# 2013/14 general medical services (GMS) contract

## Guidance and audit requirements for new and amended services

Version 3 –February 2014

NHS England

NHS Employers

# Contents

# Section 1. Introduction

## Introduction

From 1 April 2013 the NHS Commissioning Board (NHS CB) is the body legally responsible for the commissioning of primary care in England. However, the NHS CB operates under the name NHS England, therefore the name NHS England is used throughout this guidance.

Practices[1] will continue to be offered the opportunity to deliver a number of enhanced services nationally, including the continuation of the existing clinical enhanced services first established in 2008/09. Those clinical enhanced services continue with some modifications made for 2013/14 to minimise reporting requirements for practices.

Practices providing vaccination and immunisations (V&I) (additional) services will also be entitled to payments to support the introduction of new routine immunisation programmes.

NHS England has also offered four new enhanced services this year to promote quality and innovation in the delivery of general practice services. Some of these services also include roles for clinical commissioning groups (CCGs), where the requirements of the enhanced services are best driven locally.

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.

This guidance is applicable in England only.

## About this guidance

This document provides detailed guidance and audit requirements to support practices and NHS England area teams (and CCGs where relevant) for the following services:

- Alcohol-related risk reduction scheme
- Childhood seasonal influenza (two and three year old immunisation) vaccination programme
- Facilitating timely diagnosis and support for people with dementia scheme
- Learning disabilities health checks scheme
- Improving patient online access scheme

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

- MMR catch-up vaccination programme
- Pneumococcal vaccination programme
- Rotavirus (childhood immunisation) vaccination programme
- Seasonal influenza vaccination programme
- Shingles (routine aged 70 immunisation) vaccination programme
- Shingles (catch-up aged 79 immunisation) vaccination programme
- Risk profiling and care management scheme
- Remote care monitoring (preparation) scheme

The amendments to the Directions and to the Statement of Financial Entitlements (SFE)[2] which underpin the relevant enhanced services, are available on the Department of Health (DH) website. The detailed requirements for taking part in the enhanced services are set out in the Directions except for the new enhanced services, which NHS England has been directed to develop and establish and the vaccination programme services specification which are available on the NHS Employers website[3] under the relevant section. The detailed requirements for these new enhanced services are provided in the specifications[4] published by NHS England.

NHS England area teams, CCGs and contractors taking part should ensure they have read and understood the requirements in the Directions, NHS England service specifications as well as the guidance in this document.

## Calculating Quality Reporting Service and the General Practice Extraction Service

The calculating quality reporting service (CQRS) replaced the manual systems for calculating and reporting quality outcomes for many general practice services. This includes the Quality and Outcomes Framework (QOF) but also some additional and enhanced services where achievement data can be obtained from general practice clinical systems via the General Practice Extraction Service (GPES). CQRS is more efficient and cost-effective as it automates the returns process saving time and resources.

[2] DH. NHS Primary Medical Services Directions 2013. https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013
[3] NHSE. Vaccination and immunisations. http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/vaccination_and_immunisation/Pages/VaccinationandImmunisation.aspx
[4] NHS England enhanced service specification. http://www.england.nhs.uk/resources/d-com/resource-primary/

CQRS has been developed to support the services detailed below.

The following services were supported by CQRS from June 2013:

1. Alcohol-related risk reduction scheme
2. Learning disabilities health checks scheme (now quarterly payment)
3. Rotavirus (childhood immunisation) programme

The following services were supported by CQRS from 1 August 2013:

4. MMR catch-up vaccination programme

The following services are expected to be supported by CQRS by mid-September 2013:

5. Childhood (two and three years) seasonal influenza vaccination programme
6. Pneumococcal vaccination programme
7. Seasonal influenza vaccination programme
8. Shingles (routine aged 70 immunisation) programme
9. Shingles (catch-up immunisation) programme

The following services are expected to be supported by CQRS by November 2013:

10. Facilitating timely diagnosis and support for people with dementia
11. Improving patient online access scheme

The following services will not be supported by CQRS for 2013/14:

- Risk profiling and care management scheme
- Remote care monitoring (preparation) scheme

Details on when GPES will be available to provide data for enhanced services will be made available in due course. This information will be published by GPES via the HSCIC website and communicated to all CQRS users. Until that time, once an enhanced service is 'live' on CQRS payment data for that services can be inputted manually on CQRS via the web interface.

Details on how to enter data manually on CQRS for each enhanced service can be found on the Health and Social Care Information (HSCIC) website[5].

When the GPES extracts commence they will provide data for all previous months where the practice and area team have not already approved payment. If the practice and area team have agreed payment for that period CQRS will not accept the extract.

[5] HSCIC. Manual data entry. http://systems.hscic.gov.uk/cqrs/golive/payment

Please note: All GPES extracts that are provided to CQRS are aggregated counts and contain no patient identifiable data.

## Calculating Quality Reporting Service (CQRS)

All services being supported by CQRS, require that practices who intend to participate in these services record their achievement in the clinical systems using the appropriate Read codes. This should be recorded using the relevant Read codes in this guidance, or in the supporting Business Rules from the date those services commence.

GPES and CQRS are the system of choice and area teams and practices are encouraged to use their systems when available. However, it is recognised that area teams and practices can agree local arrangements in the meantime.

Practices should record whether or not they are participating in this service in CQRS by 'accepting' or 'declining' an offer of the services approved by their area team - this is referred to as the 'participation record' in CQRS. This is the record of services that are agreed between a commissioning organisation and the practice, rather than the contractual agreement which should be agreed between the practice and NHS England. It is important that practices record the services covered by this guidance using the appropriate Read codes listed in this document regardless of the availability of CQRS and GPES.

Further guidance on CQRS can be found on the HSCIC website[6].

## General Practice Extraction Service (GPES)

The data on number of patients extracted by GPES is known as the weekly, monthly or quarterly counts. Depending on whether a count is used for payment or management purposes, the counts can be referred to as Payment Counts or Management Information Counts. The relevant counts/extracts will be used to calculate and validate payments for practices participating in the enhanced services as well as the relevant counts/extracts measuring the progress and success of the programme or service.

Further guidance on GPES can be found on the HSCIC website.

[6] HSCIC. CQRS. http://systems.hscic.gov.uk/systemsandservices/cqrs

# Section 2. Clinical enhanced services

## Introduction

The alcohol and learning disabilities enhanced services were introduced as part of the 2008/09 GMS contract changes, alongside three others covering heart failure, osteoporosis and ethnicity.

The enhanced services were effective from 1 April 2008 and were originally intended to run for two years, finishing on 31 March 2010, with the exception of heart failure which was a one year enhanced service. An indicator measuring the prescribing of beta blockers for heart failure was included in the QOF from 1 April 2009. The remaining four clinical enhanced services – alcohol, learning disabilities, osteoporosis and ethnicity – were extended for a further year until 31 March 2011.

In 2011/12 the alcohol, learning disabilities and osteoporosis enhanced services were extended until 31 March 2012.

In 2012/13 the alcohol and learning disabilities enhanced services were extended until 31 March 2013. New indicators for osteoporosis (secondary prevention of fragility fractures) were introduced in QOF and therefore the osteoporosis enhanced service was not extended. Although the ethnicity enhanced services came to an end, it is expected that practices continue to record their patients' first language and ethnicity in order to assess the needs of their population. The codes for first language and ethnicity are published separately and are available on the BMA website[7].

In 2013/14 the alcohol and learning disabilities enhanced services were extended until 31 March 2014. The learning disabilities enhanced services has been modified to support quarterly payments to practices and alongside the alcohol enhanced services, both will now have payments calculated using CQRS.

[7] First language and ethnicity codes.
http://bma.org.uk/practical-support-at-work/contracts/independent-contractors/desethnicity

# Alcohol-related risk reduction scheme

## Background and purpose

Addressing the issue of illness associated with increasing alcohol consumption is a government priority. This enhanced service aims to encourage practices for case finding in newly-registered patients aged 16 or over. It also aims to deliver simple brief advice to help reduce alcohol-related risk in adults drinking at increasing or higher risk levels and consideration of specialist referral for dependent drinkers.

## Introduction

This enhanced service does not include a requirement to set up a register of increasing or higher risk drinkers.

This enhanced service requires that practices screen newly registered patients aged 16 or over, using one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaires: FAST or AUDIT-C. FAST has four questions and AUDIT-C has three questions, with each taking approximately one minute to complete.

Patients with a positive score should be given the full screening test and offered brief advice for a score between eight and 19, or be considered for referral to specialist services for a score of 20 or more.

The enhanced service is for one year from 1 April 2013.

Payment under this enhanced service will be on an annual basis. CQRS will calculate the annual payment based on the data extracted from GPES (the number of newly registered patients, aged 16 or over in the financial year, who have been screened using either the FAST or AUDIT-C tool) multiplied by £2.38.

### Initial screening

For this enhanced service, screening applies to all patients registered between 1 April 2013 and 31 March 2014, who are aged 16 or over on 31 March 2014. For the purposes of this enhanced service, the test must be applied within the financial year in which the patient registered.

### Full screening

If a patient is identified as positive, the remaining questions in the ten-question AUDIT questionnaire should be used to determine increasing, higher risk or likely dependent drinking.

### Brief intervention

Those patients identified as drinking at increasing or higher risk levels (scores 8–19) should be offered brief advice. The recommended brief advice is the basic five minutes of advice used in the WHO clinical trial of brief intervention in primary care, using a programme modified for the UK context by the University of Newcastle, *How much is too much?* The tools[8] from this programme have been further refined.

### Brief lifestyle counselling

In some areas, patients drinking at higher risk levels (scores 16–19) may receive brief advice or brief lifestyle counselling (20–30 minutes) within the practice, or be referred to, for example, a community-based counselling service for this advice, but this distinction is not recognised for the purposes of this enhanced service.

### 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.

NHS Employers, NHS England and GPC have agreed a set of joint FAQs[9] to support the implementation of this programme.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following codes will need to be used to enable CQRS to calculate payment based on the GPES extract:

**Table 1: Alcohol Read codes – initial screening**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| FAST alcohol screening test | 388u. | XaNO9 | 303471000000106 |
| AUDIT C Alcohol screening test | 38D4. | XaORP | 335811000000106 |

[8] Alcohol learning centre. http://www.alcohollearningcentre.org.uk/topics/browse/briefadvice/
[9] Enhanced services FAQs. http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices201314.aspx

There are currently no codes available which indicate a positive FAST or AUDIT-C test result therefore practices should add a value to a field associated with the code. A value of three or more is regarded as positive for FAST and a value of five or more is regarded as positive for AUDIT-C.

**Table 2: Alcohol Read codes – Full screening**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| AUDIT Alcohol screening test | 38D3. | XM0aD | 273265007 |

A value should be added to a field associated with the code to record the score:

- 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.

**Table 3: Alcohol Read codes – brief intervention**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Brief intervention for excessive alcohol consumption completed | 9k1A. | XaPPv | 366371000000105 |

**Table 4: Alcohol Read codes – brief lifestyle counselling**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Extended intervention for excessive alcohol consumption completed | 9k1B. | XaPPy | 366421000000103 |

**Table 5: Alcohol Read codes – referral for specialist advice**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Referral to specialist alcohol treatment service | 8HkG. | XaORR | 431260004 |

The Business Rules supporting this enhanced service are available to download from the NHS Primary Care Commissioning (PCC) [10] website.

[10] NHS PCC. Enhanced services Business Rules. http://www.pcc-cic.org.uk/article/des-business-rules-alcohol-reduction-learning-disabilities-and-rotavirus

## Payment and validation

Payment under this enhanced service will be on an annual basis.

CQRS will calculate the annual payment, based on the 31 March 2014 achievement data either extracted from GPES or manually input via the CQRS web interface (the number of newly registered patients, aged 16 or over in the financial year, who have been screened using either the FAST or AUDIT-C tool). The 'indicators' below are based on the Business Rules written for the GPES extraction and Read codes listed in table 1 and are used to calculate the payment:

- ALC001: The number of newly registered patients aged 16 and over within the financial year who have had the short standard case finding test (FAST or AUDIT-C)

Payment will be made based on the annual count multiplied by £2.38.

After CQRS has calculated the practice's final achievement payment, the practice should 'approve the payment value' and submit an 'achievement declaration'. NHS England 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 have been followed, then payment for the service will be sent to the payment agency for processing

NHS England is responsible for post payment verification. This may include auditing claims of practices to ensure that not only the screening was conducted but that the full protocol described in the enhanced service was followed i.e. that those individuals who screened positive on the initial screening tool were then administered the remaining questions of AUDIT and that a full AUDIT score was determined and that appropriate action followed, such as the delivery of brief advice or referral to specialist services if needed. This information will be available to practices and the NHS England area teams through CQRS.

