March 2014

GENERAL MEDICAL SERVICES CONTRACT 2014/15

GUIDANCE AND AUDIT REQUIREMENTS

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CONTENTS

SECTION 1. INTRODUCTION

Introduction

In November 2013, NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the British Medical Association (BMA) announced the agreed changes to the General Medical Services (GMS) contract for 2014/15.

The changes include some new contractual requirements for practices, a reduction in the size of the Quality and Outcomes Framework (QOF), the introduction of a new enhanced service (ES) and the continuation of a number of existing but modified ESs.

This document provides guidance for NHS England area teams and also for practices[1] that hold a GMS contract and for all practices subject to the new contractual requirements or which are offering enhanced services nationally, commissioned by NHS England.

Wherever possible, NHS England seeks to minimise the reporting requirements for the services delivered by practices where these can be supported by new systems and this guidance outlines the assurance management arrangements and audit requirements for the services detailed.

This guidance is applicable in England only.

About this guidance

This document provides information on contractual changes in 2014/15 as well as detailed guidance and the assurance management arrangements and audit requirements to support practices and NHS England area teams.

The amendments to the GMS Contract Regulations, Directions and to the Statement of Financial Entitlements (SFE), which underpin the changes to the contract, are now available.[2,3] The detailed requirements for taking part in the ESs are set out in the Directions except for the dementia and unplanned admissions ESs where the

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

[2] https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013

[3] www.legislation.gov.uk/uksi/2014/465/contents/made

detailed requirements are set out in the service specifications which are available on the NHS England website.[4]

Further guidance will be published to support the vaccination and immunisation (V&I) changes recently agreed.

Area teams, clinical commissioning groups (CCGs) and contractors taking part should ensure they have read and understood the requirements in the Regulations, Directions and NHS England service specifications, the guidance in this document as well as the Technical requirements for 2014/15 GMS contract changes. This supersedes all previous guidance on these areas.

Global sum funding and uplift

GPC and NHS England have separately submitted evidence to the Doctors' and Dentists' Review Body (DDRB) in relation to the 2014/15 uplift to the GMS Contract. The Government has accepted the DDRB recommendation to uplift GMS contracts by 0.28 per cent. This will be delivered through an uplift to the global sum.

The GMS global sum funding will also increase in 2014/15 as a number of funding streams are being transferred. This includes:

i. implementation of the phasing out of MPIG. Correction factor payments are being reduced by one seventh and the aggregate funds reinvested into GMS global sum

ii. retirement of 341 QOF points with 238 points to be reinvested GMS global sum (value calculated as the GMS share of 2012/13 achievement against those points). The remaining retired points are being reinvested in enhanced services

iii. funding attached to enhanced services which cease 31 March 2014 (patient online access, remote care monitoring) or are reduced (patient participation) is also being reinvested into GMS global sum (value based on GMS share of total funding).

The funding transferred to GMS global sum from QOF and enhanced services will not lead to any changes in the level of correction factor payments.

Further the funding transferred from QOF and enhanced services will not be subject to the out of hours (OOH) deduction where GMS contractors opt out of OOH services for their registered patients. The method being applied to achieve this is to reduce

[4] http://www.england.nhs.uk/resources/d-com/gp-contract/

the percentage value of the OOH deduction in the Statement of Financial Entitlements (SFE) which will have the effect of fixing the cost of the OOH opt out deduction to the level that discounts this reinvested funding.

The revised global sum value and OOH deduction for 2014/15 are detailed in the SFE.

NHS England is publishing separately the arrangements NHS England area teams will follow to apply these changes equitably and consistently in PMS and APMS contracts.

SECTION 2. TECHNICAL REQUIREMENTS

CALCULATING QUALITY REPORTING SERVICE AND THE GENERAL PRACTICE EXTRACTION SERVICE

The Calculating Quality Reporting Service (CQRS) is the automated system used to calculate achievement and payments on quality services. These include the QOF, ESs and other clinical services (e.g. new immunisations).

The General Practice Extraction Service (GPES) is a centrally managed service that extracts information from general practice clinical IT systems. It will be used as part of the process for providing payments to practices. In addition, GPES will extract relevant data for management information purposes to enable NHS England to monitor general practice delivery of service requirements.

This guidance provides some information on how these will be used in relation to a number of services. It is planned that GPES will be available later in 2014 and so practices participating in these services will need to enter data manually in CQRS until extractions via GPES is available.

The document *Technical Requirements for 2014/15 GMS Contract Changes*[5] contains full details of how CQRS and GPES will support services as well as the relevant Read and CTV3 codes.[6]

Both GPES and CQRS are managed by the Health and Social Care Information Centre (HSCIC).

[5] www.nhsemployers.org/GMS2014-15

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

SECTION 3. QOF AND CONTRACTUAL CHANGES

QOF

NHS Employers and GPC have identified 341 points from QOF to be retired. 238 points will be reinvested into core funding of General Practice. The GMS element of this funding will be reinvested through the Global Sum based on the 2012/13 achievement levels.

The GMS element of this funding will be reinvested through the global sum. For the indicators that were introduced before 2013/14, this will be based on practice level achievement for 2012/13 with thresholds at 2013/14 levels. The funding will be transferred as a total amount to core funding, not to individual practices based on their own QOF achievement. For indicators introduced in 2013/14, the transferred funding will be based on 100 per cent QOF achievement.

No OOH deduction will apply to this reinvestment. The remaining 103 points will be reinvested elsewhere in the contract with 100 points used to fund the new ES for avoiding unplanned admissions and proactive case management and three points to fund improvements in the learning disabilities ES. The quality and productivity (QP) and patient experience (PE) domains will cease on 31 March 2014.

As part of this negotiated settlement, it has been agreed that the planned changes in thresholds in QOF from April 2014 will be deferred for a year.

Practices and area teams should refer to the QOF guidance which sets out the full requirements of QOF for 2014/15.[7]

Named GP for Patients aged 75 or over

As part of the commitment to more personalised care for more patients with long-term conditions, NHS Employers and GPC have agreed that all patients aged 75 and over will have a named accountable GP.

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www.nhsemployers.org/QOF

The practice will be required to ensure there is a named, accountable GP assigned to each patient within the cohort (patients aged 75 and over). Practices will contact, by the most appropriate means, each patient and inform them they have been allocated a named accountable GP and who it is. An example of a template letter and patient leaflet to inform patients about their named GP will be available for practices to use. The practice will decide what the most appropriate means is given the circumstances of individual patients. Informing a patient as to the name of their accountable GP at their next routine consultation is acceptable. Newly registered patients, and any patients who turn 75 during the financial year, must be notified within 21 days of registration. All existing patients must be notified by 30 June 2014.

Where the patient expresses a preference as to which GP they have been assigned, the practice must make reasonable effort to accommodate this request. Where the named accountable GP is unable to carry out their duties for a significant period, for example through maternity leave, the patient should be informed. Where the practice considers it to be necessary, a replacement accountable GP should be assigned and the patient given notice accordingly, until such time as the named accountable GP can recommence their duties. Normally it will be reasonable for the patient to be informed of both the named accountable GP being unable to carry out their duties and the name of the replacement accountable GP (if applicable) at the next patient contact, whether initiated by the patient or the practice.

The named accountable GP will take lead responsibility for ensuring that all appropriate services required under the contract are delivered to each of their patients aged 75 and over, where required (based on the clinical judgement of the named accountable GP) they will:

- work with relevant associated health and social care professionals to deliver a multi-disciplinary care package that meets the needs of the patient
- ensure that the physical and psychological needs of the patient are recognised and responded to by the relevant clinician in the practice
- ensure the patient aged 75 years and over has access to a health check as set out in section 7.9 of the GMS Contract Regulations.

Monitoring

The *Technical Requirements for 2014/15 GMS Contract Changes*[8] document contains

[8] www.nhsemployers.org/GMS2014-15

the Read and CTV3 codes[9] that practices are required to enter into the patient's record when they are notified of their named accountable GP. These codes will enable GPES to extract data on the "number of patients aged 75 and over who have been notified of their named accountable GP".

Supporting Business Rules will be published on the HSCIC website.[10] Practices and area teams should refer to these for the most up to date information on Read and CTV3 codes.

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

Quality of out of hours services

From April 2014, there are new contractual requirements applying to all practices that have opted out of out of hours (OOH) services.

Monitoring the quality of OOH services

Practices who have opted out of OOH services will need to monitor the quality of the local OOH services offered to their registered patients and report on any concerns.

In monitoring the quality of OOH activity for its registered patients, practices will have regard for the national quality standards,[11] e.g. that the practice is receiving details of its registered patients OOH consultations by the next working day, that its registered patients are receiving a GP OOH consultation including home visit where there is a clinical need. Practices to whom this requirement applies will need to familiarise themselves with the national quality standards.

Practices will also need to consider any reported patient feedback, including reported patients complaints made to them about the OOH provider, for example, this could include multiple patient concerns reported in the practice about accessibility which could draw into question whether the provider is matching its capacity to predictable demand.

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

[10] www.hscic.gov.uk/primary-care

[11] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137271

Practices will want to ensure they have local systems in place to pick up on and record any such feedback, for example, through the routine monitoring of patient complaints, patient surveys or periodic discussion with its patient participation group.

NHS England is responsible for commissioning OOH services but has delegated this duty to CCGs. Any concerns about the quality of OOH services will therefore need to be reported to the responsible CCG under agreed local systems. The intention is that reported feedback and concerns will help to ensure the OOH commissioner (and subsequently the provider) has a firm foundation on which to ensure a quality service is commissioned and delivered. Clearly any concerns about immediate patient safety should be raised urgently.

Should practices have any concerns about reporting to the local CCG then they may raise any concerns with their area team.

Working with the local OOH provider

Practices who have opted out of OOH services will also be under a revised duty to cooperate with OOH providers.

Building on the existing contractual requirements the duty of cooperation is now extended to include:

- reviewing the clinical details of all OOH consultations received from the OOH provider on the same working day they are received by a clinician within the practice (or exceptionally the following working day)
- responding to any information requests by the OOH provider in respect of such consultations – on the same day or within one working day where that is requested by the OOH provider
- taking reasonable steps to comply with systems the OOH provider puts in place for rapid and effective transmission of OOH patient data, in particular, to agree the system for transmission of information about patients with special needs. Agreement with the OOH provider will need to be sought around timely sharing of patient data.

