engage?

Sir Ian Carruthers: It is one of a series of choices that they will have to make.

Q56 Greg Clark: They do not have any choices at all, do they?

Sir Ian Carruthers: They have a choice about the salary rates they agree to pay general practitioners. Although the Report says many felt that they were unable to make choices because of the limited number of providers able to provide the service.

Q57 Greg Clark: Could they choose to do it for the amount it was costing them beforehand?

Sir Ian Carruthers: If they agreed it with their local general practitioners and had an acceptable service and supply, they could. The National Audit Office Report said that work should be done on this and we agree with that comment. Already some have taken action and reduced salary and other costs of out of hours services.

Q58 Greg Clark: They cannot do that, as you know, because the costs have been far higher than envisaged as a result of the contract. On my calculation, £70 million a year for PCTs means that 15,000 hip replacements or 80,000 cataract operations cannot be conducted. It sounds like a rather theoretical system of accounts, but these are real choices for our constituents. This means that 23 hip replacements per constituency are not being conducted because of the incompetence of this negotiation. Is it not the case that the doctors as a result of this negotiation are laughing all the way to the bank and patients are suffering because they are not getting the treatment that they otherwise would have done?

Sir Ian Carruthers: The point I am trying to make is that the PCTs do make choices. The fact that it is £70 million over and above the allocation arises largely because the wage rates agreed with GPs were high. They were matters for local determination. Some of that can be rectified by adjusting the rates. There are examples of good practice, and there are examples in Coventry, Dorset, Somerset and Hampshire, where they are already acting in bringing down some of the costs because it is felt they are high.

Q59 Mr Khan: Is it a fair summary that the *rationale* behind the changes was concerns raised by the Ombudsman and the media about the variation in the quality of service provided, problems of recruiting and retaining GPs, *et cetera*?

Sir Ian Carruthers: That would be a fair summary.

Q60 Mr Khan: Have the new arrangements helped to solve those problems?

Sir Ian Carruthers: To our knowledge, fewer complaints have been recorded. Four out of five people are now satisfied, which is a big change in perception. I know that four out of five is not as good as five out of five, and we want to improve upon that. Generally, the perception now is that it is very much better, and the Report highlights that when compared with international practice as we compare favourably with others.

Q61 Mr Khan: The impression I garner from reading the end of the NAO Report is that it could be said some of the problems that Mr Clark and others talked about could be paraphrased as “teething problems” and as the market matures one hopes things will improve. Is that also a fair summary?

Sir Ian Carruthers: I think it is a fair summary to say that there were teething problems. This Report was prepared a matter of months after the handover date. Many of those problems are being addressed.

Q62 Mr Khan: Part two of the Report deals with the commissioning process. Do you accept that, reading the NAO Report, the commissioning process was shocking?

Sir Ian Carruthers: I would not say it was shocking.

Q63 Mr Khan: You do not find shocking some of the things that are summarised in part two?

Sir Ian Carruthers: I think that there were lessons to be learned.

Q64 Mr Khan: You tasked organisations with no experience, a busy agenda, poor management information on which to base commissioning decisions and often they had only one person or group bidding for contracts and poor service specifications. I can go on, because there are another 12 complaints. You do not find that shocking?

Sir Ian Carruthers: I would not use that word.

Q65 Mr Khan: What word would you use?

Sir Ian Carruthers: I would say there were a lot of shortcomings, which is the word used by the National Audit Office. We need to remember that before that there was not an information base at all; we were starting with a blank sheet in that context. There were no quality requirements or providers.

Q66 Mr Khan: Would it be fair to accuse you of rushing in?

Sir Ian Carruthers: It is difficult to make changes at any point and to wait for the perfect situation.

Q67 Mr Khan: Was it worth taking the plunge at that stage?

Sir Ian Carruthers: At that stage the service was in difficulty and not sustainable. Although there were shortcomings that I agree should never be repeated—

Q68 Mr Khan: One of the matters which motivated the change was the Carson guidelines. Are you familiar with those?

Sir Ian Carruthers: Not in detail, but I know that my colleague will be.

Q69 Mr Khan: Professor Colin-Thomé, are you familiar with the 22 recommendations made by Carson?

Professor Colin-Thomé: I am, but I would have to look at the exact detail. If I may add a little bit of context, in 1995 GPs stopped being the personal family doctor model because the then Government realised there was a recruitment issue in general practice and they gave funding to do out-of-hours co-operatives. It was fairly rare for a GP personally to see his own patient.

Q70 Mr Khan: But if one lives out in the sticks one will probably find a family GP there?

Professor Colin-Thomé: Yes. I am still a family GP, but we did not do our own or be on call. That was common. Only about 5% of GPs were doing that. But in 2000 because of complaints about quality the Carson review took place and he came up with those 22 recommendations.

Q71 Mr Khan: Who monitors those?

Professor Colin-Thomé: PCTs are meant to manage those.

Q72 Mr Khan: Making a sweeping generalisation, how closely do you think they are being monitored by the PCTs?

Professor Colin-Thomé: I think that varies quite considerably.

Q73 Mr Khan: Making a sweeping generalisation, how closely have they been monitored?

Professor Colin-Thomé: I would not like to hazard a guess.

Q74 Mr Khan: Is it fair to say that they are poorly monitored?

Professor Colin-Thomé: They would be monitored well in some places. It is difficult to make that judgment unless I know every PCT in detail in the country.

Q75 Mr Khan: I will give you an example. You say that the PCTs monitor the recommendations. Recommendation 22 says that the fully integrated model of out-of-hours provision should be achieved by all GPs and out-of-hours providers by 2004.

Professor Colin-Thomé: That did not happen.

Q76 Mr Khan: Recommendation 21 is that out-of-hours providers should start to report on quality standards set out in this Report from April 2001. Did that happen?

Professor Colin-Thomé: Some would, but not in a consistent way

Q77 Mr Khan: Is it not fair to say that PCTs are to blame for this not being met?

Professor Colin-Thomé: They did not handle that as recommended.

Q78 Mr Khan: What are you doing to make sure that your PCTs monitor these more fully than they are at the moment?

Professor Colin-Thomé: We have made the quality standards much more useful to PCTs. Sometimes they were difficult to deliver. There were lists of targets, guidelines and so on in those 22 recommendations. In 2004 we altered it and involved the service in coming up with some different standards, which the Report says PCTs welcomed because they were easier to measure and better reflected patient care. But the deal is that PCTs have to monitor that; if not, the local headquarters—the strategic health authority—looks at PCTs and their performance. Obviously, that has not happened in all places.

Q79 Mr Khan: That brings me to a linked point about PCTs. Do you accept that one of the reasons why my PCT, Wandsworth, has a budget deficit is the shortcomings as you call it—I call it other things—in the commissioning process?

Professor Colin-Thomé: I do not want to broaden this too much, but as a clinician one of the issues about commissioning is that a lot of clinical activity is undertaken which does not add much value to the patient's outcome, such as outpatient activity.

Q80 Mr Khan: My question is simply whether there is a link between PCTs' budget deficits and the shortcomings in the commissioning process that are talked about in part two of the Report?

Professor Colin-Thomé: I think that with better commissioning a lot of the budget deficits do not need to arise.

Q81 Mr Khan: Does it follow you are confident that as things mature deficits will reduce because that factor will be taken out of the equation?

Professor Colin-Thomé: Yes. We have also changed the PCTs to make certain.

Q82 Mr Khan: One of the matters that shocked me—maybe it was a shortcoming—was my PCT coming out top of those who were the subject of these findings in its performance against national quality requirements. With a quality score of 11 out of 23 I was top. In one respect I am pleased; in another respect I am shocked. Have you seen these sheets?

Professor Colin-Thomé: Yes.

Q83 Mr Khan: Is that acceptable?

Professor Colin-Thomé: The answer superficially is no.

Q84 Mr Khan: Are you shocked?

Professor Colin-Thomé: Perhaps I may add a rider. The NAO went for 100% compliance, meaning that 100% of all activity hits the target. We said that 95% was full compliance. Those figures would be better, but we can do a lot better and we will make certain that the performance management of PCTs will be a lot better.

Q85 Mr Khan: My question is whether that is acceptable, and were you shocked?

Professor Colin-Thomé: I was disappointed that we had not done better, but there are some technical reasons for it.

Q86 Mr Khan: I take it from your answer that it is unacceptable?

Professor Colin-Thomé: We could do better.

Q87 Mr Khan: Were you surprised that my PCT did the best out of all its PCT colleagues? There were some—I will come to them—which did even worse than Wandsworth. Does that not surprise you?

Professor Colin-Thomé: It disappoints.

Q88 Mr Khan: The Chairman referred to the golden age when one could pick up the phone and speak to one's own GP late at night and be given advice, and often the doctor would come to one's home. You said that from 1995 onwards those of you living in the city had not had that experience. When I pick up the phone at night time in an emergency and call the out-of-hours service can I be assured that the person to whom I am speaking is in the UK? There are no call centres?

Professor Colin-Thomé: Yes—and we have not sent call centres abroad at all.

Q89 Mr Khan: Do you accept that there is a problem when, for example, my hospital sees more than 99% of people in A&E within four hours and is a huge success story and the person to whom I speak on the phone will err on the side of caution and tell me to take my daughter to the A&E rather than arrange for a visit or an appointment to go somewhere tomorrow morning to see a specialist? Does that surprise you?

Professor Colin-Thomé: No. I think the whole point of the Carson Review in the first place was that to have good out-of-hours and in-hours emergency care the hospital and primary care people needed to work better together.

Q90 Mr Khan: But they are not. My hospital complains that because there are inadequately qualified people on the end of the phone who are covering their backs they send patients incorrectly to the A&E?

Professor Colin-Thomé: I think they would have a job substantiating that claim. That is a popular myth among a lot of hospital people.

Q91 Mr Khan: Do you think it is not happening?

Professor Colin-Thomé: I would like them to substantiate that there is lack of skill in the primary care assessment.

Q92 Mr Khan: How do you explain that in aggregate numbers more and more people who go to A&E have been referred by GPs?

Professor Colin-Thomé: I am not certain that they have been referred by GPs. What they are doing is going to A&E as an outlet for urgent assessment. If one looks at an integrated system that is valid. In many places the out-of-hours and hospital services work together, as does the ambulance service. That is the aim of our urgent care strategy.

Q93 Mr Khan: Are you trying to say there is a love-in between local hospitals and the PCTs about referrals to A&E?

Professor Colin-Thomé: No.

Sir Ian Carruthers: We should not underscore the success of A&E in reducing its time.

Q94 Mr Khan: Some would say that it is a victim of its success?

Sir Ian Carruthers: Some would say that, but the issue is that at certain times it is appropriate for the out-of-hours service to refer people there. We know that a lot of people choose to go there.

Q95 Mr Khan: And you want to cover your back?

Sir Ian Carruthers: There is not evidence to say that people are inappropriately qualified. We will happily look at it if it is furnished. In the main the people who receive the calls are trained and skilled.

Q96 Mr Khan: Assuming they are doctors?

Sir Ian Carruthers: Not necessarily. When we talk about an assessment, in many areas it is quite consistent for that to be given by different professionals.

Q97 Mr Mitchell: It all looks pretty amateurish. One comes across a problem and has a Report which says that the system is not working, and one then sits in as an observer on discussions between the medical bodies on how to reshape the system. One is observing; one does not influence, manage or control it. One then pushes the whole lot out to PCTs with inadequate guidance and templates. That is in

a situation where, because the performance of PCTs is widely varied because the markets all differ, they do not have any guidance from the top on how to do it. This is amateur stuff, is it not?

Professor Colin-Thomé: If I may just clarify that, when David Carson set up his review back in 2000 at that time not only did we give some guidance in 2003 on commissioning of out-of-hours service but we set up the Exemplar programme comprising about 34 sites of what good practice was. We sent it round to PCTs. We also had 11 regional centres to spread good practice out to PCTs. It was not just plucked out of the air; there was a programme to give advice to PCTs about good practice.

