July 2003

The new GMS contract explained

GPC
General Practitioners Committee

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.

Enhanced services will come into effect on 1 April 2004. However, there is no reason why many of the enhanced services cannot be implemented now.

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 will come into effect on 1 April 2004. However, there is no reason why many of the enhanced services cannot be implemented now.

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Commissioning process

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

1. Primary Care Organisations are free to commission those enhanced services they believe will meet local health needs. This must be done in discussion/consultation with LMCs (or their equivalent). PCOs are, however, required to provide all directed enhanced services from April 2004. They cannot refuse to do so after this date. You should challenge the PCO if there is any suggestion that they might be planning not to provide such services
2. PCOs have a minimum "floor" of expenditure they must spend but 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 sources in order to provide it
3. the process will replace or include current LDS, Improving Patient Primary Care Incentive schemes, services under HSG(96)31, GPwSIs and schemes to improve patient access. (Only the LDSs are relevant for Scotland)
4. existing contracts will be rationalised within a single contractual arrangement from April 2004
5. existing contracts will continue for at least the duration agreed previously with the PCO. In some cases they may run beyond 1 April 2004. It will only be possible to bring them to an end on 31 March 2004 with the agreement of the PCO. In some cases e.g. childhood immunisations and and vaccinations, the duration should be considered as "indefinite"
6. PCOs must use the published specifications for directed and national enhanced services as the basis for commissioning these services from general practice. We would not expect the PCO to try and negotiate a price lower than the nationally published ones, and would strongly advise that no practice or LMC accept a fee below these published rates. If you accept a lesser fee, you are forcing other practices to cut their fees accordingly. This will not be in the interests of patients (who will ultimately lose a service that is under funded) or GPs (who will be forced to underwrite a cheap service)
7. GPs do not have preferred provider status for enhanced services, as they do for essential and additional services. Enhanced services are GP-led services and it is anticipated that except in exceptional circumstances, PCOs will commission services from current providers
8. most of the services would be best provided from general practice e.g. childhood immunisations and vaccinations, patient access, quality information, some services for violent patients, minor surgery and many of the NESs e.g. INR and shared care drug monitoring
9. the contract states that "most contracts for enhanced services are likely to be placed with GMS or PMS providers…" [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, which includes adequate funding, for its provision. All practices can stop providing all enhanced services from 1 April 2004 if they choose. You must not feel obliged to deliver a service you previously provided if you are not being appropriately paid for it.

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Payments systems

Although enhanced services will come into effect in April 2004, the areas covered by enhanced services can be implemented now and be paid via standing Local Development Scheme arrangements or under HSG(96)31. This would also make the transition from LDSs to DESs and NESs less problematic in April 2004.

The Carr-Hill Formula is not used in the payment of enhanced services. The fees have been agreed nationally (for directed and national enhanced services) and practices should not accept anything less than the published amounts.

Even where practices currently provide these services for payment, many are being paid far less than the nationally agreed levels. When negotiating for new services it is important to make sure that all current and ongoing schemes are paying practices at least the nationally agreed prices.

The Carr-Hill Formula is not used in the payment of enhanced services. The fees have been agreed nationally (for directed and national services) and practices should not accept anything less than the published amounts.

Directed enhanced services

Directed Enhanced Services will start on 1 April 2004. However there is no reason why all PCOs cannot begin some of these now. If you are already providing these services and have not given the PCO any notice of wishing to opt out, the new contract, at paragraph 2.15(ii), states:

> "Existing contracts for such services will be rationalised into a single arrangement for enhanced services under the contract between the PCO and practice from 2004/05 and will continue for at least the duration agreed previously between the PCO and the practice"

Access is high on the political agenda. This money is meant to aid practices to work towards appointments with GPs within the individual country target. This is completely voluntary. Practices need to decide whether or not they wish to be involved. Note that there is no money for access in Scotland other than the 50 quality points for meeting the Scottish target.

Quality Information 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 to anyone treating him or her, the better the outcome of that patient's care. Summarising notes is part of this process, but date ordering results, letters etc. is part of the process too. 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.

'Flu vaccinations will be paid at the IOS B payment for over 65s and under 65s at risk in England. Wales will have the same arrangement this year. Scotland has yet to agree the uses to which enhanced services funding will be put in 2003/2004 but it is anticipated that a flat rate payment of under 65 at risk patients will be agreed. The existing sliding scale payments for the over 65 age group will continue.

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Services for 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)".

Since the new contract makes it clear that from 1 April 2004 the PCO will be responsible for the provision of services to these patients, PCOs must begin preparations for these services now if they have not already done so.

Minor Surgery is performed by almost every practice. The smaller procedures e.g. scraping and freezing of lesions are part of essential services. Injections and cutting surgery will no longer be part of practices' essential or core services. If the PCO does not have in place a new contract with each practice by 1 April 2004, practices will no longer be expected to provide these services and then should refer all patients needing these procedures to the appropriate secondary care services e.g. 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. Since practices already have the staff and the systems in place for this work and the patients are used to coming to the practice, it would be ludicrous for the PCO not to contract with practices to provide this service. Practices providing the services now should be able to continue to provide these services.

