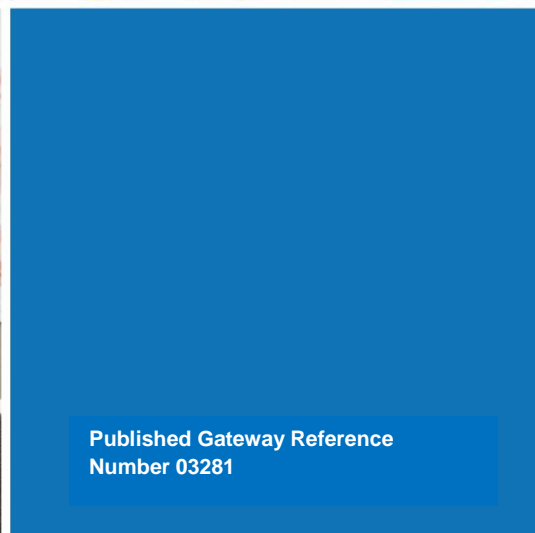
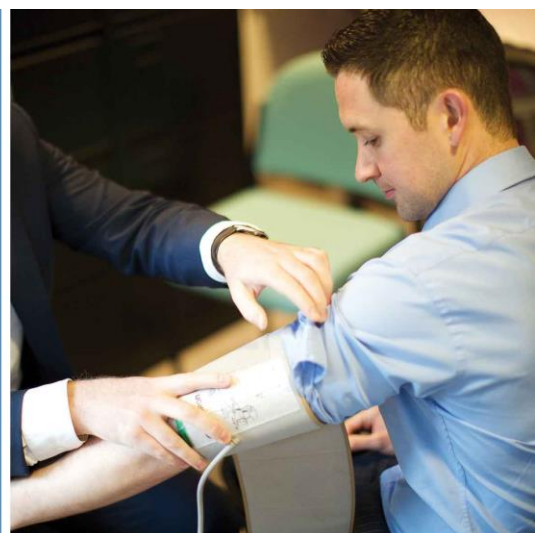


2015/16 General Medical Services (GMS) contract

Guidance for GMS contract 2015/16

March 2015



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Section 1: Introduction

In September 2014, NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the British Medical Association (BMA) announced the agreed changes to the General Medical Services (GMS) contract for 2015/16.

This document provides guidance for commissioners, local medical committees, for practices¹ that hold a GMS contract and for all practices subject to the new contractual requirements or that are offering enhanced services commissioned by NHS England.

Wherever possible, NHS England seeks to minimise the reporting requirements for the services delivered by practices where these can be supported by new systems and this guidance outlines the audit requirements for the services detailed. Separate technical guidance detailing the Read codes which practices are required to use are detailed in the document Technical Requirements for 2015/16 GMS Contract Changes².

This guidance is applicable in England only.

About this guidance

The amendments to the GMS Contract Regulations, Directions and to the Statement of Financial Entitlements (SFE), which underpin the changes to the contract, are now available^{3,4}. The detailed requirements for taking part in the ESs are set out in the Directions except for the dementia and unplanned admissions ESs where the detailed requirements are set out in the service specifications which are available on the NHS England website⁵.

The SFE has been amended⁶ to provide clarity on time limits for payment claims. Practices should submit claims within the time limits specified in the SFE where these exist; for example, where there is a specific time limit of 6 months it should be followed. This does not prohibit claims for any under or overpayment after the expiry of such time limits, providing these are made within the six years of when the original payment was due, or claims where NHS England agrees there are exceptional circumstances which make it reasonable for specified time limits to be set aside.

Commissioners and practices taking part should ensure they have read and understood the requirements in the Regulations, Directions and NHS England

¹ A practice is defined as a provider of essential primary medical services to a registered list of patients under a GMS, Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract.

² NHS Employers. Technical requirements for 2015/16 GMS contract changes.

<http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

³ www.nhsemployers.org/GMS201516

⁴ <http://www.legislation.gov.uk/ukxi/2014/465/contents/made>

⁵ <http://www.nhsemployers.org/GMS/ES/2014-15>

⁶ paragraph 25.12

service specifications, the guidance in this document as well as the Technical requirements for 2014/15 GMS contract changes. This supersedes all previous guidance on these areas.

Section 2: Technical Requirements

The Calculating Quality Reporting Service and the General Practice Extraction Service

The Calculating Quality Reporting Service (CQRS), together with the General Practice Extraction Service (GPES) calculates achievement and payments to practices. Both CQRS and GPES are managed by the Health and Social Care Information Centre (HSCIC).

CQRS⁷ is the automated system used to calculate achievement and payments on quality services. These include the Quality and Outcomes Framework (QOF), Enhanced Services (ESs) and vaccination programmes.

GPES⁸ collects information from general practice IT clinical systems for a wide range of purposes including payments to practices and the provision of relevant data for management information purposes. This enables NHS England to monitor and verify the delivery of various contract and service requirements.

The CQRS team works with NHS England to ensure CQRS supports GP contract payments.

Payments can only be processed after commissioners have offered and practices have accepted a service on CQRS. Agreement to participate in a service on CQRS is separate to confirming acceptance of a contract for services with commissioners.

Practices authorise data collection made by GPES when they accept a quality service on the CQRS system. This guidance provides information on how CQRS and GPES are used in relation to a number of services. In order to support practices, CQRS also publish guidance and issue communications as services become live on CQRS or GPES, which detail how to manually declare and enter relevant data into CQRS and enable collection. Further information on when each service will be available on CQRS and how to input data will be available on the HSCIC website⁹.

Where a service is supported by CQRS, practices are required to manually enter their achievement on CQRS until data can be automatically collected from practice systems by GPES. The data will be in relation to payment counts only, with zeros being entered in the interim for management information counts.

⁷ HSCIC. CQRS. <http://systems.hscic.gov.uk/systemsandservices/cqrs>

⁸ HSCIC. GPES. <http://www.hscic.gov.uk/gpes>

⁹ HSCIC. CQRS. <http://systems.hscic.gov.uk/systemsandservices/cqrs>

Technical Requirements for 2015/16

The 'Technical Requirements for 2015/16'¹⁰ document sets out additional detail on how CQRS and GPES will support services and provides the relevant Read2 and CTV3 codes that practices are required to use for each service. Read2 and CTV3 codes are used as the basis for the GPES collection, which allows CQRS to calculate payment based on the aggregated numbers supplied and support the management information collections, when available.

Changes which materially affect services supported by CQRS and GPES, will be updated in the technical requirements document. This is available as a 'live' document on NHS Employers website and will be updated as services move from manual reporting to collection. Relevant supporting Business Rules will also be updated and available on the HSCIC website¹¹.

Although practices are required to manually enter data until such time as GPES is available, practices should use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those codes included in the technical requirements document and the supporting Business Rules will be acceptable to allow CQRS to calculate achievement and payment and enable commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes from the start of the relevant service and if necessary will need to re-code patients as required.

¹⁰ NHS Employers. Technical requirements for 2015/16 GMS contract changes.
<http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

¹¹ HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

Section 3: Contractual changes

Global sum funding and uplift

NHS England and the GPC separately submitted evidence to the Doctors' and Dentists' Review Body (DDRB) in relation to the 2015/16 uplift to the GMS Contract.

The Government has accepted the DDRB recommendation to uplift the GP pay element of GMS contracts by 1.0%. After consultation with GPC, the government has also decided to uplift expenses by using the DDRB formula- applying a 1.0% uplift to staff expenses, and a 2.0% uplift, based on the Retail Price Index Excluding Mortgage Payments (RPIX), to other expenses. The overall effect is an uplift of 1.16%.

The GMS global sum funding will also increase in 2015/16 as a number of funding streams are being transferred. This includes:

- implementation of the phasing out of MPIG. Correction factor payments are being reduced by one seventh and the aggregate funds reinvested into GMS global sum. From 1 April 2015 there will be no out-of-hours (OOH) deduction applied to the money being transferred into global sum from correction factor
- the alcohol and patient participation ESs will cease on 31 March 2015 and the associated funding will be reinvested in global sum recognising the transfer of these responsibilities in to the contract. Again no OOH deduction will be applied
- an adjustment in October 2015 to reflect the to reflect the reduction in seniority payments and the transfer of funding into global sum.

The net effect is:

- global sum payment per weighted patient increases from £73.56 in 2014/15 to £75.77 in April 2015/16, and will be adjusted in October 2015
- OOH deduction decreases from 5.46% in 2014/15 to 5.39% in 2015/16.
- global sum payment per weighted patient will be increased again in October 2015 to reflect the reduction in seniority payments and the transfer into core funding. Details will be available from NHS Employers¹²

These revised values take effect from 1 April 2015 as detailed in the SFE.

The SFE will be amended further in-year during 2015/16 to give effect to the seniority changes from 1 October 2015 (see [Seniority](#) section).

NHS England will publish separately the arrangements commissioners will follow to apply these funding changes equitably and consistently in PMS and APMS contracts providing equivalent services.

¹² www.nhsemployers.org/GMS201516

Named accountable GP for all patients

From 1 April 2015, practices are required under the contract to allocate a named, accountable GP to all patients (including children).

All patients¹³ who were on the practice list prior to 1 April 2015 will need to be allocated their named accountable GP by 30 June 2015. Details of the coding for this will be in the 'Technical Requirements for 2015/16' document. Individual patients can be informed of their named accountable GP at the first appropriate interaction with the practice. Practices are free to determine how best to inform their patients.

All new patients who register with a practice after 1 April 2015 should be allocated their named accountable GP within 21 days of registration.

Where the patient expresses a preference as to which GP they have been assigned, the practice must make reasonable efforts to accommodate this request. Where any patient has confirmed they do not want a named accountable GP and the contractor has recorded this in their patient record, the requirement to allocate a named accountable GP does not apply.

By 31 March 2016 all practices will include on their website¹⁴ and in the practice leaflet¹⁵, reference to the fact that all patients have been allocated a named GP and information about patients' options.

The website and the practice leaflet should inform patients that they have a named GP who is responsible for patients' overall care at the practice, that they should contact the practice if they wish to know who this is, and that if they have a preference as to which GP that is, the practice will make reasonable efforts to accommodate this request.

The named accountable GP will take lead responsibility for the coordination of all services required under the contract and ensure they are delivered to each of their patients where required (based on the clinical judgment of the named accountable GP).

In addition, for patients aged 75 and over, as required by the 2014/15 GMS contract agreement and which remains unchanged, the named accountable GP will also:

- work with relevant associated health and social care professionals to deliver a multi-disciplinary care package that meets the needs of the patient
- ensure that these patients have access to a health check as set out in section 7.9 of the GMS Contract Regulations.

¹³ All patients excluding patients aged 75 and over allocated a named accountable GP under existing provisions which required a named accountable GP to be allocated by 30 June 2014.

¹⁴ If the practice does not have a practice website the information should be updated to the practice profile page on the NHS Choices website.

¹⁵ See Schedule 10 to the GMS Regulations (information to be included in practice leaflets)

Practices should review whether a change of named GP is required for patients attaining the age of 75 and any change notified to the patient within 21 days.

Where the named accountable GP is unable to carry out their duties for a significant period, for example through maternity leave, a replacement accountable GP should be assigned until such time as the named accountable GP can recommence their duties.

Monitoring

The 'Technical Requirements'¹⁶ contains the Read and CTV3 codes¹⁷ that practices are required to enter into the patient's record that patients have been assigned a named GP.

Supporting Business Rules will be published on the HSCIC website.¹⁸ Commissioners and practices should refer to these for the most up-to-date information on Read and CTV3 codes.

This data may be used by commissioners to ensure that the practice have met their contractual requirement. NHS England may make use of the information received or collected.

Practices may also be required to declare in the annual electronic practice self-declaration (eDEC) that they have complied with regard to publishing required details on their website and in practice leaflets.

Publication of GP Net Earnings

Guidance and Dataset for 2014/15 Publication of Earnings

From 1 April 2015, it is a contractual requirement for practices to publish on their practice website by the end of the financial year (i.e. 31 March 2016), the mean earnings for all GPs in their practice relating to the previous financial year (i.e. 2014/15).

If patients do not have internet access and ask to see this information, contractors are required to provide this information either in paper copy, on a poster or by showing the patient the information posted on the practice website.

All earnings reported are pre-tax, National Insurance (NI) and employee pension contributions and for contractors the figures are net of practice expenses incurred. This must include earnings from NHS England, CCGs and local authorities (for the provision of public health services) for the provision of GP services that relate to the

¹⁶ NHS Employers. Technical requirements for 2015/16 GMS contract changes.
<http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

¹⁷ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

¹⁸ HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

contract or which have been nationally determined (i.e. those that would have previously been commissioned by PCTs following direction by NHS England or the Department of Health). A dataset outlining what income and expenditure is included and excluded is at tables 1 and 2 below.

Practices should apportion variable costs as far as is reasonably practicable. Where practices experience significant difficulties doing this (identifying the level of expenditure to attribute and deduct from income sources), they should use the same basis for apportionment as they do for fixed costs. This will vary from practice to practice, but is typically around 60% expenditure: 40% income.

Alongside the mean figure, practices will publish the number of full and part time GPs associated with the published figure.

General Dental Practitioners will also publish earnings to the same timetable.

Types of GPs to be included

The mean GP earnings figure is calculated to include income for all contractors (all GPs who are party to the contract for at least six months in the financial year), salaried and locum GPs who worked full or part-time in the practice (for a total of six months or more within the 2014/15 financial year).

Dataset for calculation of contractor net income

Table 1 sets out the income and expenditure which should be included in the calculation of earnings.

Table 2 sets out the expenditure which should be excluded from the calculation of earnings. For all expenditure, practices should ensure that this is apportioned so that it solely relates to the income streams included i.e. staff costs included should only relate to the services which are listed in table 1 and not enhanced services which are commissioned locally.

Table 1: Income and Expenditure which are included

Income	Expenditure
Global sum (and PMS equivalent) <ul style="list-style-type: none"> • Global sum (after removal of OOH where a practice has opted out) • Correction Factor • Any support and assistance payments during the phasing out of MPIG 	Practice Expenses <ul style="list-style-type: none"> • Staff costs • General running of practice (stationery, telephone, heating and lighting, repairs and maintenance) • Accountancy fees and bank charges • Depreciation
Quality and outcomes Framework <ul style="list-style-type: none"> • Quality aspiration • Quality achievement 	Personal Expenses (business expenses) <ul style="list-style-type: none"> • Transport for home visits • Mobile telephone • MDU, GMC and BMA subscriptions

	<ul style="list-style-type: none"> • Business use of capital allowances that are claimed on their motor vehicles <p>(based on actual partner's claims)</p>
	Any other expenses related to items which are included
Seniority	
<p>Item of service fees for specific vaccination and immunisations service</p> <p>Childhood immunisations:</p> <ul style="list-style-type: none"> • Rotavirus • Pneumococcal/Hib Men C Booster <p>Adult immunisations:</p> <ul style="list-style-type: none"> • Shingles (Routine Age 75) 	<ul style="list-style-type: none"> • The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs
<p>Enhanced Services that have been nationally determined</p> <ul style="list-style-type: none"> • Influenza and pneumococcal immunisation • Childhood influenza • Shingles catch-up vaccination • Pertussis (Pregnant Women) Vaccination • Men C Vaccination for University Freshers • Alcohol related risk reduction scheme • Extended hours access scheme (to the level funded under the DES) • Learning disabilities health check scheme • Patient participation scheme • Timely diagnosis and support for people with dementia • Avoiding unplanned admissions and Proactive Case Management Scheme • Minor surgery scheme (commissioned from all practices) • Childhood immunisations (target payments) scheme • Smoking cessation • NHS Health checks 	<ul style="list-style-type: none"> • The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs

<ul style="list-style-type: none"> • Dispensing enhanced service (DSQS) • Violent patients scheme. 	
PA Reimbursement and fees <ul style="list-style-type: none"> • Reimbursement for PA drugs • PA fees 	
Employee's superannuation (covered in global sum but should not be deducted)	

Table 2: Items to be excluded

Income	Expenditure
Premises <ul style="list-style-type: none"> • Rent reimbursement • Rates and water • Refuse disposal 	Premises <ul style="list-style-type: none"> • Rent paid • Rates and water • Refuse disposal • Mortgage interest • Any other premises-related costs covered by premises reimbursements
Enhanced Services that have been commissioned locally and which vary from area to area: e.g. <ul style="list-style-type: none"> • Joint injection services • Near patient testing • Shared care drug monitoring • Drug and addiction services • Phlebotomy • 24 hour BP monitoring • Post-op suture removal • Sexual health services 	Any expenses related to items which are not included <ul style="list-style-type: none"> • The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs.
Dispensing doctors: <ul style="list-style-type: none"> • Reimbursement of drugs (except PA) • Dispensing fees (except PA) 	<ul style="list-style-type: none"> • The cost of drugs • Any other costs associated with the administration of drugs
Commissioning group activities: e.g. <ul style="list-style-type: none"> • CCG salaries/backfill payments • CCG led roles • CCG meetings attendance • CCG incentive schemes • CCG prescribing schemes 	<ul style="list-style-type: none"> • Expenditure incurred in engaging with CCG activities – e.g. expenses incurred in attending meetings; practice costs in supporting CCG roles

<p>Extended services: e.g.</p> <ul style="list-style-type: none"> • Extended minor surgery (beyond the scope commissioned from all practices) • Joint injections • IUCD and contraceptive implant fitting • Community based services to which other practices can refer e.g. dermatology clinic, ENT clinic • Prime Ministers Challenge Fund • Extended Hours (beyond the level of the DES) • OOH personal income paid to the practice 	<ul style="list-style-type: none"> • The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs.
<p>Education and training: e.g.</p> <ul style="list-style-type: none"> • Training grant • GP trainee salary reimbursement • Undergraduate students • Foundation year 2 students • Educational supervision • GP appraiser fees 	<ul style="list-style-type: none"> • All costs incurred associated with training GPs • GP trainee salaries • Educational supervision costs • GP appraiser costs.
<p>Other SFE Payments</p> <ul style="list-style-type: none"> • Payments for locum covering maternity, paternity and adoptive leave • Payments for locums covering sickness leave • Payments for locums covering suspended doctors • Payments in respect of prolonged study leave • Doctors retainer scheme • Returners scheme • Flexible careers scheme 	<ul style="list-style-type: none"> • The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs
<p>NHS collaborative fees</p>	<ul style="list-style-type: none"> • NHS collaborative work expenditure and relevant proportion of fixed costs
<p>Non NHS income e.g.</p> <ul style="list-style-type: none"> • Travel vaccinations and immunisations • Medical report fees • Cremation fees 	<ul style="list-style-type: none"> • Variable costs associated with each item and the relevant proportion of fixed costs

<ul style="list-style-type: none"> • Meetings and expenses • Research income • LMC salary 	
Employers' superannuation	

Calculation of mean

The mean GP earnings figure is calculated including income for all contractors (all GPs party to the contract for at least six months in 2014/15), salaried or locum GPs who worked full or part time in the practice, for a total of six months or more within the 2014/15 financial year.

