

# The PCT approach to Practice Based Commissioning

**December 2005**

# Introduction

## Introduction

Hammersmith and Fulham Primary Care Trust has developed an approach to implementing PBC in 2005 that aims to put clinicians at the centre of decision making.

Underpinning the scheme is the principle that Practice Based Commissioning offers an opportunity to improve patient care. The PCT aims to devolve and align responsibility, accountability and authority at a level where it will be most effective in improving patient care.

Over the last 6 months, we have worked with GP practices and the Professional Executive Committee to develop the local model for PBC. It is designed to minimise administration whilst providing optimum freedom, support and flexibility for clinicians to commission and clinically innovate.

## The PCT model

- Budgets are devolved to practices with a sliding scale of releasable savings dependant on how the practice and the PCT perform.
- Savings can be reinvested in the next year.
- The PBC Preparatory Scheme Local Enhanced Service provides a framework for practices to engage with the principles of PBC whilst recognising that preparation at practice level takes commitment.
- A practice and the PCT will be expected to sign up to a Service Level Agreement which stipulates what each can expect from PBC .

## [The PBC Service Level Agreement \(SLA\)](#)

Early consultation showed that practices needed to be fully aware of what would be expected of them under PBC. Equally, they also wanted to know what they could expect in support from the PCT. In response, the PCT developed a Service Level Agreement that lays out the services it will be providing as PBC support functions, and the expectations of practices in carrying out their duties under PBC.

### [PBC SLA](#)

## [The PBC Preparatory Scheme LES](#)

The PBC Preparatory Scheme is being introduced to prepare practices for full implementation of Practice Based Commissioning. The LES provides an operational framework to improve data quality, aligning activity with referral data. The scheme also aims to support some of the PCT's demand management work e.g. GPs with special interests (GPwSI) thereby maximising the management of patients in the Primary Care setting. It is also, and perhaps most importantly, a further support mechanism for the referral guidelines of the PCT.

The incentive supports practices to work with the PCT's Demand Management programme and provide a good clinical work up in primary care by using:

- Referral guidelines LES (care pathways)
- Referral to GPwSI
- Peer review in the practice and referral planning

Practices are facilitated in any 'preparatory' work for PBC uptake such as information governance, checking patient and practice details in activity information and supporting the validation of activity by the PCT. The PCT will provide tools to help with these tasks such as the unique referral identifier tool.

### [PBC LES](#)

## [Budgets were devolved to practices in November 2005](#)

The Professional Executive Committee approved the devolvement of acute services budgets at its meeting on 14 September 2005. The PEC will oversee the GP sign-up process, resultant service development and PCT support. The PEC will moderate for any uncertainties experienced with the activity and price data used to calculate the savings achieved by GP practices.

The budgets initially include acute SLAs for emergency admissions, elective admissions and outpatients 1st & follow-up (including non GP referrals)

### [Example devolved PBC Budget](#)

## **The PBC Team**

The Primary Care Trust is providing a PBC support function for GP Practice that uses the expertise within information, finance, primary care and commissioning departments.

The PBC team can be contracted at [pbct@hf-pct.nhs.uk](mailto:pbct@hf-pct.nhs.uk)

# Practice Based Commissioning

## Service Level Agreement between PCT and GP Practices

### 1 Executive Summary

1.1 Practice based commissioning is a national directive for the NHS to put patients at the centre of health care by enabling GP Practices to steer the strategic direction of their health communities. To support the implementation of practice based commissioning in Hammersmith and Fulham, this agreement sets out the responsibilities of each party to provide and validate information about commissioned service activity and finance.

1.2 The PCT has developed a financial model for the implementation of practice based commissioning (appendix 1). The PCT will provide each GP practice with indicative budgets which will include a locally agreed scale of savings in accordance with national guidance. Practices will be able to use any savings they generate on developing or commissioning further services to improve local health care provision.

### 2 Specification of the Agreement

2.1 The practice can expect to receive monthly finance and activity information by H&F PCT outlined in schedule A. This information will enable the practice to satisfy it's terms of the agreement (see schedule B) and to track the practice's performance. The PCT will call the range of services provided under schedule A the 'PBC Support Function'.

2.2 The release and use of savings is dependant on the implementation of a set of validation procedures by the practice and supported by the PCT. The use of the savings must also support local and national strategies for primary care.