Q98 Mr Mitchell: But the PCTs complain that it was not useful and effective advice, that it was insufficient and that the reporting template was too difficult for them to cope with, although you say otherwise. If it was difficult for them, why not give them guidance on how to cope with it?

Professor Colin-Thomé: We did give guidance.

Sir Ian Carruthers: There was a reporting template established and 25 used it. Its use was not mandatory, and one of the actions that we now want to pursue with the benefit of hindsight is to look at common reporting and nomenclature so we have a system that handles those things. At the time PCTs were charged with this and guidance was given. They could avail themselves of best practice. But when anything is implemented by 300 plus different bodies each will take a different approach. I think that to enable them to do that is the purpose of having a localised NHS. The real question is how we can learn from this Report and that has been undertaken. There are many learning points to be pursued.

Q99 Mr Mitchell: It is a difficult, messy learning process, is it not? Unless you give clear guidance at the start with an understandable template and decide the basic issues as to whether or not to put it out to contract with competitive bids and about urgent or unscheduled visits, and you hand down the advice accordingly, it is very difficult for a set of diverse bodies, many of which are fairly amateurish themselves, to cope?

Sir Ian Carruthers: One could take that view. On the other hand, the Report says that four out of five people were satisfied. It also says that the international comparisons are good. There are examples where early involvement of GPs and the public, for example in Hereford to name one, has made sure that there are very effective arrangements. The standards of quality handed down were those previously available from the Carson Review which were updated and made available from 1 January 2005. The notion that there was nothing at all is incorrect.

Q100 Mr Mitchell: It is just inadequate. Nobody is saying that there is nothing at all.

Sir Ian Carruthers: There is variability because some handled this better than others.

Q101 Mr Mitchell: But you knew that would be the case?

Sir Ian Carruthers: That is bound to be the case in any system where one devolves the way forward for 300 or more local organisations and gives them an element of choice.

Q102 Mr Mitchell: That does not absolve the Department from its responsibility to set it out clearly. If one considers urgent and unscheduled visits, how can one plan a service unless one knows what it is? Greg Clark drew attention to the gap. That seems to me to be fundamental to the planning of what service you are offering?

Sir Ian Carruthers: Yes, but as the Report says we were moving from one service to another where we wanted unrestricted cover for the population. Action will be taken on urgent care in the context of the new White Paper.

Q103 Mr Mitchell: Were you shocked by the fact that the costs were 22% over estimate?

Sir Ian Carruthers: "Shocked" would not be the word I use. I would prefer it if it was not the case.

Q104 Mr Mitchell: Surprised?

Sir Ian Carruthers: I think it was disappointing. On the other hand, PCTs would say that that was really down to local quality monitoring and local salaries. We have already issued to PCTs benchmark data. A number have already begun to address costs and introduced change. As the Report itself says, there was no reason why much of this could not have been commissioned within the resources available. Our aim is to get back to that point.

Q105 Mr Mitchell: The National Audit Office estimates that there could be savings of £134 million if you made the best practice a common standard. Do you accept that?

Sir Ian Carruthers: I think that as a straight calculation I would accept it, but the chances of getting everyone to be the very best is a tall order, as all of you will agree. What we can do is make major improvements. Places like Coventry and Hampshire are already looking at how they can make this better. It is really important that we pick up the lessons and go forward, because what we have is a difficult transition and a lot of information that we did not have before. We need to make it count and take it forward in reshaping the services to address the points that people have raised.

Q106 Mr Mitchell: Let us turn to the individual PCTs. Mr Khan said he was surprised and perturbed that his PCT was so good. On the whole, north east Lincolnshire was not bad; I think it does a good job, but I see that the reason for it failing in several categories, for instance 8 and 12, the simple fact is that it does not provide any data. Is the most common reason for failing the fact that they cannot provide the data you want to pass them?

Sir Ian Carruthers: That is a feature. I will ask Mr Belfield to comment. To my knowledge, there are a variety of reasons as to why people fail; some

genuinely do and some do not have the data. Obviously, there is the issue in the Report about the difference of definition, whether it is 100% or 95%. Again, we need to address that. It gives a varied picture which may not be the absolute reality, but no one disputes the Report.

Q107 Mr Mitchell: Is it an IT problem or just a failure to keep an eye on what is happening?

Mr Belfield: It can be an IT problem. One of the problems with telephone answering is that if the out-of-hours provider does not have a call management system he cannot record how long people have been waiting, and that is something we need to address. That is why sometimes it is found, for example in your own constituency, that no data have been supplied.

Q108 Mr Mitchell: Could this be remedied by new IT or what?

Mr Belfield: The IT is available to do that, which is why many of the other providers can record their telephone answering times.

Q109 Mr Mitchell: What steps are you now taking to draw attention to best practice and give PCTs the guidance to get there, given the fact that the National Audit Office believes that best practice needs to be more standardised?

Sir Ian Carruthers: First, as to the information, we are working with Adastra to look at how definitions and other matters can be improved. Secondly, we want to put a lot more into training. Thirdly, we will put out a website of best practice to draw people's attention to it. The other matter that we need to do, which is one of the big lessons to learn here, is that where there is integrated practice the service and experience for the patient is better. Through the definition of urgent care we would want to encourage greater movement to one system where A&E, walk-in centres, out-of-hours services, district nursing and other services are seen as one service. Where good practice exists movement towards integrated services has occurred. We need to encourage as many as possible to go that way.

Q110 Mr Mitchell: Why is Saturday morning a peak time, and why did you let GPs opt out of it?

Sir Ian Carruthers: In a moment I shall ask my colleague to give his own practical experience as a GP. The Saturday morning part of it was again part of a contract; it was about another way of looking at the recruitment and retention of GPs. As you are aware, the White Paper has just indicated that what people want are more Saturday morning clinics and, through that, we shall be introducing arrangements so that evening clinics and Saturday mornings can be handled. There is an example in this Report which shows that Saturday mornings need not have been a problem in the way they were. I think the example here is Bassetlaw. They knew that it would be a problem, collected some data and agreed with their practices that they would cover that area of work, and they made arrangements. In some instances it is easy to say that there were no data, but there was

local experience and some dealt with Saturday mornings better than others. It was a difficulty. I will ask my colleagues to explain why patients come on Saturdays.

Professor Colin-Thomé: There is also a peak, though not as high, on Sunday mornings. Mornings even during mid-week are a peak. Some out-of-hours providers have compensated for that. In my own PCT the GP service out-of-hours provides access to patients who want to come and see them. Some PCTs engage GPs early so we do not have a recruitment problem in getting GPs, and we address some of the less acute problems on Saturday and also Sunday morning, too. The peak is Saturday and the next one is Sunday, but mornings are always busy after the night before, as it were.

Q111 Mr Mitchell: Every morning is busy but Saturday is more so?

Professor Colin-Thomé: Saturday is more than Sunday, but obviously Monday to Friday is much busier than Saturday.

Q112 Mr Mitchell: Why were GPs left to opt out of this?

Professor Colin-Thomé: Because that was part of the negotiation. In 2003 we had a particular problem in general practice. For the past 15 years we have had a big increase in hospital consultants and no increase in general practice, even though the latter is the biggest provider of clinical care in the health service. It is also one of the reasons why the health service can be so cost-effective. We had to recruit more GPs and put in more rewards, which was what the contract was about. One of the negotiations was to say that GPs did not have to have 24-hour responsibility, which would have been Saturday morning or not. That was the judgment. The result has been good. In the past three years GP numbers have increased by 3,000.

Q113 Mr Mitchell: But now you are paying them a lot more you can push them to work on Saturday mornings?

Professor Colin-Thomé: You could, but now it is not in the contract that would be interesting. During the day the hours are defined at 8.00 am to 6.30 pm, which is longer than a lot of GPs were working. Many of us will work Saturday mornings, and some PCTs are giving incentives to do that. Not all of them need to work Saturday mornings; there is not enough work for every GP to be working then.

Q114 Chairman: The line of questioning by Mr Mitchell about the performance of PCTs is very important, leaving aside for the moment the questions that have been asked about costs. This is dealt with in detail in figure 3 on page 21. I would have thought this is a fairly basic comment that you have to answer; otherwise, why do all this? We see in 9a that fewer than 10% of primary care trusts confirm that they were dealing with urgent phone calls within the target of 20 minutes. We also note that about one-third did not know the answer at all—apparently they did not even know what

they were doing—and two-thirds knew their performance but were not meeting the basic requirement to deal with urgent phone calls within the target of 20 minutes. What is your answer to that?

Sir Ian Carruthers: There is a variety of reasons why that occurred. Some did not have the proper call-handling equipment; some were overcome with their call-handling arrangements and had difficulty recording. Some of it comes back to definitions. This is an area where we really want to—

Q115 Chairman: But this is absolutely basic.

Sir Ian Carruthers: That is so.

Q116 Mr Curry: We have been helpfully provided with a little performance chart of the PCTs in our constituencies. If you stack them in a line it is remarkable how the categories they meet and those they fail appear to be absolutely standard across the board. If, say, I had a baby aged 18 months who was ill in the night they would meet all the requirements that I would not be bothered about and fail on all the matters about which I would be bothered. Basically, I could not care a toss whether there is an exchange of audit systems and that sort of thing. This is all wonderful management-speak from the Department of Health. I would be damned concerned if there was no emergency consultation at the centre within one hour, or urgent consultation at the centre within two hours, or within six hours if it was less urgent. It is fail, fail, fail down the list. What accounts for this?

Sir Ian Carruthers: As I indicated, basically the failures are 8, 9, 10 and 12 which are related to three matters: first, the definitive clinical assessment—when an assessment is made and what it means. I mentioned earlier that we would clarify that. We may want to discuss that further. The second is call-handling. Many providers in earlier times could not cope with the amount of calls at peak times and for other reasons. The third is the face-to-face consultation. I think that in all those areas there is a need to see what we can learn and improve.

Q117 Mr Curry: Sir Ian, do you agree that in the circumstances we are talking about the person calling may well not be calling on his or her own behalf but because there is someone sick at home, perhaps a baby or an elderly person. That person is likely to be in a state, if not panic, or at least very highly anxiety?

Sir Ian Carruthers: Yes.

Q118 Mr Curry: Therefore, it is particularly important, is it not, that they should feel there is an engagement with them at the earliest possible stage?

Sir Ian Carruthers: I agree with that.

Q119 Mr Curry: But it is not happening there, is it? In my constituency this issue caused the most public concern in the whole of the preceding Parliament in terms of postbags and consultations.

Sir Ian Carruthers: Again, one goes back to the problem of definition as to what is and what is not compliance and whether it is 100% or 95%. The

Report quite rightly says that there is confusion and that we shall clarify. But the real issue is that there are a number of points at which this can be accessed: NHS Direct, out-of-hours, walk-in centres and A&E.

Mr Belfield: The point you make is a really good example of where we need to be much clearer in the sense that we accept 95% as compliance with the standard but the NHS has understood it to be 100%. If we take as an example the start of the assessment within 20 minutes, in your own area the result is 96% which would be compliant, but against the 100% target it is shown as a fail. We need to improve our communications in that area because 95% and above is acceptable.

Q120 Mr Curry: What you are saying is that the targets are unrealistic or not sensible?

Mr Belfield: What we asked people to do was to work towards 100%. We then said that 95% would be compliant and acceptable. But the NHS has tried to achieve 100% and is not making it, as you would expect.

Q121 Mr Curry: There is an air of surrealism about all this. First, you do budgeting apparently on the basis of having none of the information that allows you to do it in the first place. The budget appears to be some form of creative activity which is like putting a pin in a telephone directory. You then set a target of 100% knowing that that is not deliverable in most normal circumstances. You have a budget that is based on fiction and a target based on unrealism. Where are the bits here which touch reality?

