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Doing your enhanced services homework will bring rewards

It's all change for enhanced services! So make sure you stay on top of them. **Kathie Applebee** highlights the key areas to consider

Enhanced services began life in 2004, when they were introduced alongside the Quality and Outcomes Framework (QOF).

Initially they were divided into Directed (which had to be commissioned in every area), National (supposedly based on need but really on funding availability), and Local (which met specific local needs).

The division of enhanced services (enhanced above core-level GMS) into these three categories of DES, NES and LES has been quietly dropped, and immunisations, once part of this group, have been reclassified in *General Medical Services Contract 2014/15: Guidance and Audit Requirements*, as the 'vaccination and immunisation programmes'.

Patient online access and remote monitoring have been removed from the ES programme this year, with the former becoming a contractual requirement instead. Minor surgery and violent patient enhanced services, both reclassified to LES status, are otherwise unchanged.

Much attention has been focused on the new enhanced service, *Avoiding Unplanned Admissions*[1] but there are other changes affecting the remaining ES specifications, and these are highlighted below as they could easily be missed.

The **alcohol risk reduction scheme** requires that patients aged 16 or over who register during the financial year be screened using the FAST or AUDIT-C tests.

Patients with positive scores should then be screened further using the AUDIT questionnaire and a value recorded with the appropriate code. Those scoring 8-15 should be offered brief intervention, 16-19 brief intervention or brief lifestyle counselling, and 20 or more be considered for referral to specialist services.

This intervention is worth £2.38 and would usually be done at an initial consultation or new patient check rather than by means of an expensive recall system.

For scores of 8 or more, patients are also required to be screened for anxiety and/or depression, using

tests such as the PHQ-9.

Patients identified as anxious or depressed will then need to be treated, either by the practice or, in more severe cases, through referral. However, the guidance notes that such referrals may not be accepted until the patient's alcohol dependency is 'dealt with'.

It is essential that the correct Read codes are used for each step (as for all the ES areas) and these can be found in *Technical Requirements for 2014/15 Contract Changes (Version 3, June 2014)*.

Data extraction in England will ultimately be done through GPES, directly from patients' records as it is for QOF. Although the steps following positive screening are not directly funded (up to 16 data items, known as management information counts), they will be used for post-payment verification.

Simply screening new patients and then taking no further action over those with significant scores will not be sufficient.

The **learning disabilities health check scheme** offers relevant patients aged 14 and over an annual health check which includes producing a health action plan.

Participating practices need to have attended training, and updates will be required for new staff involved in this programme. Practices are also expected to share data with local authorities to ensure that all patients known to social services and educational support services are included in the practice register.

The requirements for training and conducting health checks are detailed in the guidance document. The health plan can use a GP system template, where available, but any information provided to patients or carers should be in a format which meets their needs.

It should also be shared with other healthcare professionals, if the patient consents, and should include any personalised care plan information, where relevant.

As for the alcohol ES, there is a code for the check and then further codes for five management information counts. Payment for the checks will be £116.00 per patient, with the post-payment verification including assessing details of patients with checks but no plans, either due to lack of offers or patient refusal.

Facilitating timely diagnosis and support for people with dementia has changed to require a more comprehensive care plan for patients diagnosed with dementia and increased support for their carers.

At-risk patients (see p41 of the guidance document) should be offered opportunistic screening following patient consent to an inquiry about their memory.

The screening includes a clinically appropriate test such as GPCOG (GP assessment of cognition) which could result in treatment or a referral, and the offer of an advanced care plan.

This should include a record of the patient's wishes for the future and identification of any carers. Where the latter are practice patients, they should themselves be offered health checks.

This ES has two payment items and 16 management information counts. One payment item is an up-front payment of 0.37p per patient, based on average practice sizes. The remaining funding, from a central pot of £42m, will be paid according to the number of completed assessments done and correctly coded.

Post-payment verification includes the numbers of patients offered referrals and/or advanced care planning sessions, and the numbers of carers offered health checks.

The **patient participation ES** has also changed. There is no longer payment for setting up a group, as this is considered a prerequisite, and the local survey is no longer a requirement in itself.

However, feedback still has to be collected. The funding has been reduced to support the introduction of the friends and family test (FFT) and

Profit Booster

Make sure you are getting paid for what you are doing 1

Is everyone coding everything correctly in your practice?

If your prevalence is lower than average – is it because of your particularly healthy patient population? Or are you not recording things properly?

Coding is likely to be a problem where there is a heavy use of locums or salaried staff, who do not benefit from coding things properly. Or it can go wrong when there is high partner turnover, when new doctors are settling into the job.