Practices are recommended to follow the definition of full time provided within the 2006/7 UK General Practice Workload Survey¹⁹, namely that those GPs that work eight sessions or more are considered full time, and any GPs working less than this are considered part time²⁰.

Practices must publish, alongside the mean, the number of full and part-time GPs in the practice.

For contractor GPs, the earnings should be calculated as set out in tables 1 and 2 above. For salaried GPs, this should be the actual salary of staff which relates to the work areas set out in table 1. For locum GPs, this should be the actual income of the locum.

Example practice mean earnings calculation:

Type of GP	Gross Earnings (net of expenses)
Full-time contractor GP	£110,000
Full-time salaried GP	£55,000
Part-time contractor GP	£45,000
Part-time contractor GP	£57,500
Part-time salaried GP	£25,000
Locum GP (8 months)	£45,000
Total number of GPs	6
Total earnings	£337,500

Mean earnings of all GPs in practice = £337,500 / 6 = £56,250

Total number of full time GPs = 2

Total number of part time GPs = 3

Total number of locum GPs employed for more than six months = 1

¹⁹ HSCIC <http://www.hscic.gov.uk/catalogue/PUB01028/gp-work-serv-rep.pdf>

²⁰ A session is normally defined as a half day.

Example publication for website

“All GP practices are required to declare the mean earnings (e.g. average pay) for GPs working to deliver NHS services to patients at each practice.

The average pay for GPs working in [insert practice name] in the last financial year was £56,250 before tax and National Insurance. This is for 2 full time GPs, 3 part time GPs and 1 locum GP who worked in the practice for more than six months.”

Monitoring

Practices may be required to declare compliance on publishing required details on their website and in practice leaflets in the annual electronic practice self-declaration (eDEC).

Seniority

As part of the 2014/15 GMS contract agreement, NHS Employers and the GPC agreed that seniority payments would cease on 31 March 2020 and that there would be an annual reduction in seniority payments year on year, with an equivalent and simultaneous transfer into core funding. This will start this year and continue until 31 March 2020 when all seniority payments will have been phased out and the full amount reinvested²¹.

It was also agreed that from 1 April 2014 there would be no new entrants to the scheme. To achieve this, the SFE payment scale is amended each year to extend by one year the number of years required before qualifying for seniority payments. For example, in 2015/16 payment for eight years reckonable service will reduce from £672 to £0.

A retrospective mechanism for achieving the annual reduction has been agreed. Broadly, any change will be made once the actual spend on seniority for a given year is confirmed²².

Each annual reduction in seniority payments will be achieved via the combined net effect of attrition (due to retirement and closing entrants to the scheme), progression (recipients moving up the seniority scale each year) and a reduction to the seniority

²¹ The Final Seniority Factor is not confirmed until 4 years after the relevant financial year so commissioners and practices will still be reconciling seniority payments until 2024; however new payments will have stopped

²² NHS England audited accounts are available in the summer of the following financial year and expected to be confirmed in September. The expenditure for 2014/15 is expected to be confirmed in September 2015 in the Technical Steering Committee paper *Investment in General Practice* <http://www.hscic.gov.uk/article/2021/Website-Search?productid=15446&q=Investment+in+general+practice&sort=Relevance&size=10&page=1&area=both#op>

payment scales (evenly across all increments). These sums will be simultaneously reinvested into global sum²³.

There will be an assessment each year as to whether the reduction is sufficient to deliver the full phasing out of payments by 2020. If not, seniority payments will be adjusted accordingly.

What this means for practices and commissioners

Exceptionally, there will be an in year adjustment to global sum and the seniority scale in 2015/16. This will apply from 1 October 2015 to deliver a reduction in seniority payments and an increase in global sum to reflect the transfer of funding.

From 2016/17 onwards this annual adjustment to global sum and the seniority scale will apply at the beginning of the financial year with no further in year adjustments to global sum or the seniority scale due to seniority changes.

In April 2016 the transfer of funds will be made using estimated spend²⁴. In April 2017, April 2018 and April 2019 seniority payments will be reduced and the money reinvested into global sum based on known spend for the previous financial year, until by April 2020 all seniority payments will have been phased out and reinvested.

Practices and commissioners will still need to make minor reconciliations to seniority payments that have already been made, as is the case now, as Final Seniority Factors (FSF) are confirmed by HSCIC. The 2019/20 FSF is expected to be confirmed in 2024.

Assurance of Out of Hours Provision

From 1 April 2015, practices who have not opted out of providing OOH care will be required to ensure that information is provided to the CCG (to be set out by the CCG) to allow the CCG to ensure that the service provider is delivering its OOH care in line with the National Quality Requirements²⁵ (or any successor quality standards). This is to ensure consistency in the monitoring of all OOH provision.

Overall responsibility for monitoring these services remains with NHS England (as reflected in the contract). However, CCGs continue to be directed to assure the provision of all OOH provision.

NHS England will therefore issue updated guidance to CCGs about the monitoring of OOHs in these terms.

²³ With no out of hours deduction being applied, and using a baseline spend on seniority of 2013/14 figures

²⁴ NHS England will model the estimated spend for 2016/17 using known figures from 2014/15 and factor in the effect of progression (contractors moving up the seniority payments scale) and attrition (contractors leaving the scheme through resignation or retirement). Using an estimated spend enables an adjustment to global sum to be made in April 2016 and avoids the need for in year change to be made. Waiting for actual spend figures to become available in October 2017 would necessitate two global sum figures in each financial year (i.e. April and October).

²⁵ <http://www.telephoneconsultationservices.co.uk/uploaded/National-Quality-Requirements-Out-Of-Hours-Services.pdf>

Changes to registration to reflect armed forces health requirements

Historically, on joining the armed forces patients have been required to de-register from their GP practice and register with a GP practice or medical centre from the Defence Medical Services (DMS). The range of services provided by DMS includes primary healthcare, dental care, rehabilitation, occupational health and occupational mental health care.

However, there are a number of situations where members of the armed forces are unable to access the full range of primary care services through the DMS, and the Ministry of Defence (MoD) has requested that in these circumstances primary care be provided by an NHS GP practice.

From 1 April 2015, GMS Regulations will allow for a serving member of the armed forces of the Crown, who has received written authorisation from DMS, to register with a GP in whose practice area they live or work during the period in respect of which that written authorisation is given, for a period of up to two years.

MoD, GPC and NHS England have agreed those authorised will be armed forces personnel as follows:

- patients requiring cancer treatment
- pregnant women or women on maternity leave
- people who are long-term wounded, injured and sick and are better cared for at home
- people posted to a location without access to a convenient MoD GP

In these circumstances, DMS will retain responsibility for meeting occupational health needs, but the individual's primary care needs would be delivered through registration for NHS primary medical services with a GP practice.

The registration of any of these patients would need to be with the explicit authorisation of DMS, and the process will be as follows:

Step 1 (DMS Authorisation).

DMS will identify patients who would be more suitably cared for by practices (i.e. those in the agreed cohort as above).

DMS will issue a letter to the patient to authorise them to register with a practice and this will include details of a military contact the practice can contact with any specific queries. The patient will also be given a summary of their medical record.

In addition DMS will send a copy of the letter of authorisation and a summary of the medical record to Primary Care Support Services, (PCSS)²⁶ which is

²⁶ Formerly known as LASCA

responsible for registration/de-registration of armed forces personnel. This letter will be sent at the point that authorisation is provided to the patient.

Step 2 (Practice registration).

The patient will request registration with a practice in the area that they live or work in presenting a copy of the letter of authorisation and a summary of their medical record.

The patient should be registered in the normal manner as any other new (permanent) registration.

Step 3 (Records transfer)

The practice will be asked to sign receipt for the summary of the medical record which it will need to return to the identified military contact within the authorisation letter in order for them to be assured that the care has been handed over and that they have details of the patient's practice.

The practice may also receive another copy of the summary of the medical record from PCSS following registration.

Any armed forces personnel registered with a practice under these amended arrangements will be funded as a fully registered patient during the time of their registration. This will be funded by the MoD through a transfer to NHS England.

The authorisation letter that accompanies the patient on registration will detail the contact point for any queries during registration, the secure mechanism by which DMS will request and if appropriate have transferred to it information relevant to the patient's occupational health during the time the patient is registered and also the process for secure transfer back to DMS at the end of registration.

Once the period of authorised registration comes to an end (two years or any point prior), it will be for the practice and DMS to agree the mechanism for transfer of the patient and a secure transfer of a copy of the medical record (or agreed summary of that record) for the time the patient was registered with the practice, back to DMS via PCSS.

In the event DMS wishes to renew registration for a further period it will instigate a further authorisation letter for those patients needing continuing NHS care. It is normally expected the patients' needs will be met within the first period of registration.

Payments for GP cover for maternity/paternity/adoption leave

From 1 April 2015, all practices will be entitled to reimbursement of the cost of GP cover for parental leave – that is maternity/paternity/adoption leave.

Reimbursement will be the lower of:

- £1,131.74 for the first two weeks and £1,734.18 three to 26.
- the actual invoiced costs during that period²⁷.

Reimbursement is intended to cover external locums and cover also provided by GPs already working within the practice (existing employees or partners) but who do not work full time (i.e. payment will be made equally where there is organisation flexibility/capacity within the practice to be able to perform the duties of the GP on leave in order to maintain the delivery of services).

Extending the scope of reimbursement for cover provided by existing GPs is anticipated to be more effective as there will be greater continuity of care for patients from being treated by a familiar GP.

The revised SFE applies the previous provisions for payments for locum cover equally to the new arrangements for payment for existing GP cover.

NHS England is working with GPC to update its policy document on paternity leave payments to support administration of these revised arrangements²⁸.

Alcohol-related risk reduction

The alcohol-related risk reduction ES will end on 31 March 2015 and the associated funding will be reinvested in global sum (with no OOH deduction being applied). This is because the current requirements are now embedded in routine general practice and are a core contractual requirement from 1 April 2015.

All practices are required under the contract to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels (using one of the two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification (AUDIT) questionnaire: FAST (which has four questions) or AUDIT-C (which has three questions)).

Once identified, practices are required to:

- offer to provide advice, lifestyle counselling and respond to any other need identified relating to their level of drinking and offer to refer to specialist services to patients as clinically appropriate
- offer to assess and screen patients for anxiety and/or depression and offer advice and treatment (including referral for specialist mental health treatment) to patients as clinically appropriate
- code the above activity, scores and information appropriately within the patient medical record.

²⁷ The SFE allows NHS England discretion over the period it will pay at the specified rates and it must set out those circumstances in a policy. That policy is currently being updated.

²⁸ This will be published on NHS England website once finalised <http://www.england.nhs.uk/medical/>

Practices are expected to enable collections of anonymised data or provide associated anonymised data to assist commissioners in monitoring contractual performance. Reports will be available for practices to compare their activity with their peers and help commissioners and practices to monitor quality of care. Practices will be able to verify data collections and amend as necessary via commissioners or on their clinical systems.

Screening

Practices must offer a short case-finding test to all patients newly registered (within the financial year), who are aged 16 or over and discuss that with them.

Practices will need to use one of two shortened versions of the World Health Organisations (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaires: FAST or AUDIT-C (or alternative tool identified by Public Health England)), with each taking approximately one minute to complete. FAST has four questions and a value of three or more is regarded as positive. AUDIT-C has three questions and a value of five or more is regarded as positive.

All patients with a positive score should be screened using the remaining questions in the ten-question AUDIT questionnaire to determine if increasing, higher risk or likely dependent drinking.

The values associated with each of the positive risk scores are as follows:

- 0–7 indicates sensible or lower risk drinking
- 8–15 indicates increasing risk drinking
- 16–19 indicates higher risk drinking
- 20 and over indicates possible alcohol dependence.

Practices are required to add a value to the field associated with the code when recording the score in a patient's record.

Patients with a score between eight and 15 should be offered brief intervention, patients with a score of between 16 and 19 should be offered brief intervention or brief lifestyle counselling²⁹ and patients with a score of 20 or more should be considered for referral to specialist services (see relevant sections below).

Brief intervention

Those patients identified as drinking at increasing or higher risk levels (scores eight –19) should be offered brief advice.³⁰

Brief lifestyle counselling

In some areas, patients drinking at higher risk levels (scores 16–19) should either be offered brief advice or brief lifestyle counselling (20–30 minutes) within the practice, or be offered referral to, for example, a community-based counselling service for this

²⁹ Referred to as 'extended intervention' in the management information counts and Business Rules.

³⁰ For example: <http://www.alcohollearningcentre.org.uk/topics/browse/briefadvice/>

advice.

Referral for specialist advice

Patients identified as possibly alcohol dependent (scores of 20 or more) should be considered for referral for specialist services. Although providing brief alcohol advice is still recommended, on its own, brief advice has not been shown to be effective for this group of patients.

Assessment/screening for anxiety and/or depression

All patients who are identified as drinking at increasing or higher risk levels (score of eight or more), should also be offered an assessment for anxiety and/or depression. This is because mental health issues could be contributing to the patient's levels of alcohol consumption. Practices will need to use an appropriate tool for the assessment/screening, for example using questionnaires such as Generalised Anxiety Disorder Scale-7 (GADS-7) and/or Patient Health Questionnaire (PHQ-9). Patients who are found to be suffering with anxiety and/or depression should, where appropriate, be offered support and treatment. This may include, but is not limited to, self-directed therapy, group therapy, counselling, behavioural therapy and medication.

In severe or refractory cases (scoring 20 or more), consideration should be given to referring the patient to specialist mental health services³¹. It is recognised that it may be appropriate for mental health services to decline referrals but only in the case of alcohol dependence that is in need of treatment. Where this is the case, referral should be kept under review whilst the patient's alcohol dependency is treated, until such a time as the mental health team will be able to accept the referral. Patients whose AUDIT score indicates that they are drinking at increasing or higher-risk (scoring eight to 19), should not be denied access to practice based, or specialist mental health services if these services are clinically indicated and the patient would benefit from this intervention

Monitoring

Commissioners are responsible for monitoring contract performance. This may include auditing practices to ensure that not only was the initial screening conducted, but also that appropriate action followed, such as the delivery of brief advice, lifestyle counselling or where needed, referral to specialist services or assessment/screening for anxiety and/or depression. Where possible NHS England will collect anonymised data to monitor the delivery of the alcohol-related risk reduction contractual requirements. This may include retrospective collections.

Practices should use the specific Read2 and CTV3 codes relevant to record where support and treatment is provided, including the specific drug, support or therapy using Read2 or CTV3 codes, where they exist, or include in free text.

³¹ <http://www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf>

The 'Technical Requirements 2015/16'³² document contained the management information counts and Read2 and CTV3 codes³³ relevant for this service. These Read2 and CTV3 codes will continue to be used as the basis for future GPES collections. The Business Rules will be updated as necessary and specify the codes that practices will be expected to use in order to facilitate data collection and enable commissioners to monitor delivery of this new contractual requirement.

Commissioners and practices should refer to supporting Business Rules for the most up-to-date information on management information counts, Read2 and CTV3 codes which will be published on the HSCIC website.³⁴

Patient participation

The patient participation enhanced service will end on 31 March 2015 and the associated funding will be reinvested in Global Sum (with no OOH deduction being applied).

From 1 April 2015, the contract requires all practices to establish (if it has not already done so as a consequence of the enhanced service) and maintain a patient participation group (PPG) and make reasonable efforts during each year for this to be representative of the practice population. The practice must engage with the PPG throughout each year, at a frequency and in a manner as agreed with its PPG, including to review patient feedback (whether from the PPG or other sources) and feedback from carers of registered patients, who themselves are not registered patients. The purpose of this engagement is to identify improvements that may be made in the delivery of services by the practice. Where the practice and PPG agree, the practice must act on suggestions for improvement using reasonable endeavours to implement these.

Existing guidance from 2014/15³⁵ and Annexes A to C on this document provide helpful information for practices on how to develop a PPG and how to ensure it is representative of the practice population, as well as links to external guidance for patient participation, patient FAQs, sample contact forms, leaflets and posters.

Purpose

The purpose of the Patient Participation Group (PPG) is to ensure that patients and carers are involved in decisions about the range, shape and quality of services provided by their practice. The requirement aims to promote the proactive and innovative involvement of patients and carers through the use of effective PPGs and

³² NHS Employers. Technical requirements for 2015/16 GMS contract changes.
<http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

³³ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

³⁴ <http://www.hscic.gov.uk/primary-care>

³⁵ <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/gms-contract-changes/contract-changes-201415>

to act on a range of sources of patient and carer feedback in order to improve the services delivered by the practice.

The role of the PPG includes:

- being a critical friend to the practice
- advising the practice on the patient perspective and providing insight into the responsiveness and quality of services
- encouraging patients to take greater responsibility for their own and their family's health
- carrying out research into the views of those who use the practice
- organising health promotion events and improving health literacy
- ongoing communication with the patient population.

This guidance supports practices to meet the contractual requirements and provides examples of the activities that support good participation.

Requirements

From 1 April 2015 it is a contractual requirement for all practices:

- to develop and maintain a PPG for the purpose of obtaining the views of patients and enabling the practice to obtain feedback from the practice population on services delivered by the contractor
- to make reasonable efforts for this group to be representative of the practice patient population
- to engage with the PPG at a frequency and in a manner agreed with the group
- to review patient feedback (whether from the PPG or other sources – FFT, patient surveys etc) with the aims of the practice and PPG agreeing improvements that could be made to services
- to act on suggestions for improvements, where the practice and PPG agree.

Practices are required to declare in the annual electronic practice self-declaration (eDEC) that they have fulfilled these requirements³⁶.

Developing a PPG

If it has not already done so, the practice must develop and maintain a properly representative PPG that obtains and reflects the views of its registered patients and carers and enables the practice to obtain feedback from a cross-section of the practice population. Practices that have previously taken part in this enhanced service will not need to create a new structure (or PPG), but should review whether the group remains representative of the practice population.

Traditionally, practices have developed a PPG through volunteers and regular meetings. Some practices have developed a virtual PPG, an email community they consult with on a regular basis, but which does not have regular face-to-face meetings. The practice should develop its PPG in the most appropriate way to effectively reach the broadest cross section of its patient population and meet the

³⁶ The annual electronic practice self-declaration (eDEC) for 2015/16 financial year will be updated on or by September 2015 at the web interface - www.primarycare.nhs.uk – and supporting guidance will be published on the NHS England website.

contractual requirements. This may be a virtual or a face-to-face group or a combination of the two.