In addition to data extracted for payment purposes, data will also be collected for the purposes of management information using the Read codes in tables 1 to 5.

Where the information for these 'indicators is not available, practices should enter zero:

- ALCMI001: The number of newly registered patients aged 16 and over within the financial year who have had the FAST short standard case finding test within the period.
- ALCMI002: The number of newly registered patients aged 16 and over within the financial year who have had the AUDIT-C short standard case finding test within the period.
- ALCMI003: The number of newly registered patients aged 16 and over within the financial year who have had the FAST or the AUDIT-C short standard case finding test and screened positive for either (3+ for FAST, 5+ for AUDIT-C) within the period.

- ALCMI004: The number of newly registered patients aged 16 and over within the financial year who have had the FAST or the AUDIT-C short standard case finding test who screened positive for FAST (3+ for FAST) or screened positive for AUDIT-C (5+ for AUDIT-C) and have undergone an assessment using a validated tool (AUDIT) within the period.
- ALCMI005: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) and who have an AUDIT assessment score of 0-7 within the period.
- ALCMI006: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) and who have an AUDIT assessment score of 8-15 within the period.
- ALCMI007: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) and who have an AUDIT assessment score of 16-19 within the period.
- ALCMI008: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) and who have an AUDIT assessment score of 20 or over within the period.
- ALCMI009: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) with an AUDIT assessment score of 8-15 who have received brief intervention to help them reduce their alcohol related-risk within the period.
- ALCMI010: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) with an AUDIT assessment score of 16-19 who have received brief intervention to help them reduce their alcohol related-risk within the period.
- ALCMI011: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) with an AUDIT assessment score of 16-19 who have received extended intervention to help them reduce their alcohol related-risk within the period.
- ALCMI012: The number of newly registered patients aged 16 and over within the financial year who have screened positive (using either FAST or AUDIT-C) with an AUDIT assessment score of 20 or over who have been referred for specialist advice for dependent drinking within the period.

The information extracted on full screening, brief intervention, brief lifestyle counselling and referral for specialist advice will not be used for payment purposes. It will be available through CQRS to support practices and NHS England to validate requirements of the enhanced service as necessary to demonstrate that the full protocol is being followed.

# Learning disabilities health check scheme

## Background and purpose

There is good evidence that patients with learning disabilities (LD) have more health problems and die at a younger age than the rest of the population. The existing QOF registers do not differentiate learning disability by severity.

This enhanced service is designed to encourage practices to identify patients aged 18 or over with the most complex needs and offer them an annual health check. Local authority (LA) lists of people known to social services primarily because of their learning disabilities, are to be used as the basis for identifying patients to be offered the checks. The rationale is to target people with the most complex needs and therefore at highest risk from undetected health conditions (usually people with moderate to severe learning disabilities). From the prevalence figures available, it is estimated that approximately 240,000 patients fall into this category across the country. Generally 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.

## Introduction

The requirements for taking part in the enhanced service are as follows:

- The practice will have liaised with their LA to share and collate information, in order to identify the patients on their practice list who are known to social services primarily because of their learning disability.
- The practice establishes a 'health check learning disability register' identified by the liaison with their LA from its registered patient list.
- The practice maintains an up-to-date 'health check learning disability register' and ensures that their QOF learning disability register (LD001) includes all patients on the health check register.
- The practice providing this service will be expected to have attended a multi-professional education session.

The minimum expectation of staff attending will include the lead general practitioner (GP), 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.

The enhanced service is for one year from 1 April 2013.

Payment under this enhanced service is made on a quarterly basis and calculated by identifying the number of completed learning disability health checks undertaken in the

quarter. CQRS will calculate the quarterly payments based on manually entered returns until GPES is available to provide automated extracts.

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.
Payment will be made based on the quarterly count multiplied by £102.16.

The Business Rules supporting this enhanced service are available to download from the NHS PCC website[11].

## Learning disability (LD) register

The practice should work with their LA (or LAs where practices' registered patients are resident in more than one authority area) to produce a register of patients who are known to social services primarily because of their learning disabilities.

Using this information and integrating it with data about patients already on the practice's QOF learning disability register, practices should establish a 'health check learning disabilities register' using the Read codes outlined in this guidance which are in line with those used for the QOF learning disabilities register.

This enhanced service 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.

### Training

Multi-professional education sessions for primary healthcare staff should be established by NHS England (or CCG where NHS England requests) and offered to primary healthcare staff. The training should be provided by the strategic primary health care facilitator for people with learning disabilities (where NHS England or CCG has invested in this support) 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).

NHS England or the CCG 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

[11] NHS PCC. Enhanced services Business Rules. http://www.pcc-cic.org.uk/article/des-business-rules-alcohol-reduction-learning-disabilities-and-rotavirus

- 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
- 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
    - using accessible information and aids
    - 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 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. NHS England and practices may find the Improving Health and Lives Learning Disabilities Observatory website[12,13]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.

[12] Improving Health and Lives Learning Disabilities Observatory. Health checks report. www.improvinghealthandlives.org.uk/news.php?nid=979
[13] Improving Health and Lives Learning Disabilities Observatory. The effectiveness of health checks.www.improvinghealthandlives.org.uk/news.php?nid=998

### Health checks

As a minimum, the health check should include:

- a review 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 of prescribed medications
- a review of coordination arrangements with secondary care
- a review of transition arrangements where appropriate.

Practices taking part in the enhanced service should base their health checks on the Cardiff health check[14] or a similar protocol agreed with NHS England. Health checks should integrate with the patient's personal health record or health action plan. 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.

Practices also participating in the new enhanced service '*facilitating timely diagnosis and support for people with dementia*' 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 aged 50 and over.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following Read codes will need to be used to enable CQRS to calculate payment based on the GPES extract:

[14] Cardiff health check protocol. Royal College of General Practitioners (RCGP) website. www.rcgp.org.uk/docs/CIRC_Cardiff%20Healthcheck%20Template.doc

**Table 6: Learning disabilities Read codes – diagnostic codes**

| | Read v2 | Read CTV3 | SNOMED CT3[15] |
|---|---|---|---|
| Mental retardation[16] | E3...% | E3...% | 91138005<br>86765009%<br>61152003%<br>31216003%<br>40700009%<br>401201000000109<br>410331000000103%<br>192157003<br>192154005% |
| [X]Mental retardation | Eu7..% | Included in E3...% | Included in the cluster definition above |
| [X]Developmental disorder of scholastic skills, unspecified | Eu81z | Eu81z | 192577001 |
| [X]Mild learning disability | Eu816 | XaREt | 526331000000104 |
| [X]Moderate learning disability | Eu814 | XaQZ3 | 508191000000109 |
| [X]Severe learning disability | Eu815 | XaQZ4 | 508171000000105 |
| [X]Profound learning disability | Eu817 | XaREu | 526341000000108 |
| On learning disability register | 918e. | XaKYb | 416075005 |
| Specific learning disability | Eu818 | XaaiS | 889211000000104 |

**Table 7: Learning disabilities Read codes – health checks**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Learning disability health examination | 69DB. | XaPx2 | 381201000000100 |

The GPES automated extraction will also identify whether each patient having received a health check in the quarter, has an associated LD diagnostic code recorded in the patient record (see table 6) for the diagnostic codes currently included in QOF). The information extracted on diagnostic codes will not be used for payment purposes and does not constitute the practices learning disability health check register. But it will be

[15] SNOMED codes are not included in the 2013/14 QOF indicator LD001.
[16] It is anticipated these definitions will be subject to future review and change given the derogatory nature of some of the terms.

used to support practices and NHS England to validate performance under the enhanced service (and may support future review to move to an automated register count).

## Payment and validation

Payment under this enhanced service will now be on a quarterly basis calculated using the number of completed health checks undertaken in the quarter. In previous years payment was an aspiration payment, based on size of learning disability health check register and a year-end achievement (reconciliation) payment.

CQRS will calculate the quarterly payments based on the number of eligible patients on the practices registered list aged 18 or over in the financial year, who are recorded as having received a learning disability health check in the relevant quarter, known as the LD health check on CQRS.

Practices will be required to manually input the number of patients recorded on their learning disability health check register (known as LD register count on CQRS) for each quarterly payment to be calculated. The health check register count will not be generated via GPES (LD001 maximum). No payments will be made if this information is not entered. While the LD register count will be an annual figure, it is recognised that this may change in year and any changes will need to be agreed by the practice and NHS England.

The 'indicators' below are based on the Business Rules written for the GPES extraction and Read codes listed in table 6:

- LD001 input number: The number of those patients aged 18 and over in the financial year on the practices agreed learning disabilities register who received a compliant health check in this quarter.
- LD001 maximum: The number of patients aged 18 and over in the financial year on the practices agreed learning disabilities register.

Payment will be made based on the quarterly count (providing it is less than or equal to the LD register count) multiplied by £102.16.

The quarterly health check count (LD health check) should never be greater than the learning disability register count, if it is this will prevent a payment being calculated on CQRS, raising a flag with the practice and the NHS England area team to review and correct manually (e.g. amend LD register or LD health check).

After CQRS has calculated the practice's final achievement payment, the practice should ‘approve the payment value’ and submit an ‘achievement declaration’. NHS England 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 have been followed, then payment for the service will be sent to the payment agency for processing

NHS England is responsible for post payment verification. This may include auditing claims from practices to ensure that there is an agreed and appropriately managed register, that the patients on the learning disabilities health check register have received the health check within the financial year and after training has been completed. In doing so, NHS England may make use of the additional information extracted by GPES on diagnostic coding.

In addition to data extracted for payment purposes, data will also be collected for the purposes of management information using the Read codes in tables 6 and 7.

Where the information for these 'indicators' is not available, practices should enter zero:

- LDMI001: The number of patients who received a learning disabilities health check in the quarter in whom there is a learning disability diagnosis.

# Section 3. Immunisations

## Introduction

Immunisation is one of the most successful and cost-effective public health interventions and a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and protecting the population's health through both individual and herd immunity.

This section outlines the technical support for the following programmes:

- Pneumococcal vaccination programme
- Seasonal influenza vaccination programme

# Pneumococcal vaccination programme

## Background and purpose

The aim of the pneumococcal vaccine programme is to protect targeted groups from pneumococcal infections and reduce the associated morbidity and mortality. This will be achieved by delivering an evidence-based, population-wide immunisation programme that:

- identifies the eligible population and ensures effective timely delivery with optimal coverage based on the target population.
- is safe, effective, of a high quality and is independently monitored.
- is delivered and supported by suitably trained, competent and qualified clinical and non-clinical staff who participate in recognised ongoing training and development.
- delivers, manages and stores vaccine in accordance with national guidance is supported by regular and accurate data collection using the appropriate returns.

There are two different types of pneumococcal vaccine: pneumococcal conjugate vaccine (PCV) and pneumococcal polysaccharide vaccine (PPV):

- PCV is offered to all children under two years and at-risk children under five years. PCV can also be offered to children over five years of age and adults in defined clinical risk groups.
- pneumococcal polysaccharide vaccine (PPV) provides protection against 23 serotypes and is offered to those aged 65 and over and to at-risk groups aged two years and over.

NHS England has been directed to establish a pneumococcal immunisation enhanced service for all adults aged 65 and over. The arrangements to deliver this include historic enhanced service agreements entered into by Primary Care Trusts with primary medical services contractors (e.g. practices) which carried over to NHS England on 1 April 2013. The minimum requirements for these arrangements are set out in the Primary Medical Services (Directed Enhanced Services) Directions 2013.

For the purpose of this enhanced service, the requirement is the offer of pneumococcal vaccination to all patients aged 65 and over by the end of the financial year. The recommended vaccine is PPV.

## Introduction

Immunisation is one of the most successful and cost-effective health protection interventions and is a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and protecting the population's health through both individual and herd immunity.

