

Benefit from GMS enhanced services

In the third of four consecutive articles, **Sue Carter**, head of prescribing and pharmacy, Adur, Arun and Worthing Teaching Primary Care Trust, gives her view on new general medical services contract enhanced services and the move towards commissioning services in primary care

For the first time, the new general medical services (GMS) contract enables primary care organisations (PCOs) to commission local services to meet local needs. Previously, the national contract allowed little flexibility in what services were provided locally, and to what specification. The new, locally agreed contract should ensure that patients, particularly those with long-term chronic diseases, have access to treatments that have previously only been provided by hospitals. Enhanced services are designated as either essential or additional services delivered to a higher standard or extra, specialised services catering for a specific local need (see Panel).

The PCO will be free to commission whatever enhanced services they consider appropriate to meet a local health need, funded by a guaranteed minimum level of investment. There is no obligation for PCOs to commission these services from GPs, or to fund the service if it was not provided before, but it is "anticipated that, except in exceptional circumstances, PCOs will commission services from current providers". Since each PCO's definition of, and inclusion of, enhanced services should be agreed with the local medical committee, it is most likely that agreement would be reached on those services offered by GP practices in preference to other providers. The contract is practice-based and decisions to opt out of or opt into enhanced services need to be made by a practice as a whole. No practice is required to continue to provide enhanced services if the PCO has not offered it an acceptable contract for their provision.

Record keeping and accurate registers will be crucial to the provision of all enhanced services, together with improved communication with community pharmacists and other primary health care professionals. A practice has no absolute right to continue providing an enhanced service if there are doubts or questions about service quality. PCOs will need new systems to deal with quality issues in primary care commissioning.

Workforce issues

There will also be complex workforce issues to deal with for some enhanced services, especially those that may result in a shift of resources and work from secondary to primary care. It could mean, for instance, a hospital-based specialist nurse or pharmacist transferring their services into a PCO-wide primary care environment, either on a contracted-out basis or by changing their employer. Education, training and continuing professional development throughout the practice team will be important to maintain and con-

tinually improve clinical standards. The new GMS contract specifies in most protocols that it is the responsibility of the GP to maintain his or her own CPD and competency for providing a specialist service, but this is still bound to have a major implication for PCO clinical governance teams and primary care pharmacists engaged in practice training. There are opportunities for multidisciplinary team working, with many enhanced services having potential for involvement from a community or practice pharmacist.

Prescribing budgets

Primary care pharmacy teams will face new challenges in prescribing budget setting and financial and clinical monitoring. For instance, one practice may provide near patient testing services for a co-operative of six practices, while another practice in the group provides care for substance misuse patients for the same co-operative.

The old methodology for prescribing budget setting needs to be completely rethought, or these two practices could be financially penalised for prescribing for patients benefiting from these enhanced services. Interpreting trends and practice comparisons will similarly require a new and more fluid approach by pharmaceutical advisers, using a good knowledge about locally commissioned services.

Some aspects of interpretation and advice to GPs differ between the Department of Health and the General Practitioners

Committee, and could give rise to local dispute in some cases. The DoH advises that benchmark prices are not mandatory, and PCOs are not obliged to offer the service at the benchmark price. However, the GPC advises practices not to offer the service for less than the benchmark price. If a lower local tariff is set, and practices refuse to do the work for less than the benchmark price, then PCOs will have to place the work elsewhere. Every PCO will be required to make a minimum level of investment in enhanced services, called the enhanced services floor.

The stated purpose of enhanced services is to improve patient choice, improve patient care, and support modernisation by shifting resources and work from secondary to primary care. They are also designed to allow practices to provide services specific to their own patients' needs, as well as give GPs themselves an acceptable income reflecting the workload. There are opportunities for the many pharmacies that already have the staff and skills in place to play a significant role in the primary care provision of enhanced services, either as partner or main provider. Community pharmacies would do well to note the structure and implications of enhanced services, only some of which are discussed here, since they may each be facing similar issues soon under the future new pharmaceutical services contract.

□ The last article in the series will look at medicines management issues.

Enhanced services in the new GMS contract

Directed enhanced services (DES) must be commissioned by every primary care organisation, but will not always be provided by every practice. DES must follow national specifications and pricing structure:

- Access — high on the political agenda, this DES should improve patient access to the primary care team within the NHS target time (currently 24 or 48 hours in England)
- Services for violent patients — it is a new responsibility of the PCO to commission a service for patients who are difficult to manage
- Childhood immunisations — to continue the service currently provided by most practices
- Quality information preparation — to make patient records more usable and accessible to whichever health care professional is treating them, in order to improve health outcomes
- Influenza vaccination — to continue improving coverage of flu vaccination in target at-risk groups
- Minor surgery — an opportunity for PCOs to move injections and other procedures from secondary into primary care

National enhanced services (NES) are optional extra services that PCOs may commission, in consultation with the local medical committee, to meet local needs. The national set minimum standard and pricing structure must be used, although this is flexible enough to allow for some local negotiation. NES include alcohol misuse, minor injury services, multiple sclerosis care, substance misuse maintenance prescribing, services to the homeless, anticoagulant monitoring and near patient testing (under shared care guidelines).

Local enhanced services (LES) are commissioned entirely by local negotiation, using the same structure as NES to meet local specific needs. Some suggestions are medical care of asylum seekers, specific services for people with learning disabilities, enhanced nursing home care and 24-hour blood pressure monitoring.