

GPC

General Practitioners
Committee



AGREEING ENHANCED SERVICES FLOORS: GPC GUIDANCE FOR LMCS

The GPC has been asked on many occasions to produce a definitive list of what constitutes essential and enhanced services under the new contract in order to facilitate LMCs' negotiations with PCOs. We have resisted doing so because we believe that it is not possible to produce a list that is comprehensive and unarguable in every situation. There will always be local exceptions that national guidance could not cover, which LMCs should be free to agree if they believe they are appropriate in their area. However, the newly formed Enhanced Services Subgroup has been able to draw up a list that reflects the results of local negotiations between LMCs and PCOs on enhanced services across the UK in 2004/05 – this can be found at appendix 1. LMCs should read the list in conjunction with the short paper 'Enhanced Services: how to tell what they are and whether or not they count towards the floor' found at appendix 2.

The list has been divided into three broad categories: services that are enhanced services that can legitimately count towards the enhanced services floor (ESF), services that either are or are not enhanced services, but cannot count towards the ESF and services that, depending on local arrangements, the inclusion of in the ESF varies.

LMCs should bear in mind that the *can* section includes services that have been negotiated somewhere in the UK, but that it is unlikely that an LMC necessarily will be able to negotiate all of these services in their area. Where activity appears here as an enhanced service, it does not necessarily follow that the Subgroup considers this the best way to provide the service. If GPs do the work, they must be funded and the enhanced services floor is the appropriate mechanism for this. However, some of the activities may be best carried out by acute or community trusts. As regards those enhanced services which will clearly result in a transfer of work from current hospital provision (e.g. some GPwSIs, diagnostics), they should be funded from the hospital commissioning budget and not from the ESF. LMCs should resist re-badging of services that historically have been funded through and provided by the secondary sector.

The *varies* section exists as a result of an example where historical, local factors mean that what in most areas would not count towards the enhanced services floor, in some areas does.

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Although such a list can be neither definitive nor exhaustive, this does represent the authoritative view of the GPC on the enhanced services that have emerged to date that either can or cannot count towards the ESF.

We hope that this document will assist LMCs in their discussions with PCOs on ESF proposals in the run up to year end on 31 March 2005 and thereafter.

Every effort should be made to reach agreement by negotiation between the LMC and the PCO. Where, despite this, local disagreement on enhanced services and use of the spending floor persists, details of the dispute should be sent via the GPC secretariat LMC Liaison Officer to the Enhanced Services Subgroup for comment and/or action as appropriate. [Full terms of reference and membership of the Subgroup can be found at appendix 3.] If the case remains unresolved, the issue can be submitted for consideration by the Implementation Co-ordination Group (ICG) of the Health Departments, the NHS Confederation and the GPC for final direction.

A handwritten signature in black ink, appearing to read 'Brian Balmer'.

Brian Balmer
Joint Chairman
Enhanced Services Subgroup

A handwritten signature in black ink, appearing to read 'Chaand Nagpaul'.

Chaand Nagpaul
Joint Chairman
Enhanced Services Subgroup

February 2005

Enhanced services floor list

Enhanced services that can count towards the ESF

1. All Directed Enhanced Services & National Enhanced Services
2. Nursing/residential homes
Includes the enhanced element of care only
3. Refugees & asylum seekers
4. Prescribing and monitoring drugs not mentioned in the 'near patient testing' NES
Includes amiodarone, gold and sulphasalazine, lithium etc.
5. Initiation of secondary care drugs
Includes insulin and initial monitoring under shared care agreements such as depot psychotropics, Ritalin and alcohol dependency prescribing
Note that "shared care" must be genuine and not merely on the instruction of a Consultant
6. Suture removals
Note where there is a specific LES
7. Dressings post operation/leg ulcers
Note where there is a specific LES
8. Minor/moderate surgery
Includes vasectomy, sigmoidoscopy, carpal tunnel release, in-growing toenails etc.
9. GPwSI (community)
Includes dermatology, psychosexual counselling, allergy, genetic counselling, joint injections, vasectomy, urology, heart failure, gynaecology, podiatry
Why? If the GPwSI is working in the community and providing enhanced community GMS, this can count towards the ESF. In addition, to count towards the ESF, the referral pathway should be GP to GPwSI and not via secondary care.
10. Contraceptive implants/fittings
Includes Proscar, Implanon, Depo-Provera etc.
Why? These implants are not part of ordinary primary medical services as they require special training and technique.
11. Other implants/injections

Includes Zoladex etc.