- The pneumococcal vaccines protect against pneumococcal infections caused by the bacterium *Streptococcus pneumoniae*. The pneumococcus is one of the most frequently reported causes of bacteraemia and meningitis and it is the commonest cause of community-acquired pneumonia.
- Invasive pneumococcal disease is a major cause of morbidity and mortality and can affect anyone. However, it particularly affects the very young, the elderly and those with impaired immunity or chronic conditions.
- Over 90 different serotypes of the pneumococcal bacterium have been identified. Prior to the introduction of pneumococcal vaccines, eight to ten of these serotypes were responsible for 66 per cent of the serious pneumococcal infections in adults and about 80 per cent of invasive infections in children.
- A worldwide increase in pneumococcal antibiotic resistance has been reported. This, added to the large burden and the severity of pneumococcal disease, resulted in the introduction of UK infant, elderly and at-risk group pneumococcal vaccine programmes.

Practices participating in this enhanced service are required to develop a register of all patients aged 65 and over by the end of the financial year and offer vaccination, developing a proactive and preventative approach with the aims of maximising uptake and meeting any public health targets in respect of such immunisations.

Public health requirements ask that practices ensure they maintain and improve current immunisation coverage (with reference to vaccine coverage public health outcomes framework indicators) with the aspiration of 100 per cent of relevant individuals being offered immunisation in accordance with the Green Book and other official DH/PHE guidance.

The enhanced service agreement is determined locally and may include requirements above the minimum specification provided by Directions and with pricing agreed locally to reflect that agreement

For the purposes of calculating payments, CQRS will support this service from 1 September 2013 to 31 March 2014 For the purpose of this enhanced service, patients who have had a previous pneumococcal vaccination in their record prior to the 1 September 2013 will not be included in this calculation. In the event that it is clinically appropriate for a patient to receive a further vaccination against pneumococcal this will need to be agreed locally

For the purpose of this enhanced service, patients who have had a previous pneumococcal vaccination in their record prior to the 1 September 2013 will not be included in this enhanced service. In the event that it is clinically appropriate for a patient to receive a further vaccination against pneumococcal this will need to be agreed locally. Once patients are given a pneumococcal vaccine from the age of two, that vaccine would provide lifetime cover although there are exceptions where patients may be given boosters.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following codes will need to be used and to enable CQRS to calculate payment based on the GPES extraction:

**Table 8: Pneumococcal vaccination Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Pneumococcal vaccination given | 65720 | XaCKa | 12866006 |
| Pneumococcal vaccination | 6572. | 6572. | 12866006 |
| Pneumococcal vaccination contraindicated | 8I2E. | XaIOS | 390795005 |
| Pneumococcal vaccination declined | 8I3Q. | Xalyy | 401086001 |
| No consent to Pneumococcal vaccination | 68NX. | 68NX. | 171292006 |
| Pneumococcal vaccination given by other healthcare provider | 657P. | XaPyX | 382551000000109 |

The Business Rules supporting this enhanced service are available to download from the NHS PCC website[17].

## Payment and validation

Payment for the pneumococcal vaccination programme will be calculated through CQRS on a monthly basis, based on the GPES extracts or data entered manually via the CQRS web interface.

CQRS will calculate the monthly payments based on the number of eligible patients on the practices registered list. The 'indicator' below is based on the Business Rules written for the GPES extraction of the Read codes listed in table 8 and is used to calculate the payments:

[17] NHS PCC. Enhanced services Business Rules. http://www.pcc-cic.org.uk/article/des-business-rules-alcohol-reduction-learning-disabilities-and-rotavirus

- PNEUM01: A Monthly count of the number of patients aged 65 and over on 31 March 2014 who have received a PPV vaccination at the general practice

Payment will be on a monthly basis. CQRS will calculate the monthly payments based on the number of patients who are recorded as having received a pneumococcal vaccination. Payment will be made based on the monthly count multiplied by £7.63[18].

The pneumococcal vaccination programme will be available on CQRS from October.

After CQRS has calculated the practice's final achievement payment, the practice should 'approve the payment value' and submit an 'achievement declaration'. The area team 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.

NHS England is responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this service, NHS England may make use of the additional information extracted by GPES on complete and incomplete vaccinations.

In addition to data extracted for payment purposes, data will also be collected for the purposes of management information using the Read codes in table 8.

Where the information for these 'indicators' is not available, practices should enter zero:

- PNEUMMI01: The number of patients aged 65 and over on 31 March 2014 who have received a PPV vaccination from another healthcare provider within the reporting period.
- PNEUMMI02: The number of patients aged 65 and over on 31 March 2014 who have a contra-indication to the PPV vaccine, up to the end of the reporting period
- PNEUMMI03: The number of patients aged 65 and over on 31 March 2014 who declined a PPV vaccination within the reporting period.
- PNEUMMI04: The number of patients aged 65 and over on 31 March 2014 who have not consented to a PPV vaccination within the reporting period.
- PNEUMMI05: The number of patients aged 65 and over on 31 March 2014 who did not receive a PPV vaccination and have no recorded reason for not receiving a PPV vaccination, up to the end of the reporting period.

[18] Or the locally agreed item of service fee as the payment for this service can be defined locally. CQRS allows area teams to set their own price for this service before it is 'offered' to practices.

# Seasonal influenza vaccination programme

## Background and purpose

The aim of the seasonal influenza immunisation programme is to protect those who are most at risk of serious illness or death should they develop influenza and to reduce transmission of the infection, thereby contributing to the protection of vulnerable individuals who may have a suboptimal response to their own immunisation. It is expected that the programme actively offers the flu vaccination to all patients in the eligible groups and that there is an uptake rate of at least 75 per cent of those 65 years and over and those under 65 in a risk group.

Further information can be found in a letter issued on behalf of the DH, NHS England, and Public Health England in June 2013[19] and the updated seasonal flu plan[20].

NHS England has been directed to establish a influenza immunisation enhanced service for defined at-risk patients. The minimum requirements for these arrangements are set out in the Primary Medical Services (Directed Enhanced Services) Directions 2013. The arrangements to deliver this include historic enhanced service agreements entered into by Primary Care Trusts with primary medical services contractors (e.g. practices) which carried over to NHS England on 1 April 2013 which may include other risk groups not covered by the enhanced service (e.g. pregnant women).

## Introduction

Flu vaccinations are currently recommended free of charge to the following:

- patients aged 65 years and over (including those becoming age 65 years by 31 March 2014)
- all pregnant women (including those women who become pregnant during the flu season)
- all children aged two and three year olds (but not four years or older) on 1 September 2013 (as part of the childhood seasonal influenza vaccination programme)
- patients with a serious medical condition such as:
    - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
    - chronic heart disease, such as heart failure
    - chronic kidney disease at stage 3, 4 or 5

[19] DH, NHS England, PHE flu letter. June 2013..https://www.gov.uk/government/publications/flu-immunisation-programme-2013-to-2014

[20] Annual flu plan 2013/14. https://www.gov.uk/government/news/planning-for-the-demands-of-flu-this-winter

- chronic liver disease
- chronic neurological disease, such as Parkinson's disease or motor neurone disease
- diabetes
- a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment).

- people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, or university halls of residence.
- people who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill.

The list above is not exhaustive and decisions should be based on a practitioner's clinical judgement. Consideration should also be given to the vaccination of household contacts of immuno-compromised individuals, specifically individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable.

Also recommended to be vaccinated as part of occupational health:

- health and social care workers with direct patient/client contact

For further information, see the Green Book[21] influenza chapter.

Flu vaccine is procured directly by practices from the manufacturer. It is recommended that practices ensure they have ordered from more than one supplier and have adequate supplies for the 2013/14 season, allowing for greater uptake than in previous years. They are also asked to pay attention to ordering the most appropriate type of vaccine such as Fluenz® for children in clinical risk groups and enough egg-free or low ovalbumin content vaccine for those patients who may require it.

Practices participating in this enhanced service are required to develop a register for at-risk patients and offer vaccination during the flu season, develop a proactive and preventative approach with the aims of maximising uptake and meeting any public health targets in respect of such immunisations. The enhanced service agreement is however determined locally and may include requirements above the minimum enhanced specification or national programme with pricing agreed locally to reflect that agreement.

This means local agreements can include some or all of the eligible patients recommended for flu immunisation . To enable practices and area teams to use CQRS

[21] Green book. https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

and GPES to extract data for this services, they are set up as one service on CQRS. This provides a 'catch all' for patients eligible for the seasonal flu vaccinations as far as these can be defined nationally. As such, area teams and GP practices will need to ensure the CQRS service is a suitable match to the contractual arrangements agreed locally. This could include proceeding with CQRS and agreeing end of season reconciliation using manual submissions to correct where there are known local omissions (or additions) from the national CQRS approach so that adjustment can be made to correct any under or over payment.

The programme will run from 1 September 2013 to 31 March 2014, although NHS England recognise that some practices had started vaccinating patients prior to the programme starting on 1 September as such, for the seasonal influenza vaccination programme the data extracts will look back to 1 August 2013 to take account of this and practices will receive payment accordingly.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

Due to the number of codes available, it is not possible to list all of the codes in this guidance document. However, the high level Read code for vaccination is as follows:

**Table 9: Seasonal influenza vaccination Read code**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Seasonal Influenza vaccination | 65ED. | XaZ0d | 822851000000102 |

## Payment and validation

Payment for the seasonal influenza vaccination programme will be calculated through CQRS on a monthly basis, based on the GPES extracts or data entered manually via the CQRS web interface..

CQRS will calculate the monthly payments based on the number of eligible patients on the practices registered list:

- FLU01: The number of patients defined as at risk, excluding patients aged two or three, who are registered at the practice and have a record of receiving an influenza vaccination within the reporting period.

Payment will be on a monthly basis. CQRS will calculate the monthly payments based

on the number of patients who are recorded as having received a seasonal influenza vaccination. Payment will be made based on the monthly count multiplied by £7.63[22].

The seasonal influenza vaccination programme will be available on CQRS from October.

After CQRS has calculated the practice's final achievement payment, the practice should 'approve the payment value' and submit an 'achievement declaration'. The area team 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.

NHS England is responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this service.

Where the information for these 'indicators' is not available, practices should enter zero:

- FLUMI01: The number of patients defined as at risk, excluding patients aged two or three, who have received a seasonal influenza vaccination given by another healthcare provider within the reporting period.
- FLUMI02: The number of patients defined as at risk, excluding patients aged two or three, who have a contraindication to the seasonal influenza vaccine within the reporting period.
- FLUMI03: The number of patients defined as at risk, excluding patients aged two or three, who have declined a seasonal influenza vaccination within the reporting period.
- FLUMI04: The number of patients defined as at risk, excluding patients aged two or three, who have not consented to a seasonal influenza vaccination within the reporting period.
- FLUMI05: The number of patients defined as at risk, excluding patients aged two or three, who received a seasonal influenza vaccination given by a pharmacist within the reporting period.
- FLUMI06: The number of patients aged 65 and over on 31 March 2014 who have received a seasonal influenza vaccination within the reporting period.
- FLUMI07: The number of patients who received a seasonal influenza vaccination that were pregnant at the time of immunisation within the reporting period.
- FLUMI08: The number of patients defined as at risk, excluding patients aged two or three, aged 65 or over or who were pregnant at the time of immunisation who received a seasonal influenza vaccination within the reporting period.

[22] Or the locally agreed item of service fee as the payment for this service can be defined locally. CQRS allows area teams to set their own price for this service before it is 'offered' to practices.

# Section 4. New immunisations

## Introduction

Immunisation is one of the most successful and cost-effective public health interventions and a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and protecting the population's health through both individual and herd immunity.

Following recommendations made by the Joint Committee for Vaccination and Immunisation (JCVI), five new vaccination programmes will be introduced through general practice in 2013. They are as follows:

- childhood seasonal flu vaccination programme for two and three year olds (from September 2013)
- MMR catch-up vaccination programme (from May 2013)
- rotavirus vaccination programme for infants (from July 2013)
- shingles (routine) vaccination programme for patients aged 70 (from September 2013)
- shingles (catch-up) vaccination programme for patients aged 79 (from September 2013).

# Childhood (two and three year olds) seasonal influenza vaccination programme

## Background and purpose

The JCVI has recommended that the seasonal influenza programme be extended to all children aged two to less than 17 years. This is in order to reduce the impact of influenza on children and lower influenza transmission to other children, adults and those in clinical risk groups at any age. This programme will initially be rolled out to all healthy two and three year olds in the 2013/14 flu season as part of a gradual step to full implementation.

This programme is in addition to the existing routine seasonal influenza programme to vaccinate children aged six months and over who have certain clinical conditions which put them more at risk of the effects of influenza.

The objective of influenza immunisation is to protect those who are most at risk of serious illness or death should they develop influenza and to reduce transmission of the infection, thereby contributing to the protection of vulnerable patients who may have a suboptimal response to their own immunisations.

