

10 February 2004



To: DAT coordinators  
Commissioners  
Drug treatment providers

## **National Treatment Agency for Substance Misuse**

Cc: Drug Strategy Directorate,  
Home Office  
Substance Misuse Team,  
Department of Health  
Government Office Drug Teams  
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Dear Colleagues,

### **Drug treatment and the new GMS contract**

As you will be aware, General Practitioners (GPs) have an important role to play in treating patients with drug problems. This includes primary health care *and* drug treatment – particularly through shared care schemes<sup>i</sup> in partnership with drug treatment specialists. *Models of care* (NTA 2002) calls for GPs to be involved in drug treatment provision in all four tiers: providing primary medical care at tier one; harm reduction services at tier two; structured drug treatment via shared care at tier three; and occasionally treatment for those in residential rehabilitation at tier four.

Recent changes in the new GP contracts have implications for the commissioning and delivery of drug treatment services. This letter, which is also available online at [www.nta.nhs.uk](http://www.nta.nhs.uk), aims to provide basic information to commissioners and treatment providers on the commissioning of GP services under the new contract. It is based on consensus reached at a provider summit held by the NTA in December 2003 (see attached).

Whatever changes are introduced as a result of the new contracts, the stability, ongoing development and continued expansion of drug treatment systems to meet the key targets of doubling the number of people in treatment and increasing the proportion appropriately retained or completing treatment, are paramount.

A number of different contractual arrangements may be utilised to commission appropriate GP shared care schemes to meet local needs. This includes:

- Contracts for National Enhanced Services (NES)<sup>ii</sup> for GPs in shared care schemes with more autonomy and meeting high level service level agreements
- Locally Enhanced Services (LES) for GPs receiving more support via shared care schemes.

It is important to note that NES and LES contracts are not mandatory. NES contracts should only be provided where GPs able to demonstrate a higher level of competence and quality and that any additional funding would be used to pay for GP support, counselling and key working, supervised consumption etc. It is also important to note that the evidence-base is stronger for methadone (and Buprenorphine) maintenance, and that detoxification requires planned provision for aftercare, prior to detoxification being commenced.

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LES contractual arrangements offer more flexibility in the models of provision and financial payment. LES contractual frameworks may be very useful for:

- GP shared care schemes operating below the threshold for NES
- maintaining the status quo in areas where local arrangements are already working well and the GPs are content with current levels of support and payment.

Local shared care monitoring groups (SCMGs) have responsibility for the monitoring of local shared care arrangements. This should continue.

The NTA recommends that:

- Joint commissioners, on behalf of local drug action teams, should **undertake brief reviews** of local arrangements for shared care and (re)commission GP shared care schemes using a mixture of NES and LES contracts according to local needs.
- Future commissioning of primary care services should aim to increase the quantity and quality of primary care provision. Such increase **should not lead to a de-stabilising** of current local drug treatment provision either through disinvestment in secondary care services *or* primary care services.
- Where **SCMGs** exist and are working effectively, they should continue to have responsibility for monitoring local shared care arrangements and advise joint commissioning groups on the most appropriate contractual arrangements.
- In areas that do not have effective SCMGs, they should be developed and include the appropriate membership as outlined in Department of Health guidelines<sup>iii</sup>.
- Local areas, via their SCMG and joint commissioners, should continue to ensure that **GPs involved in shared care schemes are increased and maintained** at a level appropriate for local need and this proportion is made explicit for planning purposes<sup>iv</sup>. In many areas, the Department of Health target to have 30% of GPs involved in shared care has been built into local delivery plans. Although the deadline for this target is past, the NTA supports the principle of increasing the proportion of GPs involved in shared care.
- Where GP services are negotiated locally, **payments should be the same within that DAT area** for comparable services and **should not vary between primary care trusts (PCTs)**. Differential payments could lead to a postcode lottery of primary care service within the DAT area where differing PCTs adopted different pay structures for GPs.
- Primary and secondary care should work together in collaborative partnerships within **integrated care pathways** to best meet the needs of drug users. *nGMS* contract implementation should compliment rather than disrupt *Models of care* implementation.
- Shared care should be supported by a **mixture of mainstream health money (via PCTs) and drug treatment pooled treatment budget** with payment linked to the level and quality of treatment activity.
- Drug treatment services in primary care should be underpinned by **robust service level agreements** with the primary care trusts which have responsibility for service provision.
- Whatever local arrangements are agreed, decision making should go through the **normal joint commissioning group and be agreed with NTA regional teams** in the context of the drug treatment planning process.

