Newsflash

Sheffield LMC

ENHANCED SERVICE SPECIFICATION - GENERAL PRACTICE REQUESTS FOR ADVICE AND GUIDANCE 2025/26

We wish to update you on the recently published Enhanced Service Specification for Advice and Guidance by NHS England (NHSE).

The document highlights a number of important facts that we highlight here:

- The offer is to any practice holding a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract.
- The offer is for the GP to seek **pre-referral advice** from a medical consultant colleague. This may be by telephone or electronic means – e-Referral Service (e-RS).
- The practice can claim a £20 fee relating to each patient. They cannot claim multiple times for the same patient relating to the same episode of care, if advice is sought more than once.
- The Enhanced Service commenced on 1 April 2025. Sign-up to the Enhanced Service needs to be **by 15 April 2025**.
- Data will be collected by the Calculating Quality Reporting Service (CQRS), which will commence from 30 April.
- Practices are required to develop a protocol for team members to follow. If a referral is not generated by a GP, then it must be reviewed by a GP prior to submission. The protocol should also identify how requests for Advice and Guidance are recorded, to ensure data collection through the CQRS system.
- The advice must come from a consultant led service in order to qualify for payment.

Currently, we have not had reassurance that Clinical Assessment, Support and Education Service (CASES) satisfies the criteria for payment under this Enhanced Service. Primary Care Sheffield (PCS) and NHS South Yorkshire Integrated Care Board (ICB) are pushing hard to get CASES approved, but no decision has yet been forthcoming from NHSE. Practices need to be aware of this issue when drawing up their protocols and seeking payment for A&G.

This contract cannot be varied locally, however, the ICB can set a cap on practice claims dependent on in-year activity.

Practices will need to make manual monthly claims within 12 days of the end of the month. It is for the commissioner to verify claims.