These are reciprocal duties to those placed on OOH providers by virtue of the national quality requirements and seek to support established working practices between practices and OOH providers.

Area teams will seek to monitor compliance with these new contractual requirements as part of the assurance framework for primary medical service contractors. This includes update to the annual practice self-declaration tool.

Seniority

It has been agreed that seniority payments will cease on 31 March 2020. In the meantime, those in receipt of payments on 31 March 2014 will continue to receive payments and progress as currently set out in the SFE. There will be no new entrants to the scheme from 1 April 2014. This means that from April 2014, GPs with up to seven years qualifying service will not receive seniority payments. The current qualifying arrangements will continue for those currently in receipt of payments – this includes those who undertake 24-hour retirement.

It is our joint expectation that the agreed changes to seniority payments will result in the quantum of seniority payments from the seniority pool falling by 15 per cent each year from 2014/15 to 2019/20. In the event that this reduction is not delivered in any year, NHS Employers and GPC will agree action to achieve this. All funding released will be added into the global sum with no OOH deduction being applied.

Patient and information

Background and purpose

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

In line with the Government's commitment to enabling patient online interaction with general practice services, the ES will cease on 31 March 2014 and will be replaced by new contractual requirements which take effect from 1 April 2014. This guidance should therefore be read in conjunction with the GMS Contract Amendment Regulations 2014 and supporting standard contract documentation (model contract and variation document).

The purpose and effect of these new contractual requirements is that from 1 April 2014 all practices in England will offer and promote patients' online access to transactional services such as booking and cancellation of appointments and ordering of repeat prescriptions and they will also provide patients with access to information from their medical records from 1 April 2014. Further requirements seek to ensure the safe and effective electronic transfer of patient records and support better referral management. These contractual requirements are seen by NHS England as an important step in expanding patients' involvement in their own care and improving accessibility of information for patients and the NHS alike.

In view of these new contractual requirements, global sum funding is being increased. The GMS share of the existing £24m which funded the ES in 2013/14 has been reinvested into Global Sum funding along with £12m from the remote care monitoring ES which will also cease on 31 March 2014. There has been no 6 per cent OOH deduction applied to this funding transfer. This funding recognises the workload and costs associated with delivering these new requirements.

In addition to the areas for implementation in 2014/15, GPC has agreed to work with NHS England during 2014/15 on the following areas:

- to permit access to the detailed patient record from other care settings, subject to satisfaction of required information governance controls
- GP practices to promote and offer patients the opportunity for secure electronic communication with their practice.

NHS England, with the Royal College of General Practitioners (RCGP) and other partners, is planning an extensive programme of communication and support for practices and for patients, building on the work of the RCGP's Patient Online: the Road Map.[12]

Requirements

The following are now contractual requirements for 2014/15:

Referral management

> From April 2014, practices must include the NHS Number as the primary identifier in all NHS clinical correspondence issued by the practice whether in electronic form or otherwise, except in exceptional circumstances where the number cannot be ascertained.

The NHS Number is the national unique identifier that makes it possible to share patient information across the whole of the NHS safely, efficiently and accurately. The NHS Number is ten numeric digits in length. The tenth digit is a modulus-11 check digit used to confirm its validity. Every individual registered with the NHS in England and Wales has a unique NHS Number.

The importance of using the NHS Number to reduce risks to patient safety has been advocated for some time as part of the NHS Number Programme. Such is its importance, provider contracts – including NHS Standard contract and GMS, PMS contracts – now require its use which will ensure that information is shared using the NHS Number both from and to primary care.

Practices should ensure, where practically possible, the use of verified NHS numbers on all NHS clinical correspondence generated in the practice. This will ensure that patients can be correctly identified and supports safe, high-quality care. In some circumstances outside of the practice's control, e.g. when a patient is seen urgently at home or presents in a confused state, the NHS number may not be readily available and therefore practices cannot include the number on urgent correspondence. It is essential that the process of clinical care is not held up in these situations.

[12] http://www.rcgp.org.uk/patientonline

Further guidance[13] supporting practices to maximise the usage of NHS numbers is available from the HSCIC.

Electronic appointment booking

> Building on the Improving Patient Online Access Enhanced Service, GP practices are contractually required from April 2014 to promote and offer the facility for all patients who wish to book, view, amend, cancel and print appointments online.

Most practices already have the technical ability to enable patients to book and cancel appointments online. More than half of practices (covering almost three quarters of the population) have already enabled the functionality giving patients the ability to book or cancel their appointments online.[14] During 2014/15 all practices will have approved national software made available to them for patients to book and cancel appointments online.

Practices offering the option to book appointments online should ensure that an appropriate number of appointment slots are able to be booked online. Whilst there is no requirement for practices to make a specific number of appointments available for online booking, practices may wish to consider reserving 20 per cent of appointments for online booking, although they should also take into account the characteristics of their population.

Online booking of repeat prescriptions

> Building on the patient online access ES, practices will be contractually required from April 2014 to promote and offer the facility for all patients who wish to order online, view and print a list of their repeat prescriptions for necessary drugs, medicines or appliances.

Most practices already have the technical ability to enable patients to order repeat prescriptions online. A majority of practices (covering nearly three quarters of the population) have already enabled functionality offering their patients the opportunity

[13] HSCIC. NHS Number guidance for practices v1.1. 2011. http://systems.hscic.gov.uk/nhsnumber/staff/guidance/gppracguide.pdf
[14] NHS England GMS Contract Q&A pages 20–23

to order repeat prescriptions online.[15] During 2014/15 all practices will have approved national software made available to them for patients to request repeat prescriptions online.

As well as requesting their repeat prescription medicines online, patients should be able to view and print a list of their repeat medicines.

Interoperable records

All practices are required to:

- enable successful automated uploads of any changes to a patient's summary information, at least on a daily basis, to the Summary Care Record (SCR) or have publicised plans in place to achieve this
- utilise the GP2GP facility for transfer of all patient records between practices, when a patient registers or de-registers (not for temporary registration), or have publicised plans in place to achieve this.

The practice should put these requirements in place as soon as possible after 1 April 2014 and must, by 30 September 2014, publicise its plans to enable it to achieve these requirements by no later than 31 March 2015. These plans are to take the form of a statement of intent made available at the premises and if the practice has one, on its website.

Practices should ensure that they have processes in place to upload any changes to the SCR at least once every working day. Further information on the SCR can be found on the HSCIC website under GP Practice Data/Infrastructure/IT Services.[16] [17]

The GP2GP facility provides the ability for patient records to be safely and quickly transferred from one practice to the next as a patient re-registers. Where the incoming record is integrated into the receiving system the chain is maintained. This will ensure that there is continuity in the record over time. Practices must activate GP2GP if this is available on their clinical system so that as patients leave to register elsewhere, requests for their records to be transferred to the new practice can be automatically processed without delay. Practices should also ensure that at the time that any patient registers with them the GP2GP record transfer process is triggered and that the resulting record is downloaded, processed and integrated into the

[15] NHS England GMS contract Q&A pages 20–23

[16] https://indicators.ic.nhs.uk/webview/

[17] http://systems.hscic.gov.uk/scr

practice system in a timely manner. Further information can be found on the HSCIC website under GP Practice Data/infrastructure/IT Services.[18]

Patient access to their GP record

> All practices are required to promote and offer the facility for patients to view online, export or print any summary information from their records relating to medications, allergies, adverse reactions and any other items agreed between the contractor and patient. The practice should put this in place as soon as possible after 1 April 2014 and must, by 30 September 2014, publicise its plans to enable it to achieve that requirement by no later than 31 March 2015.

Practices are increasingly expected to provide the facility for patients to view online the information in their patient record. For 2014/15 the information available to view should be summary information, which means data relating to medications, allergies, adverse reactions and, where agreed with the contractor and subject to the patient's consent, any other data taken from the patient's electronic record, practices will be able to make available any other data such as 'additional' record elements which the contractor has agreed the patient may access.

Practices should note that this requirement does not involve patients having access to their SCR on the Spine. Where a patient has dissented from their information being uploaded to the SCR, they should still be able to view online these data items in their patient record, if they wish. Additional guidance will be published by NHS England early in 2014/15 to provide practical support to practices in relation to patient access to records.

Data for commissioning and other secondary uses

It is already a requirement of the Health and Social Care Act that practices must meet the reasonable data requirements of commissioners and other health and social care organisations through appropriate and safe data sharing for secondary uses, as specified in the technical specification for care data.

NHS England has worked jointly with the BMA, RCGP and HSCIC to produce guidance and other supporting documentation for practices.[19]

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[18] https://indicators.ic.nhs.uk/webview/

[19] www.england.nhs.uk/ourwork/tsd/data-info/

Plans

Plans for enabling successful uploads of any changes to a patient's summary information to the SCR are required to be in place by 30 September 2014 in the form of a statement of intent made available at the premises and, if it has one, on the practice's website undertaking to have that facility available by 31 March 2015.

Plans for utilising the GP2GP facility to transfer patient records between practices are required to be in place by 30 September 2014 in the form of a statement of intent made available at the premises and, if it has one, on the practice's website undertaking to have that facility available by 31 March 2015.

Plans for making online facilities available to patients should set out a timetable, explain to patients how they will be able to access their summary information and make practice appointments and provide an opportunity for patient feedback and review. Those plans are required to be in place by 30 September 2014 in the form of a statement of intent made available at the premises and, if it has one, on the practice's website undertaking to have online facilities available by 31 March 2015.

System requirements

These changes are agreed with the understanding that the GP Systems of Choice (GPSoC) programme will be the process by which the nationally approved and funded systems necessary to satisfy these requirements will be made available to practices by NHS England. The changes to GPSoC will be delivered prior to their introduction and the requirements are also subject to the resolution of outstanding issues with GP2GP. The introduction of new GPSoC requirements from April 2014 will progressively introduce new functionality to GP systems across the whole estate, but it is recognised that not all systems will have the functionality to enable GP practices to comply with these contractual requirements from 1 April 2014.

