THE NHS CONFEDERATION

briefing

Commissioning Services under the new GMS contract

The NHS Confederation and the National Primary and Care Trust Development Programme (NatPaCT) have developed a series of briefings to assist primary care trusts (PCTs) and practices to prepare for implementing the new General Medical Services (GMS) contract in England. This briefing focuses on commissioning and what PCTs need to do to support implementation. This is particularly important in relation to the commissioning of additional and enhanced services. It does not cover commissioning processes that are unrelated to the new GMS contract, but is designed to be a helpful framework to guide PCTs and practices through new opportunities and the associated challenges. More detailed guidance on implementation will follow later.

Key points

- The briefing summarises the following elements of the GMS contract: commissioning primary care focusing on service categories; implementing the Patient Services Guarantee; investment and service development; and quality and outcomes.
- It raises questions about the approach that PCTs may wish to take; the early messages they should convey; and the actions they may want to take. The briefing urges PCTs to pay careful attention to the main aims of the contract and to develop a clear strategic vision for improvement. This needs to be balanced with early communications that try to achieve real change, at a sensible pace with consideration for stakeholders and the workforce.
- The briefing suggests a strategic approach to the patient's experience of providers and their networks. This requires strong, far-sighted management between primary and secondary care, and within primary care.
- It is suggested, in line with the new contract, that PCTs will generally be able to take a practical approach to implementation, but they will have to carry out a frank assessment of their capacity and capability to deliver it, and take immediate action to skill up.

Commissioning services – summary of the new GMS contract

A key objective of the contract is to give practices more control over the services they provide – services are categorised as a framework for decision-making. All practices will be given funding to provide essential services and additional services (although practices may opt out of providing certain additional services either temporarily or permanently, following due process).

PCTs will have funding, through their total budget, to commission enhanced

services of different kinds. These may be:

- specified nationally and mandatory at PCT level;
- specified nationally but optional at PCT level; or
- specified locally in response to local need.

Initially practices will be able to opt out of out-of-hours provision but 'opt out' will eventually be the default. There is a guaranteed minimum spend for developing these enhanced services in the following allocations: £315m in 2003/04, £563m in 2004/05 and £631m in 2005/06.

The contract emphasises the choices and freedom available to practices but also the reciprocal duties required of PCTs. There will be a new legal requirement for PCTs to deliver against the Patient Services Guarantee, which ensures that 'patients will continue to be offered at least the range of services that they currently enjoy under the existing contract'.

What does this mean in practice?

In order to fulfil these requirements, PCTs will have new powers to complement services provided by local practices with their own services or services they commission from other providers, including out-of-hours services. These key commissioning decisions will be made on the basis of necessity (where there is a PCT Strategic Service Development Plan (SSDP)), quality, accessibility and value for money. There will be closely regulated requirements for fair and transparent processes, consultation and appeal.

In order to support their strategy and deliver NHS priorities, PCTs may need to commission other providers to deliver additional services. There are a number of alternative arrangements for doing this. However, it is important that PCTs make an appropriate assessment of the needs of their population and involve clinicians to ensure that commissioning developments can achieve the required standards and meet patients' expectations.

Additional or enhanced services are most likely to be provided through alternative arrangements, however some (e.g. walk-in centres) may also be commissioned to provide additional services (e.g. vaccinations and immunisations). Practices themselves will have some flexibility to delegate work to other providers, as an alternative to opting out themselves.

PCTs will not be using the contract solely or even mainly as a way to use alternative providers to plug gaps, in cases where practices opt out of additional or out-of-hours services, or close their lists[1]. The contract provides the framework for using new financial resources effectively and PCTs will no doubt wish to use this to commission from existing practices in support of new enhanced services. These may be:

- essential or additional services delivered to a higher specified standard (for example improved access or extended minor surgery)
- services other than essential and additional services including, for example 'specialised services undertaken by GPs or nurses with specialist interests and allied health professionals and other services at the primary-secondary care interface'. They may also include services that are under development or evaluation to meet specific local needs.

Paragraph 2.15 (iii) of the contract document describes the three types of enhanced services – Directed, National and Local – and the different commissioning arrangements.

