

Focus on...

Enhanced Services

This guidance note has been produced by the General Practitioners Committee to help GPs and Local Medical Committees with the enhanced services arrangements under the new GMS contract, and is one of a series of guidance notes on the new contract. The guidance will be updated as progress is made throughout the implementation discussions and negotiations. We would advise all GPs to read the contract document and supporting documentation, available on the BMA website at www.bma.org.uk. The GPC has produced a list of frequently asked questions and answers which can also be found at the website address.

Although there may be some differences in process in each of the four countries of the UK, the principles of this guidance apply to all.

Definition of enhanced services

The contract document, at paragraph 2.13, states:

“Enhanced services are:

- (i) essential or additional services delivered to a higher specified standard, for example, extended minor surgery
- (ii) services not provided through essential or additional services. These might include more specialised services undertaken by GPs or nurses with special interests and allied health professionals and other services at the primary-secondary care interface. They may also include services addressing specific local health needs or requirements, and innovative services that are being piloted and evaluated.”

Timetable

Enhanced services officially come into effect on 1 April 2004. However, there is no reason why many of the areas covered by enhanced services cannot be implemented now. The necessary arrangements have already been put in place for Improved Access Schemes and Quality Information Preparation Schemes which had to be established by 1 January this year and for Violent Patient Schemes which had to be established by 1 February this year in England.

Commissioning process – key features

The key features of the commissioning process for enhanced services are:

1. In addition to directed enhanced services, Primary Care Organisations are free to commission such enhanced services they believe will meet local health needs. This should be done in discussion with LMCs (or their equivalent).

In England, Directions requiring PCTs to provide directed enhanced services, not delivered through the SFA for 2003/04 (see above under timetable for the implementation dates), came into force on 1 December 2003. PCTs cannot refuse to commission these

directed enhanced services after the stated dates and you should begin discussions with your PCO on which services they are planning to commission and from which providers.

2. After April 2004, PCOs will each have a minimum “floor” of expenditure they must spend but they are free to spend above this minimum. The additional money can come from other sources e.g. their unified budget and waiting list initiative money. If they want a service to be available for patients then they may have to take money from these other sources in order to provide it.

3. As indicated in paras.2.15.ii and 5.1.iv of the contract document, the process will replace current Local Development Schemes (LDSs), Improving Primary Care Incentive schemes, services under HSG(96)31, GPs with Special Interests (GPwSIs) and schemes to improve patient access. In Scotland, only the LDSs are relevant.

4. Existing contracts will be rationalised within a single contractual arrangement from April 2004. The Standard Contract in agreed form, available in draft at www.doh.gov.uk/gmscontract/implementation.htm, should be used. (There will be similar Standard Contracts in the other three countries of the UK.) In some cases, however, separate contracts can be agreed with PCOs but such contracts should follow the Standard Contract.

5. Existing contracts for services under paragraph 3 above will continue for at least the duration agreed previously with the PCO. In some cases they may run beyond 1 April 2004 and if so it will only be possible to bring them to an end on 31 March 2004 with the agreement of the PCO.

6. PCOs must use the published specifications for directed enhanced services as the basis for commissioning these services from gms contractors. The fees have been agreed nationally for directed enhanced services and practices should not accept anything less than the published amounts. Further to the publication of the new contract supporting documentation, there have been various typographical amendments made to the specifications of which the latest version will be available on the Department of Health and BMA websites. Where PCOs commission national enhanced services from GMS contractors they should use the published minimum specification and benchmark fee as the basis.

7. GPs do not have preferred provider status for enhanced services as they do for essential and additional services. However, historically, enhanced services have been largely GP-led services and it is likely that PCOs will commission services from current providers.

8. Most of the clinical directed enhanced services would be best provided from general practice e.g. childhood immunisations and vaccinations, influenza immunisation, quality information, minor surgery and many of the National Enhanced Services (NESs) e.g. INR and shared care drug monitoring, as long as resources match the provisions needed.

9. The contract document states that “most contracts for enhanced services are likely to be placed with GMS or PMS providers...” [contract document paragraph 2.15(iv)]

10. “There will be no obligation on practices to provide any enhanced service (notwithstanding that they have previously provided it) unless they enter into a new contract for its provision.” [contract document paragraph 2.16] Subject to the completion of existing contractual obligations (see para.5 above) practices can stop providing all or any of the enhanced services from 1 April 2004, if they wish to do so.