Working with system suppliers, practices will be expected to plan for the introduction of these new systems for their patients when the functionality is available. It is a contractual requirement that practices publicise their intentions for when such facilities are to be available to patients by 30 September 2014, in the form of a statement of intent made available at the premises and, if it has one, on the practice website and achieve that requirement no later than 31 March 2015.

Further guidance, *Securing Excellence in GP IT Services*, will be published by NHS England early in 2014/15. This guidance will include more practical support to

practices on implementing these changes and will also set out what support will be provided by NHS England and from IT suppliers as part of the GPSoC funding.

Monitoring

Area teams will monitor compliance as part of the assurance framework in place from PMS contractors. This will include review of nationally coordinated data from system suppliers on the availability and enablement by practices of patient online services (PHF10) and these new requirements will be reflected in annual practice self-declaration.

Other Areas of Agreement

Care Quality Commission inspections

It has been agreed that when the Care Quality Commissions' (CQC) new inspection arrangements are introduced from October 2014, practices will be required to display the inspection outcome in their waiting room(s) and on the practice's website.

These changes will be implemented through changes to the CQC regulations meaning the requirement will be on GP practices as a registered provider rather than as a requirement of holding a GMS contract. Further details and guidance will be available once the regulations have been finalised later in the summer of 2014.

Patients needing access to a practice clinician after assessment

NHS Employers and GPC have agreed that where a patient has been assessed as needing contact with a practice clinician, the practice will ensure that when the patient contacts the practice, a practice clinician will agree appropriate next steps having regard to the patient's condition and circumstances.

Publication of GP earnings

NHS Employers and GPC have agreed to work with NHS England, to develop proposals on how the publication of GP NHS net earnings relating to the contract should be implemented for 2015/16 (i.e. publication using data on 2014/15 earnings).

A working group has been established and is now working on options available to ensure that the calculation and publication of GP net earnings is on a like-for-like basis with other healthcare professionals.

Publication of this information under the chosen option will be made a new contractual requirement to commence from 1 April 2015.

This commitment is subject to the arrangements being in line with others in the NHS.

Carr-Hill formula and deprivation

NHS Employers and GPC have previously agreed to explore how the Carr-Hill formula might be adjusted to give greater weighting to deprivation factors.
It has been agreed to test whether it is possible to update the existing deprivation factors in the Carr-Hill formula (the standardised mortality ratio for under-65s and the standardised limiting long-term illness index) to ensure that the formula reflects the most up to date information on deprivation.

NHS Employers, GPC and NHS England are also working to develop changes to the formula to be implemented from April 2015, which may include the development of a bespoke deprivation index based on a number of clinical conditions which reflect deprivation. Again a working group has been established to take this forward.

Changes agreed for implementation later in 2014

Friends and Family Test

From December 2014, all practices will be under a contractual requirement to undertake the Friends and Family Test (FFT) and report the results of this. The GMS Contract Regulations will be further amended in October 2014 to introduce this change and the exact arrangements to be implemented by practices will be subject to detailed guidance, to be published no later than October 2014.

There will be one standard question for all practices and one follow up question. The current default question on the FFT is:

> "How likely are you to recommend our practice to friends and family if they needed similar care or treatment?"

The exact wording for general practice is however being considered. NHS England is running a series of pilots with practices and will be sharing the findings from these to inform the guidance to be agreed with NHS Employers and GPC. The guidance will provide further information on areas such as communicating the FFT to patients, eligible population (who should and shouldn't be asked), guidance on data collection

(practices will be free to choose their own methodology), arrangements for reporting etc.

Choice of GP practice

From 1 October 2014, all GP practices will be able to register patients from outside their traditional practice boundary areas, without any obligation to provide home visits for such patients. The GMS contract regulations make provision for this change to take effect in October and also allow existing patients registered with a practice under the patient choice extension scheme to remain registered until it is in place. It will be up to individual practices whether or not they wish to provide this service.

A joint working group has been established to work through the details of implementation, including home visiting arrangements and access to urgent care, to support the wider introduction of choice of GP practice from October. Further guidance will follow for area teams and practices.

Minimum Practice Income Guarantee (MPIG)

As part of the GP contract settlement in 2013, the DH decided to phase out MPIG payments over a seven year period. As set out in the SFE, Section 3 MPIG, 3.34 onwards, correction factor payments will reduce by one seventh in 2014/15 and this funding will be reinvested in the global sum.

SECTION 4. VACCINATION AND IMMUNISATION

A number of changes have been agreed to the vaccination and immunisation programmes. This section sets out which programmes continue without alteration, those where there have been some changes made and a number of new programmes being introduced in 2014/15.

The following programmes continue unchanged:

- childhood immunisation
- shingles (routine aged 70) vaccination programme
- pertussis (pregnant women) vaccination programme

There have been some changes to the following programmes:

- childhood influenza vaccination programme pneumococcal vaccination programme
- seasonal influenza vaccination programme
- shingles (catch-up) vaccination programme
- rotavirus (routine childhood immunisation) vaccination programme
- MMR (aged 16 and over) vaccination programme

A number of new programmes are being introduced in 2014/15:

- meningococcal C (MenC) freshers vaccination programme
- hepatitis B (newborn babies) vaccination programme

The pertussis (pregnant women) vaccination programme does not have supporting guidance but the specification provides further details and continues as a temporary programme until further notice.

Vaccination and immunisation programmes 2014/15 – guidance and audit requirements [20] will be available in April 2014.

[20] www.nhsemployers.org/VandI

SECTION 5. ENHANCED SERVICES

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

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

This document sets out the guidance and audit requirements for the following ESs:

- alcohol-related risk reduction scheme
- learning disabilities health check scheme
- facilitating timely diagnosis and support for people with dementia
- patient participation
- extended hours access

The new ES *'avoiding unplanned admissions: proactive case finding and personalised care planning for vulnerable people'* is introduced from 1 April 2014 for one year. It replaces the QP QOF indicators and the risk profiling and case management ES. Guidance for this new service is to be published separately.[21]

It has been agreed that the patient online and remote care monitoring ESs will cease on 31 March 2014. The funding associated with these services has been reinvested in global sum with no OOH deduction applied.

The minor surgery enhanced service (ES) and violent patient ES, which are locally specified, remain unchanged.

[21] www.nhsemployers.org/GMS2014-15

Alcohol-related risk reduction scheme

Background and purpose

The Government is committed to addressing the issue of physical and mental illness associated with increasing alcohol consumption. There are four recognised levels of drinking risk, namely sensible or low risk, increasing risk, higher risk and possible alcohol dependence. This enhanced service (ES) requires practices to case find newly-registered patients aged 16 or over, drinking at increased or higher levels. Once identified as at risk, patients should receive simple brief advice and where identified as alcohol dependent be considered for referral to specialised services. These patients should also be assessed/screened for anxiety and/or depression and if found to be suffering with both/either of these, to be provided with treatment and advice as appropriate, where this is accepted by the patient.

Requirements

This ES is for one year from 1 April 2014.

There is no requirement for practices to set up a register of increasing or higher risk drinkers.

Area teams will seek to invite practices to participate in this ES before 30 April 2014. Practices wishing to participate will be required to sign up by no later than 30 June 2014.

Initial screening

Screening applies to all patients registered between 1 April 2014 and 31 March 2015, who are aged 16 or over at the time the short case finding test is applied. For the purposes of this ES, the test must be applied within the financial year in which the patient registered.

Practices are required to screen newly registered patients aged 16 or over, using one of two shortened versions of the World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaires: FAST or AUDIT-C, with each taking approximately one minute to complete. FAST has four questions and a value of three or more is regarded as positive. AUDIT-C has three questions and a value of five or more is regarded as positive.

Full screening

All patients with a positive score should be screened using the remaining questions

in the ten-question AUDIT questionnaire to determine if increasing, higher risk or likely dependent drinking.

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

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

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

Patients with a score between eight and 15 should be offered brief intervention, patients with a score of between 16 and19 should be offered brief intervention or brief lifestyle counselling[22] and patients with a score of 20 or more should be considered for referral to specialist services (see relevant sections below).

Brief intervention

Those patients identified as drinking at increasing or higher risk levels (scores 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?*.[23] Public Health England's (PHE) alcohol learning centre also has a structured brief advice tool[24] and the Change4Life website[25] contains literature to support brief advice.

Brief lifestyle counselling

In some areas, patients drinking at higher risk levels (scores 16–19) should either 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. Practices should note that a distinction between the two approaches is not recognised for the purposes of this ES.

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[22] Referred to as 'extended intervention' in the management information counts and business rules.

[23] Alcohol learning centre. www.alcohollearningcentre.org.uk/topics/browse/briefadvice/

[24] www.alcohollearningcentre.org.uk/_library/structured_brief_advice_tool_nov_2010.ppt

[25] www.nhs.uk/Change4Life/Pages/drink-less-alcohol.aspx

Referral for specialist advice

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

Assessment/screening for anxiety and/or depression

Where patients are identified as drinking at increasing or higher risk levels (score of eight or more), the practice will be required to assess/screen for anxiety and/or depression. This is because mental health issues could be contributing to the patient's levels of alcohol consumption. Practices will need to use an appropriate tool for the assessment / screening, for example using questionnaires such as Generalised Anxiety Disorder Scale-7 (GADS-7) and/or Patient Health Questionnaire (PHQ-9). Patients who are found to be suffering with anxiety and/or depression should, where appropriate, be provided with support and treatment (see below).

Support and treatment for anxiety and depression

Where patients are found to be suffering with anxiety and/or depression, the practice will provide support and treatment, as appropriate. This may include, but is not limited to, self-directed therapy, group therapy, counselling, behavioural therapy and medication. In severe or refractory cases, consideration should be given to referring the patient to specialist mental health services, although it is recognised that mental health services may decline referrals until the patient's alcohol problems have been appropriately addressed. Where this is the case, referral should be kept under review whilst the patient's alcohol dependency is being dealt with, until such a time as the mental health team will be able to accept the referral. It is recognised that this depends on appropriate and accessible services. Any issues that prevent appropriate management should be raised with service commissioners.

For the purpose of management information counts (i.e. administration of the ES) practices should use the specific Read2 and CTV3 codes relevant to record where support and treatment is provided. However, with respect to the management of individual patients, it is still expected that practices will record the specific drug, support or therapy using Read2 or CTV3 codes, where they exist, or include in free text.