But it is not unknown for the subject to be raised at a practice finance meeting and for one long-standing partner to say: 'I didn't know I was supposed to record that! Do we get paid for that?'

A mixture of training and review can bring in noticeable sums of money.

is now 0.36p per patient, assuming all requirements are met.

Practices need to engage with patients, obtain feedback and produce an action plan (based on three key priority areas) which needs to be agreed with the PPG and then publicised to patients.

The practice is required to show that patients and carers have benefited from improvements. Innovative forms of patient participation are expected, such as developing patient champions, and representation of minority groups (such as those with learning disabilities) is emphasised, as is complying with the Equality Act 2010.

Extended hours access now has more flexibilities to meet local needs, including practices grouping together, offering appointments with non-GPs, and providing non face-to-face consultations.

Payment will be £1.90 per registered patient a year. Only GMS or PMS work may be done during these sessions, and practices must take into account the religious and cultural sensitivities of patients and staff when agreeing opening times and days.

It is essential that practices study the guidance and audit requirements, and the supporting technical requirements, and all these can be found on the BMA website[2]. Simply doing more of the same will not be enough this year.

1 Avoiding Unplanned Admissions Enhanced Service: Proactive Case Finding and Care Review for Vulnerable People: Guidance and Audit Requirements
2 BMA webpage for enhanced services http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/general-practice-contract/enhanced-services

Kathie Applebee, organisation psychologist for primary care, and strategic management partner at Tamar Valley Health Group Practice

OPINION

Work with us to meet your partners' aspirations

Debbie Wood, Vice Chairman, AISMA

For many AISMA member firms and their clients the annual cycle of dealing with the 31 March 2014 accounts preparation and 2013-14 tax services is well underway.

This is starting to give an insight into how practices have been faring over the past 12 months and what they can expect to find during the current financial year.

For many the difficulties around the transition from PCTs to Area Teams in the first half of the year, when cash flow was heavily affected and paperwork sadly lacking, have now been ironed out.

The day-to-day transactions seem to be settling down into the correct payment pattern via the Business Service teams.

However the impact of continuing problems with CQRS systems, withdrawal of the correction factor, and continued upward pressure on workload cannot be underestimated.

Adding to this a recruitment crisis and the re-commissioning of enhanced services and other NHS contracts means that the direction of travel is not all plain sailing.

For the current year the ongoing intention to secure equitable funding for both GMS and PMS contracts is gathering pace with many Area Teams already undertaking reviews of baseline funding and entering into discussions about phased withdrawal of so called excesses.

The key for those PMS practices affected will be to group together with other local practices and seek the support of their LMC and specialist medical accountant to assist with negotiation, understanding the financial and clinical impact and to ensure that the overall funding is retained appropriately within general practice.

Practice managers will be heavily involved in how these changes are managed and in particular the cash flow effects.

Overall this means that GPs, practice managers and their advisors need to be looking at the options open at the earliest opportunity to consider the right way forward to sustain the practice and meet the aspirations of the partners.

In a thought-provoking article for AISMA's clients, **Martin Eades** questions just how fit GP practices really are to make federations a true success

'Federation' seems to be the buzzword in general practice right now.

Every meeting I go to there are groups of practices in huddles discussing the future, planning what to do, what name to give their grouping, and what the legal vehicle should be.

It's good to see and essential that a proactive approach is adopted. To some though, federation is viewed as a panacea to the multiple, complex issues faced by the profession as we navigate our way through uncharted waters.

To others, it is viewed as safety in numbers – better together than alone. But is this rather missing the point?

In some areas of the UK where practices are closely grouped, with a similar ethos, and a harmonious view of the future it makes a great deal of sense. But is it the whole solution?

The 'New NHS' is placing previously unseen demands on general practice. Doing more for less is old hat. But the genuine shift of services from secondary care into primary and community care, with an enforced integration of health and social care, calls for a whole raft of skills and expertise not commonly found in GP surgeries.

With many business-minded GPs actively engaged on the board of CCGs and senior partners retiring in their droves there is a shortfall in the number of GPs with the business training, acumen and commercial awareness to plot a course through the myriad challenges ahead.

The federation concept is well understood as groups of practices working together. But sharing responsibility for developing and delivering high

quality, patient focused services, and implementing the ground level changes to make this happen are much harder to achieve.

Removing duplicity across practice teams, procuring services at the right prices, and putting yourself in pole position to win new contracts is not straightforward and is littered with risks.