Payments systems

The areas covered by national and local enhanced services can be implemented now and can be paid via standing Local Development Scheme arrangements or under HSG(96)31. This would also make the transition from LDSs to NESs less problematic in April 2004. The Carr-Hill Formula is not used in determining the payments for enhanced services.

Some practices currently provide enhanced services (or services closely equivalent to the newly agreed enhanced services) at payment levels below the nationally agreed levels. When negotiating for the new provision of such services it is important to make sure that all current and ongoing schemes are paying practices at least the nationally agreed prices.

Directed enhanced services

There are six directed enhanced services which PCOs must commission.

Minor surgery, childhood immunisations and influenza immunisations, currently delivered through the existing Red Book arrangements (and funded from GMS non-cash-limited funds) will be implemented as directed enhanced services from 1 April 2004.

In England, Regulations and Directions have now been sent out which establish a legal requirement for PCTs to set up, and pay for, schemes for violent patients – from 1 February, and quality information preparation and access for GMS and PMS practices – from 1 January. Although PCO-led PMS schemes are outwith the Regulations and Directions, clearly PCOs may make equivalent arrangements.

In Scotland, there is a budget of £11.9 million for 2003/04 of new investment for enhanced services. Agreement has been reached that enhanced services will be taken forward in 2003/04 as Local Development Schemes covering influenza immunisations for those aged under 65 and in an at-risk group, quality information preparation and services for staff supporting violent patients. Details of the model Local Development Schemes covering these areas were published in NHS circular PCA (M)(2003)20.

Wales has a budget of £16.4 million for 2003/04 and Northern Ireland a budget of £5 million for enhanced services.

Access is high on the political agenda. This money is meant to aid practices to work towards providing appointments with GPs and other staff within the individual country target. In England, PCTs are required to invite all practices that are not participating in existing access schemes to participate in an improved access scheme. PCOs and practices will need to agree a plan for implementation by 1 January 2004, in line with the conditions set out in the Directions and published DES specification. The price allows for a practice with an average list size (5891 registered patients) to be paid £5,000 for participating and meeting the aims of an agreed scheme in 2003/04. Where schemes have already been established, the associated resources should be taken into account in relation

to determining whether the published specification's pricing has been complied with. Participation in the DES is completely voluntary and practices need to decide whether or not they wish to be involved. In Northern Ireland, discussions are under way to establish an appropriate access target and this will be agreed by 30 January 2004. Payments for access in Wales (£5,000 per practice) were made at the end of November 2003. There is no access DES in Scotland.

Quality Information preparation is not just about getting ready for the quality and outcomes framework. There is overwhelming evidence that the better and more accessible a patient's record, the better the outcome of that patient's care. Summarising notes is part of this process, but date-ordering of results, letters etc is part of the process too. Summarising can be done by doctors, practice nurses, other professions allied to clinical medicine, medical students, or by PCOs or commercial companies employing trained summarisers.

A PCO would be wise to make this money available to practices now to improve patient care and help practices obtain higher quality points and ultimately more resources. It is in PCOs' best interests to move this forward as soon as possible because it is likely that in the future PCOs will be judged by the level of quality in their areas. In England, PCTs were legally required to invite all practices to participate and agree a plan for implementation by 1 January 2004. Where a plan is agreed a PCO is required to make payments in accordance with the Directions. A legal range has been set, namely a minimum of £1,000 to a maximum of £5,000 for a practice with an average list size, depending upon the work that needs to be done. It is recognised that this will not cover the full cost of summarising records and, as such, is only a contribution towards the work.

In Scotland, this service was funded in 2003/04 as a model local development scheme as outlined above and detailed in NHS Circular PCA (M) (2003) 20, published on 10 October 2003. Some practices will have already completed or started the notes summarising process. In 2004/05 where funding is needed, the benchmark price will be between £1000 and £5000 for a practice with an average list size, depending on the work that is required. This money is additional to funding which will be available to practices for general quality preparation and to continuing provision for the maintenance of records through the quality and outcomes framework. It is not therefore intended to cover the full cost in those practices which have not yet undertaken any summarising of their notes. It will be for PCOs to discuss with practices their requirements and agree an appropriate level of funding. In Wales, the benchmark funding for quality information preparation is £2500 per average practice for 2003/04 and this was paid at the end of November 2003. In Northern Ireland, the funding will be £3500 per average practice.