Monitoring

There is one payment count (see payment and validation section) and 16 management information counts for this service.

Practices will be required to manually input data into CQRS, on a quarterly basis, until such time as GPES[26] is available to conduct electronic data extractions. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts.

For information on how to manually enter data into CQRS, please see the HSCIC website.[27]

When GPES is available, each extraction will capture data for all 17 counts and report on activities from the start of the reporting period e.g. 1 April 2014 to the end of the relevant reporting quarter. The reporting quarter will be the quarter prior to the month in which the extraction is run, e.g. if the extraction is run in January 2015, the reporting quarter will be quarter three (October to December 2014). Counts will be cumulative for the year from the point the practice begins to deliver the service. It is important to note that when GPES takes a data extraction for a given period, the extraction only includes activity relating to patients registered at the reporting period end date (i.e. quarter-end/year-end). For example, an annual extraction would only include patients registered with the practice at the year end.

When extractions commence, GPES will provide to CQRS the quarterly counts from the relevant quarter they start in to the end of the relevant reporting quarter. For this enhanced service, reporting will be quarterly and payment will be annual. If a practice has declared achievement (payment and management information counts) for the year on CQRS and the area team has approved it, no GPES-based automated extract will be received as the payment and management information declaration in CQRS cannot be overwritten.

The document *Technical Requirements for 2014/15 GMS Contract Changes*[28] contains the payment counts, management information counts and Read2 and CTV3 codes[29] relevant for this service. The Read2 and CTV3 codes will be used as the basis for the GPES extraction, which will allow CQRS to calculate payment and support the management information extractions, when available. Although practices will be required to manually enter data until such time as GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical

[26] Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.
[27] http://systems.hscic.gov.uk/cqrs/participation
[28] www.nhsemployers.org/GMS2014-15
[29] Please note that the code descriptions in clinical systems may not exactly match the guidance text.

systems. This is because only those included in this document and the supporting business rules will be acceptable to allow CQRS to calculate achievement and payment and for Area Teams to audit payment and service delivery. Practices will need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting business rules will be published on the HSCIC website.[30] Practices and area teams should refer to these for the most up to date information on management information counts, Read2 and CTV3 codes.

Payment and validation

Area Teams will seek to invite practices to participate in this ES before 30 April 2014. Practices wishing to participate will be required to sign up by no later than 30 June 2014.

Payment under this enhanced service will be on an annual basis and calculated by identifying "count of newly registered patients, aged 16 and over at the time the short case finding test is applied, who have been screened using either the FAST or AUDIT-C tools in the reporting period" (i.e. ES payment count ALC001).

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

CQRS will calculate the annual payment, based on the 31 March 2015 achievement data either via manually entered data or data extracted from GPES.

Payment should be made by the last day of the month following the month in which the practice and area team approve the payment. Where CQRS has not been provided with data (i.e. the practice has not enabled the extraction or the extraction is not supported by their system supplier) the data will need to be entered onto CQRS manually.

After CQRS has calculated the practice's final achievement payment, the practice should review 'the payment value' and declare the 'achievement declaration'. The area team will then approve the payment (assuming that the criteria for the service have 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.

[30] www.hscic.gov.uk/primary-care

Area teams are responsible for post payment verification. This may include auditing claims of practices to ensure that not only the initial 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, lifestyle counselling or where needed, referral to specialist services or assessment/screening for anxiety and/or depression. This information could be available to practices and area teams, as an indicative check, through the management information counts as and when data extractions via GPES are available. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information extracted on full screening, brief intervention, brief lifestyle counselling, referral for specialist advice, assessment/screening for anxiety and/or depression and support and treatment for anxiety and/or depression will not be used for payment purposes. It will be available through CQRS, as and when GPES is available to extract the information, to support practices and NHS England to validate requirements of the ES, as necessary, to demonstrate that the full protocol was followed.

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

Other provisions relating to this enhanced service

This guidance should be read in conjunction with the *General Medical Services Statement of Financial Entitlements Directions 2014* and *The Primary Medical Services (Directed Enhanced Services) Directions 2014*, which contain full details for provisions relating to practices that terminate or withdraw from the ES prior to 31 March 2015, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits.

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

Learning disabilities health check scheme

Background and purpose

The government is committed to reducing the incidence of co-morbidities and premature deaths for people with learning disabilities (LD) and supports the recommendations from the Confidential Inquiry into premature deaths for people with learning disabilities (CIPOLD). [31]

This enhanced service (ES) is designed to encourage practices to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which will include producing a health action plan. From the prevalence figures available, it is estimated that approximately 240,000 patients fall into this category across the country.

Requirements

The ES is for one year from 1 April 2014.

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

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

Area teams will seek to invite practices to participate in this ES before 30 April 2014. Practices wishing to participate will be required to sign up by no later than 30 June 2014.

[31] University of Bristol CIPOLD www.bris.ac.uk/cipold/

Learning disability (LD) register

The practice will establish and maintain a learning disabilities 'health check register' of patients aged 14 and over with learning disabilities. This should be based on the practice's QOF learning disabilities register (QOF indicator LD003)[32] and any patients identified (not already on the QOF LD register) who are known to social services.

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

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

This ES requires the data to be in reasonable order to proceed with offering and delivering checks but recognises that the lists are subject to ongoing improvement. Practices will be required to confirm the count of patients on their learning disability health check register for the calculation of payments on CQRS.

Training

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

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

- an understanding of learning disabilities
- identification of patients with learning disabilities and clinical coding

[32] The register should use the Read codes outlined in this guidance which are in line with those used for the QOF learning disabilities register.

- 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, such as for advocacy, communication support and / or tools or aids to facilitate communication
  - using accessible information and aids, including provision of correspondence and documents in easy read and other accessible formats
  - physical access
  - social and cognitive attitudes
- collaborative working including:
  - working in partnership with family carers
  - the role of the community learning disability team
  - the role of social care supporters
  - the role of other healthcare professionals and services
- experiences and expectations
- consent
- the Mental Capacity Act 2005
- the Equality Act 2010
- resources – local contacts, networks, practitioners with special interest and information.

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

Area Teams and practices may find the Improving Health and Lives Learning Disabilities Observatory website[33] [34] provides helpful, easy to understand information on the health and wellbeing of people with learning disabilities, which can support the commissioning and provision of annual health checks.

Health checks

On an annual basis, practices will invite in all patients on the 'health check register' for a review of physical and mental health. Where problems or concerns are identified, practices will be expected to address them as appropriate through the usual practice routes or via specialist referral if required.

As a minimum, the health check should include:

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

[33] Improving Health and Lives Learning Disabilities Observatory. Health checks report. www.improvinghealthandlives.org.uk/news.php?nid=979

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

they can understand any support they need to communicate.

Practices taking part in the ES will be required to use a suitably accredited protocol agreed with the area team (for example, the Cardiff health check[35]). Where possible, and with the consent of the patient, this should involve carers and support workers. Practices should liaise with relevant local support services such as social services and educational support services, in addition to learning disability health professionals.

Health action plan

As part of the patient's annual health check, practices will be required to produce a health action plan. This can be created at the time of the health check using an electronic template in the GP clinical system, or, if an electronic template is not available, providing the patient with a written health action plan following the review. For the latter, practices will need to be mindful of the patient's diagnosis – that is, if the patient's specific learning disability impacts on their ability to read and/or understand the information contained in the health action plan. In these circumstances, the practice will need to ensure that the health action plan is provided in the best format[36] for the patient to maximise their understanding and involvement, including if necessary a means most suitable for a carer or advocate to support them to understand its content.

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

Practices also participating in the enhanced service *'facilitating timely diagnosis and*

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[35] Cardiff health check protocol. Royal College of General Practitioners (RCGP) website. www.rcgp.org.uk/learningdisabilities/~/media/Files/CIRC/CIRC-76-80/CIRCA%20StepbyStepGuideforPracticesOctober%2010.ashx

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

post-diagnostic 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, where clinically appropriate.

Monitoring

There is one payment count (see payment and validation section) and five management information counts for this ES.

Practices will be required to manually input data into CQRS, on a quarterly basis, until such time as GPES[37] is available to conduct electronic data extractions. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts.

For information on how to manually enter data into CQRS, please see the HSCIC website.[38]

On CQRS there are two inputs for this ES:

1. ES indicator LD001 input number: The number of those patients aged 14 and over in the financial year on the practices agreed learning disabilities register who received a completed health check in this quarter.
2. ES indicator LD001 maximum: The number of patients aged 14 and over in the financial year on the practices agreed learning disabilities register.

The ES indicator LD001 maximum input will always be manual as the data cannot be supplied by GPES unless a local LD register code(s) can be determined and agreed upon by all relevant stakeholders. The sum of the ES indicator LD001 input over the year can never exceed the ES indicator LD001 maximum (practices cannot give more health checks than those on the local LD register).

When GPES is available, each extraction will capture data for all six counts and report on activities from the start of the reporting period e.g. 1 April 2014 to the end of the relevant reporting quarter. The reporting quarter will be the quarter prior to the month in which the extraction is run, e.g. if the extraction month is January 2015, the reporting quarter will be quarter three (October to December 2014). Payment counts will be a non-cumulative quarterly counts from the point the practice begins to deliver the service and management information counts will be a mixture of non-

[37] Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.
[38] http://systems.hscic.gov.uk/cqrs/participation

cumulative and cumulative quarterly counts (which will serve for audit purposes). It is important to note that, when GPES takes a data extraction for a given period, the extraction only includes activity relating to patients registered at the reporting period end date (i.e. quarter-end/year-end). For example, an annual extraction would only include patients registered with the practice at the year end.

When extractions commence, GPES will provide to CQRS the quarterly counts from the relevant quarter they start in to the end of the relevant reporting quarter. If a practice has declared achievement (payment and management information) for the quarter on CQRS and the area team has approved it, no GPES-based automated extraction will be received as the payment and management information declaration in CQRS cannot be overwritten.