Sir Ian Carruthers: The budget was not based on fiction. There is confusion between what GPs agreed to forgo as their income and cost. The actual budget was what would be the average cost, the range being £7,000 to £14,000, of providing the service. The PCTs were reimbursed the sum of £9,500 and for those in rural areas a further £14 million was distributed. The fact that, if you like, overspending took place is down to local negotiations between the providers and the PCTs themselves. I do not say that that is fictional budgeting; there is a basis for making the allocation which in the event people through their own local mechanisms chose to change. The second point you raise about the quality requirements takes us back to the question of definition. What this is saying is that 2% met the 100%, and we do not dispute that. But, whatever it is, if we are looking at whether a 100% target can ever be achieved obviously that will always be difficult. This is why we need to be clear on the definitions. An example is your own PCT where, if the 95% score had been utilised, the target would have been met. There has been some confusion and it is our intention to clarify it. We have learned from this and can take that forward. That some things have not been implemented in the way you or I might do it does not discredit the fact that there were allocation systems and standards behind them. The fact is that experience shows that they may need revision.

Q122 Mr Curry: As you know, the PCTs are all about to be thrown in the air again. We are going to get new super-ones and we are about to end up more or less where we were in 1997. They are also under financial pressure. In north Yorkshire the Harrogate PCT which serves part of my constituency—Airedale is the other half of it—that amalgamation will be notably with one that is hugely deficit-making. We have all been told in the rather avuncular tone adopted by the Department of Health that they have to live within their means, even if the means that they have been told to expect will no longer be those that have been provided to them. What confidence can I have that with those financial pressures upon PCTs this will not be a service that gets little salami chops?

Sir Ian Carruthers: First, it is important that we pick up the issues here. We have already circulated PCT benchmarking. A number of people are looking at how they can bring down their costs given what some would regard as the very wide spread of GP pay rates in the Report. The second point is that old PCTs on average are receiving growth of over 18% over the next two years, which is a substantial sum of money. Not all have deficits. If one looks at the pattern of deficits it is very variable. The advantage of having larger PCTs is that they are best able to manage. One of the reasons for having them is so that they can manage the financial resources in a different way.

Q123 Mr Curry: I am aware of the arguments.

Sir Ian Carruthers: In relation to this, it will strengthen commissioning to deal with some of the major issues that have been raised. One of the matters raised in the Report—I share this view—is that a major difficulty has arisen where consortia PCTs have been working. There has been difficulties in PCT timeliness in terms of decision-making and difficulty in arriving at conclusions. The larger-scale will take care of that and provide a stronger commissioning arm as far as costs are concerned.

Q124 Mr Curry: In this business quite often these decisions are fairly basic. My constituency is huge; I have 900 square miles of Pennines, basically. In my constituency it is no good saying to people that they must go to the A&E; they would need to find somewhere to stay overnight in order to get that service. Where is the car based? Where do you put the car which is to take the GP in an emergency to where he needs to be? If it is 15 miles down the road or up the road it has a huge impact upon the proximity of the service. My concern is simply that that is an expensive sort of business. Some of the services which have been put together with a great deal of pain will now be perceived to be once again under negotiation.

Sir Ian Carruthers: I do not profess to know the detail of your constituency, but there are examples where I am sure best practice is employed and services like community hospitals and walk-in centres can all minimise the travel to A&E. This was the point I tried to make in saying that the next phase

was to move this on and look at greater integration of the system because of the obvious benefits of doing that.

Q125 Mr Curry: I want to turn to what the previous Minister of Agriculture, Mr Nick Brown, used to call “urban myths”. There was a bit in the papers a while ago about Ryanair being booked up with German doctors who were coming over to man the out-of-hours service. Is this a myth? Who are the external providers? Are doctors coming over? I know that when my daughter, who lives in Surrey which is not a deprived area, was directed to the A&E there was a Balkan doctor on duty, who was very good. Is this happening? How many of them are being paid to do it?

Sir Ian Carruthers: If you look at the figures, 25% are provided by private sector organisations and 70% by GP co-operatives. The rates of pay available are those which are in the range as shown in the Report and obviously any foreign doctors who come do so on the same basis. It is important, however, to stress that, first, in order for them to work here they have to be registered the same as any other doctors working here, and, secondly, they need to satisfy the requirements in terms of the English language.

Q126 Mr Curry: It may be a reflection on the rates of pay in Germany. This is nonetheless a phenomenon, however large it is?

Sir Ian Carruthers: Yes. I would not like to quantify it because they are local decisions. Many overseas doctors work in the NHS and make a fantastic contribution to it.

Q127 Mr Curry: And even more so with dentists—when you can get one! I am preoccupied about budgeting. As you said, one of the problems is that there is very little management information out there?

Sir Ian Carruthers: Yes.

Q128 Mr Curry: How do you budget when you do not have the information? What worries me is that every NHS budget over the past five years has come in hugely over estimate. The reason Harrogate PCT is in difficulties is because of the consultant’s contract and the tariff. They were providing operations below the tariff. Now you can save operations and get more for it. When was the last major NHS programme which came in below the amount of money that the NHS estimated it would cost to deliver?

Sir Ian Carruthers: That is an almost impossible question for me to answer.

Q129 Mr Curry: In the past five years has there been any major NHS programme which has been delivered at less than the NHS said it would cost to deliver?⁴

Sir Ian Carruthers: The point I would like to make is that in every local situation it is very easy to blame national costing; it is very easy to blame it on the GP

⁴ Ev 22–26

contract or the consultant contract. Implementation in all cases was handled locally, and in all those instances there have been areas that do not fall into deficit and they manage their resources. The correlation between the two is not necessarily accurate.

Q130 Mr Curry: Why does the NHS give these estimates? Why does it not say that it cannot estimate and put in brackets, “This depends on local decision-making but these are the criteria they will have to apply”? It sets itself up for this; it sits on the wall and waits to fall off it.

Sir Ian Carruthers: That is a good point for us to take away, but we give estimates because people want to know the broad order of costs. The truth is that when things are implemented locally usually there are variations.

Q131 Mr Curry: The increment of the variation always tends to come out over the top, not underneath it?

Sir Ian Carruthers: Not always. I am sure that if you look at the example we are talking about today there are situations where the NHS could provide the same at the same cost as the allocation by adopting best practice and so on; and some could even do it at less cost. The estimate is what it is and much of that depends on how one implements things.

Q132 Mr Curry: But the estimate is the basis upon which funding is then distributed to PCTs, so in the end it boils down to choices between hip operations and other treatments?

Sir Ian Carruthers: There are different methods of distributing to PCTs. Normally, it is done on the basis of capitation, but in the end it boils down to making priority choices at a local level.

Q133 Mr Curry: You said that people benchmark and they learn by experience. In that case, would you expect the trend of cost in this area to come down?

Sir Ian Carruthers: It would be my hope and expectation that we would act on these and bring the costs more into line with the allocations.

Mr Curry: As bench-marking is very much the rage, if you took for the sake of argument the top quartile how much money would you not have to spend if everybody performed at that level?

Q134 Chairman: I think that is a little unfair, Mr Curry.

Sir Ian Carruthers: The Report does not refer to “quartile”. The best I can do is to point out that the Report says that if 50% adopted best practice the saving would be £53 million.

Q135 Mr Bacon: I was not completely clear from your answers to Mr Clark whether it should be an unscheduled or emergency service. Were you saying basically that the Department had not yet made a decision about that?

Sir Ian Carruthers: I am saying that that will be defined as part of the White Paper.

Q136 Mr Bacon: It has not been decided yet?

Sir Ian Carruthers: No. We realise that it is an issue. At the start of this we wanted people to have as much unrestricted access as they could, for the very reasons explained earlier.

Q137 Mr Bacon: Turn to pages 28 and 29. You see in paragraph 4.7 a summary of the costs for the financial year 2004–05 which the Department provided. There is £180 million for opt-out money; there is a ring-fenced development fund of £92 million; and there is a sum of “£14 million to support PCTs facing the biggest challenges in developing out-of-hours services, such as those covering highly rural . . . areas”, et cetera. There is also £30 million in capital incentives. When one adds up that lot it comes to £316 million which one sees in paragraph 4.8. I can see where all that came from. If one now goes to paragraph 4.10 one sees £92 million—the development fund—£30 million of capital incentives, £33.4 million for out-of-hours and urgent care development and £3 million made available to the 53 PCTs involved in the Exemplar programme. Do you know how much that adds up to?

Sir Ian Carruthers: It does not add up to the £322 million.

Q138 Mr Bacon: It comes to £158.4 million, which means there is a further £163.6 million to go before we get to the £322 million at the bottom of that paragraph. My question is: what is that £163.6 million?

Sir Ian Carruthers: It represents the £6,000 opt-out sums of money.

Q139 Mr Bacon: You mean that it was money paid to the GPs?

Sir Ian Carruthers: No; it was money given to the PCTs in order to fund the service.

Q140 Mr Bacon: You mean the £6,000 taken from the GPs?

Sir Ian Carruthers: Yes.

Q141 Mr Bacon: Is it right that the £163.6 million is a GP contract amount that was removed from them and handed over to the PCTs?

Sir Ian Carruthers: Yes.

Q142 Mr Bacon: That gets us to £322 million which was what the Department expected to be the cost. There is a further £70 million to get to what it actually cost, or is expected to cost, namely £392 million?

Sir Ian Carruthers: Yes.

Q143 Mr Bacon: What was that £70 million? Where has it come from? Who has paid it?

Sir Ian Carruthers: That £70 million was the sum of money which PCTs chose to spend in establishing a service, and it came from their general growth allocation.

Q144 Mr Bacon: It came from their general budget?
Sir Ian Carruthers: Yes.

Q145 Mr Bacon: Did they spend it? There are two figures here: a contracted cost of £380 million and a likely cost of £392 million. Do you anticipate that the £392 million is the more accurate figure?

Sir Ian Carruthers: I would not like to say what is the most accurate figure, but in those areas I am taking it at value because I believe that it is the best survey we have without going round to every PCT. As the National Audit Office did it I am not going to dispute the £70 million. Obviously, that is the difference between the £322 million and the £392 million. If it was that high—I have no reason to say whether it was or was not—it would have come from the growth allocation budget of the primary care trust, which has been on average around 9%, and it would have meant that they had made a positive choice to invest in this rather than in other things.

Q146 Mr Bacon: Rather than paying dentists, or something like that? I am just picking an example from the air. They had to make a decision?

Sir Ian Carruthers: Yes, and they chose this.

Q147 Mr Bacon: To turn back to paragraph 4.6, it says: “The Department is clear that it funded the service based on the average cost per GP of £9,500”, which is a slightly curious way of putting it. I take it from the way that the NAO normally drafts their reports that it means the Department is clear, even if no one else is. It goes on to say that despite the Department being clear “some PCTs did not understand that the £6,000 opt-out sum was not the full cost of the service.” I add that that was despite the fact that, as we see in the second sentence, the Department had “also set up a programme to support PCTs in implementing the new out-of-hours arrangements.” Not only did you calculate an amount based on an average cost of £9,500—you were clear that that was what you had done—but you set up a programme to support PCTs in implementing the new out-of-hours arrangement, and still some PCTs did not understand that the £6,000 opt-out was not the full cost of the service. Why not?

Sir Ian Carruthers: Mr Belfield can answer that; he has the detail.

Mr Belfield: The £9,500 was identified from doing an economic analysis of out-of-hours costs across the country before the GP contract was negotiated. Based on the information that we had from the GP co-ops, we understood that the average figure was about £9,500 per GP to provide the current service before the negotiation. That is how we get to the £9,500.

Q148 Mr Bacon: My question was not about how you calculated the £9,500 but the sentence: “Despite this, some PCTs did not understand that the £6,000 opt-out sum was not the full cost of the service.” My question is why, particularly given that you had spent all this taxpayer’s money on setting up “a

programme to support PCTs in implementing the new out-of-hours arrangements”, the PCTs did not understand that the £6,000 opt-out was not the full cost. Why did they not understand that? Was it because they were all thick or it was not explained to them properly, or at all—or were they told that it was £6,000?