2.3 The PCT responsibilities are outlined in schedule A, and the practice responsibilities are outlined in schedule B.

2.4 In schedule B the practice should add their lead(s) to the third column before signing. In practice, this can be the PBC practice lead.

2.5 The PCT expects a practice to sign up for PBC by 31st March in each year they participate. This version of the document will be valid until 31st March 2005 and will be subject to periodic review.

### 3 Schedule A: PCT responsibilities under the PBC Support Function

Functions	Description	Source of original decision to include within PBC.	Lead/ named dprmt	Frequency
1. Provision of Activity information	1.1 Practice by practice data on secondary care activity 1.2 The PCT will be able to provide validation of clearnet activity to GP practice level. Clearnet data is approximately 2-3 months old, and will be replaced by SUS in 2006. 1.3. The PCT will provide Dr Foster's Hospital Activity Tracker or equivalent system or reporting mechanism to practices from January 2006 to scrutinise their own clearnet data.	Appendix 1  Appendix 1	Information Team	Monthly
2. Provision of Finance Information	2.1 Indicative budgets for each practice, with targets for savings 2.2 Performance information. This will be measured by activity using devolved indicative budgets as a benchmark for performance, broken down by practice and speciality using retrospective (clearnet) data and using the template provided in the 'Budget Development' paper (Dec 2005) Annex 1 2.3 Release of savings for the use of the practice for use in year 2 at year 1 end subject to fulfilling criteria in schedule B	Annex 1 and appendix 2	2.1 Finance Team  2.2 Information team	Annually and reviewed Monthly  Monthly  Annually
3. Local enhanced services	3.1 The PCT will provide voluntary LES service (s) that provide and develop the aims of PBC. The first scheme is the PBC preparatory scheme		Primary Care Development Team	First scheme will be time limited- future schemes may be developed
4. Choice And Booking	4.1 Support on the implementation of choose and book software 4.2 Support with links for practices to secondary providers for IBS services under choose and book (e.g. locally or using the London service)	Appendix 2	Health Informatics	
5. Patient involvement	5.1 The PCT will support the development of patient panels and continue to support patient involvement through the qualities and outcomes framework (QOF), patient survey indicators	Appendix 2	Commissioning Team	Annually and reviewed
6. Commissioning/ Contracting	6.1 The PCT will promote an invest to save to invest approach to developing primary care lead initiatives, and ensure contestability of the service redesign being proposed. 6.2 PCT will retain the responsibility for negotiation with providers as under national PBC guidance 6.3 The PCT will ensure that commissioning decisions are within the framework of national and local guidance e.g. NICE and PBC national guidance 6.4 The PCT will implement a yearly demand	Annex 2	Contracting finance Commissioning Team	Provide practice with contracting info on annual basis

#### 4 Schedule B: Practice Responsibilities under PBC

Functions	Description	Source of original decision to include within PBC.	Lead/ named department (to be completed for each practice)	Frequency
1. Activity information	1.1 If the practice has signed up to the PBC Preparatory LES, the practice will use the URID system to assign a number to all referrals to secondary care. 1.2 Using URID will enable a practice to have simple access to all their onward referral information 1.3 The validation requirements are that the practice audit a statistically significant random sample of secondary care referrals. The PCT will endeavour to ensure all audits require no more than 10 items per 1000 list size to be sampled monthly. The sample will be generated by the PCT using clearnet data. 1.4 Annually, the PCT may require an audit of the validation requirements in 1.3 and the practice will co-operate with the audit requirements	Appendix 1 and PBC preparatory scheme		Monthly  1.3 One specialty monthly. The speciality will be targeted by the PCT
2. Choice And Booking	2.1 To use CAB software or to use manual method to deliver choice for first elective outpatient appointments for all specialities			
3. Patient involvement	3.1 Under QOF, patient surveys to incorporate a section on choice and PBC			Annually
4. Commissioning/ Contracting	4.1 If a practice is directing the use of savings, the PCT will require a written plan on commissioning intentions.			
5. Technical/ IT support	5.1 Ensuring clinical system is up to date and available for clinical audit purposes.			
6. Innovations	6.1 The practice will be able to confirm the costs and business model of any proposal for use of the savings and accounts to verify spend.			
7. Educational support	7.1 The practice will ensure that relevant staff responsible for PBC will be available to attend local and national collaborative educational programmes in PBC			

#### 5 Accountability/ Governance

The PBC scheme is part of a national programme for implementing a patient lead NHS and as such, both practices and the PCT will ensure that any local schemes are within national guidance. The PCT will work to interpret guidance if there is not clarity locally about the guidance's impact on local PBC implementation.