Whilst advertising within the practice premises and in the practice patient leaflet will help, inviting patients personally to join a group (virtual or otherwise) has been shown to be very effective. Inviting new patients at the point of registration as well as at routine practice visits also helps to reach those people who attend infrequently. This can be done either at reception or at the end of the consultation by simply handing a leaflet to patients. For more information and tools on establishing a PPG see the 'Getting started guide' at Annex B.

Once patients have been recruited to the PPG, a constitution should be agreed between all members of the PPG (patients and practice) to set out the membership, how the PPG will work and the objectives.

Practices should not limit engagement to the PPG. Practices should also promote innovative forms of patient participation to provide accurate feedback from all groups, and allow a better understanding of patients and carer needs. For example:

- promoting innovative forms of communication and insight between the practice and patients to co-design services that meet the needs of their practice population
- improving communication channels with people who practices may otherwise not get the opportunity to engage, particularly vulnerable patients
- developing patient champions who work with practices to support particular issues, or particular groups such as patients with mental health conditions
- holding annual events with practice population to showcase progress achieved/future plans
- providing opportunities for patients and carers to find out more about how the practice and the wider health economy works
- providing opportunities for patients and carers to be involved in wider service developments in the area.

Practices may find the work the National Association of Patient Participation (N.A.P.P.) has done in developing PPGs. Best practice case studies and other resources can be found on the N.A.P.P. website³⁷.

Representing the practice population

Whichever approach they adopt, practices must clearly demonstrate that they have established a PPG comprising registered patients and their carers, and used best endeavours to ensure that the PPG is representative of their registered patient population. They should also demonstrate that they have made reasonable efforts to engage with any under-represented and seldom-heard groups, including patients with mental health conditions or groups with protected characteristics as identified in the Equality Act 2010³⁸. Links to guidance on engaging seldom heard groups are at Annex B.

³⁷ NAPP. <http://www.napp.org.uk/>

³⁸Age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation

To do this, the practice needs to have an understanding of its practice profile. This understanding should take into account more than age and sex i.e. this could include factors such as levels of unemployment in the area, number of carers, black and minority ethnic groups, or a large local lesbian, gay, bisexual and transsexual community. Local Healthwatch, voluntary organisations and community and faith groups may be able to support practices to engage with marginalised or vulnerable groups, such as older frail people or patients with learning disabilities. It may be useful to access the Joint Strategic Needs Assessment, available from the Local Authority or CCG which will contain information on the make-up of the local population.

All practices will have a significant number of registered patients who are children. It is up to the practice to determine how best to seek their views, subject to parental consent, and practices will wish to consider other ways in which children can be involved.

It is important that practices and PPGs also represent the roles of carers. PPGs should include the carers of registered patients, even if the carers themselves are not registered with the practice.

The practice and PPG may find it useful to reach out to a particular group of people by doing a focused piece of work to engage them, or linking with local community or voluntary sector groups. The venue and time of the PPG meeting could be changed or running a drop in session could be considered. Working with local community and voluntary sector groups will be helpful in making links with under-represented groups

Practices should particularly ensure that they comply with the Equality Act 2010³⁹ when developing a PPG. Information on compliance can be found on the Equality and Human Rights Commission website⁴⁰, in the Government Equalities Office guide⁴¹ and on the Advisory, Conciliation and Arbitration Service (ACAS) website⁴².

PPG and practice staff to review patient feedback

Practices should aim to have continual/regular dialogue around improvement with their PPG and wider registered population, and should reflect on existing and new sources of feedback such as those listed at the beginning of this guidance. The practice should agree with the PPG how regularly that feedback is reviewed.

Using a variety of sources of feedback the practice and PPG should identify areas of priority. These are likely to be based on key inputs, including the identification of themes from:

- patients and carer priorities and issues
- themes from complaints and suggestions
- planned practice changes

³⁹ Equality Act 2010. <http://www.legislation.gov.uk/ukpga/2010/15/contents>

⁴⁰ <http://www.equalityhumanrights.com/legal-and-policy/legislation/equality-act-2010/equality-act-codes-practice-and-technical-guidance>

⁴¹ <https://www.gov.uk/government/policies/creating-a-fairer-and-more-equal-society>

⁴² <http://www.acas.org.uk/index.aspx?articleid=1461>

- bespoke survey⁴³
- Care Quality Commission (CQC) related issues
- the GP patient survey⁴⁴
- the Friends and Family Test
- working with local commissioners(Clinical Commissioning Groups/NHS England/Local Authority)
- views from local voluntary and community groups, including local Healthwatch.

Develop action plan with PPG on improving practice and implementing changes

Based on feedback, practice and PPG should agree clear priorities for improvement. Areas of improvement could be around any areas of quality that are important to patients and carers. This could include what services are offered, how services are accessed and delivered or how the practice engages with patients and carers and the wider community. The action plan could include ways in which the PPG will contribute towards the improvements e.g. supporting volunteering across the practice.

Practices are recommended to agree a clear action plan, for instance in the form of a report, which the PPG and Practice can use to evidence that feedback has been taken on board and that the PPG has been properly engaged. The report could include details on the make-up of the PPG against the practice population, sources of information analysed, the areas identified for improvement, what actions were taken to address these priorities and the resulting changes made.

Practices should keep the PPG up-to-date with progress on any agreed actions, for instance through their practice website, NHS Choices website, posters in waiting rooms, PPG meetings, newsletters etc.

Practices might consider sharing their experiences with a range of groups and organisations including:

- the PPG
- the wider practice population
- Local commissioners (Clinical Commissioning Groups/NHS England/Local Authority)
- Local Healthwatch (which might facilitate effective working between the local healthwatch and the PPG)
- Local voluntary and community groups
- CQC - at the time of inspections/registration.

⁴³ When using such tools care must be taken to ensure compliance with the Data Protection Act (for example protect from gathering patient identifiable or confidential information, ensuring data is not stored on servers outside the uk etc.

⁴⁴ <http://www.gp-patient.co.uk/results/>

Patient online services and Information Technology (IT)

Background and purpose

The 2013/2014 *improving patient online access* ES was designed to allow patients to carry out online booking and cancellation of appointments, and online ordering of repeat prescriptions. Practices were rewarded for providing high quality secure electronic systems and pro-actively encouraging patients to use them.

In line with government's commitment to enabling and improving patient online interaction with general practice, the ES ended in 2014/15 and patient online services became an integral part of contractual requirements. All practices in England were required to offer and promote patients' online access to those transactional services as well as provide patients with access to information from their medical records. Further requirements were put in place to ensure the safe and effective electronic transfer of patient records and support better referral management.

The purpose and effect of the new requirements of the 2015/16 GMS contract is to build on these changes, by extending and improving patient access to online medical records and improving provision of online appointments.

NHS England and GPC have also jointly agreed to go further in encouraging the development of innovative use of technology, with appropriate governance, in the provision of services. This joint working signals a new direction of travel for NHS IT within general practice by the development of joint aims by NHS England and GPC. GPC has committed to actively promote the use of NHS IT services and will issue joint promotional guidance and good practice with NHS England.

Both NHS England and GPC recognise that to achieve these joint aims, strong leadership and enablement will be required from NHS England, CCGs, provider organisations and HSCIC.

Continuing contractual requirements

Most of the requirements of the 2014/15 agreement⁴⁵⁴⁶ continue unchanged. In particular contractual requirements on referral management, online ordering of repeat prescriptions and interoperable records all still apply in 2015/16. Previous guidance⁴⁷ therefore still applies:

- referral management: practices must include the NHS Number as the primary identifier in all NHS clinical correspondence issued by the practice whether in electronic form or otherwise, except in exceptional circumstances where the number cannot be ascertained. The NHS Number is a key tool for uniquely identifying patients and supporting patient safety.

⁴⁵ <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/gms-contract-changes/contract-changes-201415>

⁴⁶ <http://www.legislation.gov.uk/ukxi/2014/465/contents/made>

⁴⁷

<http://www.nhsemployers.org/~media/Employers/Documents/Primary%20care%20contracts/GMS/GMS%20Contract%202014-15%20-%20Guidance%20and%20audit%20requirements.pdf>

- online ordering of repeat prescriptions: practices must promote and offer the secure facility for all patients who wish to order online, view and print a list of their repeat prescriptions for necessary drugs, medicines or appliances
- interoperable records: practices must enable successful automated uploads of any changes to a patient's summary information, unless the patient has specifically objected to the use of their data for the purpose, at least on a daily basis, to the Summary Care Record (SCR); and use the GP2GP facility for transfer of all patient records between practices, when a patient registers or de-registers (not for temporary registration)⁴⁸.

2015/16 Requirements

Building on the contractual requirements from 2014/15, the following are now new contractual requirements for 2015/16:

Patient access to their GP record

- From 1 April 2015, it is a contractual requirement⁴⁹ to offer online access to all detailed information, i.e. information that is held in a coded form within the patient's electronic medical record.

There is no contractual requirement to provide online access to any free text that may be included within the patient record.

Where free text is currently embedded within coded information, technical amendments will be made to GP software, through the GPSoC contract, to allow coded information to be separated from free text to allow GPs to withhold free text whilst still meeting the contractual obligation to provide coded information.

This means coded information in a recognised NHS-supported coding scheme such as Read Codes, CTV3, SNOMED and supplier coding systems.

GP software will be configured to offer all coded data by default but GPs will have the option and configuration tools to withhold coded information where they judge it to be in the patient's interests or where there is reference to a third party.

There are circumstances where a GP may believe that it is not in the best interest of the patient to share all the information in the record. In particular there may be circumstances where it is likely to cause serious harm to the physical or mental health, or condition, of the patient or any other person, in which case a GP should withhold that information.

There may also be circumstances where information relates to, or is provided by, a third person who can be identified from the information and has not consented to the disclosure. The GP should consider whether it is reasonable to disclose the

⁴⁸ In 2014/15, practices were required to have plans in place by 30 September 2014 to achieve this by 31 March 2015 at the latest. Therefore it is a requirement that this is operational from 1 April 2015.

⁴⁹ In meeting this new requirements colleagues are reminded of key relevant legislation, the Data Protection Act, s.7-s.10, and the Data Protection (Subject Access Modification) (Health) Order 2000 – see <http://www.legislation.gov.uk/ukxi/200/413/made>

information without that third party's consent. Further guidance is available from the Department of Health⁵⁰.

Practices may make available any other items of information agreed between the patient and practice.

These changes are agreed with the understanding that the GP Systems of Choice (GPSoC) programme will be the process by which the nationally approved and funded systems necessary to satisfy these requirements will be made available to practices by NHS England. All contractors are expected to have access to the necessary system during 2015/16 to enable implementation by 31 March 2016 – where such systems are not currently available during 2015/16 contractors are required to publish a plan by 30 September 2015 on how they intend to achieve the requirement by the end of the financial year. In any event, practices are required to provide summary information, as a minimum, in line with the 2014/15 contractual requirements, where the nationally approved and funded systems have been provided by NHS England.

Further guidance is available from the Royal College of General Practitioners (RCGP)⁵¹ and NHS England.⁵²

Electronic appointment booking

- From 1 April 2015 practices must continue to promote and offer patients the ability to book appointments online but will also now need to routinely consider whether the proportion of appointments that can be booked online needs to be increased to meet the reasonable needs of their registered patients, and, if so, take such action accordingly.

In offering online appointments practices should take into account the make-up of their practice population when deciding what proportion of appointments should be available online. Practices should consider consulting their Patient Participation Group (PPG) and take steps to review demand on an ongoing basis. When considering this, practices should look to optimise and enhance patient choice and convenience.

Practices should also consider publishing the percentage of online appointments they make available.

System requirements

These changes are agreed with the understanding that the GP Systems of Choice (GPSoC) programme will be the process by which the nationally approved and funded systems necessary to satisfy these requirements will be made available to practices by NHS England. The 2014/15 requirement relating to the transfer of

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<https://www.igt.hscic.gov.uk/WhatsNewDocuments/Access%20to%20Health%20Records%20Feb%202010.pdf>

⁵¹ <http://elearning.rcgp.org.uk/patientonline>

⁵² <http://www.england.nhs.uk/ourwork/pe/patient-online/>

patient records is also still subject to the resolution of outstanding issues with GP2GP.

Working with system suppliers, practices will be expected to plan for the introduction of these new systems for their patients when the functionality is available.

Further guidance, *Securing Excellence in GP IT Services*⁵³, is available from NHS England. This guidance sets out what support is provided by NHS England and from IT suppliers as part of the GPSoC funding.

Monitoring

Commissioners will monitor compliance as part of the assurance framework in place from Primary Medical Services contractors. This will include review of nationally coordinated data from system suppliers on the availability and enablement by practices of patient online services (PHF10). Practices are required to declare in the annual electronic practice self-declaration (eDEC) that they have fulfilled these requirements.

Joint working

NHS England and GPC recognise the importance of encouraging and developing use of technology outside of contractual requirements. The Joint General Practitioners Information Technology Committee (JGPITC) will be the main forum for this work, which will be ongoing throughout 2015/16. Separate jointly agreed guidance will be available on NHS England and GPC websites, and will be publicised through bulletins, for the following four issues:

- *Improving the offer of electronic transmission of prescriptions* - to encourage all prescriptions to be transmitted electronically using Electronic Prescription Services Release 2 unless the patient asks for a paper prescription or the necessary *legislative* or technical enablers are not in place. NHS Employers and the GPC have agreed that at least 60% of practices will be expected to be transmitting prescriptions electronically using EPS Release 2 by 31 March 2016.
- *Patients' secure electronic communication with practice* - GPC and NHS England will jointly promote the use of new technology (for instance consultation by email or video) where it would bring benefits to both GP practices and patients.
- *Electronic referrals* - NHS Employers and the GPC have agreed that at least 80% of elective referrals will be expected to be made electronically using the NHS E-referral system by 31 March 2016.
- *Information governance* – NHS England and GPC will promote the completion of the HSCIC information governance toolkit including adherence to the requirements outlined within it.

⁵³ <http://www.england.nhs.uk/wp-content/uploads/2012/12/gp-it-op-model.pdf>

Changes agreed in 2014/15 and implemented in-year

Friends and Family Test

Since 1 December 2014, it has been a contractual requirement that all GP practices undertake the NHS Friends and Family Test (FFT).

The FFT question asks if people would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT question provides a mechanism to highlight both good and poor patient experience. The free text responses are a rich source of information which allows practices to consider the comments being made by patients in detail and identify actions which can be taken to improve patients' experience much more quickly than traditional survey methods.

Practices are required to submit data on a monthly basis on the level of their responses through CQRS.

Further information is available from NHS Employers⁵⁴ and NHS England⁵⁵, including data submission guidance for practices⁵⁶.

Choice of GP practice

From 5 January 2015, all GP practices in England have the option of registering patients from outside their practice boundaries without the obligation to provide:

- home visits
- immediately necessary treatment following accident or emergency when the patient is at home (all GP practices however remain obliged to provide to any patient regardless of their registration status when the patient is in their practice area)
- access to OOH services (if not opted out) when the patient is at home (and it is not reasonable to expect the patient to attend)
- other such services provided by the contractor, which for clinical or practical reasons it is not reasonable to expect the patient to attend their registered practice, e.g. this could include follow up care following hospital discharge.

Local NHS England teams have established arrangements locally to provide urgent care for patients who have registered as out of area patients and cannot access this care from their registered practice whilst at home.

Further information is available from NHS England.⁵⁷

⁵⁴ <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/friends-and-family-test>

⁵⁵ <http://www.england.nhs.uk/ourwork/pe/fft/fft-guidance/>

⁵⁶

<http://www.nhsemployers.org/~media/Employers/Documents/Primary%20care%20contracts/GMS/FFT%20Submission%20guidance%20FINAL.pdf>

⁵⁷ <http://www.england.nhs.uk/wp-content/uploads/2014/11/gp-con-guidance-out-area-reg.pdf>

A further contractual amendment is introduced from 1 April 2015 to support these arrangements.

Initial registration of out of area patients without home visits can be refused by GP practices on clinical or practical grounds. However, there was previously no equivalent term in the contract regulations for subsequently removing out of area patients registered without home visits should it become no longer clinically appropriate or practical for the patient to be registered this way.

Previous guidance on choice of GP practice is clear about the need to explain to patients registered out of area the risks, and that they may be asked to register with a practice closer to home if their circumstances change. However, it is acknowledged patient agreement may not always be possible. The regulation amendment removes the reference to the patient's disability or medical condition as exceptions to reasonable grounds for removal from the patient list. It goes on to provide the contractor the facility to remove out of area patients when:

“(aa) the reason for the removal is that the contractor considers that it is not clinically appropriate or practical to continue to provide services under the contract to the patient which do not include the provision of such services at the patient's home address;”.

Further work in 2015/16

Workforce, including retainer/returner, flexible careers and remote/rural areas
NHS England and GPC have consulted on timely solutions to workforce issues, specifically around:

- the retainer and returner scheme
- the flexible careers scheme
- recruitment problems that are affecting specific areas (e.g. remote and rural areas).

NHS England in collaboration with Health Education England (HEE), the Royal College of General Practitioners (RCGP) and the BMA have agreed a 10 point plan, *Building the Workforce - the new deal for general practice*⁵⁸ to increase the number of GPs and develop the role of other primary care staff such as nurses and pharmacists.

There are three key strands to this work:

- improving recruitment into general practice
- retaining doctors within general practice

⁵⁸ <http://www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan/>

- supporting those who wish to return to general practice

The plan is part of the NHS Five Year Forward View and the New Deal for primary care, which set out a specific commitment to tackle workforce issues. The NHS Five Year Forward view sets out a greater role, and the need for investment, in general practice.

Deprivation

GPC and NHS Employers have agreed to work with NHS England to re-examine the Carr-Hill formula with the aim of adapting the formula to better reflect deprivation.

Premises

NHS Employers, NHS England and the GPC agreed to have a broader strategic discussion about the primary care estate, including to support the transfer of care into a community setting.

A £1bn investment in primary care infrastructure (including estates, information technology and workforce development) has since been announced.

Practices have been invited to submit bids, and in the first year it is anticipated that the money will predominantly accelerate schemes which are in the pipeline, bringing benefits to patients more quickly.

This new funding, alongside the incremental premises programme, will accelerate investment in increasing infrastructure, accelerate better use of technology and in the short term, will be used to address immediate capacity and access issues, as well as lay the foundations for more integrated care to be delivered in community settings.

For further information go to:

<https://www.england.nhs.uk/commissioning/primary-care-comm/infrastructure-fund/>

Minor surgery

NHS Employers on behalf of NHS England will work with GPC to establish a consistent set of standards which commissioners (area teams or CCGs on their behalf) will apply for the provision of enhanced minor surgery services. This will ensure any variation in the qualifications required to participate in the enhanced service will be restricted to the scale and nature of the services to be provided rather than the location in England they are commissioned from.

Section 4: QOF

As part of the 2015/16 GMS contract changes, NHS Employers and the GPC agreed a number of changes to the QOF effective from 1 April 2015.