National enhanced services

These include alcohol misuse, substance maintenance prescribing, INR and shared care drug monitoring, depression, MS, sexual health, minor injury services, first response services, services to the homeless, intrapartum care, and services to the terminally ill.

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. It may be that the order of need may differ from area to area. This is quite appropriate. The PCO cannot expect GPs to continue to provide these services if they are currently doing so (paid or unpaid) after 1 April 2004 unless it offers the GPs a new, acceptable contract.

LMCs 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 refuse 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.

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Local enhanced services

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

- medical care of asylum seekers
- services for non-English speakers
- specific services for people with learning disabilities (it was intended that this should be a NES, but the GPC was unable to agree a reasonable price for the service with the Departments of Health)
- neonatal examinations within 24 hours of birth
- enhanced care of patients living in Nursing Homes
- area wide home visiting schemes.

The GPC is drafting suggested NESs schemes on asylum seekers, non-English speakers and people with learning disabilities, which we will produce shortly.

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

We would be very keen to have examples of all established LESs so that they can be made available to other LMCs in the UK. We plan to have a list of LESs 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:

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- 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 A&E (not paid from GMS, and if they were, why?)
- prescribing incentive schemes
- occupational health.

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Once you have your PCO's report on what they are 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:

hhtp://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 in other countries.

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

PCO suggested current spend

We are receiving reports that some PCOs are being "creative" in what current services count towards enhanced service spending. Some of this may be true misunderstanding of what counts as current spend. The PCO should ensure that there is proper and appropriate investment in services and in patient care.

It is worth remembering that 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 inappropriate for the PCO to add other services to the list to replace each service deleted following consultation with the LMC. If you have concerns that this may be happening, please inform the GPC office immediately.

In **Scotland**, the funding stream of £11.9m for enhanced services for 2003/20004 has not yet been allocated to PCOs. It is suggested that this would most sensibly be used to fund LDSs which will transform to DESs or NESs in 2004/2005. In the case of DESs, the only appropriate services to fund as LDSs in 2003/2004 would be 'flu immunisation for under 65 at risk patients, quality information preparation (summarising notes) and new services to support staff dealing with violent patients.

Negotiating points to consider when discussing providing enhanced services from general practice

- Patient access to services is much easier for patients from practices, rather than from fewer, more centralised locations. Much of the thrust of the new contract is to provide services closer to patients' homes. Patients forced to travel to hospitals for these services would place increasing strains on hospital transport services as well as incurring expenses for patients.

- There has been progressive determination for many years to bring as many services as

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close to patients as possible. It would be a shame for this policy to be suddenly reversed by PCOs simply in an attempt to save money.

- Many practices will have the necessary staff in place, many of whom will have the skills to provide these services, having done so for years without funds. 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 heavily in enhanced services being provided from general practice.

LMCs: how to get started

While we suggest that LMCs begin to work on establishing these enhanced schemes now, we recognise that many will have already begun to do so. 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 attracts payment, and what the level of that payment is
    - what services they might wish to provide (assuming the published levels of payments)
    - what services they have no wish to provide (assuming the published levels of payments)

- The LMC might also consider asking at the same time:

    - the practice's initial thoughts on out of hours opt out
    - if the practice would like the LMC to negotiate on its behalf with regards to enhanced services and
    - would they be willing to stop providing ALL free "enhanced services" if the PCO refuses to enter into a new contract with practices on April 2004 or begin discussions with the LMC on these services immediately?

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Opting out of enhanced services from April 2004 would include services such as:

- INR and Shared Care Drug Monitoring
- drug misuse maintenance prescribing
- all IUCD insertions
- all Joint injections
- all "cutting" minor surgery

As the contract makes it quite clear, **no** GP is required to continue to provide these services if the PCO has not offered them an acceptable new contract for the provision of these services. However the PCO is obligated to ensure that patients can access these services. GPs therefore would need to refer any patients requiring these services to the PCO nominated provider e.g:

- local medical or haematology department for INR monitoring
- local rhuematology department for rhuematology drug monitoring
- local surgical or dermatology team for "cutting" minor surgery
- local orthopaedic departments for joint injections.

Practices should begin to consider 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

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Annex 1.

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Local enhanced services - criteria

When you design a LES it may be helpful to use the NES 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 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 quality standards (in line with the Quality & Outcomes Framework when that framework includes relevant 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
3. additional staff training costs, including replacement costs
4. additional secretarial support for appointments, letter writing, data inputting, records
5. additional stationary costs
6. premise costs, e.g. extra electric, heating, phone costs
7. any increased medical defence organisation costs
8. cost of annual review activity

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9. any costs associated with PCO verification activities
10. transport costs to doctors and/or staff
11. costs of patient information material

The professional fees committee of the BMA has published excellent 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 may have to undertake
4. financial risk management you may need to cover.

How to get paid

You can either opt for an:

- item of service fee, or
- 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.

Annex 2

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