In all the above, the savings must be demonstrated across all provision in released indicative budgets. Financial balance must be achieved over the three year cycle within practice. Savings available to the practice under PBC will have a separate process which will satisfy the PCT that the savings are being invested appropriately and support enhanced patient experience.

The Executive Directors of the PCT have the delegated responsibility of the Board to ensure that the financial stability of the PCT is maintained.

**6 Review**

The PCT will review the approach to PBC annually and report to the PEC for approval of any substantial material changes to the scheme and supporting protocols.

**7 Sign off**

I agree to the terms and conditions set out in this service level agreement

Signed.....

Name.....

Date.....

PBC Lead or senior partner, (practice name)

Signed.....

Director of Commissioning, H&F PCT

# Practice Based Commissioning

Preparatory Scheme – 2005/06

## Background

The Practice Based Commissioning (PBC) Preparatory Scheme is being introduced to prepare the practice for full implementation of Practice Based Commissioning by providing an operational framework to improve the quality of the fit between activity and referral data. The scheme also aims to support some of the demand management work e.g. GPs with special interests (GPwSI) thereby maximising the management of patients in the Primary Care setting. It is also, and perhaps most importantly, a further support mechanism for the referral guidelines of the PCT.

The scheme requires practices to develop plans detailing the processes to be put in place to review their referrals and review the application of the referral guidelines. This will not only allow the development of alternative models of primary care but also establish a minimum patient work up in primary care.

The second key element of the PBC Preparatory Scheme is the opportunity for practices to see how many referrals they are making (and their cost) in comparison to other practices and in comparison with the PCT's ability to pay. Practices will be provided with indicative "budgets" or "activity" figures and with regular updates on actual activity, in comparison with the data across the PCT. This exercise is seen as essential to the proper functioning in due course of Practice Based Commissioning, through which a shift of financial resources from secondary to primary care and change of service provider becomes possible. One of the scheme's key aims is to allow practices to examine where there are high quality primary care alternatives to secondary care. This is likely over time to enable financial savings to be made across the PCT, allowing for further investment in Primary Care services.

## The Practice Based Commissioning Preparatory Scheme

The scheme will pay up to £1 per capita<sup>1</sup>. The scheme runs from 1st November 2005 to 31st December 2006. The scheme will pay 50p per capita on sign up and a further 50p on 30th April 2006 subject to review (see section, 'Review of PBC Preparatory Scheme').

### Key elements

- 1 A managerial and clinical lead for Practice Based Commissioning is to be nominated in each Practice. For smaller or single GP practices, the expectation is that this can be the same person. The clinical lead in each Practice will be required to work with the implementation of the existing referral protocols.
- 2 A referral plan to be produced by Practices to review referral management. Practices are encouraged to review internally and monitor the use of the referral guidelines and also contribute to their future refinement.
- 3 The practice uses the patient care pathways as developed by the PCT (Locally Enhanced Service for Referral Guidelines) and agreed by PEC. An audit will be undertaken by the PCT to ensure that these protocols are being used for the purpose of reviewing the usability and uptake of the referral guidelines.
- 4 All practices implement choice by December 2005: the national target date for all elective first outpatient referrals to be processed using a choice of at least four providers. The PCT is working on procedures to support delivery of choice at practice level using both choose and book software and a manual choice toolkit.
- 5 Quality: It is essential that all referrals include the

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<sup>1</sup> Per Capita in this instance will be calculated on list size as of September 30th 2005 for the first installment and for the second payment, 31st March 2006.

following information:-

#### Patient Information

- First name and Surname
- Address (checked at the time of referral)
- Telephone number  
(checked at the time of referral)
- Date of Birth
- Unique Referral ID number (generated via the PCT developed Unique Referral ID generator or URID)
- NHS number