## Introduction

Seasonal flu vaccination programme has been introduced from 1 September 2013 for a three month period in order to achieve the maximum protection before influenza begins to circulate. However, practices may continue to vaccinate eligible patients until 31 March 2014 for whom they will receive payment.

The vaccine recommended by JCVI for children is a live attenuated intranasal influenza vaccine (Fluenz®). This vaccine has a good safety record profile in children aged two years and older and has an established history of use in the United States.

Fluenz®[23] should be offered to all registered patients aged two and three, but not yet four on 1 September 2013 on either:

- a proactive call basis for patients not considered 'at-risk'; or
- a proactive call and recall basis for patients considered 'at-risk.

See the influenza chapter of the Green Book for detailed information about administration and dosage.

[23] Fluenz® has a short shelf-life and doses centrally supplied via ImmForm will have a use-by date of mid-January or earlier. Clinical advice on seasonal influenza immunisation is that vaccinations should be given as early as possible in order for immunity to increase before the virus begins to circulate.

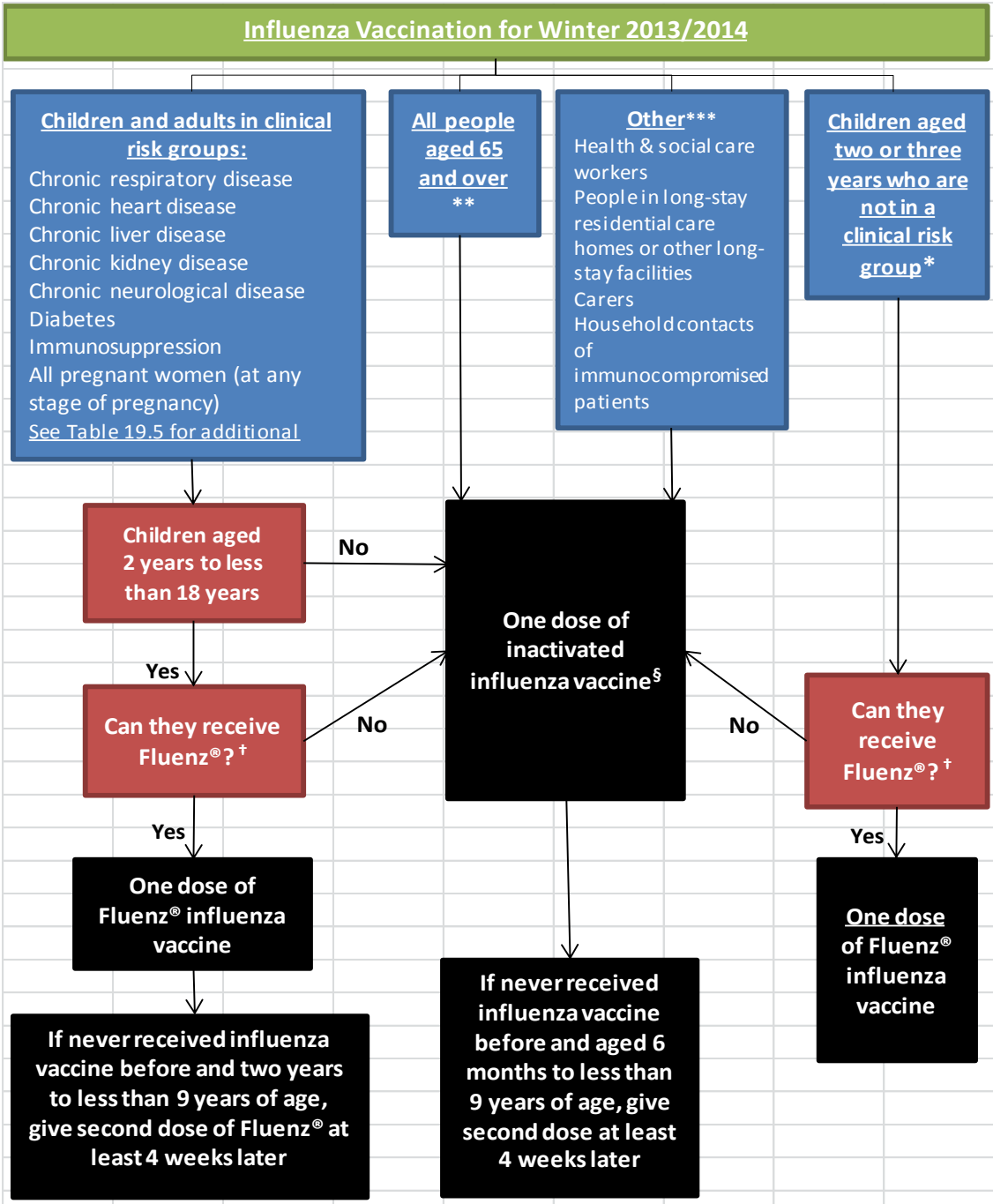
Live attenuated influenza vaccine (Fluenz®) should be offered to all children aged two or three years (see earlier for age definition) except for those for whom it is unsuitable or contra-indicated. A single dose of Fluenz® should be offered, irrespective of whether influenza vaccine has been received previously.

Where Fluenz® is contra-indicated, a suitable inactivated influenza vaccine should be offered. An inactivated trivalent vaccine can be given to both two and three years olds but the quadrivalent inactivated influenza vaccine (FluarixTM Tetra) should only be given to children aged three years and older. Children offered inactivated influenza vaccine who have not received influenza vaccine previously should be offered a second dose of the vaccine at least four weeks later. The inactivated influenza vaccines are interchangeable; the second dose, if required, should be given at least four weeks after the first dose in accordance with the manufacturer's SPC for that vaccine.

JCVI has advised that only children aged six months to under nine years who are in clinical risk groups and have not received influenza vaccine previously or are being offered inactivated influenza vaccine for the first time should be offered a second dose of vaccine. All other children should receive a single dose of influenza vaccine, including those receiving live attenuated influenza vaccine, irrespective of whether they have received influenza vaccine previously. This advice differs from that in SPCs of influenza vaccines. Children who only received one dose of influenza vaccine or who only received the pandemic monovalent influenza A(H1N1)v vaccine before should be considered as previously vaccinated.

Fluenz® is supplied in an applicator that allows a divided dose to be administered in each nostril (total dose of 0.2 ml, 0.1 ml in each nostril). The device allows intranasal administration to be performed without the need for additional training. Administration of either dose does not need to be repeated if the patient sneezes or blows their nose following administration. There are no data on the effectiveness of Fluenz® when given to children with a heavily blocked or runny nose (rhinitis) attributable to infection or allergy. As heavy nasal congestion might impede delivery of the vaccine to the nasopharyngeal mucosa, deferral of administration until resolution of the nasal congestion or an appropriate alternative intramuscularly administered influenza vaccine should be considered.

The PHE chart overleaf summarises the advice on influenza vaccination for the 2013/14 influenza vaccination programme.




* all children aged two or three years (but not four years or older) on or before 1 Sept 2013

** all those aged 65 years or older including all those aged 65 years on or before 1 March 2014

*** follow additional guidance from UK health departments

† cannot receive if: under age of two years; 18 years and older; have severe asthma (BTS SIGN step 4 or above); active wheezing at time of vaccination; egg allergy; certain immunodeficiencies; or pregnant - see contraindications and precautions for full list.

§ if quadrivalent inactivated vaccine available, consider for **children age 3 years and older only**. If quadrivalent unavailable, offer suitable trivalent inactivated influenza vaccine. See table 19.6 which lists the vaccines that can be used in young children - **some are not suitable for young children.**

Fluenz® vaccine for this programme has been procured centrally for the two and three year old children starting in September 2013. Fluenz® for this programme will be centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm.

For those two- and three-year-olds who are contra-indicated to Fluenz®, inactivated influenza vaccines that have already been ordered by practices for two and three year-old children in clinical risk groups, can now be utilised for the Fluenz®-contra-indicated children.

Supplies of Fluenz® for vaccinating children other than those aged two and three, such as those with a clinical condition which makes them more at risk from the effects of influenza, should be ordered direct from the manufacturer.

Payment under this enhanced services will be on a monthly basis, based on an item of service payment of £7.64 per dose.

For full details of the service and administrative requirements, please see the service specification[24].

Details of the national programme can be found in the following letter issued by DH, NHS England and PHE in July 2013[25].

NHS Employers, NHS England and GPC have agreed a set of joint FAQs[26] to support the implementation of this programme.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following codes will need to be used to enable CQRS to calculate payment based on the GPES extract:

[24] NHSE. Childhood seasonal influenza service specification. http://www.nhsemployers.org/PAYANDCONTRACTS/GENERALMEDICALSERVICESCONTRACT/VACCINATION_AND_IMMUNISATION/PANDEMIC-FLU/Pages/Childhood(twoandthreeyearold)influenzavaccinationprogramme.aspx

[25] DH, NHS England, PHE letter. July 2013. https://www.gov.uk/government/publications/childrens-flu-immunisation-programme-2013-to-2014

[26] Childhood seasonal flu FAQs. http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/vaccination_and_immunisation/pandemic-flu/Childhood_(two_and_three_year_old)_influenza_vaccination_programme/Pages/ChildhoodseasonalinfluenzavaccinationprogrammeFAQs.aspx

**Table 10: Seasonal influenza intranasal vaccination first dose Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Administration of first intranasal seasonal influenza vaccination | 65ED1 | Xaac3 | 884861000000100 |
| FLUENZ nasal suspension 0.2 ml | n47D. | n47D. | 19820511000001106 |
| INFLUENZA VAC nasal susp 0.2 ml | n47E. | n47E. | 19821411000001103 |
| Administration of first intranasal influenza vaccination | 65EE0 | XaaED | 871751000000104 |
| Administration of intranasal influenza vaccination | 65EE. | Xaa9G | 868241000000109 |

**Table 11: Seasonal influenza intranasal vaccination second dose Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Administration of second intranasal seasonal influenza vaccination | 65ED3 | Xaac4 | 884881000000109 |
| FLUENZ nasal suspension 0.2 ml | n47D. | n47D. | 19820511000001106 |
| INFLUENZA VAC nasal susp 0.2 ml | n47E. | n47E. | 19821411000001103 |
| Administration of second intranasal influenza vaccination | 65EE1 | XaaEF | 871781000000105 |
| Administration of intranasal influenza vaccination | 65EE. | Xaa9G | 868241000000109 |

**Table 12: TIV Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Seasonal influenza vaccination | 65ED. | XaZ0d | 822851000000102 |
| FLUVIRIN syringe 0.5 ml | n471. | n471. | 3249511000001109 |
| *INFLUVAC SUB-UNIT syr 0.5 ml | n472. | n472. | N/A |

| | | | |
|---|---|---|---|
| INFLUVAC SUB-UNIT syr 0.5 ml | n473. | n473. | 3255011000001100 |
| *INFLUVAC SUB-UNIT vials 5 ml | n474. | n474. | N/A |
| *INFLUVAC SUB-UNIT vials 25 ml | n475. | n475. | N/A |
| FLUARIX VACCINE syringe | n47d. | n47d. | 3245911000001104 |
| AGRIPPAL VACCINE syringe 0.5 mL | n47f. | n47f. | 3255311000001102 |
| INFLEXAL V syringe 0.5 mL | n47k. | n47k. | 10306611000001101 |
| ENZIRA prefilled syringe 0.5 mL | n47m. | n47m. | 9511411000001107 |
| VIROFLU p/f syringe 0.5 mL | n47n. | n47n. | 10455811000001107 |
| IMUVAC prefilled syringe 0.5 mL | n47o. | n47o. | 10859911000001105 |
| INFLUENZA VAC(SV) syrg 0.25 ml | n47y. | n47y. | 430482001 |
| INFLUENZA VAC (VIROSOME) 0.5 mL | n47z. | n47z. | 391669005 |

**Table 13: Vaccination given by other healthcare provider Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| First intranasal seasonal influenza vaccination given by other healthcare provider | 65E21 | Xaac7 | 884941000000105 |
| Second intranasal seasonal influenza vaccination given by other healthcare provider | 65E22 | Xaac8 | 884961000000106 |
| Seasonal influenza vaccine given by other healthcare provider | 65E20 | XaZ0e | 822871000000106 |
| Seasonal influenza vaccination given by pharmacist | 65ED0 | XaZfY | 849211000000109 |
| Seasonal influenza vaccination given while hospital inpt | 65ED2 | XaaZp | 883641000000103 |

The Business Rules supporting this enhanced service will be available to download from the NHS PCC website[27] by the end of September.