Mr Belfield: They certainly were not told it was £6,000; they were told consistently that it was £9,500.

Q149 Mr Bacon: How do you account for the fact that they seemed to think it was £6,000?

Mr Belfield: It was not all but only some. We do not know the individual details.

Q150 Mr Bacon: How can you make such a basic error? It is more than a 50% difference, is it not?

Sir Ian Carruthers: I think the point being made is that PCTs were told what the contribution was.

Q151 Mr Bacon: What I want to know is why it is possible for the PCTs to get it wrong by over 50%. If you multiply £6,000 by 150% you get to £9,000, so it is more than 50% wrong. How did they get it so wrong if they were told clearly that it was £9,500?

Sir Ian Carruthers: There are two points. First, this came from a survey conducted by the National Audit Office. I do not know why PCTs would write and say that the cost was £6,000 when they were told it was a different sum.

Q152 Mr Bacon: But it was your Department that calculated the £9,500?

Sir Ian Carruthers: Yes, but I do not know why people would return a survey saying that they did not know. We would have to ask them.

Q153 Mr Bacon: The number going round in the media was £6,000. If you are planning a new service like this surely it is your responsibility as a department to make sure that PCTs are aware what the costs on which you have made the calculation will be. You could summarise that in simple Noddy language on one side of A4 in a way that could not be open to misinterpretation?

Sir Ian Carruthers: Mr Belfield will correct me if I am wrong, but he said that that information was provided to PCTs. I cannot explain why they should complete a survey in this way.

Q154 Mr Bacon: In what form was it provided to PCTs?

Mr Belfield: We ran a series of workshops and put people in each SHA to talk to each PCT. We also ran a website on a number of portals to give people the information, but I still cannot answer your question.

Q155 Mr Bacon: The information itself, namely, “We have calculated this on the basis of an average cost of £9,500 and this is how we have done it”, could have been summarised clearly in simple language not open to misinterpretation on less than one side of A4, could it not?

Mr Belfield: Yes.

Q156 Mr Bacon: Did you do that?

Mr Belfield: Yes.

Q157 Mr Bacon: Can you send us a copy of what you sent to the PCTs at the time?⁵

Mr Belfield: We can.

Q158 Mr Bacon: Last week I was abroad but I saw on *BBC Breaking News* that NHS Direct had closed 12 call centres and sacked 1,000 staff. Are those the correct numbers?

Mr Belfield: That is not true. They are consulting on the closure of 12 centres. Some media reported 1,000 and that is just wrong.

Q159 Mr Bacon: If all of them were to be closed how many jobs would go?

Mr Belfield: The maximum number of posts at risk is 500, of which about half are management and 114 are nurses. We would want to look at the relocation of staff into other parts of the NHS.

Q160 Mr Bacon: Paragraph 5.15 makes the point that NHS Direct has proved rather expensive and risk-averse and often cases are referred to elsewhere in the NHS, including GPs. Am I right in saying that in many cases the NHS Direct staff in the call centres are nurses?

Mr Belfield: Yes.

Q161 Mr Bacon: Where would you reallocate them? Would you put them in hospitals or primary care centres?

Mr Belfield: NHS Direct has 54 call sites scattered across the country and many of the nursing staff already work in local hospitals and work for NHS Direct part time.

Q162 Mr Bacon: I have heard of people studying for their MAs and PhDs while in the call centres. Although I have not done it, I was told to go and look at my local NHS Direct call centre to see how much other work was going on. What do you think is the future of NHS Direct in relation to out-of-hours cover?

Mr Belfield: I think it is a very positive one. In the summer when we start to talk to the NHS about integrating services and having urgent care so they are linked together, which the NAO recommends and we want to do as part of the White Paper, NHS Direct will be crucial to that.

Q163 Mr Bacon: Page 30 of the Report says that you will save £134 million. If one deducts that from £392 million one arrives at £258 million. Are you saying that for a future complete financial year the cost of running the out-of-hours service should be £258 million?

Sir Ian Carruthers: We are not saying that. This Report says that if everyone worked to the best we could save that sum of money. It is as you well know very difficult to get everyone to work at the top one percentile, and I think that is unrealistic.

Q164 Mr Bacon: What is your realistic assessment of how much it will actually cost? If not £258 million, how much will it be?

Sir Ian Carruthers: I think this is a matter for local PCTs.

Q165 Mr Bacon: Do you not have any figure in your head?

Sir Ian Carruthers: I will come to a figure in a moment.

Q166 Mr Bacon: I do not have much time, and that is my question.

Sir Ian Carruthers: From local examples, people are achieving substantial sums. We will ask each PCT to look at this in the light of best practice. If 50% achieve what would be best practice it would be £53 million.

Q167 Mr Bacon: That is a saving of £53 million?

Sir Ian Carruthers: Yes, and that is also in the Report.

Q168 Mr Bacon: You mean compared with the £392 million?

Sir Ian Carruthers: Yes.

Chairman: I think we will have to stop it there, but we would like to have a note on how you propose to realise these savings of £134 million.⁶

Q169 Mr Bacon: Or £53 million. You are talking about £392 million minus £53 million?

Sir Ian Carruthers: I am talking about how the PCTs need to realise it.

Q170 Mr Bacon: Just to be clear, are you are saying that £392 million, less £53 million which you think you might realistically achieve, will give you a cost of £339 million?

Sir Ian Carruthers: I am not saying that. I am saying that this is a marker. I believe that we should be asking all PCTs to take action, which we have already done through the benchmark costs, to reduce the figure. I would not like to put a figure on it.

Q171 Mr Bacon: It might be wrong?

Sir Ian Carruthers: There is no way you can predict. Each organisation will handle this locally and we would want to check that it is up to its benchmark equivalent. If so, it will make a big difference.

Q172 Ian Davidson: I want to look at paragraph 4.25 which says: "Many PCTs told us that they felt their finances were at the mercy of whatever pay rates GPs demanded." Were you aware of that?

⁵ Ev 26

⁶ Ev 27

Sir Ian Carruthers: Yes, I was because at that time I was chief executive of a health authority.

Q173 Ian Davidson: What does that say for GPs then?

Sir Ian Carruthers: I think it says that in some cases—not in all—there were discussions locally which drove a hard bargain, but in others there were examples where early involvement meant that everything was dealt with pretty reasonably.

Q174 Ian Davidson: What does “drove a hard bargain” mean?

Sir Ian Carruthers: I think that is evident when we look at the hourly rates.

Q175 Ian Davidson: Does it mean “drove an extortionate bargain”? It is not really a bargain at all, is it?

Sir Ian Carruthers: One could argue that in instances like this the position in terms of pay rates was maximised in some areas.

Q176 Ian Davidson: So, some of the GPs were in this really to maximise the amount of money they could get out of it?

Sir Ian Carruthers: I do not know that, but when there is a variation of between £19 and £114 for the same shift does that not tell us something?

Q177 Ian Davidson: You have no control over that centrally; it is just a free market and basically they have got you by a part of your anatomy and you have to pay essentially what they ask?

Sir Ian Carruthers: No. This is a discussion that needs to take place between the PCT and the local GPs. In varying situations they have come up with different results. There are some here where early involvement has meant very low results.

Q178 Ian Davidson: At some of these rates GPs who had given up £6,000 would get it back pretty quickly, would they not?

Sir Ian Carruthers: It depends on how many shifts they worked, but it would be possible to do that.

Q179 Ian Davidson: Obviously, they have been watching farmers, have they not? I will leave that to one side. I turn next to paragraphs 3.24 and 3.25 where there are expressions of dissatisfaction. I know that this survey was done by MORI on behalf of the NAO, but do these figures seem reasonable to you?

Sir Ian Carruthers: Obviously, I have to accept what the MORI poll says.

Q180 Ian Davidson: Is that in line with your own assessment?

Sir Ian Carruthers: They do not seem unreasonable to me.

Q181 Ian Davidson: Perhaps I may ask the NAO whether or not when these figures were compiled there was any examination by social class of those who were asked to respond. Were the C2, Ds and Es happier or unhappier with the service?

Mr Shapcott: We do not have that information with us but we can put in a note.⁷

Q182 Ian Davidson: I would particularly like to have that information. My understanding is that, based on long tradition, many people in areas like my own are too deferential to medical people and are prepared to put up with things that others who are more vocal would not. I would be quite interested to see the results. I turn to page 36 where we see bar charts that show who got what. One of the matters that strikes me is the high level of success achieved either by co-operatives or mutual organisations. We have not touched on that at all. Are there lessons to be drawn from that which you will be taking forward into other changes that you are making in primary care?

Sir Ian Carruthers: The reason for that is that obviously there was not a requirement for competitive tendering under the audit rules; it was left to PCTs, and some chose to compete and others did not. One of the matters referred to in the Report, which is true, is that there was an overwhelming favouring of local co-operatives. That explains that distribution. One of the lessons that we need to learn in future is that we need to be much more competitive in our process.

Q183 Ian Davidson: So, is it a bad thing that it has gone to the co-ops?

Sir Ian Carruthers: It was not necessarily a bad thing, but the National Audit Office Report says that 16% felt there were declared interests around the table that could have been tested, because there was an overwhelming favouring in some areas of the local co-ops.

Q184 Ian Davidson: The co-ops are, presumably, composed of the doctors or providers so they are not entirely disinterested. I understand that when an organisation is described as “not for profit” it refers to the organisation itself and, presumably, in those circumstances it is the doctors who get the profit or surplus. Are you saying, therefore, that these contracts did not go out through the *European Journal* and had they done so things might have been substantially different?

Sir Ian Carruthers: The Report itself says that 39% of PCTs chose to tender and, therefore, 61% did not. The price between those that tendered and those that did not showed only a 29p difference per head of population. The quality standards between those that were tendered for and those that were not did not vary at all and, therefore, it could not say that tendering itself would have improved the process. But I believe that competition in this sense would be

⁷ Ev 20

 Sir Ian Carruthers, OBE, Professor David Colin-Thomé, Mr Gary Belfield and Mr Chris Shapcott

helpful, because in many instances the specifications were written by the providers, and so on. I believe that we can learn some things from that.

Q185 Ian Davidson: I picked it up because you mentioned the *European Journal*. In terms of moving forward with other changes in primary care, I am under the impression that you are much keener to bring in private sector operators than you are to encourage co-ops. Is that a fair assessment?

Sir Ian Carruthers: No. I would describe it as a move towards a pluralistic set of providers, whether they be from the voluntary sector, the private or independent sector or the NHS.

Q186 Ian Davidson: Do you say that the impression that the Department is biased against the third sector—the voluntary sector and the co-ops—is unfair?

Sir Ian Carruthers: I do not know from where they get that impression, but I think there is room for all.

Q187 Ian Davidson: I think they have got that impression from speaking to the Department?

Sir Ian Carruthers: The Department is a big place, but our official line is to say that we want plurality with everyone as far as possible being able to participate.

Q188 Ian Davidson: Would you be surprised if the co-ops and the voluntary sector and third sector thought that Mr Belfield did not regard them well?

Sir Ian Carruthers: I do not know. I will ask Mr Belfield.

Mr Belfield: As far as I am concerned, your question is absolutely right. The DH is not biased against the third sector. We look to have co-ops and mutuals providing primary care services locally. You will see more of that from the Department in the coming years.

Q189 Ian Davidson: Perhaps we will look at that in due course. I want to ask about what could be described as de-skilling and the extent to which in the provision of out-of-hours service staff other than doctors are playing an increased role. Can Professor Colin-Thomé tell me, first, whether that has happened and, secondly, whether there have been any difficulties associated with that?

Professor Colin-Thomé: I do not think there have been any difficulties. Having other staff like nurse practitioners is quite common in the case of in-hours care, too, so having nurses as first contact is well documented.

