15 October 2003

Dear Colleague,

GMS CONTRACT: INTRODUCTION TO ENHANCED SERVICES

Purpose

1. To provide guidance to LHBs on the implementation of enhanced services in 2003/4. More detailed guidance will follow on claims and payment procedures.

Enhanced Services in Wales

2. An agreement on a new GMS contract was reached between the 4 UK Health Ministers and the BMA on 17 February 2003. This was endorsed in a ballot by a majority of GPs on 20 June. The new contract requires primary and secondary legislation before it can be given legal force. This will not be completed until 1 April 2004. In the meantime the Welsh Assembly Government has undertaken to make as much progress as possible using existing legislation. Enhanced services are an area in which substantial early progress can be made. This will be done mainly by using existing powers for LHBs to commission Local Development Schemes.

3. The Assembly has negotiated an agreement with GPC Wales on the priorities for enhanced services in Wales. There is an allocation of £7.15 million to help fund these services. The funding will enable LHBs to deliver a package of 7 enhanced services. Four of these will be Directed Enhanced Services (DESs) (Access, Flu Vaccination, Quality
Information Preparation and Violent Patients). LHBs are required to offer DESs. In addition the Assembly is providing additional funding to help introduce a further 3 National Enhances Services (NESs); INR Monitoring, Near Patient Testing and Drug Misuse. LHBs have discretion as to whether to offer NESs.

4. In making decisions on enhanced services LHBs are required to take account of the views of the LMC. GPC Wales as national representative of the 5 LMCs, has indicated that the 3 NESs featured in this guidance will be the priority for GPs in Wales. LHBs can therefore expect LMCs to argue for this package of 3 NESs in addition to the mandatory DESs. These services fit well with the Assembly’s policy to fund the expansion of primary care to provide a wider range of services closer and more convenient to patients. Schemes similar to the 3 NESs are already running in many areas through local development schemes (LDSs). These are valued by patients and reduce pressure on secondary care. Enhanced services funding will allow coverage of such schemes to be extended across Wales. Where LDSs are already in place, the new money can be used further to expand primary care to meet local priorities.

Definitions

5. Essential and additional services will form the core work that most practices already provide and will continue to provide under the new contract. These are largely acute presentations and preventative work. Enhanced services represent more specialised work and many services will not be provided by every practice. The specifications will normally cover the enhanced aspects of clinical care, which are beyond the scope of essential services. The contract defines enhanced services as:

- “essential or additional services delivered to a higher specified standard, for example, extended minor surgery”.

- 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.”

6. There are three types of enhanced service:

- **Directed Enhanced Services (DES)** - under national direction with national specifications and benchmark pricing which all PCOs must commission to cover their relevant population. The DESs are:
  - Access to GMS
  - Violent patients schemes
  - Flu vaccinations
  - Vaccinations and Immunisations
  - Quality Information Preparation
  - Minor Surgery

- **National Enhanced Service (NES)** - with national minimum specifications and benchmark pricing. LHBs are not bound to commission these, but if they do, the
national minimum specification will form the basis of the agreement. The NESs are:

- Alcohol misuse
- Drug misuse
- INR monitoring
- Shared care drug monitoring
- Depression
- MS
- Sexual health
- Minor injury services
- First response services
- Services to the homeless
- Intra partum care.
- Intra-uterine contraceptive device fitting

- Local Enhanced Service (LES) - there is no national specification or benchmark price. LHBs are free to negotiate within the framework created by the contract.

Objectives

7. The key objectives of enhanced services are to:

- Improve patient care for all patients and for specific vulnerable groups;
- allow practices to develop services for their practice populations;
- Improve patient choice;
- aid the shift of work from secondary care to primary care

Legislative Basis

8. LHBs will not have the power to commission enhanced service until the Health & Social Care (Community Health and Standards) Bill comes into force and secondary legislation is in place. To enable the contract to commence quickly this year, LHBs are required to use their powers under s36 of the Primary Care Act 1997 to enter into local development schemes. Guidance on local development schemes is contained in WHC(99)174. This includes model schemes, which might be useful in developing local services. These powers can be used to implement enhanced services. To maintain consistency with other payments, flu vaccination payments will continue to be paid through the Statement of Fees and Allowances. The rate will increase from item of service rate A to rate B. This change is already in place.