#### Practice Information

- Practice telephone number and Fax number
- Referring Practitioner

- 6 Clinical Governance: The clinical governance of all commissioned services will be directed by the PCT as the services will be commissioned on behalf of GPs by the PCT with the support of the PEC. The clinical practice of the GP should not be altered by the scheme.
- 7a) Practices will be required to show evidence of putting in place peer review of selected outlying referrals using the referral guidelines to provide full an investigative process at primary care level before a patient is referred on. The evidence will be gathered as part of the PCT review process, and the PCT will negotiate with the practice on choosing a specialty to review. Peer reviewing will be incremental and as such, will not necessarily be completed by 30th April 2006 in order for practice to receive the April 2006 payment.
- 7b) The PBC Preparatory Scheme offers the following opportunities for improved referral practice:-
- by using GPwSI services. These already represent a substantial proportion of referrals for dermatology and minor surgery.
  - providing enhanced options within practices for treatment and diagnosis
  - sharing of referral practice information on a

monthly basis to practice/practitioner level

- peer to peer review of indicative budgets

Other practice innovations aimed at improvement of quality of patient referrals are welcomed, particularly where primary care alternatives are found, and should be described in addition to the above PCT led initiatives.

The use of the patient care pathways and guidelines should enable practices to re-route referrals from secondary care where this is appropriate.

### **Indicative PBC Budgets**

Indicative budgets will be devolved to practices under full PBC, with the first set of budgets associated with acute spend being made available for 1st November 2005. Indicative budgets for practices will be calculated using a formula based on 2004-5 spend (50%) and capitation based distribution across the PCT (50%).. I

indicative budgets will provide a benchmark by which the enhanced service will be reviewed.

### **Review of the Practice Based Commissioning Preparatory Scheme**

Each practice will be reviewed on their implementation of the key elements of the PBC Preparatory Scheme (items 1-6 above) to provide evidence for release of the April 2006 payment. Each practice will be provided with regular referral activity from using the Unique Referral ID tool and the PCT will provide information on performance against an activity and financial budget. The practice will be informed of the process and performance indicators prior to review.

Referral Guidelines under the Locally Enhanced Service will be reviewed twice a year and all GPs are invited to participate in this review process together with clinicians from our local acute trusts.

The scheme will be active from the 1st November 2005

and terminate on 31st December 2006.

## Payment

Practices joining the scheme after January 31st 2006 will be eligible for 50p only, and will be subject to review by June 2006.

Per Capita will be calculated on list size as of September 30th 2005 for the first installment and for the second payment, 31st March 2006.

Payment will be made on the receipt of an invoice which should be addressed to Sally Collins, Primary Care Development Team, H&F PCT.

## Application for Locally Enhanced Service Practice Based Commissioning Preparatory Scheme

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Dr's name :

Practice :

Address :

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I wish to participate in the Practice Based Commissioning  
Preparatory Scheme  (please tick box)

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I confirm that the practice will conform to the requirements of the  
Practice Based Commissioning Preparatory Scheme Local Enhanced  
Service

Signed (Partner) :

Date :

  

Practice stamp :

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Please fax back to Sally Collins, on 0208 846 6770  
or post to Sally at 5-7 Parsons Green, London, SW6 4UL

# Budget Devolvement Notification of Acute Services Budget

## Executive Summary

Practice Based Commissioning (PBC) aims to give GP practices financial control over the way health care is provided by devolving budgets directly to practices.

This will enable practices to steer the strategic direction of their health communities. It also provides practices with an opportunity to influence resourcing decisions at an early stage and offer alternatives to secondary care, where this would benefit patients. This paper provides a short summary of the scope and purpose of the scheme.

As a first stage, please be advised that your practice has been devolved a financial budget of £ 1,838,999 for 2005-06 with which to manage the acute services delivered under the acute Service Level Agreements (SLAs) held with partner hospitals.

If you would like to ask any questions or make any comments on this paper, please contact Richard Simon by email or on **020 8846 6730**.

## Services devolved

The PEC approved both the scope of the services and budgets to be devolved in 2005-06 and the methodology for calculating them, at its meeting on 14 September 2005.

The budgeted activity required to deliver the financial budget for your practice is presented in Annex 1. The following elements of the acute SLAs have been selected for devolvement because activity data by GP practice is readily available:

- Emergency admissions;
- Elective admissions (including day cases and critical care for elective admissions);and
- Outpatients 1st & follow-up

The 2005-06 activity budget for acute SLAs has been allocated to GP practices based on:

- 50% of each GP Practice's 2004-05 activity; plus
- 50% of the expected 2004-05 activity based on capitation, age and sex; less
- The reduction in activity expected as a result of the PCT's Demand Management initiatives, such as the GP panel reviewing all non GP referrals to the Hammersmith and Chelsea & Westminster Hospitals.