## Payment and validation

Payment for the childhood seasonal influenza vaccination programme will be calculated through CQRS on a monthly basis, based on the GPES extracts or data entered manually via the CQRS web interface.

CQRS will calculate the monthly payments based on the number of eligible patients on the practices registered list who are aged two and three, but not yet four on 1 September 2013 and who are recorded as being vaccinated against influenza during the period 1 September 2013 and 31 March 2014. The codes used to identify payment will be based on the codes in tables 10 - 12 in addition to the practice meeting the requirements of the qualifying criteria of age, timeframe and at-risk status. The 'indicators' below are based on the Business Rules written for the GPES extraction of the Read codes listed in the tables and are used to calculate the payments:

- CFLU001: Monthly count of doses of seasonal influenza vaccination given to patients aged two and three but not four on 1 September 2013
- CFLU001a: Count of second doses given to patients within the same month but at least four weeks after the first dose. [NB:CFLU001a will not be produced as a separate count, it will be added to the main payment count.]

Payment will be on a monthly basis. CQRS will calculate the monthly payments based on the number of patients who are recorded as having received a childhood seasonal influenza vaccination. Payment will be made based on the monthly count multiplied by £7.64.

After CQRS has calculated the practice's final achievement payment, the practice should 'approve the payment value' and submit an 'achievement declaration'. The area team 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.

NHS England is responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this service, NHS England may make use of the additional information extracted by GPES on complete and incomplete vaccinations.

In addition to data extracted for payment purposes, or will be collected for the purposes of management information using the Read codes in table 10 - 13.

[27] NHS PCC. Enhanced services Business Rules. http://www.pcc-cic.org.uk/article/des-business-rules-alcohol-reduction-learning-disabilities-and-rotavirus

Where the information for these 'indicators' is not available, practices should enter zero:

- CFLUMI001: The number of patients aged two on 1 September 2013 who received a Fluenz vaccination within the reporting period.
- CFLUMI002: The number of patients aged two on 1 September 2013 who received a 1st dose of TIV within the reporting period.
- CFLUMI003: The number of patients aged two on 1 September 2013 who received a 2nd dose of TIV within the reporting period.
- CFLUMI004: The number of patients aged three on 1 September 2013 who received a Fluenz vaccination within the reporting period.
- CFLUMI005: The number of patients aged three on 1 September 2013 who received a 1st dose of TIV within the reporting period.
- CFLUMI006: The number of patients aged three on 1 September 2013 who received a 2nd dose of TIV within the reporting period.
- CFLUMI007: The number of patients aged two and three but not yet four on 1 September 2013 who have not received a seasonal influenza vaccination.
- CFLUMI008: The number of patients aged two and three but not yet four on 1 September 2013 who have received a seasonal influenza vaccination given by another healthcare provider within the reporting period.

# MMR catch-up vaccination programme

## Background

Outbreaks of measles in England have been increasing in the last two years. In 2012, there was a total of 1,920 confirmed cases, the highest annual figure since 1994. To date during 2013, 587 cases have been confirmed in England. The key difference in the pattern of infection in 2013 is a concentration of cases in teenagers, which has not been experienced in previous years. It is most likely that the increase in this age group is related to the adverse publicity about the MMR vaccine between 1998 and 2003.

Following advice from PHE, the CMO recommended a temporary vaccination programme for measles, mumps and rubella (MMR) urgently be put in place to respond to the outbreak of infection.

## Introduction

The MMR catch-up programme service specification[28] agreed between NHS Employers and the GPC, was introduced from 1 May 2013. The programme will run until 31 March 2014. NHS England recognise that some practices had started vaccinating patients prior to the programme starting on 1 May 2013 due to the nature of the outbreak of measles. As such, for the MMR catch-up programme the data extracts will look back to 1 April 2013 to take account of this and practices will receive payment accordingly.

Practices are required to:

- identify eligible 'at-risk' children aged 10-16 years and proactively offer vaccination for MMR
- provide vaccination to all unvaccinated patients aged 16 years or over who present to the practice requesting vaccination
- ensure that the patient records of those offered the vaccination are updated accordingly.

Payment under this enhanced service is separated into two categories, as follows:

1. A payment of £1.50 per eligible patient for writing to parents/guardians inviting the patient a vaccination. Eligible patients in this cohort are children aged 10-16 years (born between 1997-2003[29]) identified as 'at-risk' (children who are not recorded as having been fully vaccination against MMR previously).

[28] NHS Employers. MMR catch-up programme service specification. http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/vaccination_and_immunisation/pandemic-flu/Pages/Childhood%28twoandthreeyearold%29influenzavaccinationprogramme.aspx

[29] Calendar year.

2. A payment of £7.64 per dose for eligible patients aged 16 years or over, who attend the practice and who are recorded as not having been fully vaccinated against MMR previously (i.e. not received both doses of vaccine and therefore either require one or two doses).

The administration of the vaccine to children aged 10-15 years is included in the existing global sum allocations, assuming the practice provides additional services. As such no additional payment will be made for vaccinating these children.

Vaccines for this programme will be centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm. For full details of the service and administrative requirements, see the service specification.

This document provides details on the audit requirements to support practices and area teams in the provision of vaccination against MMR.

Area teams and practices taking part should ensure they have read and understood the requirements in the specification, as well as the information contained in this document.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following codes will need to be used to enable CQRS to calculate payment based on the GPES extract:

**Table14. Invitation Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Measles mumps rubella catch-up vaccination invitation | 9ki3. | XaQPt | 838601000000103 |

**Table 15. First dose Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Measles/mumps/rubella vaccination | 65M1. | 65M1. | 38598009 |
| Measles/Mumps/Rubella vaccine | n4k.. | n4k.. | 61153008 |
| MMR vaccine injection 0.5 mL | n4k1. | n4k1. | 14015211000001100 |

| | | | |
|---|---|---|---|
| PLUSERIX MMR vaccine injection 0.5 mL | n4k2. | n4k2. | N/A |
| MMR II vaccine injection 0.5 mL | n4k3. | n4k3. | N/A |
| IMMRAVAX injection 0.5 mL | n4k4. | n4k4. | N/A |
| PRIORIX vaccine injection powder + diluent 0.5 mL | n4k5. | n4k5. | 4621611000001100 |
| M-M-RVAXPRO powder + solvent for susp for injection 0.5 mL | n4k6. | n4k6. | 13968211000001100 |
| [V] Measles-mumps-rubella (MMR) vaccination | ZV064 | ZV064 | 411491000000104 |
| Measles mumps rubella catch-up vaccination | 9ki1. | XaQPr | 504481000000108 |
| Measles/mumps/rubella vaccine injpdr + diluent | N/A | x00S0 | N/A |
| MMR II vaccine injection (pdr for recon) + diluent | N/A | x00S1 | 4830211000001100 |
| IMMRAVAX injection | N/A | x01LK | N/A |
| PLUSERIX MMR injection | N/A | x01LL | N/A |
| MMR II | N/A | x043V | N/A |
| PRIORIX vaccine injection (pdr for recon) + diluent | N/A | x04sw | N/A |

**Table 16. Second dose Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Measles mumps and rubella booster vaccination | 65MA. | 65MA. | 170431005 |
| MMR pre-school booster vaccination | 65MB. | 65MB. | 170432003 |
| Measles mumps and rubella | 65MC. | 65MC. | 170433008 |

| | | | |
|---|---|---|---|
| vaccination - second dose | | | |
| Measles/mumps/rubella vaccination | 65M1. | 65M1. | 38598009 |
| Measles/Mumps/Rubella vaccine | n4k.. | n4k.. | 61153008 |
| MMR vaccine injection 0.5 mL | n4k1. | n4k1. | 14015211000001100 |
| PLUSERIX MMR vaccine injection 0.5 mL | n4k2. | n4k2. | N/A |
| MMR II vaccine injection 0.5 mL | n4k3. | n4k3. | N/A |
| IMMRAVAX injection 0.5 mL | n4k4. | n4k4. | N/A |
| PRIORIX vaccine injection powder+diluent0.5mL | n4k5. | n4k5. | 4621611000001100 |
| M-M-RVAXPRO powder + solvent for susp for injection 0.5 mL | n4k6. | n4k6. | 13968211000001100 |
| [V] Measles-mumps-rubella (MMR) vaccination | ZV064 | ZV064 | 411491000000104 |
| Measles mumps rubella catch-up vaccination | 9ki1. | XaQPr | 504481000000108 |
| Measles/mumps/rubella vaccine injpdr + diluent | N/A | x00S0 | N/A |
| MMR II vaccine injection (pdr for recon) + diluent | N/A | x00S1 | 4830211000001100 |
| IMMRAVAX injection | N/A | x01LK | N/A |
| PLUSERIX MMR injection | N/A | x01LL | N/A |
| MMR II | N/A | x043V | N/A |
| PRIORIX vaccine injection (pdr for recon) + diluent | N/A | x04sw | N/A |

## Payment and validation

Payment for the MMR catch-up vaccination programme will be calculated through CQRS on a monthly basis, based on the GPES extracts or data entered manually via the CQRS web interface..

CQRS will calculate the monthly payments based on the number of eligible patients on the practices registered list. The 'indicators' below are based on the Business Rules written for the GPES extraction of the Read codes listed in tables 1, 2 and 3 and are used to calculate the payments:

- MMRCU01: Monthly count of patients aged 10-16 years invited for vaccination by letter (or email).
- MMRCU02: Monthly count of MMR vaccination doses given to patients aged 16 years and over.

For MMRCU01 there will be a payment of £1.50 per eligible patient for writing to parents/guardians inviting the patient for a vaccination. Eligible patients in this cohort are children aged 10-16 years (born between 1997-2003) identified as 'at-risk' (i.e. children who are not recorded as having been fully vaccination against MMR previously).

For MMRCU02 there will be a  payment of £7.64 per dose for eligible patients aged 16 years or over, who attend the practice and who are recorded as not having been fully vaccinated against MMR previously (i.e. patients who have not received both doses of vaccine and therefore either require one or two doses).

The administration of the vaccine to children aged 10-15 years is included in the existing global sum allocations, assuming the practice provides additional services. As such no additional payment will be made for vaccinating these children.

The MMR catch-up vaccination programme will be available on CQRS from August Practices will be able to enter achievement data manually for any payments due before the first GPES extraction is available. Practices can enter data for each month from 1 April 2013.

To enter data manually for the MMR catch-up vaccination programme practices must have first been offered and accepted the service on CQRS by their area team.

After CQRS has calculated the practice's final achievement payment, the practice should ‘approve the payment value’ and submit an ‘achievement declaration’. The area team 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.

NHS England is responsible for post payment verification. This may include auditing

claims of practices to ensure that they meet the requirements of this service, NHS England may make use of the additional information extracted by GPES on complete and incomplete vaccinations.

In addition to data extracted for payment purposes, or will be collected for the purposes of management information using the Read codes in tables 14, 15 and 16.

Where the information for these 'indicators' is not available, practices should enter zero:

- MMRMI01: The number of patients between the ages of 10-15 years (inclusive) who have not been vaccinated for MMR (0 doses).
- MMRMI02: The number of patients between the ages of 10-15 years (inclusive) who have only had one dose of MMR (1 dose).
- MMRMI03: The number of patients between the ages of 10-15 years (inclusive) who have had two doses of MMR (2 doses).
- MMRMI04: The number of patients aged 16 years or over, who have only had one dose of MMR (1 doses).
- MMRMI05: The number of patients aged 16 years or over, who have had two doses of MMR (2 doses).

# Rotavirus (routine childhood immunisation) vaccination programme

## Background and purpose

Following a recommendation by the JCVI, from 1 July 2013, vaccination against Rotavirus was introduced to the national immunisation programme to protect infants against Rotavirus.

Rotavirus can cause gastroenteritis which may lead to severe diarrhoea, vomiting, stomach cramps, dehydration and mild fever. If unvaccinated, nearly all children would have at least one episode of Rotavirus gastroenteritis before reaching five years of age. The vaccine, given orally, is over 85 per cent effective at protecting against severe rotavirus gastroenteritis. An estimated 130,000 children with rotavirus gastroenteritis would have visited their practice and approximately 12,700 of these children would have been hospitalised in England and Wales each year if there was no vaccination programme. Deaths caused by rotavirus are rare and difficult to quantify accurately, but in England and Wales there were approximately three to four each year prior to the vaccination programme commencing.