Commissioning process

9. The contract requires LHBs to commission DESs for their population. In addition they will be expected to use their powers to deliver NESs and LESs to meet local health needs. These requirements will be reflected in performance management
arrangements and the new SaFFs for 2004/5. The published specifications for directed and national enhanced services should be used as the basis for commissioning services. LHBs will negotiate an agreed rate with practices or LMCs using nationally published rates as a benchmark. The agreed rate may be higher or lower depending on local circumstances. The Assembly and the BMA accept that capacity to implement is limited. It has therefore been agreed that priority should be given to the Access and Quality Information Preparation payment DESs. Payments for this can be made from November. Other schemes should follow as soon as possible after these.

10. GPs do not have preferred provider status for enhanced services, as they do for essential and additional services. The Contract states:

"most contracts for enhanced services are likely to be placed with GMS or PMS providers, but some services may be placed with NHS trusts. After 1 April 2004, when new legislation is in place, LHBs will be able to provide the services directly, subject to rules around audit and fair competition."

11. LHBs will be required to consult their constituent local practices, LMCs and community health councils about the level of investment they propose to make on enhanced services, and how it will be used in line with the LHBs strategic objectives. Were the LHB not to develop adequate plans for developing enhanced services in primary care the regional office is required to intervene to ensure that the guaranteed expenditure floor is not breached and is spent for the purposes intended.

12. Existing LDS contracts will continue for the duration agreed previously. In some cases they may run beyond 1 April 2004. Arrangements for LDSs agreements to be converted into the new enhanced services are being considered as part of the new legislation.

13. Some practices may seek formally to close their lists in order to manage excessive workload. Whilst formal list closure will not prevent a practice from applying to provide enhanced services, the contract states that it is likely to prejudice its application.

Financial Arrangements

14. The Assembly has allocated for 2003/04 £7.15m of new money to help fund 7 enhanced services across Wales. The amount for each LHB and detailed financial arrangements will be set out in an allocation letter to be sent to every LHBs. This will be distributed using the GMS weighted capitation formula for 2003/4. The Carr-Hill Formula is not relevant to enhanced services.

15. For the first years of enhanced services the Assembly will need to monitor spend very closely to ensure that the policy is operating effectively and to provide the Minister with
the assurance that the agreement with the BMA is being delivered at national level. To enable this to happen, the cash will be held by the Assembly and LHBs will be able to draw down against need, up to the total of their individual allocation. More detail on this process and the requirements for LHBs is contained in the enhanced services allocation letter that will be issued shortly.

16. The Contract requires LHBs to establish a minimum "floor" of expenditure on enhanced services. For each LHB the floor will be the amount set in the allocation letter. LHBs must spend up to that floor, but are free to spend more. The additional money can come from other sources such as Hospital and Community Health Service budgets. This will be the mechanism by which primary care will be expanded and it will be possible to fund the transfer of work from secondary to primary care. The Technical Steering Committee (TSC) will monitor investment in enhanced services at UK level.

Accreditation

17 LHBs are responsible for ensuring that enhanced services are delivered by professionals that are properly qualified to do the job. The contract states that those doctors who have previously provided a similar enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for enhanced services, shall be deemed professionally qualified to do so. It is expected that the level of training required for a GP providing an enhanced service is identified in the GPs continuous personal development plan (CPD) and, where additional training is required, local mechanisms are found to address this.

18. Accreditation of the service should be based upon a consideration of the enhanced service plan, as set out in the application for approval, and should be determined by the LHB primary care development lead upon the advice of the medical and nursing directors. Practice visits will provide the opportunity to explore in more detail any issues that might arise in the provision of the service.

19. All doctors directly involved in the provision of an enhanced service should be required to identify that responsibility within their CPD plans and discuss the related professional development with their appraiser. They need to assure the medical director of the LHB that this has been done and the appraisal signed off. A similar model will apply for any practice nursing staff providing direct enhanced services.

Summary of Schemes

20. Detailed specifications for each DES and NES are contained on the NHS Confederation website at nhsconfed.org.uk/gmscontract. The Assembly is fully signed up to the UK contract and these specifications should be used as the basis for local negotiation. For the Access DES a supplementary agreement has been reached between the Assembly and the BMA (Annex A). This is based on the UK agreement and provides more detail on how the scheme will operate in Wales. Further information on the necessary claim forms and detailed guidance on the payment processes will be issued shortly.
**Access DES - “The Future of Primary Care” - the Welsh Assembly**

Government’s strategic plan for the development of primary care services defines the access target for Wales. This undertakes that patients will be able to access an appropriate member of the primary care team within 24 hours of requesting an appointment and much sooner in an emergency. The supplementary agreement at Annex A sets out how this will work in Wales. The benchmark price for Access is £5,000 per practice to fund preparatory work, leading to achievement and additional 50 quality points in 2004/5 for those practices that achieve the target. All practices entering the scheme must sign up to deliver the target by April 2006 and providing bi-annual progress reports to the LHB. £5000 has been agreed as payment for each of the next 3 years. This is conditional upon submission of appropriate claim forms and approval by the LHB. Payment for this DES in 2003/04 will be made at the end of November 2003.