We propose the 50:50 split as an interim approach in 2005-06 before the budgets are devolved based purely on weighted capitation in future years.

### Provision of monitoring information

The PCT will send out monthly monitoring information to show the performance of your practice against the activity and financial budget.

### Using PBC to transfer funding to primary care

The objective of PBC is to create an incentive to transfer funding to primary care, where it is the most appropriate setting, by generating savings in other areas. This first stage of implementation of PbR provides the opportunity to transfer funding from acute to primary care.

Therefore, in 2006-07, Practices will be offered additional budgets for expenditure on schemes/types of expenditure approved by the PEC to enhance primary care services based on the extent to which:

- The Practice achieves target saving in the acute activity budgets (% of out turn / budget); and
- The PCT also delivers its agreed savings on the overall Acute providers' SLA budgets.

Practices will receive additional budget if they achieve savings in their own practice, but the budget transfer will be greater if other practices also make savings on their budgets.

sample

The proportions proposed for allocating the additional budget are presented in the table below.

**table showing: Percentage of savings which the GP practice will "earn" for expenditure in 2006-07 on approved schemes**

		If the PCT achieves the following saving on the acute budgets		
		No saving	0 to 5% saving of budget	More than 5% saving of budget
If the GP practice achieves the following saving on their budget for acute services	0 to 5% saving of budget	10%	25%	25%
	5 to 10% saving of budget	10%	50%	75%
	More than 10% saving of budget	10%	75%	100%

Examples of the additional budget that you could obtain for your practice in 2006-07 are presented below for a range of PCT and GP savings that could be obtained on the 2005-06 Acute services budget.

**The additional budget for the GP practice under the following circumstances**

	2005-06 GP practice budget	GP practice saving	PCT makes Zero saving	PCT makes 5% saving	PCT makes 10% saving
<b>GP makes 5% saving</b>					
<b>Inpatient Admissions</b>	1,255,709	62,785	6,279	15,696	31,393
<b>Outpatient Attendances</b>	583,290	29,165	2,916	7,291	14,582
<b>Total</b>	<b>1,838,999</b>	<b>91,950</b>	<b>9,195</b>	<b>22,987</b>	<b>45,975</b>
<b>GP makes 10% saving</b>	<b>2005-06 budget</b>	<b>GP practice saving</b>	PCT Zero saving	PCT 5% saving	PCT 10% saving
<b>Inpatient Admissions</b>	1,255,709	125,571	12,557	62,785	94,178
<b>Outpatient Attendances</b>	583,290	58,329	5,833	29,165	43,747
<b>Total</b>	<b>1,838,999</b>	<b>183,900</b>	<b>18,390</b>	<b>91,950</b>	<b>137,925</b>
<b>GP makes 15% saving</b>	<b>2005-06 budget</b>	<b>GP practice saving</b>	PCT Zero saving	PCT 5% saving	PCT 10% saving
<b>Inpatient Admissions</b>	1,255,709	188,356	18,836	141,267	188,356
<b>Outpatient Attendances</b>	583,290	87,494	8,749	65,620	87,494
<b>Total</b>	<b>1,838,999</b>	<b>275,850</b>	<b>27,585</b>	<b>206,887</b>	<b>275,850</b>

The PCT is already well on its way to achieving its targeted savings, so enabling the GP practices also to meet or exceed their targets. Areas in which significant savings have already been made are:

- Not paying for activity which has not been referred by GPs, which account for about 33% of all new outpatient referrals, through the operation of the GP referral panel.
- Not paying for follow up outpatient activity which exceeds agreed targets, based on moving towards the national average.
- Transferring stable anti-coagulation patients into the community (either to GPs or to community clinics). Nearly 1000 such patients are now being managed in this way.
- Using the GPwSIs to review referrals before transferring them to an acute hospital. We now have three GPwSIs.
- The current trend in reduction in GP referrals in dermatology and musculoskeletal outpatients.

We estimated that savings of around 5% could be made on the acute hospital SLAs this year by measures of this type. This includes:

	potential savings (000's)
Not paying for non GP referrals and associated follow up outpatient appointments not approved by the GP referral panel - relates to both Hammersmith Hospitals and C&W referrals	2,000
Reduce GP referrals	200
Use GPwSIs to treat patients instead of hospital referral	200
Transfer anti-coagulation and diabetic patients to the community	200
Transfer patients for rehabilitation to Farm Lane	150
Treat non urgent elective patients within NHS target timescales	500
<b>Total</b>	<b>3,250</b>

Note: These are estimates only and are dependent on the favourable outcome of arbitration process and the full implementation of current plans.