Q190 Ian Davidson: Has this process accelerated that at all?

Professor Colin-Thomé: There is more in out-of-hours. If you look at some of the traditional GP co-operatives, they were very heavily doctor-based. One of the ways they could become more cost-effective was to have a better skills mix. Of course one needs doctors but not for everything. The lessons from in-hours and the GP contract have

driven some of that in-hours work of nurses who do a lot of care. There is a rich base of evidence to show that nurses can be good at many aspects of that care.

Q191 Ian Davidson: Has the change accelerated that process?

Professor Colin-Thomé: It probably has. It is difficult to know about out-of-hours but it certainly has in-hours where the number of nurses in general practice has grown by quite a few thousand in the past few years.

Q192 Ian Davidson: The Report makes points about the maturing of the market, the fact that it has gone through a difficult time and so on. To what extent is it your view that this Report is dated and if we were making an assessment of the service now it would be better?

Sir Ian Carruthers: I think it was at a particular time. From my point of view, I think the Report is very good because it highlights a lot of areas where we can improve. We are taking action on a number of matters.

Q193 Ian Davidson: Is it better?

Sir Ian Carruthers: I think it is better but there is still room for further improvement.

Q194 Ian Davidson: There always is. Finally, I want to raise the question of benchmarking with Scotland, for example. We do not have figures available here. Is it your impression that in terms of quality and cost the Scottish experience has been more or less beneficial?

Sir Ian Carruthers: I cannot answer that question because I do not relate to the NHS in Scotland.

Q195 Ian Davidson: Mr Belfield is shaking his head. I do not know whether it means yes or no.

Mr Belfield: I am not sure I can answer your question.

Q196 Ian Davidson: You have no means of comparing the two?

Sir Ian Carruthers: We have means of comparing but we do not routinely do it. This Report was compiled by the National Audit Office.

Q197 Ian Davidson: To clarify that, are you saying to us that if the National Audit Office had not come along and made this assessment you would not have done it yourself? If you have the means of making a comparison with Scotland I would have thought you would be doing so just to reassure yourselves that you are doing very well or to give yourselves a shock by realising that perhaps you are not doing nearly as well as you thought you were?

Sir Ian Carruthers: We do obviously look at international health systems, including those in the UK.

Q198 Ian Davidson: You said you could but you have not?

Sir Ian Carruthers: No, we have not because Scotland runs its own service.

Q199 Ian Davidson: I understand that—so do the French.

Sir Ian Carruthers: That is why I cannot answer questions on the French health system.

Q200 Ian Davidson: You do not compare yourselves with anybody else at all unless the NAO comes along?

Sir Ian Carruthers: This Report has compared us.

Q201 Ian Davidson: I understand that the NAO has done it for you. What I seek to clarify is that you continue along in your own track doing your own thing without comparing yourselves with anybody else, unless the NAO or somebody else comes along and does it for you?

Sir Ian Carruthers: No. We do look at things in terms of international comparisons.

Q202 Ian Davidson: Why can you not tell me anything about the comparison with Scotland?

Sir Ian Carruthers: Because you are asking about a specific subject, which is NHS24, and I do not have knowledge—

Q203 Ian Davidson: So, you make comparisons only if I do not ask you about specific subjects, but if I do not ask you about specific subjects there is not much point in asking you for comparisons, is there?

Sir Ian Carruthers: I am not the accounting officer for Scotland.

Ian Davidson: Can you write to us about whether you are aware how well this has done compared with the Scottish example? Chairman, can we have that back as a benchmark?

Q204 Chairman: You could offer it. It is true that, strictly speaking, you are not the accounting officer for Scotland so you can under the rules of this Committee, subject to guidance, refuse to give us information. I would have thought that is a reasonable question, is it not? Scotland is not a million miles away. Presumably, it is quite useful to have this kind of benchmarking exercise, is it not? You can perhaps send a note, even if you cannot answer it now. Presumably, you are not briefed on Scotland.

Sir Ian Carruthers: We will provide a note.⁸

Q205 Mr Williams: In answer to Mr Clark, you indicated early on that the Department had not defined whether it was dealing with non-scheduled or urgent out-of-hours work. You went on to say—I noted the phrase—that it was about “replicating what was there previously”. If you do not know what you are measuring how can you replicate it?

Sir Ian Carruthers: It may be that “replicate” is an inappropriate word. What people had before—

Q206 Mr Williams: It may have been inappropriate but people were rewarded for it, were they not?

Sir Ian Carruthers: If I may just finish, in the previous service members of the public could access their general practitioner through an unrestricted set of means. They would normally make their own judgment about what was urgent, and to everyone who is calling it is urgent. What was transferred across was the same ability. We were not restricting people in making contact.

Q207 Mr Williams: How do you know whether or not it succeeded if it was subjective and depended on local impression? I thought that you were about setting up a national service, were you not?

Sir Ian Carruthers: We have established a service with quality requirements set nationally following discussion with people locally in the NHS, but the implementation of that service has been left to each of the PCTs.

Q208 Mr Williams: So, it was meant to be a national standard locally determined?

Sir Ian Carruthers: No—a national standard locally implemented.

Q209 Mr Williams: Both are very different, because in one case you know what has been happening. How many PCTs are there in England?

Sir Ian Carruthers: I think there are 303 at the moment.

Q210 Mr Williams: Would you say that we are getting a uniformly high quality sustainable service from all of them?

Sir Ian Carruthers: I would say it is variable, but it is better than it was.

Q211 Mr Williams: But you do not know what it was because you were not sure what you were measuring. Otherwise, it is clear?

Sir Ian Carruthers: No. I think the evidence is that satisfaction rates are higher and the Report makes the point that it is improving.

Q212 Mr Williams: That would be all right if that was what the Department said it had set out to achieve, but it is not. You did not get what you wanted to achieve. What you set out to achieve was the Department’s requirements to provide high quality sustainable services for which PCTs were to be rewarded if they met that standard. Is it correct that you were to give them a £100,000 reward if they met your requirements and provided high quality sustainable services?

Sir Ian Carruthers: I shall ask Mr Belfield to comment on this. That refers to a particular incentive which existed only for a defined period of time.

Q213 Mr Williams: The sum of £100,000 was given as a reward for PCTs that met the Department’s requirements to provide high quality sustainable services. That was what it was set up to do, yet you told us that the standard was variable. Some of it was of a high standard and some was not.

⁸ Ev 27

Sir Ian Carruthers: No. The question you asked was what it was like now and I said that the standard was variable.

Q214 Mr Williams: No, that was not what I asked. I am still trying to find out where you are going. We have established that it was variable and what your requirements were. There was a £100,000 reward for achieving those standards. Yet every one of the 303 PCTs received £100,000 although they were of highly variable standard. This is a most peculiar situation to be in, is it not? You are giving money as a reward but you give it to those who do not meet your criteria; everyone gets it, good or bad?⁹

Sir Ian Carruthers: I understand what you are saying, but perhaps Mr Belfield can answer the question.

Q215 Mr Williams: I would be delighted if someone could.

Mr Belfield: We decided that we needed an incentive to encourage PCTs to work with their local co-ops to ensure a smooth handover. We put capital into the system, £100,000—I say this off the top of my head, and we can provide a proper note on it—of which £50,000 was a reward where the PCT had a plan in advance of the handover. Later in the year as the handover point came—the final handover was January 2005—we made an assessment of each PCT as to how it would assure itself that the quality standards were being met, and then the second payment was released. That was released before the quality standards were being achieved and it was based on a prospective look forward.

Q216 Mr Williams: Do you claim that the NAO was wrong in saying that the extra £100,000 was provided to reward PCTs that met the Department's requirements for the provision of high quality sustainable services?

Mr Belfield: They are not wrong.

Q217 Mr Williams: They are not wrong; it just went to PCTs that did not meet that standard?

Mr Belfield: They are not wrong. I take responsibility for the fact that when this was being drafted I should have picked that up.

Q218 Mr Williams: The estimate of the NAO is that much of that £30 million was not spent on the basis of proven performance. That is £30 million to start with. We have heard about the other £70 million. Let us switch to the £6,000 we have heard about on so many occasions this afternoon. Who produced the figure of £6,000? Its origin is rather vague.

Sir Ian Carruthers: It was part of the GMS contract negotiation.

Q219 Mr Williams: But you had told PCTs consistently—you may be the one who used these words—that the correct figure was £9,500?

Sir Ian Carruthers: The £6,000 represented the agreed reduction in income that GPs would forgo to opt out.

Q220 Mr Williams: I understand that, but what I am getting at is what determined that that was the appropriate figure?

Sir Ian Carruthers: It was one part of a contract negotiation.

Q221 Mr Williams: Do you mean that it was not a figure that had any basis in reality in terms of what was being saved and what it would cost; it was just a bargaining figure?

Sir Ian Carruthers: It was a figure that was about forgoing an amount of income to opt out of out of hours services. The negotiators could tell us how they arrived at that, and we can happily attempt to identify it if it would help.

Q222 Mr Williams: In that case, why were you consistently telling the PCTs that that was wrong and it was £9,500?

Sir Ian Carruthers: There were two things here: the amount of income taken from the GP and the cost of the service. As part of the negotiation, the sum of income from the GP was £6,000; the actual cost of the service was derived by the means described before as £9,500.

Q223 Mr Williams: In effect, are you saying that you gave the GPs a concealed £3,500 increase?

Sir Ian Carruthers: No, because the £3,500 increase went to the primary care trusts for them to establish the service. As you see, any increase would have arisen on how they handled their negotiations with the general practitioners in their local areas.

Q224 Mr Williams: The £6,000 was a negotiating mirage; it had nothing to do with real cost. Is it not a fact that you knew throughout that the real costs were nearer £9,500 but you took only £6,000 away from the GPs in lieu of it; in other words, you gave them a concealed pay rise of £3,500 on average?

Sir Ian Carruthers: No. What you have said is factually correct. I am not sure I would derive that conclusion, because the £3,500 went to the PCT, and not all GPs took part in the service which was then contracted.

Q225 Mr Williams: But the point is that those who gave up their £6,000 effectively benefited by not having to bear £9,500 in cost, so you gave them a £3,500 concealed pay rise. This was what it was all about.

Professor Colin-Thomé: I do not have the exact figure with me, but in 1995 when the then Government gave encouragement to GPs to work in co-operatives they gave an out-of-hours development fund. That has always been centrally funded from 1995. I do not know if it works out exactly at £3,500; I would have to have notice of that question, but GPs never paid for the whole service from 1995. That was an inducement to take some of the pressure off GPs.

⁹ Ev 27–28

Sir Ian Carruthers, OBE, Professor David Colin-Thomé, Mr Gary Belfield and Mr Chris Shapcott

Q226 Mr Williams: Between the two figures—the reward and the other figure—it cost the health service £100 million which had to come from other services. It had to come from somewhere, did it not?

Sir Ian Carruthers: Yes. Whatever the position was, there was a loss of income. The development fund of £92 million was allocated and any other costs were met from the allocations made. Clearly, the costs have come from the NHS allocation.

Q227 Mr Mitchell: I just wonder about “urgent” versus “unscheduled”. I appreciate that it is difficult. My wife is a hypochondriac so her “urgent” is probably your “unscheduled”, but it is the difference between “help is in the way” and “bugger off” and putting yourself at the mercy of a receptionist who is there to repel boarders every Monday morning, saying, “Sorry, the GP has no slots available for two weeks”, or whatever. That is a fairly crucial decision for the patient. I still cannot understand why that was left and there was no guidance given. Is it that you are waiting for the White Paper and decisions on the future of NHS Direct? Was it really a question of wider decision-making or was it that you just did not know?

Sir Ian Carruthers: The aim was really to give people access to the service. The difference between urgent and unscheduled care has been raised in a survey. The White Paper is saying that we need to look at an urgent care strategy, because many of the requirements of the White Paper are about putting in place evening clinics and different arrangements which move it ideally in a sense more into the unscheduled care bracket. I think this is an issue that we need to look at.