12. Information collecting for PCO

Includes waiting list validation

13. Unscheduled immunisations/vaccinations

Includes MMR to students, Hepatitis B for occupational health reasons etc.

14. Early morning/evening/weekend surgeries if done by practices at PCO request and funded by same

Does not include emergency work

15. More specialised chronic disease care schemes (GPwSI type)

16. Pre-operative assessments requested by the hospital

Includes MRSA screening

17. Phlebotomy that is not an essential part of GMS

Includes blood tests as requested by the hospital and/or out-patients department

18. 24 hour blood pressure monitoring

19. Cardiac event monitoring (24 hour ECGs)

20. Routine neonatal checks following early discharge or home birth

21. Audiology screening

22. Glaucoma screening

23. Teenage sexual health drop-in clinics

26. Obesity/weight management service

27. Counselling

Includes contestable service provided either by an independent organisation in the community and available to all GP patients and/or provided within surgeries

28. ECGs upon external-initiation

Includes routine ECG for hypertension, palpitations or chest pain

30. Ring pessary insertion and changes

31. Patients with learning disabilities

32. Hospital transport/ambulance organisation

Services that either are or are not enhanced services, but cannot count towards the ESF

1. GPwSI (hospital)

Why not? If a GPwSI is working as a clinical assistant/staff grade in a routine out-patient clinic, this cannot count towards the ESF which includes a GPwSI service based in the community

2. Therapies

Such as physiotherapy etc.

Why not? In most cases, this is the re-provision of secondary care in GP surgeries or community health settings and is therefore not an enhanced service (and cannot count towards the ESF). However, where a new, additional service for patients, which can be tendered for by GMS and PMS contractors, is established, this would be an enhanced service.

3. Pharmacy work

Such as pharmacy advisors

4. Dental work

5. Secondary care carried out in the community

Such as work done by consultants and specialist nurses

6. Community Hospital current contacts

Unless there is for example a new minor injury unit

7. Normal OOH work

8. Prescribing incentive schemes

Why not? They are not medical or patient services; they are not contestable; they are not provided *to* patients and the schemes have never been funded by GMS money (or hospital money), but from completely separate prescribing budgets.

9. PRIMIS facilitator

10. Citizens Advice workers (practice based)

Why not? This is not an enhanced service as it is a social, not clinical service nor is it the provision of patient care.

11. Evercare nursing model and community matrons

12. Medical certificates for patients who have been in hospital

Services that, depending on local arrangements, the inclusion of in the ESF varies

1. Mental Health workers

Enhanced services: how to tell what they are and whether or not they count towards the floor

The GMS contract guidance document 'Delivering Investing in General Practice: Implementing the New Contract' states the following in relation to the definition of enhanced services:

"2.77 PCTs will be placed under a duty through directions to commission all six current Directed Enhanced Services (DES) to meet the needs of their population. In line with paragraph 2.13 of *Investing in General Practice*, the Contract Regulations define enhanced services as follows:

“medical services other than essential services, additional services or out of hours services; or

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”.

The Contract Regulations allow the medical services to be of any type, in any setting, and to extend beyond the scope of primary medical services. There is no legal constraint as to what types of NHS medical services a PCT can commission through the four provider routes described in section A of this chapter. This will give PCTs a broad ability to develop more integrated services across the primary, secondary and acute sectors.

2.78 However, for the purposes of financial monitoring, the definition of enhanced services is drawn more tightly than the legal definition.

PCTs will be notified of their enhanced services expenditure floor level in the January 2004 allocations, which they will be expected to meet but can exceed. PCTs will need to consider carefully what constitutes an enhanced service for the purpose of accurate financial monitoring. This will be undertaken at national level by the joint BMA/NHS Confederation/Health Departments Technical Steering Committee. Whilst a precise national definition would not be sufficiently sensitive to

local issues, PCTs and contractors should bear in mind that, generally speaking, the following spend would count towards the floor:

- (i) commissioning, or direct PCT provision, of Directed, National or Locally Enhanced Services from any provider, not just GMS and PMS contractors
- (ii) Practitioners With a Special Interest (PWSIs) **except in relation to essential or additional services**
- (iii) the **plus element** of PMS Plus and the **specialist element** of specialist PMS arrangements
- (iv) local primary medical care incentive schemes commissioned from GMS or PMS providers
- (v) if the PCT proposed, for example, to re-commission a service that had previously been placed with a NHS trust it would count towards the floor, regardless of the outcome of the contest, but only providing that:
 - (a) **it was contestable for GMS and PMS contractors**
 - (b) **it is a service that might reasonably provided by GMS and PMS contractors**, for example because looking across the UK there are other such contractors delivering similar services.”

