Derby &
Derbyshire
LMC

General Practice
Task Force
Derbyshire

Non-Essential and Enhanced Services

Accepting inappropriate and un-resourced work that is being shifted from other providers risks undermining the quality of patient care in general practice

Commissioners have a duty to make sure that the quality of patient care is not compromised by the unjustified shifting of services that are not appropriate to be delivered in the community. Accepting inappropriate work from elsewhere risks undermining the quality of care for patients. If practices do act to reduce this work, they must make every effort to ensure that measures are in place to ensure that patients are not placed at medical risk and that their treatment is not unacceptably delayed.

The following are examples of inappropriate work that are, in the opinion of DDLMC, outside GP essential services (as defined in GMS Contract and PMS agreements):

- Automatic re-referrals resulting from patients not attending (DNA) hospital appointments
- Routine follow-up of hospital procedures where the GP is not best placed to follow this up, nor is it clinically appropriate
- Re-referral to a related specialty (e.g. physiotherapy referral requested by a rheumatologist) – creating unnecessary bureaucracy
- Hospitals referring patient to practices for fit note certificates when it is in the NHS Hospital contract for the hospital to do this at the time of discharge
- Patients referred by hospitals back to practices solely for the prescribing of medication which is the clinical responsibility of the requesting clinician (e.g. specialist prescriptions outside a GP's competence, acute prescriptions that should have been issued on the day by the specialist seeing the patient, or unlicensed medication). This should all be dealt with before the patient leaves the hospital
- Following up test results which are ordered in hospitals and are the responsibility of the requesting clinician
- Arrangement of hospital transport which should be done directly between the hospital transport service and patients (giving them control over timing) rather than involving practice staff
- Arranging other tests and investigations that should be part of the commissioned secondary care service

Services for patients in the community

- Wound care management (including dressings and suture removal for procedures performed outside the practice) that should be delivered by the commissioned community nursing service
- Minor injury services that should be delivered by the appropriately commissioned service
- Completion of community nursing administration charts
- Nursing care of leg ulcers and other chronic conditions (including doppler assessments)
- Nursing care for incontinent and catheterised patients
- Ear syringing that should be provided by the community nursing service
- Prescriptions for conditions being managed by community nurses, where the provider can utilise independent nurse prescribers
- Requests for practices to prescribe at seven day intervals rather than 28 day interval for patients having their drugs dispensed through multi-compartment compliance aids

- Request for a GP to visit a patient when another professional would be more appropriate, e.g. social care or district nurse

Care homes

- Requests to write in the home's administrative records in addition to recording information in the patient's GP held record. If necessary, this should be done by care home staff. Care homes can obtain additional information from practices if necessary
- Requests to complete unnecessary authorisation forms for staff to administer over the counter remedies
- Requests for home visits for ambulatory residents, where the care home should enable the patient to attend the surgery

Shared care arrangements

- Shared care protocols which are voluntary for practices are increasingly used to transfer care from hospitals into general practice, including the prescribing of specialist medication
- Shared care arrangements often require additional competencies, and it is important that GPs do not undermine care for patients by feeling pressured to treat beyond their knowledge and skills
- Shared care arrangements also require additional GP, nurse and administration time and practices should ensure they have the capacity and where appropriate suitably funded resources to deliver without undermining the core needs of their patients

In addition some services are commissioned through enhanced service schemes. If practices have signed up to provide these services then they are obliged to provide them but if not this is also additional unfunded work and practices should be wary of taking on this work
Examples may include:

- 24 hour ambulatory blood pressure monitoring
- Alcohol & drug misuse
- Asylum seekers & refugees
- Bank holiday working
- Cardiovascular health checks
- Chlamydia screening
- D-Dimer / DVT management in the community to avoid hospital admissions
- Shared care / specialist drug monitoring
- ECG recording
- Extended hours
- Flu immunisation
- GnRH analogue treatment
- HIV in primary care
- Homeless patients
- Insertion of contraceptive devices
- Insulin initiation or conversion
- Minor injuries
- Nursing Homes – enhanced services
- Phlebotomy
- Post-op suture removal
- Pre and post ops
- Primary care sexual health scheme
- Prostate cancer follow up
- Provision of immediate and first response care
- Referral review scheme
- Ring pessary insertion
- Sigmoidoscopy
- Smoking cessation programmes
- Spirometry
- Student Health
- Vasectomy
- Violent patients