Q228 Mr Mitchell: Surely, you looked at it right at the start. Everything—the expense, the amount of trouble you take and the arrangements made for alternatives—is contingent on a clear decision on that?

Sir Ian Carruthers: Yes, they were, but the service originally did not operate on that basis so that anyone had access to his GP. What we wanted to do was to make available the greatest access. What people are saying is that because of the arrangements they would prefer to have a decision between urgent and unscheduled care. This came from the survey done by PCTs. It is now a matter that we will need to deal with in the context of the White Paper.

Professor Colin-Thomé: It is a little odd, because in one sense you are right. If a patient perceives himself as being an urgent case that person needs to be attended to whatever the time, night or day. The difference is whether you provide the whole panoply of service to meet all those needs out of hours or make an assessment and decide that this can wait until tomorrow. The basis of all our care, whether the GPs did it or the co-operatives since 1995, is that assessment. Carson just talked about urgent care, but in reality I am surprised that PCTs have made that distinction.

Q229 Mr Bacon: Mr Williams asked you from whom the £6,000 had come and you said that it arose out of the GMS negotiations.¹⁰ Was it a Department of Health figure?

Sir Ian Carruthers: I do not know; we can check it. It was part of a negotiating process, and we can give you a note on how that arose. I think that is the best way, because we were not part of the negotiations.

Chairman: Thank you. That concludes our hearing. Although it is undoubtedly true that the service is now improving, nobody is meeting all their targets. It has become increasingly clear to us as the Department has worn on that the introduction of this service was shambolic, and the only people who appear to have done well out of it are the doctors. We will be issuing quite a tough Report. Sir Ian, I am afraid that your first appearance in front of this Committee has been rather underwhelming.

¹⁰ Ev 28

Letter from the National Audit Office to the Clerk of the Committee

I am writing in anticipation of the forthcoming Committee session on the above Report, scheduled for 22 May, for two reasons.

Firstly, I have been made aware that the figures on service costs provided to us by Bath and North East Somerset PCT are incorrect. Our published Report therefore contains some inaccuracies. I enclose a letter of apology from Bath and North East Somerset PCT, which is below, which makes it clear that the fault lies with them, rather than the study team. The latter made every effort to verify the accuracy of the PCT's figures, including telephoning and writing to them to check their data over the course of the past four months. However, the fact remains that some data in our published report is incorrect.

Removing the inaccurate Bath and North East Somerset data from our report means some minor changes, which are as follows.

- Bath and North East Somerset are no longer the most cost-effective PCT in the “Significant Rural” category (Figure 7).
- The most cost-effective PCT in this category becomes Cheshire West PCT, whose scores are as follows: Actual cost per head—£4.45; Quality score—12; Quality points per £ spent—2.7.

- Indicative savings figures derived from all PCTs benchmarking themselves against their most cost-effective peers fall from £134 million (paragraph 4.19) to £129 million. Savings figures based on PCTs more expensive than the average reducing their costs to the median also fall from £53 million (paragraph 4.20) to £49 million.

I hope you will agree that these changes are minor and do not undermine the thrust of our findings and recommendations.

Yours sincerely

Chris Shapcott
Director, Health VFM

Letter from Bath and North East Somerset PCT to the National Audit Office

Dear Chris

OUT-OF-HOURS SERVICES—BENCHMARKING DATA RETURN

I am writing to confirm the information I gave in an email to K Rowley on 3 May 2006.

The PCT gave the Audit Commission incorrect data on the cost of the contract it has with its main GP out-of-hours service provider. The value of the contract given to the Audit Commission was £206,359 but the correct value of the contract is £1,921,961.

We did provide correct information on the annual cost of GPs in the service ie £1,200,000 and clearly our checking was inadequate. Obviously with a GP cost of £1,200,000 the total cost had to be greater.

The incorrect value of the contract with our out-of-hours provider affected the cost per head of population figure. The benchmarking tool shows that Bath and North East Somerset PCT Out of Hours Service costs £3 per head of population. The correct cost is £12 per head of population.

I am very sorry for the embarrassment that this has caused your department and I have put in place arrangements to ensure all data is properly checked in the future.

Yours sincerely

Julia Griffith
Assistant Director of Primary Care Development

Supplementary memorandum submitted by the National Audit Office

Question 181 (*Mr Ian Davidson*): *Perhaps I may ask the NAO whether or not when these figures were compiled there was any examination by social class of those who were asked to respond. Were the C2, Ds and Es happier or unhappier with the service.*

When (the figures in paragraphs 3.24 and 3.25 of the National Audit Office Report on users' satisfaction with the out-of-hours service) were compiled, was there any examination by social class of those who were asked to respond. Were the C2, Ds and Es happier or unhappier with the service?

A. The research undertaken by MORI for the National Audit Office analysed respondents' answers by social group, working status, tenure and number of children in household. As regards the answers discussed in paragraphs 3.24 (63% of users rating quality of care as good or excellent; 19% of users rating quality of care as quite poor or very poor) and 3.25 (72% of users rating advice as fairly good or excellent; 15% of users rating advice as making "no difference"; "fewer than one in 10" users rating advice as "wrong" or "totally wrong") of the National Audit Office Report, the analysis showed there are no statistically significant differences between the social classes.

Supplementary memorandum submitted by the Department of Health

Question 15 (*Mr Edward Leigh*): *New GP Contract 2004–05 Position.*

1. Introduction of the new General Medical Services (nGMS) contract was underpinned by a three-year deal, ending in 2005–06, which guaranteed a 36% increase in resources in England, rising from £5 billion in 2002–03 to £6.8 billion in 2005–06. Negotiators agreed to measure increased investment in Primary Medical Care Services (PMS), in the three-year period ending 2005–06, through a mechanism known as the Gross Investment Guarantee (GIG).

2. Evidence from PCT expenditure returns shows primary care trusts have also made available additional resources to secure the range of services and improvements in care to meet national and local priorities. The overall increase in resources is now forecast to total between 40 to 50% for the three-year period, based on an estimated spend on primary medical care services of around £7.5 billion in 2005–06.

3. The England GIG agreed with the General Practitioners Committee (GPC) is detailed in Table 1. Current DH figures indicate the GIG for all years will be significantly over-achieved so that there will be more spend than was guaranteed.

Table 1

FORECAST ACHIEVEMENT AGAINST GROSS INVESTMENT GUARANTEE

<i>Financial Year</i>	<i>GIG £ billion</i>	<i>Outturn £ billion</i>	<i>Over £ billion</i>
2002–03 (baseline)	5.0		
2003–04	5.6	5.8	0.2
2004–05 ⁽¹⁾	6.2	6.9	0.7
2005–06 ⁽¹⁾	6.8	7.5	0.7

⁽¹⁾ Forecast outturn—still subject to validation/agreement with the GPC.

4. The 2004–05 over spend (which in part reflects the effects of the QOF in motivating General Practice to provide increased high quality evidence based clinical care for the benefit of patients) against the GIG (the minimum investment level agreed by negotiators) is around £700 million. This includes:

- Circa £150 million due to over-achievement of the Quality and Outcomes Framework (QOF).
- Circa £100 million due to pressures on the GP out of hours service.
- The remaining balance predominantly due to an increase in the level of investment in PMS contracts, over and above that initially assumed at the time GIG was set. Work is ongoing to investigate this further.

5. Broadly, the same (increased spend against the GIG and the reasons for that increase) is occurring in 2005–06.

6. Measurement of forecast spend against the Gross Investment Guarantee is not the same as spend against allocated resources. The 2004–05 position is that PCTs managed significant pressures on allocations around the QOF (£150 million) and GP out of hours services (£100 million). However, the increased investment in PMS was matched by increases in PMS allocations to PCTs.

The Gross Investment Guarantee (GIG) was negotiated with GPC in England and was only intended to fund minimum levels of investment in the new GP contract to replace the former flawed pay mechanisms under the former GMS contract arrangements. The contract allocates resources on a more equitable basis and allows practice flexibility as to how these are deployed from the global sum.

This investment was intended to form a three year GIG (2003–04 to 2005–06) which will be monitored by the Independent Technical Steering Committee. As such, it is intended to ensure that resources promised to deliver the contract will be delivered in aggregate. The England GIG was agreed with the GPC.

The GIG was never intended to match year-on-year planned PCT allocations and direct comparisons on GIG against allocations should not be made. It would have been imprudent of negotiators to attempt to set agreed allocation figures in anticipation of matching planned increases.

It is evident from the GIG, that in particular Personal Medical Services investment was higher than anticipated but were matched by increases in allocations to PCTs

For 2004–05, the overall financial pressure managed by PCTs is therefore £155 million.

Question 47 (Greg Clark): *Was the Department of Health a participant or observer in that (GP contract) negotiation.*

The new contractual arrangements for primary medical care contractors were negotiated by the NHS Confederation (as the employer representative of the NHS) with the General Practitioners Committee of the British Medical Association.

In conducting negotiations on behalf of the Department of Health, the NHS Confederation (and now NHS Employers Organisation) receives a mandate from Government setting out clear parameters for any negotiations, both in terms of outcomes or services to be provided, under contractual arrangements as well as a resource envelope. Detailed negotiations are however, a matter for the negotiating parties.

The Department of Health was an observer to these negotiations, but ultimately approved the outcomes reached on behalf of the Government.

Questions 48 & 49 (Greg Clark): *What about the dentists' contract, was the Department an observer or participant in those negotiations.*

The new contracts for General Dental Services (GDS) and Personal Dental Services (PDS) are for agreement locally between Primary Care Trusts and individual dentists, partnerships or practice owners. The contracts are, however, governed by national regulations, which set out certain core requirements. These national regulations are very closely based on a framework developed in discussions between the Department of Health and the British Dental Association (BDA) during 2003 and 2004.

NHS Employers was established in November 2004 and was not therefore involved in these discussions. The NHS Confederation (of which NHS Employers is part) was represented in the discussions with the BDA, but did not at the time have sufficient expertise in relation to primary care dentistry to play a major role.

The Department has recently invited NHS Employers to carry out negotiations with the British Dental Association on new pay, terms and conditions for dentists working in salaried primary dental care services.

Question 129 (Mr David Curry): *In the past five years have there been any major NHS programmes, which have been delivered at less than the NHS said it would cost to deliver.*

Due to the difficulties in defining what a programme is, it is not possible to say how many major programmes the Department has delivered over the past five years, but the following are some examples of what we would consider major programmes.

Examples of major programmes (revenue funded and capital investments) that the DH has managed, over the last five years, which have delivered at less than planned cost are follows:

REVENUE

Prescribing

Table 1 below compares the planned additional costs, made in the 2002 spending review, with actual spend for prescribing in the Family Health Service (FHS).

Table 1

<i>£m</i>	<i>2003–04 over 2002–03</i>	<i>2004–05 over 2003–04</i>	<i>2005–06 over 2004–05</i>
FHS Planned additional cost SR2002	762	870	1,011
FHS Actual additional cost	618	410	– 50

The DH service and financial planning for the NHS uses a model developed by the Sheffield Health Economics Group (University of Sheffield) to forecast growth in expenditure on FHS drugs. As part of the work to support the Gershon Review on efficiency, we introduced the following initiatives that led to substantial reductions in FHS prescribing expenditure:

- New PPRS agreement: started in February and includes a 7% price reduction in branded prescription medicine over five years.
- Generic Price Reductions: in the first half of 2005–06, price cuts negotiated as part of the new PPRS agreement reduced the prices of four generic medicines.

Category M medicine: in April and July 2005, changes in Category M prices have led to further reductions in prescribing costs. However, this saving has been used to offset part of the cost of the new Pharmacy contract. The funding of £300 million was used to meet the cost of three components of the contract: Practice payments, Electronic Prescription Service and Medicine Use Reviews.