The value of a QOF point will be adjusted for 2015/16 to take account of population growth and relative changes in practice list size from 1 January 2014 to 1 January 2015. The amended QOF value is £160.15 per point in 2015/16. The new national average practice population figure is also confirmed as 7233.

The changes to thresholds planned for 1 April 2015 have been deferred for one year to 1 April 2016.

A number of indicators have been removed from QOF and the associated points have been redistributed across indicators for atrial fibrillation and dementia. There have also been some amendments to a number of indicators⁵⁹. The total QOF points available remains at 559.

Practices will continue to undertake work and code activity as clinically appropriate in relation to those indicators no longer in QOF. Practices are encouraged to facilitate data collection on these indicators. Periodically, NHS England will collect anonymised data from practices' clinical systems which will provide statistical information, be processed for audit and publication and will help inform commissioners and practices. It is not intended for performance management purposes

Commissioners and practices should refer to the QOF guidance which sets out the full requirements for 2015/16 and is available on NHS Employers website⁶⁰.

⁵⁹ NHS Employers. 2015/16 QOF www.nhsemployers.org/changestoQOF201516

⁶⁰ NHS Employers. 2015/16 QOF www.nhsemployers.org/changestoQOF201516

Section 5. Vaccinations and immunisations

As part of the 2015/16 GMS contract changes, NHS Employers (on behalf of NHS England) and the GPC have agreed a number of changes to the contractual arrangements for some vaccinations and immunisations effective from 1 April 2015.

This section lists those vaccinations and immunisations which continue without alteration, those where there have been some changes made and those new in 2015/16.

The following programmes continue unchanged:

- childhood immunisation programme⁶¹
- Hepatitis B (newborn babies) vaccination programme
- Measles mumps and rubella (aged 16 and over) vaccination programme
- Rotavirus vaccination programme pertussis (pregnant women) vaccination programme.

There have been some changes to the following programmes:

- childhood immunisations (target payments)
- childhood influenza vaccination programme
- Meningitis C (freshers) vaccination programme
- seasonal influenza and pneumococcal polysaccharide vaccination programme
- shingles (catch-up) vaccination programme
shingles (routine) vaccination programme

Two new item of service payments are being introduced into the SFE in 2015/16:

- HPV booster vaccination
- MenC booster vaccination.

Commissioners and practices should refer to the 'Vaccination and immunisation programmes 2015/16 guidance and audit requirements' which sets out the full requirements for 2015/16 and is available on NHS Employers website⁶².

⁶¹ changes in the Men C require only administration of 1 dose towards the calculation of achievement rather than 2 and this is reflected in the schedule

⁶² <http://www.nhsemployers.org/vandi>

Section 6: Enhanced Services

Commissioners and contractors participating in ESs should ensure they have read and understood the requirements in the Directions and NHS England service specifications as well as the guidance in this document.

ESs are services which require an enhanced level of service provision above what is required under core GMS contracts.

This section of the document sets out the guidance and audit requirements for the following ESs which are largely unchanged from 2014/15:

- Extended hours access
- Facilitating timely diagnosis and support for people with dementia
- Learning disabilities health check scheme

Also detailed below is the updated avoiding unplanned admission ES for 2015/16.

The minor surgery ES and violent patient ES, which are locally specified, remain unchanged.

The alcohol-related risk reduction scheme and patient participation ESs end on 31 March 2015 and the associated funding will be reinvested in global sum with no OOH deduction being applied. This is because the current requirements are now embedded in routine general practice. There will be new contractual requirements for all practices to provide these services from April 2015. Further details and guidance are provided at Section 3.

Proactive Care Programme - Avoiding Unplanned Admissions: proactive case finding and patient review for vulnerable people

Background and purpose

Unplanned admissions to hospital are distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital.

This ES is designed to help reduce avoidable unplanned admissions by improving services and offering more personalised care planning for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. The ES should be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions. The ES will commence on 1 April 2015 for one year, subject to review.

The ES requires practices to identify patients who are at a higher risk of unplanned admission, using risk stratification tools or alternative method and manage them appropriately with the aid a case management register, personalised care plans and improved same day telephone access. In addition, the practice will also be required to provide timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or accident and emergency (A&E) attendances.

The risk stratification element of the ES will be used to identify a minimum of two per cent of the practice's registered adult patients (aged 18 and over) who have an increased at risk of unplanned admissions. In addition to this, any children (aged 17 and under) with complex physical or mental health and care needs who require proactive case management should also be considered for the register.

Patients identified as being at risk of unplanned admission without proactive case management and on the case management register will be assigned a named accountable GP (and where relevant a care co-ordinator). This person will have overall responsibility for co-ordinating the patient's care and sharing information with them, their carer⁶³ (if applicable) and, if the patient consents, the multi-disciplinary team (MDT) and other relevant providers involved in their care. These patients will have a personalised care plan which will have been developed collaboratively between the patient, their carer (if applicable) and the named accountable GP and/or care co-ordinator, detailing how their ongoing health and care needs will be addressed to reduce their risk of avoidable admission to hospital. The patient's care and personalised care plan will also be reviewed at regular intervals agreed with the patient and if applicable, the carer. Practices should also be aware of the needs of carers.

⁶³ Remember that the patient must understand, where they have the capacity, what role and information will be shared with their carers and the consent to their involvement should cover this issue. Commissioners and practices will be aware of the need to protect vulnerable patients and ensure necessary safeguards are in place.

Participating practices will carry out monthly reviews⁶⁴ of all unplanned admissions and readmissions and A&E attendances of patients on the case management register.

They will also review other patients who are vulnerable and who may be at risk of unplanned admissions (such as those living in care or nursing homes) to identify factors which could have avoided the admission or A&E attendance, with a view to taking appropriate action to prevent future episodes. The factors include both changes that the practice can make to their management of these patients, other community support services that need to be put in place for these patients and also changes to admission and discharge processes that will be fed back to commissioners by the practice.

This guidance should be read in conjunction with the 2015/16 NHS England ES specification⁶⁵.

Requirements

The requirements for taking part in the ES are as follows:

Practice availability

1. The practice will provide timely telephone access via an ex-directory or bypass number to ambulance staff and A&E clinicians to support decisions about hospital transfers and admissions relating to any patient on their registered list⁶⁶. This could, for example, be done by providing different extension options to callers to the practice, as long as this gets the caller straight through to the practice as a priority call. Where an ambulance staff member or A&E clinician specifically ask to speak to a clinician in the practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to whether or not to transfer or admit a patient to hospital i.e. it may be immediate, within an hour or same day. The commissioner will be required to compile a list of all the by-pass or ex-directory telephone numbers for practices participating in the ES and share it with relevant ambulance staff and A&E clinicians.
2. The practice will provide timely telephone access via an ex-directory or bypass number to care and nursing homes, encouraging them to contact the patient's practice to discuss options before calling an ambulance (where appropriate – for example, this is not applicable if the patient is at high risk of severe harm or death, if treatment is delayed). For example, this could be done by providing different extension options to callers to the practice, as long as this gets the caller straight through to the practice as a priority call. Where care or nursing home staff specifically ask to speak to a clinician in the practice, then they should be enabled to do so whenever practically possible. Access should be

⁶⁴ The reviews are to understand why each individual admission or attendance occurred and whether it could have been avoided.

⁶⁵ NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

⁶⁶ This number is only to be used when ambulance staff and A&E clinicians require support from a patient's practice in making decisions about transferring or admitting patients.

within a suitable timeframe recognising that the query being raised relates to whether or not to call an ambulance i.e. it may be immediate or within a couple of hours. The commissioner will be required to compile a list of all the by-pass or ex-directory telephone numbers for practices participating in the ES and share it with relevant care and nursing homes.

3. The practice will provide timely telephone access to other care providers (e.g. mental health and social care teams) who have any of the practice's registered patients in crisis and who are at risk of admission. Where a specific request is made by one of these individuals to speak to a clinician in the practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to a patient in crisis i.e. it may be immediate, within an hour or same day.
4. The practice will provide patients identified on the case management register, who have urgent clinical enquiries, with a same day telephone consultation and where required, follow-up arrangements (e.g. home visit, face-to-face consultation, visit by a community team etc.). This same day telephone consultation will be with the most appropriate healthcare professional in the practice.

Proactive case management and personalised care planning

1. The practice will use an appropriate risk stratification tool⁶⁷ or alternative method⁶⁸, if a tool is not available, to identify vulnerable older people, high risk patients and patients needing end-of-life care who are at risk of unplanned admission to hospital. If a risk stratification tool is used, commissioners should ensure that a suitable tool has been procured for practice use.
2. The risk stratification tool or other alternative method used should give equal consideration to both physical and mental health conditions. In the event the risk stratification tool does not account for mental health conditions, the practice should endeavour to use knowledge of their patients with mental health conditions alongside the risk stratification tool to ensure these patients are considered.
3. The practice will establish a case management register of patients identified as being at risk of an unplanned hospital admission without proactive case management. This register will be a minimum of two per cent of the practice's registered⁶⁹ adult patients (aged 18 and over). The minimum number of patients to be on the register in each six month period will be set on the 1 April 2015 and 1 October 2015 respectively. The minimum register size will be calculated as two per cent of the practice list size (patients aged 18 and over)

⁶⁷ NHS England. Handbook. Using Case Finding and Risk Stratification.

<http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

⁶⁸ This may include using clinical judgement and knowledge of the practice's patient population with regards to those patients who would benefit from this service.

⁶⁹ Head count and not weighted list.

from the Calculating Quality Reporting Service (CQRS) on each of these days. In addition to this two per cent, any children (aged 17 and under) with complex physical or mental health and care needs, who require proactive case management, should also be considered for the register⁷⁰.

4. In each six month period a tolerance of -0.2 per cent will be allowed to account for situations which temporarily lead to a dip in the number of patients on the register at the end of that six month period. Practices will also be able to submit manual data (see monitoring section) on any patients who died or moved practice during the six month periods⁷¹ and these patients will count towards the minimum two per cent. However, practices will need to ensure that over the financial year the register covers at least an average of two per cent of the practice's registered adult patients. Therefore, should the circumstances of any patient change during the first six months of the year (e.g. the patient has died or moved practice), resulting in their removal from the register, practices will need to identify additional patients as soon as reasonably possible for the second half of the financial year to ensure the two per cent is maintained.

Where a practice fails to deliver at least an average of two per cent across the financial year, payments can be reclaimed (see payment and validation).

5. Practices will need to ensure that they manage any in-year risk associated with changes in practice list size. In exceptional circumstances which temporarily lead to the register falling below the tolerance, commissioners and practices will need to discuss and review the situation.
6. The practice will undertake monthly reviews of the register to consider any actions which could be taken to prevent unplanned admissions of patients on the register e.g. the reviews may consider whether those patients requiring MDT input are receiving it, or whether the practice is receiving appropriate feedback from the district nursing team.
7. Practices will be required to inform relevant patients that they are eligible to join the programme and what they can expect from being part of this ES. Where a patient has declined participation in this ES, they should not be included on the register (or removed from the register, if added before the patient declined, using the appropriate code).

An example of a template letter/email or patient leaflet that could be used by practices (if desired), is available (Annex C).

8. Patients on the register from the previous year will already have been notified of their named accountable GP and where applicable, their care co-ordinator

⁷⁰ Children on the case register will not be counted towards the minimum two per cent as detailed in the payment and validation section.

⁷¹ This only applies to one six month period. Any patients claimed for in the first six month period would need to be replaced in the second six month period.

and need not be informed again unless there have been any changes⁷². Any new patients coming onto the register in-year should be notified⁷³ within 21 days.

9. The practice will implement proactive case management for all patients on the register. This will include, where accepted by the patient, developing collaboratively with the patient and their carer (if applicable) a written/electronic personalised care plan, jointly owned by the patient, carer (if applicable) and named accountable GP and/or care co-ordinator. If the patient consents, the personalised care plan should be shared with the MDT and other relevant providers. Personalised care plans should be developed and agreed with any new patients coming onto the register in year within a reasonable timeframe, but no later than one month after entry onto the register.
10. The aim of proactive personalised care planning is to improve the quality and co-ordination of care given to patients on the register to improve their health and well-being. This should also aid in reducing individual risk of avoidable emergency hospital admissions, readmissions or A&E attendances.

A handbook on personalised care and support planning 'The principles of care planning'⁷⁴ has been developed by NHS England and the Coalition for Collaborative Care to help support implementation and provides useful examples for practices. Annex D and provide practices with information as to what good practice care planning would take into account.

11. Patients and carers (if applicable) should be invited to contribute to the creation of the personalised care plan. Members of the MDT⁷⁵ (when relevant) and other relevant providers could be invited to contribute to the creation of the personalised care plan. These contributions should inform both the holistic care needs assessment (e.g. to take into account social factors as well as clinical requirements) and the actions that can be taken as a result.
12. The personalised care plan should, where possible and through encouragement from the attending practitioner, include a recording of the patient's wishes for the future⁷⁶. It should identify the carer(s) and give appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family.

⁷² Practices should notify patients of any changes to their named accountable GP and care co-ordinator

⁷³ This can be done via email, letter or verbally.

⁷⁴ NHS England. Handbooks on personalised care planning.

<http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

⁷⁵ NHS England. Handbook. MDT development. <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

⁷⁶ NHS England document. Actions for End of Life Care. <http://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>

13. Clinicians, working with the patient and their carer (if applicable), to develop the personalised care plan should use their clinical judgement as to what information would be helpful for proactive management of the patient's condition(s) in combination with what the patient and carer would find helpful for managing their condition(s). The following list provides an example of what information a personalised care plan could include:

- patient's name, address, date of birth, contact details and NHS number
- notification if the patient is a nursing or care home resident
- details of the patient's named accountable GP and care co-ordinator (if this is different to the named accountable GP)
- details of any other clinician(s) who play(s) a significant role in the patient's care relating to their specific condition(s) e.g. diabetic lead clinician, respiratory nurse, Macmillan nurse etc.
- confirmation/details of consent given for information sharing, including if a patient has given permission for a practice to speak directly to their carer(s)
- names and contact details of the patient's next of kin/main carer/responsible adult, if applicable
- details of the patient's condition(s) and significant past medical history
- details of any ongoing medication the patient is prescribed (this may also include over the counter (OTC) medicines, if relevant) and plans for review
- allergies
- details of any individual requirements or preferences which will aid the care and support of the individual
- details of goals and actions that are important to the individual and that they can work towards themselves e.g. steps they can take to self-manage and any help they may need with this
- key action points, for example early detection of impending deterioration with an agreed plan for escalating care, including crisis management
- where possible and as appropriate, signatories of the named GP/care co-ordinator, patient and/or carer.

14. The patient's care and personalised care plan should be reviewed at agreed regular intervals with them and if applicable, their carer. Where a patient has had no contact with any member of the MDT within the last three months, it is good practice for the practice to make contact and review whether that patient's care is in line with their needs. Clinician(s) should look at the patient's personalised care plan to ensure that it is accurate and is being implemented, making any changes as appropriate and agreeing these with the patient and where appropriate, the carer. Patients who remain on the case management register from the previous year, will need to have at least one care review, including a review of their personalised care plan, during 2015/16. In some instances, the review may be as a result of a social issue, which could require the assistance of the named accountable GP or care co-ordinator (if applicable)

to link with the right people in the MDT or as an area for commissioning or design improvement. Practices will be required to use the Read2 or CTV3 codes (see monitoring section) to record when a patient's care plan has been reviewed.

15. The development of personalised care plans should follow good medical practice, taking account of the information contained in this guidance and the information contained in the NHS England handbook on personalised care planning and support⁷⁷. The handbook includes case studies and examples of care plans. The practice will be responsible for ensuring information governance requirements are met.
16. Where a patient has had a review undertaken by a member of the MDT (i.e. outside of their practice), then the professional having conducted the review must inform the practice and the patient's record must be updated by the practice. CCGs will need to ensure, through their commissioning relationships with the organisations that work with the practice, that they inform the practice that a review has been undertaken.
17. The named accountable GP will be responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP). They will also maintain overall accountability for ensuring that the personalised care plan is being delivered and patient care, including the personalised care plan, is being reviewed as necessary.
18. The care co-ordinator for the patient (appointed by the named accountable GP, unless they plan to undertake this role themselves) will act as the main point of contact for the patient. They are responsible for overseeing care for the patient, that the care plan is being delivered and that the patient and/or carer (if applicable) is informed of and agrees any changes as required to their personalised care plan.

They will also keep in contact with the patient and/or their carer (if applicable) at agreed intervals. In the event the named accountable GP is also the care co-ordinator, then they will be required to undertake all responsibilities for both roles. Where elements of a patient's care or personalised care plan, provided by professionals outside of the practice, are not being delivered then the named accountable GP or care co-ordinator (if applicable) will be required to raise this accordingly with the relevant organisation(s) and ensure that all those involved are clear in their roles and responsibilities with respect to the patient's care and personalised care plan.

⁷⁷ NHS England. Handbooks on personalised care planning.
<http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

Reviewing and improving the hospital discharge process

1. The practice will ensure that when a patient on the register, or newly identified as vulnerable, is discharged from hospital, attempts are made to contact them by an appropriate member of the practice or community staff in a timely manner to ensure co-ordination and delivery of care. This would normally be within three days of the discharge notification being received, excluding weekends and bank holidays, unless there is a reasonable reason for the practice not meeting this time target (e.g. the patient has been discharged to an address outside the practice area or is staying temporarily at a different address unknown to the practice). A code has been identified for practices to use to record when a patient has had an emergency admission. This information will be used for management information purposes only.
2. The practice will share any whole system commissioning action points and recommendations identified as part of this process with the commissioner, to help inform commissioning decisions. Information shared with the CCG is in order to help CCGs work with hospitals to improve planning for discharge and to improve arrangements for hospital/practice handover at point of discharge.
3. CCGs are encouraged to support admission alerts for practices so they can support proactive care planning between the hospital and relevant community based services, particularly for patients flagged as high risk. Proactive sharing of information can help practices co-ordinate and prepare for discharge and improve communication between named clinicians.

Internal practice review

1. The practice will be required to regularly review emergency admissions and A&E attendances of their patients from care and nursing homes (i.e. to understand why these admissions or attendances occurred and whether they could have been avoided). The reviews should take place at a regular interval deemed appropriate by the practice, in light of the number of emergency admissions or A&E attendances by these patients. During the review, the practice should give consideration to whether improvements can be made to processes in care and nursing homes, community services, or practice availability or whether any individual care plans need to be reviewed with the patient and carer (if applicable).
2. Where a practice has a large proportion of their patients in care and nursing homes, it should focus its reviews on any emerging themes from a sample of patients and on any patients who have regular avoidable admissions or A&E attendances. Practices will be required to agree this with its commissioner at the start of the year. In some circumstances, this may require different arrangements to be made locally to support these practices in undertaking this requirement. Examples of 'local arrangements' may include, but are not limited to, support from the CCG to co-ordinate this or support through a care home

community based service.