- Directed enhanced services that are commissioned from general practice – PCTs **must** use the nationally agreed specification and price, as published in the contract supporting documentation.
- National enhanced services that are commissioned from general practices – PCTs **may** use the national minimum specifications and benchmark prices to inform the exact service they wish to commission and the funding available for providing this service.
- Local enhanced services – PCTs are free to develop their own specification according to the service to be delivered and negotiate a price locally.

The introduction of enhanced services will include existing incentive schemes and schemes which support the secondary to primary shift. These include: Local Development Schemes (LDS), Improving Primary Care Incentive Scheme, services currently delivered under HSG(96)31, GPs with Special Interests (GPwSIs) and schemes to improve patient access. Any services currently delivered under these schemes will now be commissioned under one of the three categories of enhanced services.

[1] A subsidiary aim of the contract is to reduce the need for forced patient assignments, when practices seek to close their lists, by making other provider arrangements.

'Existing contracts for such services will be rationalised into a single arrangement for enhanced services under the contract between the PCT and the practice from 2004/05 and will continue for at least the duration agreed previously between the PCT and the practice' (para 2.15(ii) of the contract document). Funding currently available for these services has been built into the PCTs' enhanced services funding spend.

The contract is focused on quality and the Quality and Outcomes Framework sets out indicators in the following areas: clinical, organisational, additional services and patient experience. PCTs will be responsible for 'reviewing' practice quality achievement, initially by visiting the practice on an annual basis.

The PCT will confirm what level of achievement funding will be given and discuss the quality standards for the practice to aim for in the following year. This is to be a 'high trust' process at practice level with minimum bureaucracy, underpinned by high quality clinical information systems. The Commission for Healthcare Audit and Inspection (CHAI) will inspect overall PCT performance against the Quality and Outcomes Framework.

Implications for PCTs

The new GMS contract is a major development that enables PCTs and practices to review and assess present provision whilst creating a vision for future services in their area. PCTs will wish to consider two issues:

- their approach in relation to the contract implementation (strategic vision and, critically, an operational plan to implement it)
- presentation of the contract to ensure maximum benefits can be gained from it.

Contract implementation and presentation

A PCT needs to be able to articulate the benefits and opportunities of the contract to its own organisation and partners in a way that engages key stakeholders, as for many it will be very much a joint commissioning process.

It is vital that PCTs establish a process for developing a clear strategic vision for services in the future. This should happen in conjunction with the practices and should start to signal how the opportunities of the new GMS contract could be used in the future.

It will be critical for the vision to clearly demonstrate engagement with local clinicians, users and carers on the main opportunities. This will be particularly important where the strategy aims to shift services from secondary to primary care. To promote understanding on the benefits of the contract it will be crucial to involve members of the public in general, and service users and their carers in particular.

PCTs will wish to start early discussions with their GMS practices about what additional services the practices wish to opt out of, and what enhanced services the PCT will commission.

The contract document underlines the roles of Local Medical Committees (LMCs) and PCTs may find it helpful to involve them from the outset.

Implications for others

Strategic health authorities

There is a real need for strategic health authorities (SHAs) to be engaged early to support the PCTs' executive role of shaping the planning and provision of GMS services. The contract outlines a number of core functions that SHAs will be required to carry out in relation to service commissioning.

- Ensuring the delivery of the guaranteed minimum spend on enhanced services. This represents a significant opportunity for SHAs to encourage innovative service delivery, local specialisms and centres of excellence.
- Supporting the PCT in the development of effective out-of-hours services. SHAs will be able to take the lead to bring together local providers. They will also have a performance management role in ensuring that the implementation timetable is achieved.
- Undertaking a supervisory role regarding the PCTs strategic objectives. There is potential to interpret this imaginatively to bring about large-scale improvements and a significant shift to primary care services provision. The SHA has the power to become actively engaged in this process and to help create the dynamism necessary to bring about real modernisation.

Out-of-Hours Providers

The contract will introduce major changes in service commissioning to out-of-hours services. By December 2004, out-of-hours services will be the responsibility of PCTs, which creates major capacity issues for many of them.

PCTs need to enter into early discussions with current providers about out-of-hours provision to ensure that a strategic commissioning plan for out-of-hours is in place. This will involve considering early on whether alternative models of delivery will need to be commissioned. A separate briefing deals with the implementation of the new out-of-hours arrangements.