Elective Activity

Table 2 below compares the assumptions, made in the 2002 spending review, on costs of activity for meeting the elective access targets to estimated actual expenditure.

Table 2

<i>£m</i>	<i>2003–04 over 2002–03</i>	<i>2004–05 over 2003–04</i>	<i>2005–06 over 2004–05</i>
Planned increased activity cost	230	491	583
Actual expenditure on increased elective activity (estimate)	170	125	180

The lower than expected costs are due to a number of factors, including the following:

- lower than forecast referrals from primary care to secondary care, as GPs have become more effective at avoiding unnecessary referrals; and
- a shift in the patterns of activity from inpatient to outpatient to the primary care setting.

However, the amount of underspent indicated may be overstated as no adjustments have been made for the costs incurred in these less intensive settings.

CAPITAL

As examples of major capital programmes completed within budget, we have included those large programmes that are specifically mentioned in section 4 of the 2000 NHS Plan on investment. In practice, this gives us a cut-off point of about £500 million in capital value. We have also included the programme to expand cardiac capacity that was launched shortly after the NHS Plan, to give four major capital programmes:

- The hospital building programme.
- NHS LIFT.
- Cancer equipment.
- Expansion of cardiac capacity.

None of these programmes has exceeded planned costs, though the hospital building programme and NHS LIFT programme have locally planned budgets for each individual project, rather than programme budgets in the normal sense. This is explained in the background below.

None of these programmes has come in at materially less than planned cost.

Background:

(a) *The Hospital building programme*

The NHS Plan of 2000 pledged “over 100 new hospital schemes in total between 2000 and 2010”. The Department is on course to exceed this target.

The 100 new hospital schemes target was launched with a commitment that there would be “£7 billion of new capital investment through an extended role for PFI by 2010”. This level of investment now looks likely to be exceeded but more hospital schemes are now complete, in construction or under negotiation than the 100 originally planned.

For the hospital schemes, project-budgets have been set by local NHS organisations rather than by the Department but a condition of approval to proceed is that their contracted for costs remain within their locally set budgets. Cost and budget increases have occurred as schemes have moved from indicative costings at their initial SOC and OBC stages to the final FBC and contract signature when the specification and costs of schemes are fixed. Crucially in PFI, any cost overruns occurring once the contract is signed are borne by the private sector. (83 of the 106 hospital schemes that are complete or under construction are PFI)

A central review of the largest (over £75 million) schemes is underway to ensure that the locally set budgets do not exceed what local health economies can afford or justify in terms of capacity.

(b) *NHS LIFT*

The NHS Plan of 2000 pledged that “Up to £1 billion will be invested in primary care facilities” and that NHS LIFT (Local Improvement Finance Trust) would be established to deliver increased investment in primary care premises.

As with PFI, budgets for individual schemes within the 49-scheme programme are set locally and the public sector’s costs are fixed when the contract is signed.

In total, £1.1 billion of investment has been committed through the 42 NHS LIFT schemes that have signed contracts (£935 million of private sector investment and £211 government enabling funds), with 91 new premises already operational and a further 64 under construction.

The earliest of these contributed to achievement of the related NHS plan targets of up to 3,000 family doctors’ premises being substantially refurbished or replaced by 2004 and 500 one-stop primary care centres by 2004, both of which were broadly met.

(c) Cancer Equipment

The NHS Plan also committed to a major modernisation of the equipment available for the diagnosis and treatment of cancer, including delivery by 2004 of 50 new MRI scanners, 200 new CT scanners and 45 new linear accelerators.

This target was met with effect that by January 2005, 87 MRI, 184 CT and 90 linear accelerators had been delivered. The Cancer Plan equipment objectives were met without any revisiting of the £447 million of budgets that were agreed covering the period 2001–02 to 2005–06.

The programme was implemented as a national procurement. We have estimated that over £36 million was been saved through the national procurements, working with local Trusts, PASA, central DH and the Device Evaluation Centres. Rather than the programme underspending, the money saved was re-invested into additional equipment.

In November 2004, an OGC gateway review of the programme concluded that the funding available had been spent wisely and that the market had been used in a thoughtful, constructive and effective manner.

(d) Expansion of Cardiac Capacity

In 2001, a £580 million programme to deliver 21 major capital investment schemes to support a major expansion of the NHS' capacity to diagnose and treat heart disease.

Currently, all bar two of the 21 schemes are on course to be complete by the 2008 target date and the programme has not needed to request additional capital funding from the Department.

Examples of programmes delivered over cost are as follows:

Consultant Contract

We invested additional, recurrent funding to meet the costs of the consultant contract. This investment, a total of £250 million, was introduced over the three-year period from 2003–04 to 2005–06.

Representations from trusts in late 2004 suggested that the costs of the consultant contract had exceeded plans by as much as £150 million, mainly due to higher levels of programmed activities. We uplifted the tariff for 2005–06 by this amount.

Evidence obtained subsequently, however, from the DH consultant contract survey (on data as at October 2004), suggested that while the levels of programmed activities were higher than expected, the difference suggested an excess cost of the order of £90 million rather than £150 million.

Data from the October 2005 DH consultant contract survey has shown a further reduction in average programmed activities from 11.17 in October 2004 to 10.83 in October 2005. It has also shown a reduction in the proportion of consultants receiving on-call supplements, which had also been cited as a cause of cost pressures.

Agenda for Change

The funding envelope for Agenda for Change from 2003–04 to 2007–08 is set out in the table below.

ESTIMATED COST OF IMPLEMENTING AGENDA FOR CHANGE

<i>Year</i>	<i>Cumulative total £ million</i> ⁽¹⁾
2003–04	60
2004–05 ^{(2) (3)}	490
2005–06	950
2006–07	1,390
2007–08	1,780

Notes:

⁽¹⁾ Totals rounded to nearest £10 million.

⁽²⁾ Original envelope figure. This was subsequently reduced to £480 million.

⁽³⁾ A further £30 million in non-recurring funding was made available in 2004–05, primarily for the transitional costs of the change in pay systems—such as backfill for staff assisting with job evaluation.

Estimated Costs

Monitoring of the costs of Agenda for Change in 28 sample sites in 2005 suggested that in the first 12 months from October 2004 to September 2005 direct earnings costs exceeded those originally estimated by 0.5% of the Agenda for Change paybill, or around £120 million a year in cash terms. In the same period, this data suggested that the indirect costs of replacing additional hours and leave arising from Agenda for Change exceeded those originally estimated by at least £100 million a year. However, these indirect costs are based on trust estimates rather than actual payroll records, and are susceptible to management action.

Reasons for Cost Overruns

In terms of the reasons for the cost overruns suggested by the 28 sample sites data, for direct costs (basic pay, unsocial hours, overtime, geographic allowances etc) most elements came close to their original forecast except overtime where an expected small saving of around 0.1% of pay bill became a small cost of 0.1%. The original estimate was based on the assumption that the savings from abolition of higher premium rates for Sunday working for significant numbers of staff would exceed by small amount the additional cost from paying overtime at premium rates to some smaller groups who had not previously been entitled to that, and the effect on overtime of increases in basic pay. This variation accounted for nearly half the overall variance in direct costs. The remainder was the net effect of small variations (both up and down).

In terms of indirect costs there is a significant difference between the sample site Trusts stated policies on replacement of hours and leave compared to assumptions in the original forecasts. There was also an assumption in the original estimates—based on the evidence we had at that time—that the old NHS extra-statutory days (additional bank holiday days) were still being staffed at premium rates or had been bought out by additional leave on the basis of three days normal leave for the two extra-statutory bank holidays. Whereas evidence from the sites monitored during assimilation suggested that in most cases these had already been bought out with additional leave on a two for two basis in some cases with unrelated concessions (for example on car-parking). This contributed around £80 million to the estimated variance in indirect costs within the sample sites.

We accept that initial costs have been higher than expected, but this is a huge system change affecting the pay of over 1 million staff who previously had vastly differing arrangements with hundreds of different grades each with different conditions and different, often arcane, allowance structures.

Agenda for change has already played a big part in delivering the NHS plan targets on capacity and access.

It has helped to control the NHS pay bill at a time of rapid investment and ambitious recruitment targets.

It has also put us ahead of the game in areas such as equal pay where the risks of litigation are significant (and growing).

New GMS Contract

Based on unaudited accounts, PCTs' expenditure on the GMS contract in 2005–06 is estimated at £7,691 million against an allocation of £7,495 million.

The new contracts were backed by a guaranteed 36% increase in resources in England, rising from £5 billion in 2002–03 to £6.8 billion in 2005–06. Such increases for primary care are unprecedented and a measure of the Government's commitment to improved care for all.

Evidence from PCT expenditure forecasts show that PCTs have made available additional resources to secure the range of services and improvements in care to meet national and local priorities. The overall increase in resources is now forecast to be nearly 50% for the three-year period (equating to spend on primary medical care services of around £7.7¹ billion in 2005–06).

The increased investment is directly benefitting the vast majority of patients who are experiencing improvements not only in the range of services available locally but also improvements in the quality of clinical services they receive.

We identified for 2004–05 that PCTs had to manage a financial pressure of £150 million in 2004–05. Current 2005–06 forecasts identify there is likely to be a similar financial pressure that PCTs will be managing overspends of £150 million to 200 million, however, final figures will not be available until late autumn to confirm in the context of up to a £7 billion allocation as a consequence of resourcing the contracts.

This is a consequence of continued overspend on allocation primarily from:

- high achievement in the Quality and Outcomes Framework;
- increased spend on out-of-hours; but
- offset by further efficiency savings in PMS contracts.

¹ Forecast outturn—still subject to final validation.

High levels of achievement in the Quality and Outcomes Framework are to be congratulated. It shows we have a system in place that motivates general practice to provide high quality evidence based clinical care. This benefits the vast majority of patients and improves health prevention in 10 of the most common long-term illnesses as well as impacting on the wider NHS, for example, fewer avoidable hospital admissions due to better chronic disease management.

Increased spending on out-of-hours shows that PCTs are maximising use of their unified budgets in order to establish integrated networks of unscheduled care provision so that when patients contact out-of-hours services they can be assured that their clinical needs will be consistently met through fast and convenient access to care, delivered by the most appropriate professional in the most appropriate place.

Question 157 (Mr Richard Bacon): *Can you send us a copy of what you sent to the PCTs at the time (Some PCTs told the NAO that they did not know about the £9,500 and thought the service should cost £6,000).*

The Department, working with the NHS Confederation and the National Primary and Care Trusts (NATPACT), set out the actual costs of providing a GP out-of-hours service for PCTs in guidance described below. The guidance was reinforced through a number of workshops, which were held by regional out-of-hours coordinators and conferences. In addition, a comprehensive website was set up to share knowledge and best practice. (Where the average of £9.5k comes from is explained in the answer to Q229.) The information explaining the financing of the out-of-hours service was issued in a variety of media and included:

NHS CONFEDERATION/NATPACT—OOHS SERVICES UNDER THE NEW GMS CONTRACT—JULY 2003

Funding

GPs who opt out will lose an—average of £6,000 a year, which will be available to the PCT to fund out-of-hours services. The cost of providing services, though, will be greater than this, so PCTs will be able to use the following:

- Existing Out-of-Hours Development Fund money—The rules on using this budget will be relaxed and the statutory ring fence removed to give PCTs greater flexibility in how they use the money.
- Extra money—An extra £110 million is being made available to PCTs for out-of-hours modernisation over the next three years: £7 million 2003–04, £52 million 2004–05, £52 million 2005–06. The funding for 2003–04 will be used for development in PCTs outside the existing out-of-hours exemplar programme, and the funding for 2004–05 and 2005–06 will be made available to all PCTs to support provision.
- Unified budgets—Delivering out-of-hours modernisation is a key local development plan target and should be reflected in plans for their unified budgets. Integrating primary medical out-of-hours services with other out-of-hours services will also lead to savings that can be reinvested in developing better out-of-hours services

KEY FIRST STEPS IN DELIVERING A SUSTAINABLE INTEGRATED AND HIGH QUALITY SERVICE—DOCUMENT ISSUED IN OCTOBER 2003

Paragraph 39—Financial Structure—*Reconfiguration of OOHs, will allow PCTs to integrate existing and predominantly medical OOH services with other unscheduled and emergency care services and to pool allocations from across the unified budget for local emergency provision—not just the enhanced OOH Development Fund monies or the funds released by GPs opting out. It is important that PCTs consider all available funds, which will allow more effective use of the whole resource available in a more integrated model.*

Regional Out-of-Hours Coordinators

The DH appointed a number of OOH coordinators. The primary focus of the out-of-hours regional coordinators was to work with local health communities (SHA, PCTs, OOH providers) to promote and support the development of out-of-hours services following the Carson Report. The main objectives of the coordinators consisted of:

- Assisting in the implementation of the Department of Health's out-of-hours policy.
- Understanding the local agenda for their area.
- Providing a communication conduit both up to the Department and down to the PCTs, practices and providers.
- Educating and training on the out-of-hours policy.
- Providing guidance and support to SHA out-of-hours leads.