## Managing data uncertainty in 2005-06

It is proposed that the PEC will be vested with powers to moderate for any uncertainties experienced with either the activity monitoring data or the prices used by the Finance department to calculate the savings achieved by GP practices.

Miles Freeman  
Head of Primary Care Development  
November 2005

sample

Annex 1 Financial and activity budgets for Acute services for  
Dr xxx practice in 2005-06

Practice Based Commissioning - Practice Name E00000

List Size: 5161 190695  
 Total Cost 1,838,999 173%  
 Inpatient Activity Total activity 3,689 87%

HRG	Elective Inpatient Admissions		Elective Daycase Admissions		Non Elective Admissions		
	2005-06 Budget		2005-06 Budget		2005-06 Budget		
	Activity	£	Activity	£	Activity	£	
A	Nervous System	3	5624	5	5354	12	39564
B	Eyes and Periorbital	4	6047	13	13186	2	4100
C	Mouth, Head, Neck and Ears	10	17228	19	19208	8	16368
D	Respiratory System	2	4017	5	4498	30	89303
E	Cardiac Surgery and Primary Cardiac Conditions	3	13809	2	2610	36	99382
F	Digestive System	9	17360	31	21090	37	83054
G	Hepato-biliary and Pancreatic System	2	4251	1	752	5	17139
H	Musculoskeletal System	9	31839	12	13755	29	84972
J	Skin, Breast and Burns	5	10577	16	10987	14	35985
K	Endocrine and Metabolic System	1	1971	2	1056	2	5327
L	Urinary Tract and Male Reproductive System	5	8901	13	9235	17	44717
M	Female Reproductive System	6	12410	9	7198	9	11834
N	Obstetrics and Neonatal Care	1	650	0	0	182	191294
P	Diseases of Childhood	2	2440	4	3889	39	45269
Q	Vascular System	3	7338	2	3089	5	30915
R	Spinal Surgery and Primary Spinal Conditions	2	8829	0	0	4	10665
S	Haematology, Infectious Diseases, Poisoning and Non-Specific Groupings	5	4768	20	21741	23	50707
T	Mental Health	1	3099	0	0	17	58714
U	Unknown	1	3436	1	2919	11	31239
<b>Total</b>		<b>74</b>	<b>164,594</b>	<b>155</b>	<b>140,567</b>	<b>482</b>	<b>950,548</b>

Outpatient and A&E Activity

Specialty	OP - New Attendances		OP - Follow Up Attendances		
	2005-06 Budget		2005-06 Budget		
	Activity	£	Activity	£	
100	General Surgery	75	16721	158	20007
101	Urology	24	5184	46	7026
110	Trauma & Orthopaedics	111	23489	151	17237
120	E.N.T.	42	6938	54	4980
130	Ophthalmology	54	8122	128	10188
140	Oral Surgery	20	3537	28	3250
150	Neurosurgery	2	528	4	849
160	Plastic Surgery	5	944	18	1950
170	Cardiothoracic Surgery	1	168	4	386
171	Paediatric Surgery	11	2753	10	1680
300	General Medicine	5	1554	23	3357
301	Gastroenterology	34	8916	121	16156
302	Endocrinology	13	4253	39	12730
303	Clinical Haematology	10	3951	89	74062
310	Audiological Medicine	4	815	5	967
315	Palliative Medicine	0	0	0	0
320	Cardiology	55	12228	120	15002
330	Dermatology	40	9016	72	9620
340	Thoracic Medicine	15	4852	57	13043
350	Infectious Diseases	2	409	12	2354
361	Nephrology	4	963	41	10390
370	Medical Oncology	5	2053	54	9548
400	Neurology	32	8444	54	11253
410	Rheumatology	19	5654	73	10823
420	Paediatrics	138	49319	239	47468
430	Geriatric Medicine	5	2028	10	4050
501	Obstetrics	71	14924	182	19969
502	Gynaecology	66	14036	116	14077
	Other	46	9680	161	19389
<b>Total</b>		<b>909</b>	<b>221,479</b>	<b>2,069</b>	<b>361,811</b>

sample