The document *Technical Requirements for 2014/15 GMS Contract Changes* [39] contains the payment counts, management information counts and Read2 and CTV3 codes[40] relevant for this service. The Read2 and CTV3 codes will be used as the basis for the GPES extraction, which will allow CQRS to calculate payment and support the management information extractions, when available. Although practices will be required to manually enter data until such time as GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting business rules will be acceptable to allow CQRS to calculate achievement and payment and for area teams to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting business rules will be published on the HSCIC website.[41] Practices and area teams should refer to these for the most up to date information on management information counts, Read2 and CTV3 codes.

Payment and validation

Area teams will seek to invite practices to participate in this ES before 30 April 2014. Practices wishing to participate will be required to sign up by no later than 30 June 2014.

[39] www.nhsemployers.org/GMS2014-15

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

[41] www.hscic.gov.uk/primary-care

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

CQRS will calculate the quarterly payment, based on the quarterly achievement data either via manually entered data or data extracted from GPES.

Payment should be made by the last day of the month following the month in which the practice and area team approve the payment. Where CQRS has not been provided with data (i.e. the practice has not enabled the extraction or the extraction is not supported by their system supplier) the data will need to be entered onto CQRS manually.

After CQRS has calculated the practice's final achievement payment, the practice should review 'the payment value' and declare the 'achievement declaration'. The 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.

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

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

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

The information extracted on numbers of patients receiving or being offered health action plans will not be used for payment purposes. It will be available through CQRS, as and when GPES is available to extract the information, to support practices and NHS England to validate requirements of the enhanced service, as necessary, to demonstrate that the full protocol was followed.

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

Other provisions relating to this enhanced service

This guidance should be read in conjunction with the *General Medical Services Statement of Financial Entitlements Directions 2014* and *The Primary Medical Services (Directed Enhanced Services) Directions 2014*, which contains full details for provisions relating to practices that terminate or withdraw from the ES prior to 31 March 2015, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits.

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

Facilitating timely diagnosis and support for people with dementia

Background and purpose

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

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

Introduction

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

A system-wide integrated approach is needed to enable patients with dementia and their families to receive timely diagnosis and to access appropriate treatment, care and support. National tools and levers 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 produced by the Royal

College of General Practitioners[42] (RCGP)

- the Royal College of Psychiatrists' Memory Services National Accreditation Programme.[43]

This ES 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.

The specification and guidance for the 2014/15 ES expands on the 2013/14 guidance in that it now requires contractors to provide a more comprehensive care plan for patients diagnosed as having dementia and increase support provided to carers.

Service requirements

This ES is for one year from 1 April 2014.

Area teams will seek to invite practices to participate in this enhanced service before 30 April 2014. Practices wishing to participate will be required to sign up by no later than 30 June 2014.

The requirements for this ES are:

A. The practice undertakes to make an opportunistic offer of assessment for dementia to 'at-risk' patients on the practices registered list, where the attending practitioner considers it clinically appropriate to make such an offer. Where an offer of assessment has been agreed by a patient then the practice is to provide that assessment. For the purpose of this ES, an opportunistic offer means an offer made during a routine consultation with a patient identified as 'at risk' and where there is clinical evidence to support making such an offer. Once an offer has been made, there is no requirement to make a further offer during any future attendance, but it is expected that attending practitioners will use their clinical judgement for any concerns raised by the patient or their carer.

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

    - patients aged 60 and over with cardiovascular disease, stroke, peripheral vascular disease or diabetes

[42] RCGP. Dementia. www.rcgp.org.uk/clinical-and-research/clinical-resources/dementia.aspx

[43] www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/memoryservices/memoryservicesaccreditation.aspx

- patients aged 40 and over with Down's syndrome
- other patients aged 50 and over with learning disabilities
- patients with long-term neurological conditions which have a known neurodegenerative element, for example Parkinson's disease.

These assessments will be in addition to other opportunistic investigations carried out by practices for whom the attending practitioner considers to have a need for such investigations (i.e. anyone presenting raising a memory concern).

C. The assessment for dementia offered to at-risk patients shall be undertaken only following the establishment of patient consent to an enquiry about their memory.

D. The assessment for dementia offered to consenting at-risk patients shall be undertaken following initial questioning (through appropriate means) to establish whether there are any concerns about the attending patient's memory (GP, family member, the person themselves).

E. The assessment for dementia offered to consenting at-risk patients for whom there is concern about memory (as prompted from initial questioning) shall comprise administering a more specific test (where clinically appropriate[44]) to detect if the patient's cognitive and mental state is symptomatic of any signs of dementia, for example the General Practitioner assessment of Cognition (GPCOG) or other standardised instrument validated in primary care.

F. The 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.

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 an advanced care planning

[44] 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 www.rcpsych.ac.uk/files/pdfversion/cr155.pdf

discussion focusing on their physical, mental health and social needs and including, where appropriate, referral/signposting to local support services.

I. The care plan should, where possible and through encouragement from the attending practitioner, include a recording of the patient's wishes for the future. It should identify the carer(s) and give appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family. For the purpose of this service, 'carer' will apply to a person – usually a family member, friend or acquaintance who takes responsibility for the patient's care needs but will not include professional carers who have been employed for this purpose by the patient or their representative.

J. The care plan should be shared with the patient and their carer(s), being reviewed on an appropriate basis.

K. The practice will seek to identify any carer (as defined above) of a person diagnosed with dementia and where that carer is registered with the practice offer a health check to address any physical and mental health impacts, including signposting to any other relevant services to support their health and well-being.

L. Where the carer of a patient, on a practice's register, who is diagnosed with dementia is registered with another practice, the patient's practice will inform the patient's carer that they can seek advice from their own practice.

M. The practice should record in the patient record relevant entries including the required Read2or CTV3 codes to identify where an assessment for dementia was undertaken, where applicable, that a referral was made and patients diagnosed, as well as whether or not an advance care planning discussion was given or declined. The practice should record in the carer record relevant entries including the required Read2or CTV3 codes.

Monitoring/GPES extraction

There are two payment counts and 16 management information counts for the service. The two payment counts are an upfront payment and an annual end year payment. The upfront payment is not supported by CQRS. The end year payment reflects the number of completed assessments carried out per practice up to the end of the financial year as a proportion of the total number of assessments carried out nationally.

Practices will be required to manually input data into CQRS, on a quarterly basis, until such time as GPES[45] is available to conduct electronic data extractions. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts.

For information on how to manually enter data into CQRS, please see the HSCIC website.[46]

When GPES is available, each extraction will capture data for all 17 counts and report on activities from the start of the reporting period e.g. 1 April 2014 to the end of the relevant reporting quarter. The reporting quarter will be the quarter prior to the month in which the extraction is run e.g. if the extraction month is January 2015, the reporting quarter will be quarter three (October to December 2014). Counts will be cumulative for the year from the point the practice begins to deliver the service. It is important to note that, when GPES takes a data extraction for a given period, the extraction only includes activity relating to patients registered at the reporting period end date (i.e. quarter-end/year-end). For example, an annual extraction would only include patients registered with the practice at the year end.

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

The document *Technical Requirements for 2014/15 GMS Contract Changes*[47] contains the payment counts, management information counts and Read2 and CTV3 codes[48] relevant for this service. These codes will be used as the basis for the GPES extraction, which will allow CQRS to calculate payment and support the management information extractions, when available. Although practices will be required to manually enter data until such time as GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting business rules will be acceptable to allow CQRS to calculate achievement and payment and for area

[45] Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.
[46] http://systems.hscic.gov.uk/cqrs/participation
[47] www.nhsemployers.org/GMS2014-15
[48] Please note that the code descriptions in clinical systems may not exactly match the guidance text.

teams to audit payment and service delivery. Practices will need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting business rules will be published on the HSCIC website.[49] Practices and Area Teams should refer to these for the most up to date information on management information counts, Read2 and CTV3 codes.

Payment and validation

Area teams will seek to invite practices to participate in this ES from 1 April 2014. Practices wishing to participate will be required to sign up by no later than 30 June 2014.

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

Component 1

An upfront payment of £0.37 per registered patient. This represents a payment of £2622.19 to an average-sized practice (where average size is based on a registered population of 7087).

Payment will be made to practices by area teams on the last day of the month following the month during which the practice agreed to participate in the ES (i.e. by no later than 31 July 2014).

CQRS and GPES will not support payment of component 1 of this service. Area teams 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 (using the relevant codes relating to 'assessment for dementia') carried out by practices during the financial year as a proportion of the total number of assessments carried out nationally under this ES.

The number of assessments carried out by 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 Read2 or CTV3 codes 'assessment for dementia'.

[49] www.hscic.gov.uk/primary-care

Example of component 2 payment calculation:

If GPES reports Practice A as completing 192 assessments for dementia during 2014/15 and nationally CQRS calculates that 1,197,408 assessments were carried out in 2014/15, then the end year payment is calculated as follows:

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

CQRS will be populated with data extracted via GPES (or via manual entry if GPES is not available). The practice and area team will then have until a specified date (to be communicated in due course) to review and amend the data accordingly, with the aim of agreeing it is correct before the specified date. At the specified date, CQRS will then calculate payments, based on the data entered.

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

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

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

Area teams are responsible for post payment verification. This may include auditing claims of practices to verify:

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

Area teams 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.

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

The information extracted on patients offered advanced care planning sessions and patients who are carers offered health checks will not be used for payment purposes. It will be available through CQRS, as and when GPES is available to extract the information, to support practices and area teams to validate requirements of the enhanced service, as necessary and to demonstrate that the full protocol was followed.

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

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 2015, 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.[50]

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the first few paragraphs of the Annex to the service specification,[51] *Facilitating timely diagnosis and support for people with dementia*.

[50] http://www.england.nhs.uk/resources/d-com/gp-contract/
[51] http://www.england.nhs.uk/resources/d-com/gp-contract/

Patient participation

Background

The NHS Constitution states: "*The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve services*."[52]

GPC supports this approach:

"Patients have a key role to play as partners in both supporting the development of general practice and in ensuring the sustainability of the NHS as a whole. An enabler to achieve this includes strengthening patients' input to the organisation and delivery of their general practice services through the development of practice-based patient participation groups."[53]

Participation activity should always take into account barriers such as language, age, disability, access to information; great participation reaches people who find it difficult to get their views heard, it doesn't just speak to those who are already engaged and informed. Patients' input must be sought and valued regardless of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

This document provides practices and area teams with information to support the patient participation ES and to ensure services are more efficient and more responsive to the needs of people who use them. The service has been commissioned for a further year effective from 1 April 2014 until 31 March 2015. The ES applies to England only.