Regional out-of-hours coordinators have confirmed that the funding arrangements were discussed and explained locally. This included the fact that the £6,000 released by the GP was only part of the funds available to run the OOHs service.

Question 168 (Mr Edward Leigh): *We would like a note on how you propose to realise these savings of £134 million.*

The NAO Report makes clear that it is unrealistic to expect savings of £134 million but that savings of some £53 million should be achievable if PCTs running the least efficient services upped their game. PCTs need to examine how their services compare to the most cost effective in their benchmarked groups and look to improve cost effectiveness by:

- Driving value for money from future tendering processes based on real competition.
- Continuing to test the cost effective use of other health professionals alongside GPs in out of hours teams.
- Develop activity and cost data so as to improve provider performance.
- Analyse case mix to see if particular patient groups can be targeted by specialist primary or secondary care teams in order to reduce reliance on the out-of-hours services.
- Commission integrated urgent and unscheduled care services in order to reduce duplication.
- Providers making further operational improvements to deliver more effective utilisation of staff and infrastructures.

By taking the appropriate actions, all parts of the NHS will be able to improve, both in terms of the quality of patient care and the value for money their service deliver.

The report also suggests that there is no single model of provision which will work best for all PCTs but commissioners should continue to experiment with different arrangements.

We are supporting the NHS in this in three ways:

1. We wrote to PCTs on the day of publication of the NAO report with data showing their position compared to the most cost effective service in their grouping. We expect PCTs will consider the data and take action to improve their respective position. SHAs will have a key performance management role in ensuring this.
2. The NAO report highlighted inconsistencies in the commissioning process at PCT level. We will review and revise guidance on commissioning to incorporate good practice covering cost effective models. The National Audit Office has agreed to help write the revised guidance, which we aim to have completed by early July.
3. The National Audit Office and Department will host a conference for PCTs and out-of-hours providers in July. We are working with the NAO on the structure of the conference and expect it to include representatives from the NAO, DH, PCTs, and out-of-hours providers at the conference as a way of sharing best practice. The conference will also involve workshops/master classes to ensure PCTs can identify and take action on the changes required in their benchmark groupings as well as any general lessons.

Question 204 (Mr Ian Davidson): *What data is available to show how England compares to Scotland in out-of-hours provision.*

This data is not available. The NAO asked for data on costs from Audit Scotland, NHS24 and the NHS Boards in Scotland in order to make comparisons. Reliable data was not however made available from NHS Scotland.

Audit Scotland is currently embarking on a formal audit of GP out-of-hours services in Scotland. The report is due to be published in Spring 2007

Out-of-hours arrangements in Scotland, Wales and Northern Ireland

GP out-of-hours services in Scotland, Wales and Northern Ireland have broadly adopted the same basic system of care as England with a telephone assessment (triage) followed by mainly GP care. The administrations have adopted similar published quality standards. Their approaches have been influenced by the pre-contract quality standards introduced in England, but are less detailed.

All three countries implemented the new GMS contract with all GPs in Wales and Northern Ireland, and the vast majority in Scotland, opting out of the responsibility for the provision of out-of-hours care.

Questions 214 & 215 (Mr Alan Williams): *Yet every one of the 303 PCTs received £100,000 although they were of highly variable standard. This is a most peculiar situation to be in, is it not? You are giving money as a reward but you give it to those who do not meet your criteria; everyone gets it, good or bad.*

To reward PCTs in England for having robust arrangements in place for taking on their new responsibilities for out-of-hours (OOH) services and for ensuring that high quality sustainable services are in place, £30 million was available (100k for every PCT) in capital incentives over two phases.

First phase

All SHAs, informed DH of the number of PCTs who were eligible for the first 50k capital incentive when they demonstrated a state of readiness to take over out-of-hours responsibilities.

Second phase

The second payment was given to PCTs, who demonstrated to SHAs, that they were capable of delivering a sustainable high quality service, since assuming responsibility for out-of-hours services. SHAs were responsible for performance managing PCTs against locally set criteria before informing the Department about PCT eligibility for payment. A particular emphasis was placed on ensuring any handover between existing OOH providers and the PCT was managed effectively.

NAO Report

Providing out-of-hours services has always been challenging and sometimes the service is not always perfect. As the NAO report highlights, out-of-hours services have improved as a result of the changes implemented with no detriment to patient safety. The new arrangements, which gave PCTs responsibility, means that local services, will continue to be improved and developed into a better service for patients.

Question 229 (Mr Richard Bacon): *Mr Williams asked you from whom the £6,000 had come and you said that it arose out of the GMS negotiations. Was it a Department of Health figure.*

Yes. The figure was established as part of a wider range of negotiations for the agreement of the whole GMS contract.

Prior to the GP contract negotiations, the Department conducted economic analysis of GP co-operatives, analysing figures for urban, rural and mixed areas, to estimate the cost to GPs of providing the service.

The costs encompassed two elements: those met directly by GPs and additional out-of-hours development funds allocated to PCTs for investment in GP practices. Total OOH costs for PCTs varied from £7,000 per year to £14,000 per year per GP, with a mean of approximately £9,500. The precise sum varied between GPs, depending on list size and other factors.

The £6,000 figure represented a reasonable assessment of actual GP costs, excluding additional funding from PCT budgets. The outcome of the negotiations was an agreement to an amount of £6,000 to be foregone by GPs from their income.

In addition to the £6,000 sum refunded by the GPs, the Department provided development funding to PCTs of some £3,500 per GP to help establish the new service. This recognised that the economic analysis of the existing service suggested that a mean of approximately £9,500 would be required to provide an OOH service.

Letter from Chief Executive, National Health Service to the Clerk of the Committee

PRIMARY MEDICAL CARE SERVICES EXPENDITURE FORECASTS (2004–05 & 2005–06)

This note provides you with the final expenditure figures for primary medical care services in 2004–05 and 2005–06. The aggregate level of spend in 2004–05 is the same as the provisional figure we have already shared with you. The figure for 2005–06 remains provisional, but our latest estimate suggests an overall increase in total spend of £56 million. However, I have decided to write to the Committee/NAO/Audit Commission setting out the latest position because we have also revised the presentation of the figures for some of the services within the overall primary medical care services envelope.

The main difference in the figures is that we have changed the way we are recording the level of funding available to fund Out of Hours services. There are two elements that make up this funding. The first is a specific funding stream to cover the cost of PCT obligations for providing Out of Hours services, and these are the figures we were initially showing as the resources allocated for Out of Hours services. The second relates to the funding made available to practices as part of Global Sum and Personal Medical Services (PMS) contract payments, which includes an element of funding to compensate practices for providing Out of Hours services.

However, where responsibility for providing Out of Hours services has transferred from practices to PCTs, the new contracting arrangements requires that some of the Out of Hours funding transfers from practices to PCTs. In both 2004–05 and 2005–06 a significant proportion of primary care contractors have taken the opportunity to transfer responsibility for providing Out of Hours care to PCTs. As a result of the transferred responsibility, there is a reduction in practice income. In our revised presentation, we are now

showing this funding as being available for PCT provision of Out of Hours services. In the revised presentation the total funding available for PCT provision of Out of Hours is more accurately aligned with the expenditure.

The more accurate presentation shows that in 2005–06 the reported overspend for Out of Hours has reduced from the £242 million originally reported to an overspend of £76 million.

For completeness and to allow comparisons, I have attached a table showing a breakdown of allocations and expenditure for each service within the primary medical services envelope, covering both 2004–05 and 2005–06.

I apologise if this change in approach is potentially confusing, but I believe the revised presentation is a more accurate reflection of the actual position with Out of Hours services. I will, of course, provide you with additional information if you would find that useful.

Yours sincerely,

David Nicholson CBE
NHS Chief Executive

Table 3

2004–05 PRIMARY MEDICAL CARE SERVICES

	<i>Total National Allocation to PCTs £ million</i>	<i>(1) Total National Spend by PCTs (Final PFR1A-C) £ million</i>	<i>Variance Over (+)/ Under (–) Spend £ million</i>
GMS Contracts (Global Sum & MPIG) (includes APMS & PCTMS additional, essential and other payments)	1,934	1,959	
(2) less notional transfer to PCTs to commission Out of Hours services	– 54		
Total	1,880	1,959	79
PMS Contracts	2,213	2,012	
(2) less notional transfer to PCTs to commission Out of Hours services	– 36		
Total	2,177	2,012	– 165
Quality Outcome Framework	504	659	155
Enhanced Services	601	588	– 13
PCO Administration, eg seniority payments	89	197	108
Premises eg cost and notional rent schemes	386	370	– 16
Information Technology	64	66	2
Out of Hours	105	209	
(2) add notional transfer from GMS/PMS	90		
Total	195	209	14
Other	59	43	– 16
Dispensing	847	854	7
Grand Total	6,802	6,957	155

(1) Source: 2004–05 audited PFR1A-C returns from 303 PCTs England.

(2) Takes into account the sums surrendered by those GMS and PMS practices who chose to opt out of providing out of hours services during 2004–05, ie these practices surrendered a sum broadly equivalent to £6k per average GP. Assumes a stepped approach to opt out across the year, 30% by June/July 2004, 60% by September 2004 and 90% by January 2005.

2005–06 PRIMARY MEDICAL CARE SERVICES

Table 4

	<i>Total National Allocation to PCTs £ million</i>	<i>(1) Total National Spend by PCTs (Final PFR1A-C) £ million</i>	<i>Variance Over (+)/ Under (-) Spend £ million</i>
GMS Contracts (Global Sum & MPIG) (includes APMS & PCTMS additional, essential and other payments	1,941	1,967	
(2) less notional transfer to PCTs to commission Out of Hours services	- 95		
Total	1,846	1,967	121
PMS Contracts	2,254	2,025	
(2) less notional transfer to PCTs to commission Out of Hours services	- 65		
Total	2,189	2,025	- 164
Quality Outcome Framework	927	1,095	168
Enhanced Services	676	656	- 20
PCO Administration, eg seniority payments	94	195	101
Premises eg cost and notional rent schemes	452	420	- 32
Information Technology	65	68	4
Out of Hours	142	378	
(2) add notional transfer from GMS/PMS	160		
Total	302	378	76
Other	50	48	- 2
Dispensing	883	883	0
Grand Total	7,483	7,735	252

(1) Source: 2005–06 audited PFR1A-C returns from 303 PCTs England.

(2) Takes into account the sums surrendered by those GMS and PMS practices who chose to opt out of providing out of hours services during 2004–05, ie these practices surrendered a sum broadly equivalent to £6k per average GP. [By April 2005, 90% of GPs chose to opt out of providing out-of-hours care. This equates to a total surrender value of circa £160 million].