Simply bringing GP practices together under an umbrella organisation is not the whole solution. It certainly has benefits but there are strings attached.

Firstly, federations lack commercial credibility or a proven track record of delivery.

The size of the healthcare budget and the complexity of the contracts are often beyond the capabilities of many in the private sector let alone up-scaled GP practices.

Understanding the rules of commerce and more specifically NHS services, beyond the basics and traditional primary care boundaries, are pre-requisites for the future.

Secondly, can GP practices really achieve the efficiencies required in back office services?

Bottom line this involves reducing the headcount and making staff redundant. I was a graduate trainee at Marks and Spencer's head office in London when they made redundancies for the first time.

Negative press aside I witnessed first-hand the shock wave that reverberated through the business and the resulting impact on productivity.

With GP practices attracting a narrow demographic in the back office and often operating as 'extended family' rather than profit making commercial enterprises this is an area that is fraught with danger.

Employment law is very clear in this respect and from my experience very few practices have adopted and maintained robust staff performance appraisals that make the redundancy process fair and safe.

The implications are very serious both financially and in terms of practice reputation. While the number of practices with professional HR staff is minimal, and those accessing HR services is on the increase, very few are in the position where they can remove duplicity and achieve the anticipated savings without the very real prospect of employment tribunals and staff morale plummeting.

Getting to the point where they can is a lengthy process that will be measured in years rather than months.

And then there is the emotional aspect. Potentially loyal staff members of the team for many years being told that their jobs are at risk has an impact on morale, productivity and reputation. For some practices this will be a process they have never had to undertake or even consider.

Thirdly, the 'New NHS' will require GPs, in whatever guise, to bid for the activities that are being transferred from secondary care.

Understanding the contract, terms of service provision, finance and associated risks are of utmost importance. These contracts are likely to be very different from primary care contracts which GPs are familiar with (GMS/PMS/QOF and the various flavours of enhanced services).

Do practices' staff, including GP partners, have the specific skills to unpick and analyse in true detail what they are bidding for so that they do not expose themselves to financial and service delivery risks? In most cases the answer is no.

Does federating address this? No. For GP practices to compete head-to-head with private organisations that have whole teams dedicated to scanning the healthcare market place, identifying and analysing viable contracts and then completing the bidding process with the minimum of cost and resources, they must engage the appropriate experts.

A poorly executed bid could be costly in terms of the resources dedicated to an unsuccessful tender or worse still winning a contract that you have under-priced or are unable to fulfil.

Finally, will GP federations take the lead role on delivering the Health and Social Care Act 2012? The key to the future of care provision is the integration of health and social care.

Profit Booster

Make sure you are getting paid for what you are doing 2

Are claims being made correctly, to the right department and in a timely manner?

And do you have a system to ensure that payment is received for all claims?

With all the changes in the past year it's been particularly hard to pin down exactly what payments are for what – particularly when split between different payers.

But it is time well spent to make sure you are getting paid exactly what you should be getting.

And in the rare cases when you are being overpaid, it's better to know and plan to repay it, rather than get a nasty shock later.

A spreadsheet showing what you are expecting to get, and noting what has been received, can be a simple visual way of keeping control.

This is so important, in fact, that we have an Act of Parliament to ensure this happens. Coupled with the shift of healthcare funding to integrated health and social care (£3.8bn Better Care Fund) this is essential to the delivery of cost effective patient care for the future.

Breaking down many boundaries – political and financial, putting in place the communication channels, at a personal and organisational level, and resolving data issues is a massive challenge that cannot be underestimated.

With no real overarching governance structure spanning health and social care it will fall to those with the energy, drive, enthusiasm and vision to take ownership and drive through the changes required.

This will require tact, negotiating skills, political awareness, and a single minded determination to deliver a clear plan of action. This requires significant practice resources that few possess, and even if they do can they be released from the day job sufficiently to make a real go of it? Unfunded?

The message is clear and for once it is consistent from all corners – bigger is better, or at least safer. Even CCGs are encouraging practices to come together. This makes commissioning simpler at a time when primary care commissioning is transferring to CCGs from NHS England.

CCGs also need options in terms of the tender process and the safe transition of services from secondary to primary care is a priority. The offer of assistance from Commissioning Support Units (via CCGs) may appear attractive but these are essentially the same PCT teams that have taken such a beating from GPs in the past over their poor performance.

Profit Booster

Make sure you are getting paid for what you are doing 3

If you are a PMS practice then check that the baseline budget is what you were expecting. Simple keying errors in setting it up (a decimal point in the wrong place is one example we've seen), can make a material difference.