## Introduction

The new rotavirus immunisation programme was introduced from July 2013. It comprises two doses of rotavirus vaccine given to infants at the age of two months and three months (that is two doses four weeks apart) when they attend for their first and second routine childhood immunisations.

Vaccinations and immunisations are an additional service under the GMS contract and changes to the GP contract for 2013/14 introduce a new item of service payment of £7.63 for a completed rotavirus course for GMS providers of the additional service.

For the purposes of calculating payment under the contract, a completed course is defined as 'two doses of rotavirus vaccination given from age six weeks (the earliest the vaccine can be given) with a minimum of four weeks between doses with the second dose due before the patient reaches the age of six months (the vaccine must not be given to anyone over 24 weeks of age). Only one payment will be made per patient vaccinated.

The Business Rules supporting this enhanced service are available to download from the NHS PCC website[30].

[30] NHS PCC. Enhanced services Business Rules. http://www.pcc-cic.org.uk/article/des-business-rules-alcohol-reduction-learning-disabilities-and-rotavirus

Further details on background to the programme, dosage and timings can be found in the letter from NHS England, PHE and the DH dated 30 April[31].

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following codes will need to be used to enable CQRS to calculate payment based on the GPES extract:

**Table 17: Rotavirus Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| First rotavirus vaccination | 65d0. | Xaa9n | 868631000000102 |
| Second rotavirus vaccination | 65d1. | Xaa9o | 868651000000109 |
| Rotavirus vaccination contraindicated | 8I2s. | Xaa9q | 868691000000101 |
| Rotavirus vaccination declined | 8IEm. | Xaa9r | 868711000000104 |
| No consent to Rotavirus vaccination | 68Nw. | Xaa9s | 868731000000107 |
| Did not attend first rotavirus vaccination | 9Nih. | XaaBo | 870011000000106 |
| Did not attend second rotavirus vaccination | 9Nii. | XaaBn | 870041000000107 |
| First rotavirus vaccination declined | 8IEm0 | XaaWN | 882201000000107 |
| Second rotavirus vaccination declined | 8IEm1 | XaaWO | 882221000000103 |
| H/O: rotavirus vaccine allergy | 14L50 | XaadN | 885901000000106 |
| [X]Rotavirus vaccine causing | U60K5 | Xaait | 889571000000106 |

[31] DH, NHS England, PHE letter. April 2013. https://www.gov.uk/government/publications/national-immunisation-programme-planned-changes-for-2013-to-2014

| | | | |
|---|---|---|---|
| adverse effects in therap use /<br>Adverse reaction to rotavirus vaccine | | | |

## Payment and validation

Payment for the Rotavirus vaccination programme will be calculated through CQRS on a monthly basis, based on the GPES extracts or data entered manually via the CQRS web interface.

CQRS will calculate the monthly payments based on the number of eligible patients on the practices registered list who are recorded as having received a completed course of rotavirus vaccination. The codes being used to identify payment will be those relating to first rotavirus vaccination and second rotavirus vaccination subject to the qualifying criteria of age and time being met. The 'indicator' below is based on the Business Rules written for the GPES extraction of the Read codes listed in table 13 and are used to calculate the payments:

- Rota001: The number of the contractors registered patients whose clinical notes include a record of completed rotavirus immunisation being given before 6 months of age in the financial year.

Payment will be on a monthly basis. CQRS will calculate the monthly payments based on the number of patients who are recorded as having received a completed course of rotavirus vaccination. Payment will be made based on the monthly count multiplied by £7.63.

After CQRS has calculated the practice's final achievement payment, the practice should ‘approve the payment value’ and submit an ‘achievement declaration’. The area team 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.

NHS England is responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this service. In addition to data extracted for payment purposes, data will also be collected for the purposes of management information using the Read codes in table 17.

Where the information for these 'indicators' is not available, practices should enter zero:

- RotaMI001: The number of contractors registered patients who attain the age of 6 months old within the period whose clinical notes suggest the patient has received the 1st dose of rotavirus vaccination (anytime from 6 weeks after their birth) but have not received a 2nd completing dose of rotavirus immunisation.

- RotaMI002: The number of patients who attain the age of 6 months old within the period whose clinical notes suggest the patient has received the 1st dose of rotavirus vaccination (anytime from 6 weeks after their birth) and have received a 2nd dose but this 2nd dose has been given within 4 weeks of the 1st dose.
- RotaMI003: The number of contractors registered patients who attain the age of 6 months old within the period whose clinical notes suggest the patient has received the 2nd dose of rotavirus vaccination but has not received the 1st dose.
- RotaMI004: The number of contractors registered patients who attain the age of 6 months old within the period with no rotavirus immunisation (either a record that indicates the vaccination was declined/contraindicated or that there is neither a 1st nor 2nd dose of the vaccination).

# Shingles (routine aged 70 immunisation) vaccination programme

## Background and purpose

Data from a number of general practice-based studies[32, 33, 34, 35] suggest that more than 50,000 cases of shingles (herpes zoster) occur in patients aged 70 or over. The severity of shingles generally increases with age and can lead to post herpetic neuraligia (PHN)and hospitalisation. Around one in 1,000 shingles cases is estimated to result in death in people aged 70 or over.

In March 2012, the JCVI recommended that patients aged 70 should be routinely offered vaccination against shingles and a catch-up programme for patients aged 71 to 79.

## Introduction

The new shingles immunisation programme is being introduced from 1 September2013 comprising a single injection to last a lifetime, offered routinely to patients who are aged 70 (as at 1 September 2013). Vaccines for this programme will be centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm.

The GMS contract changes announced for 2013/14 include payments arrangements in lieu of the commencement of the routine age 70 shingles immunisation programme for GMS providers of vaccination and immunisation additional services. This comprises a new item of service payment of £7.63 for each patient who receives shingles immunisation in the financial year and who were aged 70 years but not yet 71 years on 1 September 2013.

The shingles vaccination may be given at the same time as inactivated influenza vaccination. If the Shingle vaccine is given at the same time as influenza vaccination, care should be taken to ensure that the appropriate route of injection is used for all the vaccinations and to check there are no contraindications to administering a live vaccine

[32] Gauthier A, Breuer J, Carrington D et al 2009. Epidemiology and cost of herpes zoster and post-herpetic neuralgia in the UK. Epidemiol Infect 137(1): 38-47. http://www.ncbi.nlm.nih.gov/sites/entrez/18466661

[33] vanHoek AJ, Gay N, Melegaro A et al 2009. Estimating the cost-effectiveness of vaccination against herpes zoster in England and Wales. Vaccine 27( 9): 1454-67. http://www.ncbi.nlm.nih.gov/sites/entrez/19135492

[34] Fleming DM. Weekly returns service of the RCGP 1999. Commun Dis Public Health 2(2): 96-100. http://www.ncbi.nlm.nih.gov/sites/entrez/10402742

[35] McCormick A, Charlton J and Fleming D. Assessing health needs in primary care 1995. Morbidity study from general practice provides another source of information. BMJ 310(6993): 1534. http://www.ncbi.nlm.nih.gov/sites/entrez/7787617

to individuals in at-risk groups presenting for seasonal influenza vaccination. This should ideally be given at the same time as other live vaccines. If live vaccines cannot be administered simultaneously, a four week interval is recommended.

Payment under this enhanced service will be on a monthly basis, based on an item of service payment of £7.63 per patient vaccinated.

NHS Employers, NHS England and GPC have agreed a set of joint FAQs[36] to support the implementation of this programme.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following codes will need to be used to enable CQRS to calculate payment based on the GPES extract:

**Table 18: Shingles Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Herpes zoster vaccination | 65FY. | XaZsM | 859641000000109 |
| Herpes zoster vaccination contra-indicated | 8I2r. | Xaa9i | 868531000000103 |
| Herpes zoster vaccination declined | 8IEl. | Xaa9j | 868551000000105 |
| No consent for herpes zoster vaccination | 68Nv. | Xaa9l | 868601000000108 |
| Did not attend Herpes Zoster vaccination | 9Nig. | XaaAb | 869131000000101 |
| Herpes Zoster vaccination given by other healthcare provider | 65FY0 | Xaa9g | 868511000000106 |

[36] Shingles vaccination programmes FAQs. http://www.nhsemployers.org/PAYANDCONTRACTS/GENERALMEDICALSERVICESCONTRACT/VACCINATION_AND_IMMUNISATION/SHINGLESVACCINATIONPROGRAMME/Pages/ShinglesvaccinationprogrammesFAQs.aspx

## Payment and validation

Payment for the Shingles vaccination  programme will be calculated through CQRS on a monthly basis, based on the GPES extracts or data entered manually via the CQRS web interface..

CQRS will calculate the monthly payments based on the number of eligible patients on the practices registered list who are recorded as having received a shingles vaccination. The code used to identify payment will be the 'herpes zoster vaccination given' code providing the qualifying criteria of age and time are met.  The 'indicator' below are based on the GPES extraction of the Read codes listed in table 18 and are used to calculate the payments:

- SHROU01:  Monthly count of the number of patients aged 70 on 1 September 2013 who have a record of receiving a shingles vaccination at the general practice

Payment will be on a monthly basis. CQRS will calculate the monthly payments based on the number of patients who are recorded as having received a shingles vaccination. Payment will be made based on the monthly count multiplied by £7.63.

After CQRS has calculated the practice's final achievement payment, the practice should ‘approve the payment value’ and submit an ‘achievement declaration’. The area team 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.

NHS England is responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this service.
In addition to data extracted for payment purposes, the following indicators will be collected for the purposes of management information using the Read codes in table 18.

Where the information for these 'indicators' is not available, practices should enter zero:

- SHROUMI01: The number of patients aged 70 on 1 September 2013 who were contra-indicated to the shingles vaccination within the reporting period.
- SHROUMI02: The number of patients aged 70 on 1 September 2013 who have declined a shingles vaccination within the reporting period.
- SHROUMI03: The number of patients aged 70 on 1 September 2013 who have not consented to a shingles vaccination within the reporting period.
- SHROUMI04: The number of patients aged 70 on 1 September 2013 who have received a shingles vaccination from another healthcare provider within the reporting period.
- SHROUMI05: The number of patients aged 70 on 1 September 2013 who did not

attend their shingles vaccination within the reporting period.

- SHROUMI06: The number of patients aged 70 on 1 September 2013 who did not receive a shingles vaccination and have no recorded reason for not receiving a shingles vaccination, up to the end of the reporting period.

# Shingles (catch-up) vaccination programme – commencing September 2013

## Background and purpose

In March 2012, the JCVI recommended that patients aged 70 should be routinely offered vaccination against shingles and a catch-up programme for patients aged 71 to 79. This catch-up programme is aimed at practices delivering vaccination and immunisation services in England.

## Introduction

The catch-up shingles immunisation programme has been introduced from 1 September 2013 for a 12 month period. This vaccination comprises a single injection to last a lifetime and will initially be offered to all registered patients aged 79 years on 1 September 2013.

There is no requirement for practices to operate active call and recall, but instead offer vaccination to eligible patients when they access general practice services. The programme may be extended in-year, to patients aged 78 years[37], subject to vaccine supply and advice to practices from PHE.

Vaccines for this programme will be centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm.

The shingles vaccination may be given at the same time as inactivated influenza vaccination. If the Shingle vaccine is given at the same time as influenza vaccination, care should be taken to ensure that the appropriate route of injection is used for all the vaccinations and to check there are no contraindications to administering a live vaccine to individuals in at-risk groups presenting for seasonal influenza vaccination. This should ideally be given at the same time as other live vaccines. If live vaccines cannot be administered simultaneously, a four week interval is recommended.

Payment under this enhanced service will be on a monthly basis, based on an item of service payment of £7.64 per patient vaccinated.

For full details of the service and administrative requirements, please see the service specification[38].

[37] CQRS has been set up to allow for the roll-out of this service to patients aged 78, but this will only be offered to practices following directions from NHS England and PHE.
[38] NHSE. Shingles catch-up programme service specification.
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/vaccination_and_immunisation/shinglesvaccinationprogramme/Pages/Shinglescatch-upcampaign.aspx

NHS Employers, NHS England and GPC have agreed a set of joint FAQs[39] to support the implementation of this programme.

## GPES extraction

Details on when GPES will be available to provide data for the 2013/14 enhanced services will be made available by the HSCIC in due course. Until that time, once an enhanced service is 'live' on CQRS, payment data for those services can be inputted manually on CQRS via the web interface.