3. The practice will undertake monthly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the register⁷⁸. Practices should give consideration to including any other registered patients on the register for this service who frequently have unplanned admissions or A&E attendances. During the reviews, the practice will give consideration to:
 - the practice's processes
 - identifying factors, within the practice's control, that could have avoided the admission(s), readmissions and A&E attendances
 - rectifying any deficiencies in the patient(s) personalised care plan(s)
 - amending or improving the hospital admission and discharge processes; and
 - identifying factors outside the practice's control, including any system gaps in community and social care provision and either resolving them (if within the practice's control) or raising them with the commissioner as appropriate.
4. The practice will ensure that any serious incidents are reported to the commissioner and CCG (if the CCG is not the commissioner of the ES) both as and when they occur.

Patient survey

Subject to the outcome of a feasibility study (currently underway), practices may be required to survey patients on the case management register using a nationally developed and provided survey questionnaire. The practice would be provided with all printed materials and postage (if applicable), and would only be required to identify the correct patients within the identified two per cent cohort and to either send it out or give it to them (exact method to be confirmed). Final survey details would be subject to the outcome of a feasibility study. In the event the survey does go ahead, then funding of £500,000 will be available to support practices in implementing the survey.

DATA

Commissioners will need to ensure the provision of timely practice level data on admissions and hospital discharges (as well as anonymous benchmarking data for comparison) to their practices. This may require commissioners and/or CCGs (if not the commissioner of the ES) to review their arrangements for the provision of data, to ensure appropriate support for practices.

Monitoring

The practice will complete a reporting template on a biannual basis, no later than the 31 October 2015 and 30 April 2016 respectively. The reporting template will be for submission to the commissioner and CCG (if not the commissioner of the ES). The

⁷⁸ This applies to all patients on the practice's registered list.

final end year report (i.e. the second report) should take account of the entire year and is due for submission to the commissioner on or before 30 April 2016. A national reporting template has been developed and sets out the minimum reporting requirements (Annex E). The reporting template is designed to assess the practice's performance against the five key requirements of the scheme:

- practice availability
- proactive case management and personalised care planning
- reviewing and improving the hospital discharge process
- internal practice review, taking account of both internal and external practice processes
- patient survey (subject to feasibility study).

Additionally the practice may also be required, on an exceptional basis, to participate in peer reviews relating to assessment of the practice's implementation of this ES. This would only apply where there were concerns regarding a practice's performance in adhering to the terms of this ES. It is recommended that in this instance, the Local Medical Committee should be involved.

Practices will be required to manually input numerical data into CQRS, until GPES⁷⁹ is available to conduct electronic data collections. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC website⁸⁰.

Practices will be required to manually submit data to support claims for achievement reporting and associated payment claims. Data will be collected on:

- the number of patients on the case management register
- the number of patients on the register who have/have not been informed of their named accountable GP
- the number of new patients on the register who have had a personalised care plan agreed with the practice
- the number of patients on the register who have declined a personalised care plan with informed dissent⁸¹
- the number of patients on the register who have no record of a personalised care plan or declining a personalised care plan
- the number of patients on the register who have had/have not had care review(s)⁸² (including a review of their personalised care plan); and
- the number of patients on the register who have a record of an emergency hospital admission.

⁷⁹ Details as to when GPES becomes available to support this service will be communicated via the HSCIC.

⁸⁰ HSCIC. <http://systems.hscic.gov.uk/cqrs/participation>

⁸¹ These would be patients who agree to be on the case management register to receive benefits from the service but have, post a discussion, declined to have a care plan.

⁸² Where a patient declines a care review, their initial care plan will become invalid and a declined code will need to be added to the patient record.

Where necessary, practices will be required to submit manual data relating to any patient who may have been on the case management register but who died or moved practice prior to 30 September 2015 and 31 March 2016 respectively. This would be required where a practice has failed the minimum 1.8 per cent in each six month period and because the practice has not had reasonable time to replace the patient on the case management register or where the whole year register size falls below the minimum two per cent without taking account of these changes. Those patients claimed for in the first six month period under these circumstances cannot be counted in the second six month period and practices will need to find new patients for the case management register. Practices will be required to provide the commissioner with the following information, within two weeks of the deadline dates above, relating to each patient being claimed for:

- the patient's NHS number
- the patient's date of registration with the practice (where known)
- the patient's date of death
- evidence that the patient was informed of their named accountable GP
- and evidence that a personalised care plan had been developed (see payment and validation).

Where a practice registers a new patient in one of the six month periods who had been on the case management register at their previous practice, the patient will only count in the new practice if the care plan is re-discussed with the patient and where applicable their carer. The data collection will therefore search for a care plan code post the date of registration for this patient to be counted.

The manually submitted data from each six month period and automatically collected data from each six month period will be combined to calculate achievement for the component two and three payments respectively (see payment and validation section). Manual data will only count once, for the relevant six month period it was submitted to support. Practices will also be required to complete the relevant sections of the reporting template (Annex E) to confirm that all requirements have been met to date.

The data collected on the number of patients on the register, number of patients informed of their named accountable GP and number of patients with developed, reviewed or declined personalised care plans will be used as key performance indicators. If all three of these are achieved then payments will be triggered. Where required, manually submitted data will also be taken into account in determining if these three key performance indicators have been met. Commissioners will also need to ensure the other requirements of the service have also been met (see payment and validation).

Practices will be required to use the relevant Read2 and CTV3 codes as published in the supporting Business Rules on the HSCIC website. The 'Technical requirements'⁸³ document lists the Read2 and CTV3 codes relevant for this service. The Read2 and CTV3 codes will be used as the basis for the GPES collection, which

⁸³ NHS Employers. 2015/16 technical requirements. <http://www.nhsemployers.org/GMS201516>

will allow CQRS to calculate payment based on the aggregated numbers supplied and support the management information counts. Although practices will be required to manually enter data until GPES is available, it is required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting Business Rules will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and, if necessary, re-code patients as required.

Where a CCG is not the commissioner of the ES, they will be involved in supporting practices to deliver this ES.

Payment and validation

Commissioners will invite practices to participate in this ES before 30 April 2015. Practices wishing to participate will be required to sign up to this service by no later than 30 June 2015. Practices signing up to this service will be signing up to all three components.

The total funding available for this ES is £162 million⁸⁴.

The payments will be based on a maximum of £2.87 per registered patient. Table 1 provides full details of what payments can be expected for fully achieving the requirements of the ES. For the purposes of payments, the contractor's registered population (CRP) will be as at 1 April 2015 or be the initial CRP if the practice's contract started after 1 April 2015. A practice with an average list size of 7087 would receive payments of £20,339.69 for delivering the ES in full.

Payment under this ES for 2014/15 will be made in five components:

- **Component One** – an upfront 'establishment' payment of 46 per cent
- **Component Two** – quarter two register payment of 27 per cent (subject to achieving all of the following requirements):
 - i. For maintaining the register at a minimum of two per cent for the first half of the year (i.e. 1 April 2015 to 30 September 2015). Achievement of this component will be determinant on practices having a minimum of 1.8 per cent⁸⁵ of patients on the register on 30 September 2015 as a proportion of the list size taken on the 1 April 2015.
 - ii. For identifying the named accountable GP and care co-ordinator (if applicable) and informing any new patients added to case management register.
 - iii. For developing personalised care plans⁸⁶ for any new patients on the case management register or, for all patients already on the register undertaking at least one care review in the last 12 months. The

⁸⁴ This figure could be increased by £500,000 to support the patient survey if implemented.

⁸⁵ This takes into account the -0.2 per cent tolerance.

⁸⁶ Including those patients who have declined a care plan with informed dissent but still wish to remain on the case management register to benefit from other aspects of this ES.

- development or review of care plans will be undertaken with the patient and where applicable their carer.
- iv. For implementing or continuing a system for same day telephone consultations for patients on the case management register with urgent enquires.
 - v. For specifying and using the practice's ex-directory or by-pass telephone number.
 - vi. For reviewing and improving the hospital discharge process for patients on the case management register, including attempting to contact these patients, by an appropriate member of the practice or community staff, in a timely manner to ensure co-ordination and delivery of care.
 - vii. For undertaking regular practices reviews of emergency admissions and A&E attendances of all their registered patients in care and nursing homes, as well as undertaking monthly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the case management register.
 - viii. For participating in the survey⁸⁷.
- **Component Three** – quarter three register payment of 27 per cent (subject to achieving all of the requirements):
 - i. For maintaining the register at a minimum of two per cent for the second half of the year (i.e. 1 October 2015 to 31 March 2016). Achievement of this component will be determinant on practices having a minimum of 1.8% of patients on the register on 31 March 2016 as a proportion of the list size taken on the 1 October 2015.
 - ii. See component two ii to vii for requirements.

Practices will need to ensure that they manage any in-year risk associated with changes in practice list size. In exceptional circumstances, which temporarily lead to the register falling below the tolerance, commissioners and practices will need to discuss and review the situation.

The component one payment will be payable on the 31 July 2015.

The component two payment will be payable no later than 30 November 2015 subject to the practice delivering the minimum requirements of the ES. Payment will be triggered on the basis that the practice has a minimum of 1.8 per cent of patients on the register on 30 September 2015 as a proportion of the list size taken on the 1 April 2015 who have been informed of their named accountable GP and who have had in the last 12 months either a care plan developed or a care plan reviewed or a care plan declined⁸⁸. This will be determined from manually submitted data and automated data collections. Commissioners will also be required to check that the other requirements listed under component two payment are being delivered.

⁸⁷ Subject to feasibility study and survey being implemented.

⁸⁸ Payment will only be triggered if each of these requirements are met and information is supplied in support of the other requirements attached to each component.

The component three payment will be payable no later than 31 May 2016 subject to the practice delivering the minimum requirements of the ES. Payment will be triggered on the basis that the practice has a minimum of 1.8 per cent of patients on the register on 31 March 2016 as a proportion of the list size taken on the 1 October 2015 who have been informed of their named accountable GP and who have had in the last 12 months either a care plan developed or a care plan reviewed or a care plan declined⁸⁹. This will be determined from manually submitted data and automated data collections. Commissioners will also be required to check that the other requirements listed under component three are being delivered.

While there is an accepted tolerance of -0.2 per cent in each six month period, practices will need to ensure that across the financial year, their register maintains at least an average of two per cent of the eligible cohort. This will be calculated by taking an average of the percentages in each six month period (i.e. first six months % + second six months % divided by two), calculated as described above in this section i.e. based on the list taken at 1 April 2015 and 1 October 2015 respectively. If there are exceptional circumstances which lead to the average not being maintained, commissioners and practices will need to discuss and review the situation.

Practices can submit a manual claim, relating to patients who have died or moved practices, if they have not achieved the minimum 1.8 per cent in each six month period. This would only apply if the practice was unable to replace these patients on the case management register within a reasonable timeframe and any patient claimed for in the first six month period cannot be counted again in the second six month period. Practices will be required to submit the relevant information described under the monitoring section in support of any manual claims, within two weeks of 30 September 2015 and 31 March 2016 respectively.

A practice that registers new patients in-year who have been on a case management register at their previous practice will only count towards the minimum two per cent if their care plan is re-discussed with the patient and carer.

CQRS will calculate all payments.

Table 1: Summary of payments, amounts and payment due dates

Payment	Percentage of total funding	Per registered patient (total £2.87)	Payable (no later than ⁹⁰)
Component 1	46%	£1.33	31 July 2015
Component 2	27%	£0.77	30 November 2015
Component 3	27%	£0.77	31 May 2016

⁸⁹ Payment will only be triggered if each of these requirements are met and information is supplied in support of the other requirements attached to each component.

⁹⁰ Payment by this date is subject to all elements of the payment process being delivered in time, including the practice supplying any manually submitted data to the commissioner.

In the event a practice does not achieve components two and three and maintain the case management register at least an average of two per cent of the eligible patient cohort across the financial year, then in accordance with table 2 the commissioner will not be required to make payments or will be able to claw back payments made. Any claw back of payments will be made at the end of the financial year.

Table 2: Scenarios for action to be taken in the event a practice does not deliver all⁹¹ requirements under this ES

Scenario	Component 2	Component 3	Register	Action
A	Y	Y	Y	Pay components 2 & 3. Practice keeps component 1 payment
B	Y	Y	N	Pay components 2 & 3, commissioner claws back 40% of component 1 (in line with 14/15 claw back on failing register across the year)
C	Y	N	Y	Pay component 2, do not pay component 3. Commissioner claws back 20% of component 1
D	Y	N	N	Pay component 2, do not pay component 3. Commissioner claws back 40% of component 1
E	N	Y	Y	Do not pay component 2, pay component 3. Commissioner claws back 20% of component 1
F	N	Y	N	Do not pay component 2, pay component 3. Commissioner claws back 40% of component 1
G	N	N	N	Do not pay component 2 or 3. Practice is required to demonstrate they have delivered the ES requirements (named GP and personalised care plans) to a minimum 25% of 2% register, as well as undertaking the other requirements in the ES. If the practice can demonstrate this,

⁹¹ If there are exceptional circumstances which lead to a practice not achieving one element of each component and the reason for doing so can be justified, then the commissioner and practice will need to discuss and review the situation.

Scenario	Component 2	Component 3	Register	Action
				<p>commissioner claws back 21% of component 1.</p> <p>If the practice cannot demonstrate this, commissioner claws back entire component 1 payment (46%).</p>

Commissioners will be responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this ES. Commissioners may make use of the information received or extracted.

Where required, practices must make available to commissioners any information they reasonably require and that the practice can reasonably be expected to obtain, in order to establish whether or not the practice has fulfilled its obligation under the ES arrangements.

Extended hours access

Background and purpose

There is evidence to suggest that while the majority of patients rate all aspects of GP services positively they want more convenient access to appointments. This ES was designed to secure access to routine appointments at times outside of practices core contracted hours to allow patients to attend the practice at a time when it is more convenient for them (e.g. at weekends, early mornings and evening).

Requirements

Requirements for practices under 2015/16 ES Directions.

The requirements for practices participating in this ES in 2015/16 are as follows:

- i. **The provision of additional clinical sessions (routine appointments including emergency appointments), provided outside of core contracted hours.** For GMS practices, core hours are from 08:00 to 18:30 and for PMS it is the core hours as set out in their contract. For some PMS (and APMS) practices, core hours may already include opening at times outside this period.
- ii. **Opening hours for providing those routine appointments must be in line with patient expressed preferences**, either through the GP patient survey or through preferences expressed through patient participation groups (PPGs), the friends and family test (FFT) or other recorded feedback.
- iii. **The additional period of the routine appointments provided by the practice must, as a minimum, equate to weekly extended hours access of 30 minutes per 1,000 registered patients**, calculated using the following formula:
$$\text{additional minutes}^* = \text{a practice's CRP}^{**} \div 1000 \times 30$$

*convert to hours and minutes and round, either up or down, to the nearest quarter hour

**Contractor registered population (CRP) will be determined at the start of the first quarter during which extended opening begins for individual practices.
- iv. **Routine appointments must be provided by the practice in continuous periods of at least 30 minutes** and may be provided in a manner which is line with patient expressed preferences i.e. face-to-face, telephone consultations, using other technology or a mixture of these methods.
- v. **Extended hours access must be provided on a regular basis in full each week** including providing sickness and leave cover and should also ensure that its patients are aware of any cancellation of extended hours sessions, which should normally be discussed and agreed with NHS England in advance, including arrangements for re-provision.
- vi. **Where a practice provides OOH services, it must not limit access to any of these clinical sessions** to those patients it would have been obliged to see anyway

under the OOH arrangements. In general, this should be a matter for the practice to manage and communicate to its patients.

Further options

Practices can deliver for their own practice solely or choose to offer as a group of practices.

For example three practices currently each provide 3 x 1 extended hours sessions throughout the week with poor utilisation but stated patient preference for weekend opening, practice plans submitted propose instead 1 x 3 hour session on a Saturday morning with each practice delivering the service on a rotational basis whether delivered from the premises of each practice or from a common location e.g. practice convenient to most patients.

Routine appointments can be offered with all clinical practice staff⁹², not just those registered with appropriate professional bodies, i.e. health care assistants working under supervision and alongside appointments with healthcare professionals (e.g. where there is patient preference for such appointments).

Process/Requirements for Commissioners

Commissioners are required to ensure that all practices have the opportunity to enter into an extended hours access scheme under this ES (or a scheme under local arrangements offering at least the minimum requirements of this ES).

Commissioners will not accept or remunerate any practice proposals for any period of extended access hours which is currently covered by the core hours set out in their contract.

Commissioners and practices will need to continue to take into account results from the latest GP patient survey and PPG views, including those resulting from participating in the patient participation ES when agreeing extended opening hours.

During core contracted hours, existing standards of access and availability should be maintained. NHS England should continue to support all practices in ensuring that they are meeting the reasonable needs of patients during core hours.

Offer of extended hours access under this ES and time limits

Commissioners must, by 30 April 2015 offer to all existing practices under their contractual arrangements the opportunity to enter into this ES under the 2014 ES Directions. Where reasonably practicable, commissioners must, after considering and agreeing to practices' proposals (see section on practice proposals) enter into

⁹² With regard to sessions provided by healthcare assistants, Directions say: "the arrangements must include the provision of a specified number of clinical sessions, provided by a registered health care professional or by another person employed or engaged by the contractor to assist that health care professional in the provision of primary medical services under the contract"

these arrangements with practices no later than 1 July 2015⁹³. Commissioners are not required to enter into extended hours access arrangements under this ES after 30 June 2015, except in exceptional circumstances as set out below. However, the commissioner retain the discretion to do so if they wishes.

There are exceptions to the time limit mentioned above, if the following conditions are met:

- that the practice has not provided commissioners with its proposals to participate in this ES before 1 July 2015
- commissioners offered the practice the opportunity to participate in the ES but did so with less than 28 days to elapse before 30 June 2015
- the practice has provided commissioners with its written proposals to participate in the ES within 28 days of the commissioner offer.

If all of the above conditions are met, then commissioners must after the 30 June 2015, consider the practice's proposals. This will be with a view to agreeing them and entering into arrangements with the practice to deliver extended hours access under this ES.

Agreements under this ES are effective up to and including 31 March 2016.

The SFE details the arrangements for managing practice mergers and splits and commissioners and practices should consult here for managing practical proposals, etc in such circumstances.

Commissioner consideration of practice proposals

Commissioners are obliged to consider any proposals for the arrangements of extended hours access put forward by a practice in accordance with the time limits and exceptions explained under the offer of extended hours access under this ES and time limits' section. This consideration should not be delayed unreasonably nor should commissioner agreement to such proposals be unreasonably withheld. In making the decision, consideration should be given to local circumstances such as patient preferences and relevant guidance.