The ES guidance has developed in two significant ways from the 2013/2014 version.[54] There is no longer any payment weighting for the development of a patient participation group (PPG) as this is now a prerequisite and there is no longer a requirement to carry out a local patient survey, though collecting feedback is still required to inform the development of the action plan. Since 2013/14 the scope of the ES has been revised and the funding set at a maximum of £20m with the remaining

[52] www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf, NHS Constitution p3/4

[53] Developing General Practice today: Providing healthcare solutions for the future, British Medical Association General Practitioners Committee, p10

[54] Components 2, 3 and 4 from the 2013/14 version have been subsumed into Component 2 in 2014/15.

£40m of funding to be reinvested in global sum to fund the workload and costs associated with the introduction of the friends and family test (FFT).

The guidance should be read in conjunction with the Primary Medical Services (Directed Enhanced Services) (England) Directions 2014 (the DES Directions)[55] and the Statement of Financial Entitlements (SFE).[56]

Purpose

The purpose of the patient participation ES is to ensure that patients and carers are involved in decisions about the range, shape and quality of services provided by their practice. The ES aims to promote the proactive and innovative engagement of patients and carers through the use of effective PPGs and to act on a range of sources of patient and carer feedback such as:

- the GP patient survey
- reviewing complaints and suggestions, for example in a practice post box or on online forums, or any other existing practice survey
- local voluntary or community groups or existing groups attached to the practice
- Healthwatch
- practice champions and peer support groups
- other local surveys arranged by CCGs or Commissioning Support Units (CSU)
- CQC reports
- the FFT (when available).

Progress against the resulting action plan should be reported back and agreed with the PPG and publicised to the practice population on the practice website, in the practice and by any other reasonable means.

The ES aims to build on the existing arrangements by:

- promoting innovative forms of patient participation
- ensuring participation is representative – particularly in seldom heard groups, including patients with mental health conditions who may be underrepresented
- improving the focus on outcomes of patient participation as opposed to processes.

[55] www.nhsemployers.org/GMS2014-15
[56] www.nhsemployers.org/GMS2014-15

It is intended that the ES should promote innovative forms of patient participation to provide accurate feedback from all groups, and allow a better understanding of patients and carer needs for example:

- innovative forms of communication and insight between the practice and patients to co-design services that meet the needs of their practice population
- improving communication channels with people whose practices may otherwise not get the opportunity to engage, particularly vulnerable patients
- developing patient champions who work with practices to support particular issues, or particular groups such as patients with mental health conditions
- supporting patients so that they are able to manage and make decisions about their own care
- holding annual events with practice population to showcase progress achieved/future plan
- providing opportunities for patients to find out more about how the practice and the wider health economy works.

Implementing the patient participation ES under the ES Directions

Requirements

There are a number of key requirements to this ES:

- develop/maintain a PPG that gains the views of patients and carers and enables the practice to obtain feedback from the practice population. This is a prerequisite of participation in the ES
- PPG and practice staff to review patient feedback received by the practice from sources such as those listed at paragraph 5. Feedback should be reviewed at a frequency agreed with the PPG
- practice and PPG should develop and agree an action plan (based on three key priority areas) and agree how the practice will implement improvements
- practice should publicise actions taken to practice population including providing the PPG with updates on progress and assessment of subsequent achievement within the timescales agreed. The practice and PPG will have to complete a reporting template to report actions taken during the year, involvement of the PPG and the outputs which have been achieved, i.e. how have patients and carers benefited from improvements. The reporting template should be posted on the

practice website and displayed in the practice along with any other steps taken to publicise improvements to the practice population, including to seldom heard groups.

Develop a PPG

Where a practice is engaging in this ES for the first time in 2014/15, then the practice must develop a properly constituted representative PPG that both reflects and gains the views of its registered patients and enables the practice to obtain feedback from a cross section of the practice population which is as representative as possible. Practices that have previously taken part in this ES will not need to recreate a new structure (or PPG), but should review whether the group remains representative of the practice population.

Traditionally, practices have developed a PPG through volunteers and regular meetings. Some practices have developed a virtual PPG, an email community they consult on a regular basis but which does not have regular face-to-face meetings. The practice should develop its PPG in the most appropriate way to effectively reach the broadest cross section of its patient population. This may be a virtual or a face-to-face group or a combination of the two. See links to guidance at Annex B.

Whichever approach is adopted by the practice, there should be a structure or process in place to enable regular engagement with a representative sample of the practice population. Many localities have incredibly diverse patient populations and all have patients of different ages and with a wide variety of health and social care needs. Practices participating in this ES should strive to obtain feedback from a cross section of the practice population. Practices should be able to outline the steps they have taken to do this and demonstrate they have made an effort to engage with any underrepresented and seldom heard groups, including patients with mental health conditions or groups with protected characteristics as identified in the Equality Act 2010.[57] See links to guidance on engaging seldom heard groups at Annex B.

To do this, the practice needs to have an understanding of its practice profile. This understanding should take into account more than just age and sex i.e. this could include factors such as levels of unemployment in the area, number of carers, black

[57] Age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

and minority ethnic groups, or a large local LGBT community. Local Healthwatch[58] and voluntary organisations may be able to support practices to engage with marginalised or vulnerable groups, such as older frail people or patients with learning disabilities. It may be useful to access the Joint Strategic Needs Assessment, available from the Local Authority or CCG which will contain information on the make-up of the local population.

There are steps that practices can take to ensure patient groups are as representative as possible.

All practices will have a significant number of registered patients who are children. It will be up to the practice to determine how best to seek their views. While there is no requirement for under-16s to be part of the PPG, practices may involve them, subject to parental consent, and may wish to consider other ways in which children can be involved.

The starting point is to use the age and sex make up of their registered population. Practices should be recording ethnicity routinely in order to be able to demonstrate that they meet the health needs of their registered population. It is important that the ethnic make-up of the practice is reflected in the representative group as much as possible. The practice team will also have local knowledge of specific care groups that the practice caters for, for instance it may look after a number of nursing homes, or a learning disabled community, or it may have a high number of drug users. The practice should try to ensure that such specific care groups are reflected in the PPG wherever possible. Practices should set up a PPG of a reasonable size which is representative of the practice population.

Where a practice has been unable to encourage patient participation by a certain patient group or groups, it must demonstrate what steps have been taken to try and engage that group. The practice and PPG may find it useful to reach out to a particular group of people by doing a focused piece of work to engage them, or linking with local community or voluntary sector groups. The venue and time of the PPG meeting could be changed or running a drop in session could be considered. Working with local community and voluntary sector groups will be helpful in making links with under-represented groups.

The practice must clearly demonstrate that it has established a PPG comprising only

[58] Local Government Association. Local and National Healthwatch. www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3511523/ARTICLE-TEMPLATE

registered patients and used its best endeavours to ensure that the PPG is representative of its registered patient population.

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

Practices should particularly ensure that they comply with the Equality Act 2010[59] when developing a PPG. Information on compliance can be found on the Equality and Human Rights Commission website,[60] in the Government Equalities Office guide[61] and on the Advisory, Conciliation and Arbitration Service (ACAS) website.[62]

To engage patients, practices may find it useful to learn from the work the National Association of Patient Participation (N.A.P.P.) has done in developing PPGs. Best practice case studies and other resources can be found on the NAPP website.[63] There is also a recent study available to registered practice managers on the Practice Management Network website.[64] NHS England has also recently published some bite-sized guides on participation.[65]

PPG and practice staff to review patient feedback received by the practice and agree on changes to services

Practices should aim to have continual/regular dialogue around improvement with their PPG and wider registered population, and should reflect on existing and new sources of feedback such as those listed at paragraph five at the beginning of this

[59] Equality Act 2010. www.legislation.gov.uk/ukpga/2010/15/contents

[60] Equality and Human Rights Commission. http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/

[61] Government Equalities Office guide. http:/www.equalities.gov.uk/staimm6geo/pdf/401727_Geo_EqualityLaw_PublicSector_acc.pdf

[62] ACAS. www.acas.org.uk

[63] NAPP. www.napp.org.uk/des2.html

[64] Practice Management Network. http:/www.practicemanagement.org.uk/Community-Voices-ReportandGuide

[65] NHS England, Public Voice team, http://www.england.nhs.uk/2014/03/13/pat-pub-participation/

section. The practice should agree with the PPG how regularly that feedback is reviewed.

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

- patients and carer priorities and issues
- practice priorities and issues including themes from complaints
- planned practice changes
- CQC related issues
- National GP patient survey issues.[66]

Key priorities

Based on the variety of sources of feedback such as the input of patient champions, regular feedback events, the GP patient survey, practice complaints/suggestions and, when available, the results of the FFT, practices should agree at least three clear priorities for improvement with the PPG.

Practices and PPGs should agree an action plan for the priority areas, how the practice will report back how these priorities have been met and how they have achieved improvements for the quality of outcomes for patients. Areas of improvement could be around any areas of quality that are important to patients and carers. This could include what services are offered, how services are accessed and delivered or how the practice engages with patients and carers and the wider community. The action plan could include ways in which the PPG will contribute towards the improvements e.g. the creation of practice champions.

If the practice plans any significant change in a service or services provided, or the way in which services are delivered, the practice must, before it makes the change, seek the agreement of its PPG to any proposals it makes. Where a practice proposes any significant change to a service or services it provides to which the PPG agreement has not been obtained, the practice must obtain the agreement of NHS England (or other appropriate organisation where such functions may have been delegated) to its proposals. Significant change would include a change in opening hours. Changes which impact on contractual arrangements also need to be agreed with NHS England.

[66] www.gp-patient.co.uk/results/

Develop action plan and agree with PPG how the practice will implement changes

Following review of patient and carer feedback and identification of priorities, an action plan will be agreed with the PPG. The practice should then seek the agreement of the PPG in implementing the changes and where necessary inform NHS England (or other appropriate organisations where such functions may have been delegated). This could take place at the same meeting, at separate meetings via an email group or a combination of these or other methods. Practices should keep the PPG up to date with progress against the action plan.