The following is a simple check-list of questions to which if the answer is NO, then the service does not count towards the Enhanced Services Floor (ESF):

- 1. Does it provide a higher level or specialisation of care to patients?**
- 2. Is it contestable by GPs?**
- 3. Can it reasonably be provided by GPs?**

The following questions, if answered YES, would again suggest that the proposed service is NOT an enhanced service that counts towards the ESF:

- 1. Does it provide essential or additional services to patients?**

2. **Is it spend on primary care services funded through other routes?**
3. **Is it spend on essential services, e.g. premises, greenfield sites?**
4. **Is it funding the provision of OOH services?**
5. **Is it baseline spend for services provided by Trusts e.g. A&E, existing services provided by GPs in community hospitals or as clinical assistants, and provided under an existing contract?**

The LMC should be consulted about the proposed level of spend and the PCO should seek to obtain LMC agreement that the proposed services count within the above definition for financial monitoring purposes. Where there is a dispute over what counts towards the floor, the LMC and PCO should seek to resolve this locally in the first instance.

PCOs will be under a **legal obligation** to commission services for violent patients (from 1 February 2004), influenza immunisations, and minor surgery (both from 1 April 2004). These can be commissioned from any provider, or the PCO can provide the service itself. However, it is likely that PCOs will in most instances want to commission these services from the patients' own GMS and PMS contractors, to ensure continuity of care.

The PCO commissions enhanced services as primary medical services; they only become GMS services when they are provided as part of a GMS contract. The PCO has discretion to draw up specifications on the basis of local need and it can also decide when it wants to commission most enhanced services.

For example, a PCO could choose to commission minor surgery from a PMS or commercial contractor using a different specification and at a different price from the GMS NES specification. Nonetheless, PCOs may wish to be guided by the twelve GMS NES specifications as detailed in the 'Supporting Documentation' (i.e. second, thicker blue book). GMS contractors may expect, and may only be willing, to offer enhanced services on the basis of the GMS NES specifications and prices.

Some PMS practices may already be funded for some enhanced service activity within their existing contracts and the PCO may choose to review these.

Commissioning decisions are entirely a matter for local negotiation (and the contract dispute resolution procedure described in chapter 6 does not apply); PCOs will want to make commissioning decisions on the basis of quality, accessibility, choice, and value for money. PCOs will also want to consider the duration of such contracts.

APPENDIX 3

Enhanced services subgroup of the GPC's primary care development subcommittee

TERMS OF REFERENCE

- To comment on Enhanced Services spending floor proposals from PCOs as and when necessary at the request of LMCs (as routed via the LMC Liaison Officer)
- To comment on definitions of essential and enhanced services as and when necessary at the request of LMCs (as routed via the LMC Liaison Officer)
- To recommend to the GPC UK negotiators where a dispute between an LMC and PCO regarding the Enhanced Services spending floor should be considered by the Implementation Coordination Group (ICG)
- To collect/disseminate examples of good practice from/to LMCs
- To build a library of agreed LES specifications for dissemination among LMCs

MEMBERSHIP

Joint Chairmen

- Brian Balmer Chief Executive of North and South Essex LMCs (and GPC member)
- Chaand Nagpaul Chairman of the GPC's Primary Care Development Subcommittee

GPC negotiators

- Andrew Dearden Chairman of GPC Wales
- Richard Vautrey Medical Secretary of Leeds LMC

LMC representatives

- Andrew Green Chairman of East Yorkshire LMC
- Peter Jolliffe Chief Officer of Devon LMCs

Primary Care Development Subcommittee

- Helena McKeown
- Sally Nelson Director of Public Health, South Wiltshire PCT
- Simon Poole Chairman of Cambridgeshire LMC
- Peter Swinyard