Focus on… the financial monitoring of enhanced services

This guidance note has been produced by the General Practitioners Committee to help LMCs in their role of agreeing with their Primary Care Organisations (PCOs) which enhanced services count towards the PCO-level expenditure floor. It is one of a series of guidance notes about the new GMS contract.

Introduction

The Technical Steering Committee (TSC)[*] has been given the following roles:

1. monitoring total enhanced services spending; and

2. (a) for 2003/04, monitoring at national level enhanced services spending as part of the four national Gross Investment Guarantees

   (b) from 2004/05 onwards, monitoring PCO-level enhanced services expenditure to determine the achievement of PCO-level floors which, aggregated to national level, forms the enhanced services component of each of the four national Gross Investment Guarantees.

The breakdown of national monitoring has yet to be finalised.

Given that the TSC will be collecting PCO-level data, it is essential that LMCs are fully aware of their role in agreeing PCO-level expenditure on enhanced services, as detailed in paragraph 2.80 of the Department of Health's guidance "Delivering Investment in General Practice: Implementing the New GMS Contract". Similar arrangements apply in all four countries.

Understanding Enhanced Services

The concept of enhanced services envisaged by the negotiating parties is detailed in paragraphs 2.13 to 2.16 of the contract document "The New GMS Contract: Investing in General Practice". These paragraphs highlight a number of key features:

a. enhanced services are:
   (i) essential or additional services delivered to a higher specified standard
   (ii) services not provided through essential or additional services, for example more specialised services by health professionals, services at the primary-secondary care interface or services meeting specific local health needs

b. that PCOs will be free and able to commission whichever enhanced services they consider appropriate to meet local health needs – this freedom will subsume existing LDSs, the Improving Primary Care incentive scheme, services currently delivered under HSG(96)31, GPs with special interests and schemes to improve patient access

c. directed enhanced services (DESs) – those services that PCOs are nationally directed to commission

d. national enhanced services (NESs) – those services that have national minimum specifications and benchmark pricing, including services outwith current GMS arrangements that will contribute to the resourced shift of work from the secondary to the

[*] An independent committee led by Department of Health statisticians commissioned jointly by the GPC, the Department of Health and the NHS Confederation. Previously, its role has been to inform the Doctors and Dentists Review Body about GPs' income and expenses.

primary care sector. Where these services are commissioned from general practice, the national specifications will be used as the basis

e. local enhanced services (LESs) – those services that may be developed in response to local need, for which the terms and conditions will be discussed locally between the PCO and the practice, with either party able to ask the LMC for its support in the process

f. that many contracts for enhanced services are likely to be placed with GMS or PMS providers because historically they have been providing the services, although some may be placed with alternative providers including NHS trusts. PCOs will also be able to provide the services themselves.

Defining Enhanced Services

The NHS (GMS Contracts) Regulations (2004) provide a very broad legal definition of enhanced services:

> "(a) services other than essential services, additional services or out-of-hours services; or
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> (b) essential services, additional services or out-of-hours services or an element of such a service that a contractor agrees under the contract to provide in accordance with specifications set out in a plan, which requires of the contractor an enhanced level of service provision to that which it needs generally to provide in relation to that service or element of service."

However, for the purpose of financial monitoring against the PCO-level expenditure floor, it is necessary to restrict this definition and provide a steer as to which services should be counted.

The GPC has been asked to provide a detailed list of services that should be regarded as enhanced services. This is not possible. There will always be local exceptions that the national guidance could not cover, which LMCs should be free to agree if they believe they are appropriate in their area. As enhanced services are partly defined as essential or additional services delivered to a higher specified standard, there is some overlap which local discussions will need to bear in mind.

The following are guiding principles:

A. All DESs, which are to be commissioned by all PCOs (with the exception that there is no access DES in Scotland) are, by definition, enhanced services.

B. All NESs are, by definition, enhanced services. If any of those services are to be provided by practices, those practices should expect the services to be resourced.

C. Anything that is a GMS (or PMS-equivalent) essential or additional service, by definition, cannot be an enhanced service.

D. Services that are moved from the secondary care sector and instead provided in primary care by primary health care professionals are by definition enhanced services. The following combination of factors would seem to be relevant when determining that a former secondary care service has been shifted to primary care:
- a service now being provided in the primary care setting
- a service now being provided which is contestable for GMS and PMS contractors and might reasonably be provided by them.

E. Local development schemes, incentive schemes or practitioners with a special interest (excluding essential or additional services work) etc, funded by current expenditure, are enhanced services.