**Quality Information Preparation DES -** This is a scheme to fund the summarisation of medical records for essential and additional services. It is part of the process of preparation for the introduction of the quality and outcomes framework. There is overwhelming evidence that better and more accessible patients’ records lead to better patient care. There are 9 service protocols for this scheme, which are set out in paragraph 4 of the QIP DES. Practices are required to conduct an annual review. The benchmark funding for this DES is £2,500 per average practice. This DES is payable for 2 years. For 2003/04 the funding agreement is £2500 per average practice and payment will be paid at the end of November 2003. Again, this is conditional upon practices submitting appropriate claim forms and approval by the LHB. This DES for note summarising is distinct from the Quality Preparation Payments which are payable to all practices. Both payments are payable for 2 years only.

**Flu Vaccinations -** Payments will continue to be made through the Statement of Fees and Allowances for this year. The rate for 65s and over will remain at IOS B. For patients who are under 65s and in the at-risk categories the payment will increase from IOS A to IOS B. This DES is from 1st September 2003 and a circular to that effect has already been issued to the service.

**Services for Violent Patients DES** - The new contract makes it the responsibility of the LHB to ensure that general medical services are provided to patients who are difficult to manage. These services should already be in place. Additional funding is being provided to enable LHBs to strengthen their services and, where necessary, to extend provision to ensure full coverage across the LHB area. The purpose is to provide services to patients who are potentially aggressive and who have been removed from a practice list because of their violent behaviour. The benchmark price is based on a £2000 retainer plus a consultation fee of £40-80 in hours and £50-100 out of hours.

As from 1st April 2004, it is the responsibility of the LHB to ensure that there is a service available to patients who are difficult to manage, and this will be commissioned separately as an enhanced service. GPC(W) have indicated that the preferred choice for GPs would be a Safehaven arrangement for these patients. £0.5m is being made available for the 2nd half of this year for LHBs.
Anti-coagulation Monitoring NES - Warfarin is being used in the management of increasing numbers of patients and conditions, including patients post-myocardial infarction, arterial fibrillation, DVT and other disorders. Therapy should normally be initiated in secondary care, for recognised indications for specified lengths of time. Warfarin monitoring aims to stabilise the INR within set limits to help prevent serious side effects while maximising effective treatment. A benchmark price will be set according to the level of services that the practice provides. Price ranges are set out in the DES. An allocation of £1.9m for the last 6 months of this year is being made available to LHBs to commission this service. Once agreement has been reached to commission this service, any members of the primary care team wishing to provide INR must follow the process to gain approval onto the inclusion list. Information on this list will follow with the appropriate claim forms.

Provision of Near-Patient Testing NES - The treatment of several diseases within the field of medicine, is increasingly reliant on drugs that need regular blood monitoring. This is due to potentially serious side effects that can occasionally be caused. It has been shown that the incidence of side effects can be reduced significantly if this monitoring is carried out in a well-organised way close to the patient’s home. This NES establishes a shared care drug monitoring service for the following specified drugs: Penicillamine, auranofin, sulphasalazine, methotrexate, sodium aurothiomalate. A benchmark price will be set according to the level of services that the practice provides. Price ranges are set out in the DES. £0.5m has been allocated from 1st October 2003 for 2003/04 for this service. As above, the inclusion list process must be followed.

Drug Misuse NES - This NES provides coordinated care and support for drug users and help in accessing local detoxification procedures provided by other agencies and professionals. The services will be delivered in a secure environment appropriate for the delivery of such services. The benchmark price will be an annual retainer of £1,000; £500 withdrawal per patient per annum; and £350 maintenance per patient per annum. £1.0m has been allocated from 1st October 2003 for 2003/04 for this service. As above, the inclusion list process must be followed.

Yours sincerely

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Primary Care Division
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Introduction

1. There is increasing evidence that patients value improved access to primary care services. Many primary care providers are currently investing in management methods to improve patient access to health professionals.