Patient Groups and Forums

PCTs have an obligation to consult with Patient Forums in developing local enhanced services. The Patient Services Guarantee also gives real impetus to shaping services around the user – to involve the local community in reshaping the way that services are commissioned and delivered, such as the dimensions, optimum location, type, provider, impact on carers, families, and involvement of and impact upon other local services.

Local Medical Committees

LMCs represent a powerful and influential voice for the local medical community. They are therefore a useful partner in planning services and involving practices in shaping their future direction. The contract requires PCTs to consult them over plans for developing services, but there is considerable scope for a greater contribution and to make full use of their expertise.

Links to relevant national initiatives

GPs with Special Interests (GPwSIs)

GPwSIs in addition to providing the full range of GMS services to their own patients, will have additional training and expertise which enables them to take referrals from colleagues for the assessment and/or treatment of patients outside GMS who might otherwise have been referred direct to a secondary care consultant. They are also able to provide an enhanced service for particular conditions or patient groups. Funding for GPwSIs will be built into the PCTs' enhanced services funding within the total budget. PCTs will want to consider how they use GPwSIs to deliver enhanced services in primary care, particularly in relation to those services more traditionally available in secondary care.

Diagnostic and Treatment Centres (DTCs)

Diagnosis and Treatment Centres (DTCs) provide elective surgery for a range of conditions, including hip and knee replacements, hernia repair and gallbladder and cataract removal. They have been designed to give high-quality treatment, mainly for day surgery or short-term hospital stay patients, and to make the most efficient use of resources, including beds, operating theatres, diagnostic equipment and staff.

DTCs will play an increasingly important part in the modernised NHS. In relation to the new contract, DTCs will increase the choice and capacity for PCTs in terms of their commissioning options for a range of specialised services.

Local examples of innovation and good practice

Darlington Primary Care Trust become one of the first in the country to set up a dedicated GP unit for minor surgery and skin treatment using special interest GPs. The two Darlington doctors are qualified to deal with a host of complaints – including lumps and lesions, moles and ulcers – without the patient having to be admitted to hospital. It is estimated that having a dedicated GP unit would either halve costs or double capacity and reduce waiting lists. The new unit may also have the capacity to carry out treatment for other PCTs and hospitals in the region, some of which have already expressed an interest in the new service. It would be capable of treating up to 4,000 cases a year with one evening clinic a week and a Saturday morning surgery every month.

Bournemouth PCT is currently engaged in establishing an Orthopaedic Referral Centre to create more treatment options for GPs, which they can access without having to refer to secondary care. The new service will include the establishment of a multi-disciplinary team including GPwSIs, extended scope physiotherapists, extended scope nurses, and other professionals as appropriate.

Patients will be able to access a more local service for assessment, diagnosis and treatment. Patients requiring surgery will be referred at the most appropriate time to meet their clinical needs. Patients who are surgical emergencies or have been 'red flag' indicated will be forwarded directly to the Orthopaedic Surgeons.

Initially this facility is focusing on the development of alternative, primary care based treatments, but in time, it may involve purchasing services from alternative providers by means of the financial flows mechanism. The overall objective of this development is to reduce waiting times, enable patients to exercise greater choice and overall,

to improve the quality of the service across the eastern side of Dorset.
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Somerset Coast PCT use a Referral Management Centre (RMC) as the conduit for specialised primary care referrals. This RMC then garners information from the referrals and directs them to identified slots with acceptable capacity, thus avoiding patient waits. Financial flows are dictated by activity completely. Secondary to this process, the RMC identifies areas where there is particular need, either due to capacity or appropriateness. This can then be addressed by either identifying and funding more capacity, or creating a new pathway that is more patient friendly and cost-effective, for example, setting up Interface Clinics run by Practitioners with Special Interests (PwSI) that have secured access to more special investigations. This ensures that developments are need-led rather than based on local interest or historical structures. Patient choice of 'where' and 'when' at the GPs consultation is also increased through this process. More importantly, the Interface Clinics also offer a 'what' choice.
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Westwood Park DTC is one of the first NHS primary care diagnostic and treatment centres in the country. It is one of three facilities in Bradford South & West PCT where expanded primary care services are offered to patients. Facilities include:

- An operating theatre providing cataract surgery & minor surgery;

- An endoscopy suite, providing gastroscopy, cystoscopy, and flexible sigmoidoscopy;

- Nine outpatient rooms – neurology, dermatology, Ear, nose and throat (ENT), ophthalmology, rheumatology/orthopaedic medicine, gynaecology, general surgery, vascular surgery, urology, and urotherapy.