Influenza immunisations are paid at the IOS B payment for over-65s and at-risk under-65s in England, Scotland, Wales and Northern Ireland.

Services to support staff dealing with violent patients should already be in place. The new contract, at paragraph 6.30, states:

“It is the responsibility of the PCO to ensure that there is a service available for patients who are difficult to manage, and this will be commissioned separately as an enhanced service as set out in chapter 2” (of the new contract document).

In England, where no arrangements are in place for the provision of services to violent patients, PCTs are legally required to establish the service by 1 February 2004. PCOs are required to consult on plans for setting up this service with the LMC. In Wales, as from 1 April 2004, it is the responsibility of the Local Health Board to ensure that there is a service available to patients who are difficult to manage. In Scotland, PCTs/NHS Boards have been advised to develop a Local Development Scheme building on the work that has already been done. In Northern Ireland, a £500 retainer will be paid every quarter to practices providing this service plus payment per consultation.

Minor Surgery is performed by almost every practice. The smaller procedures e.g. scraping and freezing of lesions will be part of additional services but injections and cutting surgery will, in future, be an enhanced service. If the PCO does not have in place a new contract with each practice by 1 April 2004 for enhanced service work, practices will no longer be expected to provide these services and should then refer all patients needing these procedures to the appropriate secondary care services eg joint injections to rheumatology or orthopaedics. In fact, the wise PCO may see this as an opportunity to move more of this kind of work into primary care now it has a clear funding mechanism for doing so.

Childhood immunisations and vaccinations. Having a GMS contract confers a right and obligation to provide essential services; an expectation and a right to provide additional services; and a right to provide the access, quality information preparation and childhood vaccination and immunisation directed enhanced services. Whilst, practitioners have a right to continue to provide childhood immunisations and vaccinations as an additional service they will have to contract with PCTs to provide the service at the directed enhanced level.

National enhanced services

These include INR and shared care drug monitoring, more specialised drug and alcohol misuse services, substance maintenance prescribing, more specialised depression services, more specialised services for patients with multiple sclerosis, more specialised sexual health services, minor injury services, immediate care and first response services, enhanced care of the homeless, IUCD fitting and intra partum care.

It will be up to the PCO in consultation with the LMC (or its equivalent) to decide its own local needs and priorities in these areas. The order of need may differ from area to area. This is quite appropriate. However, the PCO cannot expect GPs to continue to provide these services after 1 April 2004, if they are currently doing so (extra-contractually), unless it offers the GPs a new, acceptable contract.

LMCs (or their equivalent), if they have not already done so, should immediately survey their GPs to find out what local practices do and do not wish to provide. The LMC should then approach the PCO to begin discussions. If the PCO refuses to do so, then the LMC and GPs should give formal notice of their intention to withdraw from these services, en bloc, on 1 April 2004.

Local enhanced services

Local enhanced services (LESSs) are based on the same principles as the DESs and NESs but are tailored to the specific needs of the area. Examples of LESSs could include:

- enhanced medical care of asylum seekers
- enhanced services for non-English speakers
- specific services for people with learning disabilities
- neonatal examinations within 24 hours of birth
- enhanced care of patients living in Nursing and Residential Homes
- area-wide home visiting schemes.

The GPC is drafting model LESSs for asylum seekers, non-English speakers and people with learning disability, which we will produce shortly.

A list of the issues for consideration when LMCs or practices are looking to develop and negotiate a LES is at annex 1.

We would be very keen to have examples of all established LESSs so that they can be made available to other LMCs in the UK. We plan to have a list of LES specifications available for this purpose. Please send these to the GPC office at info.gpc@bma.org.uk

Funding of enhanced services – what counts as current spend and what doesn't

The GPC received reports that some PCOs were indicating that they would not be able to commit a minimum level of resource for enhanced services. We sought assurances about this and in a letter from John Hutton to the GPC and Primary Care Organisations in England, it was made clear exactly what could be counted as current spend in relation to the expected floor this year (2003/04). These include:

- primary care access
- local primary care incentive schemes (encouraging innovation in general practice)
- demand management initiatives
- HGS(96)31 schemes
- GPs with a special interest
- Local Development Schemes
- other specialist services, provided by GPs, not funded by GMS.