Practices should consider sharing the action plan with and gathering views from any local groups including Healthwatch.

Monitoring

Practices should publicise actions taken and provide the PPG with updates, report actions taken during the year, involvement of the PPG and the outputs which have been achieved.

Practices will be expected to make their practice population aware of the actions taken for the three priorities as they see fit. The practice can choose to do this through one or more of the following options: through their practice website, NHS Choices website, posters in waiting rooms and/or summary results sent to those who provided survey input (electronically or by post, as appropriate). Where there is an ongoing disagreement with the PPG on proposed actions, this must be publicly highlighted with the practice's rationale for deviating from the accepted plan.

Practices should report back to NHS England via the standard template (see Annex D). The report will include details on the make-up of the PPG against the practice population, the three priority areas identified, what actions were taken to address these priorities and the resulting changes made. It is expected that the report should be discussed and agreed with the PPG and confirmation that this has happened should be included in the report. The PPG should complete the relevant section of the reporting template. It is up to the practice and PPG to decide how PPG views are collated for the reporting template. However, there should be evidence that the PPG is content with the views expressed in the reporting template.

Practices should ensure that the following are made aware that the report is available, and where it can be viewed:

- the PPG

- those who answered any bespoke surveys issued by the practice
- the wider practice population
- the CCG
- local Healthwatch (which might facilitate effective working between the LH and the PPG)
- local voluntary and community groups
- CQC – at the time of inspections/registration.

Again, practices should consider how best to publicise the report via their website, posters and direct emails.

Payment and validation

Practices will receive an overall payment of £0.36 per registered patient based on its achievement of the various components as follows:

ES Component	Weighting of payment
Develop a PPG	Prerequisite of ES
PPG and practice to review patient feedback received by the practice (from a variety of sources such as those listed at point 5) at a frequency agreed with the PPG and reach agreement on priority areas	30%
Practice and PPG to develop action plan for implementing changes based on at least three key priority areas.	30%
Practice to implement improvements and publicise actions taken to practice population including providing the PPG with updates on progress and assessment of subsequent achievement within the timescales agreed. Practice and PPG to complete the reporting template to report actions taken during the year, involvement of the PPG and the outputs which have been achieved. Practices to post reporting templates on website by 31 March 2015.	40%

Payment will be made to the practice by NHS England (or other appropriate organisation where such functions may have been delegated) and will be based on the content of the report submitted to NHS England.

The report must have been submitted by no later than 31 March 2015 using the form in Annex D. No payments will be made to a practice under the terms of this ES if the

report is not submitted by 31 March 2015.

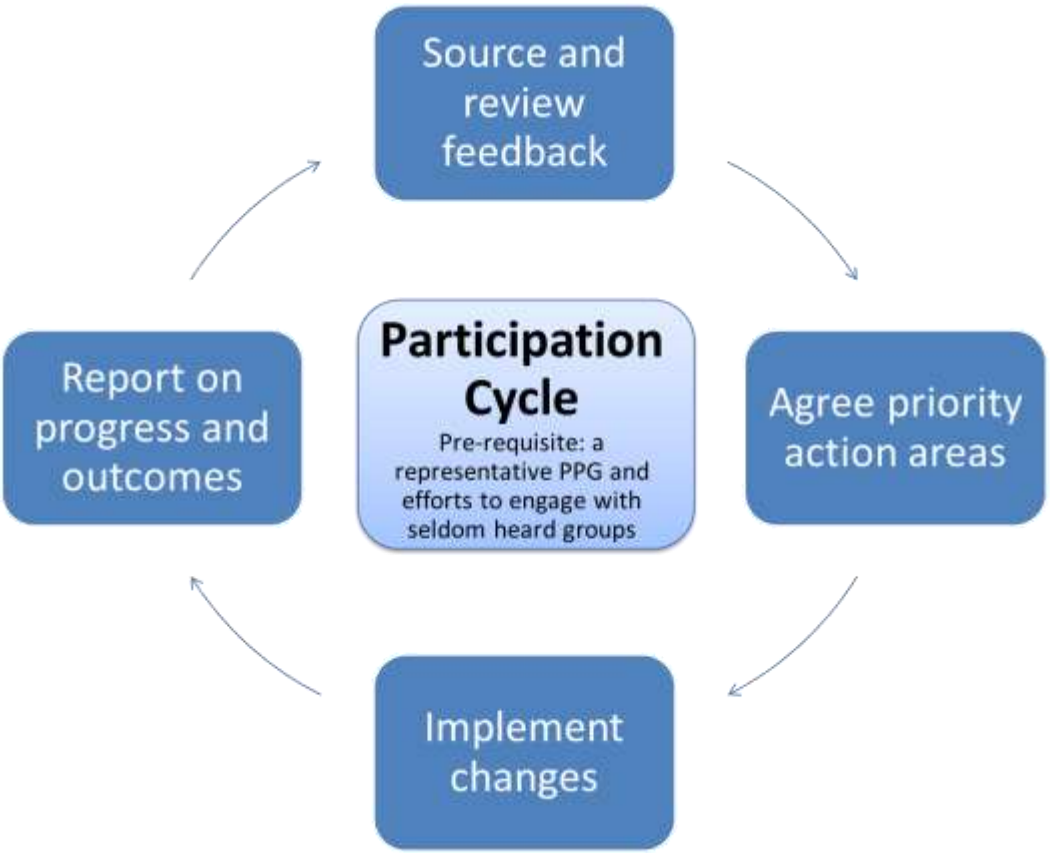
Submission by or before the 31 March 2015 is the responsibility of the practice.

Payment will be based on the evidence provided in the practice report that each successive component has been achieved.

Should a practice not complete any component by the 31 March 2015 deadline date for submitting the practice report, it will not receive the payment due for that component. Payment for the achievement of a component is dependent on the previous components having been successfully completed.

The patient participation ES was introduced in 2011/12. Where a practice has participated previously, the subsequent year reports should build upon the previous year's report, demonstrating how progress has been made on issues raised in the previous year(s).

Annex A: Principles of participation



Annex B: Guidance and links for patient participation

Transforming Participation in Health and Care, NHS England:
www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

National Association for Patient Participation: www.napp.org.uk/

NHS Networks Smart Guides: www.networks.nhs.uk/nhs-networks/smart-guides

NHS England, bite-sized guides to participation:
http://www.england.nhs.uk/2014/03/13/pat-pub-participation/

Healthwatch: www.healthwatch.co.uk/

NICE Publication, 'Community Engagement':
http://publications.nice.org.uk/community-engagement-ph9

NICE 'Patient Experience Guidance in Adult Services':
http://guidance.nice.org.uk/CG138

Pride and Practice (Lesbian and Gay Foundation): www.lgf.org.uk/prideinpractice

Centre for Mental Health: www.centreformentalhealth.org.uk/

MIND: www.mind.org.uk/

Engagement of mental health service users:
http://apt.rcpsych.org/content/11/3/168.full.pdf

NICE guidance on adult mental health:
www.nice.org.uk/nicemedia/live/13629/57534/57534.pdf

Community Health Champions, Altogether Better:
www.altogetherbetter.org.uk/community-health-champions

NHS England Accessible Information project:
www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

Annex C: Creating a PPG – getting started guide

Introduction

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

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

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

Content of the guide

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

Common patient questions and answers

Why are you asking patients for their contact details?
We would like to be able to contact patients and carers occasionally to ask them questions about the practice and how well we are doing to identify areas for improvement.

Will my doctor see this information?
This information is purely to contact patients to ask them questions about the practice, how well we are doing and ensure changes that are being made are patient focused. If your doctor is responsible for making some of the changes in the practice they might see general feedback from patients.

Will the questions you ask me be medical or personal?
We will only ask general questions about the practice, such as short questionnaires.

Who else will be able to access my contact details?
Your contact details will be kept safely and securely and will only be used for this purpose and will not be shared with anyone else.

How often will you contact me?
Not very often... [Insert how often you plan to contact patients]

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

Do I have to leave my contact details?
No, but if you change your mind, please let us know.

What if I no longer wish to be on the contact list or if I leave the practice?
We will ask you to let us know by email if you do not wish to receive further messages.

Sample contact form

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

Name:
Email address:
Postcode:

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

Are you? Male☐ Female☐

Age: Group	Under 16	☐	17–24	☐
	25–34	☐	35–44	☐
	45–54	☐	55–64	☐
	65–74	☐	75–84	☐
	Over 84	☐		

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

White									
British group	☐	Irish	☐	Gypsy or Irish traveller	☐	Other white	☐		
Mixed									
White &black Caribbean	☐	White &black African	☐	White & Asian	☐	Other mixed	☐		
Asian or Asian British									
Indian	☐	Pakistani	☐	Bangladeshi	☐	Chinese	☐	Other Asian	☐
Black or black British									
Caribbean	☐	African	☐	Other black	☐				
Other ethnic group									
Arab	☐	Any other	☐		☐				

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

Regularly	☐
Occasionally	☐
Very rarely	☐

Thank you.

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

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

Developing a survey

Practices are no longer required to carry out a local survey as part of this ES, but if you wish to do so there are a number of online survey tools available which are simple to use and have clear instructions on how to set up a survey. Once you have finalised your survey questions it takes just minutes to set up the survey online. Some free survey tools are set out below:

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

Script for patient group members

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

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

Are you interested in giving your views?

Please provide your contact details on this form; we will only use information to

contact you and will keep your details safely.

Script for staff in practices with a PPG

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

Are you interested in leaving your email contact details?

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

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

Suggested wording for an LED display

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

This information could also be added to prescriptions.

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

Suggested leaflet content

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

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

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

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

Suggested poster content

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

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

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

Contact forms are available in the waiting area.