Consideration does not have to be given, nor do decisions have to be made where:

- a. The practice has not submitted a written proposal within 28 days of the commissioner offer to enter into an arrangement under the 2014 DES Directions; or
- b. The practice has not provided any information requested by commissioners in order to make a decision as to whether the proposal to enter into arrangements under the 2014 DES Directions meets its requirements.

⁹³ It may be the case that the GP practice has made its written proposals within the time limits but commissioners seek clarification on certain issues. If this is the case, the practice retains the right to enter into the DES (subject to commissioners agreeing the terms of the proposals) after 30 June 2014.

Monitoring

The practice must co-operate with commissioners in reviewing the arrangements to establish whether the pattern of additional hours is meeting the requirements of its patients. For example, to establish whether a practice is still meeting patients' needs, consideration may be given to the results of the most recent patient surveys. Both the commissioner and the practice should ensure that they fully understand how demand from patients might change at times over the course of the agreement e.g. a practice may wish to alter its extended opening hours following results from a local patient survey and/or discussions with its patient reference group.

The arrangements entered into under this ES must set out the requirements for a practice to provide commissioners with information that is reasonably necessary for the running of the arrangements. In agreeing these requirements, both parties may wish to have regard to the principles in the Code of Practice on Confidentiality and Disclosure of Information and its requirements.⁹⁴

The arrangements entered into under this ES must set out the arrangements by which commissioners will monitor performance and delivery of the provision of services under the scheme. This may include doing so through NHS Choices.

The arrangements entered into under the ES must set out the arrangements for the practice and commissioner to ensure that patients are aware of the availability of extended hours access. The practice should promote and publicise details of the days and times of its additional clinical session(s), e.g. on the NHS Choices website, the practice website, on a waiting room poster or by writing to patients. This should also be included in the practice leaflet.

Commissioners should also consider how best to communicate extended hours access to their local populations by publicising information to help patients identify which practices are offering appointments at given times. This may include using local media or making information available in places such as NHS premises, libraries or community facilities.

Payment and validation

Payments to practices in respect of services provided under the ES will be made by commissioners in accordance with Section 7 of the SFE.

Extended hours access payments will be calculated at the start of the service provision either for the full financial year or for the remainder of the financial year during which the service commences. A practice offering extended hours access under this ES will be paid £1.90 per registered patient (CRP) per annum. Where the service provision commences in year then the payment will be made on a pro-rata basis for the number of days remaining in the relevant financial year.

Payments will be made in quarterly instalments, payable on the last day of the

⁹⁴

http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/en/publicationsandstatistics/publications/publicationslegislation/dh_4107306

quarter until 31 March 2016. Payments are only payable in respect of periods during which the service is provided. The following conditions are applicable to any payments:

- the practice makes available information which the commissioner does not have but reasonably requires and that the practice either has or could reasonably be required to obtain, in order to establish that the practice has fulfilled the requirements of the scheme
- the practice makes any returns required of it (either computerised or otherwise) to the Exeter Registration System and do so promptly and fully.

All information supplied in respect of these points should be accurate.

Where there is evidence that routine appointments are consistently underutilised, the commissioner may decide to decommission the service at that practice. Where this decision has been taken, the commissioner will communicate this, in writing to the practice, giving the agreed notice period.

If the practice breaches any of the above conditions, then the commissioner may, in appropriate circumstances withhold payment.

In the case of PMS practices, the scheme must set out the payment arrangements. These must reflect the provisions in the SFE (which will already apply to GMS practices).

No payment will be made for any period of extended access hours which is currently covered by the core hours set out in their contract.

When required, practices must make available to commissioners information they reasonably require and that the practice can reasonably be expected to obtain, in order to establish whether or not the practice has fulfilled its obligation under the ES arrangements.

The SFE⁹⁵ sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in these directions.

⁹⁵ This will be available at www.nhsemployers.org/GMS201516

Other issues relevant to extended hours access

Special clinics

Special clinics (e.g. such as flu clinics) cannot be counted as the extended hours access period as they do not provide for routine consultations. Such clinics may be run concurrently to routine consultations.

Non-NHS work

Practices should not use extended opening hours to deliver non-NHS work.

Safety and security

In developing arrangements for extending opening hours, commissioner and practices should consider how identified risks to safety and security of both practice staff and patients could be mitigated as a consequence of the arrangements entered into under this ES.

Religious and cultural sensitivities

When agreeing opening times and days of opening under the arrangements for extended opening hours, commissioners should be sensitive to the religious and cultural requirements of both the practice staff and its patients.

Disputes - conciliation, arbitration and appeals

In the event of disagreement or dispute, commissioners and practices will be expected to use their best endeavours to resolve the dispute without recourse to formal arbitration. If unsuccessful, the matter will be determined in accordance with the normal contractual dispute resolution process.

Commissioning other services

When commissioning extended opening hours, commissioners should consider whether there is a need to review the commissioning of other services e.g. pharmacy, diagnostic and pathology services as well as out-of-hours services. When the opening hours of practices are extended, there is likely to be a change in the pattern of demand for these services. Demand may fall at some times as well as rise during the extended hours period. Commissioners may wish to discuss with its Clinical Commissioning Groups whether there is a need to review the commissioning of these services.

Discussions with Local Medical Committees (LMCs)

Commissioners may wish to discuss with any relevant LMCs any plans it has for arrangements for offering extended opening hours to its patient population.

Facilitating timely diagnosis and support for people with dementia

Background and purpose

Improving diagnosis and care of patients with dementia has been prioritised by the Department of Health (DH) through the NHS Mandate and by NHS England through its planning guidance for CCGs. This ES is designed to encourage practices to take a proactive approach to the timely assessment of patients who may be at risk of dementia.

For patients with dementia, their carer(s) and families, the benefits of timely diagnosis and referral will enable them to plan their lives better, to provide timely treatment if appropriate, to enable timely access to other forms of support and to enhance their quality of life.

Introduction

The aims of this ES are to encourage practices to identify patients at clinical risk of dementia, offer an assessment to detect for possible signs of dementia in those at risk, offer a referral for diagnosis where dementia is suspected and where a referral is considered appropriate by the GP and in the case of a diagnosis, provide advanced care planning in line with the patient's wishes. The ES also aims to increase the health and wellbeing support offered to carers of patients diagnosed with dementia.

A system-wide integrated approach is needed to enable patients with dementia and their families to receive timely diagnosis and to access appropriate treatment, care and support. National tools and levers available to support local system-wide improvements include:

- a national dementia calculator to support practices to understand prevalence of dementia in their registered population
- a national Commissioning for Quality and Innovation (CQUIN) scheme for all health care services commissioned through the NHS Standard Contract, to incentivise case finding, prompt referral on to specialist services for diagnosis and support, as well as improved dementia care in hospitals
- commissioning guidance for memory assessment services produced by the Royal College of General Practitioners⁹⁶ (RCGP)
- the Royal College of Psychiatrists' Memory Services National Accreditation Programme⁹⁷.

⁹⁶ RCGP. Dementia. <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/dementia.aspx>

⁹⁷ RCP. Memory Services National Accreditation Programme.

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/memoryservices/memoryservicesaccreditation.aspx>

This ES is designed to support practices in contributing to these system-wide improvements by supporting timely diagnosis, supporting individuals and their carers and integrated working with health and social care partners.

Service requirements

This ES is for one year from 1 April 2015.

Commissioners will seek to invite practices to participate in this ES before 30 April 2015. Practices who participate in this ES should respond to the commissioner offer within 42 days. The agreement should be recorded in writing with their commissioner by 30 June 2016.

Participating practices are also required to sign up to CQRS and GPES. Further guidance relating to CQRS and GPES will be provided by HSCIC when services are updated⁹⁸. Further information is provided in the document Technical Requirements for 2015/16 GMS Contract Changes ⁹⁹

The requirements for this ES are:

- A. The practice undertakes to make an opportunistic offer of assessment for dementia to 'at-risk' patients on the practices registered list, where the attending practitioner considers it clinically appropriate to make such an offer. Where an offer of assessment has been agreed by a patient then the practice is to provide that assessment. For the purpose of this ES, an opportunistic offer means an offer made during a routine consultation with a patient identified as 'at risk' and where there is clinical evidence to support making such an offer. Once an offer has been made, there is no requirement to make a further offer during any future attendance, but it is expected that attending practitioners will use their clinical judgement in response to any concerns raised by the patient or their carer.
- B. For the purposes of this ES, 'at-risk' patients are:
 - patients aged 60 and over with cardiovascular disease, stroke, peripheral vascular disease or diabetes
 - Patients who are over 60 and have a 'high-risk' of CVD, for instance because of smoking, alcohol consumption or obesity
 - Patients who are over 60 with a COPD diagnosis
 - patients aged 40 and over with Down's syndrome
 - other patients aged 50 and over with learning disabilities
 - patients with long-term neurological conditions which have a known neurodegenerative element, for example Parkinson's disease.

These assessments will be in addition to other opportunistic investigations carried

⁹⁸ HSCIC. GPES. <http://www.hscic.gov.uk/gpes>

⁹⁹ NHS Employers. Technical requirements for 2015/16 GMS contract changes. <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

out by practices for whom the attending practitioner considers to have a need for such investigations (i.e. anyone presenting raising a memory concern).

- C. The assessment for dementia offered to at-risk patients shall be undertaken only following the establishment of patient consent to an enquiry about their memory.
- D. The assessment for dementia offered to consenting at-risk patients shall be undertaken following initial questioning (through appropriate means) to establish whether there are any concerns about the attending patient's memory (GP, family member, the person themselves).
- E. The assessment for dementia offered to consenting at-risk patients for whom there is concern about memory (as prompted from initial questioning) shall comprise administering a more specific assessment (where clinically appropriate¹⁰⁰) to detect if the patient's cognitive and mental state is symptomatic of any signs of dementia, for example the General Practitioner assessment of Cognition (GPCOG) or other standardised instrument validated in primary care.
- F. The analysis of the results, for the assessment to detect dementia, is to be carried out by healthcare professionals with knowledge of the patient's current medical history and social circumstances.
- G. If as a result of the completed assessment the patient is suspected as having dementia the practice should:
 - offer a referral, where a referral is considered appropriate by the GP and where this is agreed with the patient or their carer, to specialist services such as a Memory Assessment Service or Memory Clinic for a further assessment and diagnosis of dementia
 - respond to any other identified needs arising from the assessment that relate to the patient's symptoms
 - provide any treatment that relates to the patient's symptoms of memory loss.
- H. Patients diagnosed as having dementia will be offered an advanced care planning discussion focussing on their physical, mental health and social needs and including, where appropriate, referral/signposting to local support services.
- I. The advanced care plan should, where possible and through encouragement from the attending practitioner, include a recording of the patient's wishes for the future. It should identify the carer(s) and give appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family. For the purpose of this service, 'carer' will apply to a person - usually a family member or friend - who takes responsibility for the patient's care needs but will not include professional carers who

¹⁰⁰ It is recognised that in some cases (i.e. for people with severe learning disabilities) such a test may not always be appropriate. Further guidance on the assessment of dementia in people with learning disabilities has been produced by the RCP and the British Psychological Society. Dementia and People with Learning Disabilities. <http://www.rcpsych.ac.uk/files/pdfversion/cr155.pdf>

have been employed for this purpose by the patient or their representative.

- J. The advanced care plan should be shared with the patient and their carer(s), being reviewed on an appropriate basis.
- K. The practice will seek to identify any carer (as defined above) of a person diagnosed with dementia and where that carer is registered with the practice offer a health check to address any physical and mental health impacts, including signposting to any other relevant services to support their health and well-being.
- L. Where the carer of a patient, on a practice's register, who is diagnosed with dementia is registered with another practice, the patient's practice will inform the patient's carer that they can seek advice from their own practice.
- M. The practice will record in the patient record relevant entries including the required Read2 or CTV3 codes to identify where an assessment for dementia was undertaken, where applicable, that a referral was made and patients diagnosed, as well as whether or not an advance care planning discussion was given or declined. The practice will record in the carer record relevant entries including the required Read2 or CTV3 codes¹⁰¹.

Whilst payment is made for a completed assessment in accordance with paragraph E, commissioners and practices are reminded that the full requirements of this ES must be met, particularly paragraphs C and D before undertaking an assessment.

Monitoring/GPES collection

There are two payment counts for the service¹⁰². The management information counts will be outlined in the Technical Requirements document.

The payment counts are an upfront payment and an annual end year payment. The upfront payment is not supported by CQRS. The end year payment reflects the number of completed assessments (i.e. GPCOG) for registered patients, carried out per practice up to the end of the financial year as a proportion of the total number of assessments carried out nationally.

Practices will be required to manually input data into CQRS, on a quarterly basis, until such time as GPES¹⁰³ is available. The manual data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts. For information and communications on how to manually enter data into CQRS, please see the HSCIC website¹⁰⁴.

When GPES is available, each data collection will capture data relating to all counts and report on activities from the start of the reporting period e.g. 1 April 2015 to the

¹⁰¹ HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

¹⁰² The payment and management information counts are detailed in the technical requirements document.

¹⁰³ Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.

¹⁰⁴ HSCIC. <http://systems.hscic.gov.uk/cqrs/participation>

end of the relevant reporting quarter. The reporting quarter will be the quarter prior to the month in which the collection is run e.g. if the collection month is January 2016, the reporting quarter will be quarter three (October to December 2015). It is important to note that, when GPES takes a collects data for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. quarter end / year-end). For example, an annual collection would only include patients registered with the practice at the year end.

When data collections commence, GPES will provide to CQRS the quarterly counts from the relevant quarter they start in until the end of the relevant reporting quarter. Once CQRS has calculated the dementia payment at the end of the year, no automated collection will be received as the payment and management information cannot be overwritten.

The 'Technical Requirements'¹⁰⁵ document contains the payment counts, management information counts and Read2 and CTV3 codes¹⁰⁶ which are required for this service. The Read2 and CTV3 codes will be used as the basis for the GPES collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to manually enter data until such time as GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting Business Rules¹⁰⁷ will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes from the commencement of this service and re-code patients where necessary.

Supporting Business Rules will be published on the HSCIC website. Commissioners and practices should refer to these for the most up-to-date information on management information counts, Read2 and CTV3 codes.

Payment and validation

Commissioners will seek to invite practices to participate in this ES before 30 April 2015. Practices who participate in this ES should respond to the commissioner offer within 42 days. The agreement should be recorded in writing with their commissioner by 30 June 2016.

Practices participating in this programme are required to sign up to CQRS no later than 31 July 2015. Further guidance relating to CQRS and GPES will be provided by HSCIC when services are updated¹⁰⁸. Payments can only be processed after

¹⁰⁵ NHS Employers. Technical requirements for 2015/16 GMS contract changes. <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

¹⁰⁶Please note that the code descriptions in clinical systems may not exactly match the guidance text.

¹⁰⁷ HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

¹⁰⁸ HSCIC. GPES. <http://www.hscic.gov.uk/gpes>

commissioners have offered and practices have accepted a service on CQRS.

Total funding available for this ES is £42 million. Payments will be comprised of two components, with approximately half of the total funding available for each component.

Component 1 - An upfront payment of £0.37 per registered patient. For example, this represents a payment of £2622.19 to an average-sized practice with a registered population of 7087.

Payment will be made to practices by commissioners on the last day of the month following the month during which the practice agreed to participate in the ES (i.e. by no later than 31 July 2015).

CQRS and GPES will not support payment of component 1 of this service. Commissioners must make arrangements for this payment locally.

Component 2 - The remaining funding will be distributed as an end of year payment based on the number of completed assessments (i.e. GPCOG) (using the relevant code relating to 'assessment for dementia') carried out by practices during the financial year as a proportion of the total number of completed assessments carried out nationally under this ES.

The number of completed assessments carried out by practices individually and nationally will be based on returns to CQRS (automated via GPES or via a manual year end entry) identifying the number of completed assessment for consenting at-risk patients, using the Read2 or CTV3 code 'assessment for dementia'.

Example of component 2 payment calculation:

If GPES reports Practice A has 38 completed assessments for dementia during 2015/16 and nationally CQRS calculates that 250,000 assessments were carried out in 2015/16, then the end year payment is calculated as follows:

$$\frac{38}{250,000} \times £21,000,000 = £3,192$$

CQRS will be populated with data collected via GPES (or via manual entry if GPES is not available). The commissioner and practice will then have until a specified date (to be communicated in due course¹⁰⁹) to review and amend the data accordingly, with the aim of agreeing it is correct before the specified date. Commissioners should review with practices, the ratio of completed assessments compared to practice list size to detect for possible outliers and exceptions as these may be indicative of reporting or other problems.

At the specified date, CQRS will then calculate payments, based on the data

¹⁰⁹ HSCIC. GPES. <http://www.hscic.gov.uk/gpes>

entered. There will be no opportunity to amend data after the specified date.

Payments will then be made by commissioners accordingly. Payments made under this ES are to be treated for accounting and superannuation purposes as gross income of the practice in the financial year.

The commissioner will initiate the payment via the payment agency's Exeter system. Due to the nature of the payment mechanism for component 2, there will be no declaration and approval process for this service (apart from that required by commissioners and practice per the specified date as set out above).

Commissioners are responsible for post payment verification. In addition to verifying the payment count for number of patients who received a completed assessment, commissioners will use anonymous data collected by GPES (or equivalent data provided manually where necessary) and available through CQRS to verify that the full requirements of the service have been met, including:

- the number of patients being offered an initial assessment/questioning
- the number of patients referred to memory clinic for formal diagnosis where the disease is suspected
- the number of patients who have been diagnosed with dementia and offered an advanced care planning session
- the number of patients recorded as a non-professional carer of a person with dementia and where the carer is registered with the practice, who have been offered a health check.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the programme, as necessary, to demonstrate that the full protocol was followed.

This information could be available to support commissioners and practices, as an indicative check, through the management information counts as and when data collections via GPES are available. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

Where required, practices must make available to commissioners information they reasonably require and that the practice can reasonably be expected to obtain, in order to establish whether or not the practice has fulfilled its obligation under the ES arrangements.

The NHS England service specification¹¹⁰ sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when

¹¹⁰ <http://www.england.nhs.uk/commissioning/gp-contract/>

payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, where contract merge, split etc.).

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the Facilitating Timely Diagnosis and Support for People with Dementia service specification.

Learning disabilities health check scheme

Background and purpose

The government is committed to reducing the incidence of co-morbidities and premature deaths for people with learning disabilities (LD) and supports the recommendations from the Confidential Inquiry into premature deaths for people with learning disabilities (CIPOLD)¹¹¹.

This ES is designed to encourage practices to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which will include producing a health action plan. From the numbers currently on practice registers, it is estimated that approximately 240,000 patients fall into this category across the country. There is thought to be a total of 1.2 million people with learning disabilities currently living in England.