The following codes will need to be used to enable CQRS to calculate payment based on the GPES extract:

**Table 19: Shingles Read codes**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| Herpes zoster vaccination | 65FY. | XaZsM | 859641000000109 |
| Herpes zoster vaccination contraindicated | 8I2r. | Xaa9i | 868531000000103 |
| Herpes zoster vaccination declined | 8IEl. | Xaa9j | 868551000000105 |
| No consent for herpes zoster vaccination | 68Nv. | Xaa9l | 868601000000108 |
| Did not attend Herpes Zoster vaccination | 9Nig. | XaaAb | 869131000000101 |
| Herpes Zoster vaccination given by other healthcare provider | 65FY0 | Xaa9g | 868511000000106 |

## Payment and validation

Payment for the shingles catch-up vaccination programme will be calculated through CQRS on a monthly basis, based on the GPES extracts or data entered manually via the CQRS web interface.

CQRS will calculate the monthly payments based on the number of eligible patients on the practices registered list, who attain the age of 79 on 1 September 2013 and who

[39] Shingles vaccination programmes FAQs. http://www.nhsemployers.org/PAYANDCONTRACTS/GENERALMEDICALSERVICESCONTRACT/VACCINATION_AND_IMMUNISATION/SHINGLESVACCINATIONPROGRAMME/Pages/ShinglesvaccinationprogrammesFAQs.aspx

are recorded as being vaccinated against shingles (herpes zoster) between 1 September 2013 and 31 August 2014. The code used to identify payment will be the 'herpes zoster vaccination given' code providing the qualifying criteria of age and time are met. The 'indicator' below is based on the Business Rules written to support the GPES extraction of the Read codes listed in table 19 and are used to calculate the payments:

- SH79CU01: Monthly count of the number of patients aged 79 on 1 September 2013 who have a record of receiving a shingles vaccination at the general practice

Payment will be on a monthly basis. CQRS will calculate the monthly payments based on the number of patients who are recorded as having received a shingles vaccination. Payment will be made based on the monthly count multiplied by £7.64.

After CQRS has calculated the practice's final achievement payment, the practice should 'approve the payment value' and submit an 'achievement declaration'. The area team 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.

NHS England is responsible for post payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this service.

In addition to data extracted for payment purposes, data will also be collected for the purposes of MI using the Read codes in table 19.

Where the information for these 'indicators' is not available, practices should enter zero:

- SH79CUMI01: The number of patients aged 79 on 1 September 2013 who were contra-indicated to the shingles vaccination within the reporting period.
- SH79CUMI02: The number of patients aged 79 on 1 September 2013 who have declined a shingles vaccination within the reporting period.
- SH79CUMI03: The number of patients aged 79 on 1 September 2013 who have not consented to a shingles vaccination within the reporting period.
- SH79CUMI04: The number of patients aged 79 on 1 September 2013 who have received a shingles vaccination from another healthcare provider within the reporting period.
- SH79CUMI05: The number of patients aged 79 on 1 September 2013 who did not attend their shingles vaccination within the reporting period.
- SH79CUMI06: The number of patients aged 79 on 1 September 2013 who did not receive a shingles vaccination and have no recorded reason for not receiving a shingles vaccination, up to the end of the reporting period.

# Section 5. New enhanced services

## Introduction

Four new enhanced services were developed by NHS England for 2013/14. These new services are funded by the £120 million released through the retirement of the QOF organisational domain, as part of the GMS contract changes implemented in 2013/14. The four new enhanced services introduced from April 2013 will:

- support general practice to make the most effective and efficient use of resources
- improve quality of care in relation to the diagnosis and care for people with dementia, for frail or seriously ill patients, enabling patients to have on-line access to services and helping people with long term conditions monitor their health
- ensure that the arrangements also support GP practices in working collaboratively and with peer support through their CCG to achieve these improvements and to help improve overall use of NHS resources.

The enhanced services are for:

- the identification and management of patients identified as seriously ill or at risk of emergency hospital admission (risk profiling and care management scheme)
- a proactive approach to the timely assessment of patients who may be at risk of dementia (facilitating timely diagnosis and support for people with dementia)
- preparatory work to support the subsequent introduction of remote care monitoring for patients (remote care monitoring (preparation) scheme)
- enabling patients to utilise electronic communications for appointment booking and obtaining repeat prescriptions (improving patient online access).

# 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 DH through the NHS Mandate and by NHS England through its planning guidance for CCGs. This enhanced service 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 carers 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 the quality of life.

## Introduction

The aims of this enhanced service[40] 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 support the health and wellbeing of 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 need to be aligned to support local system-wide improvements:

- A national dementia calculator is available to support practices to understand prevalence of dementia in their registered population.
- A national Commissioning for Quality and Innovation (CQUIN) scheme for all healthcare 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 currently being produced by the Royal College of Physicians[41] (RCP).

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

[40] NHS England. 2013/14 enhanced service specifications. www.england.nhs.uk/resources/resource-primary/
[41] RCP. Dementia. http://www.rcgp.org.uk/clinical-and-research/clinical-resources/dementia.aspx

## Service requirements

The requirements for this enhanced service are:

A. The practice undertakes to make an opportunistic offer of assessment for dementia to 'at-risk' patients on the practices registered list. 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 the attending practitioner considers it appropriate to make such an offer. Once an offer has been made, there is no requirement to make a further offer during any future attendance.

B. For the purposes of this enhanced service, 'at-risk' patients are:

   - patients aged 60 or over with cardiovascular disease, stroke, peripheral vascular disease or diabetes
   - patients aged 40 or over with Down's syndrome
   - other patients aged 50 or 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 out by practices (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 test (where clinically appropriate[42]) 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 validate in primary care

F. The assessment of the results, for the test to detect dementia, is to be carried out by healthcare professionals with knowledge of the patient's current medical history and social circumstances

[42] 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 Royal College of Psychiatrists and the British Psychological Society. Dementia and People with Learning Disabilities at http://www.rcpsych.ac.uk/files/pdfversion/cr155.pdf

G. If as a result of the assessment the patient is suspected as having dementia the practice should:

- offer a referral, 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 a care planning discussion focussing on their physical, mental health and social needs and including referral/signposting to local support services.

I. The practice will seek to identify any carer (but not including professional carers) 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 impacts, including signposting to any other relevant services to support their health and well-being

J. The practice should record in the patient record relevant entries including the Read Codes in table 20 to identify where an assessment for dementia was undertaken, where applicable, that a referral was made and patients diagnosed. The practice should record in the carer record relevant entries including the Read Codes in table 20a..

NHS England invited practices to sign up and participate in the enhanced service by 30 June 2013. Practices who signed up by this date, qualified for the upfront payment (component one) as set out in the payment and validation section below.

This enhanced service will be reviewed for 2014/15 in light of possible changes to the QOF for 2014/15.

NHS Employers, NHS England and GPC have agreed a set of joint FAQs[43] to support the implementation of this programme.

## Monitoring/GPES extraction

GPES is intended to support this enhanced service for the 2013/14 financial year. NHS England and the HSCIC are working on how systems will be provided with extracts of the relevant information recorded by practices from 1 April 2013 and further information will be available from the HSCIC in due course

Practices will be required to provide this information either by opting in to the relevant GPES extracts or, where GPES is not supported, provide a quarterly return based on a

[43] Enhanced services FAQs.
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices201314.aspx

manual report of the required patient counts within 28 days following the end of the financial year.

The following Read codes should be used to record activity from 1 April 2013 and to enable CQRS to calculate payment (component 2) from the GPES extraction:

**Table 20: Dementia Read codes (to be recorded in the patient's record)**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| **To assist in identifying any patient in an at risk group** | | | |
| At risk of dementia | 14Od. | XaQyJ | 516651000000105 |
| **To record initial questioning for memory concern (or offer)** | | | |
| *Initial memory assessment* | *38C15* | *Xaahy* | *888901000000102* |
| *Initial memory assessment – declined* | *8IE50* | *Xaahx* | *888881000000100* |
| **To record an assessment (or offer) for dementia in patients with a memory concern** | | | |
| Assessment for dementia | 38C10 | XaaBD | 869561000000101 |
| *Dementia screening declined* | *8IEu.* | *XaaTn* | *880571000000101* |
| **To record any referral (or offer) for a diagnosis of dementia** | | | |
| Referral to memory clinic | 8HTY. | XaJua | 415276009 |
| Referral to memory clinic declined | 8IEn. | Xaa9t | 868751000000100 |

**Table 20a: Read Codes (to be recorded in the carer's record)**

| | Read v2 | Read CTV3 | SNOMED CT |
|---|---|---|---|
| **To record, for diagnosed patients, any identified carer and offer of a health check where the carer is registered with the practice** | | | |
| Carer of person with dementia | 918y. | XaZ4h | 824401000000105 |
| Carer annual health check | 69DC. | XaX4N | 754731000000108 |

| | | | |
|---|---|---|---|
| Carer annual health check declined | 8IEP. | XaZKp | 837271000000107 |

## Payment and validation

Details on the payment an MI counts used to calculate and validate payments for practices participating in the enhanced services as well as the relevant counts/extracts measuring the progress and success of the programme or service will be available from the HSCIC in due course.

NHS England will monitor services and calculate payments for this enhanced service using CQRS wherever possible. This will minimise the reporting requirements for practices.

Payments will compromise two components, with approximately half of the total funding available under this enhanced service.

**Component 1**
An upfront payment of £0.37 per registered patient. This represents a payment of £2,557 to an average-sized practice (where average size is based on a registered population of 6,911).

Payment will be made to practices by NHS England on the last day of the month following the month during which the practice agreed to participate in the enhanced service (i.e. 31 July 2013).

CQRS and GPES will not support payment of component 1 of this service, NHS England must make arrangements for payments locally.

**Component 2**
The remaining funding will be distributed as an end of year payment based on the number of completed assessments carried out by practices during the financial year as a proportion of the total number of assessments carried out nationally under this enhanced service.

The number of assessments carried out be practices individually and nationally will be based on returns to CQRS (automated via GPES or manual end year entry) identifying assessments offered to consenting at-risk patients using the Read code 'assessment for dementia' (see table 17).

Example of component 2 payment calculation:

If GPES reports Practice A as completing 192 assessments for dementia during 2013/14 and nationally CQRS calculates that 1,197,408[44] assessments were carried out in

[44] This figure represents approximately half the estimated number of people in the risk groups.

2013/14, then the end year payment is calculated as follows:

$$\frac{192}{1{,}197{,}408} \times £21{,}000{,}000 = £3{,}367$$

Payments will be made by NHS England on the last day of the month following the month during which NHS England has the information it needs from participating GP practices in order to calculate the number of completed assessments carried out (nationally). Payments made under this enhanced service are to be treated for accounting and superannuation purposes as gross income of the practice in the financial year.

NHS England is responsible for post payment verification. This may include the audit of the number of patients who have been identified as at risk of dementia being offered an initial assessment and referral to memory clinic for formal diagnosis where the disease is suspected. NHS England will use anonymous data returned from the GPES (or equivalent data provided manually where necessary) to provide assurance on the proportion of the risk group population assessed.

## Other provisions relating to this enhanced service

Full details for provisions relating to practices that terminate or withdraw from the enhanced service prior to 31 March 2014, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits are available in the enhanced service specification[45].

Payments made under this enhanced service, or any part thereof, will be made only if practices satisfy the conditions set out in paragraph 3 of the facilitating timely diagnosis and support for people with dementia scheme annex.

[45] NHS England. 2013/14 enhanced service specifications. http://www.england.nhs.uk/resources/resource-primary/

# Improving patient online access

## Background

This enhanced service is designed to encourage practices to facilitate improvements in the electronic interaction of registered patients with general practice services. This enhanced service will allow for further development and adaption to the services adopted in 2013/14, to take into account the Government's commitment for implementing secure online communication and viewing of patient records.

This enhanced service will facilitate patient online access through non-recurring annual rewards to practices for the successful preparation, establishment, adoption and exploitation of electronic services to deliver patient online access during the period 2013/14 to at least 2014/15.

## Introduction

The aim of this enhanced service is to establish patient online access to practice information systems through enabling and utilising electronic communications for booking/cancelling of appointments, enabling and utilising electronic communications for repeat prescriptions and registering patients (issuing passwords and using verification practices) to enable patient online access.

This enhanced service requires that the practice puts in place the necessary arrangements to ensure the following electronic services are available for registered patients' electronic interaction with the general practice's information:

- electronic communication for booking (and cancelling) appointments
- electronic communication for ordering repeat prescriptions.