There are many things that PCOs have been funding that do not count as current spending, amongst others:

- clinical governance
- community nursing services
- GPs working in community hospitals and working as clinical assistants or hospital practitioners
- prescribing incentive schemes
- occupational health.

Once you have your PCO's report on what it is including as current spend towards the enhanced services floor, check it against the list above and the substance of the Hutton letter, which can be found on the BMA website at:

<http://www.bma.org.uk/ap.nsf/Content/hutton140503>

Attached to the Hutton letter is a spreadsheet that can be downloaded and used to check the items the PCO has included. Although this applies to England only, it may assist GPs and LMCs in other countries.

If you have any concerns or queries on monies included please contact the GPC office – details are given below. This will help us to take up any issues that have not been resolved locally with the NHS Confederation. Do not let potentially mistaken views of the PCO go unchallenged.

PCO-suggested current spend

Once the PCO has stated publicly what services are included in its spending floor, any service which is deleted from that list following consultation with the LMC releases a sum of money that would be regarded as “unspent” for enhanced services. This money can then rightly be considered available for use in developing enhanced services.

It would be bad practice for the PCO to attempt to include other inappropriate services to replace those “enhanced services” which have been deemed inappropriate and deleted following consultation with the LMC. If you have concerns that this may be happening, please inform the GPC office immediately. Equally, please send the GPC any documentary evidence of PCOs wrongly interpreting what current services count towards enhanced services spending. Enhanced services will be performance-managed by Strategic Health Authorities, (or their equivalent) to ensure effective and appropriate deployment. Should a PCO not develop enhanced services appropriately, the Strategic Health Authority will intervene to ensure that the guaranteed floor is not breached and is spent for the purposes intended.

Negotiating points to consider when discussing the provision of enhanced services from general practice

- Patient access to services is much easier and more appropriate for patients when services are provided in practices, rather than from fewer, more centralised locations.

Much of the thrust of the new contract is to provide services closer to patients' homes. Forcing patients to travel greater distances for these services would place increasing strains on transport services as well as incurring expense for patients.

- There has been progressive determination for many years to bring as many services as close to patients as possible. This has been again emphasised in the recent Wanless reports. It would be a shame for this policy to be suddenly reversed by PCOs simply in an ill-considered attempt to save money or commission services from alternative providers.
- Many general practices will already have the necessary staff in place, most of whom will have the skills to provide these services, having done so for years. The advantage of having staff in place immediately, rather than the PCO or other provider having to recruit and train new staff, places practices in a good position to provide these services.
- The stated purpose of enhanced services is to:
 - a. improve patient care for all patients and for specific vulnerable groups
 - b. improve patient choice
 - c. aid the resourced shift of work from secondary care to primary care
 - d. allow practices to develop enhanced services for their practice populations.

It would be against the spirit of the new contract for the PCO to ignore these aims by not investing sufficiently in the provision of enhanced services in general practice.

Informing patients of the need to withdraw from service provision

Many GPs are worried that if they have to withdraw from direct service provision to patients, their patients will not understand the issues and blame their GPs. This fear is compounded when considering the position often taken by the media in these matters.

There are several points it is worth making when informing patients, their representatives and others of a proposed GP withdrawal from services.

1. Remind them that you have been providing these services for the past few years without any/or proper funding from the NHS i.e. at personal expense.
2. Point out that if you were to continue to provide these services without the necessary additional funding it would have a detrimental effect on other areas of the services provided to patients by the practice
3. Explain to patients that the new GMS contract was designed to allow you to continue to provide the work but with appropriate funding from the PCO.

4. Explain that every PCO in the UK has been given a specific amount for spending on the continuation and development of enhanced services, of which the particular service in question is one.
5. Explain to patients that the PCO has made a decision not to resource the provisions of this service from the practice or practices in the area. It is the PCO's responsibility to ensure that the proper range of services patients require are commissioned.
6. Reassure your patients that the PCO will have to commission directed enhanced services and that you will have to refer them to the alternative provider, as you would do now for a consultant opinion.
7. Make it clear to your patients that you wanted to continue to provide the enhanced service, that you approached the PCO about this, but the PCO had decided not to commission the service from your practice(s).
8. Some LMCs have prepared a standard letter for practices to give to their patients. You may wish to ask your LMC if a standard letter is available.