Requirements

The ES is for one year from 1 April 2015.

The requirements for taking part in the ES are as follows:

- the practice will establish and maintain a learning disabilities 'health check register' of patients aged 14 and over with learning disabilities. This should be based on the practice's QOF learning disabilities register (QOF indicator LD003) and any patients identified (and not already on the QOF LD register) who are known to social services
- the practice providing this service will be expected to have attended a multi-professional education session (training is mandatory for any new practices wishing to participate in this service and should be updated as the practice requires)
- the practice will invite all patients on the register for an annual health check and produce a health action plan.

Commissioners will invite practices to participate in this ES before 30 April 2015. Practices are required to respond to the commissioner offer within 42 days (otherwise the commissioner is not required to agree an arrangement with the practice for the financial year). The agreement should be recorded in writing by 30 June 2015¹¹².

Participating practices are also required to sign up to CQRS and GPES¹¹³. Further guidance and communications relating to CQRS and GPES will be provided by HSCIC when services are updated¹¹⁴.

Learning disability (LD) register

The practice will establish and maintain a learning disabilities 'health check register'

¹¹¹ University of Bristol CIPOLD: www.bris.ac.uk/cipold/

¹¹² This will be available at www.nhsemployers.org/GMS201516

¹¹³ Practices authorise data collection made by GPES when they accept a Quality Service on the CQRS system.

¹¹⁴ HSCIC. GPES. <http://www.hscic.gov.uk/gpes>

of patients aged 14 and over with learning disabilities. This should be based on the practice's QOF learning disabilities register (QOF indicator LD003)¹¹⁵ and any patients identified (not already on the QOF LD register) who are known to social services.

The practice should also continue to liaise with their local authority (LA) (or LAs where a practice has patients resident in more than one LA) to share and collate information. This is to ensure the register includes appropriate patients who are known to social services but who may not be included on the QOF LD register. This could be because the LA criteria for access to social care services are related to complexity of need, although sometimes individuals with mild learning disabilities and other additional health needs, usually associated with mental health needs, will meet social services eligibility criteria.

Where it has not proved possible to agree a current register with the LA, practices will be allowed to use the previous year's register which is to be agreed with their commissioner.

This ES requires the data to be in reasonable order to proceed with offering and delivering checks but recognises that the lists are subject to ongoing improvement. Practices will be required to confirm the count of patients on their learning disability health check register for the calculation of payments on CQRS. We would expect that most practices should have a learning disability prevalence of at least 0.5 per cent of their population.

Training

Multi-professional education sessions for primary healthcare staff should be established by commissioners (or CCG where the commissioner requests) and offered to primary healthcare staff. The training should be provided, as required, by the commissioners or CCG and/or members of the local community LD team (this may need to be commissioned via the local specialist NHS trust) in partnership with self-advocates and family carers (as paid co-trainers).

Commissioners or CCGs should use their internal procedures to approve the content of the training for their locality using this suggested framework:

- an understanding of learning disabilities
- identification of patients with learning disabilities and clinical coding
- understanding of the range and increased health needs associated with learning disabilities
- understanding of what an annual health check should cover (see health checks section)
- information that should be requested prior to an annual health check

¹¹⁵ [The register requires the use of Read codes detailed in technical requirements document which are in line with those used for the QOF LD register.](http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16) NHS Employers. Technical requirements for 2015/16 GMS contract changes. <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

- understanding what adjustments the practice might need to make to facilitate good uptake and access to the health check
- understanding of health action plans
- understanding and awareness of 1:1 health facilitation and strategic health facilitation
- ways to increase the effectiveness of health checks
- overcoming barriers including:
 - communication needs, such as for advocacy, communication support and / or tools or aids to facilitate communication
 - using accessible information and aids, including provision of correspondence and documents in easy read and other accessible formats
 - physical access
 - social and cognitive attitudes
 - collaborative working including:
 - working in partnership with family carers
 - the role of the community learning disability team
 - the role of social care supporters
 - the role of other health care professionals and services
 - experiences and expectations
 - consent
 - the Mental Capacity Act 2005
 - the Equality Act 2010
 - resources – local contacts, networks, practitioners with special interest and information.

The training should be completed by healthcare professionals before health checks are conducted. At a minimum, participating staff should include the lead general practitioner (GP) for LD, lead practice nurse and practice manager/senior receptionist. Practices may also wish to involve specialist LD staff from the community learning disability team to provide support and advice.

Commissioners and practices may find the Improving Health and Lives Learning Disabilities Observatory website^{116,117,118} provides helpful, easy to understand information on the health and wellbeing of people with learning disabilities, which can support the commissioning and provision of annual health checks.

Health checks

On an annual basis, practices will invite all patients on the 'health check register' for

¹¹⁶

http://www.ihal.org.uk/publications/1224/Making_reasonable_adjustments_to_primary_care_services_supporting_the_implementation_of_annual_health_checks_for_people_with_learning_disabilities

¹¹⁷

http://www.improvinghealthandlives.org.uk/publications/1197/Health_checks_for_people_with_learning_disabilities_in_England,_2012/2013

¹¹⁸

http://www.improvinghealthandlives.org.uk/publications/1168/Improving_the_Uptake_of_Health_Checks_for_Adults_with_Learning_Disabilities._Evidence_into_practice_report_no.6%20The%20data%20or%201013/14

a review of physical and mental health. Where problems or concerns are identified, practices will be expected to address them as appropriate through the usual practice routes or via specialist referral if required.

As a minimum, the health check should include:

- a collaborative review with the patient and carer (where applicable) of physical and mental health with referral through the usual practice routes if health problems are identified, including:
 - health promotion
 - chronic illness and systems enquiry
 - physical examination
 - epilepsy
 - dysphagia
 - behaviour and mental health
 - specific syndrome check
- a check on the accuracy and appropriateness of prescribed medications
- a review of whether vaccinations and immunisations are up-to-date, for instance seasonal influenza
- a review of coordination arrangements with secondary care
- a review of transition arrangements where appropriate
- a discussion of likely reasonable adjustments should secondary care be needed
- a review of communication needs, including how the person might communicate pain or distress
- a review of family carer needs
- offering support to the patient to manage their own health and make decisions about their health and healthcare, including through providing information in a format they can understand any support they need to communicate.

Practices taking part in the ES will be required to use a suitably accredited protocol agreed with the commissioner (for example, the Cardiff health check¹¹⁹). Where possible and with the consent of the patient, this should involve carers and support workers. Practices should liaise with relevant local support services such as social services and educational support services, in addition to learning disability health professionals.

Health action plan

As part of the patient's annual health check, practices will be required to produce a health action plan. This can be created at the time of the health check using an electronic template in the GP clinical system, or, if an electronic template is not available, providing the patient with a written health action plan following the review. For the latter, practices will need to be mindful of the patient's diagnosis -

¹¹⁹ Cardiff health check protocol. Royal College of General Practitioners (RCGP) website. <http://www.rcgp.org.uk/learningdisabilities/-/media/Files/CIRC/CIRC-76-80/CIRCA%20StepbyStepGuideforPracticesOctober%2010.ashx>

that is, if the patient's specific learning disability impacts on their ability to read and/or understand the information contained in the health action plan. In these circumstances, the practice will need to ensure that the health action plan is provided in the best format¹²⁰ for the patient to maximise their understanding and involvement, including if necessary a means most suitable for a carer or advocate to support them to understand its content.

The focus of the health action plan should be the key action points discussed (whether for the patient, the practice, or other relevant parties involved in the patient's care) and agreed with the patient and carer (where applicable) during the health check. It should also summarise what was discussed and any other relevant information (e.g. what is important to the patient, what their goals or outcomes are that they want to achieve). Where the patient has a personalised advanced care plan in place, it is expected that this would also form part of the patient's health action plan. Where possible, and if the patient is mentally competent to provide it with their consent, the health action plan should be shared with other relevant professionals who are involved in the care of the patient.

Practices also participating in the Facilitating Timely Diagnosis and Support for People with Dementia enhanced service may find that the annual learning disability health check also provides an ideal opportunity to check for possible memory concerns and assessment for dementia for attending patients, where clinically appropriate.

Monitoring

There is one payment count (see payment and validation section) for this ES. The management information counts will be outlined in the Technical Requirements document.

Practices will be required to manually input data into CQRS, on a quarterly basis, until such time as GPES¹²¹ is available to conduct electronic data collections. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts.

For information on how to manually enter data into CQRS, please see the HSCIC website¹²².

On CQRS there are two inputs for this ES:

¹²⁰ NHS England has announced its intention to publish an information standard providing clear direction to organisations as to expectations around the recording of disabled patients' information and communication support needs, and steps to be taken to meet those needs. See <http://www.isb.nhs.uk/documents/isb-1605/amd-08-2013/1605082013an2.pdf>

¹²¹ Details as to when GPES is available to support this service will be communicated by HSCIC at <http://www.hscic.gov.uk/news-and-events>

¹²² <http://systems.hscic.gov.uk/cqrs/participation>

1. ES indicator LD001 input number: The number of those patients aged 14 years or over in the financial year on the practice's agreed learning disabilities register who received a completed health check in this quarter.
2. ES indicator LD001 maximum: The number of patients aged 14 years or over in the financial year on the practices agreed learning disabilities register.
The ES indicator LD001 maximum input will always be manual as the data cannot be supplied by GPES as a local LD register code(s) is not available. The sum of the ES indicator LD001 input over the year can never exceed the ES indicator LD001 maximum (practices cannot give more health checks than those on the local LD register). When entering data manually, the LD001 maximum must be entered even when providing a nil return to LD001 input – many practices mistakenly returned a zero value for the register size when providing a nil return for the number of completed health checks.

When GPES is available, each collection will capture data for all counts and report on activities from the start of the reporting period e.g. 1 April 2015 to the end of the relevant reporting quarter. The reporting quarter will be the quarter prior to the month in which the collection is run, e.g. if the collection month is January 2016, the reporting quarter will be quarter three (October to December 2015). Payment counts will be non-cumulative quarterly counts, from the point the practice begins to deliver the service. Management information counts will be a mixture of non-cumulative and cumulative quarterly counts (which will serve for audit purposes).

It is important to note that, when GPES takes a data collection for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. quarter end/year-end). For example, an annual collection would only include patients registered with the practice at the year end.

When collections commence, manual entry will cease and GPES will provide to CQRS the quarterly counts from the relevant quarter they start in to the end of the relevant reporting quarter.

If a practice has declared achievement (payment and management information) for the quarter on CQRS before the GPES collection, and the commissioner has approved it, no GPES-based automated collection will be received as payment and management information declarations in CQRS cannot be overwritten.

The 'Technical Requirements'¹²³ document contains the payment counts, management information counts and Read2 and CTV3 codes¹²⁴ which are required for this service. The Read2 and CTV3 codes will be used as the basis for the GPES collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to

¹²³ NHS Employers. Technical requirements for 2015/16 GMS contract changes.
<http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services/enhanced-services-2015-16>

¹²⁴ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

manually enter data until such time as GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting Business Rules will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes from the commencement of this service and re-code patients where necessary.

Supporting Business Rules¹²⁵ will be published on the HSCIC website. Commissioners and practices should refer to these for the most up-to-date information on management information counts, Read2 and CTV3 codes.

Payment and validation

Commissioners will invite practices to participate in this ES before 30 April 2015. Practices are required to respond to the commissioner offer within 42 days (otherwise the commissioner is not required to agree an arrangement with the practice for the financial year). The agreement should be recorded in writing by 30 June 2016¹²⁶.

Practices participating in this programme are required to sign up to CQRS no later than 31 July 2015. Further guidance relating to CQRS and GPES will be provided by HSCIC when services are updated¹²⁷. Payments can only be processed after commissioners have offered and practices have accepted a service on CQRS.

Payment under this ES will be on a quarterly basis comprising £116.00 for each registered patient aged 14 and over in the financial year on the practice's agreed learning disabilities register who receives a compliant health check in that quarter. Only one payment may be made as regards to any patient, in a given practice, in any one financial year.

CQRS will calculate the quarterly payment, based on the quarterly achievement data via either manually entered data or data collected from GPES. Where CQRS has not been provided with data (i.e. the practice has not enabled the collection or the collection is not supported by their system supplier) the data will need to be entered onto CQRS manually.

After CQRS has calculated the practice's final achievement payment, the practice should review 'the payment value' and declare the 'achievement declaration'. The commissioner will then approve the payment (assuming that the criteria for the service has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the service will be sent to the payment agency for processing.

¹²⁵ HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

¹²⁶ This will be available at www.nhsemployers.org/GMS201516

¹²⁷ HSCIC. GPES. <http://www.hscic.gov.uk/gpes>

Payment should be made by the last day of the month following the month in which the practice and commissioner approve the payment.

Practices will be expected to ensure that the count of patients who have received a health check over the year does not exceed the number of patients on the agreed learning disability register. Practices cannot give more health checks than those on the local LD register, and they can only receive one payment per patient.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that the number of health checks given does not exceed the number of patients on the agreed learning disabilities register. It may also include assessing the number of patients who have received health checks over the year, as well as the number of those who have received a health check but declined a health action plan, and the number of patients who have received a health check and are eligible for a health action plan but have not been offered one.

This information could be available to commissioners and practices, as an indicative check, through the management information counts as and when data collections via GPES are available. Checks will be 'indicative' as it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the programme, as necessary, to demonstrate that the full protocol was followed.

Where required, practices must make available to commissioners any information they require and that the practice can reasonably be expected to obtain, in order to establish whether or not the practice has fulfilled its obligation under the ES arrangements.

The SFE¹²⁸ sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the Directions¹²⁹.

¹²⁸ This will be available at www.nhsemployers.org/GMS201516

¹²⁹ This will be available at www.nhsemployers.org/GMS201516

Section 7: Queries process

Queries can be divided into three main categories:

1. those which can be resolved by referring to the specification or guidance
2. those which require interpretation of the guidance or Business Rules¹³⁰
3. those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

NHS Employers' website has a [frequently asked questions](#) page for QOF, enhanced services and other non-clinical aspects of the GMS contract.

If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

Where queries cannot be answered by reading this guidance document or any of the supporting Business Rules and FAQ documents, queries should be directed as follows:

1. Queries relating to Business Rules/coding queries should be sent to the HSCIC via enquiries@hscic.gov.uk. Where required, the HSCIC will work with other key stakeholders to respond.
2. Policy, clinical and miscellaneous queries should be sent to:

NHS Employers for commissioners via:

- GMScontract@nhsemployers.org
- QOF@nhsemployers.org
- vandi@nhsemployers.org

GPC for general practice via info.gpc@bma.org.uk

¹³⁰ HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

Query

Have you checked if the following documents address your query:

1. Guidance and/or FAQs
2. Business Rules
3. Statement of financial entitlement and/or Regulations?

Payment queries

Practices to commissioners in the first instance

CQRS

<http://systems.hscic.gov.uk/cqrs>

GPES

<http://www.hscic.gov.uk/gpes>

Guidance and clinical queries to

gms@nhsemployers.org

Business Rules and Read code queries to

enquiries@hscic.gov.uk

HSCIC liaise with NHS England, NHS Employers and GPC to agree responses where appropriate

Practices queries to GPC via

info.gpc@bma.org.uk

Annex A: Guidance and links for patient participation

Transforming Participation in Health and Care, NHS England

<http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

National Association for Patient Participation - <http://www.napp.org.uk/>

Practice Management Network - [Improving Access, responding to patients: A 'how-to' guide for GP Practices](http://www.practicemanagement.org.uk/265)

<http://www.practicemanagement.org.uk/265>

Practice Management Network – guide on patient engagement

<http://www.practicemanagement.org.uk/patient-engagement>

NHS Networks Smart Guides

<http://www.networks.nhs.uk/nhs-networks/smart-guides>

Healthwatch - <http://www.healthwatch.co.uk/>

NICE Publication, 'Community Engagement'

<http://publications.nice.org.uk/community-engagement-ph9>

NICE 'Patient Experience Guidance in Adult Services' -

<http://guidance.nice.org.uk/CG138>

Pride and Practice (Lesbian and Gay Foundation) -

<http://www.lgf.org.uk/prideinpractice>

Centre for Mental Health - <http://www.centreformentalhealth.org.uk/>

MIND - <http://www.mind.org.uk/>

Engagement of mental health service users :

<http://apt.rcpsych.org/content/11/3/168.full.pdf>

Community Health Champions, Altogether Better

<http://www.altogetherbetter.org.uk/community-health-champions>

NHS England Accessible Information project

<http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/>

Annex B: Creating a PPG - Getting started guide

Note: the 'getting started guide' was produced for the Patient Participation Directed Enhanced Service. It has been included to support practices if they do not already have a Patient Participation Group.

Introduction

The 'getting started guide' has been developed to support practices in setting up virtual PPGs; it contains a few simple tools that practices can use at the various stages of setting up a PPG. It should be noted that a virtual PPG may not be appropriate for capturing views from all sections of the practice population and other forms of communication should also be considered for engaging with seldom heard groups of patients and carers or people who do not have access to email/internet.

The Department of Health commissioned the development of this guide in consultation with patients, staff and patient group representatives¹³¹. It is deliberately simple and 'low-tech' in the hope that it provides a range of quick and easy ways to create a list of patients willing to help practices by giving their views. Email is a fast and effective way to carry out simple surveys to get feedback from patients.

Your practice may or may not already have in place a 'real' PPG which meets face-to-face. If it does, it may be simplest to use the 'real' PPG as the main point of email contact. If you do not already have a 'real' PPG, creating an email contact list is a good starting point.

Content of the guide

- a. Common patient questions and answers
- b. Sample contact form
- c. Developing a survey
- d. Script for patient group members
- e. Script for staff in practices with a PPG
- f. Suggested wording for an LED display
- g. Suggested leaflet/flyer content
- h. Suggested poster content

Common patient questions and answers

Why are you asking patients for their contact details?

We would like to be able to contact patients and carers occasionally to ask them

¹³¹ Patient and Public Involvement Solutions Ltd. www.patientpublicinvolvement.com

questions about the practice and how well we are doing to identify areas for improvement.

Will my doctor see this information?

This information is purely to contact patients to ask them questions about the practice, how well we are doing and ensure changes that are being made are patient focused. If your doctor is responsible for making some of the changes in the practice they might see general feedback from patients that does not identify individuals.

Will the questions you ask me be medical or personal?

We will only ask general questions about the practice, such as short questionnaires.

Who else will be able to access my contact details?

Your contact details will be kept safely and securely and will only be used for this purpose and will not be shared with anyone else.

How often will you contact me?

Not very often... [Insert how often you plan to contact patients]

What is a patient group/patient participation group?

This is a group of volunteer patients who are involved in making sure the practice provides the services its patients need.

Do I have to leave my contact details?

No, but if you change your mind, please let us know.