F. Services that are provided by GPs in the secondary care sector, eg certain services in community hospitals or as a clinical assistant, are not enhanced services.

G. The provision of enhanced services is not restricted to GMS or PMS providers.

H. For financial monitoring purposes, LMCs (or their equivalent) should agree which services count as enhanced services.

In addition to these principles, the recent Department of Health guidance "Delivering Investment in General Practice: implementing the new GMS contract" sets out examples of what would and would not count towards the PCO-level expenditure floor (paragraphs 2.78 and 2.79).

Role of the LMC (or equivalent)

The PCO's commissioning strategy should be signed off by its Professional Executive Committee (PEC) (or its equivalent). The LMCs should be consulted on the proposed level of spend and its agreement sought on those services to be counted within the definition of enhanced services for the purposes of the local expenditure floor.

The best way for LMCs to take forward this particular role would seem to be to propose a building-block system of categories, as follows.

1. Expenditure on directed enhanced services

2. Expenditure on national enhanced services

3. Expenditure on local enhanced services provided by GMS or PMS practices that are approved by the PEC and the LMC (or equivalents) in the roles described in the Department of Health guidance

4. Expenditure on local enhanced services or other services provided by allied health professionals, secondary care providers or any other third party provider in the primary care setting that are approved by the PEC and the LMC (or equivalents) in the roles described in the Department of Health guidance.

This is a useful guide in terms of local discussions.

Defining enhanced services for local negotiation

PCOs, practices and LMCs have been encouraged to agree a strategy on developing enhanced services by the end of February. This does not require all issues relating to contracts for enhanced services to be in place. However, the strategy should include issues relating to how both previously unresourced services and expanded ranges of enhanced services will be commissioned as part of strategic service development.

On the former, we are aware that sometimes a different emphasis has been placed on the distinction between essential and enhanced services. We are absolutely clear that the definition of essential services is not all services that were already being provided by the practice and are equally clear that enhanced services are not by definition limited to new services only. The national guidance is clear that practices will be funded through the global sum or MPIG to provide services equivalent to those for which they were funded through GMS previously.

However, under the old GMS contract, practices have been providing enhanced services for which they were receiving little or no funding. This will vary between practices and PCO areas.

The NES specifications may provide a useful starting point for discussing which services may fall into the enhanced services category locally. Practices should be clear how patients (for example, patients who are alcohol or drug misusers or who are depressed) will receive services over and above those required for essential services. All three negotiating parties have a clear expectation that services described as NESs should be paid for as an enhanced service, although the provider and the price are down to local determination. If practices cannot reach agreement on funding for enhanced services, they will not do the work. We are aware that some LMCs and PCOs have reached agreement, where negotiations are getting stuck on relatively small volume services, that these could be grouped together into a "basket" of services, clearly specified and with agreed funding over a limited period. The range and volume of these could then be monitored and appropriate changes made as necessary.

Sorting out these aspects of enhanced services is critical to successful implementation of the contract at a local level. It also allows LMCs and PCOs to discuss the development of extra services that we all want to see in primary care - services which many practices have an appetite to deliver.

Some of these difficulties about enhanced services have arisen because of their very nature: they are services that the PCO is entitled to choose whether to commission and from whom to commission. It is important that all parties remember that enhanced services are a local initiative. This is why they are largely subject to local negotiation (based on national specifications and benchmarked pricing in the case of NESs). Quite rightly LMCs have a role in agreeing which services should, or should not, count towards the PCO-level expenditure floor. They should be consulted on the services being commissioned in their area and, for financial monitoring purposes, agree whether certain services should count towards the expenditure floor where it is agreed that they are an appropriate use of that part of the enhanced services budget for primary care that counts against the Gross Investment
Guarantee.

It is not possible for the GPC nationally to approve or not approve such services or to decide whether they should form part of the PCO floor. This must be agreed at local level to reflect local health needs. Whilst we can try to give some guidance, what is important is that examples of good practice are disseminated widely. This is not only important in order to promote them, but also to set precedents and to try to deliver appropriate consistency across the country. This will be helpful to practices, LMCs and PCOs. If LMCs are having difficulties, examples of other LMCs which have come to satisfactory agreements with their PCOs will help them in their negotiations. Therefore, we would like to encourage LMCs to promulgate their deals widely, including via the LMC listserver.

Ultimately, the definitions of essential services and enhanced services are clearly laid out in the Regulations. It is important to remember one of the key phrases in the definition of enhanced services: "…a service that a contractor agrees to provide under the contract…".

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