LMCs: how to get started

If LMCs have not already done so, they need to begin to work on establishing enhanced schemes now. LMCs may wish to consider the following steps:

Survey all practices now by asking them:

- what services they are currently providing without funding and on what contractual basis
- what services they are currently providing which attract payment, and what the level of that payment is
- what services they might wish to bid to provide (assuming that the published or appropriate levels of payments are available)
- what services they have no wish to bid to provide (assuming that the published or appropriate levels of payments are available)

The LMC might also consider asking at the same time:

- the practice's initial thoughts on opting out of out-of-hours responsibility
- if the practice would like the LMC to negotiate on its behalf with regard to enhanced services
- whether the practice would be willing to stop providing ALL free "enhanced services" if the PCO refuses to enter into new contracts with practices on April 2004 or begin discussions with the LMC on these services immediately.

Opting out of unfunded or under funded enhanced services from April 2004 could include services such as:

- INR and shared care drug monitoring
- drug misuse maintenance prescribing
- all IUCD insertions and contraceptive implants
- all joint injections
- all “cutting” minor surgery.

As the contract makes quite clear, no practice is required to continue to provide enhanced services (after any existing contract comes to a natural end, or is brought to an end by earlier mutual agreement) if the PCO has not offered the practice an acceptable new contract for the provision of these services. However, in the case of directed enhanced services, the PCO is obliged to ensure that patients can access these services. GPs therefore would need to refer any patients requiring these services and any other enhanced services the PCO wishes to continue to commission, either to the provider with whom the PCO has agreed a contract or to a standing secondary care arrangement e.g:

- to the alternative GP provider, or to the
- local medical or haematology department for INR monitoring
- local rheumatology department for rheumatology drug monitoring
- local surgical or dermatology team for “cutting” minor surgery
- local orthopaedic department for joint injections.

Practices and LMCs should be considering these issues now.

Enquiries and information

Please send enquiries and/or information about enhanced services to the GPC office at:

info.gpc@bma.org.uk

Annex 1.

Local enhanced services – criteria

When you design a LES it may be helpful to use the NES specifications as a template. The various sections of the terms and conditions may be:

- clinical evidence and data to determine the design, size and scope of service provision
- service protocols to facilitate the development of the service which would typically include the following elements:
 - > developing and maintaining a register of patients
 - > determining the service to be delivered

- > specifying the skills required to deliver the service
- > providing a personal health and record plan
- > ensuring that the care given is recorded in the lifelong GP-held patient record
- > involving, where appropriate, carers and support workers/services
- > ensuring regular liaison, where appropriate, with carers and support workers/social services
- > developing screening procedures to improve clinical outcomes, including medication reviews
- > providing patient reference material
- > continuing professional development
- > annual review and audit of the service
- > developing appropriate quality standards
- > special training
- > accreditation
- > additional resources
- > infrastructure/costs, e.g. staff time, equipment etc.

How to work out the “cost” of the local enhanced service

When determining the “cost” of providing a LES remember:

- the actual cost to you of service provision
- the profit element you wish to make for providing the service.

Actual Costs

1. additional staff hours e.g. direct service provision, extra time for liaison with social services
2. additional staff costs, including employers’ contributions to pensions and national insurance
3. additional staff training costs, including replacement costs
4. additional secretarial support for appointments, letter writing, data inputting, records
5. additional stationery costs
6. premises costs, e.g. extra electricity, heating, phone costs
7. any increased medical defence organisation costs
8. cost of annual review activity
9. any costs associated with PCO verification activities
10. transport costs for doctors and/or staff
11. costs of patient information material.

The Professional Fees Committee of the BMA has published guidance on calculating this type of service provision cost to a practice. This can be found on the BMA website at www.bma.org.uk

Profit

The factors to consider are:

1. the complexity of the work
2. any increased risks associated with the work especially litigation
3. any further training you and your staff may have to undertake
4. financial risk management you may need to cover.

How to get paid

The two principal means for being paid are:

- an item-of-service fee, or
- a block payment to provide a service, irrespective of actual patient numbers. In some cases (there are a few examples of this in the NES list) a block payment is supplemented with an IOS payment to make it more workload sensitive.

The following are examples of work, which if commissioned from GPs and paid for from PCO monies are not GMS work and must not be funded from GMS monies unless suitable identified monies together with annual growth allocations are transferred into the GMS budget:

- work performed by GPs in community hospitals
- work under the collaborative arrangements.