What if I no longer wish to be on the contact list or if I leave the practice?

We will ask you to let us know by email if you do not wish to receive further messages.

Sample contact form

If you are happy for us to contact you periodically by email please complete your details below and hand this form back to either reception, a patient group representative, or post in the 'secure box'.

Name:

Email address:

Postcode:

This additional information will help to make sure we try to speak to a representative sample of the patients registered at this practice.

Are you? Male Female Prefer not to say

Age: Group	Under 16	<input type="checkbox"/>	17 - 24	<input type="checkbox"/>
	25 - 34	<input type="checkbox"/>	35 - 44	<input type="checkbox"/>
	45 - 54	<input type="checkbox"/>	55 - 64	<input type="checkbox"/>
	65 - 74	<input type="checkbox"/>	75 - 84	<input type="checkbox"/>
	Over 84	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>

To help us ensure our contact list is representative of our local community please indicate which if the following ethnic background you would most closely identify with?

White	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
British group	<input type="checkbox"/>	Irish	<input type="checkbox"/>	Gypsy or Irish traveller	<input type="checkbox"/>	Other white	<input type="checkbox"/>		
Mixed									
White & black Caribbean	<input type="checkbox"/>	White & black African	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>	Other mixed	<input type="checkbox"/>		
Asian or Asian British									
Indian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>
Black or black British									
Caribbean	<input type="checkbox"/>	African	<input type="checkbox"/>	Other black	<input type="checkbox"/>				
Other ethnic group									
Arab	<input type="checkbox"/>	Any other	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>				

How would you describe how often you come to the practice?

Regularly	<input type="checkbox"/>
Occasionally	<input type="checkbox"/>
Very rarely	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

Thank you.

Please note that no medical information or questions will be responded to.

The information you supply us with will be used lawfully, in accordance with the Data Protection Act 1988. The Data Protection Act 1988 gives you the right to know what information is held about you, and sets out rules to make sure that this information is handled properly.

Developing a survey

There are a number of online survey tools available which are simple to use and have clear instructions on how to set up a survey. Once you have finalised your survey questions it takes just minutes to set up the survey online. Some free survey tools are set out below:

- Survey Monkey. Mart survey design. <http://s3.amazonaws.com/SurveyMonkeyFiles/SmartSurvey.pdf>
- Kwik surveys. <http://kwiksurveys.com/>
- eSurveys pro. <http://www.esurveyspro.com>
- Smart survey. <http://www.smartsurvey.co.uk>

Script for patient group members

Hello, I am a member of a patient group *[insert name of group]*. We want to ensure that the views of patients and carers are being fed into the practice regarding the services they deliver and any changes or new services that are being considered.

To do this we are compiling a contact list of email addresses so that we can contact you by email every now and again to ask you a question or two.

Are you interested in giving your views?

Please provide your contact details on this form; we will only use information to contact you and will keep your details safely.

Script for staff in practices with a PPG

Hello, Our Patient Participation Group *[insert name of group]* is encouraging patients to give their views about how the practice is doing. They would like to be able to ask the opinions of as many patients as possible and are asking if people would like to provide their email addresses so that they can contact you by email every now and again to ask you a question or two.

Are you interested in leaving your email contact details?

If you could fill in this quick form and hand it back to reception (or provide your details over the phone to me) we will pass your details to the Patient Participation Group.

Your contact details will only be used for this purpose and will be kept safely.

Suggested wording for an LED display

THE PATIENT PARTICIPATION GROUP *[INSERT NAME OF GROUP]* NEEDS YOUR VIEWS! PLEASE ADD YOUR EMAIL TO THE FORM AT RECEPTION TO JOIN OUR CONTACT LIST.

This information could also be added to prescriptions.

Copies of the contact form should be available at reception with the option to drop them into a secure box.

Suggested leaflet content

Would you like to have a say about the services provided at *[insert name of practice]*?

The *[insert name of group or surgery]* would like to hear your views.

By providing your email details, we can add them to a contact list that will mean we can contact you by email every now and again to ask you a question or two.

Fill in the details on the reverse side of this leaflet and hand it back to reception or post it into the secure box and we will add your email address to a contact list.

Suggested poster content

Would you like to have a say about the services provided at *[insert name of practice]*?

The *[insert name of group or practice]* would like to hear your views.

By leaving your email details we can contact you every now and again to ask you a few questions.

Contact forms are available in the waiting room

Annex C. Template letters and leaflets to inform patients of enrolment into enhanced service

Template adult letter / email text

[Practice Address]

[DATE]

[Patient Address]

Dear [Patient Name]

New service for patients

The NHS has agreed a service to help people keep well and avoid unplanned hospital visits, such as in an emergency. We would like to invite you to be one of the people who receives more tailored, active support from the GP surgery. We believe personal care planning could help you with your health and wellbeing.

As a member of this programme, you will have Dr XX as your named GP and they will have overall responsibility for the care and support that our surgery will provide you. We will also make sure that you have a named care co-ordinator, who may be your named GP or another health professional involved in your care and is likely to be the person you see the most. Your named care co-ordinator will be responsible for sharing information with you, your carer and – if you are happy for us to do so – with other health professionals involved in your care. Information would only be shared with other care organisations (e.g. hospitals, emergency services and if you have one, your social care team) to help co-ordinate your care. These new arrangements do not prevent you making an appointment or seeing any doctor, of your choosing within the surgery, as you would normally do.

Your named GP or named care co-ordinator will work with you to develop a personal care plan and review / discuss with you any changes needed. We will also invite, with your agreement, other health or care professionals involved in your care to help develop and keep your personal care plan up to date.

Your care planning discussion will help us (you, [your carer], your named GP and named care co-ordinator) to think about your health and care needs. With your agreement, your personal care plan may include information like:

- details of your named GP and care co-ordinator
- details of any other health or care professionals who are involved in your care
- confirmation that you have agreed to sharing your care plan with relevant health and care professionals
- details of your condition(s) and significant past medical history
- details of any medication(s) you are taking and plans for reviewing them
- any allergies you may have
- the action that you are taking to help manage your health and any help you need with this
- how you can detect any early signs that your health may be worsening and what you should do if this happens
- who to contact if you think you need to see a doctor urgently

Your named GP and named care co-ordinator will work with you to review your health needs as often as necessary. They will ensure that you receive support from us and others to help you manage your health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer not to receive this service, please contact us on [phone number] or at [email address].

Kind Regards

[Name]

Template letter / email text (for a parent of a child on register)

[Practice Address]

[DATE]

[Patient Address]

Dear [Patient Name]

New service for patients

The NHS has agreed a service to help people keep well and avoid unplanned hospital visits, such as in an emergency. We would like to invite you to be one of the people who receives more tailored, active support from the GP surgery. We believe personal care planning could help you with your health and wellbeing.

Your child will have Dr XX as his or her named GP and they will have overall responsibility for the care and support that our surgery provides to him or her. We will also make sure that he or she has a named care co-ordinator, who will be the named GP or another health professional involved with his or her care and is likely to be the person that he or she (and you) see the most. The named care co-ordinator will be responsible for sharing information with you, where appropriate your child and – if you and he or she (where appropriate) are happy for us to do so – with other health and care professionals involved in your child's care. Information would only be shared with other care organisations (e.g. hospitals, emergency services) to help co-ordinate care. These new arrangements do not prevent you making an appointment or seeing any doctor, of your choosing within the practice, as you would normally do.

Your child's named GP or named care co-ordinator will work with you and your child, where it is applicable to involve him or her, to develop a personal care plan for your child and review / discuss any changes needed. We will also invite, with your and where appropriate your child's agreement, other health and care professionals involved with your child's care to help develop and keep the personal care plan up to date.

Your child's care planning discussion will help us (you, your child if appropriate, your named GP and named care co-ordinator) to think about your child's health and care needs. With your agreement, your child's personal care plan may include information like:

- details of the named GP and care co-ordinator
- details of any other health and care professionals who are involved in your child's care

- confirmation that you have agreed to sharing your child's care plan with relevant health or care professionals
- your name and contact details (as the child's parent)
- details of your child's condition(s) and significant past medical history
- details of any medication(s) your child is taking and plans for reviewing them
- any allergies your child may have
- the action that you and your child can take to help manage his or her health and any support needed with this
- how you can detect any early signs that your child's health may be worsening and what you should do if this happens
- who to contact if you think that your child needs to see a doctor or nurse urgently

Your child's named GP and named care co-ordinator will work with you and your child to review your child's health needs as often as necessary. They will ensure that you and your child receive support from us and others to help manage your child's health. We may also be able to help you find local community resources that you and your child may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse about your child, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer your child does not to receive this service, please contact us on [phone number] or at [email address].

Kind Regards

[Name]

Template letter / email text (for a guardian of a child on register)

[Practice Address]

[DATE]

[Patient Address]

Dear [Patient Name]

New service for patients

The NHS has agreed a service to help people keep well and avoid unplanned hospital visits, such as in an emergency. We would like to invite you to be one of the people who receives more tailored, active support from the GP surgery. We believe personal care planning could help you with your health and wellbeing.

As a member of this programme, [patient name] will have Dr XX as his or her named GP and they will have overall responsibility for the care and support that our surgery provides to him or her. We also make sure that he or she has a named care co-ordinator, who may be the named GP or another health professional involved with his or her care and is likely to be the person he or she (and you) see the most. The named care co-ordinator will be responsible for sharing information with you, where appropriate the child and – if you and he or she (where appropriate) are happy for us to do so – with other health and care professionals involved in his or her care. Information would only be shared with other care organisations (e.g. hospitals, emergency) to help co-ordinate care. These new arrangements do not prevent you making an appointment or seeing any doctor of your choosing within the practice as you would normally do.

The child's named GP or named care co-ordinator will work with you and with the child, where it is applicable to involve him or her, to develop a personal care plan and review / discuss any changes needed. We will also invite, with your and where appropriate the child's agreement, any other health or care professionals involved with his or her care to help develop and keep this personal care plan up to date.

Your child's care planning discussion will help us (you, the child if appropriate, the named GP and named care co-ordinator) to think about his or her health and care needs. With your agreement, the personal care plan may include information like:

- details of the named GP and care co-ordinator
- details of any health or care professionals who are involved in the child's care
- confirmation that you have agreed to sharing the care plan with relevant health or care professionals

- name and contact details for you as the child's guardian (and any other relevant next of kin)
- details of the child's condition(s) and significant past medical history
- details of any medication(s) the child is taking and plans for reviewing them
- any allergies the child may have
- the action that you and the child will be taking to help manage his or her health and any help you need with this
- how you can detect any early signs that the child's health may be worsening and what you should do if this happens
- who to contact if you think the child needs to see a doctor or nurse urgently

The named GP and named care co-ordinator will work with you and the child to review his or her health needs as often as necessary. They will ensure that you and the child receive support from us and others to help manage his or her health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer your child not to receive this service, please contact us on [phone number] or at [email address].

Kind Regards

[Name]

Template leaflet for adult patients

The NHS has agreed a service to help people keep well and avoid unplanned hospital visits, such as in an emergency. We would like to invite you to be one of the people who receives more tailored, active support from the GP surgery. We believe personal care planning could help you with your health and wellbeing.

What does this mean for you, as a patient?

As a member of this programme, you will have a named GP from our surgery and they will have overall responsibility for the care and support that our surgery provides for you. We will also make sure that you have a named care co-ordinator, who may be your named GP or another health professional involved in your care and who will likely be the person from our surgery who you see the most. Your named care co-ordinator will be responsible for sharing information with you, [your carer] and – if you are happy for us to do so – with other health or care professionals involved in your care. Information will only be shared with other care organisations (e.g. hospitals, emergency services and, if you have one, your social care team) to help co-ordinate your care. These new arrangements do not prevent you making an appointment or seeing any doctor of your choosing within the surgery, as you would normally do.

Your named GP and named care co-ordinator will work with you to develop a personal care plan and review/discuss any changes needed. We will also invite, with your agreement, other health and care professionals involved in your care to help develop and keep your personal care plan up to date.

Your care planning discussion will help us (you, [your carer], your named GP and named care co-ordinator) to think about your health and care needs. With your agreement, your personal care plan may include information like:

- your NHS number
- details of your named GP and care co-ordinator
- details of any other health and care professional who are involved in your care
- confirmation that you have agreed to sharing your care plan with relevant health or care professionals
- details of the your condition(s) and significant past medical history
- details of any medication(s) that you are taking and plans for reviewing them
- any allergies
- the action that you are taking to manage your health and any help you need with this
- how you can detect any early signs that your health may be worsening and what you should do if this happens
- who to contact if you think that you need to see a doctor or nurse urgently.

Your named GP and named care co-ordinator will work with you to review your health needs as often as necessary. They will ensure that you receive support from us and others to help you manage your health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer not to receive this service, please contact us on [phone number] or at [email address].

Template leaflet for parents or guardians of child patients

The NHS has agreed a service to help people keep well and avoid unplanned hospital visits, such as in an emergency. We would like to invite your child to be one of the children who receives more tailored, active support from the GP surgery. We believe personal care planning could help improve their health and wellbeing.

What does this mean for your child or a child in your care?

As a member of this programme your child will have a named GP from our surgery and they will have overall responsibility for the care and support that our surgery provides to him or her. We will also make sure that your child has a named care co-ordinator, who may be the named GP or another health professional involved in his or her care and who will likely be the person from our surgery who you and him or her see the most. Your child's named care co-ordinator will be responsible for sharing information with you, as their parent or guardian and – if you and your child (where appropriate) are happy for us to do so – with other health and care professionals involved in his or her care. Information will only be shared with other care organisations (e.g. hospitals, emergency services and if the child has one, the social care team) to help co-ordinate care. These new arrangements do not prevent you making an appointment or seeing any doctor, of your choosing within the surgery, as you would normally do.

Your child's named GP and named care co-ordinator will work with you and your child, where it is applicable to involve him or her, to develop a personal care plan and review/discuss with you any changes needed. We will also invite, with your and where appropriate your child's agreement, any other health and care professionals involved in your child's care to help develop and keep the personal care plan up to date.

The care planning discussion will help us (you, your child if appropriate, the named GP and named care co-ordinator) to think about your child's health and care needs. With your agreement, your child will have a personal care plan that may include information like:

- the child's NHS number
- details of the named GP and care co-ordinator
- details of any other health and care professionals who are involved in your child's care
- confirmation that you have agreed to sharing the care plan with relevant health and care professionals
- name and contact details for you as the child's parent or guardian
- details of your child's condition(s) and significant past medical history
- details of any medication(s) your child is taking and plans for reviewing them
- any allergies your child may have

- the action that you and your child are taking to help manage his or her health and any help you need with this
- how you can detect any early signs that your child's health may be worsening and what you should do if this happens
- who to contact if you think that you need to see a doctor or nurse urgently

Your child's named GP and named care co-ordinator will work with to review your child's health needs as often as necessary. They will ensure that your child receives support from us and others to manage his or her health. We may also be able to help you find local community resources that you may find helpful.

We will also make sure that, whenever you have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

If you have any questions, or would prefer your child not to receive this service, please contact us on [phone number] or at [email address].

Annex D. Principles of personalised care planning

The ES requires practices to follow a collaborative process of personalised care planning with patients. It is important that the personalised care plan is developed collaboratively between the clinician, patient and if applicable the patient's carer(s). The patient and carer (if applicable) should feel informed and supported in managing their health and care needs. The personalised care plan should outline a co-ordinated package of care and the patient and their carer (if applicable) should have a copy of the written or electronic care plan. The personalised care plan should be reviewed at agreed regular intervals with the patient and the carer (if applicable) or as necessary.

Further information

NHS England. Handbook on personalised care and support planning. This may help commissioners, CCGs and practices in understanding how to deliver effective, personalised care planning. <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

National Voices. A guide on what care and support planning means for patients and carers. <http://www.nationalvoices.org.uk/what-care-and-support-planning>

Annex E: Reporting template

[Name] Commissioners

2015/16 Avoiding Unplanned Admissions Enhanced Service – Reporting Template

Practice Name:

Practice Code:

Signed on behalf of practice:

Date:

SECTION 1 – practice availability	
1. Please specify how health and social care services can contact the practice in emergency situations regarding patients on the practice's registered list?	
a. A&E and ambulance staff	

b. Care and nursing homes	
c. Other care providers (e.g. mental health and social services)	
2. Does the practice have a system in place to enable patients on the case management register to receive same day telephone consultations for their urgent enquires?	YES / NO
SECTION 2 – proactive case management	
1. Has the practice agreed personalised care plans or undertaken at least one care review during the year, with at least 1.8% per cent of eligible patients (i.e. patients aged 18 and over) by:	
a. 30 September 2015?	YES / NO
b. 31 March 2016?	YES / NO
2. Has the practice agreed personalised care plans with all patients on the case management register or undertaken at least one care review during the year? (i.e. for a minimum of 2% of the practice population aged 18 and over on the register between 1 April 2015 to 31 March 2016)	YES / NO
	YES / NO

3. Has the practice submitted manual data relating to any patients who have died or moved in each of the six month periods?	
4. Have all patients on the case management register been notified of their named accountable GP?	YES / NO
SECTION 3 – hospital discharge process	
1. Is there a system in place for contacting patients post-discharge from hospital?	YES / NO
<p>2. What recommendations has the practice made to the commissioner and CCG (if not the commissioner of the ES) to support improvements in the commissioning of services for patients in this group?</p> <p>Please provide brief details.</p>	
SECTION 4 – internal practice reviews	
1. Has the practice carried out reviews of emergency admissions and A&E attendances for:	
a. their registered patients living in care and nursing homes?	YES / NO
b. their patients on the case management register?	YES / NO
3. What recommendations has the practice made to the commissioner and CCG (if not the commissioner of the ES) to support improvements in the commissioning of services for patients in this group?	

Please provide brief details.

SECTION 5 – patient survey

1. Has the practice undertaken the survey of patients on the case management register using the materials provided?

YES / NO

Reporting template - notes

Reports are required to be submitted, to the commissioner and CCG (if not the commissioner of the ES) on a twice yearly basis by no later than the last day of the month following the end of the six month period.

This reporting template should be read in conjunction with the specification and guidance.

It is the practice's responsibility to ensure that they are familiar with the guidance set out nationally and that they fully understand the ES requirements for the completion of reporting submissions. Failure to understand the requirements of this ES may result in components not being met and payments being withheld – see section on payment and validation in the service specification or guidance.

It is essential that practices engage with their CCG throughout the process.

The reports should be submitted electronically and any additional documents should be scanned in where possible to minimise paper requirements. The submission email address [is...to be added by commissioner / will be confirmed closer to the deadline date]. Please contact your contract manager if you have any queries in the meantime.

**General Practitioners
Committee**
www.bma.org.uk/gpc

NHS Employers
www.nhsemployers.org

NHS England
www.england.nhs.uk

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