Alternatives

What are the alternatives? There has been a significant increase in the number of GP mergers over the last 12 months as practices seek safety in size.

Mergers are hard work and not to be undertaken lightly. Do the partners in the practices really have the same ethos and aspirations? It is better to find out early on by comparing that clear vision of the practice's future you documented in your three - five year business plan.

Furthermore, unless one or more of the merging parties brings the operational and business management skills to the table you still have a problem, only now it is bigger.

Strategic alliances are forming, between GP practices, GP practices and primary/community care companies, and all manner of other couplings. Each alliance is formed for the purpose of bidding for and winning a new contract. They are single minded and focused.

They are efficient and make effective use of internal resources and possess the ability to buy in where there are gaps. All parties have to agree when and where to co-operate or compete and the rules of engagement must be clear and complied with.

The continuing theme of little or no operational and business management has seen the emergence of new companies who, born of general practice, specialise in providing outsourced GP management.

From HR, IT, regulatory matters, finance and contract management through to administration services they plug a gap filled by a departing practice manager.

And they deliver the capabilities required but missing in merging or federating practices. They provide a very real alternative to directly employing staff when it is not financially viable, justified, or desirable.

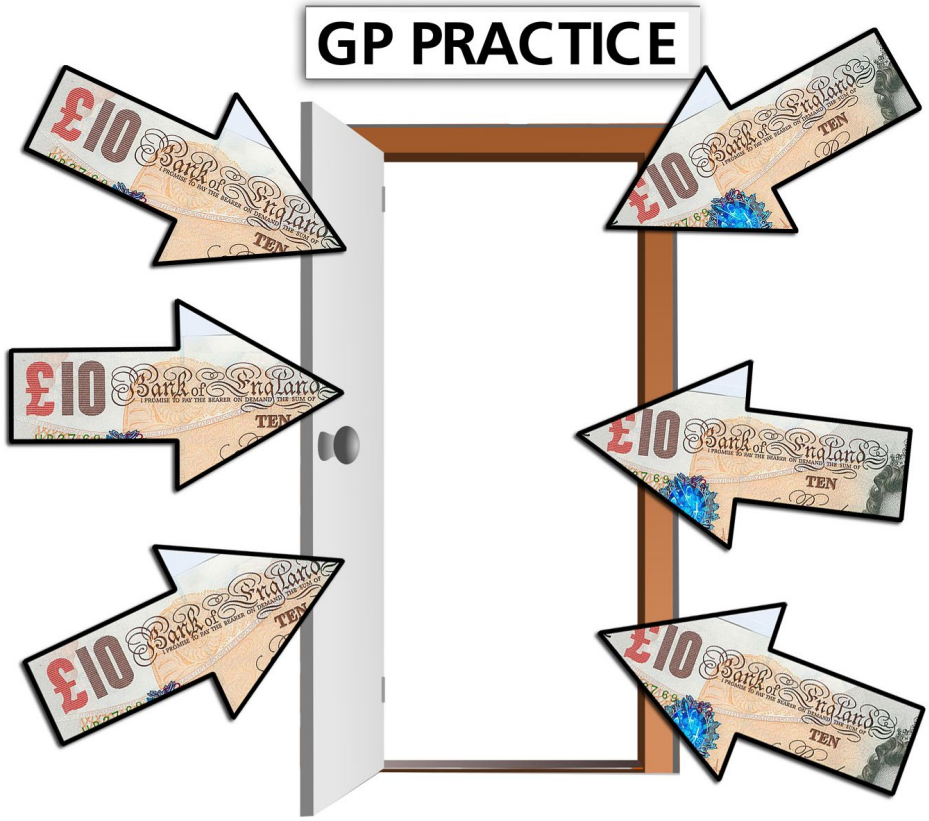
In conclusion, there are obvious benefits to federating but it is not the whole story. The critically important layer of operational and business expertise needs to be sourced and engaged, be it on an employed, contracted or outsourced basis.

GPs want to be left to do what they do best, treating the sick, and delivering a first class clinical service to their patients without compromising the work-life balance.

Welcome to the brave new world of general practice, or to put it another way, welcome to the real world.

Tips for GP 'outside earners'

'Outside work' can be a lucrative attraction but **Alison Oliver** outlines some of the issues that you should consider when taking on any kind of appointment away from your practice



It is not uncommon for GPs to be involved in activities outside their main GP practice. This work could include:

- Working for an out-of-hours service.
- Providing private medical services.
- Being involved in another organisation which provides private or NHS services.
- Holding an executive position with the CCG.
- Training, appraising or mentoring others.
- Writing or lecturing.
- Working in the media.
- Involvement in a family business.