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I hope that you find this information useful. If you require further clarification, please contact your NTA regional team.

Yours sincerely,

A handwritten signature in black ink that reads "P. J. Hayes". The signature is written in a cursive style with a large initial 'P' and a dot at the end.

Paul Hayes  
Chief executive

Enc: Consensus statement

#### Notes

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<sup>i</sup> Definition of shared care: "The joint participation of specialists and GPs (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange and beyond routine discharge and referral letters. It may involve the day to day management of the GP of the patient's medical needs in relation to his or her drug misuse. Such arrangements should make explicit which clinician is responsible for different aspects of the patient's treatment and care. These may include prescribing substitute drugs in appropriate circumstances". (*Drug Misuse and Dependence: Guidelines on Clinical management*. Department of Health 1999)

<sup>ii</sup> Investing in General Practice: The New General Medical Services Contract.  
<http://www.doh.gov.uk/gmscontract/thecontract.htm> (accessed 10/12/03)

<sup>iii</sup> Terms of reference and membership of Shared Care Monitoring Groups: *Drug Misuse and Dependence: Guidelines on Clinical management*. Department of Health 1999.

<sup>iv</sup> National target to have 30% GPs participating in shared care. In Adult Drug Treatment Plan 2004/05 Guidance notes for drug action teams. National Treatment Agency: London, 2003.



***National Treatment Agency  
for Substance Misuse***

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**New General Medical Services Contract and  
Commissioning Primary Care Services**

Consensus statement from the General Practitioner  
Summit

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# **New General Medical Services Contract and Commissioning Primary Care Services Consensus statement from the General Practitioner Summit**

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## **Introduction**

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### **Background**

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Recently the NHS Confederation and the General Practitioners Committee completed negotiations of the New General Medical Services (nGMS) Contract. The nGMS Contract will have implications for future primary care service provision. The National Treatment Agency (NTA) held a summit in London on 19/11/03 to draw together key stakeholders from the field of primary care drugs treatment. It sought to draw consensus on how the nGMS Contract can be implemented in the primary care setting in a way that maximises the quality and quantity of care offered to drug users.

### **Aim of the summit**

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To consider the implications of the nGMS Contract for primary care drug treatment services and to build a consensus statement to inform future commissioning activity

### **Summary of outcomes**

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A consensus statement on the most effective means of implementing the nGMS contract in the primary care drug treatment setting.

## **Contents**

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GP summit consensus statement

- key discussion points from the GP summit
  - Implications for maintenance treatment modalities
    - Personal Medical Services Pilot Schemes
    - The patient fulfilling several NES criteria
    - Performance management of a LES or NES contract
    - Quality and outcome framework
- GP summit participants
- References

## GP Summit consensus statement

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The following consensus statements were agreed by delegates:

- Future commissioning of primary care services should aim to increase the quantity and quality of primary care provision
- Such an increase should not de-stabilise of current local drug treatment provision either through disinvestment in primary or secondary care services
- Primary and secondary care should work together in collaborative partnerships within integrated care pathways to best meet the needs of drug users
- The terms of reference of shared care monitoring groups should be reviewed. They should have an explicit role ensuring quality in local primary care service provision. They should have representatives from both primary care and secondary care and be in a position to recommend to joint commissioning groups
- Commissioners should be free to commission shared care services for drug users under a locally enhanced service (LES) contract
- GPs should not treat drug users in isolation. Where GPwsi(s) are providing drug services under a nationally enhanced service (NES) contract there should be adequate drug link/liaison worker support
- Ongoing treatment provision should be underpinned by ongoing education, training, supervision and appraisal to ensure a sustained improvement in quality of primary care drug treatment provision
- nGMS contract implementation should compliment rather than disrupt *Models of care* (MoC) implementation.
- Payment should be linked to level and quality of treatment activity
- Drug treatment services in primary care should be underpinned by robust service level agreements with the primary care trusts which have responsibility for service provision.