The arrangements should include:

- the practice proactively offers registered patients access to those services
- the practice provides registered patients with the necessary information so they are able to access these services with clear expectations
- the practice registers patients, who would like access to these services, by issuing passwords and verifying identity as recommended by guidance from Royal College of General Practitioners (RCGP).

NHS England invited practices to sign up and participate in the enhanced service by 30 June 2013. Practices may choose to participate after this date and can do so with the agreement of NHS England providing it is no later than 31 December 2013. Practice participation in this enhanced service will be recorded via CQRS which will support the calculation of payments from 1 October 2013. This service will not be supported by GPES.

This enhanced service is for one year from 1 April 2013 and may be subject to further development for 2014/15.

## Payment and validation

NHS England will monitor services and calculate payments for this enhanced service using CQRS wherever possible. This will minimise the reporting requirements for practices.

The payments for this enhanced service are in three components, each representing a third of the investment available for this enhanced service:

**Component 1**
A single annual payment of £0.14 per registered patient, which represents a payment of £967 per average-sized practice (with an average registered list of 6,911) based on satisfactory evidence of enabling and utilisation of online booking.

**Component 2**
A further single annual payment of 0.14 per registered patient, which represents a payment of £985 per average-sized practice (with an average registered list of 6,911) based on satisfactory evidence of enabling and utilisation of online repeat prescribing.

**Component 3**
A flat rate annual payment of £985 for each practice based on satisfactory evidence of a proportion of registered patients being issued with passwords for accessing services online.

The evidence required for payment purposes, is outlined in table 21 and will be obtained from existing planned data extractions.

**Table 21: Evidence to validate payments**

| Payment | Evidence |
|---|---|
| Component 1 – enabling and utilisation of online booking of appointments | HSCIC data confirms usage of online booking for appointments by the practice's registered patients in at least one quarter of the financial year 2013/14 |
| Component 2 – enabling and utilisation of online requests for repeat prescribing | HSCIC data confirms online requests for repeat prescribing by the practice's registered patients in at least one quarter of the financial year 2013/14 |
| Component 3 – proportion of registered patients being issued with passwords for accessing services online | Self declared field on CQRS confirming passwords issued to at least five per cent of patients on the practice's list by 31 March 2014, confirmed by standard, practice-available reports. This information may be verified as part of any annual practice visit. |

Payment will be made by NHS England, to the practice, on the last day of the month following the month during which evidence of achievement has been confirmed (see evidence to validate payments table). Payments made under this enhanced service are to be treated for accounting and superannuation purposes as gross income of the practice in the financial year.

Payments made under this enhanced service, or any part thereof, will be made only if practices satisfy the conditions set out in paragraph three of the improving patient online access scheme annex[46].

CQRS will support the calculation of all payments due under this enhanced service from 1 October 2013. Details on how CQRS will support this enhanced service will be available from the HSCIC in due course.

NHS England may, in appropriate and reasonable circumstances, choose to make payments to a practice on a pro-rata basis for one or more components where in its opinion the practice has sought to achieve the component but been unable to do so due to circumstances beyond their control.

NHS England is responsible for post-payment verification. This may include auditing claims of practices to ensure that they meet the requirements of this service.

## Other provisions relating to this enhanced service

Full details for provisions relating to practices that terminate or withdraw from the enhanced service prior to 31 March 2014, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits are available in the enhanced service specification.

[46] NHS England. 2013/14 enhanced service specifications.http://www.england.nhs.uk/resources/resource-primary/

# Remote care monitoring (preparation) scheme

## Background and purpose

This enhanced service is designed to encourage practices to undertake preparatory work in 2013/14 to support the subsequent introduction of remote care monitoring arrangements for patients with long-term but relatively stable conditions in 2014/15.

Remote care monitoring can support improvements in outcomes for patients and reduce the need for acute care as part of a whole system approach to care management and self-care. There are many different types of remote monitoring schemes, which, for maximum impact, should be embedded into the local care delivery model and which offer different levels of support for patients dependent on their needs.

For further information and resources on the long-term conditions programme see the DH LTC workstream[47], 3millionlives programme[48] and NHS Improvement[49].

## Introduction

The aims of this enhanced service are for practices to identify and agree the priority area for remote care monitoring to be implemented in 2014/15, record appropriate patient preferences for receiving and monitoring the required test results, maintain up-to-date contact details for relevant patients for the purpose of implementing such preferences and plan a system for registering patients for remote care monitoring of the agreed local priority.

## Service requirements

The requirements for this enhanced service are to:

A. agree with the CCG the long-term condition that is to be the local priority area for remote care monitoring in 2014/15

B. identify the ongoing test or bodily measurements required to support the stable management of the chosen condition (i.e. weight, blood pressure, pulse, blood oxygen saturation levels, blood glucose etc.) and how these tests and measurement will be accessed or fed in by patients with the condition

C. identify the options available to participating patients for the monitoring of results from such tests and measurements other than in the context of a face-to-face consultation (i.e. video call, telephone, text, email or letter) and the governance arrangements to support these options, including the safe and confidential

[47] DH.LTC workstream.http://ahp.dh.gov.uk/2012/05/01/call-for-applications-early-implementer-sites-for-the-qipp-ltc-year-of-care-funding-model/
[48] 3millionlives programme. Improving your access to telehealth and telecare. http://3millionlives.co.uk/
[49] NHS Improvement. Long-term conditions. http://www.improvement.nhs.uk/LongTermConditions.aspx

governance of information

D. update patient records to identify the preferences of those with the long-term condition and maintain up-to-date contact details as appropriate to the preferences

E. plan a registration system for patients with the chosen long-term condition wishing to participate in the remote care monitoring service.

NHS England invited practices to sign up and participate in the enhanced service by 30 June 2013.

This enhanced service will be reviewed for 2014/15 to reflect transition to implementation of the agreed remote care monitoring arrangements.

NHS Employers, NHS England and GPC have agreed a set of joint FAQs[50] to support the implementation of this programme.

## Payment and validation

The payment available under this enhanced service will be £0.21 per registered patient, which for the average-sized practice (average registered list size of 6,911) represents a payment of £1,451.

Payment will be made by NHS England on the last day of the month in the month following the end of the quarter in which the practice agrees to participate in the enhanced service (i.e. 31 July 2013). This upfront payment is made in recognition of the costs to be incurred in preparing for the implementation of remote care monitoring arrangements in 2014/15. Payments made under this enhanced service are to be treated for accounting and superannuation purposes as gross income of the practice in the financial year.

Practices will need to submit an end of year return. The template[51] provided by NHS England, provides a summary of the local decisions against the requirements A, B and C and evidence of progress against E and D.

NHS England  is responsible for post-payment verification.

[50] Enhanced services FAQs.
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices201314.aspx

[51] NHSE. Remote care monitoring enhanced service report template.
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices201314.aspx

## Other provisions relating to this enhanced service

Full details for provisions relating to practices that terminate or withdraw from the enhanced service prior to 31 March 2014, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits are available in the enhanced service specification[52].

Payments made under this enhanced service, or any part thereof, will be made only if practices satisfy the conditions set out in paragraph 3 of the remote care monitoring (preparation) scheme annex.

[52] NHS England. 2013/14 enhanced service specifications. http://www.england.nhs.uk/resources/resource-primary/

# Risk profiling and care management scheme

## Background and purpose

This enhanced service is designed to encourage practices to identify and case manage patients identified as seriously ill or at risk of emergency hospital admission.

## Introduction

The aims of this enhanced service are to encourage practices to undertake risk profiling and stratification of their registered patients, work within a local multi-disciplinary approach to identify from the list produced, those patients who are seriously ill or at risk of emergency hospital admission and to co-ordinate with other professionals the care management of those patients identified who would benefit from more active case management.

NHS England has asked CCGs to lead responsibility for designing and managing this ES, so that such schemes are locally and clinically driven. The specification[53]sets out the minimum requirements that all local schemes will need to meet and the funding that will be available. CCGs will be required to invite and agree arrangements with practices under this enhanced service by 30 June 3013.

Where CCGs do not have an existing agreement in place, they will offer on behalf of NHS England an enhanced service agreement which at a minimum is in line with these requirements:

A. The practice carries out, on at least a quarterly basis, risk profiling of its registered patients to identify those who are predicted of becoming or are at significant risk of emergency hospital admission.

   Where available, this list can be produced using a risk profiling tool procured by a CCG (or a commissioning support service acting on behalf of a CCG).

B. The practice works within a local multi-disciplinary team approach to assess the list produced to identify those patients in significant need of active case management (as opposed to those patients for whom ongoing general practice support and management are appropriate).

C. The criteria for active case management are to be agreed with the CCG. This could for instance be an agreed percentage of patients identified at most significant risk in the list or based on factors such as co-morbidities.

D. The practice works with the multi-disciplinary professionals, meeting at least quarterly, to achieve a shared and integrated approach to the case management of

[53] NHS England. 2013/14 enhanced service specifications. www.england.nhs.uk/resources/resource-primary/

each patient to improve the quality of care and reduce their individual risk of emergency hospital admission.

E. There is a nominated lead professional who is responsible for each patient identified for case management, including undertaking a review and care planning discussion with each patient at a frequency agreed with the patient.

Where CCGs do have an existing local agreement in place with GP practices for 2013/14 they will offer, on behalf of NHS England, either:

- an enhanced service agreement that supplements the existing local agreement with the aims of providing additional activity/benefits that are proportionate to the available funding; or
- in agreement with practices, replace the existing local agreement with this enhanced service and use the local funding they would otherwise have invested in a manner that is agreed locally.

CCGs were required to notify NHS England of participating practices by 31 August 2013, so that payments can be made under this enhanced service by NHS England.

This enhanced service will be subject to review by NHS England for 2014/15.

NHS Employers, NHS England and GPC have agreed a set of joint FAQs[54] to support the implementation of this programme.

## Payment and validation

CCGs will be responsible for specifying the necessary audit information to be submitted by practices on at least a quarterly basis. The CCG will be responsible for satisfying itself that practices are meeting the requirements agreed on the basis of this information including assurance for payments. The audit information is expected to include the analysis of the patients identified through risk profiling and numbers of patients identified for case management and any exceptions.

Payment will be made based on £0.74 per registered patient, which represents a payment of £5,114 for an average-sized practice (registered population of 6, 911).

CCGs will be asked to provide assurance to NHS England that either the minimum requirements of this enhanced service (or additional requirements agreed with the CCG) have been satisfied before payments under this enhanced service will be made. This assurance must be given within 28 days of the end of the financial year (i.e. April 2014).

[54] Enhanced services FAQs.
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices201314.aspx

NHS England is responsible for post-payment verification. This may include the audit of the number of patients who have been predicted to be at significant risk of unplanned hospital admission through a risk profiling tool and for whom care management arrangements have been put in place.

Payments will be made to practices by NHS England on the last day of the month following the month during which the CCG (or practice directly) provides assurance that the minimum requirements were met (i.e. payment by 31 May 2014).

## Other provisions relating to this enhanced service

Full details for provisions relating to practices that terminate or withdraw from the enhanced service prior to 31 March 2014, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits are available in the enhanced service specification.

# Section 6. Queries process

Queries can be divided into three main categories:

3. those which can be resolved by referring to the specification or guidance
4. those which require interpretation of the guidance or Business Rules
5. 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.

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:
   - Primary Care Commissioning only via the helpdesk http://helpdesk.pcc-cic.nhs.uk/
   - NHS Employers for NHS England area teams via GMScontract@nhsemployers.org for enhanced services and vandl@nhsemployers.org for vaccinations
   - GPC for general practice via info.gpc@bma.org.uk

## Further information

Enhanced services FAQs
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices201314.aspx

MMR catch-up campaign FAQs
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/vaccination_and_immunisation/MMRcatchup/Pages/Frequentlyaskedquestions.aspx

Childhood seasonal flu FAQs
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/vaccination_and_immunisation/pandemic-flu/Childhood_(two_and_three_year_old)_influenza_vaccination_programme/Pages/ChildhoodseasonalinfluenzavaccinationprogrammeFAQs.aspx

Shingles vaccination programmes FAQs
http://www.nhsemployers.org/PAYANDCONTRACTS/GENERALMEDICALSERVICESCONTRACT/VACCINATION_AND_IMMUNISATION/SHINGLESVACCINATIONPROGRAMME/Pages/ShinglesvaccinationprogrammesFAQs.aspx

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www.england.nhs.uk