If taking up any such role there are a number of issues that you should consider from the point of view of both you and your practice.

Professional duties

In any position that you undertake you should be mindful of adhering to your professional duties. In particular, the following aspects of the GMC's Good Medical Practice 2013 should be considered:

- **You must recognise and work within the limits of your competence**: while you have expertise to practise medicine as a GP, do you have the right skills and expertise to competently carry out any external activities you are considering?

- **You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession and, when communicating publicly, you must maintain patient confidentiality:** you may be at particular risk of breaching these duties when carrying out work in the media such as a TV doctor role.

- **You must be honest in financial and commercial dealings, must not allow any interests you have to affect the way you treat patients, and must be open about conflicts of interest:** this duty should be particularly borne in mind if you provide private medical services or have an interest in another organisation that provides medical services to which your patients are referred.

Partnership issues

Involvement of GP partners in external activities is one of the most common causes of dispute between partners. Examples of situations where disputes frequently arise include:

- Where a partner's external work is carried out during time when he would normally be performing practice duties, meaning that the partnership has to cover his duties.

- If a partner's interest in outside activities conflicts or is perceived to conflict with the interests of the practice, for example, if a partner performs services on behalf of another healthcare provider which might, in certain circumstances, be in competition with the practice.

- If a partner's involvement in outside work has a negative impact on his ability to perform his duties, for example if he is performing out-of-hours services late at night and is tired the next day.

- If an outside activity is actually or potentially damaging to the professional reputation of the GP concerned or the reputation of the practice.

- Where a partner uses practice facilities to carry out external activities.

- Where there is a lack of clarity about who is entitled to retain the fees or other income from external activities.

A well-drafted partnership agreement should contain provisions which deal with the following:

- Whether partners are permitted to engage in activities outside the main partnership practice and, if so, whether consent of the other partners is required in all or in specified circumstances.

- Whether an external role is to be treated as work for and on behalf of the practice, or whether it is to be treated as an entirely separate activity.

- Who will retain the fees or other income from a partner's outside work.

- Whether the partner may use practice facilities and, if so, whether a charge will be made.

- Whether, and in what, circumstances, the other partners may require a partner to cease an outside activity where it is having – or might reasonably be expected to have - a negative impact on the practice.

If considering an external role, check the provisions of your agreement and ensure that you comply with the terms.

Be aware that even if there is no specific provision in your partnership agreement regarding external activities, there may be general or implied duties which affect your freedom to engage in such activities.

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You should provide your partners with information about the role that you propose to undertake, be prepared to discuss the possible impact on the practice and how you propose to manage this, and obtain the consent of your partners. This will help to avoid bad feeling and a possible dispute about your activities.

Personal considerations

Aside from the above issues, you need to consider what benefits the role may bring to you personally. It may be tempting to accept new challenges but you need to weigh up this temptation against the possible negative consequences. You should consider:

- Is this something that you really want to do? Will it benefit you professionally and/or personally?

- Do you have the right skills and expertise to carry out the role? Will you need to learn new skills in order to carry out the role effectively? Is this something you are realistically able to do?

- How much time will the role take up? Will you have the time to fulfil all your duties properly? If not, is it possible to reduce your hours in general practice in order to undertake these other activities? What impact will this have on your role as a GP and will your partners agree?

- Will the role put particular pressure on you personally? Do you think you can cope with this?

- Will the role mean that you have a conflict of interest? How will you deal with this?

- Do you have the support of your friends, family and colleagues?

If you decide that you do want to go ahead, ensure that you:

- Obtain the written consent of your partners to undertaking the role and the terms applicable to that consent.

- Obtain written confirmation of the terms and conditions applicable to the role and consider taking legal advice on the terms if they appear unclear, complex or particularly onerous.

Profit Booster

Make sure you know what your partners can do!

At a recent meeting with GPs, we highlighted their low minor surgery returns - and discovered that some doctors did not know that one partner could do joint injections.
The practice needed to ensure that the partner had time to carry out this work, of course.
But some small changes resulted in improved patient experience - and more money earned.

- In particular, ensure that the terms enable you to withdraw from the role if you or your practice decides that it is compromising your position as a GP or if you otherwise decide that it is not what you want to do.

- Speak to your accountant regarding the financial and tax consequences of the role.

Alison Oliver is an associate solicitor in the healthcare practices team at Ward Hadaway law firm. She specialises in providing commercial and regulatory law advice to GPs and other healthcare providers.