### • Key discussion points from the GP summit

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#### 2.1. Commissioning of drug services in primary care

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Delegates discussed the relative merits of providing primary care treatment of drug users through a locally or nationally enhanced service contract:

- The nGMS contract negotiations have resulted in nationally enhanced drug service fees of £500 per patient per annum for withdrawal and £350 per annum for maintenance payment, providing the service adheres to a rigorous service specification
- It was felt that many generalist practitioners would be unlikely to meet such a specification without the support of a shared care scheme
- Some delegates felt that commissioners could negotiate shared care service provision under a locally enhanced scheme (LES)
- Some delegates felt GPs with special interests (GPwsi) could provide a primary care drug treatment service under a NES contract if the service reached the necessary service specification
- Recommended payments for NES provision could lead to disinvestment in primary care services if widely applied to all GPs working with drug users as such as scenario could prove unaffordable.

#### ○ Implications for maintenance treatment modalities

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Delegates commented that differential payments for detoxification and maintenance treatment could offer perverse incentives for practitioners to offer detoxification rather than maintenance therapy.

- This would not be in keeping with current best practice guidelines as described in MoC and the Department of Health clinical guidelines.

- Whilst delegates felt that the ideal should be the same sum per treatment place per annum, it was agreed that it was not the place (nor indeed was it possible) for Summit delegates to re-negotiate the GP contract.
- Rather the sum of “£500 for withdrawal” required further interpretation. Many drug users fail to achieve or maintain successful withdrawal and would fail to qualify for the payment.

#### ○ **Personal Medical Services Pilot Schemes**

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- Personal medical services (PMS) pilot schemes have proved successful in providing both registrations with a GP and drug treatment for large number of drug users.
- PMS contracts are negotiated locally. Some delegates expressed a view that commissioners should be encouraged to work with primary care colleagues to consider PMS schemes as an option to increase drug treatment provision.
- PMS schemes can draw on both nGMS or DAT pooled treatment budgets for drug services.

#### **2.4 The patient fulfilling several NES criteria**

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- Some drug users with a co-existing mental health problem, homeless drug user, or drug user who is also alcohol dependent will fulfil both a drug use and a mental health NES.
- Delegates felt that such users would not attract multiple NES payments.

#### ○ **Performance management of a LES or NES contract**

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- Drug Action Teams accountable to the NTA have a core responsibility to performance monitor drug services in their area. This will include primary care services under LES or NES contracts.
- Delegates expressed a view that shared care monitoring groups – as sub-groups/committees of DATs have a key role in implementing and monitoring the performance standards as described in MOC. It is important that PCT representatives, specialists and GPs are represented on shared care monitoring groups.

#### ○ **Quality and outcome framework**

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- The nGMS contract places an increased emphasis upon quality of care within a practice-based contract.
- nGMS does not suggest quality indicators for primary care drug treatment provision.
- Some delegates felt that the retainer payment of £1000 per practice under nGMS could incorporate agreed quality outcomes as demonstrated by those described in MOC.

### **3. GP summit participants**

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Representatives from the following stakeholders were invited to the summit:

- National Treatment Agency - Quality directorate
- Home Office
- Department of Health
- Royal College of General Practitioners
- British Medical Association
- Royal College of Psychiatrists
- Substance Misuse Management in General Practice (SMMGP)
- General practitioner representatives from mainstream general practice
- General practitioners representing primary care based community drug services
- Specialist Clinical Addiction Network (SCAN).

### **4. References**

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National Treatment Agency for Substance Misuse. Models of Care for Treatment of Adult Drug Misusers. 2002. London, National Treatment Agency.

Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services NI. Drug Misuse and Dependence - Guidelines on Clinical Management. 1999. London, The Stationery Office.

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