Annex D: Standard Reporting Template

[Name] Area Team

2014/15 Patient Participation Enhanced Service – Reporting Template

Practice Name:

Practice Code:

Signed on behalf of practice: Date:

Signed on behalf of PPG: Date:

1. Prerequisite of Enhanced Service – Develop/Maintain a Patient Participation Group (PPG)

Does the Practice have a PPG? YES / NO
Method of engagement with PPG: Face to face, Email, Other (please specify)
Number of members of PPG:

Detail the gender mix of practice population and PPG:

%	Male	Female
Practice		
PPG		

Detail of age mix of practice population and PPG:

%	<16	17-24	25-34	35-44	45-54	55-64	65-74	> 75
Practice								
PPG								

Detail the ethnic background of your practice population and PPG:

	White				Mixed/ multiple ethnic groups			
	British	Irish	Gypsy or Irish traveller	Other white	White &black Caribbean	White &black African	White &Asian	Other mixed
Practice								
PPG								

	Asian/Asian British					Black/African/Caribbean/Black British			Other	
	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	African	Caribbean	Other Black	Arab	Any other
Practice										
PPG										

Describe steps taken to ensure that the PPG is representative of the practice population in terms of gender, age and ethnic background and other members of the practice population:
Are there any specific characteristics of your practice population which means that other groups should be included in the PPG? e.g. a large student population, significant number of jobseekers, large numbers of nursing homes, or a LGBT community? YES/NO If you have answered yes, please outline measures taken to include those specific groups and whether those measures were successful:

2. Review of patient feedback

Outline the sources of feedback that were reviewed during the year:

How frequently were these reviewed with the PPG?

3. Action plan priority areas and implementation

Priority area 1
Description of priority area:
What actions were taken to address the priority?
Result of actions and impact on patients and carers (including how publicised):

Priority area 2
Description of priority area:
What actions were taken to address the priority?
Result of actions and impact on patients and carers (including how publicised):

Priority area 3
Description of priority area:
What actions were taken to address the priority?
Result of actions and impact on patients and carers (including how publicised):

Progress on previous years

If you have participated in this scheme for more than one year, outline progress made on issues raised in the previous year(s):

Free text

4. PPG Sign Off

Report signed off by PPG: YES/NO Date of sign off:
How has the practice engaged with the PPG: How has the practice made efforts to engage with seldom heard groups in the practice population? Has the practice received patient and carer feedback from a variety of sources? Was the PPG involved in the agreement of priority areas and the resulting action plan? How has the service offered to patients and carers improved as a result of the implementation of the action plan? Do you have any other comments about the PPG or practice in relation to this area of work?

Extended hours access

Background

The NHS Outcomes Framework requires practices to provide routine appointments at weekends and/or evenings, to reflect patient needs. As part of the GMS contract changes for 2014/15 in England, the current extended hours access enhanced service (ES) will be re-commissioned for a year effective from 1 April 2014. This ES is underpinned by the 'Primary Medical Care Services (Directed Enhanced Services) (England) Directions 2014' (the 2014 DES Directions) and the 'Statement of Financial Entitlements' (SFE) 2014.

The 2013/14 ES has been revised to allow area teams and practices more flexibility in providing arrangements which reflect the needs of the practice population. Detailed below is the guidance for a revised extended hours access ES.

There are a number of developments from the 2013/14 ES. The timings of extended hours clinical sessions will continue to be closely linked to expressed patient preference. Practices will also have more flexibility in the way they provide these services. They can operate either solely or as a group, appointments can now be offered with all practice staff and there is an option to provide telephone consultations and use other methods of communication.

This guidance supersedes extended hours access directed enhanced service (DES) 2013/14 and any other or previous communications from the DH on this subject. No changes have been made to the payment of this scheme, which will remain the same as that applied for the period 1 April 2013 to 31 March 2014.

Purpose

The aim of this ES in 2014/15 is for practices to provide appointments at times outside of core contracted hours to allow patients to attend the practice at a time when it is more convenient for them.

Requirements

Requirements for practices under 2014/15 ES Directions.

The requirements for practices participating in this ES in 2014/15 are as follows:

The clinical sessions are provided outside of core contracted hours. For GMS practices, core hours are from 08:00 to 18:30 and for PMS it is the core hours as set out in their contract. For some PMS (and APMS) practices, core hours may already include opening at times outside this period.

Opening hours must be in line with patient expressed preferences, either through the GP patient survey or through preferences expressed through patient participation groups (PPGs), the friends and family test (FFT) or other feedback.

The amount of the extended hours access remains 30 minutes per 1,000 registered patients, using the following formula:

> additional minutes* = a practice's CRP** ÷ 1000 × 30
>
> *convert to hours and minutes and round, either up or down, to the nearest quarter hour
> **Contractor registered population (CRP) will be determined at the start of the first quarter during which extended opening begins for individual practices.

Further options

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

> For example, three practices currently each provide 3 x 1 extended hours sessions throughout the week with poor utilisation but stated patient preference for weekend opening, practice plans submitted propose instead 1 x 3 hour session on a Saturday morning at the practice convenient to most patients with each practice delivering the service on a rotational basis.
>
> Appointments can be offered with all practice staff not just those registered with appropriate professional bodies, i.e. health care assistants and may be provided in a manner which is line with patient expressed preferences i.e. face-to-face, telephone consultations, using other technology or a mixture of these methods.

The clinical sessions must be for continuous periods of at least 30 minutes.

Requirements for NHS England

NHS England must ensure that all practices have the opportunity to enter into an extended hours access scheme under this ES (or a scheme under local arrangements offering at least the minimum requirements of this ES). However, NHS England will not remunerate PMS (or APMS) practices under this 2014/15 ES for any period of extended access hours which is currently covered by the core hours set out in their contract.

Extended opening hours should be set according to the needs and wishes expressed by patients. NHS England and practices should therefore continue to take into account results from the latest GP patient survey and PPG views, including those resulting from participating in the patient participation ES when agreeing extended opening hours.

There is no set number of appointments that should be provided within any given period of time. However, on average, practices are likely to be able to offer no fewer than two appointments for every 30 minutes of extended opening.

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

Offer of extended hours access under this ES and time limits

NHS England must, by 30 April 2014 offer to all existing practices under their contractual arrangements the opportunity to enter into this ES under the 2014 ES Directions. Where reasonably practicable, NHS England must, after considering and agreeing to practices' proposals (see section on practice proposals) enter into these arrangements with practices no later than 1 July 2014.[67] NHS England is not required to enter into extended hours access arrangements under this ES after 30 June 2014, except in exceptional circumstances as set out below. However, NHS England retains the discretion to do so it if wishes.

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

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

- that the practice has not provided NHS England with its proposals to participate in this ES before 1 July 2014
- NHS England offered the practice the opportunity to participate in the ES but did so with less than 28 days to elapse before 30 June 2014
- the practice has provided NHS England with its written proposals to participate in the ES within 28 days of the NHS England offer.

If all of the above conditions are met, then NHS England must, after 30 June 2014, consider the practice's proposals. This will be with a view to agreeing them and entering into arrangements with the practice to deliver extended hours access under this ES.

Agreements under this ES are effective up to and including 31 March 2015.

Practice mergers

Where two or more practices merge, then NHS England must, within 28 days of the merger enter into a new arrangement with the newly formed practice if:

a. The practice continues to provide extended hours access following the merger that are broadly comparable with services required under the 2014 DES Directions; and

b. The practices proposals for extended hours access meets with the minimum requirements of the arrangements under the 2014 DES Directions.

Practice splits

Where a practice splits NHS England must within 28 days of the split enter into arrangements with the newly formed practice(s) if:

a. The practice(s) continue(s) to provide extended hours access following the split that is/are broadly comparable with services required under the 2014 DES Directions; and

b. The practice(s) proposals for extended hours access meets with the minimum requirements of the arrangements under the 2014 DES Directions.

NHS England consideration of practice proposals

NHS England is obliged to consider any proposals for the arrangements of extended hours access put forward by a practice in accordance with the time limits and exceptions explained under the offer of extended hours access under this ES and time limits' section. This consideration should not be delayed unreasonably nor should NHS

England agreement to such proposals be unreasonably withheld. In making the decision, consideration should be given to local circumstances such as patient preferences and relevant guidance.

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

a. The practice has not submitted a written proposal within 28 days of the NHS England offer to enter into an arrangement under the 2014 DES Directions; or

b. The practice has not provided any information requested by NHS England in order to make a decision as to whether the proposal to enter into arrangements under the 2014 DES Directions meets its requirements.

Monitoring

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

Where a practice provides out of hours (OOH) services, it must not limit access to any of these clinical sessions to those patients it would have been obliged to see anyway under the OOH arrangements. In general, this should be a matter for the practice to manage and communicate to its patients.

The arrangements entered into under this ES must set out the requirements for a practice to provide to NHS England with information that is reasonably necessary for the running of the arrangements. In agreeing these requirements, both parties may wish to have regard to the principles in the Code of Practice on Confidentiality and Disclosure of Information.[68]

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

[68] DH. Code of Practice on Confidentiality and Disclosure of Information [archived].http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4088615

The arrangements entered into under the ES must set out the arrangements for changing or ending the agreed extending opening. This procedure should include an agreed notice period (e.g. two weeks) for significantly changing or ceasing extended opening.

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

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

The practice should maintain the agreed extended opening times by providing sickness and leave cover and should also ensure that its patients are aware of any cancellation of extended hours sessions, which should normally be discussed with NHS England.

Payment and validation

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

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

Payments will be made in quarterly instalments, payable on the last day of the quarter until 31 March 2015. Payments are only payable in respect of periods during which the service is provided. The following conditions are applicable to any payments:

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

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

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

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

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

NHS England should not remunerate PMS (or APMS) practices under the 2014 DES for any period of extended access hours which is currently covered by the core hours set out in their contract.

Other issues relevant to extended hours access

Non-NHS work

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

Safety and security

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

Religious and cultural sensibilities

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

Disputes – conciliation, arbitration and appeals

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

Commissioning other services

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

Discussions with Local Medical Committees (LMCs)

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

SECTION 6. QUERIES PROCESS

Queries can be divided into three main categories:

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

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

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

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

1. Queries relating to Business Rules/coding queries should be sent to the HSCIC via enquiries@hscic.gov.uk.Where required, the HSCIC will work with other key stakeholders to respond.
2. Policy, clinical and miscellaneous queries should be sent to:
   - NHS Employers for NHS England area teams via GMScontract@nhsemployers.org, QOF@nhsemployers.org
   - GPC for general practice via info.gpc@bma.org.uk

NHS Employers

www.nhsemployers.org

General Practitioners Committee

www.bma.org.uk/gpc

NHS England

www.england.nhs.uk