2. This DES rewards practices for the period leading to achievement of the national access targets, until April 2006. Maintenance of the relevant national access target will be rewarded through the 50 bonus points available through the quality and outcomes framework.

3. “The Future of Primary Care” - the Welsh Assembly Government’s strategic plan for the development of primary care services which is reflected in the New GP GMS contract, has defined the access target for Wales. “Patients will be able to access an appropriate member of the primary care team within 24 hours of requesting an appointment and much sooner in an emergency”.

Definitions

4. The following are definitions of terms used in this DES:

- “access” - This means direct contact between the patient and the professional, in line with the practice’s consultation arrangements. In most cases, this consultation will be face to face, but telephone consultation will be a useful alternative for many patients. Patients’ wishes in this matter will need to be taken into consideration. A professional, clinical opinion and/or diagnosis is required in order to determine a further course of action e.g. to treat, to refer or to decide that no further action is required. This must be recorded in the normal way in accordance with terms and conditions of service.

- “24 hours” - clinical advice will be sought and given within one working day in accordance with the clinical needs of the patient. If a patient requests a consultation on Friday, he or she should be dealt with at a convenient time no later than Monday of the following week. If the practice has identified a planned closure for staff training/bank holiday on the Monday, the consultation should be arranged no later than the end of Tuesday. Out of Hour organisations may be used to assist in achieving the access targets if local arrangements are agreed and in place.

- “A member of the primary care team” - this means a doctor, practice nurses, allied health professionals or other health care staff within the practice, who is competent to deal with the patient’s clinical needs.

- “Patients” - are those people (including temporary residents) who are registered with the practice. Those patients not registered with the practice are exempt from the access target.
5. The definition excludes:

- situations where the patient does not wish to consult within 24 hours;
- situations where the patient specifies a particular professional or individual, where an appropriate, alternative professional is available within 24 hours;
- pre-planned courses of elective treatment or care programmes where access arrangements are established in advance e.g. chronic disease management, treatment or screening programmes;
- out-of-hours coverage i.e. outside the normal working hours of the practice;
- planned closures e.g. public holidays or staff training.

- Patients not registered with the practice

Process

6. Each participating practice will submit to the PCO its intentions regarding this DES. Practices will need to agree a plan for implementation with the PCO. There will be a number of ways in which 24 hour access can be delivered. The approach will vary between practices recognising that existing services are organised and delivered in different ways. Where 24 hour access cannot be delivered within the first year, milestones should be agreed to set out progress to full achievement. Access plans are likely to cover one or more of the items listed below. This list is not exhaustive and innovation will be encourage.

- profiling the demand for appointments within the practice;
- identifying and implementing approaches to shaping demand within the practice in order to use consultation more effectively;
- matching the capacity of the practice to the demand for appointments on a daily basis and reducing any backlog of appointments as required;
- collecting data on a 3 monthly basis to demonstrate improvement (eg third available appointment measure for GPs and nurses within the practice);
- Open access surgeries may feature, but this is unlikely to be the only element in the plan and care must be take not deliver access at the expense of unreasonably long waiting times;
- introducing ‘Advanced Access’ to provide some day appointments;
- achieving practice accreditation, training practice accreditation or QPA where the access criteria have been achieved
- introducing telephone consultation or doctor or nurse triage.
Funding

7. A payment, benchmarked at £5,000, will be authorised by the LHB on receipt of a satisfactory plan and an application for payment. Further annual payments will be made in 2004/5 and 2005/6 on receipt of a report that demonstrates that the target has been achieved or significant progress has been made in accordance with the milestones and that the target is likely to be met by April 2006. Practices that experience difficulties in progress e.g. recruitment of new staff should discuss these with LHBs at the earliest opportunity.

8. The suggested benchmark price for the DES for 2003-04 is £5,000. The Welsh Assembly Government has earmarked £2.6m as part of the funding package for enhanced services. Practices will also be paid for achieving the target through the Quality and Outcomes Framework in the form of 50 points, which will be paid as an achievement payment.

Monitoring arrangements

9. Local Health Boards will be responsible for approving and monitoring access plans for practices in their area. LHBs will also be responsible for supporting practices experiencing difficulties in reaching the agreed milestones. Practices will need to be able to demonstrate that they are achieving the required level of access or are working towards the target in accordance with agreed milestones.

Timescale

10. The target should be achieved by most practices by April 2006 and many practices are expected to achieve it well before that.