Six nurses and seven administrative staff provide the core staffing for the DTC, which also welcomes visiting teams of consultants, GPs with a special interest, nurses and other practitioners. The services are a mixture of ones provided by PCT and acute trust and some joint services provided by both.

Quick Wins for PCTs

PCTs will wish to consider the considerable capacity they will need to carry out their new GMS functions.

It will be important to get an early picture of the services that practices aspire to provide; their ambitions in terms of quality; and the capacity, capability and readiness of practices to achieve their aims.

There is a clear need for baseline assessment of:

- the **essential, additional** and **enhanced** services currently being provided

- providers of these services (within and outside general practice)

- the levels of volume and quality

- the price.

PCTs will need to look at the full range of options allowed for by the contract – in terms of out-of-hours providers, special interest practitioners, the independent and voluntary sectors, secondary care or PCT provision.

There will have to be a needs assessment, particularly in relation to those locally shaped enhanced services that involve a wide constituency of contributions and are not covered by a single discipline. Decision-making processes will need to be agreed, fair, inclusive and transparent.

It will be crucial to engage with the local community as soon as possible through patient forums, local patient groups and advocates to get a clear idea of patient needs and the optimum design and scope of services.

At a very early stage PCTs will need to plan their engagement with stakeholders (SHAs, LMCs, clinicians and other partners):

- How are they going to engage with practices in order to agree the range and quality of services to be provided?

- Who will actually do this: do the skills exist on a sufficient scale to conduct negotiations credibly and effectively?

PCTs with significant Personal Medical Services (PMS) experience will have a big advantage in terms of both experience and the amount of fresh GMS contracting that will be necessary. Other examples might be found in Local Delivery Plan (LDP) schemes and neighbouring PCTs.

In assessing the above, PCTs will have identified gaps that need to be addressed, in order for them to commission and deliver new services. PCTs may be able to use support and development resources, from the Modernisation Agency or other partners, to help address increasing capacity requirements, but more often than not it will be a question of developing increased skills and capability.

PCTs will also need other skills and knowledge and will require a different relationship in their commissioning role with Primary Care Services. This will be critical in instances where strategic commissioning plans require service changes or development of new models of care, for example.

An important first step is for PCTs to carry out a critical self-assessment of its capability and capacity to commission Primary Care Services.

Competencies

NatPaCT's PCT Competency Framework is an online self-assessment tool that is being extensively revised to take account of the new agendas facing PCTs, including the new GMS contract. Under each domain the Framework sets out a number of statements of competency and examples of evidence – showing what should be achieved and how achievement can be recognised. Each domain is linked to discussion forums, relevant news stories, and a growing library of key resources. Domain 2 of the Framework, Primary care, is being re-written to take into account material in these briefings, and will be posted shortly at **www.natpact.nhs.uk/newcf**.

There are also competencies directly relevant to the issues raised in this briefing in Domain 4 Commissioning: Initial Competencies. Further competencies on Financial Flows, Choice and Booking are also being prepared.

Acknowledgements

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Signposting and references

The GMS Contract – Investing in General Practice,
NHS Confederation/BMA 2003
NHS Confederation: **www.nhsconfed.org/gmscontract**

The Confederation's website also contains supporting documentation, and helpful resources such as a series of summary factsheets.

The NatPaCT and Modernisation Agency websites signpost a number of local and national initiatives programmes and support tools:
www.natpact.nhs.uk and **www.modern.nhs.uk**

Department of Health Commissioning Toolkit – Evidence Based Commissioning: A Directory: **www.doh.gov.uk/pricare/pctdirectory.pdf**

GP/Practitioners with a Special Interest:
www.doh.gov.uk/pricare/GP-specialinterests/index.htm
www.gpwsi.org/subindex.shtml

Delivering the NHS Plan: **www.doh.gov.uk/deliveringthenhsplan/index.htm**

Improvement, Expansion and Reform: Priorities and Planning Framework 2003-6: **www.doh.gov.uk/planning2003-2006/index.htm**

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